Georgetown Law Journal
December, 1989

***241** OBJECTIVE AND SUBJECTIVE STANDARDS OF NEGLIGENCE: DEFINING THE REASONABLE PERSON TO INDUCE OPTIMAL CARE AND OPTIMAL POPULATIONS OF INJURERS AND VICTIMS

Warren F. Schwartz [FNa]

I. INTRODUCTION

Although the question of whether negligence should be defined objectively or subjectively arises repeatedly and has often been debated, the issue has never been resolved. Until very recently, no effort has been made to provide a comprehensive theory to resolve either of the following issues: (1) when should an individual's conduct be judged by a standard requiring that she act in a way that is reasonable (optimal for the economically oriented), given her actual ability to take care, and when should it be judged by some objective standard [FN1] that is uniformly applicable to all persons without regard to each one's ability to take care, and (2) if an objective standard is to be applied, how should it be determined?

The discussion of these issues by courts and legal scholars manifests a tension. [FN2] On the one hand, there is concern that a person who is ill- equipped to take care to avoid injury to herself or others will cause too much harm if asked to behave only in a way that is "reasonable" for a person with her capacity to take care. At the same time, there is a reluctance to impose unreasonable requirements on people who, because of disabilities such as blindness or old age, are impaired in their ability to take care to avoid injury.

***242** In this article, I build on the work of Landes and Posner [FN3] and Shavell [FN4] and attempt to provide a coherent and comprehensive theory for reconciling these conflicting impulses. In doctrinal terms, the issue is to define the circumstances in which it is appropriate to apply either an objective or subjective standard of negligence. I demonstrate through the use of economic analysis that both standards attempt to achieve the same results: (1) inducing each person who engages in an activity to take what is optimal care for that person, and (2) minimizing the number of people who engage in an activity when, because of their inability to take sufficient care, they should not. I focus principally on the two means employed to achieve the second of these objectives. When we use a subjective standard to determine an individual's adequacy of care while engaging in an activity, we exclude from the activity those with too little ability to take care by explicitly determining whether, given her ability to take care, the particular individual should have engaged in the activity. When we use an objective standard to measure the adequacy of the care taken while engaging in the activity, people who are poorly equipped to take care exclude themselves from the activity because they view the applicable standard of care as excessively onerous. I show that we prefer each approach under different empirical conditions. Suprisingly, the courts' treatment of these issues is remarkably consistent with my analysis, despite the courts' apparent inability to articulate a coherent theory to justify their rulings.

I begin by introducing the economic analytic framework used in this article. I then formally define the problem and apply the economic analysis, starting with a number of assumptions that permit me to focus on the essentials of the problem and modifying the analysis as I relax successive assumptions. The analysis demonstrates that both an objective and a subjective standard serve the same end, differing only in the choice of means. Finally, I compare this conclusion with court opinions and legal commentary to determine whether the theoretical conclusions are consistent with actual practice.

II. THE ANALYTIC FRAMEWORK

Individuals vary in their ability to take care to avoid harming others and to avoid being harmed by the actions of others. A blind person, for example, cannot observe the relevant circumstances of her environment and must instead rely upon other senses, other people, trained animals, or mechanical devices. In the analysis that follows, I place the sighted person and the blind person on a common scale by reducing these varying methods to a standardized unit that is defined in terms of cost and

associated risk reduction. Thus, ***243** that the precautions blind and sighted persons actually employ are different does not enter the analysis.

The sighted person is better able to take care in the sense that she can achieve each reduction in the risk of harm at a lower cost than is possible for the blind person. Graphically, as depicted on Figure A, the marginal cost curve of taking care for the blind person is above that for the sighted person.

FIGURE A
TABULAR OR GRAPHIC MATERIAL SET FORTH AT THIS POINT IS NOT DISPLAYABLE
TABULAR OR GRAPHIC MATERIAL SET FORTH AT THIS POINT IS NOT DISPLAYABLE

The optimal level of care for a given person is the quantity that results when, at the margin, the cost of care is equated with the accompanying benefit in terms of a reduction in the risk of harm. This is the level of care that minimizes the sum of the costs of care and the expected value of harm. I assume that for all individuals the cost of care in the relevant region rises as more care is taken. Thus, as depicted on Figure A, it will be optimal for the person better able to take care (the person with cost curve C2) to take more care, because the upward sloping cost curve intersects the benefit curve at a later point (a point that lies to the right of the corresponding point for the less able caretaker).

Much of my analysis focuses on whether a given individual should engage ***244** in a particular activity. Although we want everyone who engages in an activity to act in a way that is optimal for her, certain people possess so little ability to take care that they should not engage in certain activities. [FN5] Throughout this article, "should engage in the activity" means that if the individual were to engage in the activity, taking what is for her optimal care, the sum of the costs of care and resulting harm would not exceed the benefits of engaging in the activity. "Benefits of engaging in the activity" means the value of engaging in the activity net of the costs of engaging in the activity, other than those incurred in avoiding harm. These costs consist of expenditures for capital inputs, such as an automobile, and the opportunity cost to the individual of spending time engaging in the particular activity. The term "minimal level of care" means the amount of care that will be optimal for the person least able to take care who should engage in the activity. [FN6] If, returning to the example of the sighted and the blind person, the blind person should not engage in a particular activity, the minimal level of care will exceed what is optimal care for the blind person.

To focus on the question of what standard should be applied, I will make certain simplifying assumptions throughout this article. These assumptions are: (1) everyone is perfectly informed about the governing legal rules; (2) the legal system makes no errors; and (3) the damages assessed are equal to the harm caused to the victims, so that victims are indifferent between not being harmed and being harmed but compensated. [FN7]

III. THE NATURE OF THE PROBLEM

This article explains the benefits of a uniformly applicable standard over one based on individual ability to take care and suggests a formulation for such a uniform standard. It begins by considering why we employ any standard as contrasted to a rule of strict liability or no liability. [FN8] The latter rules would place all costs on the injurer or victim, respectively, without regard to ***245** whether the injurer's conduct meets any standard. I thus consider three possible rules: (1) strict liability or, its equivalent for victims, no liability; (2) subjective negligence, which means that each individual is required to take what is for that person optimal care, given that person's actual ability to take care; and (3) a uniformly applicable standard of care that must be complied with irrespective of each individual's ability to take care. The uniformly applicable standard means that the risk of harm must be reduced to some specified level or, equivalently, that every person must provide a specified number of the standardized units of care without regard to her individual ability to take care. [FN9]

We must evaluate a liability rule in terms of the incentives it creates over the range of relevant decisions by injurers and victims and the magnitude of associated process costs for injurers, victims, and the legal system. It may also be important whether injurers or victims bear the costs of that harm which does occur. [FN10] Each of the three possible rules--strict liability, subjective negligence, and a uniformly applicable prescribed standard of care-- will systematically vary in these respects. Their valuation will depend upon the importance of various factors in the interaction between injurer or victim: (1) differences in the ability to take care among injurers and among victims; (2) whether the injurer or victim should have been engaging in the activity; (3) whether the injurer or victim's ability to take care could have been efficiently improved by earlier acts; (4) whether the injurer or victim's optimal level of care is materially affected by the other's optimal level of care; and (5) whether the benefits of engaging in the activity for either injurers or victims are difficult to determine and vary substantially

among victims or injurers.

I begin the analysis by considering a situation in which: (1) only the injurer's behavior in taking care to avoid harm is relevant; (2) injurer's ability to take care varies; and (3) some people should not be engaging in the activity by reason of their relatively poor ability to take care. Initially, I also assume that no prior acts could have efficiently improved the ability of any injurer to take care; the benefits of engaging in the activity are the same for all injurers and are known; and it is a matter of indifference whether injurers or victims bear the costs of the harm suffered by victims.

A. STRICT LIABILITY

The simplifying assumptions applied to this analysis make only two decisions relevant to achieving an optimal result: first, whether the injurer will ***246** engage in the activity, and second, whether the injurer will take what is for her optimal care. Under a rule of strict liability, [FN11] both of these decisions will be made correctly. There will be no need to promulgate or to apply a standard of care to the injurer's actions.

The injurer, if she engages in the activity, will take what is for her optimal care to minimize the sum of the cost of care and her expected liability. She will only engage in the activity if the benefits exceed the sum of the costs of what is for her optimal care and the costs of compensating victims.

B. A SUBJECTIVE STANDARD

Imposing any standard is thus unnecessary to achieve an optimal result under present assumptions. If, however, we desired (as would be the case if we relaxed various of these assumptions) to apply a standard to the injurer's behavior that yielded an optimal result, that standard would have to require that the injurer take what is for her optimal care if she engages in the activity. It would also require that she engage in the activity only if the benefits derived from engaging in the activity exceed the sum of the costs of taking what is for her optimal care and the harm caused when taking such care.

This standard is subjective because it requires the individual to take what is for her optimal care. Moreover, whether a person should engage in an activity depends upon her ability to take care, which in turn determines the sum of the costs of taking care and harm caused while engaging in the activity.

A rule that only requires the injurer to take what is for her optimal care while engaging in the activity cannot achieve the optimal result. Under such a rule, some injurers who should not engage in the activity will nevertheless do so. This class consists of all injurers for whom the benefits of engaging in the activity exceed the costs of taking what is for them optimal care but do not exceed the sum of the costs of optimal care and the harm to victims. By taking what is for them optimal care, such injurers can avoid bearing the costs of the harm they cause victims. Injurers will, consequently, ignore those costs in deciding whether to engage in the activity.

C. A PRESCRIBED STANDARD

A prescribed standard of care can reduce the process costs associated with a rule of subjective negligence in two ways. First, applying a single standard avoids the costs of ascertaining what is optimal care for a particular individual. Second, imposing a single standard can exclude from the activity some ***247** people who should not engage in the activity, without requiring the legal system to determine whether they should engage in the activity.

1. Choosing an Optimal Single Standard

Economic analysis of a single standard primarily emphasizes the first of the functions identified above--reducing process costs by avoiding the necessity of determining what is optimal care for each individual. [FN12] When, however, scholars have analyzed the consequences associated with a single standard, the second function--deterring people who should not engage in the activity from doing so--has emerged as an inevitable byproduct. I complete this evolution by urging that what has been viewed as merely a by-product of the process of economizing on information costs is really the principal, or at the least an equally important, function of an objective standard.

2. Economizing on Information Costs

Landes and Posner most systematically analyze an objective standard from the perspective of economizing information costs. [FN13] They begin by asserting, consistent with the position taken in this article, that " i f the costs to the courts of informing themselves about an individual's ability to avoid accidents were zero, they would set a different due care level for each individual in every accident case." [FN14] At this point, Landes and Posner apparently assume away the possibility that an individual should not engage in the activity.

In their view, a prescribed standard is designed to reduce the process costs associated with determining optimal care for each individual. However, this savings requires a departure from the theoretically correct liability rule. Landes and Posner recognize that this departure entails costs in the form of inducing suboptimal behavior [FN15] for two groups of injurers: (1) those whose optimal level of care exceeds the prescribed level but who will meet only that level of care because they can avoid all liability by doing so, [FN16] and (2) those whose optimal level of care is below the prescribed level but who will find it ***248** worthwhile to meet that level to avoid all liability. [FN17]

FIGURE B
TABULAR OR GRAPHIC MATERIAL SET FORTH AT THIS POINT IS NOT DISPLAYABLE
TABULAR OR GRAPHIC MATERIAL SET FORTH AT THIS POINT IS NOT DISPLAYABLE

Figure B depicts the Landes and Posner analysis. [FN18] They assume that the ability to take care is normally distributed and that the prescribed level is the ***249** mean of the distribution. Those whose level of care is equal to the prescribed level conform to the standard and behave optimally. Those in Area II find it worthwhile to meet the standard and to take what is for them excessive care to avoid all liability. The group in Area III, whose level is above the standard, conform to the standard by taking what is for them too little care, and also avoid all liability. [FN19] The people in Area I do not find it worthwhile to conform to the standard and, if they engage in the activity, take what is for them optimal care.

Landes and Posner do not specify a theory for choosing the optimal level of care to be embodied in the single standard. They choose, for illustrative purposes (as depicted on Figure B), a standard that represents average care for a population they characterize as "a group of potential injurers." [FN20] They do not, nor could they, claim that this is an optimal standard. This is because, presumably, everyone is a "potential injurer," and the population so defined would include people very poorly equipped to engage in the activity. Average care for this group might be very low and might result in large allocative losses from people in Area III who take too little care. [FN21] More fundamentally, why should average care for any population constitute an optimal standard? Landes and Posner claim that their analysis explains why courts use a single standard, [FN22] but they do not assert that the average care standard they consider is the one that courts employ.

Although Landes and Posner do not formulate a theory for devising an optimal standard, their discussion does include important elements for such a theory. An important element that Landes and Posner identify is maximizing the benefit of saving information costs. Such savings must be net of the costs resulting from people in Area III, who take too little care, and people in Area II, who take too much care. Thus, if all single standards realized the same savings in information costs, courts would choose the standard that minimizes the costs resulting from suboptimal behavior.

There is, however, another element that must be considered in the choice of an optimal standard. Landes and Posner correctly analyze the behavioral consequences of imposing a single standard on the people in Area I, who do not find it worthwhile to meet the standard and consequently, if they engage in the activity, take what is for them optimal care. They do not, however, explore the implications of these consequences for a theory governing the choice of an optimal single standard. Landes and Posner correctly point out ***250** that people in Area I act as if the rule were strict liability; because it is too costly for them to meet the standard, they will take what is for them optimal care and thus be liable if they engage in the activity. However, not all of the people in Area I confronted with the equivalent of a rule of strict liability will choose to engage in the activity. Those for whom the benefits of engaging in the activity are exceeded by the sum of the costs of taking what is for them optimal care and the costs of harm will refrain from engaging in the activity.

Consequently, the people in Area I are of two kinds: those who should engage in the activity and those who should not. Under what is functionally a rule of strict liability, those who should engage in the activity do, and those who should not engage in the activity refrain from doing so.

Landes and Posner thus recognize that the single standard will deter some people who should not engage in the activity from doing so. However, they fail to appreciate that this constitutes a benefit unique to the single standard. This benefit is wholly independent of the savings in the process costs upon which they focus. Even if it were costless to ascertain each individual's

ability to take care, a rule of subjective negligence would be more costly to apply than a single standard because, under a subjective standard, it would also be necessary for the legal system to determine if the individual should have engaged in the activity. This issue can, to a material extent, be avoided under a single standard. Thus, a single standard is preferable to a rule of subjective negligence because, unlike a rule of subjective negligence, it creates self-enforcing incentives for optimal behavior in deciding whether to engage in the activity.

3. Creating Self-Enforcing Incentives to Deter Individuals Who Should Not Engage in the Activity

A theory of an optimal single standard must, then, seek to maximize the benefit of self-enforcing incentives to deter individuals who should not engage in an activity from doing so. This issue, which is not addressed by Landes and Posner, is considered by Steven Shavell. Figure C is a graphic depiction of Shavell's analysis. [FN23]

Shavell uses the standardized unit of care to capture the effects of individual variations in the ability to take care on whether a specific individual should engage in the activity. The vertical axis is the level of care taken and the horizontal axis the per unit cost of care. The lower the per unit cost of care, the more care is optimal. Consequently, the line running from the upper left to the lower right depicts the optimal levels of care of individuals with decreasing capacities to take care. The upper left thus represents the individual best able to take care, who should take the most care, and the lower right represents the person least able to take care, who should, consequently, ***251** take the least care. Optimal levels of care for all individuals between these extremes are depicted as points arrayed on the diagonal line.

FIGURE C
TABULAR OR GRAPHIC MATERIAL SET FORTH AT THIS POINT IS NOT DISPLAYABLE
TABULAR OR GRAPHIC MATERIAL SET FORTH AT THIS POINT IS NOT DISPLAYABLE

Those whose optimal levels of care fall between a and k are those who should engage in the activity in question. That is, if they engage in the activity and take what is for them optimal care, the benefits will exceed the sum of the costs of taking care and the costs of the harm they impose on others. By contrast, the people in the region k to b should not engage in the activity because the sum of the harm they will impose and the cost of taking what is for them optimal care will exceed the benefits.

The level of care at k represents what I have defined above as the minimal level of care: the optimal care required for the person with the minimum ability to take care who should engage in the activity to engage efficiently in the activity. Accordingly, the population that should engage in the activity consists of all those persons who have at least this ability to take care.

Shavell, however, does not set the optimal single standard at the minimal level of care. If the standard were set at this level, some people who should not engage in the activity would nevertheless do so because they would find it worthwhile to take what is for them excessive care to meet the standard and ***252** avoid all liability. [FN24] Raising the standard from the minimal level of care counteracts this effect, but at a cost. Some people who should engage in the activity, but whose level of care is below the prescribed standard, will be obliged to take too much care. The optimal standard is set to minimize the sum of these two costs. Figure C depicts this as "due care," or the standard of care prescribed by the governing rule.

In this analysis, the benefit derived from imposing the single standard is the exclusion of the people from k2 to b from the activity. This class consists of those who should not engage in the activity, because the sum of the costs of what is for them optimal care and the harm they cause even though they take such care exceeds the benefits of engaging in the activity. The allocative cost of employing the single standard is the excessive care taken by the people in the k-k2 region, who should not engage in the activity but who are nonetheless induced to meet the standard, and the excessive care taken by people in the k1-k region, who should engage in the activity and who are obliged to meet a standard that exceeds what is for them optimal care.

Shavell assumes away one issue identified by Landes and Posner: the effect of the standard on those whose optimal level of care exceeds the standard (Area III on Figure B). He does this by specifying that each person in this group will be required to take what is optimal care for that person. That is, Shavell would impose a rule of subjective negligence for this group. Presumably, Shavell does this because his focus is on affecting the population that engages in the activity. He only considers the impact on the care taken to the extent that inducing excessive care is a cost of trying to achieve an optimal population by setting a standard of care. The group whose optimal level of care exceeds the standard will, in any event, engage in the activity. Thus, from the perspective of affecting the group engaging in the activity, nothing is lost by requiring the higher

level of care and, obviously, the higher level is preferred.

It should be emphasized, however, that although Shavell's focus is on maximizing the benefits of excluding from the activity those people who should not be engaging in it, his analysis is entirely consistent with Landes and Posner's to the extent it applies to those whose optimal level of care does not exceed the prescribed standard. Shavell accepts the costs of excessive care that result from imposing a single standard as a constraint on the choice of a standard. These costs derive from the same behavioral consequences identified by Posner and Landes. Because Shavell does not consider the benefit of avoiding the costs of assessing individual ability to take care, he does not reach the issue of whether on that ground a single standard should also ***253** apply to those whose optimal level of care exceeds the standard yielded by his analysis.

If we are to formulate a single standard that will apply to the group whose optimal level of care exceeds the standard yielded by Shavell's analysis, we must start with the intuition that the optimal standard will be higher than the one yielded by Shavell's analysis. For if the standard were set at Shavell's lower level, there would be an allocative loss. Those whose optimal level of care was greater would conform to the lower standard and thus avoid all liability. This undesirable consequence will be reduced as the standard is raised. But raising the standard also entails a cost. Some people who should engage in the activity, but whose level of care is below the standard, will be required to meet the standard and thus take excessive care. This cost, however, will be mitigated to some extent because raising the standard will cause some people who should not engage in the activity to choose not to do so. Had the standard been lower, some of these people may have found it worthwhile to take what was for them excessive care to meet the standard and engage in the activity. It would seem then that we could devise a uniformly applicable optimal standard, taking these costs into account.

4. The Costs of Devising an Optimal Single Standard

I have identified the essential elements of a theory for devising an optimal single standard. If we assume that all single standards are equally costly to formulate, we will choose that standard which maximizes the benefit of excluding from the activity those who should not engage in it, net of the costs of suboptimal behavior induced by applying the standard.

The assumption that all standards are equally costly to devise, however, implicates a crucial issue. What are the information costs of devising a single standard? After all, determining individual ability to take care is costly, but devising a single standard entails costs of its own. And if the standard is to be optimal, the empirical issues upon which optimality depends need to be resolved.

As noted above, prior to Shavell's work no one had attempted to articulate a theory for setting an optimal standard. Consequently, there was no basis for knowing how costly it would be to devise one. No one has yet considered the costliness of devising a single standard under any theory. Landes and Posner simply assume average care as the standard and say nothing about the costliness of determining what that might be. The cases are equally uninformative in this regard; they neither articulate a theory for devising a single standard nor consider how costly it is to decide how the "reasonable person," however defined, would behave.

The information required to implement the theory developed in this article is very extensive. In principle, it would be necessary to know the entire distribution ***254** of the ability to take care over the population to minimize the misallocative effects produced by the single standard. It is, consequently, by no means obvious that the sum of process costs and misallocative effects under a single standard would in all circumstances to be less than those under a rule of subjective negligence. As discussed below, although the courts more frequently employ a single standard than a subjective one, in fact they untilize both. [FN25] They also take factors like blindness, age, and physical disability into account. Moreover, as I will attempt to demonstrate, the results that the courts reach using objective or subjective standards are essentially responsive to the considerations implicated by the economic analysis.

It is also important to emphasize that when the courts employ an objective standard, they speak in terms that are consistent in spirit with Shavell's analysis. It is clear that they use the concept of the "reasonable person" in an ideal, aspirational sense and not in Landes and Posner's sense of average behavior. The "reasonable person" possesses some minimal ability to take care. Although, as far as I have been able to determine, it has never been articulated in a decision or legal commentary, it seems consistent with this notion to define the minimal ability of the reasonable person in terms of the appropriateness of the individual engaging in the activity. In other words, the reasonable person engaging in the activity is the person who should engage in the activity-- that is, the person who, if she engages in the activity, can take care such that the benefits of doing so exceed the costs.

IV. PRIOR INVESTMENT IN THE ABILITY TO TAKE CARE

I will now relax the assumption made to this point that prior investments do not affect the ability to take care. This, of course, extends the analysis to an important dimension. The care one is able to take when engaging in an activity is determined in large measure by investment in technology and information that can reduce the risk of harm to others. Thus, one's ability to avoid harm while driving is affected by one's choice of the car's features and one's skill as a driver. The ability to take care can also be improved by acquiring information about relevant risks and the effectiveness of responses to them. Because technology can be adapted to compensate for the physical limitations of the driver, many ways exist to improve one's ability to take care and avoid hurting others.

Both strict liability and subjective negligence standards extending to decisions affecting the ability to take care will yield optimal investment in the ability to take care. Strict liability induces optimal behavior because the injurer ***255** bears all costs of harm to victims and thus will make all expenditures that will minimize the sum of the cost of preventing harm and the cost of harm. Subjective negligence, which defines optimal care for the individual as the care that would be optimal if the individual made all cost- effective investments in the ability to take care, also induces optimal behavior because failure to make expenditure that would optimally reduce harm will result in liability. Moreover, the individual need not make an expenditure that is not optimal to avoid liability. Such a rule of subjective negligence, however, is very costly to devise and apply because it requires judicial scrutiny of all of the possible prior investment decisions that could have been made in light of the individual characteristics of each person.

In the following section, I compare a subjective negligence rule with a single standard. I explore the incentives to make prior investment decisions under the two rules, assuming in both cases that courts do not scrutinize those decisions.

A. A RULE OF SUBJECTIVE NEGLIGENCE ABSENT SCRUTINY OF INVESTMENTS TO IMPROVE THE ABILITY TO TAKE CARE

The misallocative effects of failing to scrutinize a particular decision are somewhat subtle, but are always in the direction of inducing too little investment in the ability to take care. Figure A illustrates the misallocative effect of applying a rule of subjective negligence to the care taken but not to investments that could have affected one's ability to take care. Without the prior investmet, the cost of reducing harm to victims is represented by cost curve C1. At the cost depicted, that is, the probability that a victim will be hurt can be reduced by some assumed amount. The cost curve is assumed to be upward sloping because incremental decreases in the probability of harming victims are increasingly costly to achieve. The benefit curve is assumed to be horizontal to reflect that the benefit of reducing the probability of harm by a given amount is the same at all points. Optimal care is 01, the intersection of the cost and benefit curves.

Assume that by making some expenditure, the costs of avoiding harm to victims can be reduced to the level depicted by cost curve C2. Now the optimal level of care is 02-- the intersection of the new cost curve and the benefit curve.

An example may be helpful. Assume initially that an individual is driving a car with brakes that permit her to stop at various speeds in some specified time after she observes that she may hit someone. Thus, the time in which she can stop is determined by three factors: (1) brakes that do not vary as circumstances change, (2) the speed at which she is driving when she observes someone in danger, and (3) the exogenous circumstance of how far away from the car the potential victim is when the driver first sees her. 01 is ***256** the optimal level of care when the car has brakes of a given quality. The variable input in taking care is the car's speed, which determines how quickly the car can be stopped. The slower the operator drives, the more costly care is to her because she arrives later at the place to which she is going. We can assume that if there were no risk of harm to victims, the driver would choose some optimal speed. The cost of care is thus the reduction from this speed that the driver will make to reduce the harm to others. The further away a victim is when the driver observes her in the car's path, the less the driver will have to reduce speed to avoid hitting her. Thus, C1 slopes upward to reflect the greater costliness of reducing the risk of harm by lowering speed as victims are first observed closer and closer to the car.

TABULAR OR GRAPHIC MATERIAL SET FORTH AT THIS POINT IS NOT DISPLAYABLE
TABULAR OR GRAPHIC MATERIAL SET FORTH AT THIS POINT IS NOT DISPLAYABLE

FIGURE A

On open highways, drivers will generally see victims well in advance of a possible collision, so that small reductions from the driver's optimal speed will yield large reductions in harm. By contrast, on crowded streets, where pedestrians may

suddenly enter the car's path, the driver will need more time to stop and must travel at lower speeds, which impose greater costs of delay on the driver.

The cost of reducing speed to prevent some set of injuries to victim exceeds the benefits of doing so. In other words, to avoid all "freak" accidents, those in which the victim suddenly enters the car's path, the driver would ***257** have to maintain extraordinarily slow speeds, at excessive cost. All accidents to the right of O1 are of this kind.

Now assume that the driver acquires brakes which permit quicker stopping. This generates two benefits. In the region to O1, in which slowing down was previously a cost-effective way to prevent harm, it is no longer necessary to slow down as much to achieve the same reduction in the incidence of harm. In our example, the driver can maintain greater speed on the open road. This is Area A on the diagram. In addition, some slowing down that previously was not cost-effective has now become so, because of the shorter time required to stop after the driver sees a potential victim. The driver should now avoid some accidents that were "freaks" when the car was equipped with the former brakes. Thus, in some circumstances after the better brakes are installed, the driver will have to take more care because reductions in speed have been made more effective. This is the region from O1 to O2 on Figure A. Area C represents the social surplus, that is the excess of harm reduction over the cost of care in these circumstances. If the better brakes do not cost more than the sum of Areas A and C, the driver should install them.

The individual has inadequate incentives to make this kind of socially beneficial investment under a legal regime in which courts require optimal care but do not scrutinize the optimality of prior expenditures affecting the ability to take care. Under such a regime, the individual captures one portion of the benefit produced by the investment--the reduction in the cost of providing that amount of harm reduction that would have been required even without the investment (Area A). By contrast, Area B, the cost of providing the additional quantity of harm reduction that has become optimal by reason of the investment, represents a cost from a private perspective. The injurer does not take into account the benefit of greater harm reduction because it is realized entirely by victims.

In summary, injurers should make an investment to improve their ability to take care as long as the cost does not exceed the total value represented by Areas A and C. From a private perspective, under the rule now assumed to control, they will make the investment only if Area A exceeds Area B by more than the cost of the investment. This incentive system induces dramatic underinvestment in the ability to avoid harm to victims.

B. A SINGLE STANDARD OF CARE ABSENT SCRUTINY OF INVESTMENTS TO IMPROVE THE ABILITY TO TAKE CARE

A rule that imposes a uniform standard of care but does not scrutinize the prior decision whether to invest in the ability to take care has imperfections of its own. Like a subjective standard that does not scrutinize prior investments, an objective standard that does not scrutinize may not create sufficient ***258** incentives to invest in the ability to take care. It is difficult to generalize whether the subjective or objective rule is more imperfect.

Figure A illustrates the allocative effects of a prescribed standard. Suppose that an individual's ability to take care is depicted on cost curve C1, so that C1 represents optimal care for that individual. By investing in the ability to take care, the individual can reduce the costs of taking care to the lower level depicted by cost curve C2.

Assume that the prescribed level is O2. The individual can pursue two possible courses when C1 obtains. She can provide O1 of care, the optimal level for her, and compensate victims for all harm caused. Or, she can provide what is for her excessive care, O2, and avoid liability.

There would be two benefits if an individual who prior to making the investment elected to take optimal care and compensate victims moved to C2 by making the investment. These would be: (1) the lower cost of providing O1 care (Area A), and (2) the ability to avoid liability to victims by taking O2 care.

The lower cost of providing O1 care when C2 obtains is a social gain. Avoiding liability for the harm that occurs when O1 care is taken merely shifts the cost of harm from injurer to victim. To the extent that this shift constitutes part of the incentive to make the cost-reducing investment, injurers may spend too much to improve their ability to take care.

This excess in incentives will, however, be offset by the same disincentive to invest that exists with respect to the subjective

negligence rule previously considered. In the region O1-O2, the injurer will consider only the additional cost of providing care (albeit at the lower cost per unit of care). She will ignore the benefit to victims in the reduced risk of harm. In sum, there are misallocative effects in both directions, that is inducing too little and too much care when a single standard applies and prior to making the investment, the individual would have engaged in the activity, taken what was for her optimal care, and been held liable to victims.

If, prior to making the investment, the injurer would have provided O2 care to avoid all liability, and would have done so even if it were not optimal for her, the gain to society and the individual from moving to C2 is the entire cost saving between C2 and C1 in providing O2 care. Because victims receive the same level of care under both outcomes, the private and social cost calculations are the same.

If the prescribed standard were below O2, there would be too little incentive to invest and thus move from C1 to C2. The injurer would meet the prescribed standard but would not take care in excess of that prescribed. This is so even if the cost of care were reduced because all that would be required to avoid liability would be to satisfy the prescribed standard. Thus, ***259** the injurer would not take into account the social surplus that could be generated by utilizing optimally the new lower-cost ability to take care.

C. SUMMARY OF INCENTIVE EFFECTS

A subjective rule of negligence that does not extend to investment decisions that improve the ability to take care creates a systematic bias against investment. An objective rule that does not scrutinize prior investment decisions may create misincentives in either direction or correct incentives, depending upon whether prior to investment the injurer would have been better off meeting the standard or accepting liability. If the standard is set below what would be optimal under the lower cost conditions that would prevail if the individual made the investment, there will be a systematic bias against investment. Similarly, if the standard is set above what would be optimal, there will be a systematic bias for investment.

If we assume that prior investment decisions will not be scrutinized, no definitive statement can be made about the relative efficacy of a rule of subjective negligence or a single standard to create incentives to invest in the ability to take care. Because it seems that the rule of subjective negligence creates a great bias toward underinvestment, however, it might be worthwhile to explore the possibility of devising a single standard, or perhaps a set of standards, to induce appropriate investment. Such a standard would have to be formulated to minimize its misallocative tendencies.

V. BENEFITS AND DISTRIBUTIONAL CONSEQUENCES

Until now, I have assumed that all injurers derive the same benefits from engaging in an activity. If I relax that assumption, it will no longer be true that only one minimal level of care exists at which an individual may engage in an activity efficiently. This is so because if an individual derives greater benefit from an activity, then a larger total of the cost of taking care and the cost of harm is justified.

Figure A can be reinterpreted to illustrate this point. If we now take C1 and C2 as the cost curves for avoiding harm to others while engaging in an activity for two individuals, the optimal level of care is O1 for Individual 1, and O2 for individual 2. Individual 2 is better able to take care than is Individual 1. The costs of Individual 1 engaging in the activity are: (1) the costs of care, represented by the entire area under C1 curve to the point O1, and (2) the harm to victims, which is whatever harm would occur if no care were taken less the reduction in harm achieved by taking O1 units of care. The costs for Individual 2 are less for two reasons. First, with respect to O1 quantity of care, Area A depicts the savings resulting from the change. In addition, the extra units of care is the region O1 to O2 yield a reduction in harm to victims in excess of the costs of care. This reduction is equal to Area ***260** C. Thus, when engaging in the activity, Individual 2's combined cost of care and cost of harm to victims is less than Individual 1's by an amount equal to the sum of Areas A and C.

It may nevertheless be that O1 represents minimal care for Individual 1 and O2 represents minimal care for Individual 2. This would be so if the added costs of Individual 1 engaging in the activity, Area A plus Area C, are offset by the greater benefits that Individual 1 derives.

As stated above, for purposes of this analysis I have defined the benefits of engaging in an activity as the value of engaging in the activity net of the costs other than the costs of taking care to avoid harm to victims. These other costs consist of capital inputs, like automobiles, and the opportunity cost of time devoted to the activity.

The benefits of the activity thus can vary among individuals if: (1) they derive different amounts of value from engaging in the same activity, and (2) the costs, other than those associated with taking care to avoid harming others, are different.

Material inputs would probably not vary significantly in cost among individuals. However, there might be significant differences in the next best alternative for spending time. The more valuable the alternative, the more costly it is to engage in the activity. Thus, people with poor alternatives incur low opportunity costs when engaging in the activity and are more likely to be within the group that should engage in it. Similarly, individuals who regard the activity as particularly valuable are more likely to be within the group who should engage in the activity. In short, there is not one minimal level of care but a series of levels that vary with the benefits derived. The greater the benefits, the less able to take care an individual must be to engage in the activity efficiently. [FN26]

Although this analysis demonstrates that we must establish many standards, each standard remains uniformly applicable in the sense that it does not vary with individual ability to take care. Consequently, we need not incur process costs to determine individual ability. The optimal standard will, however, be different for each group of people deriving different benefits from engaging in the activity. Thus, we must incur costs of determining the benefits that each individual derives.

If we desire to avoid the costs of determining individual variations in benefits, we can set a single standard to apply uniformly without regard to an individual's benefits or her ability to take care. The theory that defines an optimal standard from this perspective is based upon certain elements identified ***261** in the discussion above. But there is a fundamental drawback to this approach. Shavell, operating under the assumption of uniform benefits, proceeds by first determining the minimal level of care required to engage efficiently in the activity. His purpose is to deter from engaging in the activity those people whose optimal level of care is below the minimum. However, because I have relaxed the assumption of uniform benefits, there is no single minimal level of care. Because optimality depends upon the ability to take care and the benefits derived, prescribing the level of care in a manner that does not consider variations in benefits will not induce optimal behavior. As a result, a single standard, stated only in terms of care, cannot segregate those who should engage in the activity from those who should not.

Variations in benefits thus introduce another cost-minimization element into the process of devising a single optimal standard. The discussion so far may be summarized as follows: The single standard should be set to maximize the benefits of: (1) reduced information costs from avoiding any examination of individual ability to take care, and (2) a reduction in the number of people who should not engage in the activity but who do engage in the activity. These benefits should be net of the costs of insufficient or excessive care resulting from the uniform application of a single standard without regard to variations in the ability to take care or benefits derived.

The possibility of variations in benefits also implicates a distributional question that may be significant in influencing legal decisions. It may be desirable to exclude certain benefits from the calculation because for some reason they are thought to be "socially invalid." The psychological reasons for wanting to do this are understandable. An individual who claims the right to engage in an activity because of the unusually large benefits she derives, but who is poorly equipped to take care when engaging in that activity, will cause much harm to others by claiming that right.

All of the rules discussed so far--subjective negligence, strict liability, and a single standard of negligence--will grant this claim. A person who derives greater benefit from engaging in the activity than the sum of the costs of care and the costs of harm to others always has the option to elect a de facto rule of strict liability and to engage in the activity. Consequently, none of the rules we have considered will deter a person who should engage in the activity from doing so. The only way to deter these people from engaging in an activity is to impose costs that exceed the harm they cause while engaging in the activity, such as by awarding punitive damages.

The rules differ markedly, however, in the distributional consequences of who bears the cost of harm--injurer or victim. [FN27] Under a rule of subjective ***262** negligence, which credits the injurer's valuation of benefits, victims bear all costs of harm. Under strict liability, injurers bear all costs of harm. A single standard has more complex consequences. We may view these consequences as a compromise between the polar results of the subjective negligence and strict liability rules.

In Figure B, we subject the people least able to take care (those in Area I) to the equivalent of strict liability and require them to bear the cost of harm to victims. The subset of these people who choose to engage in the activity despite their poor ability to take care must derive large benefits from doing so. We require them to pay the social cost of these benefits. Those in Area II are better able to take care than those in Area I, but their optimal level still falls below the prescribed level. We grant them

what may be characterized as a species of "affirmative action" status. We give them the opportunity to avoid bearing the costs of harm they cause to victims provided that they pay partial compensation by taking care in excess of the level that is optimal for them. In other words, we admit them to the activity only if they are prepared to work "very hard" to avoid harming others. This form of compensation is inefficient because the benefits of reduced harm to victims are less than the cost to injurers of creating such benefits. In distributional terms, however, victims still prefer this outcome to a rule that would allow these people to take what is for them optimal care and avoid all liability. However, for victims this outcome is inferior to a rule of strict liability. For injurers, the rule is superior to strict liability, albeit inferior to subjective negligence.

VI. THE RELEVANCE OF VICTIMS' BEHAVIOR

Victims' behavior is relevant to these issues in two respects. First, when victims realize the benefits from the injurer's engaging in the activity, as when the injurer sells a good or service to victims, victims can influence the injurer's behavior by threatening to forego the good or service and to withhold payment. Victims' behavior is also relevant when, analogous to the injurer, victims can reduce the sum of the costs of harm and harm avoidance by investing in their ability to take care to prevent being harmed. [FN28]

When victims are consumers of injurers' goods or services and are fully informed about the cost of harm associated with their consumption, we can largely avoid the issues considered in this article. Injurers will be induced to engage in an activity only when it is efficient to do so, and they will take due care when engaging in the activity even if they are not liable for the harm they cause to consumer-victims. In these circumstances, even if the consumers ***263** must bear all costs, they will take those costs into account when deciding how much they are willing to pay for the good or service. Any injurer who can reduce the costs of harm by an expenditure that is less than the cost reduction can gain a competitive advantage by offering the good or service at a lower total price--the nominal price plus the cost of harm borne by the consumer-victim. In efficiently taking additional care, the injurer increases the nominal price of her good or service by the cost of taking such care. However, such an increase is more than offset by the benefits to the consumer-victim. Competition among injurer-suppliers will thus yield optimal behavior even though the injurer is not liable to the victim for harm.

Under conditions of perfect information, consumer-victims will also have self-enforcing incentives to behave optimally to minimize the sum of the costs of harm and harm avoidance. This will occur because a consumer essentially will choose between the supplier's offer of harm reduction and that which she can supply herself. She will optimally combine a product with an associated risk of harm with her own efforts to reduce the harm she will suffer.

When full information can induce optimal behavior by injurers and victims without imposing liability, we need not face the choice among subjective negligence, strict liability, and a single standard and can avoid any legal proceedings. When, however, injurers realize the benefits of engaging in the activity so that victims' threats of abstention cannot influence their behavior, or when victims are not informed about the costs resulting from their use of the good or service, the no-liability solution cannot yield optimal behavior.

VII. VICTIM BEHAVIOR AND THE CHOICE OF A LIABILITY RULE

When injurers and victims cannot achieve optimal behavior through interaction as suppliers and consumers, their behavior will be determined by the liability rule that applies to them. If we postulate that both injurers and victims can act to reduce the total costs of harm avoidance and harm, the choice between strict liability (or its counterpart, no liability) and imposing a standard upon which liability depends is a difficult one. Although we can generate correct incentives by imposing costs on the injurer or victim without regard to whether their behavior satisfies any standard, a rule of strict or no liability cannot provide ideal incentives if we want to influence the behavior of both injurer and victim. [FN29] This results from the current structure of the tort system, which requires that the the injurer's damages be paid to the victim as compensation and thus makes it impossible for both injurers and victims to each bear all costs. If the injurer is strictly liable, the victim bears no costs, and if the injurer is not liable, the injurer bears no costs. The only ***264** way that both bear all costs would be if the injurer were strictly liable but the victim did not receive the damages.

Thus, if we are to realize the process advantages of not formulating or applying a standard, it will be at the cost of foregoing either the injurer or the victim's contribution to minimizing the sum of the costs of harm avoidance and harm. The person who does bear the costs will act optimally. But this optimal adjustment will occur in a suboptimal world, in which the person who does not bear the costs will do nothing to reduce the risk of harm.

It is also the case, if we desire to influence the behavior of both injurer and victim, that a standard will have to be applied to the behavior of both. On first impression, it would seem that if the rule were strict liability for an injurer provided that the victim should have engaged in the activity and exercised optimal care while doing so, we would only need to consider the victims's behavior. This rule would create self-enforcing incentives for injurers to take optimal care to avoid harming those victims to whom they would would be liable--those who should engage in an activity and who take optimal care while doing so.

However, we must also resolve the issue of the standard of care governing the injurer. The appropriateness of the victim's behavior depends upon the risk of harm that the injurer creates. If we want optimal victim behavior for a world of optimal injurer behavior, then the harm that the victim should consider in taking care is that created by the universe of injurers who should engage in the activity and who take optimal care while doing so. Thus, optimal victim behavior cannot be determined without first defining optimal injurer behavior.

The reason for this result is the interdependence of injurer and victim behavior. Optimal behavior for each is always based on some assumption regarding the behavior of the other. If the end is overall optimality, each must assume that the other has acted optimally. But for our purposes the point is more general. We must incorporate some standard for the conduct of the other actor in the rule governing the conduct of the person to whom the rule applies. We need not determine whether the person to whom the rule does not apply has actually conformed to this standard. For example, under this rule it is not necessary to determine if the injurer acted optimally, but because optimal injurer behavior is an element governing the victim's behavior, it is necessary to know what optimal injurer behavior would have been. The injurer will have self-enforcing incentives to behave optimally without having her liability depend upon whether she conformed to the assumed standard, because if the victim conforms to the victim's standard, the injurer will be liable. [FN30]

***265** Thus, a strict liability rule that does not require a court to define optimal behavior is possible only if we have a rule that influences the behavior of either injurers or victims, but not both. The process advantages of such a rule are great, because the rule creates self-enforcing incentives for optimal behavior by the person upon whom it places costs. If, however, we believe that foregoing the contribution of injurer or victim is too great a cost to secure these process advantages, we must apply a standard to one or the other.

Formulating a standard for either the injurer or the victim inevitably implicates the standard for the other. We must confront the issues that I have identified if we are to apply such a standard. The ability to take care varies from person to person, as do the benefits they derive from engaging in an activity. Some people should not engage in an activity, given their ability to take care and the benefits they derive. Prior investment in the ability to take care can improve one's ability to take care. Finally, the distributional consequences of different standards vary.

I now turn to actual cases that have used subjective or objective approaches to formulate a standard. I use these cases to test the power of my analysis and to explain what has occurred in the legal system.

VIII. GENERAL LEGAL THEORY

A comprehensive theory that deals with the issues under consideration must specify how to answer two interrelated questions. First, in what circumstances will we hold an individual to a subjective standard, and in what circumstances will we require her to conform to a standard that departs from what is for her optimal care? Second, if we apply a nonsubjective standard, what are the determinants of that standard?

Neither the legal commentators nor any of the reported cases have formulated a theory that provides a systematic answer to these questions. However, they do acknowledge the importance of certain elements that economic analysis dictates should be included in such a theory. They have not specified any coherent means of taking these factors into account. Moreover, they have not addressed the relevance of variations in benefits realized.

Holmes, in his influential book The Common Law, [FN31] identified two reasons for employing an objective standard that are also implicated by economic analysis: avoiding the costs of determining an individual's ability to take ***266** care, and the importance of the ability to take care in determining how much care is necessary for the individual to act optimally. He stated:

The standards of the law are standards of general application. The law takes no account of the infinite varieties of temperament, intellect, and education which make the internal character of a given act so different in different men. It does

not attempt to see men as God sees them, for more than one sufficient reason. In the first place, the impossibility of nicely measuring a man's powers and limitations is far clearer than that of ascertaining his knowledge of law, which has been thought to account for what is called the presumption that every man knows the law. But a more satisfactory explanation is, that, when men live in society, a certain average of conduct, a sacrifice of individual peculiarities going beyond a certain point, is necessary to the general welfare. If, for instance, a man is born hasty and awkward, is always having accidents and hurting himself or his neighbors, no doubt his congenital defects will be allowed for in the courts of Heaven, but his slips are no less troublesome to his neighbors than if they sprang from guilty neglect. His neighbors accordingly require him, at his proper peril, to come up to their standard, and the courts which they establish decline to take his personal equation into account. [FN32]

Holmes thus recognized the costs involved in determining individual ability to take care, referring to "the impossibility of nicely measuring a man's powers and limitations." I interpret this to mean that Holmes considered these costs excessive. Although he did not offer a theory by which to judge the excessiveness of these costs, he characterized the attempt to determine individual ability to take care as "impossible."

Holmes did not principally rely on the desire to avoid these costs as the reason for using an objective standard. Rather, he asserted that "when men live in society, a certain average of conduct, a sacrifice of individual peculiarities going beyond a certain point, is necessary to the general welfare." What he appeared to mean is that a certain level of care, even if optimal for the individual, is insufficient for society as a whole. [FN33] What Holmes did not specify is how to determine the level that should be maintained to meet this social obligation. Indeed, he seemed unsure of how to do this and equivocated with ***267** the phrase "beyond a certain point." Economic theory can help define this "certain point" in a way that is essentially consistent with Holmes' conception. The required ability is the ability the individual should have if she is to engage in the activity.

Holmes was concerned about more than defining optimal care from a social point of view. He also considered people who have a limited ability to take care because of an impairment, like blindness, that is not their fault. He stated:
There are exceptions to the principle that every man is presumed to possess ordinary capacity to avoid harm to his neighbors, which illustrate the rule, and also the moral basis of liability in general. When a man has a distinct defect of such a nature that all can recognize it as making certain precautions impossible, he will not be held answerable for not taking them. A blind man is not required to see at his peril; and although he is, no doubt, bound to consider his infirmity in regulating his actions, yet if he properly finds himself in a certain situation, the neglect of precautions requiring eyesight would not prevent his recovering for any injury to himself, and, it may be presumed, would not make him liable for injuring another. [FN34]

There is an apparent tension between this quotation and the preceding one. If there is to be a "sacrifice of individual peculiarities" to serve the general welfare, why should we not require the same sacrifice of a blind person? Holmes resolved this tension in a manner consistent with the analysis offered in this article. He limited his willingness to apply a subjective standard to situations in which the blind person "properly finds himself." [FN35] This can be interpreted as the equivalent of saying that the subjective standard applies only when the blind person should engage in the activity. Those blind people who should not engage in the activity will be negligent and held liable if harm results.

Apparently without realizing it, Holmes advocated a single substantive view that we can reach through alternative legal means. For those governed by an objective standard, we would exclude the subgroup with too little ability to take care through their unwillingness to meet the standard. For those governed by a subjective rule, we would exclude the subgroup with too little ability to take care through an express determination that they should not engage in the activity.

Holmes' discussion deals only tangentially with the question of investing in an individual's ability to take care. He implicitly viewed the physically disabled as a group for whom prior investments were not feasible. One can only speculate whether Holmes' choice of an objective rule for the non-physically ***268** disabled was motivated, at least in part, by a desire to create incentives for prior investment by these people.

The question of benefits was not expressly addressed by Holmes. However, the critical cryptic phrase "properly finds himself in a certain situation" could be interpreted to refer to benefits realized as well as costs incurred.

The Restatement (Second) of Torts [FN36] approaches these questions in essentially the same way as Holmes. What is notable, however, is that the only reason the Restatement offers for an objective rule is that the reasonable person represents some desirable ability to take care. The Restatement states:

In dealing with this problem the law has made use of this standard of a hypothetical "reasonable man." sometimes this person is called a reasonable man of ordinary prudence, or an ordinarily prudent man, or a man of average prudence, or a man of reasonable sense exercising ordinary care. It is evident that all such phrases are intended to mean very much the same thing. The actor is required to do what this ideal individual would do in his place. The reasonable man is a fictitious person, who is never negligent, and whose conduct is always up to standard. He is not to be identified with any real person; and in particular he is not to be identified with the members of the jury, individually or collectively. It is therefore error to instruct the jury that the conduct of a reasonable man is to be determined by what they would themselves have done. [FN37]

Thus, the Restatement appears to reject Landes and Posner's conceptions that the theoretical purpose of tort law is for each person to act optimally given her ability to take care, and that the objective standard is intended to economize on the information costs of achieving this objective.

The Restatement also seems to resolve the tension concerning people who suffer from a physical disability by applying a subjective standard but also determining if the individual should have engaged in the activity. Like Holmes, the Restatement does not make this point explicitly. Rather, it does so in a comment dealing with someone who suffers a heart attack:
[A]n automobile driver who suddenly and quite unexpectedly suffers a heart attack does not become negligent when he loses control of his car and drives it in a manner which would otherwise be unreasonable; but one who knows that he is subject to such attacks may be negligent in driving at all. [FN38]

Both the Restatement and Holmes are interested not only in the care taken, but in whether an individual should engage in the activity given her ability to take care. What neither recognizes is that we can achieve the same end either through an objective standard or through a subjective standard ***269** that expressly asks whether the individual should have engaged in the activity.

In sum, the legal discussion of the use of an objective standard extends both to care taken and to the decision to engage in the activity. What is not made clear is which factors determine whether the better rule is an objective standard or a subjective standard coupled with scrutiny of the decision to engage in the activity. Courts employ both rules. The next issue, then, is how courts choose the method for dealing with characteristics that tend to impair an individual's ability to take care.

A. THE CONSEQUENCES OF APPLYING AN OBJECTIVE OR SUBJECTIVE STANDARD

Both the objective and subjective approaches have the same purposes: those members of a population who engage in an activity should be those who should engage in the activity, and they should exercise what is for them optimal care. A single standard of care accomplishes this objective while saving process costs, but it does so at a cost of creating inferior incentives.

Both methods require us to determine minimal care. In one case, we need to know minimal care to set the single standard, and in the other to determine whether the individual should engage in the activity. If we set and apply a single standard, we do not need to determine what is optimal care for the individual in question. People under an objective standard will signal what optimal care is for them by whether they engage in the activity and conform to the standard. The signal is imperfect, and it results in the misallocative effects noted earlier. [FN39] Balanced against this imperfection, however, are the savings in not having to determine individual ability to take care.

The relative efficacy of the two approaches depends upon the magnitude of the misallocative effects of a single standard, as compared to the greater process costs of a subjective standard. If efficiency is the criterion that governs the choice of approaches, I would expect that differences in courts' approaches would be explicable in terms of the relative magnitude of these costs.

B. DOES THE THEORY PREDICT THE LEGAL APPROACH?

Courts most frequently use a single standard with respect to individual variations in the ability to take care because of intelligence, experience, mental deficiency, and the use of alcohol or narcotics. This suggests that across the range of these variations in ability, savings in process costs outweigh the better incentives yielded by the two-stage subjective approach. What is more difficult to explain is courts' use of the subjective approach ***270** with respect to physical disabilities, blindness being the most important, but also, as enumerated by the Restatement, "deafness, short stature, or a club foot, or the weaknesses of age or sex." [FN40]

There is an initial puzzle. The Restatement and the courts state that the behavior of people with these disabilities need not

conform to that of the reasonable person. By this they mean that we require less care of individuals with these characteristics. But we also may require that persons with these disabilities take more care in the sense that they may have to refrain from an activity. [FN41]

What the Restatement and the courts do not expressly acknowledge is that the controlling standard for these people is not the optimal level of care for them, but the minimal level of care that such people must be able to take if they are not to be held liable for negligently engaging in the activity. This is because the subjective optimal care that defines the required standard will in all cases be at least equal to minimal care. If it were less, the actor would be liable for negligently engaging in the activity. But if the actor meets the standard of minimal care, she also satisfies the higher standard of the "reasonable person." Thus, any apparent relaxation of the standard appears to be nullified by the requirement that the individual's optimal level of care be such that she should engage in the activity.

The opinion in Sleeper v. Sandown [FN42] exemplifies this basic confusion over the standard to be applied under a rule of subjective negligence. Defendant built a bridge with a guard rail on only one side. Plaintiff was a blind man who fell off the bridge and sustained injuries. Defendant apparently conceded that it was negligent not to have a rail on both sides. [FN43] In considering Plaintiff's contributory negligence, the court compared Plaintiff to sighted people at night, stating:
If the jury, in passing upon the question of the plaintiff's contributory negligence, were to be precisely confined to his conduct in the single act of crossing the bridge,--that is, if in order to show that he was in the exercise of ordinary care he must show that he took the same heed to his last step, which precipitated him from the bridge, as he did to all that preceded it tending to the same result, as persons in general with eyesight would have taken under the same circumstances,--the argument would seem to be wellnigh conclusive; and whether the question of negligence, in that view, were to be considered one of law or of fact, could make but little difference. The result would be likely to be the same in either view,--although we should not, perhaps, be warranted in saying that a blind man might not ***271** make such vigilant use of his remaining senses as to put himself in possession of all the facts relating to the defect which a man with vision would ordinarily acquire.
But we think this view cannot be sustained. [FN44]

The interesting portion of this excerpt is the language "we should not, perhaps, be warranted in saying that a blind man might not make such vigilant use of his remaining senses as to put himself in possession of all the facts ... which a man with vision would ordinarily acquire." The court apparently meant that the blind man could have reduced the risk of harm to the point that would be optimal for a sighted person, but that he could have done so only at excessive cost. The blind man was only required to reduce the risk by taking what was for him optimal care. This part of the opinion suggests that the blind man was held to a lower standard than the reasonable person (who the court assumed without discussion to be sighted).

The court then turned to the question of whether the blind man was negligent for engaging in the activity, that is, crossing the bridge:
Now if, in the present case, the plaintiff knew or ought to have known that it was dangerous for him to attempt to cross this bridge alone, as he did, his attempt to do so would, beyond all question, be want of due care, and he could not recover for the injury that ensued. But he had a right to assume that the bridge was reasonably safe and free from defect, --that is, that the legal duty of the town with respect to its condition had been performed, -- and to act upon that assumption. If, considering its location, the kind and amount of travel usually passing over it, & a rail on each side was necessary to its legal sufficiency, this plaintiff, although blind, had the same right to assume the existence of a rail on each side that any traveller passing either in the daytime or in the night-time would have; and if an accident happened to him by reason of the want of a rail, his own fault not contributing, no reason can be conceived why he is not as much entitled to recover as though, having the sense of vision, he had attempted to cross by night and the same mishap had befallen him. He could only assume that the town had done what they were legally bound to do; but the legal insufficiency and defect of the bridge being ascertained, we think the question of his negligence depends, not upon the exact mode in which the defect caused the injury, or whether it might have been avoided by the use of eyesight, but upon the character and complexion of his act in making the attempt to pass. Was his physical and mental condition such that he might fairly suppose he could safely travel on foot over this highway and over this bridge without a guide, or was it such as to make his attempt to do so an imprudence? Taking into consideration his total blindness, and at the same time his familiarity with the road, his ability to do various kinds of work, to go about unattended and take care of himself, the increased activity, fidelity, ***272** and power of his other senses consequent upon his blindness, if the fact were so,--could he undertake to cross this bridge (assuming it to be in the condition in which the town were bound to keep it), at the time and in the way he did, with a reasonable assurance of safety? That, we think, was the question; and that question being answered in the affirmative, we are unable to see how he can be charged with want of ordinary care, even though the accident would not have happened but for his want of sight. [FN45]

By this the court seemed to mean that optimal care for this blind person was such that he should have engaged in the activity. If, however, his ability to take care constituted "minimal care," and this defined the behavior of the "reasonable person," we must conclude that the blind man acted like a reasonable person. In these circumstances, a sighted person would have an ability to take care exceeding that of a reasonable person in crossing the bridge.

The implication of the court's reasoning is that the blind man would have been contributorily negligent if his ability had not been such that it was reasonable for him to cross the bridge. Thus, the governing standard was the blind man's ability to take minimal care, and not his individual ability to take care

The effect of using the subjective approach, then, is not to relax the governing standard to what is optimal care for the particular individual. Rather, by incurring greater process costs, the subjective approach avoids the misallocative effects of a single standard. From the point of view of people with physical disabilities that impair their ability to take care, this is beneficial (but much less so than being able to avoid liability solely by taking what is optimal care for the particular individual). The subjective standard protects people with physical disabilities from having to meet a standard of care that is set above the minimal level. [FN46] It should be emphasized that this is a benefit realized only by those people who, despite the disability, should engage in the activity. The subjective approach, in which we inquire whether an individual should engage in the activity, is also detrimental to some people with a disability. For if we applied a single standard, some people with disabilities who should not engage in the activity would prefer to meet the standard and engage in the activity without liability. Under a subjective standard, these people would be liable if they engaged in the activity.

Courts and legal commentators do not seem to understand the real differences between the two approaches. Nevertheless, it is possible that the process ***273** costs and incentive considerations identified by economic analysis can explain their choice of rules.

From the perspectives of process costs and incentive considerations, we will prefer the two-stage subjective approach as the misallocative effects of a single standard increase and the process costs of determining individual ability to take care decrease. If the magnitudes of these two effects correlate with the characteristics that lead courts to use one approach or the other, then the courts and commentators' choice of rule is consistent with economic analysis.

We may dismiss one type of misallocative effect in our consideration of people with physical disabilities. Because these people are unlikely to be exceptionally able to take care, we need not worry that that they will take too little care if they meet a single standard.

A critical empirical question is whether large numbers of people with physical disabilities cluster in the k1-k2 range on Figure C. That is, are there many whose optimal level of care is close enough to minimal care that they will take too much care if we apply a single standard? In the case of those who should not engage in the activity but are induced to take excessive care, the misallocative loss is greater than if we apply a two-stage subjective approach. This is because under the subjective approach, people who should not engage in the activity would be liable if they do; therefore, they are deterred from acting. The misallocative effect of imposing a single standard will, accordingly, depend upon the number of people who are induced to take excessive care to meet the standard and engage in the activity.

Although it may be difficult to generalize, it seems that people with various physical disabilities will have similar abilities to take care. It also seems that for many activities, optimal care for many physically disabled people is close to minimal care. If many of these people fall in the k1-k2 zone, we may realize large gains by individually assessing their ability to take care.

There appears to be less opportunity to realize such a gain with respect to those characteristics to which courts apply an objective standard. These characteristics, including intelligence, experience, mental deficiency, and the use of alcohol or drugs, are alike in that they represent a range of possibilities. Thus, people will vary as to their intelligence, experience, mental state, the amount and type of alcohol and drugs they have consumed, and the effect on them of the alcohol or drugs. It seems that they will be widely dispersed in their ability to take care. As a result, the chances that they are concentrated in the k1-k2 range are less than the chances that people with a physical disability are concentrated there.

The Restatement explicitly relies on the variations in information costs in distinguishing mental deficiencies from physical disabilities. Thus, it cites the following factors to justify courts' failure to consider mental deficiencies:
***274** 1. The difficulty of drawing any satisfactory line between mental deficiency and those variations of temperament, intellect, and emotional balance which cannot, as a practical matter, be taken into account in imposing liability for damage

done.
2. The unsatisfactory character of the evidence of mental deficiency in many cases, together with the ease with which it can be feigned, the difficulties which the triers of fact must encounter in determining its existence, nature, degree, and effect; and some fear of introducing into the law of torts the confusion which has surrounded such a defense in the criminal law. Although this factor may be of decreasing importance with the continued development of medical and psychiatric science, it remains at the present time a major obstacle to any allowance for mental deficiency. [FN47]

And, in the comment with respect to physical disability, the Restatement asserts that:
The explanation for the distinction between such physical illness and mental illness probably lies in the greater public familiarity with the former, and the comparative ease and certainty with which it can be proved. [FN48]

In summary, the analysis offered here can provide the basis for making complete and coherent the theory that implicitly underlies the legal view of subjective and objective standards of care. We cannot confidently conclude that the courts are behaving efficiently, given their lack of awareness of the relevant consequences of the different rules and their uncertainty over the magnitude of the relevant costs. Nevertheless, there is a striking correspondence between theoretical expectation and judicial practice.

C. IS THE LEGAL APPROACH CONSISTENT WITH THE THEORY?

Shavell's analysis provides the key element of a theory for determining a uniform standard of care: an individual must have a minimal ability to take care to engage in the activity efficiently. The courts, however, appear to be unaware of the possibility of employing such a concept. Nor do they articulate any alternative basis for determining the uniform standard that they apply.

The decisions are fundamentally confused in failing to recognize that there is not one, but a distribution of, abilities to take care in every population. Under only one conception are the courts correct in believing there is a single ability to take care. But this view is a tautology in which the definition includes all relevant characteristics, so that all members have the same ability to take care.

When the courts talk about reasonable behavior for children, adults, doctors, ***275** sighted persons, and so on, they are inevitably referring to the distribution of a particular population's ability to take care. The courts could point to the average, the median, or the mode of such a population to find the optimal level of care, but we still must ferret out a reason for reason defining the relevant population and choosing one of these concepts.

Courts invoke neither considerations of process costs nor incentives to answer these questions. The most that we can say is that the courts appear to be groping toward the notion of minimal care that Shavell has identified as the critical theoretical element.

The courts' treatment of children illustrates this process. We do not require children below a certain age to exercise any care at all. [FN49] Above that age, we hold them to the standard of reasonable care for a child when they engage in children's activities, [FN50] and to the standard of reasonable care for an adult when they engage in adult activities. [FN51]

We can justify all of these rules as efforts to approximate minimal care. Below a certain age, the ability to take care is so low that taking none is optimal. The standard of care may be no care for two reasons. First, because the child is unable to determine whether to engage in the activity, requiring ***276** care will not induce her to refrain. [FN52] Second, the benefits from engaging in the activity exceed the costs of taking care and the costs of harm even though the child takes no care but the adults interacting with her take optimal care. This seems plausible given that very young children will not undertake activities that entail substantial risks of harm to others.

We hold children above a specified age who engage in children's activities to the standard of reasonable care for children. The concept "reasonable care for a child" has no precise meaning. It does, however, crudely capture the idea that because children's activities are less dangerous, they require a lesser ability to take care. When children engage in an activity like driving a car, the activity requires a greater ability to take care. This idea is captured, albeit imprecisely, by the requirement that they conform to an adult standard.

Legal decisions setting an objective standard of care do not proceed from a coherent theory. They do, however, evidence a

tendency to set the level of care at what I have called minimal care. Courts could clarify the law by explicitly adopting the criterion of minimal care. Although this would require them to confront formidible empirical issues in devising a standard that minimizes misallocative effects, theoretical clarification would force the courts to focus on the correct empirical issues.

D. THE ROLE OF BENEFITS IN THE COURTS' CHOICE OF RULES.

Although I have been unable to identify any legal commentator or court that has explicitly addressed the issue, the facts of particular cases frequently present the question whether the prescribed standard of care should vary with the benefits that the injurer realizes. State v. Williams [FN53] provides a dramatic example.

In Williams, the parents were charged with manslaughter for negligently failing to take care of their child. The child had developed a tooth infection that grew increasingly serious. The parents took care of the child by administering aspirin but did not seek medical care. The defendant-parents were American Indians of limited education and experience who were fearful that if they brought their sick child for medical attention, they might lose custody for neglecting the child.

The court noted the parents' education, experience, and apparent fear of involvement with what they viewed as a hostile and insensitive governing authority. Nevertheless, it applied an objective standard of care and affirmed a verdict of guilty. [FN54]

***277** The court, like all legal authorities, did not specify the theory it used to derive the objective standard it applied to the defendants' conduct. It implied that the standard exceeded optimal care for these defendants. Indeed, the court emphasized the defendants' affection for their child, suggesting that they may have fully internalized the value of the child's life, irrespective of any liability they might face. If that were so, economic theory would predict that they would behave optimally in caring for their child.

The preceding analysis suggests that the critical issue is to define minimal care. If courts apply an objective standard, they must know what minimal care is to determine that standard. If courts use the two-step subjective approach, they must know what minimal care is to determine if the defendants were negligent in engaging in the activity of being parents.

There is an initial conceptual difficulty in defining "should have engaged in the activity" with respect to being a parent. Because a parent's role is to care for children, the "harm" from engaging in the activity of being a parent is atypical--it does not involve causing harm, but rather involves preventing less harm than some benchmark parent would have prevented. The question of what is the correct benchmark for this analysis does not have an obvious answer. To focus on the benefit issue, however, I will assume this question away and postulate that a benchmark exists. Thus, we can evaluate parents in terms of the "harm" they cause based on their departure from that standard.

By making this assumption, I can apply the analysis developed in this article. If a parent takes what is for that parent optimal care, and the sum of the harm to the child (as defined above) and the cost of care do not exceed the benefits derived from being a parent, the individual should engage in the activity of being a parent. What is critical in this assessment is the value that the individual places on being a parent. In particular, if being parents to the child in Williams was a source of great satisfaction to the defendants, the analysis suggests that we should require them to meet a lower standard of care than we would require of parents deriving less benefit from parenthood.

This case brings sharply into focus several aspects of the role of benefits in defining a controlling standard. First,this problem is very general. Recall that the issues considered here are important only when the injurer derives the benefits. [FN55] In this situation, we will have no self-enforcing incentives for valuing benefits, resulting in a lack of reliable signals as to the value derived. (These signals consist of choices to consume goods or services of different quality offered at different prices.) Instead, the legal system will have to place values on these activities in all cases. Second, the benefit derived consists either of consumption or of investment in human capital (as when one ***278** learns by doing through actually engaging in an activity). These benefits will vary widely among individuals and will be extremely difficult to measure. Third, when benefits loom as a large factor, the distributional differences between a single standard and the two-step subjective approach may have significant allocative consequences.

In cases like Williams, holding injurers liable for engaging in the activity is equivalent to placing all the costs of harm upon them. If we apply an objective standard, some subset of potential parents will have a chance to avoid these costs by providing the additional care required to meet the standard. This difference could be critical for people of limited wealth in determining whether they engage in the activity of parenting.

The issue of benefits, although not explicitly addressed, seems to be involved in many cases. Consider the consumption value of speeding when driving a car, the benefits of gaining experience in an activity, the value of rescuing a child or a kitten, and the benefits in the overall quality of care that may result if doctors in sparsely populated areas engage in lesser specialization.

All one can say with confidence is that variations in benefits are relevant in principle. Whether and to what extent courts should consider differences in the benefits injurers receive from engaging in an activity depends in major part on just how great are the substantial difficulties of assessing benefits of this kind. We cannot determine whether variations in benefits are in fact taken into account without knowing the actual grounds upon which courts decide cases. Perhaps we can take the doctrinal silence as evidence of the difficulty of the question.

IX. CONCLUSION

There are two types of "law and economics" articles: those that claim that because the courts do not understand economics, they render bad decisions, and those that claim that the courts somehow manage to reach good results anyway. I started out believing I was writing the first type and found myself writing the second.

The economic theory underlying the use of a single standard explains judicial practice to a remarkable degree. When the balance of high information costs and small misincentive effects favors an objective standard, the courts apply such a standard. When the misincentive effects of an objective standard are high and the information costs to determine individual ability to take care are low, courts take the subjective approach. Not surprisingly, because the economic theory implicates difficult empirical questions, courts base their decisions upon crude, unarticulated estimates of the relevant magnitudes. Perhaps explicit attention to these issues could improve the decisionmaking process. But on the whole, the results seem remarkably good.

***279** There are two aspects of the problem that courts do not deal with very well. Prior investment to improve the ability to take care is an important phenomenon. Individually assessing these investment decisions is extremely costly and error-prone. Thus, a single standard, while substantially flawed as a source of incentives for efficient investment, does have some desirable properties. Most significantly, everyone who finds it worthwhile to meet the standard has perfect incentives to invest so as to meet the standard at lower cost. I have not systematically explored the implications of these incentive effects in devising an optimal single standard. I have an intuition that such an exploration would be fruitful.

The second aspect of the problem that leaves me uneasy is the relevance of benefits. Courts do not explicitly address the issue and yet I believe it is pervasive. After all, it is not obvious whether we should entrust the care of a child to a person who is not very good at being a parent but derives much satisfaction from being one. I suspect that this issue arises frequently in torts and other legal contexts. I have tried to clarify the consequences associated with different legal responses. I cannot, however, explain what courts actually do or offer confident suggestions as to what should be done.

[FNa] Professor of Law, Georgetown University Law Center. I wish to thank the students in my Torts classes for their challenging questions concerning the subject matter of this article. The persistent refusal of my 1988 class to accept as adequate the explanations I initially offered them inspired me to try to find out what I really thought about the "reasonable person". Steven Shavell's suggestions have been very helpful in attempting to do this. I also wish to thank Frank Flegal, Michael Gottesman, Gillian Hadfield, Tom Krattenmaker, Peter Menell, James Oldham, Steven Salop, Michael Trebilock, William Vukowich, and workshop participants from George Mason University Law School, Georgetown University Law Center, and Harvard University Law School for comments on earlier drafts, and Amy Brennan and Robert Mueller for their research assistance.

[FN1]. The terms objective standard, prescribed standard, and single standard will be used interchangeably in this article.

[FN2]. In particular, see the passages in O.W. HOLMES, THE COMMON LAW (1881), discussed infra at part VIII.

[FN3]. See W. LANDES & R. POSNER, THE ECONOMIC STRUCTURE OF TORT LAW (1987).

[FN4]. See S. SHAVELL, ECONOMIC ANALYSIS OF ACCIDENT LAW (1987).

[FN5]. I formulate the problem so that we can compare the costs and benefits of engaging in the activity on some assumed number of occasions. Under a more complicated formulation, the individual would decide not only whether, but how often, to

engage in an activity. Introducing this complication would make the analysis more complex but would not materially affect any of the conlusions.

[FN6]. If, as discussed infra at Part V, the benefits of engaging in the activity vary, there will be a different minimal level of care for each group of people realizing the same benefits.

[FN7]. Obviously, these assumptions do not hold true "in the real world." Nevertheless, I make these assumptions to allow us to focus on problems that still exist if the assumptions are relaxed. This is especially true with respect to the assumption that the legal system makes no errors. For a discussion of the adjustments in an individual's behavior resulting from legal error, see S. SHAVELL, supra note 4, at 79-83, 93-99.

[FN8]. Throughout this article, I will utilize Shavell's convention of referring to the classes of individuals involved in an accident as injurers and victims. As Shavell suggests, it may help the reader to think of injurers as automobile drivers and of victims as bicyclists. See id. at 5, 33.

[FN9]. The standardized unit of care is defined supra at Part II.

[FN10]. Harm can occur when either victim or injurer, or both, fail to take sufficient care. Harm can also occur when both victim and injurer take sufficient care, because not all accidents can be avoided in an efficient manner. See S. SHAVELL, supra note 4, at 7.

[FN11]. The analysis would be the same if we assumed that only the behavior of victims mattered and the rule was no liability for injurers.

[FN12]. As developed infra in Part III.c.2, we can realize these savings in process costs only by creating incentives that lead some people to take too little and others too much care while engaging in the activity.

[FN13]. See W. LANDES & R. POSNER, supra note 3, at 123-32.

[FN14]. Id. at 123.

[FN15]. "Suboptimal behavior" is a term of art indicating any deviation from optimality. Thus, those in Area II of Figure B act suboptimally by taking what is for them excessive care. Similarly, those in Area III act suboptimally by taking what is for them insufficient care.

[FN16]. In many instances, we may avoid this result by applying a subjective standard rather than the prescribed standard to those people whose optimal level of care is above the prescribed level. See PROSSER AND KEATON ON TORTS 185 (5th ed. 1984).

[FN17]. This is the standard misallocative effect that may result when one can avoid liability by conforming to a legal requirement. Consider the following example:

Units of Care	Cost of Care	Marginal Benefit of Care
1	$1	$2.50
2	$2	$2.50
3	$3	$2.50

Two units of care are optimal, because the third unit costs $3 and reduces harm by only $2.50. This is how a person subject to a rule of strict liability would behave. However, if the legal rule provides that the injurer will not be liable for any harm if she provides three units of care, it may be worthwhile for the injurer to provide the additional unit. Assume, for example, that the injurer's liability with two units will be $5. The benefit of providing the third unit will be avoiding this $5 liability, and not the $2.50 reduction in harm resulting from the additional care taken.

[FN18]. W. LANDES & R. POSNER, supra note 3, at 125 (graph).

[FN19]. If we governed those whose optimal level of care was above the prescribed level by a subjective standard, we would incur large process costs to determine the optimal level of care for each of the individuals.

[FN20]. W. LANDES & R. POSNER, supra note 3, at 125.

[FN21]. Id.

[FN22]. Id.

[FN23]. S. SHAVELL, supra note 4, at 90 (graph).

[FN24]. This is the same effect as that in Area II of the Landes and Posner analysis.

[FN25]. See RESTATEMENT (SECOND) OR TORTS §§ 283 (objective standard is general rule), 283A (subjective exception for children), 283C (subjective standard for physical deficiency), 293B (objective standard for mental deficiency) (1965) [hereinafter RESTATEMENT].

[FN26]. My colleague Michael Gottesman, a Visiting Professor of Law at Georgetown University Law Center, insists that I qualify this statement by pointing out that, as a normative matter, many people will draw a line beyond which they cannot justify greater harm to others by the greater benefits received.

[FN27]. The possibility that these distributional differences will have allocative consequences is discussed infra at Part VI.

[FN28]. The victim may be engaging in the same activity as the injurer, as when both are driving automobiles. Conversely, both may be engaging in separate activities, as when the injurer is driving an automobile and the victim is a bicyclist. See supra note 7.

[FN29]. These rules are preferred when the actions of only victims or injurers matters.

[FN30]. Several colleagues have suggested that the interdependence of the behavior of injurers and victims constitutes another reason for applying a single standard. An injurer will have lower information costs if she can assume that all victims are conforming to a single standard of care. As in the case of decisionmaking by courts, she achieves this savings at the cost of suboptimal behavior by many victims. I leave open the possibility that we can devise a more inclusive theory of an optimal single standard incorporating these additional considerations.

[FN31]. O.W. HOLMES, supra note 2.

[FN32]. Id. at 108.

[FN33]. Holmes, in discussing the objective standard based upon the "reasonable man," noted:
The law considers, in other words, what would be blameworthy in the average man, the man of ordinary intelligence and prudence, and determining liability by that. If we fall below the level in those gifts, it is our misfortune; so much as that we must have at our peril, for the reasons just given. But he who is intelligent and prudent does not act at his peril, in theory of law. On the contrary, it is only when he fails to exercise the foresight of which he is capable, or exercises it with evil intent, that he is answerable for the consequences.
Id. at 108-09.

[FN34]. Id. at 109.

[FN35]. Id. (emphasis added).

[FN36]. RESTATEMENT, supra note 25.

[FN37]. Id. § 283C, comment c (emphasis added).

[FN38]. Id. (emphasis added).

[FN39]. See supra Part III.c.2.

[FN40]. RESTATEMENT, supra note 25, § 283C, comment a.

[FN41]. Id. § 283C, comment b.

[FN42]. 52 N.H. 244(1872). This opinion perceptively separates the issues of the care to be used and whether the person should have engaged in the activity.

[FN43]. Id. at 250.

[FN44]. Id. at 251.

[FN45]. Id. at 252 (emphasis added).

[FN46]. Recall that to counteract the effects of people who engage in the activity although they should not, we set an optimal single standard above minimal care. We also do this so that those people whose optimal level exceeds minimal care will not take only minimal care. See supra Part III.c.3.

[FN47]. RESTATEMENT, supra note 25, § 283B, comment b.

[FN48]. Id. § 283C, comment b.

[FN49]. See MacConnell v. Hill, 569 S.W.2d 524, 526 (Tex. Civ. App. 1978) (child under five incapable of negligence) (citing Yarborough v. Berner, 467 S.W.2d 188, 190 (Tex. 1971)); Harris v. Moriconi, 331 So.2d 353, 355 (Fla. Dist. Ct. App. 1976) (child under six cannot be held liable for negligence); Holbrock v. Hamilton Distrib. Inc., 11 Ohio St. 2d 185, 189, 228 N.E.2d 628, 630 (1967) (child under seven is incapable of contributory negligence); Dorr v. Atlantic Shore Line Ry., 76 N.H. 160, 161, 80 A. 336, 337 (1911) (contributory negligence not imputable to a 5-1/2 year-old child); Goodale v. York, 74 N.H. 454, 455-56, 69 A. 525, 526-27 (1908) (boy of 16 with limited comprehension and experience could not be expected to appreciate the risk of operating machinery).

[FN50]. See, e.g., Norfolk & Portsmouth Belt Line R.R. v. Barker, 221 Va. 924, 929, 275 S.E.2d 613, 616 (1981) (child held to standard of reasonable person of like age, intelligence, and experience under like circumtances) (quoting Restatement (Second) of Torts § 464(2) (1985)); Caradori v. Fitch, 200 Neb. 186, 189, 263 N.W.2d 649, 652 (1978) (standard is that degree of care which an ordinarily prudent child of the same capacity to appreciate and avoid danger would use); Davis v. Bushnell, 93 Idaho 528, 530-31, 465 P.2d 652, 654-55 (1970) (eight-year-old child operating bicycle held to child's standard of care); Hamel v. Crosietier, 109 N.H. 505, 506-07, 256 A.2d 143, 145 (1969) (standard of care for child using slingshot is determined with reference to particular child's age, intelligence, and experience); Bresnehan v. Gove, 71 N.H. 236, 239, 51 A. 916, 917 (1902) (eleven-year-old plaintiff is not relieved of the obligation to use care and prudence that persons of his age and intelligence would be expected to use under the same circumstances).

[FN51]. See Robinson v. Lindsay, 92 Wash. 2d 410, 413, 598 P.2d 392, 394 (1979) (thirteen-year-old operating snowmobile, which is an inherently dangerous activity, held to adult standard of care); Goodfellow v. Coggburn, 98 Idaho 202, 203-04, 560 P.2d 873, 874-75 (1977) (thirteen-year-old operating tractor on a public highway held to adult standard); Krahn v. LaMeres, 483 P.2d 522, 525-26 (Wyo. 1971) (sixteen-year-old operating automobile held to adult standard); Harrelson v. Whitehead, 236 Ark. 325, 327, 365 S.W.2d 868, 869-70 (1963) (child operating motorcycle held to adult standard); Betzold v. Erickson, 35 Ill. App. 2d 203, 209-10, 182 N.E.2d 342, 345 (1962) (thirteen- year-old driving truck held to adult standard); Dellwo v. Pearson, 259 Minn. 452, 457-58, 107 N.W.2d 859, 863 (1961) (child operating automobile, airplane, or powerboat held to adult standard).

[FN52]. This is, of course, weakened by the possibility that parents will be induced to keep their child from engaging in the activity.

[FN53]. 4 Wash. App. 908, 484 P.2d 1167 (1971).

[FN54]. Id. at 913, 919, 484 P.2d at 1171, 1174.

[FN55]. Cf. supra Part VI (discussing the relevance of the victim's behavior).

END OF DOCUMENT