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Can You Trust a Doctor You Can't Sue?

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INTRODUCTION

This Article explores the consequences of medical malpractice reform for patients' trust in their physicians and in the health care delivery system. I focus on trust because I view this as a core value in medicine; it is therefore a value that health care law should take account of, just as family law obviously should consider the special qualities of marital or parental relationships, or banking and securities law should consider the conditions necessary to maintaining trust in monetary systems and financial markets.

In the medical arena, trust is vitally important for both instrumental and intrinsic reasons. Doctor-patient relationships are characterized by levels of intimacy, dependency, and vulnerability that are matched or exceeded only by family relationships. Without a high level of trust, patients would not submit to examination, reveal necessary confidences, or undergo invasive or risky treatment. Therefore, trust sets the stage for, even if it does not resolve, most of the major issues in health care law.[1] Health care law is concerned both with maintaining the levels of trust necessary for the effective delivery of medical care, and with punishing and deterring breaches of this trust.

Suits for medical malpractice obviously are central to any inquiry about the connection between law and medical trust. Threat of liability is one of the most effective ways the legal system promotes conditions of trustworthiness—by encouraging physicians to avoid mistakes that cause injury. Also, the ability to sue is the primary method an injured patient can seek to assuage the strong sense of betrayal that can result from egregious medical error, as injured patients sue to teach the doctor a lesson or make the hospital pay.

These connections with trust could easily be framed in terms of the classic tort law purposes of deterrence and corrective justice. However, I prefer initially to use a framework of trust because this helps us to think of medical malpractice law as part of the fabric of health care

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1. *See generally* Mark A. Hall, *Law, Medicine, and Trust*, 55 STAN. L. REV. 463 (2003).

law, rather than as simply an application of generic tort law principles to a particular set of specialized services. In saying this, I am reminded of a comment Professor John Coffee once made about the law of class actions, that "[j]ust as war is too important to be left to generals, civil procedure . . . is too important to be left to proceduralists."[2] Likewise, it is important to consider malpractice law as part of a trust-based law of medical care in order to remind ourselves that these lawsuits arise from a uniquely important relationship with special features that the law should explicitly take into account.[3]

General tort law, in my view, does not offer a well-developed set of analytical tools for thinking about personal injuries arising from deeply trusting relationships. Classic tort law is mainly concerned with isolated events between complete strangers or between parties that have only thin or brief contractual relationships.[4] Therefore, when personal injury arises from relationships of vulnerability, such as the doctor-patient relationship, general tort law principles require significant adjustment in order to fit the special circumstances.[5]

Evidence of this point can be seen in the many special rules that alter how general tort law applies to family relationships. Spouses were once immune from tort suits against each other in order to avoid disturbing family harmony.[6] Currently, this is not the law, but, for similar reasons, parents are still immune in many jurisdictions from tort suits by their children,[7] and courts take into account the special features of family relationships in limiting the duties that general tort

2. John C. Coffee, *The Regulation of Entrepreneurial Litigation: Balancing Fairness and Efficiency in the Large Class Action*, 54 U. CHI. L. REV. 877, 877 (1987).

3. For more on the relational basis for health law, see Mark A. Hall & Carl E. Schneider, *Where Is the "There" in Health Law? Can It Become a Coherent Field?*, 14 HEALTH MATRIX 101 (2004).

4. *See* Thomas C. Grey, *Accidental Torts*, 54 VAND. L. REV. 1225 (2001) (documenting the transition of tort law from isolated applications of the negligence concept to a freestanding body of law concerned with accidents generally). At one time, workplace injury was the primary counterexample of an ongoing relationship of vulnerability that occupied a major portion of tort law, but no-fault workers' compensation moved the employment arena outside of normal tort law almost a century ago. *See generally* PRICE FISHBACK & SHAWN KANTOR, A PRELUDE TO THE WELFARE STATE: THE ORIGINS OF WORKERS' COMPENSATION (2000).

5. Consider, for instance, the special tort principles that apply to common carriage and other forms of "special relationships." RESTATEMENT (THIRD) OF TORTS § 41 (Tentative Draft No. 4, 2004) (on file with author); W. PAGE KEETON ET AL., PROSSER AND KEETON ON THE LAW OF TORTS §§ 34, 56 (5th ed. 1984); DAN B. DOBBS, THE LAW OF TORTS §§ 317, 323 (2000).

6. HOMER H. CLARK, JR., 1 THE LAW OF DOMESTIC RELATIONS IN THE UNITED STATES 370 (2d ed. 1988); DOBBS, *supra* note 5, § 279.

7. CLARK, *supra* note 6, at 375–81; DOBBS, *supra* note 5, § 280; DONALD T. KRAMER, 1 LEGAL RIGHTS OF CHILDREN 468 (2d ed. 1994).

theory might otherwise apply to family members.[8] My point is not that these doctrines should be transplanted directly from family law to malpractice law. Instead, my point is that when courts apply tort law to family relationships, they carefully consider the impact on the special features of family relationships. The same considerations should be true for medical malpractice law.

Other health law scholars have focused a great deal of attention on how well malpractice law creates incentives for improving medical safety and deterring errors, or indeed whether deterrence is excessive by taking the form of "defensive medicine."[9] This is a worthwhile focus, but it misses many of the important connections between malpractice law and the doctor-patient relationship. The primary connection between deterrence and relational concerns is to promote conditions of trust*worthiness*, that is, to encourage physicians to live up to their patients' expectations. Trustworthiness, however, differs from trust itself. Trustworthiness is a normative judgment about what level of competence physicians should achieve. The subjective psychological experience of trust itself might not match objective evaluations of trustworthiness. Patients' actual trust might either exceed or fall below the levels of trust they should have, judged from a normative perspective. Therefore, I consider how malpractice law might relate to *actual* levels of trust, rather than to background conditions that may or may not affect trust directly.

II. MEDICAL MALPRACTICE AND MEDICAL TRUST

In prior work, I outlined two distinct attitudes that law might take toward trust: proactive and reactive.[10] In its proactive stance, law attempts to increase or sustain trust.[11] In its reactive stance, "law takes the existence of trust as a factual premise for imposing a particular rule."[12] As such, "[t]he legal rule does not depend on any assumptions about how law affects trust [as a psychological phenomenon], only that there *is* trust."[13] In contrast, law in its proactive stance seeks

8. DOBBS, *supra* note 5, § 281. For instance, courts are reluctant to allow former or current spouses to sue for intentional infliction of emotional distress because of the difficulty inherent in defining what constitutes unacceptable behavior between spouses. *See generally* Ira Mark Ellman & Stephen D. Sugarman, *Spousal Emotional Abuse as a Tort?*, 55 MD. L. REV. 1268 (1996).

9. *See, e.g.*, Michelle M. Mello & Troyen A. Brennan, *Deterrence of Medical Errors: Theory and Evidence for Malpractice Reform*, 80 TEX. L. REV. 1595, 1606–16 (2002).

10. Hall, *supra* note 1, at 485–86.

11. *Id.* at 486.

12. *Id.*

13. *Id.* (emphasis added).

to produce trust; trust does not produce law.[14] The proactive stance is thoroughly empirical and psychological. Its justification depends on the belief that law actually affects the level of trust.[15] The reactive stance, in contrast, is largely normative; law seeks to punish violations of trust in a fashion that recognizes the levels and types of trust that patients have in physicians and medical institutions.[16]

Under these two broad viewpoints, the first observation about medical malpractice law is that it reacts to trust but does not affect trust. The ability to sue one's doctor for negligent mistakes is not plausibly meant to sustain trust or to restore it once it is violated. Instead, malpractice suits redress violations of trust. Realistically, patients undergoing treatment and worried about their physician's competence are not likely to take much solace in knowing they can sue if the doctor makes a horrible mistake. And, if a medical disaster happens, a successful lawsuit is not likely to restore trust. Other aspects of medical law attempt to keep treatment relationships strong, such as the duty to treat and to keep patient information confidential.[17] But malpractice law, like divorce law, assumes that when it is invoked, relationships are irreparably damaged.

In a distant way, malpractice actions might marginally increase the public's confidence in physicians, in the same way that visible police enforcement increases a community's sense of safety. More plausibly, however, such publicity has just the opposite effect, since highlighting the very worst in the profession casts seeds of doubt about all physicians. Regardless, no one plausibly assumes that conventional malpractice law can repair the particular treatment relationships that give rise to malpractice suits. Hence, malpractice law is not concerned with restoring trust. Instead, malpractice law reacts to the trust-based attributes of medical relationships when it crafts the legal consequences of a breach of these relationships.

Compared with traditional tort theory, my perspective resonates with corrective or retributive justice approaches, which view tort law as punishing wrongdoers or as assigning responsibility for rectifying the consequences of wrongful actions.[18] These theories of tort law have been developed mainly in the context of accidents between strangers, but they have even greater relevance to the thick form of

14. *Id.*

15. *Id.* at 473.

16. Hall, *supra* note 1, at 498.

17. *Id.* at 499; Lois Shepard, *HIV, the ADA, and the Duty to Treat*, 37 HOUS. L. REV. 1055, 1095–98 (2000).

18. *See generally* JULES COLEMAN, RISKS AND WRONGS (1992); Ernest J. Weinrib, *Corrective Justice*, 77 IOWA L. REV. 403 (1992).

trust created by medical relationships.[19] The strong sense of betrayal that can result from the breach of this highly emotive form of interpersonal trust creates morally laden conditions that are highly relevant to retributive or corrective theories of justice.[20] A corrective justice perspective might well have a different quality here than in general tort law because of the unique moral concerns that arise from breaches of duty within interpersonal relationships of great vulnerability.

Unlike existing scholarship on theories of justice, however, I want to inform this normative analysis with empirical information. Corrective or retributive justice scholarship has been criticized as tending toward excessively abstract moralism, consisting of reasoning that either is impenetrable other than by philosophical analysis or that is driven by assertion of *priori* moral premises.[21] In my view, the best approach to justice should not be determined solely by philosophical reflection; instead, law should also recognize how real patients actually respond psychologically to different approaches for compensating injuries arising from medical relationships. I do not claim that justice considerations should be analyzed primarily through empirical methods, but rather that empirical insights should at least be considered where they address relevant aspects of the inquiry. For tort duties arising from medicine, focusing on the trust dimension of medical relationships helps to leaven abstract philosophical analysis with a healthy dose of psychological empiricism.

Other scholars have also observed that concepts such as fairness, justice, and retribution should be studied as psychological constructs that are amenable to measurement through methods of social sci-

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19. For instance, Jules Coleman, a leading corrective justice theorist, goes to great lengths to create and define duties of compensation as arising out of the "relationship" that is created when one person injures another. COLEMAN, *supra* note 18, at 316–18. In medical malpractice, however, this relationship obviously exists prior to any injury and is well-defined in law and ethics. Although Saks and colleagues report that corrective justice ranks at the bottom of relevant considerations for malpractice reform, they still find that it is relevant, and notably that is it more relevant to patients than to other interest groups. *See generally* Michael J. Saks et al., *A Multiattribute Utility Analysis of Legal System Responses to Medical Injuries*, 54 DEPAUL L. REV. 277 (2005).

20. *See generally* David E. Rogers, *On Trust: A Basic Building Block for Healing Doctor/Patient Interactions*, THE PHAROS, Spring 1994, at 2. These conditions exist even in medical relationships of very short duration, such as during surgery or childbirth, because trust results from the deep vulnerability created by illness and medical treatment rather than the patient's extensive knowledge of or experience with a physician.

21. Gary T. Schwartz, *Mixed Theories of Tort Law: Affirming Both Deterrence and Corrective Justice*, 75 TEX. L. REV. 1801, 1810 (1997) ("[T]he more recent literature on corrective justice . . . has become highly abstruse and abstract in ways that render it all but inaccessible to readers lacking a formal training in philosophy.").

ence.[22] These efforts are the focus of the procedural justice branch of law and society scholarship.[23] Procedural justice scholarship, as its name indicates, is not focused on substantive law, however. My approach extends this social science perspective by studying the connections between substantive medical law and patients' trust in physicians and medical institutions.

Those who have studied medical trust note its paradoxical nature.[24] Patients can feel a deep sense of betrayal when treatment goes poorly, but they also have a high capacity to forgive mistakes or to view bad outcomes as unavoidable when they think that care providers are well intentioned.[25] Current malpractice law reflects both the betrayal and the forgiveness attributes of trust-based medical relationships.[26] Malpractice law sets the standard of care according to prevailing medical practices rather than letting juries decide what is reasonable to expect; in part, this is meant to guard against the tendency of some juries to be unduly punitive by expecting an unrealistic degree of perfection from the medical system.[27] However, courts have also liberalized malpractice law in a variety of ways, in part to overcome juries' reluctance to find fault against well meaning physicians, even when negligence is clear.[28] An indication that law embodies both halves of this dualism in large measure is that physicians see strong distrust emanating from the medical malpractice system,[29] whereas many researchers and

22. *See* Neil Vidmar, *Retribution and Revenge, in* HANDBOOK OF JUSTICE RESEARCH IN LAW 33 (Joseph Sanders & V. Lee Hamilton eds., 2001) [hereinafter HANDBOOK] (stating "[g]iven the pervasiveness of retribution and revenge as justice motives, it is remarkable that so little empirical research has been devoted to these topics"). *See also* James Konow, *Which Is the Fairest One of All? A Positive Analysis of Justice Theories*, 41 J. ECON. LIT. 1188 (2003) (surveying empirical literature about various types of justice).

23. *See generally* HANDBOOK, *supra* note 22; TOM R. TYLER ET AL., SOCIAL JUSTICE IN A DIVERSE SOCIETY (1997).

24. *See generally* Mark A. Hall et al., *Trust in Physicians and Medical Institutions: What Is It, Can It Be Measured, and Does It Matter?*, 79 MILBANK Q. 613 (2001).

25. *Id.* at 617.

26. Hall, *supra* note 1, at 492–96.

27. *See generally* Philip G. Peters, *The Role of the Jury in Modern Malpractice Law*, 87 IOWA L. REV. 911 (2002).

28. *See generally id.* (regarding the behavior of malpractice juries); *see also* NEIL VIDMAR, MEDICAL MALPRACTICE AND THE AMERICAN JURY (1995).

29. JETHRO K. LIEBERMAN, THE LITIGIOUS SOCIETY 89–92 (1981) (using malpractice litigation to illustrate declining trust in the professions).

scholars see excessive deference.[30] Reflecting the psychological paradoxes of trust, both views are based in reality.[31]

III. TRUST IMPLICATIONS OF MALPRACTICE REFORM PROPOSALS

How do various medical malpractice reform proposals take account of the complex connections between law and medical trust? First, it is unlikely that most alternative approaches to compensating medical injuries will assume any more of a proactive stance toward trust than does conventional malpractice law. Almost all approaches to defining medical duties and remedying breaches are likely to have no effect on injured patients' trust in their particular care providers. This is not a criticism of these proposals, but simply a statement of likely reality. Therefore, to the extent one is concerned about issues of trust, the relevant inquiry is how well these proposals take account of the normative aspects of trust-based relationships, and not whether these proposals actually affect the level of trust as an empirical matter.

One possible exception to this generalization is the form of elective no-fault, also known as "early offer" or "neo-no-fault," that encourages care providers to disclose medical errors and to offer fair compensation for the resulting injuries, regardless of technical definitions of fault.[32] Research reveals that, often, what injured patients most desire are candid acknowledgements of medical errors, a sincere apology that conveys genuine remorse, and constructive steps toward corrective actions.[33] Some versions of elective no-fault encourage these

30. *See* PAUL C. WEILER, MEDICAL MALPRACTICE ON TRIAL 13 (1991) (noting that "a large gap obtains between the number of tort events taking place inside hospitals and those that eventually filter into the court system").

31. For a recent overview of both sides of this debate, see David Studdert et al., *Medical Malpractice*, 350 NEW ENG. J. MED. 283 (2004).

32. Jeffrey O'Connell is the original architect of this idea, but his approach still relies on patients to initiate a claim before providers are expected to come forward with an offer of compensation. *See generally* Jeffrey O'Connell, *Neo-No Fault Remedies for Medical Injuries: Coordinated Statutory and Contractual Alternatives*, 45 J.L. & CONTEMP. PROBS. 125 (1986); Jeffrey O'Connell, *Offers That Can't Be Refused*, 77 NW. U. L. REV. 589 (1982). Other approaches seek to encourage providers to step forward earlier, before a claim is filed, or even before the patient may realize he or she has been affected by a medical error. *See* INST. OF MED., FOSTERING RAPID ADVANCES IN HEALTH CARE: LEARNING FROM SYSTEM DEMONSTRATIONS 81–89 (Janet M. Corrigan et al. eds., 2002).

33. Jonathan R. Cohen, *Advising Clients to Apologize*, 72 S. CAL. L. REV. 1004, 1009 (1999); Thomas H. Gallagher et al., *Patients' and Physicians' Attitudes Regarding the Disclosure of Medical Errors*, 289 JAMA 1001 (2003); Gerald B. Hickson et al., *Factors That Prompted Families to File Medical Malpractice Claims Following Perinatal Injuries*, 267 JAMA 1359 (1992); Kathleen M. Mazor et al., *Health Plan Members' Views About Disclosure of Medical Errors*, 140 ANNALS INTERNAL MED. 409 (2004). It is noteworthy that scholarship on the need for law generally to facilitate apology often discusses medical malpractice cases as leading examples. *See, e.g.*, Jonathan R. Cohen, *Apology and Organizations: Exploring an Example from Medical Practice*,

proactive steps by the responsible party rather than relying on patients' sense of wrongdoing to initiate a malpractice claim.[34] This approach has the potential to maintain or promote trust by pre-empting a breach in the treatment relationship, or by encouraging a form of reconciliation that might restore a broken relationship.[35] All other reform proposals, however, continue to rely on patients to initiate claims and to place providers in a defensive, non-apologetic position. Therefore, they assume, perhaps correctly, that medical relationships are irretrievably broken.

Even if reform proposals cannot hope to sustain or restore trust, it is still important to consider the corrective justice perspective of how well various reform proposals account for the trust-based characteristics of treatment relationships. One prominent reform measure is to cap non-compensatory damages at a level such as $250,000.[36] This appears to blunt the retributive element of tort law and to undermine the goal of corrective justice to restore patients fully to their pre-injured position—even in the most severe cases where justice places the greatest demands. Viewed normatively, then, a damages cap is difficult to defend.[37]

Viewed empirically, however, a damages cap may not in fact undermine the psychological foundations of corrective justice. Social science studies of people's sense of fairness in a wide variety of legal settings reveal that people respond as much or more to the procedural as to the substantive dimensions of the legal system.[38] Litigants recognize unfavorable outcomes as legitimate if they believe they have

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27 FORDHAM URB. L.J. 1447 (2000); Lee Taft, *Apology Subverted: The Commodification of Apology*, 109 YALE L.J. 1135 (2000).

34. *See* INST. OF MED., *supra* note 32, at 81–89.

35. *See* sources cited *supra* note 33. *See generally* RESTORATIVE JUSTICE: PHILOSOPHY TO PRACTICE (Heather Strang & John Braithwaite eds., 2000); Douglas N. Frenkel & Carol B. Liebman, *Words That Heal*, 140 ANNALS INTERNAL MED. 482 (2004); Erin Ann O'Hara, *Apology and Thick Trust: What Spouse Abusers and Negligent Doctors Might Have in Common*, 79 CHI.-KENT L. REV. 1055, 1079–81 (2004).

36. *See* U.S. DEP'T OF HEALTH & HUMAN SERVS., CONFRONTING THE NEW HEALTH CARE CRISIS (July 2002), http://www.aspe.hhs.gov/daltcp/reports/litrefm.pdf.

37. *See generally* Maxwell J. Mehlman, RESOLVING THE MEDICAL MALPRACTICE CRISIS: FAIRNESS CONSIDERATIONS (Report of the Pew Charitable Trusts Project on Med. Liability in Pa., June 2003), *available at* http://medliabilitypa.org/research/mehlman0603/MehlmanReport.pdf; Saks et al., *supra* note 19. Others, however, argue that caps are consistent with corrective justice because nonpecuniary losses are speculative. *See* DON DEWEES ET AL., EXPLORING THE DOMAIN OF ACCIDENT LAW 119 (1996).

38. E. Allan Lind et al., *In the Eye of the Beholder: Tort Litigants' Evaluations of their Experiences in the Civil Justice System*, 24 LAW & SOC'Y REV. 953, 980–86 (1990); Tom R. Tyler & E. Allan Lind, *Procedural Justice*, *in* HANDBOOK, *supra* note 22.

been treated fairly during the proceedings.[39] Therefore, diminishing the size of a favorable outcome might not significantly diminish patients' sense of vindication or retribution from winning a malpractice verdict.

Might physicians' psychological sense of fairness and justice be any more responsive than patients' to capping damages? This is not likely for physicians who lose cases (and therefore for whom a damages cap is relevant). Losing physicians still suffer the ignominy of being found negligent and of having a sizeable verdict assessed against them.[40] Applying the procedural justice model of Professors Tom R. Tyler and E. Allan Lind,[41] physicians' extreme displeasure with the legal system stems not from the size of verdicts but from the fact that, even when they win,[42] physicians are treated by the litigation process in a way that undermines their sense of being trusted and respected professionals, which threatens their sense of standing in society.[43] None of that is changed by capping damages.

A second category of reforms consist of administrative no-fault compensation systems.[44] These dispense with any attempt to assess blame for medical injuries; therefore, they might be expected to mollify physicians but at the same time to deny patients the vindication they sometimes seek from the tort system. Moreover, they minimize the "voice" that, according to procedural justice studies, litigants seek from adversarial proceedings—namely the sense that their claim has been heard and fairly considered.[45] On the other hand, studies show

39. Tyler & Lind, *supra* note 38, at 75; Tom R. Tyler & E. Allan Lind, *A Relational Model of Authority in Groups*, *in* 25 ADVANCES IN EXPERIMENTAL SOCIAL PSYCHOLOGY 115, 145–49 (Mark P. Zanna ed., 1992).

40. *See* William M. Sage, *Principles, Pragmatism, and Medical Injury*, 286 JAMA 226 (2001) (describing the "moral opprobrium" that physicians attached to allegations of professional malpractice).

41. *Id.*

42. *See, e.g.*, MARK A. HALL ET AL., HEALTH CARE LAW AND ETHICS 266–67 (6th ed. 2003) (recounting a physician's outrage at being named in a lawsuit, even though he was soon dismissed); Daniel Merenstein, *Winners and Losers*, 291 JAMA 15–16 (2004) (recounting a physician's negative reaction to a jury trial that he won but his clinic employer lost).

43. For various accounts of physicians' attitudes toward being sued for malpractice, see HOWARD C. SNYDER, JURY OF MY PEERS: A SURGEON'S ENCOUNTER WITH THE MALPRACTICE CRISIS (1991); F. Patrick Hubbard, *The Physician's Point of View Concerning Medical Malpractice*, 23 GA. L. REV. 295 (1989); Nathaniel Hupert et al., *Processing the Tort Deterrent Signal: A Qualitative Study*, 43 SOC. SCI. & MED. 1 (1996).

44. *See, e.g.*, Randall R. Bovbjerg et al., *Obstetrics and Malpractice: Evidence on the Performance of a Selective No-Fault System*, 265 JAMA 2836 (1991); Randall R. Bovbjerg & Frank A. Sloan, *No-Fault for Medical Injury: Theory and Evidence*, 67 U. CIN. L. REV. 53 (1998); David Studdert, *Toward a Workable Model of No-Fault Compensation for Medical Injury in the United States*, 27 AM. J.L. & MED. 225 (2001).

45. Lind et al., *supra* note 38, at 981; Tyler & Lind, *supra* note 38, at 75.

that procedural justice can be achieved through a wide variety of alternative forms of dispute resolution.[46]

Regardless of who pays, or according to what standard, medical injury claims unavoidably target a care provider and identify a medical error. This may be sufficient to give patients the sense of justice they seek. Certainly, physicians are likely to take umbrage at payment of claims involving care they render even when fault is not assessed and even when someone else pays. This is one reason physicians previously responded so coolly to proposals for exclusive enterprise liability,[47] which would hold only hospitals or health plans liable for physicians' errors.

Ultimately, we cannot know for sure how an administrative no-fault claims system would affect either party's sense of justice until the question is studied empirically. Even when this is done, however, it is likely the results will be inconclusive. Empirical studies of complex psychological phenomena usually find that different and sometimes contradictory positions are held simultaneously. This likely indeterminacy should not keep us from examining these questions empirically, however. Examining these questions helps to make more explicit whether various positions are based on empirical assumptions that lack any evidentiary support. Further, this helps to examine more openly the inevitable trade-offs one faces between competing values such as justice and efficiency.

IV. CONCLUSION

On balance, the reforms that call for early-offer no-fault compensation are the most consistent with trusting medical relationships. This approach satisfies both the goals of corrective justice and the "restorative justice" desire to maintain effective medical relationships. Other reform approaches continue to address only law's reactive stance toward trust, but do not attempt to promote trust. In the reactive stance, some reforms might appear to detract materially from law's ability to respond appropriately to serious violations of trust, but these in part are empirical claims that have not been tested.

Beyond these limited insights into particular reform proposals, this Article attempts to develop a more robust approach to analyzing medical malpractice law from a perspective of corrective justice. This perspective has been neglected to date in favor of more instrumentally

46. Lind et al., *supra* note 38, at 959.

47. *See generally* Frances Miller & Anthony Harrison, *Malpractice Liability and Physician Autonomy*, 342 LANCET 973 (1993).

focused inquiries about deterrence and efficient compensation.[48] Focusing on the intensely trusting qualities of medical relationships forces us to consider how law should account for the strong sense of betrayal that can result from a breach of this trust. But, unlike corrective justice theorists, I prefer to do this using the social science tools of procedural justice studies. These allow us to test empirically, or at least to hypothesize, whether different approaches to medical malpractice reform will give injured patients and accused physicians a greater or lesser sense that justice is being done. Although this should not be the sole, or perhaps even the primary, basis for deciding what is best to do, this empirical psychological perspective should not be neglected in considering how law responds to injuries arising from deeply trusting medical relationships.

48. *See generally* David A. Hyman, *Medical Malpractice and the Tort: What Do We Know and What (If Anything) Should We Do About It?*, 80 TEX. L. REV. 1639 (2002) (providing a comprehensive overview of medical malpractice literature).