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Three Prespectives on Medical Injury: A Commentary

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THREE PERSPECTIVES ON MEDICAL INJURY: A COMMENTARY

*Robert L. Rabin**

INTRODUCTION

One way of thinking about the role of tort law in our sociopolitical system is to pose this question: To what extent does tort law make a positive contribution to addressing the problem of accidental harm? Unfortunately, engaging in this inquiry raises more questions than can confidently be answered. In recent years, criticism of the tort system has cast considerable doubt on each of its foundational precepts. The *optimal deterrence* goal of the system is grounded in economic theory that has never been demonstrated to have strong empirical support.[1] The *compensation* goal of the system comes at a very high administrative cost, and by definition fails to satisfy a corollary principle of fundamental fairness in treating like injuries in like fashion.[2] And agreement on the substantive content of a commitment to *corrective justice* remains a bone of contention among philosophically minded scholars.[3]

If this state of affairs inspires a general sense of humility—let alone unease—among torts enthusiasts, there has been little in the way of respite by avoiding the broad terrain of tort and instead focusing on particular sub-areas of accidental harm. As a consequence, one approaches a Symposium on medical malpractice, entitled *Starting Over?: Redesigning the Medical Malpractice System*,[4] with some trepi-

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1. *See generally, e.g.*, Don Dewees & Michael Trebilcock, *The Efficacy of the Tort System and Its Alternatives: A Review of Empirical Evidence*, 30 OSGOODE HALL L.J. 57 (1992); Gary T. Schwartz, *Reality in the Economic Analysis of Law: Does Tort Law Really Deter?*, 42 UCLA L. REV. 377 (1994).

2. For an oft-cited study, finding that accident victims generally received somewhat less than half of the dollars distributed in tort awards, see JAMES S. KAKALIK & NICHOLAS M. PACE, COSTS AND COMPENSATION PAID IN TORT LITIGATION (1986).

3. *See generally, e.g.*, PHILOSOPHICAL FOUNDATIONS OF TORT LAW (David G. Owen ed., 1995) (discussing a wide array of perspectives). For a critique of a slightly earlier generation of corrective justice scholars, see Gary T. Schwartz, *The Vitality of Negligence and the Ethics of Strict Liability*, 15 GA. L. REV. 963 (1981).

4. Symposium, *Starting Over?: Redesigning the Medical Malpractice System*, 54 DEPAUL L. REV. 203 (2005).

dation, but also, more positively, with the conviction that multiple pathways are open for exploring the contribution that tort law can make to accident reduction, victim reparation, and an overall sense of fair treatment.

On that score, the three articles that I have been asked to comment on examine the medical malpractice system from decidedly different vantage points. In *Can You Trust a Doctor You Can't Sue?*, Professor Mark Hall adopts as his focal point the doctor-patient relationship, and explores, as he puts it at the outset, "the consequences of medical malpractice reform for patients' trust in their physicians and the health care delivery system."[5] By contrast, Professor Lori Andrews's article, *Studying Medical Error* In Situ*: Implications for Malpractice Law and Policy*, takes a systems analysis approach and reports on an observational case study of the internal dynamics of medical error identification in a large teaching hospital.[6] Finally, from still another perspective, Professor Neil Vidmar and his co-authors' article, *Uncovering the "Invisible" Profile of Medical Malpractice Litigation: Insights from Florida*, sets its sights on an empirical examination of medical malpractice litigation, offering recent data on claims and costs from a study of the Florida tort system.[7]

While each of these articles represents a distinct genre of scholarship, it is possible to view them as different aspects of the broader inquiry I identified above—whether tort, in any given area, makes a positive contribution to addressing the problem of accidental harm. Beyond this loose connection, for purposes of organizing my comments, it is possible to view these three articles as dealing with the following "flow" of physician-patient relations: from (1) initial contact at the time of a presenting problem (Hall on the relationship of "trust"); through (2) treatment procedures in a hospital setting (Andrews on medical error in the hospital context); and culminating at times in (3) claims of adverse outcomes that trigger litigation (Vidmar et al. on malpractice litigation claims and awards). I will discuss the articles in that order.

5. Mark A. Hall, *Can You Trust a Doctor You Can't Sue?*, 54 DEPAUL L. REV. 303 (2005).

6. Lori Andrews, *Studying Medical Error* In Situ*: Implications for Malpractice Law and Policy*, 54 DEPAUL L. REV. 357 (2005).

7. Neil Vidmar et al., *Uncovering the "Invisible" Profile of Medical Malpractice Litigation: Insights from Florida*, 54 DEPAUL L. REV. 315 (2005).

II. The Dynamics of Medical Injury

A. Trust

Hall's article rests on the premise that the physician-patient relationship is distinct from tort law generally because most tort cases involve "strangers" or "thin contractual relationships."[8] By contrast, the physician-patient relationship is ongoing and characterized by trust.[9] I could not agree more strongly with the importance of a sense of trust to the ongoing relationship between patients and their physicians. But it is far from clear to me that the trust relationship can bear the great weight that Hall would assign to it. In the myriad of "thin" relationships that give rise to tort suits, something closely akin to trust—if not quite so heavily freighted a concept—seems generally to be in play. The product user victimized by a defective lawnmower or vehicle braking system, the bus passenger injured by the carelessness of her driver, or the retail shopper buried under a cascade of falling boxes certainly has suffered a serious jolt to standing expectations such that in the ordinary course of dealing with a service or product supplier there will be, at a minimum, no deviation from customary norms of safety. I am not sure one would call this "trust," but in thinking about *liability rules*, I am equally unsure what turns on a distinction between trust and normal expectations of safety.[10]

There is a more fundamental point here, it seems to me, that can be characterized in *ex ante* and *ex post* terms. Hall tracks this characterization, in a sense, by distinguishing between trustworthiness and trust.[11] Trustworthiness, as he views it, is promoted by the received doctrinal apparatus of medical malpractice, which is meant to promote adherence to customary standards of medical practice—hence, encouraging physicians to exercise due care *ex ante*.[12] Trust, by contrast, is an empirical, "psychological" phenomenon according to Hall—a patient may have expectations about the physician's competence that in fact exceed the norms of customary expertise (or, I suppose, hypothetically at least, the patient might harbor sub-optimal expectations).[13] Again, while I would not quarrel with this point, I am

8. Hall, *supra* note 5, at 304.

9. *Id.*

10. In fact, Hall might have developed the relational theme more expansively through discussion of the *physician's* perspective on the breakdown of trust: in particular, the correlative concern about the costs of anticipatory defensive medicine. Hall's focus is primarily on the patient's perspective in the relationship. *Id.* at 303.

11. *Id.* at 305.

12. *Id.*

13. *Id.*

not certain what significance should be attached to it. I say this because trust, once Hall turns to the medical malpractice perspective, is an *ex post* phenomenon; that is, he examines it in light of various medical malpractice reform proposals and links it to a discussion of restorative corrective justice principles.[14]

But the difficulty here is that *ex post*, trust seems no longer to have any relevance to the physician-patient relationship. In the provision of health care services, most malpractice occurs in the course of surgery, post-surgical care, or nonsurgical, in-patient procedures: consider, for example, the obstetrician who delivers a birth-damaged child or botches an episiotomy, the nurse or resident who triggers a drug-related mishap, or the anesthesiologist who is responsible for neurological damage. In virtually all of these instances, there is no continuing relationship; indeed, in the modern era of medical specialization, "thin" relationships are the norm in circumstances where medical malpractice may occur.[15]

More broadly, however, once a patient is sufficiently aggrieved by perceived medical incompetence to pursue a tort claim, it seems deeply counterintuitive to think that trust can be reestablished. Alternatively, it is plausible to think that a sense of fair treatment under the circumstances can be created retroactively—what Hall seems to refer to as fair process near the end of his article.[16] Any effort to design a liability system that establishes a sense of fair treatment and just compensation—let alone a system that promotes optimal prevention by efficiently identifying medical errors—seems an entirely different enterprise from striving to recreate trust in a broken relationship.

Hall is not indifferent to this point. Indeed, he observes that "malpractice law, like divorce law, assumes that when it is invoked, relationships are irreparably damaged."[17] As a consequence, his central theme addresses the question of how malpractice reform proposals ought to take into account the special claims for redress arising from a broken relationship of trust.[18] From this vantage point, he offers brief observations on an array of current tort reform proposals: neo-no fault (encouraging early offers by health care providers limited to eco-

14. Hall, *supra* note 5, at 306–12.

15. *See infra* Part II.B (developing this point in greater detail and discussing preventable medical errors).

16. Hall, *supra* note 5, at 311–12.

17. *Id.* at 306.

18. *Id.* Note that this focal point is at odds with his opening intention of exploring "the consequences of medical malpractice reform for patients' trust in their physicians." *See supra* text accompanying note 5. The causal arrow appears to point in the opposite direction. His perspective seems to focus on the consequences of patients' trust for medical malpractice reform.

nomic loss), caps on non-economic loss, and administrative no-fault compensation schemes.[19] Hall's discussion is, by his own account, speculative—largely aimed at raising questions that deserve further empirical exploration: the extent to which each of these strategies addresses vindication of a sense of betrayal experienced by a malpractice victim as a consequence of breach of trust.[20]

While I have no quarrel with empirical inquiry into the psychological aspects of breach of trust, I come full circle back to my earlier observations about the universe of tort victims in thin relationships. Surely, the claim of a rape victim against a landlord for providing inadequate security, the claim of a serious burn victim against a manufacturer for selling an excessively flammable product, or, for that matter, the claim of a seriously injured transport victim against a perceived careless driver rests on a complex mix of desires. These desires include economic redress as an end in itself and more subtle psychological motivations, such as seeking accountability, vindication, and/or vengeance for a sense of betrayed expectations. Perhaps it indicates a failure of imagination on my part, but I see no particular reason to think that breach of patient-physician trust, despite its singular context, would play out differently from these other relationships in assessing current tort reform strategies.

B. Preventable Medical Error

With all due respect, then, for the importance of trust in relationships between patients and physicians, it is difficult to see its bearing on the potential goals of medical malpractice reform strategies. But precisely what are those goals? In the political arena, the principal goal appears to be easing the liability burden imposed on physicians by reducing tort claims and damage awards.[21] Over the course of three decades, there have been continuous waves of state legislative tort reform, with the medical malpractice critics playing a prominent role in the efforts to scale back costs imposed on physicians by tort

19. Hall, *supra* note 5, at 309–12.

20. *Id.* at 312.

21. These aims can be traced back to the enactment of the Medical Injury Compensation Reform Act (MICRA) by California in 1975, which established a $250,000 cap on pain and suffering recovery, maximum percentages on contingency fee awards, and a variety of other limitations. *See* Medical Injury Compensation Reform Act of 1975 (MICRA) (codified at CAL. BUS. & PROF. CODE § 6146 (West 2003), CAL. CIV. CODE § 3333 (West 1997), CAL. CIV. PROC. CODE §§ 340.5, 1295 (West 1982)). For a recent empirical study of the impact of MICRA's caps on California jury trials, see NICHOLAS M. PACE ET AL., RAND INST. FOR CIVIL JUSTICE, CAPPING NON-ECONOMIC AWARDS IN MEDICAL MALPRACTICE TRIALS: CALIFORNIA JURY VERDICTS UNDER MICRA (2004).

litigation.[22] These reform efforts rest on related assumptions that there is excessive malpractice litigation at too high a cost. As I will discuss below, the Vidmar article contributes to an empirical literature that calls these premises into question to some extent through examination of malpractice litigation trend data.[23]

But a more fundamental issue is raised by the Andrews article: Does the litigation-related data on claims in fact accurately reflect the existing universe of preventable medical error?[24] If not, one can argue that the reform movement is in some measure misguided. It is difficult to sustain the position that there is excessive litigation against physicians if in fact tort suits constitute only the tip of an iceberg of preventable medical errors that lies below the surface of identified malpractice. Of course, it could still be the case that physicians in certain areas of specialization are subjected either to an inordinate volume of claims or intolerably high insurance premiums (or both); obstetricians have been especially vociferous in this regard.[25] But high-volume, undetected preventable medical error—largely off the radar screen of present medical malpractice litigation—surely would rank as a public health and liability law concern of the first order.

More recently, this phenomenon of medical injury has attracted attention of interdisciplinary research teams whose focus has been on the identification and prevention of medical error from a systems analysis perspective, focusing on the incidence of medical negligence in the hospital setting. Two especially prominent efforts have been the Harvard Medical Practice Study (Harvard Study)[26] and the Institute of Medicine Report (IOM Report).[27]

The Harvard Study focused on determination of the incidence of "adverse events" in the course of medical treatment by examining hospital discharge records of patients based on neutral physician re-

22. The successive waves of tort reform litigation are described briefly, with cites to relevant articles, in MARC A. FRANKLIN & ROBERT L. RABIN, TORT LAW AND ALTERNATIVES: CASES AND MATERIALS 787–91 (7th ed. 2001).

23. In recent years, there have been empirical studies in this vein extending beyond the medical malpractice area. *See generally, e.g.*, Marc Galanter, *Real World Torts: An Antidote to Anecdote*, 55 MD. L. REV. 1093 (1996).

24. Andrews, *supra* note 6, at 357.

25. *See* Sarah Kershaw, *In Insurance Cost, Woes for Doctors and Women*, N.Y. TIMES, May 29, 2003, at A16; Maria Newman, *In Mass Trenton Rally, Doctors Protest Malpractice Insurance Costs*, N.Y. TIMES, June 14, 2002, at B5.

26. HARVARD MEDICAL PRACTICE STUDY, PATIENTS, DOCTORS AND LAWYERS: MEDICAL INJURY, MALPRACTICE LITIGATION, AND PATIENT COMPENSATION IN NEW YORK (1990). The data and conclusions of this study are cogently discussed in PAUL C. WEILER, MEDICAL MALPRACTICE ON TRIAL (1991).

27. INST. OF MED., TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM (Linda T. Kohn et al. eds., 2000).

view.[28] The IOM Report reviews the Harvard findings and two follow-up studies in Colorado and Utah hospitals employing similar methodology, in the course of a thorough analysis and set of recommendations addressed to the reduction of preventable error.[29]

Where does the Andrews study fit into this picture? In contrast to the Harvard Study and IOM Report, which were based principally on retrospective expert review of patient records, Andrews and her colleagues undertook an observational study of medical error. As she reports it, they relied upon a group of "trained ethnographers" to attend work rounds and clinical meetings of medical teams at a large (unidentified) teaching hospital over a nine-month period—1,047 team discussions in all.[30] These observers did not make independent judgments about what constituted medical error generally, or preventable medical error with serious consequences—the latter defined as errors resulting in "temporary physical disability, permanent disability, or death."[31] Rather, the observers relied on their coded notes from the sessions, recording preventable errors discussed by the medical teams in the course of their work rounds and meetings.[32]

The conclusions offered in the Andrews study are distinctly unsettling:

> Nearly one in five patients had errors with a serious harm. Yet very little was done to prevent further errors. The person who committed the error was rarely held accountable. And, when the error was caused by an administrative problem (such as faulty equipment), the administration was rarely informed, so it did not have the opportunity to correct the situation to prevent future errors. The findings of this study point to a crying need to find other means of pressuring or inducing hospitals to identify, remedy, and prevent medical errors.[33]

There are methodological issues that can be raised with the Andrews study. To begin with the most obvious, the observers monitored only a single hospital. As with all case studies, this raises a threshold issue of generalizability. In this instance, that threshold concern is somewhat exacerbated by the fact that the study was conducted at a *teaching* hospital. There is no compelling reason to think that the findings would carry over to the universe of non-teaching hospitals where the

28. *See generally* HARVARD MEDICAL PRACTICE STUDY, *supra* note 26.

29. For a succinct analysis of these developments, see Michelle M. Mello & Troyen A. Brennan, *Deterrence of Medical Errors: Theory and Evidence for Malpractice Reform*, 80 TEX. L. REV. 1595, 1598–1603 (2002).

30. Andrews, *supra* note 6, at 359.

31. *Id.* at 361 n.9.

32. *Id.* at 359.

33. *Id.* at 358 (footnote omitted).

reflective pedagogical structure of work rounds and clinical meetings is not a core commitment of the institution.[34]

Moreover, the study looks exclusively at *surgical* services.[35] By contrast, nonsurgical services—ranging from in-patient treatment of pneumonia to cardiac patients—would not necessarily involve a like set of procedures and potential errors. This is especially salient because the Andrews article indicates that a substantial percentage of the identified errors occurred in post-operative routines, which by definition would not be precisely replicated in nonsurgical cases.[36]

Apart from the intrinsic limitations of case study methodology, there is a more subtle dimension to the emphasis on post-operative conduct as well. Recall that the observers are privy only to the discussions of errors emerging in the course of work rounds and clinical meetings—and by Andrews's own report, these discussions tended to focus on blameworthiness in the conduct of lower status members of the team, rather than in the conduct of attending physicians.[37] One can question whether surgical errors reflecting poor techniques in the operating room would even surface in these discussions.

Finally, to close the circle on threshold methodological issues, there is a basic question about coding techniques employed by the observers. It appears that they were instructed not to make independent assessments of error.[38] But of course any such instructions, however appropriate they may be, are to some extent illusory. It seems highly unlikely that any uniform set of linguistic signals characterized the discourse among the constantly shifting hospital personnel, engaging in discussion under a variety of temporal and situational constraints. Under such circumstances, it seems likely that ambiguity about what constituted reference to "error" would arise with at least some degree of frequency.[39]

I want to be very clear that these methodological points are in no way meant to undermine the significance of the conclusions reached by Andrews and her colleagues. I raise them solely in the spirit of

34. It does not follow from the less structured patterns of self-criticism in nonteaching hospitals that there would be systematic differences in one direction or the other from teaching hospitals in the incidence of preventable error; other quality of care-related variables would also need to be taken into account.

35. Andrews, *supra* note 6, at 358–359.

36. And, of course, the surgical errors would have no counterpart in nonsurgical procedures.

37. Andrews, *supra* note 6, at 367.

38. *Id.* at 359.

39. A variant on this concern is raised by the author when she cautions that serious injuries may have been more frequent than the nearly one in five identified by the observers, because "for many patients the level of harm was not discussed by the health care providers." *Id.* at 358 n.2.

constructive criticism. Indeed, many of these methodological concerns, if they have validity, would suggest that in other hospital settings the incidence of preventable medical error identified by the study—"[e]rrors seriously impacted 17.7% of the patients, ranging from temporary disability to death"[40]—may be even higher than this case study suggests.

And what precisely is at the core of these failures of communication and deficiencies in intra-system information flow regarding medical error? In my view, the portrayal that emerges from this study is not one of indifference to error; rather, the observational findings reveal a professional enterprise characterized by a sharp disjuncture between commitment to performance review and sensitivity to system-based change. So long as the mission of critical assessment in work rounds and clinical meetings is "getting it right the next time" as an end point, without seriously evaluating larger organizational dysfunction, a significant portion of medical errors arguably will be endemic to the system.

The Andrews article does not venture into particularized speculation on this point.[41] But in the spirit of inquiry—and with a strong disclaimer of expertise—I will pursue the point very briefly through conjecture. Suppose that a statistically significant number of nurse-generated errors are committed by relatively inexperienced personnel in the initial six months of service. Or perhaps, that a high proportion of resident-attributable errors arise during the latter hours of round-the-clock, on-call service when sleep deprivation is a serious concern. Or, that medical technicians experience continuing logistical difficulties in dealing with administrators over equipment failures. If the focus of self-criticism is on the trees rather than the forest—that is, criticism focusing on event-limited discussion of identified errors, as contrasted to aggregate data assessment and analysis—it almost certainly assures that as personnel change, or indeed as they continue to operate in the same work environment, errors will repetitively recur.

The Andrews article is certainly sensitive to these concerns. Indeed, the study was designed to track the relationship between identified errors, occurrence reports, and patient claims. And the article targets the disjuncture to which I refer:

> There were only a few instances in which the errors led the health care workers to think systematically about a problem and to devise a response that involved preventing future errors rather than cor-

40. *Id.* at 361.

41. The study identifies three categories of error: "individual, interactive, and administrative." *Id.* at 363. But there is not much detail offered about the precise nature of these errors.

> recting them after the fact. In 68.7% of the errors (which had a response) there was a response aimed at correcting the immediate problem, compared to less than 1% with a response aimed at devising specific means for preventing future errors. In fact, more errors (4%) had responses aimed at talking to patients to cool them out than responses aimed at preventing future errors.[42]

In the final analysis, however, I remain somewhat skeptical about the prospects for achieving significant gains in reduction of medical error through the malpractice reforms discussed in the article. The strategy for reform that the article initially discusses—creating a duty to disclose errors on the part of the health care provider—requires no expansion of existing case law doctrine, as Andrews herself indicates.[43] Just such a duty is a natural extension of the fiduciary obligations growing out of the physician-patient relationship. Yet, there is at present almost invariably no disclosure of the low-visibility errors identified in this study, as the study itself documents.[44]

A cluster of strategies that Andrews appears to find most promising would target the hospital for organizational responsibility resulting from all incidents of preventable medical error, rather than maintaining the current system of assigning malpractice liability to blameworthy physicians.[45] This proposal first achieved wide currency in the aftermath of publication of the Harvard Study, and has been forcefully promoted by members of that interdisciplinary team.[46] While the concept of organizational liability on its face seems nicely congruent with the systems-based empiricism of the Andrews study, I remain skeptical about whether it would lead to meaningful change.

As a threshold matter, if one gives credence to Andrews's findings, there is a serious question of the extent to which organizational liabil-

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42. *Id.* at 365.

43. Andrews, *supra* note 6, at 373.

44. *Id.* at 369. Andrews makes passing mention of a second strategy, referred to as "other health care providers' duty to disclose," which would, as she describes it, "require not only that the erring physician disclose his or her errors, but also that other health care providers who witness the error or its effects disclose as well." *Id.* at 378. In this situation, it seems far less likely that the courts would recognize a duty to report on the part of the third-party provider. *See, e.g.*, Clarke v. Hoek, 219 Cal. Rptr. 845 (Ct. App. 1985) (holding no duty owed by defendant doctor who was proctoring an operation performed by a surgical team). Even if such a duty were recognized, the likelihood that third-party providers would report on their brethren in these low-visibility situations seems slight.

45. Along with organizational liability, Andrews mentions, very briefly, liability under standard agency principles of *respondeat superior* and corporate liability. Andrews, *supra* note 6, at 378–82. Surprisingly, she makes no mention of no-fault liability, which has been frequently proposed in tandem with organizational liability. *See* WEILER, *supra* note 26, at 114–58; *see also* Mello & Brennan, *supra* note 29, at 1626–28.

46. *See, e.g.*, WEILER, *supra* note 26, at 122–32; *see also* Mello & Brennan, *supra* note 29, at 1624–28.

ity would cast a substantially wider net than is presently the case. By her estimation, ninety-two percent of preventable errors are attributable to medical team personnel whose negligence would currently impose liability on a hospital under conventional *respondeat superior* doctrine.[47] Only the attending physicians are ordinarily characterized as "independent contractors"—consequently shielding the hospital from liability as a principal—in the hospital setting that the Andrews team observed.[48]

Moreover, there is a residual category of malpractice liability that occurs outside the context of in-patient hospitalization.[49] Presumably, this latter subset of negligent incidents—ranging from diagnostic errors in outpatient care in an office or clinic setting to care in an assisted living facility—are either independent of the reach of organizational liability or raise systemic issues distinct from those discussed in this Commentary. At the outset, then, and even aside from the tort immunities for charitable and municipal liability that Andrews notes as obstacles,[50] a question warrants further exploration: How much additional coverage would an effectively implemented system of organizational liability provide?

This question, in turn, raises correlative issues about the likely *penetration* of a system of organizational liability—that is, the likelihood that organizational liability would in fact unblock the systematic deficiencies in channels of communication that constitute the principal findings in the Andrews study. The central question here is whether there would be likely positive incentive effects from adopting organizational liability.

Two substantial obstacles occur to me.[51] From a top-down vantage point, one can ask why a hospital would have greater incentives than is presently the case to ferret out preventable errors by insisting on

47. Andrews, *supra* note 6, at 386.

48. Another traditional category of independent contractors in the hospital milieu has been emergency room doctors, but they are outside the scope of the Andrews study. It should be noted, however, that in some instances, emergency room doctors—and less frequently, attending physicians—might come under the cloak of *respondeat superior* through resort to the doctrine of apparent, or ostensible, authority. *See, e.g.*, Baptist Mem'l Hosp. Sys. v. Sampson, 969 S.W.2d 945 (Tex. 1998) (holding that the hospital did not create ostensible authority when a variety of warnings were issued to disclaim liability).

49. Andrews cites an estimate that eighty percent of malpractice claims arise in a hospital setting. *See* Andrews, *supra* note 6, at 359 n.3. But the studies she cites are from the mid-1980s or earlier. *Id.*

50. *Id.* at 384.

51. For a more detailed discussion of reservations about organizational liability, see David A. Hyman, *Medical Malpractice and the Tort System: What Do We Know and What (If Anything) Should We Do About It?*, 80 TEX. L. REV. 1639, 1647–54 (2002).

more effective channels of communication. If identification and communication of low-visibility preventable errors were somehow likely to be enhanced by moving to organizational liability, that would be a promising development. But why would this occur? The mechanism by which any such action-forcing would be attained is not self-evident. The desired response seems to depend on the magnitude of the additional costs hospitals would incur by shouldering liability currently assignable to affiliated physicians. Those costs would have to signal the likely imposition of liability that would, in turn, trigger systemic revamping of information and communication flows within the institution. This raises empirical cost-benefit questions, of course, and Andrews's data do not provide a clear answer. Indeed, the prospect of more substantial organizational liability might well cut in the opposite direction—towards dampening the organizational enthusiasm for identifying low-visibility error. At best, there seems to be a missing link in the argument here.

Similarly, the prospects for action-forcing on the part of attending physicians and hospital personnel are elusive. One can phrase the matter as the following: Is there reason to think that immunity of medical personnel from personal liability would unblock the channels of communication? As the Andrews study indicates, a considerable proportion of medical error is assignable presently to hospital employees, who as a practical matter are shielded from liability.[52] Yet, the predicament remains.

Most critically, however, a tension exists in the claims being made for organizational liability. Thus, Andrews asserts that "the cost of litigation would be less and there would be less delay due to finger-pointing, because each of the health care providers involved in the care of a particular patient would no longer have an incentive to blame the error on someone else."[53] This statement follows close upon the prediction that organizational liability "would create incentives for hospitals to better monitor and respond to problems in the delivery of health care."[54] But if identification of errors by providers does not lead to potential sanctions, either in the form of reassignment of responsibilities, revocation of privileges, or loss of employment, it seems a toothless affair. Cognizant of these possible consequences of highlighting responsibility, why would the reticence

52. *See supra* note 47 and accompanying text.

53. Andrews, *supra* note 6, at 384.

54. *Id.* at 383.

of medical service providers to communicate error information be reduced, even if there was no prospect of personal tort liability?[55]

I am not suggesting that preventable medical error is necessarily an intractable problem. But it remains to be demonstrated that the tort liability system can make a meaningful contribution to this effort. Most critically, tort appears to be largely endogenous to the dynamics that drive the system of organizational behavior in the hospital setting. As I have suggested above, at least as portrayed in the Andrews study, that system is largely task-oriented: the focal point is treatment and assessment on a patient-by-patient basis, with the larger dimensions of *institutional* performance standards largely off the radar screen.[56]

Moreover, intrinsic features of the tort system itself reinforce the disconnect in medical malpractice cases. Tort can only serve as a sensitive barometer of health and safety concerns if evidence of injury is readily identifiable to the victim. But in singular fashion within the universe of accidental harms, there is a failure of transparency in the landscape of medical error due to the preexisting health problems that trigger medical care in the first instance. Victims of a defective product or auto accident are clearly cognizant of the fact that they have suffered a discrete injury; mishaps in the course of medical treatment are frequently not self-evident.

Under these circumstances, the two reformist camps seem disconcertingly off-center in the menus of medical malpractice reforms that they offer for public policy consumption. The MICRA-model tort reform enthusiasts may well succeed in reducing the costs of malpractice liability for beleaguered medical specialists like obstetricians.[57] But this strategy addresses a distinctly different set of issues from the public health concerns associated with preventable medical error. The organizational liability/no-fault proponents are closer to being on target. Nonetheless, the thrust of their proposals, to the extent the focus is on the tort forum, is significantly blunted by the informational prerequi-

55. Indeed, Andrews asserts that "[i]f physicians are no longer named in suits, there will need to be an alternative mechanism for providing their names to [a national practitioner] Data Bank." *Id.* at 384.

56. Nonetheless, I am mystified by Andrews's finding that it is relatively unusual for providers, in the course of detecting errors, to communicate information about *equipment failures* to hospital administrators. *Id.* at 358. This inattentiveness seems to cross the border from lack of commitment to institutional performance standards into indifference to prospective case-by-case error avoidance in an especially compelling way.

57. For recent evidence of the substantial impact of MICRA-type caps, see Rhonda L. Rundle, *Effect of Malpractice Caps Is Tallied*, WALL ST. J., July 13, 2004, at D4. The article discusses the RAND Institute for Civil Justice's recently published report on the impact of caps in California (*see supra* note 21). *See also* Rachel Zimmerman & Joseph T. Hallinan, *As Malpractice Caps Spread, Lawyers Turn Away Some Cases*, WALL ST. J., Oct. 8, 2004, at A1.

sites of tort claiming—that is, the need to characterize oneself as an injury victim—and the internal norms of medical team self-critiquing in the work routines just discussed.

Delineating the pathway to effective reform is beyond the scope of this brief Commentary, as well as beyond my limited expertise in the highly complex world of provision of health care services. But the road to efficacious reform seems to point in the direction of far greater reliance on the medical profession than on the lawyers.[58] At a macro-level, the economics of delivering health care services may shape core characteristics of medical practice that enhance the risk of what is viewed as preventable medical error—such as alertness-challenging, physician on-call schedules. If reform at this foundational level is to be undertaken, surely the lead must come from the medical profession rather than the judicial forum in the course of tort litigation.

Moreover, a similar assessment seems just as applicable to micro-level patterns of preventable error—whether the focal point is systematically occurring errors in routine interventions by nursing personnel, repetitive errors by especially risk-prone medical team members, or sub-optimal protocols for administering drug orders. Unless a more proactive role is assigned to hospital quality assurance committees, and a concomitant commitment is made by hospital administrators to greater transparency, it seems likely that a decade or so from now, when another round of projects like the Andrews study or the IOM Report is published, not much will have changed.

C. Claims and Costs

Does the foregoing discussion cast the Vidmar article, reporting trend data on claims and costs in Florida medical malpractice litigation, in an anticlimactic light? I would prefer to say that it puts the findings in clearer perspective. By the authors' own admission, the data have no bearing on how much medical error is in fact occurring.[59] Rather, Vidmar's principal data source is closed claim files of award payments by Florida insurers.[60] Notably, this is a source based on *pa-*

58. *See, e.g.*, Gina Kolata, *Program Coaxes Hospitals to See Treatments Under Their Noses*, N.Y. TIMES, Dec. 25, 2004, at A1. The article discusses a rating system recently developed by federal Medicare administrators that identifies lifesaving treatments for heart attacks, heart failure, and pneumonia. The system responds to the systematic underutilization of these treatments with carrot and stick sanctions (targeting identified hospitals for bonus payments or public disclosure on the Internet, respectively).

59. *See* Vidmar et al., *supra* note 7, at 329.

60. The study covers a fourteen-year period from 1990 through 2003. *Id.* at 318. A secondary data source is an archive of jury verdict reports compiled by Westlaw. *Id.*

tient identification of medical error and consequent filing of a tort claim. Moreover, there is no necessary correspondence between filing of a tort claim and *accurate* perception of medical error; indeed, other studies have suggested a substantial disparity between success in court and negligence in fact on the part of the defendant physician.[61] What follows from these intrinsic limitations of the Vidmar findings, in view of my earlier discussion, can be visualized as concentric circles representing two universes that overlap only minimally—in one instance, Andrews's observed system of preventable medical error in a hospital setting, and in the other instance, Vidmar's claims-based system of contested tort cases.

As a consequence, the main import of Vidmar's analysis is the light it sheds on the continuing tort reform debate in the political forum. On this score, it provides ammunition for contestants on both sides of the battlefield. Tort reform enthusiasts can point to the steadily rising median and mean award levels between 1990–2003, in support of their argument that medical malpractice awards continue to generate pressures of higher insurance costs for physicians.[62] The plaintiffs' bar, in turn, can take comfort in Vidmar's findings that aggregate trend data on both claims and litigation costs have remained relatively level over the same period.[63]

Stepping aside from the heat of battle, it is hard to know what to make of all this. On the one hand, should the observer be reassured by a finding that the trend-line of malpractice claims is holding steady, if—to return to the earlier discussion—formal legal claims represent only the tip of the iceberg of public health concerns associated with preventable medical error? On the other hand, should one be unsettled by the steadily rising—and not readily explained—trend-line in mean and median size of awards for injury claims of varying degrees of severity, without some baseline indication of what would be the "correct" range of awards for the harms in question? It is hard to

61. *See, e.g.*, Stephen D. Sugarman, *Dr. No*, 58 U. CHI. L. REV. 1499, 1501 (1991) (analyzing the data from the Harvard Medical Practice Study and Paul Weiler's subsequent interpretive account (*see* sources cited *supra* note 26), and concluding that "some thirty percent of the claims where malpractice did not occur also result in some payment . . . albeit a payment that is often substantially discounted from the amount of the claimant's likely recovery had liability been clear").

62. Vidmar et al., *supra* note 7, at 338. There are possible responses, of course, such as that inflation in medical costs is itself a principal source of rising award levels. Vidmar surveys this and other possible explanations, and concludes that there is no clear single factor explanation. *Id.* at 338–39.

63. *Id.* at 334. Vidmar is careful to note that because of the time-lag between filing and closing claims, the data may not fully reflect increases in claims after 2000.

resist the impulse to conclude that the adversaries are skirmishing inconclusively on the less consequential public health battleground.

III. CONCLUSION

If there is a single point of convergence among these three studies, and in my own thinking as well, it is on the importance of continuing empirical investigation of the phenomena surrounding medical mishaps. In particular, both Andrews and Vidmar provide case studies—of a single hospital and a single state, respectively. Before we can reach any definitive conclusions about what systematic changes in organizational behavior ought to be put in place, a good deal more information needs to be generated at the ground level, so to speak, on typologies of preventable errors and particulars of provider settings in which prevention measures would be—or currently are being—implemented. Similarly, before we can sensibly assess the sharply contrasting viewpoints on more conventional medical malpractice reform, we need more precise aggregate data on claims and costs across a wider array of states, as well as a focused inquiry on liability costs by area of professional specialization and in organizational settings. In sum, these articles point in the right direction, but are closer to an agenda for further policy-oriented research than a roadmap for meaningful reform.