

THE PROCESS PARADIGM: RETHINKING MEDICAL MALPRACTICE

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I. INTRODUCTION

Nothing could be more hackneyed than the medical malpractice debate. Trial lawyers, insurers, doctors, and politicians have been repeating the same arguments for thirty-five years¹ with no evidence that they are listening to each other and little concern for the facts. No one is satisfied with the present system, but improving it seems to have fallen victim to a failure of imagination.

Perhaps this is because we have not been as careful as we might be to articulate what the goals of a sensible medical malpractice system ought to be and because we have paid too little attention to how best to *proceed* to achieve the system's goals. Interest group politics in legislatures and mud slinging litigation may not be the best ways to sort out the needs of everyone involved in the health care system. What would a medical malpractice system designed to maximize institutional competences look like?

The quest for such a system has implications far beyond medical malpractice reform. I have previously attempted to demonstrate that focus on process will lead to better results in areas that others call "bioethics" than will focus on substance.² If that is also true with medical malpractice, one may begin to wonder whether it is true of health law in general, and, if so, whether health law could

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1. For a convenient summary of the activities of the last thirty-five years, see William M. Sage, *The Forgotten Third: Liability Insurance and the Medical Malpractice Crisis*, HEALTH AFF., July/Aug. 2004, at 10, 12-17.

2. See generally ROGER B. DWORIN, LIMITS: THE ROLE OF THE LAW IN BIOETHICAL DECISION MAKING 169-71 (1996).

take the lead in directing legal questions away from irresolvable conflicts about substantive preferences to more productive approaches. Maybe the law really does have a life of its own, and maybe the nation would be better off if we let it live it.

II. THE CHARACTERISTICS OF THE MEDICAL MALPRACTICE ISSUE

Sound lawmaking requires matching the characteristics of a social issue with the characteristics of legal institutions to see which institution or combination of institutions is most likely to deal with the issues most satisfactorily.³ Once the characteristics are understood, goals that a neutral observer would approve can be articulated, and institutional responses can be made.⁴

What are the characteristics of medical malpractice as a social issue? Medical malpractice involves injuries whose genesis, nature, and extent can be evaluated only by experts.⁵ The experts are members of the same professional groups as the persons who are alleged to have caused the injuries. The injuries are alleged to have occurred during the course of a relationship in which a person with expertise acts on a person who is unlikely to have expertise to relieve the nonexpert person's fear or suffering, or both, usually in exchange for a fee. The fear and suffering relate to the person's health, an interest of the highest value. The actor is a member of a loosely regulated group that the state has granted a monopoly on providing services. The idea of efficient breach—purposely providing lower quality care than promised because that is economically efficient—is almost inconceivable in this setting,

3. "Most satisfactorily" does not mean "best." Legal institutions are created and operated by human beings. Thus, they are imperfect. The most satisfactory legal response to a social issue will be the response that makes the fewest, cheapest, and most easily correctable mistakes, not the approach that gets it right. Searching for perfection is doomed to create expensive failures. As I have argued before, in law half a loaf is not only better than none, but also better than a whole one. Roger B. Dworkin, *Anything New Under the Sun? Trying to Design a New Legal Institution to Deal with Biomedical Advance*, 155 WELTINNENRECHT 165 (2005). See generally DWORKIN, *supra* note 2, *passim*.

4. The most satisfactory response is that which would satisfy a neutral observer or that would be acceptable to all interested parties. To define most satisfactory any other way would be to say that the best legal response is the one that happens to serve one's substantive preference. That is what health law has done for too long as it has purported to serve the substantive goal of patient autonomy. That approach has been neither successful nor honest. See, e.g., Roger B. Dworkin, *Getting What We Should from Doctors: Rethinking Patient Autonomy and the Doctor-Patient Relationship*, 13 HEALTH MATRIX 235 (2003).

5. See *infra* Part II.A.

although using cost-benefit analysis to decide what has been promised is commonplace.⁶ The services that allegedly cause the injuries are provided to persons of widely disparate wealth in a society where most persons are at least partly dependent on public or private insurance to pay for their health care but 15.7% of the population is uninsured.⁷ Medical care in the United States costs more than anywhere else in the world,⁸ yet Americans fare poorly compared to people in many other countries in terms of infant mortality, length of life, and other measures of the quality of health care.⁹ Medical malpractice gives rise to intense political disagreements, but not to deep moral divides like abortion or assisted suicide. Clearly, malpractice has nothing to do with the nature and structure of the government.

A. *Expertise*

Medical malpractice involves injuries whose genesis, nature, and extent can be evaluated only by experts. The experts are members of the same professional groups as those who are alleged to have caused the injuries.

All personal injury cases involve injuries whose nature and extent can be evaluated only by experts. Medical malpractice differs in that the genesis of the injuries also requires expertise to evaluate and in that the experts are members of the same profession as those charged with causing the harm. Expertise is seldom required to pinpoint the cause of tort injuries. For example, in auto wreck cases, a previously healthy person is rear-ended, smashes into the steering wheel, and has a broken sternum. The crash caused the injury. Even the classic conundrum cases that fill Torts casebooks¹⁰ are problematic for reasons unrelated to the need for expertise.

In medical malpractice, on the other hand, the plaintiff (patient) was sick or injured or in need of diagnosis before he or she visited the defendant (doctor, hospital, etc.). The question is whether something the defendant did or failed to do made the plaintiff's

6. See E.J. MISHAN, COST-BENEFIT ANALYSIS 13-15 (1971) (explaining how cost-benefit analysis has been used in assessing disease control).

7. CARMEN DENAVAS-WALT ET AL., U.S. CENSUS BUREAU, INCOME, POVERTY, AND HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2004, at 23 (2005), available at <http://www.census.gov/prod/2005pubs/p60-229.pdf>.

8. See *infra* note 20 and accompanying text.

9. See *infra* notes 21-22 and accompanying text.

10. *E.g.*, *Summers v. Tice*, 199 P.2d 1, 5 (Cal. 1948) (applying joint and several liability to two hunters using the same size shot and the same gauge shotguns who negligently shot in the direction of a companion who was injured by one or both of the shooters); *Kingston v. Chi. & Nw. Ry.*, 211 N.W. 913, 915 (Wis. 1927) (joining liability for damage caused by two fires).

condition worse or prevented it from getting better. Only someone with expertise can form a meaningful opinion about that. Moreover, only an expert can evaluate professional performance, so that if fault or even the ability to avoid the harm is to be required for compensation, expertise will be required again.¹¹

The problem is obvious: only medically trained persons have expertise about medicine. Inexpert legal decision makers are dependent upon the very persons whose liability they are considering for the facts on which to base their decision. The fox is guarding the chicken coop.

Interestingly, in the present litigation setting, doctors, whom one would expect to approve of the focus on expertise, are often dissatisfied. A frequently made claim is that charlatans will testify to almost anything for a fee.¹² The same incompetence that disables courts from seeing through “expert” opinion that is biased in favor of doctors also prevents them from evaluating “expert” testimony that is biased against doctors. Thus, the need for expertise coupled with the courts’ lack of that expertise, and their dependence on doctors for it, is one crucial characteristic of the malpractice problem that must be considered in attempting to craft a solution.

B. *The Doctor-Patient Relationship*

Patients, as well as lawmakers, usually lack medical expertise. In the doctor-patient relationship, these inexpert patients are acted upon by physicians who have, or at least claim to have, relevant expertise. The action involves the patient’s health, an interest of the highest importance. The patient is often suffering, frightened, or both, and he or she is abjectly dependent upon the doctor for relief. Thus, the relationship is dramatically unequal with an inexpert, frightened, or suffering person depending upon an expert to restore the patient’s health. This suggests that any legal regime will have to take the inequality into account and protect the patient from unfulfilled expectations of expertise and commitment.

C. *The Medical Profession*

Physicians are members of a restricted-entry guild with

11. Medical malpractice cases are not unique in this regard. Similarities may exist in toxic tort cases, adverse reaction cases, and others. The effort here is to describe the characteristics of malpractice cases. To the extent that other cases share some or all of those characteristics, they may benefit from legal responses similar to those adopted for malpractice.

12. For an example of a doctor making this argument in an unsuccessful attempt to dissuade a court from adopting a national standard of care, see *Hall v. Hilbun*, 466 So.2d 856, 875 (Miss. 1985).

monopoly power.¹³ The state limits the practice of medicine to persons it licenses. Doctors control the educational and training systems that qualify one for a license. Hospitals and managed care organizations further limit the availability of physicians to treat specific patients and specific conditions. Thus, patients' choices of healers are highly restricted. This lack of choice also is relevant to determining an appropriate system to deal with injuries that result from medical practice.

D. Efficient Breach and Cost-Benefit Analysis

Patients (at least competent, conscious patients) agree to be treated by health care providers and to pay for the services they receive. The providers agree to provide the services in exchange for the fee. Thus, the provider-patient relationship looks contractual. Yet the relationship is very different from ordinary contractual arrangements.

In addition to the disparities in expertise and bargaining power between health care providers and patients, another major difference exists. Efficient breach is nearly inconceivable.

Suppose ABC Corporation ("ABC") manufactures widgets. It agrees to pay ten million dollars to Machine Corporation ("Machine Corp.") to purchase one of Machine Corp.'s new widget testing machines. Before delivery and payment, ABC breaches the contract because Innovative Corporation ("Innovative Corp.") has developed a new eight million dollar widget tester, which makes fewer mistakes, both false positive and false negative, than Machine Corp.'s tester does. If paying Machine Corp.'s damages plus the cost of an Innovative tester results in ABC being able to produce more and better widgets at a lower price than complying with its original contract, then breaching the contract was the right thing to do. It was an efficient breach. If Machine Corp. receives damages, it is no worse off, and everyone else is better off than if ABC honored its contract. Rather than being a "dirty contract breaker," ABC has behaved like a responsible corporate citizen.

Such a situation in the medical context is almost impossible to imagine. A doctor or other health care provider can promise to achieve a specific result, to perform at a higher than normal level, or, most typically, to provide reasonably competent care. It can

13. Joseph A. Califano, Jr., *Rationing Health Care: The Unnecessary Solution*, 140 U. PA. L. REV. 1525, 1533-34 (1992). See generally Sue A. Blevins, *The Medical Monopoly: Protecting Consumers or Limiting Competition?*, CATO POLICY ANALYSIS No. 246 (1995), available at <http://www.cato.org/pubs/pas/pa-246.html> (discussing the effect of licensure laws and federal regulations in creating a medical monopoly).

never be desirable to provide less than reasonable care because one of two possibilities must exist. One is that reasonable care means efficient care so that efficiency and reasonableness are synonymous; if efficiency is the measure of desirability, reasonable care must be provided. Alternatively, reasonable care may mean care that is better for the society than efficient care because health is different than widgets, and other values outweigh efficiency. If that is the case, then efficient, but unreasonable, care is undesirable. Thus, a doctor who provides unreasonable care will never have done anything desirable.

That does not mean that cost-benefit analysis and efficiency judgments are irrelevant to medical decision making. As just noted, reasonable care may be efficient care. Even if it is not, efficiency is part of the calculus of reasonableness. Therefore, a doctor may well decide that refusing to do a test is appropriate because the likelihood of the patient having the tested-for condition is too low. If a court agrees, it has not decided that the doctor efficiently breached a contract with the patient. Rather, it has decided that the doctor had no obligation to breach.

If the doctor promised to achieve a specific result or to cure the patient, the doctor may decide to breach the contract because it is not worth carrying out. A promise to make a person the double of a named movie star for ten thousand dollars may turn out to be foolish because the job will consume one hundred thousand dollars worth of time, equipment, and expertise. However, if the doctor breaches this contract, we do not praise him or her for doing the efficient thing. Instead, (1) we either expect the promise to be fulfilled because its nonperformance does not benefit society like producing cheaper, better widgets does, or (2) we do not expect the contract to be performed because it should never have been entered into in the first place. It is an illegal contract, not a valid contract that circumstances have made inefficient to enforce.

The one medical situation in which efficient breach may occur is in the area of informed consent. Courts require so much information to be given to patients to make their consents to treatment adequately informed¹⁴ that a sensible business strategy for a doctor may be to refrain from informing the patient and paying him or her if the bad result occurs. After all, we are talking about low-probability harms not caused by negligence and liability covered by insurance. It may make much more sense for a doctor to rely on

14. See, e.g., *Cobbs v. Grant*, 502 P.2d 1, 11 (Cal. 1972) (an early case adopting the so-called materiality standard of disclosure). For a particularly egregious example, in which a drug company rather than a doctor was the defendant, see *Reyes v. Wyeth Labs.*, 498 F.2d 1264, 1269 (5th Cir. 1974).

the law of averages than the law of informed consent and not to waste time informing patients about all and sundry “material” risks.

The irrelevance of efficient breach except in the informed consent context is another relevant characteristic of the medical malpractice issue.

E. Financing Health Care

The medical malpractice issue arises in a society whose population runs the gamut from fabulous wealth to crushing poverty.¹⁵ Yet medical care is so expensive that only the truly rich can afford to pay for it unaided. Almost everybody else is dependent on some type of insurance.¹⁶ The insurance “system,” if it can be called that, is a crazy quilt of private insurance paid for by employers, private insurance paid for by individuals, federal insurance (Medicare) for the elderly and mixed federal-state insurance (Medicaid) for the very poor.¹⁷ Approximately forty-six million persons in the United States are without health insurance,¹⁸ which means that except for certain emergency care,¹⁹ they are dependent upon benevolence for their health care. To the extent that care is provided free, someone must pay for it. It either will come out of the pockets of providers (true benevolence) or will be factored into the costs that are charged to paying patients.

American medical care is the most expensive in the world.²⁰ Yet by most measures it is not the most successful. The oft-repeated

15. However, New Zealand has adopted a much more egalitarian approach to injury compensation than the United States, despite its similarly great wealth disparity. Injury Prevention, Rehabilitation and Compensation Act 2001, 2001 S.N.Z. No. 49 (N.Z.) (as amended 2005); DAVID SKILLING & ARATI M. WALDEGRAVE, *THE WEALTH OF A NATION: THE LEVEL & DISTRIBUTION OF WEALTH IN NEW ZEALAND* 7-8 (2004), available at http://www.nzinstitute.org/Images/uploads/pubs/The_Wealth_of_a_Nation_Full_Report.pdf.

16. DENAVAS-WALT ET AL., *supra* note 7, at 16-17.

17. *Id.* at 16.

18. Press Release, U.S. Census Bureau, Income Stable, Poverty Rate Increases, Percentage of Americans Without Health Insurance Unchanged (Aug. 30, 2005), http://www.census.gov/Press-Release/www/releases/archives/income_wealth/005647.html.

19. 42 U.S.C. § 1395dd (2000).

20. American per capita expenditure on health is \$5,274 (in international dollars), more than any other country. The United States' total expenditure on health is 14.6% of gross domestic product, also the highest in the world. The second highest total expenditure is Cambodia's 12%. General government expenditure on health in the United States is 23.1% of total government expenditures, tied for fourth highest in the world. WORLD HEALTH ORGANIZATION, *WORLD HEALTH STATISTICS 2005* 46-47, 52-53 (2005), available at http://www3.who.int/statistics/world_health_stats_2005_part1.pdf.

claim that American health care is the best in the world may be better understood as meaning that those who can find and afford the best our system has to offer will receive better care than they could anywhere else in the world. For everyone else, the claim is misleading. The United States ranks twenty-seventh in the world in male and thirtieth in female life expectancy at birth; twenty-eighth in male and female healthy life expectancy at birth; thirty-sixth in male and forty-first in female adult mortality rate (probability of dying between ages fifteen and sixty per one thousand population); thirty-fourth in neonatal mortality rate; twenty-ninth in maternal mortality rate; seventy-ninth in rate of people living with AIDS (i.e., seventy-eight countries have lower rates of persons infected with AIDS); sixty-first in infants with low birth weight; seventy-second in measles immunization, fifty-fourth in diphtheria, tetanus, and pertussis (DTP3) immunization; and fifty-fourth in hepatitis B3 immunization.²¹ Overall, the World Health Organization rates America's health care system thirty-seventh in the world, immediately behind Costa Rica's and immediately ahead of Slovenia's.²²

E. Politics and Morals

Medical malpractice is a hot political issue. However, unlike some political issues of our age—abortion, euthanasia, stem cell research, for example—it is not a moral issue except in the sense that doing justice is always a moral issue. There is nothing comparable here to the deeply held, often religiously based divide between those who believe that human life exists from the moment of conception and those who believe that a fetus is simply a parasite in a woman's body.

The absence of a moral dimension means two contradictory things. First, there is no room here for the criminal sanction, which is inappropriate to punish anything other than nearly universally morally condemned behavior. Second, extreme legal responses, like use of the criminal law or constitutional adjudication, are not likely to engender civil disobedience and massive disrespect for the law as they have, for example, in the abortion context.

F. Nature and Structure of Government

Obviously, medical malpractice does not raise fundamental issues of the nature and structure of the American government.

21. *See generally id.* (listing health statistics from around the world).

22. Geographic.org, The World Health Organization's Ranking of the World's Health Systems, <http://www.photius.com/rankings/healthranks.html> (last visited Mar. 30, 2006).

That means that there is no reason to seek resolution through constitutional litigation and no reason to expect that constitutional litigation would make a useful contribution to resolving the problem.²³

III. GOALS OF A MEDICAL MALPRACTICE SYSTEM²⁴

Having identified the characteristics of medical malpractice as a legal issue, one should next attempt to identify the goals that a malpractice system should serve. To the extent that the goals are inconsistent, the inconsistencies must be recognized so that the ultimately proposed solution can sacrifice as little as possible of each desirable end.

A. *Compensation*

Persons who have been injured in a serious way through no fault of their own should receive compensation for their injuries. This is hardly a novel concept, providing as it does the basis for the entire law of torts. Compensation has both ethical and practical roots. First, simple justice requires it. Without compensation, similarly situated persons would be treated dissimilarly: injury victims would be arbitrarily singled out to bear the costs of activities that could just as well have harmed someone else and from which the society at large benefits.²⁵ Second, it is required to provide a perception of justice. A person injured by another will feel that something must be paid to make things right. Third, compensation is required to maximize the likelihood that an injured person will receive the treatment and other assistance that he or she needs, either to be restored to productivity or to make up for the lost productivity of those who must care for him or her. Often, without compensation, a person would not get better, with the result that his or her life would not be as productive as it otherwise would have been from either the person's or the society's perspective.

None of this is controversial. Controversy lies in the questions of how much compensation is proper and from whom it should come.

23. See DWORKIN, *supra* note 2, at 15-18, 171.

24. For a somewhat different list of goals, see Michael J. Saks et al., *A Multiattribute Utility Analysis of Legal System Responses to Medical Injuries*, 54 DEPAUL L. REV. 277, 285-86 (2005).

25. One could argue that justice requires compensation even for seriously injured persons who have been victims of acts of God. They too have been singled out arbitrarily to suffer. This view, which has much to recommend it, explains the desirability of social insurance. However, a discussion of non-humanly inflicted injuries is beyond the scope of this Article.

1. Amount

Although a few states have capped economic, as well as noneconomic, damages,²⁶ most persons would agree that at least some items of economic damage should be fully compensated. These include medical, hospital, and rehabilitation expenses. At the margins, room exists to argue about what is a proper rehabilitation expense—a helper dog, a Braille reader, etc.—but those are minor questions in the context of the malpractice issue as a whole. More serious questions may exist about whether a person should receive the present value of lost future income.²⁷ On the one hand, such amounts are likely to be hard to calculate, and in some cases they will be very high. On the other hand, if the purpose of compensation is to put the victim back as near as possible to the pre-accident state, such compensation is proper. The system will have to include a mechanism for answering this question.

Noneconomic damages are more controversial than economic ones.²⁸ Money cannot take away pain, but it can provide substitutes for the pain that may make a victim's life better, and it can indicate the value that society places on the suffering that a victim undergoes. However, pain and suffering and other noneconomic damages are notoriously hard to calculate and to keep within reasonable bounds. Moreover, while everyone in the society may benefit from restoring an injured person to a state of productive good health, it is hard to see what benefit the rest of us receive from compensating victims for noneconomic losses. Of course, benefit to all of us only matters if the payor is someone who passes costs on to the rest of us. The system must have a way to answer the questions about the propriety and amount of compensation for noneconomic damages.

Punitive damages serve no legitimate compensatory function. Therefore, consideration of whether they are appropriate must involve some goal other than compensation.

26. See, e.g., COLO. REV. STAT. ANN. § 13-64-302 (2004) (capping total damages at \$1,000,000, but limiting recovery of economic damages to \$750,000).

27. See Gary A. Anderson & David L. Roberts, *Economic Theory and the Present Value of Future Lost Earnings: An Integration, Unification, and Simplification of Court Adopted Methodologies*, 39 U. MIAMI L. REV. 723, 732 (1985) (discussing the reasons for awarding present value of future income and suggesting different models for determining present value).

28. Many more states have limited noneconomic damages than have limited economic ones. See Saks et al., *supra* note 24, at 283 & 283 n.30; see also H.R. 4280, 108th Cong. § 4 (2d Sess. 2004) (President Bush's proposed limitation on noneconomic damages).

2. *Payor*

The next question about compensation is from whom it should come. Once we have decided that there should be compensation (i.e., that losses should not lie where they fall), an almost infinite array of possible payors exists, including the person who caused the harm, the person whose fault it was, the employer of the person who caused the harm or whose fault it was, one of those persons' insurance companies, the injured person's insurance company, the employer of the injured person, or the employer's insurance company, the state or federal taxpayers, etc.

One must think through the implications of each of these approaches. For example, placing the loss on an individual implies that a decision has been made that conduct control and/or blame assessment are goals of the system. Allowing costs to be passed to insurance companies undercuts those goals.²⁹ Imposing costs on taxpayers disregards conduct control and blame assessment and is based on the notion that we are all in this together and that justice requires that we share the arbitrary losses that fall on some members of the community. Placing losses on insurance companies is a partial step in the same direction.

Obviously, compensation is not the only way to achieve blame assessment and conduct control. Therefore, even if blame assessment and/or conduct control are important goals of the system, all possible sources of compensation remain available. Indeed, part of the problem with the current malpractice system may be that it attempts to achieve compensation, loss distribution, and conduct control through the same mechanism. Compensation even without insurance is an inefficient way to achieve conduct control. With insurance it is close to worthless.³⁰ The reasons to provide compensation are justice, the perception of justice, and restoration, all for the victim. None of those reasons requires focusing on the actor who caused the harm or whose fault it was. Compensation is an important policy apart from conduct control or blame assessment. Therefore, conduct control and blame assessment should not be considered in deciding upon whom to place losses unless one is convinced that placing losses on appropriate actors really will achieve appropriate levels of blame assessment and conduct control. As discussed below, that seems very unlikely.

B. *Conduct Control*

Conduct control—getting the health care system and those who

29. See discussion *infra* Part III.B.

30. See discussion *infra* Part III.B.

act within it to cause the optimal number of accidents—is an important rhetorical part of the present malpractice system. Trial lawyers often accuse doctors of practicing bad medicine,³¹ unbiased studies suggest that there is much more bad medical practice than there is litigation about it,³² and the system itself speaks the language of fault, theoretically imposing liability only on negligent practitioners.³³ Doctors and their allies often complain that the system works too well to control conduct, leading doctors to practice “defensive medicine,” i.e., to do things to avoid litigation, rather than because the patient’s condition requires it.³⁴

Let’s think about this. First, conduct control is not a policy that can be pursued the same way for different actors and different kinds of actions. Hospitals, HMOs, and other organizations are much more likely to have their behavior affected by the law than are doctors. An organization acting to maximize profits (or at least to minimize losses) and with time to plan its behavior can seek legal advice and act on it. If it is negligent for a hospital with more than one hundred beds to fail to have a Magnetic Resonance Imaging (“MRI”) scanner, then a hospital with ninety-five beds can decide to forego expansion, or can expand and buy an MRI. The law will affect its behavior.

An individual physician is much less likely to be affected by the law. As discussed earlier, efficient breach by a physician is almost inconceivable.³⁵ No physician other than the occasional lunatic wants or tries to injure a patient or to provide substandard care. Physician negligence is most likely to involve an unplanned mistake—a missed shadow on an X-ray, a slip of the scalpel, a forgotten possible diagnosis, etc. The threat of liability cannot make a person avoid unplanned mistakes. Everybody gets tired, gets careless, gets overconfident, has a clumsy moment, and so forth. Law can affect some individual behavior. For example, if a doctor is told that it is always negligent to fail to do a glaucoma test on a

31. See, e.g., Leo Boyle, *President’s Page: The Truth about Medical Malpractice*, TRIAL, Apr. 2002, at 9, 9.

32. See, e.g., JOINT COMM’N ON ACCREDITATION OF HEALTH CARE ORGS., HEALTH CARE AT THE CROSSROADS: STRATEGIES FOR IMPROVING THE MEDICAL LIABILITY SYSTEM AND PREVENTING PATIENT INJURY 4 (2005), available at <http://www.jcaho.org/NR/rdonlyres/167DD821-A395-48FD-87F9-6AB12BCA-CB0F/o/Medical-Liability.pdf> [hereinafter JCAHO].

33. See DAN B. DOBBS, THE LAW OF TORTS 631 (2000).

34. See, e.g., David M. Studdert et al., *Defensive Medicine Among High-Risk Specialist Physicians in a Volatile Malpractice Environment*, 293 JAMA 2609, 2609-10 (2005).

35. See *supra* Part II.D.

patient under the age of forty,³⁶ the doctor will either always do the test or decide that the rule is so stupid that he or she will not follow it. Liability in that instance will enforce the legally desired behavior or result in payment (i.e., suffering) by the doctor. In most cases, however, liability is unlikely to affect the behavior of individuals. Even so-called cases of defensive medicine are like the glaucoma case—doing unnecessary tests—not examples of avoiding slip-ups.

Second, as noted above,³⁷ compensation of victims by those who (perhaps negligently) caused their harm is a woefully bad way to control conduct, even for organizational actors. If one wants another person to behave in a certain way, one must tell the person in clear language in advance what to do. A common law system that tells people after they have acted that they did the wrong thing and that decides cases one at a time based on subtle factual differences is ill-designed to achieve compliance.

Moreover, allowing tortfeasors to pass losses on to their insurance companies undercuts the conduct control function of compensation. If a potential defendant knows that it will have to pay one million dollars if it negligently causes a one million dollar injury to someone, it is more likely to try to avoid injury than if it knows that its insurer will pay the one million dollars, and all the provider will have to pay is a premium that reflects a small part of the one million dollars and that is also affected by things beyond the provider's control, like other providers' behavior and the insurance company's investment experience. After all, the whole point of insurance is the sharing and distribution of costs so that their impact on any one individual is minimized. That is not consistent with controlling the conduct of individuals.³⁸

Finally, conduct control seems to have greater rhetorical than real weight if one looks at what courts actually do. The clearest conduct control cases would seem to be those in which courts adopt a rule to be universally followed in the future. For example, *Helling v. Carey*³⁹ involved a thirty-two-year-old woman who repeatedly consulted her ophthalmologist about problems with her eyes, but who had no symptoms of glaucoma. Uncontradicted medical testimony revealed that the chances of an asymptomatic patient under the age of forty having glaucoma was one in twenty-five thousand and that ophthalmologists, therefore, do not test such patients for glaucoma. Ms. Helling did have glaucoma, which caused her to lose most of her vision before it was diagnosed. In her

36. See *Helling v. Carey*, 519 P.2d 981, 983 (Wash. 1974).

37. See *supra* Part III.B.

38. See discussion *infra* Part III.E.

39. 519 P.2d 981.

lawsuit against her ophthalmologist, the Supreme Court of Washington held that failure to give Ms. Helling the glaucoma test was negligent as a matter of law.⁴⁰ That is because glaucoma is a serious disease whose damage can be arrested if there is a timely diagnosis,⁴¹ and because the test is simple, safe, inexpensive, accurate and requires no judgment.⁴² Patients under forty years of age are entitled to the same protection as patients over forty.⁴³

The conduct control message is clear: ophthalmologists (at least) must give the glaucoma test to all their patients, including asymptomatic infants. Physicians must give all tests that are as safe, inexpensive, accurate, and judgment-free as the glaucoma test to all patients with a risk of one in twenty-five thousand or more for all diseases that are as serious (whatever that means) as glaucoma. One can only wonder what the risk factor would be if a disease were "worse" than glaucoma, a disease were not quite as bad, but the test was safer, etc. Given *Helling*, routine physical exams in the state of Washington should take weeks and cost thousands of dollars. Of course, that is absurd. No doctor in his or her right mind would allow *Helling* to govern his or her conduct, and no sane patient would want him or her to. *Helling* is a decision about who should bear the costs of youthful glaucoma, not about controlling conduct.

Similarly, *Quintal v. Laurel Grove Hospital*⁴⁴ appears to be about conduct control. There a young boy was to undergo elective surgery for crossed eyes. He had heightened indicators of possible cardiac and respiratory arrest from anesthesia: crying, agitation, unsatisfactory sedation despite double the dose of medication used only two months before, a runny nose, and maybe a fever.⁴⁵ The ophthalmologist and anesthesiologist made no plans for how to deal with a cardio/respiratory arrest should one occur. While the anesthesiologist was administering anesthesia, the child suffered a cardiac and respiratory arrest. The ophthalmologist did not know how to perform a thoracotomy (opening of the patient's chest) to do internal heart massage. By the time he located a general surgeon who was able to do the procedure and restart the heart, the patient had been without oxygen for so long that he was rendered blind, mute, spastic, and quadriplegic.

Despite having no evidence to support its conclusion, the Supreme Court of California held that a jury could find the

40. *Id.* at 983.

41. *Id.*

42. *Id.*

43. *Id.*

44. 397 P.2d 161 (Cal. 1964).

45. *Id.* at 163-66.

ophthalmologist negligent for failing to have someone in the operating room who could do a thoracotomy or for being unable to do one himself.⁴⁶ As a way to provide compensation to a tragically injured child or to allocate the costs of anesthesia injuries, the case is easy to accept. As a conduct control case, on the other hand, it is absurd. Do we really want surgeons (a scarce resource) to be standing around in operating rooms doing nothing except raising the cost of surgery instead of operating on patients? If the ophthalmologist could not do a thoracotomy, whose “fault” was that? Likely, it was the “fault” of his medical school or residency training program. How absurd it is to think that a court should use a lawsuit against a physician to instruct medical schools and residency programs that are not even parties to the litigation what their curricula should be! Again, compensation and conduct control are two entirely different, and not necessarily related, goals.

Res ipsa loquitur cases are yet another example of the lack of connection between compensation and conduct control. For example, in *Ybarra v. Spangard*,⁴⁷ the court used res ipsa to hold four doctors and two nurses jointly and severally liable for an injury that *may* have happened while the patient was unconscious and that *could not* have happened in the presence of all of the defendants.⁴⁸ Even more strikingly, in *Anderson v. Somberg*,⁴⁹ the court applied a doctrine “akin” to res ipsa loquitur⁵⁰ to *require* a jury verdict against at least one of four defendants, two of whom had not even been sued for negligence, in a situation in which numerous other persons could just as well have been responsible for the harm.⁵¹ Cases like these may be about trying to force defendants to testify against each other or may just be about compensation and loss spreading, but they have nothing to do with controlling conduct outside the courtroom.

Controlling health care providers’ conduct to get them to practice as closely as possible to optimally is an important social goal. Achieving that goal through providing compensation seems unlikely.

C. *Placing Blame*

Closely related to conduct control is blame assessment. When something goes wrong we always like to know whose fault it is. Placing blame makes us feel that we understand what has happened

46. *Id.* at 166-68.

47. 154 P.2d 687 (Cal. 1944).

48. *Id.* at 688-89, 691.

49. 338 A.2d 1 (N.J. 1975).

50. *Id.* at 5.

51. *Id.* at 3, 7-8.

and relieves the non-blameworthy of the stigma of guilt.⁵² If accompanied by publicity, placing blame can hurt wrongdoers economically as well as emotionally. If patients have any sense and any choice at all, they will presumably choose doctors who have never or seldom been blamed for injuring patients, rather than those who have often been labeled wrongdoers. This suggests that placing blame plus publicity may have some effect on providers' conduct to the extent that the conduct can be changed. The conduct control comes from placing blame, not from compensating the victim.

D. Satisfying Expectations

Medical care involves the abject dependence of an inexperienced patient on an expert physician or other health care provider. These providers are limited in part because of the monopoly provided by the state.⁵³ The patient is ill-equipped to bargain about the services to be provided. Therefore, the patient must be protected in his or her expectation that the provided services will be competent. Innkeepers and common carriers have traditionally been held to a higher standard of care than members of most other industries⁵⁴ because of the total dependence of guests or passengers upon them and because anyone, if asked, would say (whatever he or she paid) that they were buying a safe room for the night or safe passage from Point A to Point B. Medical care is similar, but the monopoly and other restrictive practices noted above⁵⁵ make the need to protect expectations even stronger than they are with regard to carriers and lodgings. Somebody has to make sure that the patients get what they pay for.

52. What Torts teacher has not been driven crazy by first-year law students who insist on discussing whether a tort defendant was "guilty," rather than the correct question of whether the defendant is liable? I suggest that this misuse of the concept of guilt results from two things: (1) human beings' insatiable appetite for placing blame, and (2) the insistence of our tort system on basing liability on "fault," a concept that bears little relation to what "fault" means to an ordinary person speaking English. Note that even the supposedly strict liability area of products liability has been moving rapidly back in the direction of liability based on fault, *see, e.g.*, RESTATEMENT (THIRD) OF TORTS: PRODUCTS LIABILITY § 2 (1998) (listing categories of product defect); DAVID G. OWEN, PRODUCTS LIABILITY LAW 33 (2005) (noting how strict liability is increasingly giving way to principles of negligence); and even the supposedly non-fault-based concept of causation is really part of assessing blame. Imagine a four-year-old child who is alone in a room when Mommy's priceless antique vase falls to the floor and breaks. What is the child's instinctive response when Mommy runs into the room? "I didn't do it, Mommy. It's not my fault."

53. *See supra* Part II.C.

54. *See* DOBBS, *supra* note 33, at 261, 383-84.

55. *See supra* Part II.

E. Cost Distribution

Any system that provides compensation for injured persons must be concerned about the way the costs of compensation are distributed. This is part of the question of who the payor should be.⁵⁶ Before that question can be addressed, however, one must decide whether distribution among a number of payors is desirable. This is the question of loss spreading.

The theory of loss spreading is that a huge loss will have a less devastating effect if it is borne in small increments by a large number of persons than if it is borne entirely by one person.⁵⁷ On this view it is no better for an injurer to bear an entire loss than for an injured person to do so. Except for the different marginal utility of dollars for persons with different degrees of wealth,⁵⁸ the impact of a one million dollar loss is just as devastating for a doctor as for a patient. Therefore, if minimizing the negative impact of losses is a goal, and if spreading really does minimize impact, one goal of the system should be to spread losses. This suggests that insurance should be allowed or that taxpayers should bear the costs of medical injuries. Either approach is inconsistent with using liability as a means of conduct control.

As between insurers and taxpayers, the question is whether all consumers of health care should pay for medical injuries or whether all citizens should bear the cost. With medical care, unlike with luxury products like private jet airplanes, for example, the two classes of potential payors are likely to overlap very significantly. Almost everyone is a consumer of health care, just as almost everyone is a taxpayer. If that is so, the questions become (1) whether it is more fair⁵⁹ to place costs on consumers/taxpayers generally or to place them on consumers of specific services by, for example, making patients of ophthalmologists pay for eye injuries and patients of obstetricians pay for injuries they suffer while giving birth, and (2) whether one system is easier⁶⁰ and cheaper⁶¹ to administer than the other.

56. See *supra* Part III.A.2.

57. See Young B. Smith, *Frolic and Detour*, 23 COLUM. L. REV. 444, 456 (1923) (noting that it is more expedient to spread loss among a large group than to focus it on a few individuals).

58. At the time the system is being created, we cannot know how rich a particular injurer or a particular injured person will be, although it will probably often be the case that a health provider is richer than a patient. Therefore, we must assume that a dollar is a dollar as the system is designed.

59. See *infra* Part III.H.

60. See *infra* Part III.G.

61. See *infra* Part III.F.

F. Cost Containment

Whoever is to bear the costs of medical injuries, the costs should not be excessive. Excessive costs imposed on an individual payor are unfair; excessive costs imposed on a collective are wasteful. The difficulty lies in determining excessiveness. At first blush, excessive costs would seem to be those that increase the costs of accidents. For example, if a medical accident causes \$1,000,000 worth of damage, but the insurance company (and through it, providers and eventually patients) are required to pay \$2,000,000 plus \$700,000 in legal fees and other litigation costs, and the taxpayers pay \$5,000 to administer the system, and providers also raise prices because the decision leads them to practice defensive medicine, then the system seems excessively expensive.

However, that may be an overly simplistic view. In the hypothetical instance just described, three kinds of costs are involved: compensation costs, administrative costs, and conduct control costs. With regard to compensation, the real question is not whether the payor should pay more than the injury's cost; the question is: what is the cost of the injury? This takes us back to the question of economic versus noneconomic damages. It is arbitrary to say that noneconomic damages are not part of the true cost of an injury and, therefore, to consider all noneconomic awards excessive. What is required is to devise a system in which the decision maker is charged and well suited to assess the accurate costs of an injury and to impose them and no more. If noneconomic damages are sometimes too high, that may not be because such damages are improperly considered or not arbitrarily limited. It may be because jurors are ill-equipped to make accurate cost decisions, and lawyers are presently almost required to whip jurors into a frenzy of anger at the provider in order to obtain any damages at all. That anger may lead to excessive awards. This suggests that changing the decision maker and the threshold for any award may be the most effective way to determine which awards would be excessive and to avoid them.

Administrative costs also are not necessarily excessive even though they obviously add some cost to the cost of the accident itself. Every compensation or conduct control system imaginable has to be administered. Only letting losses lie where they fall is administratively cost-free. However, this does not mean that administrative costs are wasteful or excessive. They are the cost we pay for having a civilized society, the costs of the rule of law. They provide far more benefits than simply sorting out a medical malpractice claim.

Here what cost containment and the avoidance of excess require

is not the elimination of administrative costs, but rather avoiding the creation of a system that adds extra costs for no good end. In the malpractice setting, that suggests that we should rethink a system that requires lengthy, ultimately unproductive litigation about whose “fault” an accident was and that is misguidedly directed toward conduct control. Systems based on factors other than fault can be administered more cheaply than fault-based systems. If nothing is lost for the savings, they should be pursued.

Similarly, conduct control costs, like the costs of defensive medicine, are not necessarily excessive. “Defensive medicine” is a slogan with political bite, not a meaningful concept. Suppose a doctor or other health care provider really does do something to avoid litigation or to increase the chance of winning if litigation should arise. That is defensive medicine. Is it necessarily wasteful? No. Defensive medicine is only wasteful and, therefore, excessively costly if the *socially* best practice of medicine is the *medically* best practice of medicine. People who argue against defensive medicine assume that the level of practice that doctors think appropriate *is* appropriate. One could argue that the lesson of decades of malpractice decisions is that society does not accept that view. If society wants better medical care than doctors think they should provide, then it makes sense for society to try to push doctors toward providing the desired level of performance. Only a blind failure to recognize that health is a value that far transcends economic efficiency would suggest that medicine should be left to the doctors any more than war should be left to the generals. Defensive medicine is excessively costly if, and only if, doctors are doing things that *society*, rather than the medical profession itself, thinks they should not do.

Cost containment is important. Like all other goals, it is complicated. What is needed is a system that can evaluate claims of excessive cost and avoid them, not an a priori determination that some kinds of costs are always excessive.

G. *Ease of Administration*

Related to cost containment is the goal of ease of administration. Usually the simpler a system is to administer, the cheaper it will be. In addition, simplicity reduces the likelihood of errors, promotes public understanding, and generally makes everyone’s life easier. All else being equal, a system that is easy to administer is better than one that is hard.

H. *Fairness*

Obviously, any medical malpractice system should be fair. That

means several things: it should treat like cases alike, it should avoid inappropriate stigmatization, and it should be honest.

The present system does not treat like cases alike. It is unfair to both providers and patients. The system, based on negligence, is so arbitrary and haphazard in its determinations that, in terms of plaintiffs' recovery, it has often been likened to a lottery.⁶² Few plaintiffs recover anything; a few, who are no more deserving, recover gigantic amounts. From defendants' point of view, the system is at least equally arbitrary. Not only does a doctor's liability depend on the bad luck of his or her conduct hurting somebody, but also on the injured person figuring that out, finding an effective lawyer, hanging on through years of litigation, and prevailing in the tort lottery. Moreover, as we have already suggested, courts often make decisions on bases other than fault,⁶³ so that one doctor will be held liable and another will not for exactly the same conduct.

This practice of labeling as negligent behavior that no fair-minded person speaking English would call negligent is also horribly unfair to doctors in that it stigmatizes them for doing what any other competent member of their profession would have done in the same circumstance. As Washington Supreme Court Justice Utter noted in his concurring opinion in *Helling v. Carey*, this is the application of strict liability, and no useful purpose is served by attaching the stigmatizing label to the doctor.⁶⁴ No wonder many physicians hate the legal system!

Finally, and again related, the system is not fair to the extent that it is dishonest. If the system purports to base liability on fault, but instead bases it on judgments about whether physicians are appropriate conduits through whom to pass losses, it cheats the public out of being able to evaluate its legal system and leads to stigmatization and unequal treatment. A system must be honest to be fair.

I. *Scientific Accuracy and Scientific Sense*

Medicine is partly based on science. One goal of a malpractice system should be to make scientific sense or at least not to be scientifically inaccurate. However, it would be easy to overstate the importance of this goal. Medicine is only partly a matter of science, and medical malpractice is only partly a matter of medicine. Like all law, medical malpractice is a multidimensional *social* issue. Just

62. A Google search of the term torts lottery (without quotations), on April 1, 2006, resulted in 437,000 hits. <http://www.google.com>.

63. See *supra* notes 33, 44-46 and accompanying text.

64. 519 P.2d 981, 984 (Wash. 1974) (Utter, J., concurring).

as the criminal law question of “insanity” is a question of what is the best thing to do with certain offenders in terms of their mental abilities *and* the demands of justice, costs and ease of administration, impact on persons outside the system, etc.,⁶⁵ so too the question of medical malpractice is the question of how the society can best deal with certain kinds of injuries in order to achieve justice, avoid waste, encourage doctors to do what the society wants, etc., *and* make scientific sense. It is possible that when all the goals are pursued it may make sense to sacrifice scientific accuracy sometimes.

IV. DESIGNING THE SYSTEM

What would a sensible medical malpractice system that recognized the characteristics of the problem and attempted to sacrifice as little as possible of each of its goals look like? First and most importantly, a properly designed medical malpractice system would be not one system but two. The critical insight in dealing with medical malpractice is that conduct control and loss allocation are two problems that are best resolved separately. Tort litigation is too clumsy, too indirect, too fact specific, too backward looking, and too tied to liability insurance to permit sound conduct control. It can lead to defensive medicine or to inadequate regard for patient safety, but there is no reason to believe that it will lead to optimal medical conduct. Similarly, compensation tied to the elusive goal of conduct control will lead to lottery-like payoffs (nothing for most persons, bonanzas for a few), unfairness in the sense that neither similarly situated doctors nor similarly situated plaintiffs are treated alike, inappropriate stigmatization, and too little concern for scientific accuracy and medical good sense.

A. *Compensation*

Perhaps surprisingly, the compensation system may be the easier of the two to create. Compensation divorced from conduct control requires the same expertise that would be required to decide on proper compensation for injuries caused by an automobile accident, an accidental shooting, a defective product, or any other kind of injury. It also requires some expertise to decide whether medical conduct caused the injury. However, it does not require expert evaluation of the behavior that caused the injury. Thus, doctors asked to participate in the system by evaluating injuries may do so with less temptation to protect or to punish their colleagues than if the system based compensation on an evaluation

65. See DWORKIN, *supra* note 2, at 4, 167, and authorities cited therein.

of conduct.

Second, all patients who have suffered similar injuries caused by medical mal-occurrences need similar remediation.⁶⁶ Thus, the amount of damages awarded can be determined without attention to the particular conduct that caused the injury other than to find that it was medical conduct. This still raises two questions: (1) What is “medical conduct,” and (2) what does one mean by causation?

Medical conduct is simply conduct that a professional is performing pursuant to his, her, or its authorization to practice. It includes failures to act (not ordering tests) as well as actions, but it does not include things that a nonprofessional might do, like driving to the hospital, even if one is driving fast to reach a patient in need of speedy assistance. Whatever would be considered the practice of medicine under a state’s medical practice act would be medical conduct.

Causation is more problematic. If conduct control is not part of the compensation decision, then no need exists to determine whether a doctor’s conduct was blameworthy. However, causation has inescapable hints of blame. Why else do we apologize when we hurt someone even if we have done nothing wrong, and why do we couple claims of innocence with claims of noninvolvement: “I didn’t do it; it’s not my fault.” Fault considerations often slip into supposedly non-fault inquiries, like whether a product was defective.⁶⁷ Thus, the system must struggle mightily to repress considerations of blameworthiness from the apparently morally neutral inquiry into causation. One way to do that is to have compensation (including causation) decisions made by trained decision makers who have been taught to distinguish factual causation from placement of blame. This begins to suggest the nature of the decision-making body.

A second problem with causation is one alluded to earlier.⁶⁸ Persons who suffer medical injuries started out with a problem. Somebody must separate the inevitable consequences of the patient’s injury or illness from those that were medically caused. Unfortunately, that task requires medical expertise, which means that there will still be some danger of professional self-interest entering the process. This too has implications for the nature of the

66. This is actually true of all injured persons, regardless of what caused their injuries. However, exploring the feasibility of a New Zealand-style compensation system for all accidental injuries in the United States is beyond the scope of this Article. *See supra* note 15.

67. *See* RESTATEMENT (THIRD) OF TORTS: PRODUCTS LIABILITY § 2 (1998) (listing categories of product defect).

68. *See supra* note 11 and accompanying text.

process.

Once the decision maker has decided that medical conduct caused an injury, it must decide how much compensation to award. Many approaches are possible. Damages could be litigated and evaluated like they are now in the tort system. A schedule, similar to a workers' compensation schedule, could be developed. Each person could be evaluated in an effort to return him or her to the pre-accident position; persons could be placed into groups based on wealth, occupation, previous health, family obligations, etc.; or we could take the position that all persons are equal, so that for compensation purposes an arm is an arm.

What position to take is a quintessentially political question. It will reflect the society's values about individualism versus communitarianism; rewarding past achievement and high birth or attempting to engage in economic leveling; how expensive to make medical services, etc. In other words, it is a question for the legislature.

So, too, is the question about whether to permit and, if so, whether and how to limit noneconomic damages. Punitive damages, on the other hand, would plainly be inappropriate as they would be inconsistent with the focus on compensation divorced from conduct control and would risk creating an overlap with the conduct control mechanism and making medical care unduly expensive.⁶⁹

Given these observations, the proper course is fairly clear. Each state legislature⁷⁰ should create and empower a medical compensation board which will provide the exclusive remedy for patients injured by medical conduct. The legislature should determine the compensation scheme—methods of valuation, what to do about noneconomic damages, etc.—and charge the board to administer it. At least a majority of the board members should not be health professionals, and conflict-of-interest rules should eliminate insurance company executives, hospital board members, and the like.

The board members must be trained to separate claims of factual causation from claims of blameworthiness. Evidence about professional standards and other evidence that could invite consideration of fault should be inadmissible before the board. The nonphysicians on the board must not only hold a majority of the seats, they must also be high-powered individuals who are unlikely

69. See *supra* Part III.A.1.

70. Malpractice is traditionally a state matter, and values can be expected to differ from state to state. When trying something new it is usually a good idea to follow Justice Brandeis's advice and use the states as laboratories. *New State Ice Co. v. Liebmann*, 285 U.S. 262, 311 (1932) (Brandeis, J., dissenting).

to be cowed by their professional colleagues' claims of expertise.

In making its initial decision to remit compensation decisions to the board, the legislature will have to decide who is to provide the compensation. The most sensible decision would probably be to have compensation financed by the taxpayers. That would have several advantages. First, it would make everybody pay what has been independently determined to be their appropriate share of state expenses for services from which everyone benefits. Second, it would free the cost of medical care from being affected by the successful or unsuccessful investment strategies of insurance companies. Third, it would get a lobbying force out of the process, thereby maximizing the likelihood that the system will be beneficial to all. Fourth, it would give the state a measure of control over one component of medical costs. Given the importance of controlling medical costs for everyone, and especially the importance of controlling taxpayer costs for financing medical care for the poor without affecting the quality of care, this is an extremely important advantage.

Nonetheless, the decision about how to finance the system is properly a political decision, and the compensation board approach could function even if the legislature decided to have it funded by insurance companies, by a surtax on doctors, or in some other way.

B. Conduct Control

The tort system does a lousy job of getting doctors to practice optimal medicine, as do both state-run and intra-professional approaches to medical discipline.

1. Torts

For reasons discussed before,⁷¹ a common law tort system is unlikely to be very effective for controlling physician behavior. However, it will lead to inappropriate stigmatization, professional alienation from the system, wasteful litigation expense, and unfair compensation. This is not only theoretically true. It is true in fact.

Malpractice litigation could try to achieve both general and special deterrence; i.e., it could try to prevent an offending doctor from offending again, and it could try to make an example of an offending doctor so that other doctors do not make the same missteps as the defendant. It will not be very good at either.

First, in order for a particular doctor to be "disciplined" by the system, the doctor must be very unlucky. His or her negligent behavior must hurt somebody, and the injured patient must be one

71. *See supra* Part III.B.

of the two percent of medically injured patients who figures out the medical cause of his or her injury, decides to do something about it, and finds a lawyer to take the case.⁷² Then, the patient must persist for several years before seeing whether he or she has won the tort lottery. The doctor will only lose if the patient's lawyer is good, the patient is persistent, and the judge and jury happen to find for the plaintiff. All told only thirty-four percent of patients win jury verdicts in medical malpractice cases.⁷³ That means that even if all of those verdicts result in judgments, only 0.68% of patients injured by medical activities obtain a judgment.⁷⁴

On the other hand, many doctors are terrified of the tort system. Some may practice defensive medicine. Others will simply be irate when confronted with the occasional totally unfair determination of negligence. They will quite properly ignore the apparently irrational demands of the law. If a person is arbitrarily exposed to the whims of the law, that person may under-react or overreact, but it would be naive to believe that the person will respond by practicing socially optimal medicine.

Similarly, how can the system hope to cause physicians in general to practice good medicine? Physicians see colleagues winning and losing lawsuits apparently at random. They do not learn any lessons because there are no lessons to learn. When the system does occasionally say something clear—like do a glaucoma test on everybody⁷⁵—the doctor has two choices: (1) comply, in which event the system has achieved conduct control, but only by making doctors do something ill-advised and wasteful, or (2) not comply, in which event better medicine will have been achieved by flouting the system than by following it. Some better approach to making doctors practice optimal medicine must be found.

2. Discipline

Two systems of medical discipline exist: (1) state discipline administered by boards of medical practice, and (2) intra-professional discipline administered by hospital credentials committees and by such devices as morbidity and mortality conferences.

As presently constituted, state disciplinary boards are not up to

72. See JCAHO, *supra* note 32, at 4, 44 nn.3-4.

73. Medical Malpractice Today.com, Health Care Providers Win Most Cases, <http://www.medicalmalpracticetoday.com/medicalmalpracticestats-hcp-winmore.html> (last visited Mar. 30, 2006) (citing jury verdict research from 1995 to 2000).

74. Of course, some patients obtain settlements.

75. See *supra* notes 39-43 and accompanying text.

the task. Traditionally, professional incompetence was not even a ground for professional discipline in most states.⁷⁶ Moreover, state disciplinary boards are underfunded and understaffed.⁷⁷ They rely on complaints and reports of tort judgments and settlements to find candidates for discipline, rather than having significant case-finding operations. Once again, whether a doctor is exposed to professional discipline is largely a matter of luck. The discipline system has virtually no effect on making doctors practice good medicine.

Hospital committees are a bit better. Doctors who practice badly enough can be denied privileges or have privileges conditioned, suspended, or revoked.⁷⁸ This does have the effect of getting some of the worst doctors out of positions where they can do the most harm. In addition, morbidity and mortality conferences within a medical institution can both educate physicians about their mistakes and the mistakes of others and how to avoid repeating them and expose bad practice to colleagues who might otherwise refer patients to the offending physician.⁷⁹

Nonetheless, this is a far from adequate system of conduct control. Some practice can be done without needing to be on a hospital staff. Morbidity and mortality conferences only occur after a bad result has occurred, not after bad practice has occurred. Despite federal databases,⁸⁰ physicians can obtain privileges at different hospitals in their community or move. Hospital conferences and credentialing decisions occur in secret, so that patients have almost no chance to become informed and make prudent decisions about which doctors to employ.

In addition to these shortcomings, the hospital committee system has other failures. First, it is run by doctors, which means that at best it will promote medically best medicine—the medicine doctors think should be practiced. However, as we have noted, the goal is to encourage doctors to practice socially best medicine, which

76. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE, REPORT OF THE SECRETARY'S COMM'N ON MEDICAL MALPRACTICE, DHEW PUBLICATION NO. (OS) 73-88, 51-55 (1973), *reprinted in* WALTER WADLINGTON, JOHN R. WALTZ, & ROGER B. DWORKIN, CASES AND MATERIALS ON LAW AND MEDICINE 79-82 (1980).

77. *Id.* at 51-55, *reprinted in* WALTER WADLINGTON, JOHN R. WALTZ, ROGER B. DWORKIN, CASES AND MATERIALS ON LAW AND MEDICINE 79-82 (1980).

78. *See* Peter M. Mellette, *The Changing Focus of Peer Review Under Medicare*, 20 U. RICH. L. REV. 315, 325 (1986) (explaining revocation of hospital privileges for repeated improper treatment methods).

79. *See, e.g.,* David A. Hyman & Charles Silver, *The Poor State of Health Care Quality in the U.S.: Is Malpractice Liability Part of the Problem or Part of the Solution?*, 90 CORNELL L. REV. 893, 943-44 (2005) (explaining disclosure to co-workers in morbidity and mortality conferences).

80. *See* 42 U.S.C. §§ 11131-11137 (2000).

may be something very different indeed.⁸¹

Finally, the hospital credentialing and discipline system is unfair to doctors. Doctors have too few procedural protections and far too little protection against exclusion from privileges because of racial, sexual, or other prejudice; animus based on the nature of their practice; economic protectionism; or general distrust of newcomers.⁸²

Clearly, some alternative system of controlling physician behavior is required.

3. *A Better Way?*

In order to do as good a job as possible of controlling physician behavior, a system must have the ability to find doctors who practice poorly regardless of whether their bad practice resulted in patient injury. It must be able to recognize and punish the practice of socially sub-optimal medicine. It must satisfy patient expectations, publicize its decisions in order to protect patients, and impose sanctions that increase the likelihood of improving the quality of care, not simply driving doctors out of practice. It must be fair to doctors, and while it should not defer to medical opinion about what is good medicine, it should value such opinion, and it should make medical-scientific sense.

Only an administrative body can accomplish these goals. State medical disciplinary boards should be expanded in size and should have their budgets substantially increased. They should be composed of physicians from many specialties and nonphysicians with the education and strength of personality to challenge their professional colleagues. They must have an investigative staff that both responds to complaints and does routine, periodic quality audits of hospitals and physicians.

Physicians whose audits suggest they are in need of discipline should receive a hearing before the board or a panel of it. They should be entitled to representation by counsel and to substantial procedural protections, such as notice of charges, confrontation of witnesses, etc. Hearing panels should include both physicians and nonphysicians, probably with nonphysicians in the majority. The panels should have the authority to revoke or suspend a doctor's license, place a doctor on probation, restrict a doctor's practice,

81. *See supra* Part III.F.

82. *See, e.g.,* Guerrero v. Burlington County Mem'l Hosp., 360 A.2d 334, 336 (N.J. 1976) (upholding defendant hospital's decision to deny admission to two surgeons based allegedly on limited capacity). The inadequate federal effort to deal with these problems may be seen at 42 U.S.C. §§ 11101-11113 (2000).

require retraining and reexamination, require abstinence from alcohol or drugs coupled with participation in rehabilitation programs, and whatever other penalties are appropriate. They must conduct their hearings in public and publish their conclusions and recommendations in a form and location where ordinary patients can readily access them. Doctors should have a right to appeal.

While a system such as this seems likely to be expensive, it will probably actually save money. Remember that it is to accompany an administrative-based compensation system that will not involve determinations of fault and that will probably reduce the size of awards.⁸³ Net savings may well result.

More importantly, separating the compensation and conduct control functions of malpractice law should make both parts function better. Lottery-style recoveries, inequality, arbitrariness, and excessive damage awards should all be avoided, while the quality of medical practice and the ability of patients to make informed choices about their health care providers should be improved. All the goals of the malpractice system will be served better than any of them are being served now.

V. CONCLUSION

A focus on legal process, comparing the characteristics of the medical malpractice problem and the goals of the malpractice system with the characteristics of legal institutions, leads to the conclusion that abandoning tort recovery for malpractice and devising separate, unrelated systems for patient compensation and physician discipline will significantly improve our system for dealing with medical mal-occurrences. A similar focus on characteristics of problems and characteristics of institutions may well be superior to substantively based approaches to other issues of health law and perhaps to other areas of law as well.⁸⁴

83. *See supra* Part IV.A.

84. Professor Einer Elhauge has pointed out to me that one could reach the same conclusions about medical malpractice reform that I have suggested by using different modes of analysis, such as law and economics. That is correct. However, the legal process approach suggested here is attractive in part because it is ideologically neutral and does not require a person considering reform to start with a substantive preference.