The recent national debate about health care reform has again focused public attention on malpractice litigation. One malpractice reform proposal that has gained prominence in the 1990s is enterprise medical liability. Under this approach the focus of malpractice litigation would be shifted from individual physicians to the health care organizations under whose auspices patients are treated. In this Article, Professors Abraham and Weiler, who originally developed this policy proposal in the late 1980s, analyze how such a change should be made in medical liability law.

The authors first chronicle how, beginning in the 1960s, courts gradually developed a measure of hospital liability for physician negligence, at the same time as other changes in the health care system were motivating hospitals to exercise greater control over both the quantity and quality of medical services that physicians provided to patients. The authors then show why completion of this evolution, by making hospitals liable for all malpractice by their affiliated physicians, would better serve the goals of tort law than does the current individual liability regime. The authors also explain why imposing liability on enterprises such as hospitals engaged in the delivery of patient care is preferable to imposing liability on health plans that finance patient care.

After detailing how enterprise medical liability could be introduced on an elective basis, Professors Abraham and Weiler conclude by explaining why this shift in the target of malpractice litigation might serve as a step on the way to a fundamentally different, no-fault medical liability regime.

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Although the death of health care reform in the 103rd Congress leaves in doubt the immediate prospect for federal action in this sphere, two years of intense national debate have placed this subject on the public agenda as never before. Future improvements in the health care system may come principally through private action in the medical marketplace or through public action by state and federal governments. Regardless of the avenue taken, however, hopefully such reforms will reflect a more informed and sophisticated appreciation of the strengths and weaknesses of both the current system and proposed alternatives.

Malpractice litigation has now become a prominent focus of national health care politics, as it has been for the last two decades in state capitals. A prime candidate for such attention is the law’s imposition of malpractice liability on the individual physician. Because doctors now practice in an environment in which health care enterprises have become increasingly dominant, shifting liability from the physician to the enterprise is an increasingly plausible direction for malpractice reform.

The concept of enterprise medical liability had been quietly analyzed in scholarly publications for a number of years, but the idea gained public prominence in the spring of 1993 as the Clinton Administration made ready its proposed health care reforms. Reports circulated that the legislation would completely abolish the liability of individual physicians for medical malpractice. Common law physi-

1 We had been studying and developing a systematic case for the concept of enterprise — we called it "organizational" — liability in our scholarly work for some time. First, the Harvard Medical Practice Study (HMPS), in which Professor Weiler was the principal lawyer participant, documented the failings of the current individual liability model of malpractice litigation. The findings of the HMPS are distilled in PAUL C. WEILER, HOWARD H. HIATT, JOSEPH P. NEWHOUSE, WILLIAM G. JOHNSON, TROYEN A. BRENNAN & LUCIAN L. LEAPE, A MEASURE OF MALPRACTICE (1993). Second, a major study by the American Law Institute (ALI) analyzed high-stakes tort litigation — not only litigation about medical injuries but also that concerning environmental, product, and occupational hazards. Professor Weiler served as Chief Reporter for the ALI Study and Professor Abraham was Associate Reporter. See 2 AMERICAN LAW INST., REPORTERS' STUDY: ENTERPRISE RESPONSIBILITY FOR PERSONAL INJURY 113-19 (1991) (analyzing and endorsing the concept of organizational medical liability). Third, a byproduct of these two projects was a book by Professor Weiler that included a detailed argument for imposing liability on hospitals rather than on physicians. See PAUL C. WEILER, MEDICAL MALPRACTICE ON TRIAL 122-32 (1991).

2 The Administration’s recommendations were embodied in the proposed Health Security Act, S. 1775, 103d Cong., 1st Sess. (1993). We were delighted that the core concept of enterprise liability was about to be proposed as an important component of national health care reform, although we informed the President’s Health Care Task Force of our reservations about its choice of the untested health plan rather than the well-established hospital as the institutional candidate for this new brand of malpractice liability.

cian liability was to be replaced by "enterprise liability," under which the statutorily defined health plans that were to provide care under the new system would bear all liability for medical malpractice. Enterprise liability had the potential simultaneously to garner individual physicians' support for the Administration's broader health care reforms and to place legal responsibility for health care decisionmaking on a business enterprise whose role was to be central in the Administration's vision of the reformed health system.

What happened next should be recorded as one of the great ironies in the history of political lobbying. Primarily through two of its major organizations, the American Medical Association (AMA) and the Physician Insurer Association of America (PIAA), the medical profession descended on Washington, and began to work strenuously to persuade the Administration to reconsider its plan to immunize physicians from personal liability for their negligence. Having bemoaned for decades the baneful effects of malpractice liability, doctors now pleaded, in effect, "Please don't take our liability away from us!"

A number of institutional and ideological concerns produced this surprising reaction to the Administration's trial balloons. The PIAA was evidently concerned that if physicians no longer were liable for malpractice, they would no longer need liability insurance. In that brave new world, physician-owned mutual malpractice — or "bedpan" — insurers would have lost their raison d'être. The AMA, which had seen national health care reform as a possible vehicle for securing its favored malpractice reform — the highly regressive California model of a fixed ($250,000) ceiling on pain and suffering awards — was unwilling to settle for a second-best option such as enterprise liability. And many physicians, especially those represented by the AMA, were wary of a proposal that, while promising to get lawyers off their backs, might simply put insurance company bureaucrats or hospital administrators in the lawyers' place. The rest is history: when physicians' organizations made it publicly clear that they did not find enterprise liability particularly attractive, the Administration retreated. At that point, the enterprise liability idea seemed to have passed into oblivion after its brief appearance at center stage.

The concept of enterprise liability, however, has deep and enduring intellectual roots. The basic idea of enterprise-based tort liability lies at the heart of the centuries-old doctrine of respondeat superior, which

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4 PIAA is the trade organization of physician-owned mutual insurance companies ("bedpan mutuals") that were formed in the 1970s in many jurisdictions to write medical malpractice liability insurance when commercial insurers became reluctant or unwilling to do so.


makes firms liable for the torts of their workers. For at least fifty years, expansion of tort liability to focus legal responsibility for personal injury on the enterprise in the best position to make risk/safety tradeoffs has been a dominant theme in tort law scholarship and has contributed to the evolution of tort law doctrine. In the field of medical malpractice, a version of enterprise liability was proposed as a solution to the malpractice crisis of the mid-1970s, under the label "channelling." At the same time, other common law developments were expanding the liability of conventional hospitals. Finally, the liability insurance crisis of the mid-1980s—which, unlike its predecessor, concerned not only medical but other forms of liability—created the conditions under which proposals for major tort liability reform would be taken seriously.

Perhaps in part for these reasons, when the Administration’s reform package finally saw the light of day in the fall of 1993, it revived enterprise liability in the form of a proposal for federal funding of demonstration projects that would test the value of this alternative assignment of medical malpractice liability. As we write in late 1994, enterprise liability has become more than an idea that intrigued the Clinton Administration in the spring of 1993; rather, the idea occupies a solid position on the malpractice reform agenda.

The remainder of this Article undertakes an analysis of the idea of enterprise liability—the cluster of approaches that would depart from traditional individual liability for medical malpractice and impose liability on health care enterprises. As a simple shorthand, we call this cluster of approaches “enterprise medical liability,” or “EML.” We first trace the evolution of hospital liability and of hospital-physician relations—developments that have created the conditions for treating health care as an enterprise-based industry and shifting tort liability to the industry’s constituent enterprises. We next discuss the way in

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9 See Kenneth S. Abraham, Medical Malpractice Reform: A Preliminary Analysis, 36 Md. L. Rev. 489, 520-22 (1977); Myron F. Steves, Jr., A Proposal to Improve the Cost to Benefit Relationships in the Medical Professional Liability System, 1975 Duke L.J. 1305, 1324-31. Although the idea of channelling did not come to legislative fruition in the ensuing years, something resembling it took shape in some teaching hospitals and closed-staff health-maintenance organizations (HMOs) that burgeoned in the 1980s. These hospitals and HMOs often took full responsibility for the purchase of malpractice insurance to cover their physicians, thus insulating them from malpractice liability economically, if not legally. See William M. Sage, Kathleen E. Hastings & Robert A. Berenson, Enterprise Liability for Medical Malpractice and Health Care Quality Improvement, 20 Am. J.L. & Med. 1, 17-18 (1994).
10 See infra Part I.
which the goals of the tort system would be better served by EML than by the traditional system of individual liability for malpractice; the form and character of EML that we prefer; and the manner in which demonstration projects testing the advantages of elective EML might be undertaken. Finally, we suggest the reasons that EML, if adopted, could serve as a bridge to broader medical liability reform.

As we move from a period of intense political controversy into more prolonged deliberation about health care reform, a better understanding of the evolution and interplay of our civil justice and health care institutions is likely to make EML an increasingly attractive option.

I. THE LEGAL AND ECONOMIC EVOLUTION OF THE HOSPITAL

Fifty years ago, adoption of enterprise medical liability would have radically reversed the basic assumptions underlying malpractice liability. Given developments in the law since that time, however, the initiative we are proposing now constitutes a significant but logical extension of trends that have been evolving over several decades in both the allocation of legal responsibility for negligently caused patient injuries and the increasingly commercialized organization of health care. We discuss both trends below.

A. The Rise of Hospital Liability for Medical Injuries

1. Charitable Immunity. — Long the dominant enterprise in the provision of American health care, hospitals were almost totally immune from malpractice liability until the 1940s. In particular, non-profit hospitals enjoyed “charitable immunity” from tort suits brought by their patients. The main justification for charitable immunity was an implied waiver by patients who were receiving services free of charge. But the implied waiver applied to paying as well as non-paying patients, and to unconscious as well as conscious admittees to the hospital.

A key ruling in the demise of charitable immunity was President of Georgetown College v. Hughes, in which the Court of Appeals for the District of Columbia both noted anomalies in the application of charitable immunity, and criticized the idea that a hospital might spend its

14 The best scholarly treatments of the shifting allocation of liability are Diane Janulis & Alan Hornstein, Damned If You Do, Damned If You Don’t: Hospitals’ Liability for Physicians’ Malpractice, 64 Neb. L. Rev. 689 (1985), and Arthur Southwick, Hospital Liability: Two Theories Have Been Merged, 4 J. Legal Med. 1 (1983).

15 The leading early case creating and justifying such immunity was McDonald v. Massachusetts General Hospital, 120 Mass. 432, 434-36 (1876), which held that a non-profit hospital was immune from liability for the potential negligence of an attending surgeon, provided that hospital administrators were not negligent in the selection of the surgeon.

16 See id. at 434-35.

17 130 F.2d 810 (D.C. Cir. 1942).
funds on a host of operating costs (including insurance against liability to strangers) and still be protected against the need to purchase insurance against liability to its own patients.\textsuperscript{18} The scholarly analysis in \textit{Hughes} proved highly influential in the subsequent widespread erosion of charitable immunity.\textsuperscript{19}

Even after the removal of charitable immunity, the courts sometimes viewed hospitals not as themselves providing medical care to patients, but as suppliers of the means by which doctors, nurses, and others provided such care.\textsuperscript{20} Hospitals therefore were not necessarily liable for negligent treatment, although they could be held liable for negligence in carrying out the non-treatment duties they did perform.\textsuperscript{21} Although removal of the charitable immunity blanket was well underway by the 1950s, the underlying protection of hospitals from the norms of medical liability remained, generating a host of cases about how and where to draw the line between inherently medical, as contrasted with administrative, activities.\textsuperscript{22} Slowly, however, courts removed this obstacle to the imposition of malpractice liability on hospitals, and hospitals employing doctors or nurses became governed by the universal tort standard of respondeat superior, which "both assures payment of an obligation to the person injured and gives warning that justice and the law demand the exercise of care."\textsuperscript{23}

2. \textit{Agency Liability}. — Once the unique legal obstacles to the imposition of any kind of liability on hospitals for medical malpractice were removed, special legal avenues developed for imposing liability

\textsuperscript{18} See id. at 815–27.

\textsuperscript{19} The rule of charitable immunity has now been eliminated in a substantial majority of states. See, e.g., Ray v. Tucson Medical Ctr., 330 P.2d 220, 223–25, 229–30 (Ariz. 1951); Tunkl v. Regents of the Univ. of Cal., 383 P.2d 441, 448–49 (Cal. 1963); Durney v. St. Francis Hosp., Inc., 83 A.2d 753, 757–59 (Del. Super. Ct. 1951). See generally Janet F. Fairchild, Annotation, \textit{Tort Immunity of Non-Governmental Charities — Modern Status}, 25 A.L.R.4th 517, 525–46 (1983) (finding that 29 jurisdictions have wholly abolished charitable immunity for hospitals and that a number of other jurisdictions have severely limited its scope and applicability). The doctrine does, however, retain considerable force in a number of states, including its place of origin, Massachusetts. For the story of the Massachusetts experience, see English v. New England Medical Center, Inc., 541 N.E.2d 329, 330–31 (Mass. 1989), in which the Supreme Judicial Court noted that charitable immunity was in full effect until 1971, when it was altered by legislative action to allow liability up to $20,000 for torts committed in the course of hospital activities — a flat dollar ceiling that has not since been adjusted for inflation, including the price of health care.

\textsuperscript{20} This distinction was in place even before the abolition of charitable immunity. See, e.g., Schloendorff v. Society of N.Y. Hosp., 105 N.E. 92, 93–94 (N.Y. 1914). As the courts viewed the health care system in the early part of this century, hospitals did not undertake to provide medical care to patients. Instead they furnished facilities where trained medical personnel were gathered, professionals whose specialized knowledge and skill warranted personal responsibility for careful patient treatment. See id.

\textsuperscript{21} See Bing v. Thunig, 143 N.E.2d 3, 15 (N.Y. 1957); Schloendorff, 105 N.E. at 94.

\textsuperscript{22} Several illustrations of debatable issues are presented in Bing, 143 N.E.2d at 4–5. For example, giving blood transfusions to the wrong patient was labelled an "administrative" error, but giving the wrong blood to the right patient was a "medical" error.

\textsuperscript{23} Id. at 8.
upon hospitals for the malpractice of physicians with whom they were affiliated but whom they did not "employ." That development got seriously underway in the 1970s, and by the early 1990s had borne fruit in the doctrines of agency and corporate liability.

The vast majority of physicians affiliated with hospitals — family physicians, internists, obstetricians, surgeons, and most other physicians — enjoy an independent-contractor rather than an employer-employee relationship with the hospital, even though they are designated as the institution's medical "staff." Physicians have the privilege of admitting their patients to the hospital's beds and treatment facilities, and in return they perform a number of administrative functions for the hospital. Despite this relationship with hospitals, physicians are self- or group-employed professionals and entrepreneurs whose services are contracted for by the patients themselves. Consequently, there is usually no conventional basis for agency liability, and the typical enterprise medical liability claim must rest instead on apparent or ostensible authority.

The usual setting for such a claim is a hospital emergency room (ER). Because the nurses, technicians, and residents working in the ER are salaried employees of the hospital, the hospital is vicariously responsible for their tortious conduct. Often, however, independent-contractor physicians are also working in the ER and overseeing its staff. In this setting, courts have clearly held the hospital (as well as the physician) liable for the physician's malpractice, notwithstanding the physician's independent-contractor status; the judicial theory of agency liability is based on "apparent authority."25


25 Courts in 20 or so states have confronted this question, and have relied on the Restatement of Agency or the Restatement of Torts in answering it. Section 267 of the Restatement (Second) of Agency (1958) provides:

One who represents that another is his servant or other agent and thereby causes a third person justifiably to rely upon the care or skill of such apparent agent is subject to liability to the third person for harm caused by the lack of care or skill of the one appearing to be a servant or other agent as if he were such.

Section 429 of the Restatement (Second) of Torts (1965) provides:

One who employs an independent contractor to perform services for another which are accepted with the reasonable belief that the services are being rendered by the employer or
The courts’ reasoning in these cases is that hospitals hold themselves out to potential patients as providers of high quality emergency room services. Although the hospital knows whom it has employed and with whom it has merely contracted to provide ER treatment, the patient knows only that the hospital has selected all the personnel who provide ER treatment in the hospital’s facility. Consequently, courts conclude, it is only reasonable for the patient to assume that the hospital will be liable for the malpractice of anyone providing health care in its ER facility. Underlying this rationale is a judicial conception of the modern hospital as an entrepreneurial venture that stands in stark contrast to the image of the “charitable” institution that was protected from liability until the 1940s.26

Although emergency room treatment is the most prominent setting for apparent-authority claims against hospitals, comparable vicarious liability suits have been successfully launched against hospitals for the alleged negligence of anesthesiologists,27 radiologists,28 pathologists,29 and even occasionally against a surgeon whose services the patient used because he was on the hospital staff.30 Almost all acute care hospitals provide these important health care services to all of the patients treated within their facilities. Under the doctrine of apparent authority, the fact that the medical specialists performing these functions happen to have an independent-contractor rather than employment relationship with the hospital will not insulate the hospital from vicarious liability for their malpractice.

It is crucial to see, however, that there is both a large element of fiction and a pivotal ambiguity in the apparent-authority rationale for the hospital’s liability. Patients certainly are under the impression that it is the hospital and not individual physicians that provides emergency, radiology, or anesthesiology services. Patients may also believe, for example, that the radiologists reading their x-rays are hospital employees rather than independent contractors. But it is not at all clear

26 For a reflection of this changing image, see Kashishian v. Port, 481 N.W.2d 277, 282 (Wis. 1992).
what legal outcomes should turn on these impressions. The tacit premise of courts that impose agency liability on hospitals based on apparent authority is that patients, so informed, would shop around for hospitals that did employ their physicians. Otherwise, the impression created by the hospital — the “apparent” clothing of independent contractors with authority to act for the hospital — would be irrelevant.

But few cases either make this premise explicit or require the patient to prove what is effectively detrimental reliance on the false impression created by the hospital.\(^3\) Moreover, although the courts that rest hospital liability on the appearance of agency authority would seem logically required to decline to impose liability when the hospital dispels that appearance, they virtually never do so.\(^3\) Only the Alaska Supreme Court has explicitly held that the hospital’s legal responsibility for malpractice by its physicians is non-delegable and non-waivable — the same duty that now governs airline liability, for example, even if an airline uses pilots or mechanics on an independent-contractor basis.\(^3\) In the absence of any requirement that patients prove detrimental reliance or of any serious and legally effective effort by a hospital to dispel the appearance of agency, however, the effect in other jurisdictions is the same: the hospital bears vicarious liability for the torts of at least some of its independent-contractor physicians.

3. Corporate Liability. — Although a non-delegable duty on the part of the hospital is the substance if not the form of agency liability, corporate liability on the part of the hospital embodies both the form and substance of a non-delegable duty. Corporate liability extends the scope of a hospital’s potential liability to cover not only injuries stemming from the malpractice of physicians selected by and under contract to the hospital (such as radiologists, anesthesiologists, and ER physicians), but also injuries stemming from the malpractice of certain physicians chosen by the patient (such as internists, surgeons, and obstetricians). Corporate liability first emerged in the malpractice context in cases involving hospitals that had failed to check properly the credentials and qualifications of physicians they had accorded admitting privileges, to monitor the subsequent quality of care provided by

\(^3\) In one of the few cases to scrutinize closely the assumption that apparent authority makes a difference, the Ohio Supreme Court held that agency liability must rest upon some kind of detrimental reliance by the patient on the hospital’s representation, and that in the absence of tangible evidence to the contrary, the more plausible starting point is that patients do not pick hospitals on the basis of the employment status of physicians. See Albain v. Flower Hosp., 553 N.E.2d 1038, 1050 (Ohio 1990), overruled in part by Clark v. Southview Hosp. & Family Health Ctr., 628 N.E.2d 46 (Ohio 1994).

\(^3\) Cf. H. Ward Classen, Hospital Liability for Independent Contractors: Where Do We Go From Here?, 40 Ark. L. Rev. 469, 501–02 (1987) (recommending that hospitals try to remove this basis of liability through signs in ER waiting rooms, identification badges on physician uniforms, and notices in patients’ signed admission forms).

the physicians, or to suspend or revoke admitting privileges where necessary. In some of these cases, the person treating the patient had actually never been affiliated with the hospital at which he claimed prior consultant privileges, or turned out not to be a physician at all. In still others, the hospital failed to discover or to react to the existence of other tort claims that had been brought against the physician for analogous incidents.

Today, the Joint Commission on the Accreditation of Health Care Organizations (JCAHCO), state legislatures, and even hospitals themselves, have codified the courts’ view that hospitals have a duty to their patients to verify the qualifications of admitted physicians and to review their performance. The JCAHCO guidelines, standard state medical licensing regulations, and many hospital bylaws require hospitals to establish procedures for evaluating the qualifications of physicians before granting admitting privileges and periodically to review physicians’ performance to decide whether to continue the affiliation. These regulatory mechanisms contemplate that judgments about physician competence will be made through a process of peer review,

34 The leading early case that is often regarded as having taken the first step toward corporate liability is Darling v. Charleston Community Memorial Hospital, 211 N.E.2d 253 (Ill. 1965), cert. denied, 383 U.S. 946 (1966). In Darling, however, the principal focus of the malpractice claim was the negligence of the hospital staff in failing to monitor and report on the deteriorating condition of the patient while he remained in the hospital for 10 days after the initial surgical procedure. See id. at 256, 258. Though Darling is regularly cited for its discussion of a hospital’s liability for physician malpractice, see id. at 261, the case actually imposed vicarious liability on the hospital for the malpractice of its nursing staff, see id. at 258.


35 See, e.g., Johnson, 301 N.W.2d at 159, 173-74.

36 See, e.g., Insinga v. LaBella, 543 So. 2d 209, 210 (Fla. 1989).

37 To some extent, this evaluation process has been facilitated by the National Data Bank for Adverse Information on Physician Health Care Practitioners established under the Health Care Quality Improvement Act of 1986, 42 U.S.C. §§ 11101-11152 (1988). All payments made as a result of malpractice claims, all adverse licensing decisions by state medical boards, and all hospital suspensions or revocations of practice privileges must be reported to the National Data Bank, and this information is made available to any hospital considering whether to grant or continue privileges to members of its medical staff. See id. §§ 11131-11137.
which is normally conducted by the self-governing medical staff of the hospital. Even though the vast majority of physicians who perform this peer review function on behalf of hospitals are independent contractors rather than employees, courts have uniformly concluded that hospitals must bear legal responsibility for this key component in the delivery of quality medical care to patients.\textsuperscript{39}

Corporate liability is in some ways narrower, and in some ways broader, than agency liability. Although under each doctrine a physician's malpractice is a prerequisite to establishing the hospital's liability,\textsuperscript{40} corporate liability is narrower because it is fault-based and requires that the patient also establish the hospital's negligence. It imposes an independent duty on the hospital to use reasonable care to scrutinize and verify the (continuing) qualifications of its physicians. However, corporate liability is broader than agency liability in the sense that the hospital may be held liable even if the physician (for example, an obstetrician) was selected by the patient and practices in the hospital as an independent contractor. In contrast, under a regime of agency liability the hospital is liable for the malpractice of independent contractors only if they possessed actual or apparent authority.

For example, proof that an anesthesiologist, hired by a hospital as an independent contractor, committed malpractice will support the imposition of agency liability on the hospital; however, if the malpractice was committed by a surgeon selected by the patient but with admitting privileges in the hospital, corporate liability requires proof of the hospital's negligence in assessing the surgeon's competence. Because hospital credential committees now routinely check and catch the most blatantly unqualified physicians, proof of this particular brand of hospital negligence has become considerably more difficult. Yet in cases in which patient damages significantly exceed the policy limits of the individual physician's liability insurance, plaintiffs have a strong financial incentive to try to overcome this difficulty in order to secure full recovery.\textsuperscript{41} Adding this question whether the hospital also was

\textsuperscript{39} See, e.g., Johnson, 301 N.W.2d at 164-71.

\textsuperscript{40} See Humana Medical Corp. v. Traffanstedt, 597 So. 2d 667, 668-69 (Ala. 1992) (reversing a jury verdict of corporate hospital liability because it was inconsistent with the same jury's finding that the treating physician had not committed malpractice).

\textsuperscript{41} The liability of the hospital in this situation can be significant because a settlement with the physician for a sum within the limits of a personal malpractice insurance policy does not preclude suit against the hospital for a larger sum. For example, in Uhr v. Lutheran General Hospital, the court refused to find excessive a judgment against the hospital for $1.87 million with a set-off of $300,000 for settlements the patient had reached with the physicians. See 589 N.E.2d 723, 727, 745 (Ill. App. Ct. 1992), vacated, 614 N.E.2d 319 (Ill. App. Ct. 1993). Similarly, in Campbell v. Pitt County Memorial Hospital Inc., the jury’s verdict against the hospital was for $6.5 million even though the defendant physician had settled for $1.5 million prior to trial. (Part of the verdict was later set aside and the case was remanded for a new trial because of a finding that the verdict was excessive.) See 352 S.E.2d 902, 903-04 (N.C. Ct. App.), aff'd, 362 S.E.2d 273
negligent to an already emotional legal dispute about whether the individual physician was guilty of malpractice inevitably makes medical litigation even more contentious and costly.42

A further practical problem involves the attempt by the patient’s counsel to establish corporate liability on the part of the hospital through evidence of prior malpractice suits or disciplinary proceedings involving the treating physician. Because evidence of such earlier incidents is not directly related to the issue whether the physician committed malpractice in the case at hand, it would ordinarily be inadmissible. Such material is relevant, however, in determining whether the hospital itself was negligent in granting or continuing the physician’s privilege to treat patients in the institution. The evidence may therefore be admissible in any case alleging hospital corporate liability, regardless of its prejudicial effect upon the question of the physician’s liability.43

Finally, the impact of corporate liability malpractice litigation on internal hospital review procedures is potentially troubling. In order to establish the hospital’s corporate liability, plaintiff’s counsel often uses discovery to determine whether the hospital’s credentials and case review committees had previously expressed qualms about the treating physician’s abilities. It is crucial to the effective discharge of such committee responsibilities, however, that frank appraisals be elicited about the qualifications and performance of physicians under scrutiny. Committee members typically serve on a voluntary, pro bono basis, and the physician in question is a colleague within their profession and community, if not already in their hospital. Candid, tough-minded appraisals of the physician’s competence might be deterred by committee members’ knowledge that their remarks may be disclosed in later tort litigation. Thus, although a major purpose of corporate liability is to give hospitals the legal and financial incentives to institute meaningful peer review of physicians’ performance, the threat of disclosure of information about peer review deliberations in corporate liability litigation might limit the capacity of peer review to accomplish this objective.44

42 Another legal limitation on corporate liability is that although hospital negligence can arguably be the proximate cause of malpractice occurring outside the facility, some courts have held that the physician’s malpractice must occur within the hospital. See, e.g., Pedroza v. Bryant, 677 P.2d 166, 171-72 (Wash. 1984).


44 Tucson Medical Center, Inc. v. Misevich reflects one court’s effort to design rules of discovery in corporate liability cases to accommodate these competing objectives. See 545 P.2d 958, 960-62 (Ariz. 1976). For a discussion of the role of peer review in malpractice litigation, see Mitchell J. Nathanson, Hospital Corporate Negligence: Enforcing the Hospital’s Role of Administrator, 28 TORT & INS. L.J. 575, 584-90 (1993).
4. Summary: Toward Enterprise Liability. — In contrast to the state of medical liability law fifty years ago, there now are several legal bases upon which to find hospitals liable for injuries inflicted by negligent physicians who are associated with the hospital in some capacity. If the physician is an employee, the hospital is subject to the standard rules of vicarious liability. If the physician enters into a contract with the hospital to deliver emergency care, radiology expertise, or other such services offered by hospitals to patients, then the hospital is likely to be liable for the physician’s malpractice under the doctrine of agency liability. If the physician is a surgeon, obstetrician, or other specialist selected by the patient but granted admitting privileges by the hospital, the hospital is likely to be subject to corporate liability for its own negligence if it failed to investigate properly the physician’s credentials and competence.

Expansive as these bases for hospital liability may be, significant doctrinal obstacles remain in the way of recovery from hospitals for physician malpractice; and, indeed, the bulk of malpractice premiums are paid by physicians, who are still the targets of most malpractice claims. Pockets of charitable immunity persist, the degree to which an independent-contractor physician possessed apparent authority may be uncertain in an agency liability claim, and the hospital’s negligence in monitoring the quality of care provided under its auspices is a hotly contested issue in a corporate liability action. These impediments to plaintiffs’ recovery produce costly litigation that a simpler liability regime could avoid. The adoption of enterprise liability would remove these obstacles and complete the legal evolution that we have traced to this point.

Under our proposal, as under present-day vicarious, agency, and corporate liability theories, the malpractice of physicians and other health care personnel would remain a prerequisite to the imposition of liability on the hospital. In contrast to these existing forms of liability, however, hospitals under enterprise liability would be the exclusive bearers of medical liability for all malpractice claims brought by hospitalized patients — regardless of the provider’s status as employee, independent contractor, or holder of admitting privileges, and regardless of the site of the provider’s malpractice. In turn, physicians would be insulated from, or at least insured against, personal liability

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45 This rule applies to HMOs as well. At university medical centers, once physicians have completed their residencies and become board-certified in their specialties, they are more likely to be employed (if they are not independent contractors) by HMOs than by hospitals. As a result, HMOs are clearly subject to vicarious liability for the malpractice of their employee-doctors. See Sloan v. Metropolitan Health Council, 516 N.E.2d 1104, 1109 (Ind. Ct. App. 1987).
to injured patients, in the same way as are nurses and other medical staff working for hospitals under the current legal regime.

B. The Evolution of Hospital-Physician Relations: Health Care as a Business Enterprise

At the same time that the law governing hospital liability has evolved, the health care system has developed into a business with a trillion-dollar share of the economy. Hospital-physician relations have evolved in response. As recently as twenty years ago, enterprise liability would have radically transformed hospital-physician relations in most hospitals. Today, however, the adoption of EML would provide full legal recognition to a transformation that is already occurring and is destined to continue.


   Historically, physicians were almost completely autonomous actors, both outside and inside hospitals. It is only a slight exaggeration to say that the hospital functioned as a patient hotel and physician laboratory, exercising little control over the manner in which individual physicians practiced medicine. In the 1970s this longstanding tradition of physician autonomy began to change, but, until the 1980s, the hospital-physician relationship was not altered fundamentally. Today, the prevalence of both fixed per-procedure reimbursement from Medicare and “capitated” per-patient sums from private insurers has wrought a fundamental shift in hospitals’ relationships with their physicians. Modern hospitals face strong financial incentives to exercise tight control over physicians’ treatment decisions.

   The watershed event was Medicare’s adoption of the prospective payment system employing Diagnosis-Related Groups (DRGs).

46 It goes without saying that any such change in the allocation of malpractice liability must be accompanied by removal of the vestiges of hospital charitable immunity that remain in states such as Massachusetts (as described in note 19 above).


48 For example, peer review and malpractice suits questioning the quality of services provided by physicians became more common, and the industry began to heed public calls for increased scrutiny and discipline of physicians for improper conduct. See, e.g., Robert C. Derbyshire, Medical Ethics and Discipline, 228 JAMA 59, 60–62 (1974) (describing the ineffectiveness of disciplinary procedures at the time and advocating an increase in both disciplinary vigilance and reporting); Steves, supra note 9, at 1312–17 (citing evidence of a steep increase in both the frequency and severity of medical malpractice insurance claims); Note, Federally Imposed Self-Regulation of Medical Practice: A Critique of the Professional Standards Review Organization, 42 Geo. Wash. L. Rev. 822, 823–30 (1974) (detailing the expanded role of peer review after Congress mandated the creation of the Professional Standards Review Organization, which had the power to reject Medicare and Medicaid claims).

Under this new system, hospitals generally are paid a fixed fee per Medicare procedure, rather than being reimbursed on the basis of actual costs incurred. Fees vary depending on which of the hundreds of DRGs — such as cardiac arrest, hypertension, or heart transplant — applies to the patient’s condition. Although by its terms the prospective payment system governs only hospital charges under Medicare, the system has engendered significant changes in hospital-physician relations. Under traditional cost-based reimbursement systems, physician decisions about the patient’s diagnosis and treatment affected the hospital’s income only indirectly; even then, the longer the stay and the more treatment provided, the greater was the hospital’s income. In contrast, under the prospective reimbursement system a hospital’s income can be maximized by diagnosing a patient’s condition to fall in a comparatively high-payment DRG, by reducing the length of any given patient’s stay in the hospital, and by minimizing the medical services provided to a patient.

Under the new system, then, decisions traditionally left entirely to physician discretion now have a more direct impact on hospital income because hospitals profit if their actual costs are lower than the amount received per DRG, and they incur a loss if their costs exceed the per-DRG rate of payment. Hospital management now has a greater incentive than in the past to influence diagnosis, length of patient stay, and treatment protocol. Cost containment has emerged as a primary concern for hospital administrators, leading them to attempt measures that restrict the freedom of physicians to make traditionally "medical" decisions. The distinction between medical and economic concerns has become greatly blurred.

2. The Private Sector Follows: Managed Care and Quality Assurance. — These changes induced by the prospective payment system have been paralleled by developments in the private sector that have
also reduced traditional physician autonomy and altered the hospital-physician relationship. Just as the federal government's desire to contain Medicare costs led to adoption of the prospective payment system, analogous concerns in the private sector have generated cost-containment initiatives that have accelerated the transformation of health care from a purely professional undertaking to a business enterprise providing professional services.

For example, escalating health care costs have contributed to the rise of HMOs. Physicians who work for HMOs surrender much of their traditional medical autonomy and must be more sensitive to cost-containment concerns than traditional fee-for-service professionals. Similarly, the creation of preferred-provider organizations (PPOs) and other forms of managed care have further restricted physician discretion by placing limits on the levels of reimbursement for treatment of particular conditions — limits that often are more intrusive than the DRGs in the Medicare system.

Even more important for EML, however, is the fact that hospitals themselves are beginning to accept fixed, or capitated, payments from managed-care insurers for the treatment of patients. Under such an arrangement, the hospital typically contracts with the insurer for an annual rate per covered patient life, irrespective of the actual cost of the treatment a particular patient will receive. The trend toward capitated contracts is growing; respondents in a recent survey of hospital CEOs predicted that, by 1996, 92% of their contracts with HMO insurers will be capitated arrangements — nearly treble the current figure. Capitated contracts, in which hospitals bear the risk of cost overruns, are popular among hospitals because they feel they can exploit their comparative advantages in expertise and monitoring in order better to contain treatment costs.

These hospital incentives and capacities for controlling the quantitative features of physician practice are also applicable to the quality of care being delivered to patients. Not surprisingly, then, quality assurance (QA) initiatives have begun to infringe further on physician autonomy and to alter the physician-hospital relationship. Since the early 1970s, the JCAHCO has required hospitals to establish programs to improve the quality and appropriateness of patient care. In addi-

54 See Stevens, supra note 53, at 322–27.
58 See Joint Comm'n on Accreditation of Health Care Orgs., Accreditation Manual for Hospitals xv–xiii, 44 (1994); Timothy S. Jost, The Joint Commission on Accreditation of Hospitals: Private Regulation of Health Care and the Public Interest, 24 B.C. L. Rev. 835,
tion, a number of states now require hospitals to formulate risk-management programs, and some publicly funded health care programs have adopted QA initiatives. These various requirements have spawned an entire field populated with different strategies, terminology, and even journals. The incipient movement for the adoption of “practice guidelines” and the study of outcomes under different systems of care are but two of the many tools being employed to help monitor and improve the quality of health care services.

Virtually all QA programs employ personnel other than the patient’s treating physicians to evaluate, recommend, or require protocols for the care provided by those physicians. Such external evaluation and supervision is the antithesis of the traditional model of independent, autonomous physicians who treat their patients without outside “interference” of any kind. In addition, QA programs often focus on the overall quality of care provided by a particular hospital, thereby giving the hospital an even more direct stake in the quality of care provided by individual physicians on its premises. Directly or indirectly, then, the quality of physician treatment of patients has become a concern of the hospital in which the patients are being treated. Just as cost-containment concerns have helped transform the delivery of health care into a more organizationally based undertaking, so have


59 See Laura L. Morlock & Faye E. Malitz, Do Hospital Risk Management Programs Make a Difference?: Relationships Between Risk Management Program Activities and Hospital Malpractice Claims Experience, LAW & CONTEMP. PROBS., Spring 1991, at 1, 2 n.8 (noting that ten states require some form of risk-management program as a condition of obtaining a license).


62 For example, such terms as “quality assurance,” “total quality management,” and “continuous quality improvement,” and their acronyms, continually appear in the literature. See, e.g., Donald M. Berwick, Continuous Improvement as an Ideal in Health Care, 320 NEW ENG. J. MED. 53, 54 (1989); Stephen B. Kritchevsky & Bryan P. Simmons, Continuous Quality Improvement: Concepts and Applications for Physician Care, 266 JAMA 1817, 1817 (1991); Mara M. Melum & Marie E. Sinioris, Total Quality Management in Health Care: Taking Stock, QUALITY MGMT. HEALTH CARE, Summer 1993, at 59.

63 One such journal is Quality Management in Health Care, in which the article by Melum and Sinioris, cited in the preceding note, appears.


hospitals' efforts to assure the quality of care delivered under their auspices.

3. The New Era of Economic Competition. — The last two decades have ushered in a new health care era in which virtually all providers find themselves increasingly constrained by the marketplace. Because the public perceives the services that hospitals sell to include the quality of care provided by physicians treating patients within the hospital itself, the hospital-physician relationship now requires that both parties recognize their shared economic as well as ethical interests in assuring the quality of patient care.

These trends will only be reinforced by the kind of group purchasing of health care coverage that the Clinton Administration wanted to make mandatory, but which is evolving in the private health care market anyway. As the cost of care becomes even more important to all health care providers because of the manner in which competition is shaping the process of health care delivery, both physicians and hospitals will increasingly find themselves linked in health care provider “networks” designed to assure the most cost-efficient provision of care. Such networks will be supervised by the enterprises that contract with patients, who likely will be purchasing coverage in sizable groups with correspondingly greater market power. The economic interests of different individual and enterprise health care providers will be linked, and their relationships increasingly regulated by a series of contracts between and among patients, individual physicians, hospitals, HMOs, and insurance companies. The transformation of health care delivery from a free-standing professional pursuit into an integrated economic enterprise will then be one step closer to completion; accordingly, the old justifications for focusing malpractice liability on individual physicians will have largely disappeared.

II. The Advantages of EML

Part I traced the expansion of the hospital's presence and authority in the health care arena and described the variety of techniques that courts have devised to make hospitals legally responsible for patient injuries caused by negligent treatment. Part I also suggested that although adoption of our proposal to force hospitals to shoulder the burden of malpractice liability would constitute a significant change in the status quo, such a step would be in the direction in which both the

66 The quality of care would have become an especially important focal point under the Administration's proposal for the nationwide development and dissemination of quality-of-care measures. See Health Security Act, S. 1775, 103d Cong., 1st Sess. §§ 5001-5013 (1993).

67 See generally Carl H. Hitchner, Clare Richardson, Judith E. Solomon & Charles B. Oppenheim, Integrated Delivery Systems: A Survey of Organizational Models, 29 WAKE FOREST L. REV. 273 passim (1994) (discussing the ways in which distinct health care services may be packaged together in "integrated delivery systems").
legal and health care systems have been moving for the last several decades.

The fundamental policy question, therefore, is whether the core principle of enterprise medical liability would be an improvement over the individualistic focus of traditional malpractice law. The answer depends on the criteria used to evaluate this or any other tort reform. In our view, EML would be a more sensible system of compensating injured patients, a more economical method of administering such compensation, and a more effective vehicle for prevention of medical injury than the current system of individual liability for malpractice.

The traditional justification for medical malpractice liability, as for all tort liability, has been the value of corrective justice. According to this view, a malpractice suit is a contest between patient and physician. If the physician's treatment involved malpractice and that malpractice injured the patient, corrective justice requires that the "wrong" be "corrected" through payment of the innocent victim's losses by the "culpable" physician. Absent demonstrated fault, however, the legal system has no affirmative reason for shifting losses from the shoulders of injured patients and their families.

In fact, the current malpractice system serves corrective justice in only the most attenuated fashion. Although tort law increasingly imposes liability for physician malpractice on hospitals, medical malpractice litigation remains heavily focused on individual, not institutional, responsibility. However, it is customary for all physicians in a particular geographic area within the same specialty to pay the same premium, whether or not they have ever committed malpractice or been successfully sued. Thus, in a malpractice suit against an individual physician, it is the physician's malpractice insurer whose economic interest is really at stake. The insurer selects and pays for the defense attorney, decides whether to settle or to contest the claim, and pays the bill for the jury verdict if the physician is held liable.

The insurer finances these expenditures through the liability insurance premiums initially paid by physicians. However, because physicians and patients are in a financial as well as a therapeutic relationship, physicians collect from patients, through their treatment fees, the revenues necessary to pay for malpractice overhead costs. In turn, the vast majority of physician fees are reimbursed by private or

68 See 1 American Law Inst., supra note 1, at 24–25.
69 See supra pp. 385–94.
70 In 1984, just under 75% of malpractice actions were filed against doctors, dentists, nurses, and other individual providers, while only 21% were brought against hospitals and 4% against HMOs and other health care institutions. See Weiler, supra note 1, at 6 n.22 (citing U.S. Gen. Accounting Office, Report to Congressional Requesters: Medical Malpractice: Characteristics of Claims Closed in 1984, at 52–53 (1987)).
public insurers to whom patients have paid health insurance premiums, either directly or through their employers or the government. Because malpractice liability is a judicially mandated (non-waivable) feature of the patient-physician relationship, the tort system essentially requires all potential patients to help support the purchase of insurance against the risk of malpractice-caused injury. The real function of the litigation process is to serve as the port of entry to these risk pools, determining how much money will be paid to which candidates from the larger pool of injured patients. In short, malpractice litigation hardly serves corrective justice, if it does at all, because individual physicians do not "correct" any particular "injustice" they may have committed.

On this view, the primary challenge facing reformers of modern malpractice law is not how best to obtain corrective justice, but how to design a system that offers the fairest and most efficient form of insurance to patients injured by malpractice. As a preliminary step in the design of such a system, patients can be subdivided into three categories with distinct interests. The first group consists of patients who have already suffered injury as a result of their treatment. These patients need fair and easily accessible compensation for their losses. The second group comprises patients who are about to be treated for their illnesses. These patients want the threat of malpractice liability to create incentives for effective prevention of injury without impeding optimal treatment. The third group comprises persons who, knowing they are likely to be patients at some time in the future, are now paying the health-insurance premiums that fund the health care system. These patients want the compensation and prevention functions they are paying for to be accomplished through the most economical mode of administration.

The legal challenge is how to design a single liability system that will secure the optimal blend of these three, often-competing objectives of sensible compensation, effective prevention, and economical administration. The following sections address the critical issue whether substituting hospital-based EML for conventional malpractice liability improves the prospects for all three categories of patients.

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72 See Weiler, supra note 1, at 94-95 & nn.2-3 (discussing, inter alia, Tunkl v. Regents of the Univ. of Cal., 383 P.2d 441 (Cal. 1963), which involved the striking down of contractual waivers of provider liability by patients).

73 For discussions of medical malpractice policy that focus on considerations other than corrective justice, see 2 American Law Inst., cited above in note 1, at 111-26; Patricia M. Danzon, Medical Malpractice: Theory, Evidence, and Public Policy 208-19 (1985); and Randall R. Bovbjerg & Clark C. Havighurst, Foreword to Symposium, Medical Malpractice: Can the Private Sector Find Relief?, Law & Contemp. Probs., Spring 1986, at 1, 1-3.
A. EML as More Sensible Compensation

The system of individual liability for medical malpractice works far less effectively than is desirable, either for physicians or for patients. EML would constitute a superior method of assuring compensation to injured patients. Although certain transitional problems might arise in moving from individual liability to EML, one can readily design both short-run and long-run adjustments to deal with the financial crunch that hospitals would otherwise suffer from their increased liability. In addition, because the availability of a hospital or other "deep-pocket" enterprise as the defendant in every malpractice action is more palatable if there is a method of assuring that damages awards in such cases are principled and predictable, we propose such a method below.

1. The Weaknesses of the Present System. — (a) From the Physician Standpoint. — Under the current system, individual physicians purchase malpractice liability insurance. Because liability for malpractice is a creature of state law, and because malpractice insurance premiums are subject to state regulation, the maximum size of any malpractice insurer's risk pool for purposes of loss-prediction and premium-setting is the number of physicians practicing in the state in question. For practical purposes, however, the size of insurers' risk pools is much smaller. First, insurers find it necessary to divide the physicians they insure into risk classes and to charge physicians who practice in high-risk specialties, such as neurosurgery and obstetrics, far higher premiums than they charge physicians in low-risk specialties, such as pediatrics and dermatology. Thus, any given insurer's risk pool for a particular specialty is likely to contain a small percentage of the total number of physicians practicing in a state. Second, in most states no insurer has a complete monopoly; the market is typically split among a number of different insurers.

The actuarial consequence of the small size of malpractice insurance risk pools is that insurers cannot spread among a large number of physicians the risk that a few will be the subject of a significant number of claims, some of which may produce extremely large verdicts. Instead, a comparatively small number of physicians comprising

74 For example, physicians would have to be individually insured against liability for the "tail" of claims from treatment provided prior to the adoption of EML, and health insurance reimbursement rates would have to be adjusted downward for physicians and upward for hospitals. For a discussion of these transitional issues, see below pp. 429-32.
75 See infra pp. 404-06.
76 See Sloan, Boivjerg & Githens, supra note 71, at 166.
77 For example, in 1985, the year of the most-recent malpractice insurance "crisis," there were less than 500 practicing neurologists and neurosurgeons in Florida, out of a total of just over 20,000 practicing physicians. See David J. Nye, Donald G. Gifford, Bernard L. Webb & Marvin A. Dewar, The Causes of the Medical Malpractice Crisis: An Analysis of Claims Data and Insurance Company Finances, 76 GEO. L.J. 1495, 1532 (1988).
each pool is charged with the aggregate cost of this risk. On its face, that arrangement seems economically sensible. Why should the practitioners of dermatology, for example, have to subsidize the liability costs of the riskier practice of obstetrics? As noted earlier, though, the financial burden of liability insurance in both areas of medicine is ultimately borne by the entire population that is paying for health insurance. And funneling liability dollars through a host of malpractice insurance categories can have a number of unfortunate consequences. For example, inevitable changes in the frequency or severity of claims against a particular specialty in a particular state — changes that might result in modest rate changes for the members of a large risk pool — have an exaggerated effect on a small pool. The result is that physicians practicing high-risk specialties pay malpractice premiums that are many times the premiums paid by physicians practicing low-risk specialties in the same jurisdiction. In addition, when premiums increase, they often increase sharply, creating cash-flow shortages and unanticipated reductions in physician incomes. These shocks in the market for malpractice coverage produce not only economic effects, but also political repercussions that generate ill-designed tort reform of various sorts.78

(b) From the Patient Standpoint. — The system of individual liability for medical malpractice also creates adverse consequences for the compensation of claimants. As mentioned, the periodic shocks in the insurance market that are in part a result of the small size of malpractice risk pools have generated physician demand for, and legislative enactment of, such “reforms” as caps on recoverable damages.79 These caps have a regressive impact on patient rights and recoveries.80 In addition, despite the easy availability of malpractice insurance and the comparatively high incomes of physicians, the current system of individual liability for malpractice imposes on a few claimants the risk that much of a judgment will be unrecoverable. While most malpractice verdicts and settlements are readily paid, many physicians do not purchase enough insurance to cover them against liability for multi-

78 For example, during both the medical malpractice “crisis” of the mid-1970s and the liability “crisis” of the mid-1980s, physicians and other potential defendants were often successful in persuading state legislatures to enact their favored tort reforms. For catalogues of the results, see Joseph Sanders & Craig Joyce, “Off to the Races”: The 1980s Tort Crisis and the Law Reform Process, 27 Hous. L. Rev. 207, 218–23 (1990), and Comment, An Analysis of State Legislative Responses to the Medical Malpractice Crisis, 1975 Duke L.J. 1417 passim.

79 For a discussion of the underwriting “cycle” explanation for these shocks, see Abraham, cited above in note 11, at 400–01. For a list of states that enacted caps on recoverable damages during the most recent “crisis,” see Sanders & Joyce, cited above in note 78, at 220–22.

80 Caps on recoverable damages (even on particular damage categories, such as pain and suffering) affect recoveries of only the most seriously injured claimants, leaving untouched those with less serious injuries whose damages would not exceed the maximum awardable sum even absent a statutory ceiling.
million dollar judgments.\footnote{Indeed, some physicians even decline to purchase any insurance. \textit{See} Sloan, Bovjerg \& Githens, \textit{supra} note 71, at 70 \& n.17. Instead, they “go bare,” transfer their financial assets to relatives, and thus make it financially pointless for a patient to sue for malpractice.} Like caps on awardable damages, these provider practices have a regressive impact on claimants.\footnote{The patients with the most serious and longest-lasting injuries are also those who are most likely to be entitled to the largest recoveries. Yet these are the claimants who are least likely to recover all of their losses when their physicians have purchased less malpractice insurance than is necessary to afford full compensation for catastrophic injuries.} One result is the tendency of seriously injured claimants to sue all health care providers—hospitals as well as physicians—who might potentially be responsible for the claimants’ injuries to help assure that a fund is available from which to pay all the compensation awarded. This practice complicates the lives of the physicians involved and the litigation into which they are brought as remote defendants.

2. \textit{The Comparative Strength of EML as a Compensation System}.— EML would be a superior compensation system from the standpoint of both physicians and claimants. For physicians, shifting liability from individual physicians to hospital enterprises could ameliorate the effect of sharp changes in premium levels that result from the small size of insurer risk pools. Each liability-bearing enterprise would serve, in effect, as a large pool consisting of the risks posed by all the doctors and nurses for whose malpractice the enterprise would be liable.\footnote{This system also would provide a more efficient alternative to the present system’s method of charging physicians the same premiums regardless of the number of patients treated or volume of particular procedures performed. The effect of the current system is that a physician cannot practice part-time or perform certain specialized procedures (for example, delivering babies) on a limited basis without paying a full annual premium for coverage. This phenomenon may account in part for the difficulty of finding certain medical services in rural areas. \textit{See} \textit{I} \textit{Institute of Medicine, Medical Professional Liability and the Delivery of Obstetrical Care} 42–44 (1989); Weiler, \textit{supra} note 1, at 85–86. The premium paid by the hospital, however, could more easily take such volume differences into account. Thus, the hospital could offer a better insurance product to part-time or low-volume practitioners than does the present system.} For claimants, and especially those who suffered severe and permanent injuries, EML would virtually eliminate the risk that a large judgment would go unrecovered.

In addition, EML could prove to be a superior insurance system from the standpoint of hospitals. Though some hospitals now self-insure their liability for malpractice,\footnote{See Sloan, Bovjerg \& Githens, \textit{supra} note 71, at 70.} this practice probably would be rendered more feasible by enterprise liability, because the increased number of events for which hospitals would be liable would render their annual claims experience even more predictable. Moreover, whether a hospital self-insures or purchases market insurance, hospitals are better able to plan and budget for the variable costs of mal-
practice insurance than are individual physicians or small practice groups.\footnote{although we believe that hospitals could more effectively plan and budget for the effects generated by these risk-classification practices than can individual physicians, the problems might simply shift from individuals to enterprises. many hospitals have fewer affiliated physicians practicing in each specialty or subspecialty than comprise any current malpractice insurer's risk pool. any self-insured hospital would face some of the same problems now faced by malpractice insurers providing coverage to small pools of specialists, and any hospital purchasing commercially sold malpractice insurance to cover enterprise liability would be vulnerable to the risk-classification practices that such insurers decided to employ in covering this new form of liability — practices that might replicate those currently in use.}

3. Rationalizing Damage Awards. — We will not rehearse a decade of debates about reform of the law of tort damages.\footnote{for a detailed discussion of our views, together with citations to the literature, see 2 American Law Inst., cited above in note 1, at 161–318. for a more recent synopsis, see Kenneth S. Abraham, Robert L. Rabin & Paul C. Weiler, Enterprise Responsibility for Personal Injury: Further Reflections, 30 San Diego L. Rev. 333, 340–47 (1993).} In our view a central problem is the variability, and hence the unpredictability, of the magnitude of awards by different juries in similar types of cases, especially those involving severe and permanent injury.\footnote{for a graphic illustration of this phenomenon, see the table presented in Randall R. Bovbjerg, Frank A. Sloan & James F. Blumstein, Valuing Life and Limb in Tort: Scheduling "Pain and Suffering," 83 NW. U. L. Rev. 908, 937 (1989).} But both the frequency with which defendants are exonerated and the amount of damages awarded when claimants are successful probably would change if a single enterprise were the defendant in a malpractice action, although the direction of the change is not entirely certain. Some may feel that the attenuated relationship between the physician who actually committed the malpractice and the enterprise bearing liability for that malpractice may lead the jury not to impose liability where it would have done so under a system of individual liability, or to award less in damages than would have been awarded in a case against the individual physician whom the jury blames for the injury. We suspect, however, that any such effect would be offset by a greater willingness of juries in other cases to impose liability on a large enterprise, or to award more in damages than they believe fair in suits against individual physicians. It is difficult, of course, to quantify either of these two effects or to estimate the degree to which the latter would dominate the former. But one cannot ignore the possibility of a significant "deep-pocket" effect resulting from adoption of enterprise liability. For these reasons, among others, the law governing damage awards should be reformed.\footnote{the other reasons for reforming malpractice damage awards, together with a systematic program for such reform, are spelled out in chapter 3 of Weiler, cited above in note 1, at 44–69.}
awards for pain and suffering alone. 89 We have always opposed damage caps of this kind because of their disparate impact on patients who have suffered the most severe injuries from negligent treatment. Our objection to damage caps must be tempered, however, by our unease about tort law's treatment of pain and suffering claims. From the standpoint of a sensible compensation policy, the case for permitting any recovery of damages for pain and suffering is far from clear. 90 Nonetheless, other considerations argue in favor of awarding damages for pain and suffering. The most important factor is deterrence. Potential victims may not wish to insure against future pain and suffering, but as a society we want to prevent injuries that sharply impair people's enjoyment of life. Making the party responsible for a medical accident pay for non-financial as well as financial costs of the patient's injury provides a necessary incentive for this party to take the (often costly) precautions that will avoid the medical mishap in the first place. A second factor is the contingent fee system that now finances plaintiffs' counsel fees. Funding this system requires either direct awards of counsel fees to successful plaintiffs or substantial pain and suffering damages out of which victims can pay the additional financial expense generated by their injuries. Otherwise, even successful plaintiffs will receive much less than full compensation for their economic losses, and potential plaintiffs' access to legal services will eventually be impeded down the line.

For these reasons, we have advocated an alternative to both the open-ended common law treatment of pain and suffering damages and the statutory imposition of (typically fixed) dollar caps on such damages. The alternative we prefer is a set of pain and suffering damages guidelines, scaled downwards from a reasonably generous ceiling, and perhaps also subject to a floor in the form of a self-insured deductible. Those guidelines would apply to all injuries, from the minor to the most serious. 91

89 See Sanders & Joyce, supra note 78, at 220–22.
90 There is no market for first-party insurance covering pain and suffering, at least in part because of very limited demand for this coverage. For a discussion of the adverse selection and moral hazard problems that contribute heavily to the limited market for disability insurance as a whole, see Kenneth S. Abraham & Lance Liebman, Private Insurance, Social Insurance, and Tort Reform: Toward a New Vision of Compensation for Illness and Injury, 93 Colum. L. Rev. 75, 102–04 (1993). In addition, it makes little sense to pay a premium today to protect against losses that may be suffered tomorrow unless those losses have a financial component. Otherwise, why should people bear the substantial transaction costs of “saving” through insurance dollars that could just as easily be spent and enjoyed now rather than at an uncertain date in the future? If people would not insure against their own pain and suffering, it is unclear why a litigation system should provide them with such insurance in the event they are injured by tortious activity.
91 For a detailed discussion of the pain and suffering damages scale, see Weiler, cited above in note 1, at 58–61. See also 2 American Law Inst., supra note 1, at 221–23 (describing the scale approach). Such a scale could employ either mandatory damages guidelines or merely a set of examples given to the jury from which the jury could depart in extraordinary situations (subject to more meaningful judicial review than is available at present). At the top of the scale.
This approach would have two major advantages. First, it would render pain and suffering awards more predictable and more equitable, not only at the high end but at all degrees of severity. In this respect a damages scale would be superior to caps on awards, which affect (by limiting) only the high end. Second, the enhanced predictability and cost-containment capacity of damages guidelines would offset the legitimate concern that the introduction of enterprise liability would increase award levels through substitution of "deep pocket" enterprises for individual physicians as defendants in malpractice actions.

B. EML as a More Economical Administrative System

Adoption of EML would almost certainly reduce the costs of administering medical malpractice litigation, because EML would eliminate multiple individual defendants. When each defendant has separate counsel, legal costs are bound to be substantially higher, as are total malpractice insurers' expenditures for monitoring the case and otherwise participating in it. In addition, whenever arriving at a settlement depends on securing the agreement of each of a number of defendants, the prospect of settlement is reduced, and additional litigation costs are incurred.

EML would likely reduce both sets of administrative costs. Because individual physicians would not be defendants under EML, the costs of multiple representation would be eliminated. Similarly, because the responsible enterprise would be the sole defendant, the additional litigation costs that are sometimes incurred when some, but not all, defendants are willing to agree to a global settlement would also be eliminated. Although we cannot systematically quantify these cost savings, we estimate that they could easily amount to twenty to thirty percent of the current cost of malpractice insurance.\footnote{These are the estimates of senior officials of New York's Federation of Jewish Philanthropy (FOJP) hospitals and of Harvard Risk Management, two of the pioneers in developing a form of enterprise medical liability insurance. Interview with Daniel Creasey, President of Harvard Risk Management, in Cambridge, Mass. (Oct. 9, 1992); Interview with Robert Markowitz, President of FOJP, in New York, N.Y. (July 30, 1992). In 1994, for example, CRICO, the Harvard insurer, would be a range of pain and suffering damages to be awarded for very serious, long-term disabilities such as quadriplegia or blindness suffered by those with life expectancies exceeding 50 years. At the bottom of the scale would be the least serious category of pain and suffering for which damages could be awarded, linked to a dollar range awardable for that category. Below this floor no damages for pain and suffering would be recoverable. As an alternative to a floor, if all claimants were to be entitled to at least some pain and suffering damages, a mandatory cap on the amount of damages awardable for minor, short-term pain and suffering would be established. In the intermediate range of the scale, a series of profiles of cases involving pain and suffering of intermediate severity would be established, along with corresponding ranges of awards. All such ranges would be indexed to inflation, so that ranges that are reasonable when established do not become unreasonably low over time. The ranges of awards contained in the scale could be set directly by statute, or (preferably) established under legislative direction through a statistical calculation of historically "normal" jury awards for the different categories of injury severity and permanency in each jurisdiction.}
C. EML as a More Effective Injury-Prevention System

Present-day tort scholars rank optimal injury prevention as a crucial objective of the tort system.\(^9\) At least in the sphere of personal injuries to human beings (as contrasted with financial injuries to business organizations), heading off a serious — perhaps fatal — accident before it occurs is far more valuable than providing even generous compensation to the victim (or surviving dependents) after the fact. Moreover, tort litigation is an extremely expensive vehicle through which to deliver compensation to injured victims.

We recognize, however, that whatever the theoretical promise of tort law, achieving effective accident prevention through tort litigation is a somewhat speculative venture. The assumption — or at least the hope — of the tort system is that imposing liability on the immediate tortfeasor will deter future actors from engaging in malpractice. But there is no guarantee that verdicts or settlements in the judicial process actually influence behavior in the outside world, or, even if they do, that such reactions reduce the risk of injury rather than simply the risk of suit.\(^9\)\(^4\) Nowhere has this uncertainty been more intense than in debate about the "defensive" reactions of health care providers to the threat of liability for malpractice.\(^9\)\(^5\)

To tort law's proponents, liability for medical malpractice may seem the ideal vehicle for injury prevention, because liability in this field has retained a distinctively personal quality. Unlike a scientist conducting research for a drug manufacturer, a surgeon treating a patient is individually responsible for the disabling or fatal consequences of negligent treatment. Notwithstanding the numerous judicial steps we traced earlier toward greater hospital liability, the vast majority of malpractice suits are still filed against named physicians, not against faceless institutions.\(^9\)\(^6\) Similarly, hospital peer review committees and morbidity/mortality investigations still tend to concentrate on the per-

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96 See supra note 70.
sonal failings of the physician in charge. Finally, the National Practitioners Data Bank focuses its documentation on malpractice by individual providers.

The individualistic quality of malpractice litigation, however, is more of an obstacle to, than a vehicle for, effective injury prevention. Malpractice insurance is a near-universal feature of physician practice. Malpractice liability insurers, not physicians, actually pay the awards to malpractice claimants — thus diluting the direct incentives that physicians might otherwise have to enhance their quality of care in order to avoid paying jury verdicts to injured patients. Moreover, the premiums physicians pay for their malpractice coverage are eventually accounted for in fee schedules established in the nation’s health insurance plans (paid by or for patients) that routinely cover this item in physician practice overhead.

Of course, because liability insurance does not reimburse all of the losses inflicted on defendants by malpractice litigation, even insured defendants feel threatened by the prospect of such litigation. Insurance covers the sum awarded the claimant (up to the amount insured) and the costs of legal defense, but it does not compensate for a physician’s lost time and money from practice, let alone the emotional drain and possible damage to his reputation. Indeed, were it not for such physician, as opposed to liability insurer, losses, it would be difficult to explain the widespread incidence of defensive medicine. These uninsured litigation costs are inflicted on all tort defendants, innocent as they may be. See Sanford E. Feldman & Thomas G. Rundall, PROs and the Health Care Quality Improvement Initiative: Insights from 50 Cases of Serious Medical Mistakes, 50 MED. CARE REV. 123, 141–45 (1993) (discussing peer review organizations); Haya R. Rubin, William H. Rogers, Katherine L. Kahn, Lisa V. Rubenstein & Robert H. Brook, Watching the Doctor-Watchers: How Well Do Peer Review Organization Methods Detect Hospital Care Quality Problems?, 267 JAMA 2349, 2353–54 (1992). The Data Bank documents all meritorious malpractice claims and disciplinary measures against individual physicians, and directs all hospitals to check the data for a “bad apple” practicing within their institution. A recent effort by the federal government to alter its injury-prevention focus is described in Stephen F. Jencks & Gall R. Wilensky, The Health Care Quality Improvement Initiative: A New Approach to Quality Assurance in Medicare, 268 JAMA 90 pas-sim (1992).

A survey by the AMA found that less than three percent of physicians are uninsured, most of them in low-risk categories of practice. See Stephen Zuckerman, Medical Malpractice: Claims, Legal Costs, and the Practice of Defensive Medicine, HEALTH AFF., Fall 1984, at 128, 132–33 (reporting that only 2.6% of physicians “have discontinued their liability insurance completely”). See generally WEILER, supra note 1, at 73–82 (assessing the role of malpractice insurance in improving patient care).

A state-wide survey of a large sample of New York physicians, conducted as part of the Harvard Medical Practice Study, found that defendant physicians lost an average of six days of practice, and experienced substantial psychological distress from being sued. See WEILER, HIATT, NEWHOUSE, JOHNSON, BRENNAZZ & LEAPE, supra note 1, at 117–19, 126.

For a general discussion of defensive medicine, see OFFICE OF TECHNOLOGY ASSESSMENT, cited above in note 95, at 1–93.
well as guilty — a failing that is exacerbated in the malpractice context by the fact that a majority of claims filed are unwarranted.103

With respect to valid claims, at least, injury-prevention incentives could be preserved even for insured physicians if premiums paid by individual physicians were adjusted to take account of their claims experience. This kind of experience rating has been a long-time feature of business liability and workers' compensation insurance. Because the prices paid by consumers for products and the wages paid to labor tend to be standardized in their respective markets, safer firms make a profit and dangerous firms incur a loss from experience rating. The prospect of such profits and losses tends to give firms the incentive to reduce the risks of injury to optimal levels.104

However, a noteworthy feature of malpractice insurance is the almost total absence of experience rating of individual physicians' premiums.105 There are, of course, marked differences in the premiums that are charged physicians in different specialties and geographic regions. A surgeon or obstetrician practicing in New York or Miami, for example, pays many times the malpractice insurance premium of an allergist in Indiana or a general practitioner in Arkansas, because the

103 See Weiler, Hiatt, Newhouse, Johnson, Brennan & Leape, supra note 1, at 71. The malpractice litigation system does a far better job than is popularly believed at sifting out the valid claims from the invalid, paying the latter either no money at all or only cents on the dollars that are paid for valid claims. See Frederick W. Cheney, Karen Posner, Robert A. Caplan & Richard J. Ward, Standard of Care and Anesthesia Liability, 261 JAMA 1599, 1602-03 (1989); Henry S. Farber & Michelle J. White, Medical Malpractice: An Empirical Examination of the Litigation Process, 22 RAND J. ECON. 199, 213-15 (1991); Mark I. Taragin, Laura R. Willett, Adam P. Wilczek, Richard Trout & Jeffrey L. Carson, The Influence of Standard of Care and Severity of Injury on the Resolution of Medical Malpractice Claims, 117 ANNALS INTERNAL MED. 780, 781-84 (1992). These three studies, which applied different methodologies to different claims samples, agreed in their basic findings that almost all meritorious malpractice claims receive payment by settlement or verdict; the majority of non-meritorious claims are either withdrawn or dismissed; and even the minority of likely unfounded claims that get some payment receive only a fraction of the amounts paid for valid claims involving similarly serious injuries. The benefits of this expensive process of sifting the litigation wheat from the chaff, however, largely accrue to the insurers (and their clientele) whose resources are protected from unjustified awards, rather than to the individual physicians who may have to live for years with the anguish of a pending suit that has impugned their professional competence and reputation.


105 See Weiler, supra note 1, at 76-77. The striking absence of experience rating from malpractice insurance did move the legislatures in New York and Massachusetts to mandate that insurers take account of individual claims experience in setting the premiums to be charged physicians within their states. See Lori L. Darling, Note, The Applicability of Experience Rating to Medical Malpractice Insurance, 38 CASE W. RES. L. REV. 255, 265-71 (1987).

What the lawmakers ignored — caught up as they were in the malpractice crises of the 1980s — was the reason (explained in the text) why insurance companies had not voluntarily made experience rating a standard feature of their premium structures. After all, it would seem that the best way to attract the business of the safer physicians — an insurer's ideal customers — would be to offer them lower prices.
risk of suit is much higher for the former than the latter. But the individual Miami obstetrician or New York surgeon typically pays the same premium as his colleagues even if he has never been the target of a malpractice suit, let alone a successful one.

The implicit premise underlying the absence of experience rating is that prior claims experience is generally a poor index of comparative physician quality and of the physician’s likely future claims experience. From the perspective of the health care system as a whole, many malpractice claims within different regions and specialties are brought. In contrast, from the individual physician’s perspective, being named as a malpractice defendant is a comparatively rare event. It occurs only a handful of times in the entire careers of even physicians who practice in the high-risk specialties. Even the actual commission of malpractice produces a tort claim only if the error in question happened to cause an injury serious enough to make litigation worthwhile. And the chance that a patient will make a claim turns at least as much on the tone of her personal relations with the physician as on the quality of treatment actually rendered. Thus, with the exception of a tiny number of malpractice recidivists, past claims experience tends not to be a reliable index of future liability risk.

In contrast, the premiums that insurers charge health care enterprises for malpractice coverage can reliably reflect the prior claims experience of the particular institution. Indeed, larger systems such as the Harvard Medical School teaching hospitals are self-insured, and thus their liability costs reflect only their own claims experience. Such enterprises generate sufficient claims experience within usable time frames to make this experience an actuarially credible index of the probability that future claims will be brought. It follows that shift-

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106 See Weiler, supra note 1, at 4-5, 76-77.  
108 At the same time, there are far fewer suits filed in court than there are negligent injuries inflicted in hospitals. See Weiler, Hiatt, Newhouse, Johnson, Brennan & Leape, supra note 1, at 43-45, 55-56, 69-76.  
109 Cf. James F. Holzer, Liability Insurance Issues in Anesthesiology, 27 INT’L ANESTHESIOLOGY CLINICS 205, 206 (1989) (reporting that there were 6.7 malpractice suits per 100 physicians in 1987, but that 37% of American physicians — 57% of obstetricians and 50% of surgeons — had been sued at some point in their careers).  
111 See Frank A. Sloan & Mahmud Hassan, Equity and Accuracy in Medical Malpractice Insurance Pricing, 9 J. HEALTH ECON. 289, 311-18 (1990) (demonstrating that the liability experience of the entire medical staff at a hospital is, statistically, far more credible than the experience...
ing the focus of liability from the individual physician to the hospital, or to some other health care enterprise, could vastly increase injury-prevention incentives.

Even more importantly, such a shift to EML would target the component of the health care system that possesses the greatest capacity for continuously improving the quality of care. No better illustration of this assertion can be found than the transformation of anesthesia safety that was initiated in the Harvard teaching hospitals during the 1980s. In the mid-1980s, anesthesiologists' premiums at Harvard, as elsewhere, were among the highest for any specialty, due in large part to the severity of anesthesia-related mishaps. Anesthesia procedures generated only three percent of claims but eleven percent of payments. Close scrutiny by an arm of Harvard's own insurance company of the cases that had generated suits and payments over the prior decade disclosed that the bulk of the claims were valid and that the patient injuries in question could and should have been avoided. But rather than focus on the different physicians involved in these tragic incidents, the study group recommended that the hospitals prescribe new procedures and technologies designed to avoid similar results in the future.

of a single physician). Systematic research about differences in adverse medical outcomes irrespective of whether a malpractice claim was filed has demonstrated that the hospital and its characteristics are a crucial injury-risk factor. Important recent studies include Helen R. Burstin, Stuart R. Lipsitz, I. Steven Udvarhelyi & Troyen A. Brennan, The Effect of Hospital Financial Characteristics on Quality of Care, 270 JAMA 845, 847-48 (1993), which analyzed data from the Harvard Medical Practice Study, and Emmett B. Keeler, Lisa V. Rubenstein, Katherine L. Kahn, David Draper, Ellen R. Harrison, Michael J. McGinty, William H. Rogers & Robert H. Brook, Hospital Characteristics and Quality of Care, 268 JAMA 1709, 1711-12 (1992).


See Practice Standards, supra note 112, at 56.

See Eichhorn, supra note 112, at 573-75.

See Practice Standards, supra note 112, at 56-57. Equipment measuring and displaying the patient's respiration, circulation, and oxygen levels was to be installed; an alarm was to sound if the patient's condition dropped close to a danger point. See Patient Monitoring, supra note 112, at 1018-19. Trained personnel would be continuously present during an anesthesia procedure, able to respond instantly to an alarm and take steps necessary to prevent irreversible brain damage to the patient. See Practice Standards, supra note 112, at 57. Careful analysis demonstrated that the per-case cost to Harvard of this new equipment and additional personnel was much lower than the per-case cost of anesthesiologists' malpractice insurance. See Patient Monitoring, supra note 112, at 1020. This cost comparison did not take into account the much greater uncompensated harm suffered by brain-damaged patients and their families.
The desire of the Harvard hospitals' administrators to endorse and establish these new standards of practice evoked considerable controversy among their physician staffs about the dangers of "cookbook" styles of medical practice. The hospitals eventually decided, however, to mandate compliance with the new standards. When experience under those standards was reviewed several years later, it became clear that anesthesia-related mishaps and claims had dropped sharply and that malpractice premium ratings for Harvard anesthesiologists had been cut in half. The new practice standards are now spreading throughout the rest of the country.

A number of important lessons about the impact of malpractice litigation on medical quality can be drawn from this success story. First, although many tort claims do involve real malpractice, valid claims often result from momentary, inadvertent lapses of attention, rather than from deliberate or systematic efforts to constrain treatment quality. Even the most elaborate training could never eliminate all the personal frailties of physicians, nurses, and technicians. A hospital is an unforgiving setting for human error. Merely momentary errors may have tragic consequences, and they do constitute malpractice in the eyes of the law. There are severe limits, however, on the capacity of the threat of malpractice suits to increase levels of personal concentration in the high-pressure world of modern medicine.

Second, the most valuable insights about medical accidents generated by the Harvard anesthesia study came from the institution's piecing together a series of apparently idiosyncratic incidents to find common patterns in the way that errors, by people or equipment, occurred. The critical points at which the introduction of new procedures and technology could prevent medical mistakes from turning into patient injuries were then isolated through further organizational effort. Under a regime of enterprise medical liability, malpractice liti-
gation can give an institution with the required capacities the incentive to mount this kind of scientific investigation about ways to reduce patient risk and to introduce cost-effective measures for improving the quality of treatment offered by the typical good physician — an approach far superior to legal detection and punishment of "bad apple" outliers.123

In short, the inevitable human frailty of individual physicians and the undeniable effectiveness of "team" approaches to reducing patient injury point to the health care enterprise as the most effective mechanism for addressing medical malpractice. The truth is that the individual physician is now typically a member — admittedly a crucial member — of a larger team of medical personnel, all of whom have their own special training and responsibilities for the course of treatment of the same patient. One of the important ways in which things sometimes go wrong within such medical teams is through failures of communication among the physicians, clinicians, nurses, and other staff members (for example, about a patient's earlier adverse reaction to a particular drug).124 One of the best techniques for protecting patients from these and other medical failings is (when necessary) to redesign both the organization of and the equipment used by the medical team.125 At the present time, at least, the hospital occupies an ideal strategic position within the health care system from which to accomplish this crucial quality assurance mission.

Although enterprise medical liability offers considerably greater potential for prevention than does traditional individual liability, the current malpractice regime does deter substandard care by creating uninsured litigation costs — loss of practice time and income, personal emotional stress, and harm to professional reputation.126 Some might

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124 See, e.g., Feldman & Rundall, supra note 97, at 129-30.

125 In one Harvard study case, an old anesthesia machine without an oxygen monitor was used in an x-ray suite with relatively poor lighting. During the medical procedure, oxygen to the patient was accidentally shut off, and the patient eventually died as a result. To prevent similar mishaps, the Harvard team recommended and installed devices that automatically sound an alarm if problems develop in the breathing apparatus used during anesthesia. See Practice Standards, supra note 112, at 57-59; Patient Monitoring, supra note 112, at 1018-19.

126 Although there are more non-meritorious than meritorious tort claims filed against physicians, the odds that a claim will be filed are significantly greater if the physician was at fault than if not. See WEILER, HIATT, NEWHOUSE, JOHNSON, BRENNAN & LEAPE, supra note 1, at 75-76. Physicians react to the prospect of being sued by adopting a host of defensive medical practices. Evidence from the Harvard Medical Practice Study reveals that these same defensive
worry, therefore, that pursuit of systemic quality improvements through enterprise liability would sacrifice the ability of the current system to deter substandard care by individual providers. However, because an EML regime would still base liability on documented physician malpractice, physicians would suffer and thus attempt to avoid the uninsured emotional and reputational effects of such a fault-based regime.

In fact, EML would expand the incentives generated by the legal system for dealing with especially accident-prone physicians. Given the current financial pressures within the health care system, hospitals granting admitting privileges to physicians must be seriously concerned about the quantity of patient stays and revenues that such physicians will generate for the hospital. If the hospitals were legally responsible for all malpractice claims filed by patients admitted by these physicians, however, each hospital would also have a greater financial incentive to assure the quality of care rendered by its affiliated physicians. Adoption of EML would probably result in a more serious threat of withdrawal or limitation of admitting privileges and therefore in a net increase in the quality of care, and with it a reduction in patient injuries resulting from medical malpractice. A few malpractice insurers now investigate those policyholders producing a disproportionate number of claims and occasionally refuse to renew the malpractice insurance of especially poor risks.\(^\text{127}\) Under EML more refined monitoring of the quality of physician care would take place continuously within the hospital environment — with occasional limitation or withdrawal of practice privileges for the especially accident-prone. And unlike malpractice liability, the threat of removal of a physician’s affiliation with a hospital constitutes a major professional and financial loss against which a physician cannot insure.\(^\text{128}\)

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\(^{128}\) There are, of course, obstacles, both legal and practical, to the withdrawal or limitation of admitting privileges: on the practical side, physicians involved in the credentialing process may be reluctant to sanction their colleagues; on the legal side, the small but remaining exposure of hospitals and their peer review committees to antitrust liability may deter the withdrawal or limitation of privileges. *See* Health Care Quality Improvement Act of 1986, 42 U.S.C. §§ 11131–11134 (1988).
III. APPROACHES TO EML

We turn next to the operational details of EML. A number of major choices must be made in fashioning an EML system. The first choice is whether and to what extent the system should be elective rather than mandatory. Though we believe that EML should be elective at least at the outset, we set aside discussion of that issue until the following Part, in which we introduce a blueprint for experimental EML that addresses the alternative ways in which EML can be rendered “elective.” The second choice that must be made in fashioning an EML system is which enterprise or enterprises should bear liability. The third choice is the scope of the system’s coverage. A final choice is how to make the economic adjustments necessary for adoption of EML, including changes in malpractice premium structures and health insurance reimbursement rates.

A. The Responsible Enterprise

In our initial development of the case for EML, we recommended that the principal bearer of such liability be the hospital.129 This recommendation was based on the history we traced in Part I: at least in the eyes of the law, hospitals have gradually evolved into the major institutional bodies responsible for the quality of health care. Viewed along the three dimensions of compensation, administration, and prevention, the hospital is a far better candidate for malpractice liability than are individual physicians.

Hospitals do not so clearly emerge as the better candidate, however, when compared to other health care enterprises — insurance companies financing health insurance, network HMOs, or the newly developing integrated health plans that the Clinton Administration sought to make the centerpiece of its health care reform. The central question, as we have debated it with members of the Malpractice Reform Group of the Administration’s Health Care Task Force,130 concerns whether the subjects of malpractice liability should be institutions such as hospitals or HMOs that actually deliver health care to patients, or institutions such as health plans or other health insurers that finance the provision of health care.

1. Delivery-Based Liability. — As far as insurance and compensation are concerned, there seems little if any difference between the two candidates. Both hospitals and health plans can readily afford to pro-


vide the kind of liability insurance that a fair and effective tort system requires for both physicians and patients. Regarding economical administration, however, the comparative verdict depends on whether the liability of a financing enterprise for negligently caused patient injuries can effectively replace not only the liability of individual physicians, but also that of hospitals. As we indicated in Part I, hospitals are now potentially liable for a patient’s injury on several scores: directly, as providers of defective equipment or facilities; vicariously, as employers of negligent nurses or technicians as well as physician employees; and, under the theories of agency and corporate liability, for malpractice of non-employee physicians who have patient admitting privileges. Even if financing enterprises were to assume legal responsibility for physician malpractice, these other important sources of multi-party litigation and medical finger-pointing could remain in the litigation system. That is, unless financing-based enterprises were liable for every source of patient injury, costly litigation would be required to identify the cause of a patient injury as either the negligence of a treating physician, or of some other party for which the hospital would continue to bear vicarious or agency liability.

The additional administrative cost entailed in financing-based EML could, of course, be removed by requiring financing enterprises to assume legal responsibility not only for treating physicians but for hospitals as well. Such an approach poses the key question that must be answered to appraise the differences between financing-based and delivery-based EML: which kind of enterprise is in the better position to channel liability signals into more effective modes of medical injury prevention?

On the face of it, the preferable option is the enterprise that actually delivers, rather than merely finances, health care. The vast majority of the injuries that result from malpractice stem from treatment delivered under the auspices of hospitals — if only by physicians with the right to admit their patients to the hospital. Hospitals are typically responsible for selecting and providing the supplies, facilities, and equipment used in treatment, as well as for hiring and firing the employees who play an important role on the patient care team. Hospitals also grant admitting privileges to physicians, and can restrict, suspend, or terminate the privileges of doctors whose poor quality of treatment has come to the hospital’s attention. In each of these respects, hospitals are in the best position to make judgments about whether any such steps will reduce the risk of injuries to their patients. And some hospitals — particularly the more prominent teaching hospitals — are most likely to conduct serious research and

131 For example, the General Accounting Office found that “about 80 percent of the claims closed involved an injury that occurred in a hospital.” U.S. GEN. ACCOUNTING OFFICE, supra note 70, at 24.
development about ways of enhancing the quality of care in the overall health care system. To the extent, then, that imposing malpractice liability may influence these cost-benefit judgments about patient safety, hospitals would seem to be the prime candidates for that legal role.

Proponents of financing-based enterprise liability point, however, to the limited scope of the delivery-based EML model. First, some portion of the health care delivered in this country is not provided under the auspices of a hospital or HMO (for example, psychiatric treatment by specialists who have no institutional affiliation). Moreover, hospitals and HMOs do not have effective control over certain aspects of the care that is delivered under their auspices, such as office-based care provided on a fee-for-service basis or as part of a preferred-provider organization.

Finally, even the care provided by physicians within hospitals is not automatically or easily subject to influence by the hospital enterprise. Although in recent years physician autonomy has been reduced by the increasing involvement of hospitals in risk-management and quality assurance, in many facilities this devolution constitutes a change in the degree, rather than in the kind, of control exercised over health care provision. In addition, the financial pressure felt by many hospitals to fill their beds with patients sometimes cuts against the trend towards greater hospital control by promoting "economic credentialing"132 of physicians who have the capacity to populate a hospital with their patients.

2. Financing-Based Liability. — The alternative to delivery-based enterprise liability is to impose responsibility for malpractice-related injuries on the enterprises that bear financial risk under the health care system. Aside from the growing number of hospitals and other providers willing to accept this risk, these are the insurance companies and health plans that receive capitated premiums in return for their promise to assure the provision of care to policyholders and beneficiaries. The principal advantage that this approach would have over delivery-based liability is the capacity of these enterprises to control utilization decisions (decisions regarding the amount and kind of health care to provide a patient) by health care providers.

At present, utilization decisions are increasingly influenced by financing enterprises. However, health care providers bear liability for malpractice. This bifurcation of responsibility creates conflicting incentives.133 Financing enterprises have the incentive to press providers

132 “Economic credentialing” is a colloquial term used to refer to hospitals’ tendency to provide admitting privileges based on the capacity of physicians to generate revenue for the hospital.

133 For a recent and illuminating analysis of this problem, see Jonathan J. Frankel, Note, Medical Malpractice Law and Health Care Cost Containment: Lessons for Reformers from the Clash of Cultures, 103 YALE L.J. 1297, 1315–22 (1994).
to achieve lower utilization rates (in effect to require lower utilization through managed care), whereas providers have the incentive to protect themselves against liability for malpractice by increasing utilization through the practice of defensive medicine. In contrast, under financing-based enterprise liability, the same enterprise would bear the consequences of both under-utilization and over-utilization. Utilization might thus be more nearly optimized.\(^{134}\)

Similar optimization, however, is beginning to occur under delivery-based EML. Financing enterprises are finding it in their interest to contract with hospitals and even individual physicians on a capitation (or DRG-like) basis. Thus, if a hospital contracts with a financing enterprise to treat coronary patients for a specified dollar amount per patient, the hospital bears the same incentive as the financing enterprise to optimize the mix of treatment quality and cost. It is easy to envision such incentives under either delivery- or financing-based EML, because they currently exist in the DRG reimbursement model under Medicare and in much managed care provided under private health insurance contracts.

Moreover, financing-based enterprises suffer important disadvantages relative to delivery-based enterprises. One such disadvantage is that financing-based enterprises are one step removed from the actual delivery of care and consequently would find it more difficult to affect the actual quality of care. Not only would financing-based enterprises have to make decisions from a distance about the appropriate changes and investments needed to assure the optimal quality of care, but they would also have to enforce compliance with their decisions by health care providers.\(^{135}\) The escalation of health care costs over the past two decades displays the difficulties that these enterprises have encountered in accomplishing their cost containment objectives. The enterprises that finance the vast majority of health care in this country — commercial and non-profit private insurers, as well as the governmental agencies that finance Medicare and Medicaid — have not been successful in controlling the volume and cost of the health care delivery that they finance.\(^{136}\) These enterprises probably would have difficulty controlling costs in their effort to enhance the quality of care under financing-based enterprise liability.

In addition, financing enterprises have virtually no liability-bearing experience, whereas delivering enterprises such as hospitals have long

\(^{134}\) See Abraham & Weiler, *supra* note 130, at 34–35.

\(^{135}\) Cf. id. at 34–35 (arguing that the hospital “is best placed to make decisions about how to assure medical quality and prevent patient injury”).

shouldered the burden of at least some liability for malpractice. Hospitals, therefore, are likely to have a comparative advantage at legal risk-bearing. And because hospitals have long purchased malpractice liability insurance, the cost of insuring hospitals would likely prove lower than the cost of insuring financing enterprises—a task that would present a new and distinctive challenge for underwriters. In the future, of course, the distinction between financing-based and delivery-based enterprises may become increasingly cloudy as insurers, hospitals, and physicians become linked in integrated health care networks. Under tighter forms of managed competition these networks might be held to higher standards of accountability and therefore behave more like health care deliverers and less like pure financiers. In such a world, liability might optimally be imposed on these networks, which could not easily be classified in our binary analysis.

3. The Default-Rule Approach. — In the absence of contracting costs, two potentially liable parties will arrive at an optimal allocation of liability even in the absence of a legal rule prescribing the scope of their respective obligations. Because the enterprises that finance health care regularly contract regarding a host of issues with those that deliver health care, it is reasonable to suppose that they would be able to arrive at contractual solutions to this liability-allocation problem. Moreover, although hospitals are generally likely to be better risk-bearers than other health care enterprises would be, precisely the same allocation of liability may not be optimal in all settings.

Thus the enterprise initially singled out for liability—the hospital under our proposal—should be permitted to contract out of this allocation by transferring its liability to an enterprise in the corresponding financing system. A critically important feature of any enterprise liability rule, therefore, is that it should serve as a "default" rule that can be varied by contract, rather than as a mandatory allocator of liability.

In order to minimize the cost of contracting around a default rule, however, an optimal rule should allocate liability in a manner that the parties would most frequently adopt on their own. We prefer a delivery-based default rule on the several grounds we have already noted.

137 See supra p. 398.
138 For example, certain day-surgery clinics may find it in their interest to bear liability, rather than to be relieved of liability but unable to operate with total independence from a local hospital.
139 For a discussion of the functions of default rules in contract law, see Richard Craswell, Contract Law, Default Rules, and the Philosophy of Promising, 88 Mich. L. Rev. 489, 503–16 (1989); Charles J. Goetz & Robert E. Scott, The Limits of Expanded Choice: An Analysis of the Interactions Between Express and Implied Contract Terms, 73 Cal. L. Rev. 261, 273–80 (1985); and Jason S. Johnston, Strategic Bargaining and the Economic Theory of Contract Default Rules, 100 Yale L.J. 615, 620–26 (1990). We should emphasize that our endorsement of contractual freedom to alter the initial allocation of tort liability applies to contracts between the enterprises that play different roles within the health care system, and not to enterprises outside this system.
In fact, the capacity of hospitals to manage the incidence of malpractice is sufficiently great that many hospitals will affirmatively desire to undertake enterprise liability as one feature of the package they offer to financing enterprises to compete for the latters' patients.\textsuperscript{140} For these reasons, a default rule that imposes liability on the enterprises that deliver health care seems preferable to a financing-based allocation.

\textbf{B. The Scope of Liability}

Even assuming that hospitals are the preferred candidates for enterprise medical liability, an important question remains about the precise scope of hospital responsibility for the malpractice of affiliated physicians. The issue is whether enterprise liability should be confined to injuries produced by treatment that takes place within the hospital, extend to all malpractice-related injuries suffered by patients who are hospitalized in connection with the illness that occasioned the treatment, or encompass all malpractice-related injuries suffered by the patients of physicians whose principal affiliation is with the hospital. In connection with each of these legal options, the relationship between hospitals and other delivery enterprises (such as HMOs) must also be considered.

1. \textit{In-Hospital Treatment}. — The most obvious, but also the most limited, step would be to render hospitals liable for the physician malpractice that takes place within their walls. This form of liability would serve the core purpose of EML by placing on the hospital's shoulders the legal responsibility for negligent treatment that takes place in the setting that seems most conducive to hospital control. This approach would bring within the orbit of enterprise liability the bulk of the surgical and obstetrical claims that now suffer from the deficiencies of individualistic malpractice litigation.

However, confining hospital liability in this fashion has the major disadvantage that treatment of many patients occurs both inside and outside the hospital facility. Physicians commonly examine and diagnose patients in their offices, only later admitting some of these patients to the hospital. If the hospital were assigned liability only for malpractice occurring within its facilities, physicians would still have to purchase insurance to cover the remainder of their exposure to malpractice liability; patients would have to identify, and hospitals and physicians would contest, the location of the alleged malpractice; and responsibility would have to be divided when malpractice occurred both inside and outside hospital facilities. Because one major objective of EML is to reduce the unnecessary administrative costs of mal-
practice litigation, it probably would be a mistake to draw the inside/outside distinction.

2. Hospitalized Patients. — Certain of these problems could be alleviated by holding the hospital liable for all malpractice-related injuries suffered by any patient admitted to the hospital in the course of the treatment during which the malpractice occurred, regardless of where the malpractice occurred or whether the malpractice was committed before, during, or after hospitalization. This approach would remove most of the incentive that would otherwise be created for claimants to join physicians as well as the hospital in any malpractice suit, in order to assure that the responsible party was a defendant.141

Because individual physicians would remain personally liable for malpractice to patients never hospitalized, however, physicians still would have to maintain insurance against liability for this residual risk. Indeed, because physicians would be sheltered from individual liability only if their patient were hospitalized, this approach would create an incentive on the part of physicians to hospitalize patients simply to secure the benefits of EML immunity. While the EML program could easily include an exception for such cases of purely “defensive” admissions, that exception would add another legal issue to a malpractice regime that EML is designed to streamline.

3. Principal Physician Affiliations. — In view of the complications that would be associated with the preceding two approaches, the best approach seems to be to expand the EML envelope to make the hospital responsible for all malpractice of its affiliated physicians that affects both patients in the hospital and patients not admitted to any hospital. This approach would not only avoid the problems entailed in the effort to divide liability between hospitals and physicians, but would also completely eliminate the need for physicians to purchase additional malpractice insurance to protect against suits by patients not covered by a more limited EML regime. In the case of physicians now affiliated with more than one hospital, we would follow the lead of New York’s current law requiring hospitals to provide supplementary physician coverage and allocate liability to the hospital with which the physician is principally affiliated.142

A possible objection to this expansive approach to EML is that the hospital may seem to have little or no capacity to influence the quality of treatment delivered outside its walls. This objection is misplaced.

141 Some potential would remain for litigation over the connection between the negligently produced injury and the hospitalizing condition, but serious disputes over this issue would be far fewer than disputes over whether the injury was produced by negligence.

142 See Act of July 8, 1986, ch. 267, 1986 N.Y. Laws 506, reprinted as amended in N.Y. Ins. Law § 3437 note (McKinney 1994). There will remain some physicians (for example, some psychiatrists) who have no affiliation with any hospital or other institution. Probably the most sensible course with this group is to leave the individuals liable for their malpractice until they develop an enterprise affiliation.
The law has long imposed liability upon enterprises such as airlines whose pilots were negligent in the sky\(^{143}\) and law firms whose lawyers were negligent in the courtroom.\(^{144}\) In each of these settings, whatever steps might have been taken beforehand, there was nothing that management of the enterprise could do to alter or avoid the careless actions at the very moment they were taking place. Hospital management's capacity to avoid careless mishaps is just as limited, whether the mistake takes place in the hospital operating room or in physicians' offices. What the hospital — like the airline or the law firm — can do is judge which physicians have the experience and ability to receive and keep the (valuable) privilege of admitting patients to the hospital, as well as what kinds of treatment protocols should be developed and followed to reduce the hazards of occasional human error by even a highly qualified physician staff. Such legally induced efforts by hospitals to improve the quality of treatment offered by their affiliated physicians can make a pronounced difference in the care offered in the physicians' offices as well as inside the hospital itself.

4. Relations Between Hospitals and Other Delivery Enterprises. — We discussed earlier the ways in which any of the three alternative approaches to hospital-based liability could be varied by contract with financing-based enterprises.\(^{145}\) There remains, however, the question of the proper relationship between hospitals and other enterprises that deliver health care, such as staff-model HMOs, outpatient surgical centers, and the like. Because in recent years there has been a trend toward the provision of increasing amounts of care outside of hospitals,\(^{146}\) it might be thought that hospital-based enterprise liability runs counter to this trend. But the vast majority of complex surgical or obstetrical procedures that commonly figure in malpractice claims are still performed in hospitals.

In addition, the other enterprises that typically deliver health care vary enormously in size, function, and risk-bearing ability.\(^{147}\) For small enterprises, bearing liability would generate most of the same problems that now trouble individual physicians. Also, under no plausible scenario would these enterprises be made legally responsible for

\(^{143}\) See, e.g., United Air Lines, Inc. v. Wiener, 335 F.2d 379, 388–90 (9th Cir.), cert. dismissed, 379 U.S. 95 (1964); Cudney v. Braniff Airways, Inc., 300 S.W.2d 412, 417–18 (Mo. 1957).

\(^{144}\) See, e.g., Simpson v. James, 903 F.2d 372, 377 (5th Cir. 1990); Priddy v. MacKenzie, 103 S.W. 968, 972 (Mo. 1907).

\(^{145}\) See supra pp. 419–20.

\(^{146}\) See Carolyn S. Donham, Brenda T. Maple & Lekha Sivarajan, Health Care Indicators, 15 HEALTH CARE FINANCING REV. 202, 207–08 (1993) (finding that inpatient surgeries declined 31.8% from 1981 to 1991 and that outpatient surgeries increased 228.8% during the same period).

\(^{147}\) For example, certain physician group practices and day-surgery clinics are formally "enterprises" but in reality are small partnerships or corporations that differ little from groups of several individuals practicing under the same roof. These small "enterprises" do not operate like hospitals and cannot diversify their malpractice liability risk in the way that hospitals can.
anything other than malpractice occurring directly under their auspices. Therefore, allocating liability to them by law, even if only by default rule, would inevitably result in many of the same factual disputes about the location and context in which malpractice had occurred that would trouble the two limited forms of hospital-based liability discussed above.\footnote{See supra pp. 420–21.}

Even though automatically allocating liability to these enterprises would be ill-advised, it would sometimes be optimal for them to bear liability for malpractice occurring under their auspices. In some circumstances these enterprises probably would be the optimal risk-bearers, depending on their size, function, and relationship with local hospitals. Accordingly, these health care delivery enterprises should have the same freedom to contract with hospitals regarding the allocation of liability as we earlier recommended be afforded to health care financing enterprises. In this way, hospital-based enterprise liability would then simply function as the default rule governing liability in the absence of contracts allocating liability among hospitals, health plans or insurance companies, and other health care enterprises.

C. Necessary Economic Adjustments

Under EML, physicians’ malpractice insurance costs would decline or disappear while hospitals’ corresponding costs would increase. Therefore, the shift to EML would have to be accommodated financially either by contract between physicians and hospitals or by adjustment in their respective health insurance reimbursement rates. The underlying question is how the economic relationships among individual physicians, health insurers, hospitals, and HMOs would evolve, as large enterprises came to provide what amounts to malpractice insurance for physicians.\footnote{Part of this evolution in relationships would also have to involve changes in the relevant law. For example, in some jurisdictions the de jure authority of a hospital to manage medical staff is limited by licensing laws and rules governing the unlawful practice of medicine by hospital administrators untrained in medicine. See, e.g., Mark A. Hall, Institutional Control of Physician Behavior: Legal Barriers to Health Care Cost Containment, 137 U. Pa. L. Rev. 431, 452–54 (1988); Jeffrey F. Chase-Lubitz, Note, The Corporate Practice of Medicine Doctrine: An Anachronism in the Modern Health Care Industry, 40 Vand. L. Rev. 445, 451–52, 464–70 (1987). But the adoption of EML would only marginally exacerbate this problem, which hospitals already face in implementing cost constraints on medical staff members who are not legally under the hospitals' control. See Sanford L. Weiner, James H. Maxwell, Harvey M. Sapolsky, Daniel L. Dunn & William C. Hsiao, Economic Incentives and Organizational Realities: Managing Hospitals Under DRG’s, 65 Milbank Q. 463, 478–80 (1987).}
ers and others to hospitals and physicians would be left unaffected. For example, the hospital could simply be paid a surcharge by each physician to whom it granted the privilege of admitting patients. The initial payment would likely be set by reference to the physician’s current malpractice premium (perhaps adjusted for volume).

This simple contractual arrangement would eliminate any need for immediate adjustments in physician fees or charges for hospital services resulting from the adoption of enterprise liability. In effect, the physician would simply pay premiums to the hospital instead of to the malpractice insurer. Indeed, this method would address a flaw in current malpractice insurance arrangements — namely, the lack of a volume adjustment in premiums, which, arguably, over-encourages specialization. For example, it is financially difficult for a family physician in a sparsely populated area to pay for full-time obstetrical insurance while maintaining just a part-time obstetrical practice. A volume-adjusted charge by the hospital would alleviate this by-product of the current annualized malpractice premium.

The principal risk posed by this approach is that the hospital might attempt to pass on to its affiliated physicians more than the additional cost of the hospital’s new liability. There would, however, be checks on such actions. For example, competition among hospitals for physicians at the local level would help to prevent overcharging. Indeed, economic transactions now being entered into by hospitals and some of their affiliated physicians suggest that the market can, and in some contexts already does, offer protection against overcharging.

One example of hospitals contractually assuming liability is obvious: that of the physician who is an employee of the hospital. Many hospitals now pay for the malpractice insurance of their employees, even if they cannot legally insulate them from liability. In such cases, the malpractice premium is presumably passed on in the form of a reduced salary received by the physician; the same would surely be true under enterprise liability. This example suggests that physicians’ fears about overcharging by hospitals are probably exaggerated, because market forces would exert discipline over the tendency of hospitals to overcharge physicians for the adoption of enterprise liability. Market forces, however, would not force hospitals to ignore differences

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150 For example, a volume adjustment would allow a physician who practiced only half of her time as an obstetrician to pay about half of the typical obstetrical premium. To the extent, of course, that the injury risk is greater among physicians who only occasionally perform certain procedures, the per-case charge should gradually fall to reflect the declining risk from specialization.

151 In the short run, the small number of hospitals in many markets might limit such competitive protection. Over the longer run, this problem would diminish through operation of the national market for physicians’ services. New physicians would not be attracted to a community whose only hospital exploited its monopoly position by overcharging for the malpractice immunity it was providing.
among physicians' likelihoods of committing malpractice. For this reason, we regard the capacity of the hospital to vary its surcharges to be an important tool for influencing the quality of care provided under its auspices.

2. Modification of Insurance Reimbursement Rates for Medical and Hospital Services. — Under a different, longer-run approach, the hospital would receive additional revenue from health insurers in recognition of its additional liability; physicians, in turn, would receive less revenue in recognition of their reduced liability. The multiplicity of insurers under the current system would make this approach awkward, though not impossible to implement. However, this approach might well be easier to implement under a system in which there would be only a few insurers in each region who would be responsible for both physician and hospital payments.

For example, it would not be difficult to adjust payment levels in Medicare, the federally run and financed health insurance program for the elderly. 152 The Medicare fee schedule for physicians already contains an adjustment for malpractice insurance costs. 153 The amount of these adjustments could simply be deducted from the Medicare Part B schedule (applicable to physician payments) and transferred to Part A (applicable to hospital payments). 154 This reallocation could be prorated across all patient admissions or more accurately adjusted for differential risks of malpractice by Diagnosis-Related Group 155 or other risk-related dimensions. In contrast, the payment method of Medicaid, the state-run program of federally funded health insurance for the poor, varies from state to state, 156 and there appears to be no formal malpractice adjustment in any state. Although Medicaid payments to physicians account for only about five percent of physician revenues, 157 a more complex method of adjusting payment schedules than could be employed for Medicare would have to be developed.

The more important issue, because of the large percentage of total health care revenues involved, is how to make adjustments within the

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155 For an explanation of the DRG system, see notes 49–53 above and accompanying text.


157 Medicaid payments for physician services rendered by hospital employees such as emergency room physicians are accounted for as hospital expenditures rather than as physician expenditures and thus are not included in this figure. See Burner, Waldo & McKusick, supra note 152, at 26.
employment-based health insurance of persons under the age of sixty-five. Within this realm, the percentages of gross revenues in various specialties that are earmarked for the payment of malpractice premiums can easily be calculated. For physicians, therefore, a reasonable starting point for adjustment would be for health insurers to reduce insurance payments to physicians by that percentage, specialty-by-specialty and locality-by-locality. There is, of course, no guarantee that private insurers could accomplish this adjustment automatically, because each insurer is but one actor in a market for physicians' services. However, there has been increased price competition in physician markets as a result of the rise of preferred-provider and analogous arrangements, and this competition suggests that liability insurance premium adjustments could work.

Similarly, for hospitals (as in the case of Medicare), a sum corresponding roughly to the amount of the aggregate reduction in physician payments by insurers would have to be added to hospital payment rates. Because these rates typically are negotiated between insurers and hospitals, the adjustments could be negotiated periodically. Hospitals that maintained superior malpractice records would need lower adjustments in their rate structures; for precisely that reason, they would be better able to attract patients in this far more cost-conscious era of health insurance.

IV. ELECTIVE EXPERIMENTATION WITH EML

The foregoing discussion suggests that the case for adopting EML is strong and that its implementation would be feasible. But there are many details regarding EML that remain to be worked out. EML has provoked intense concern on the part of physicians about the possible loss of autonomy to hospital administrators or to a health insurance bureaucracy. The possible deep-pocket effects of EML on malpractice juries are also a matter of legitimate concern. Finally, any major liability change is bound to have unanticipated side effects. Thus, experimentation, rather than wholesale mandatory change, may well be the order of the day. In this Part we sketch the outlines of an EML "experiment."

The ideal site for an EML experiment would be a single community hospital or group of hospitals most of whose affiliated physicians have admitting privileges without being employees. The hospitals and physicians at this site should at present be insured by no more than one or two malpractice insurers, in order to facilitate the arrangements that would have to be made to conduct the necessary pilot or demon-

In addition, consideration would have to be given to whether elective EML experiments would be legislatively implemented or fashioned by contract, and to what transitional adjustments would have to be made in order to facilitate such experiments.

A. Methods of Implementation

i. Legislative Authorization. — The preferred method of implementing experiments is through legislative authorization. Under any legislative approach, an enabling statute enacted by a state legislature should authorize hospitals to elect EML on the following terms:

(a) Any hospital electing EML would be liable to its patients for malpractice by any affiliated physician, nurse, or other individual provider, whether or not the provider was a hospital employee. The hospital would assume liability for all patients treated by its affiliated physicians, whether or not those patients were ever admitted to the hospital.

(b) Patients would be given clear notice, both by the physician’s office and by the EML hospital’s admitting branch, of the hospital’s expanded liability and the resulting immunity of its affiliated physicians.

(c) Individual health care providers would be relieved of liability for malpractice, with an exception for injuries caused by a health care provider who acted with intent to cause harm or with reckless indifference to the welfare of the patient.

(d) All individual physicians relieved of malpractice liability by a hospital’s election of EML would be obligated to pay the hospital an annual surcharge in order to reimburse the hospital for the anticipated increase in its malpractice insurance costs. The surcharge would take into account the anticipated reduction in malpractice insurance costs charged the physician.

(e) The amount of the surcharges would be set by agreement between each participating hospital and its affiliated physicians. Surcharge levels would be reviewable by the state’s Commissioner of Insurance on the same basis that the Commissioner may now review medical malpractice premium levels. In most states new rates can be filed and may be used unless the Commissioner formally objects. Ideally, each physician could designate a single hospital to be his or her “primary” hospital and pay a surcharge to that hospital alone. Alter-

159 A number of large, urban health care complexes have already developed “channelling” arrangements that resemble features of an EML system. See, e.g., FEDERATION OF JEWISH PHILANTHROPIES SERV. CORP., VOLUNTARY ATTENDING PHYSICIANS PROFESSIONAL LIABILITY INSURANCE PROGRAM (describing the channelling programs at five New York City hospitals). The experiments that might generate real insights into the effects of EML should occur in other kinds of hospital settings, because such innovations would involve economic and legal arrangements that differ radically from their current regimes.
natively, separate surcharge rates could be set for physicians affiliated with more than one hospital so that these providers would not be required to pay excessive duplicate surcharges.

(f) As another alternative, hospitals and affiliated physicians, through negotiations with health insurers and other third-party payers, could arrange adjustments in the charges for services and reimbursement rates payable for medical and hospital services to take account of the shift in liability resulting from elective EML.

(g) Hospitals electing EML would be required, to the extent that they had not already done so, to set up peer review mechanisms to ensure that quality care is provided. Such peer review mechanisms would have to include procedures for revoking the admitting privileges of physicians who fail to comply with the hospital’s standards.

The length of a legal experiment in EML would depend on the criteria used to evaluate it. If the issue were whether it is possible to design and introduce this new allocation of liability in a fashion that is acceptable to the hospital and its physician staff, we believe that a reliable answer probably could be generated in two or three years. On the other hand, if the issue were whether an EML “single tort payer” model reduces the multiplicity, contestability, and administrative costs of malpractice litigation, at least six or seven years of experience with claims processing probably would be required. And if the ultimate criterion of success were whether EML induces hospital management and physicians to devise and implement mechanisms that improve the quality of the health care they provide, a decade-long adjustment might well be required. Given what we have learned about our century-old physician-focused malpractice regime, a serious decade-long experiment is easily justifiable.\(^ {161} \)

\(^ {160} \)See Weiler, Hiatt, Newhouse, Johnson, Brennan & Leape, supra note 1, at 55–59, 73–76 (describing the implications of the Harvard Medical Practice Study).

\(^ {161} \)A related consideration involves the National Practitioner Data Bank. The “data bank” would likely continue to be used even after the adoption of EML. We consider the principle underlying the data bank to be salutary — hospitals and other enterprises considering whether to employ or affiliate with a physician should have a ready means of determining the physician’s previous involvement in malpractice claims. Even were hospitals or other enterprises to assume complete control of malpractice litigation, however, physicians’ interests would still be affected by the actions of enterprises in settling malpractice actions that may result in data bank reporting.

It is necessary, then, to develop a fair method of determining when and what to report to the data bank. A number of different approaches seem plausible, and there is no reason that a single approach should be mandated. Enterprises and their affiliated physicians could fashion approaches that best suit their concerns, as long as the purposes of the data bank continue to be served. The model we favor would allocate to liability-bearing enterprises the authority in the first instance to determine whom and what to report to the data bank, subject to the right of any physician to “appeal” a proposed report of his negligence to a committee comprised of representatives of both the enterprise and its affiliated physicians. Such an approach would enable reports to be made routinely in cases not subject to dispute, but would help protect physicians’ interests in fair and accurate reporting.
2. EML by Contract. — Even absent legislative authorization of EML, it would still be possible to fashion an elective EML program by voluntary contract. Under this approach, the EML program would be created by trilateral contracts executed by hospitals, individual health care providers, and malpractice insurers. The contracts creating the program would contain components paralleling those that we recommended for inclusion in authorizing legislation.\footnote{162}

Under a contract system, the parties affected — hospitals, physicians, and malpractice insurers — would have to negotiate an agreement concerning the amount of the surcharges paid to hospitals and the amount of the malpractice insurance premium adjustments. This agreement would then form part of the trilateral contract creating the program of EML. Because these contracts would only change the relationship among the contracting parties and not the law governing their liability to patients, each participating physician would remain formally subject to medical malpractice liability. But by virtue of the contractual indemnity provided to individual providers by hospitals, participating doctors would have no actual financial responsibility for any liability imposed on them. In effect, they would be insured for unlimited amounts by hospitals.

B. Transitional Adjustments

1. Insurance Risk and the Surcharge Issue. — At the outset of any EML experiment, malpractice insurers, as well as physicians and hospitals, would face insurance risk. There are two forms of uncertainty, which, unless addressed, might decrease the likelihood that malprac-
tice insurers would participate in an elective EML program. First, it is unclear whether the immunity from liability afforded physicians would withstand challenge in court. Second, there is uncertainty about whether adoption of EML would result in a net increase in the frequency and severity of claims because of the perceived "deep pocket" of each hospital and the possibility that patients would be more willing to sue hospitals rather than physicians. Both forms of uncertainty could be reduced or completely eliminated by the use of "retrospective premiums." These premiums could be charged physicians for insurance against their residual malpractice liability — that is, against any liability they might bear to non-hospital patients in the event that only limited EML were adopted. Similar retrospectively adjusted premiums could be charged hospitals for insurance against their liability.

The insurance risk faced by physicians and hospitals would mirror the risk faced by malpractice insurers. To the extent that a retrospective premium system protected malpractice insurers, it would expose physicians and hospitals to risk. There is no feasible way to eliminate risk for both sides. Because the advantages of EML would accrue heavily to physicians and hospitals and not to malpractice insurers, we believe that the former should bear that portion of the unavoidable insurance risk associated with EML.

As we noted earlier, however, physicians would have reason to be concerned about surcharge levels assessed by hospitals. This concern could be alleviated in the following manner. First, the surcharges could be set through negotiations between the hospital and the medical and other professional staffs of the hospital, rather than fixed unilaterally by the hospital. Ideally, these negotiations would be statutorily protected against any possible antitrust liability for such collective physician action. Second, the initial rule of thumb could be that a surcharge would not exceed eighty percent of any health care provider's prior malpractice premium. If the same insurer who provided most of the individual medical malpractice insurance in the area also insured the hospital, the insurer might act as an intermediary in helping set the surcharges. Alternatively, a medical or nursing staff might find it useful to employ the actuarial services of a malpractice insurer to aid in negotiating the surcharges. Finally, because the

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163 A retrospective premium would result in either an additional charge or a refund payment to the policyholder, calculated a number of years after the close of a policy period. Through retrospective premiums, malpractice insurers could protect themselves against any uncertainty that EML would create in the first few years after its adoption, but policyholders could ultimately receive refunds for the cost of their insurance if EML generated the cost-reducing effects predicted for it. Consequently, any statute authorizing EML should expressly permit insurers to rate retrospectively the malpractice liability insurance premiums that they charge health care providers and hospitals that participate in the system.

164 See supra p. 425.
surcharges would be quasi-premiums themselves, they could be subject to review by the state's Commissioner of Insurance on the same basis as conventional premiums, to assure that they are not excessive, inadequate, or unfairly discriminatory.165

2. Continuity of Coverage and the Viability of Experimental Immunity. — (a) Continuity of Insurance Coverage. — Continuity of coverage would have to be assured both upon initiation of an EML demonstration project and, if EML were not eventually adopted, upon its termination. Upon adoption of EML, physicians would cease to purchase their own malpractice insurance (or under limited EML, cease to purchase full malpractice insurance) because they would be immune from liability arising out of diagnosis or treatment provided from that point forward. Such providers would continue to be liable, however, for malpractice arising out of diagnosis or treatment provided prior to the adoption of EML. Any health care provider who previously had been insured under an "occurrence" form of malpractice liability insurance would nonetheless have continuity of coverage in this situation; that provider's prior policies would cover any liability arising out of past treatment, and the hospital would bear liability arising out of treatment provided after adoption.

In contrast, any physician who previously had been covered under a "claims-made" policy would not be covered under any past policy against claims made after the adoption of EML, even if those claims arose out of treatment provided before adoption.166 This gap in coverage for physicians previously covered by claims-made policies could be closed in one of two ways: the hospital itself could undertake responsibility for claims against participating providers arising out of past treatment but not made until after the adoption of EML, or each physician could purchase an insurance policy covering the "tail" of claims in question.167

Transitional insurance adjustments would not only be necessary at the start, but also at the end of any experiment. To assure coverage of all liability arising out of treatment provided during the period of the

165 Most malpractice premium rates are subject to "file and use" regulation, under which rates go into effect automatically unless disapproved by the Insurance Commissioner under the quoted standard. See KENNETH S. ABRAHAM, INSURANCE LAW AND REGULATION 104–05 (1990).
166 For example, suppose that a provider were covered under claims-made policies through December 31, 1994, and that EML were made effective on January 1, 1995. The provider's 1994 claims-made policy would not cover a claim made after December 31, 1994 arising out of treatment provided in 1994, but the hospital would have legal responsibility only for claims arising out of treatment provided beginning on January 1, 1995.
167 Each of these approaches would assure continuity of coverage, but at additional cost for the hospital or for each participating health care provider. Because this "transition cost" (at least, above what the physician would otherwise have paid) of assuring continuity of coverage would be a necessary part of any demonstration project, the federal funds or research grant supporting the demonstration project would have to include funds sufficient to allow the purchase of such coverage, either by the hospital or by individual providers.
demonstration project, the enabling statute (or contracts) authorizing the project should impose responsibility for all such liability on the hospital, whether a claim alleging liability was made during or after the termination of the project. Moreover, upon termination of the project (if EML were not made permanent), individual providers would have to be guaranteed access to individual medical malpractice insurance policies again. Under normal conditions most providers would be able to purchase these policies without difficulty and thereby assure continuity of coverage. At the outset, however, the terms of the project should include a guarantee that, if a physician is unable to secure insurance because of adverse market conditions, the hospital will insure that physician for up to four years for a reasonable fee.\(^{168}\)

(b) Viability of Experimental Immunity. — It is possible that the validity of EML will be challenged in court, either at its outset through a declaratory judgment suit or as part of an actual malpractice suit. The legal costs associated with defending the validity of the system should be funded separately rather than paid as part of the hospital's malpractice insurance premiums. Like the other transitional costs incurred as part of the EML arrangement, these legal costs should be funded as part of any grant awarded to the hospital to support the demonstration project.

V. EML AS A BRIDGE TO BROADER MEDICAL LIABILITY REFORM

In addition to its intrinsic advantages, EML can serve as a starting point for assessing the advisability of broader reforms, including most prominently no-fault medical liability.\(^{169}\) Two issues loom large in the consideration of no-fault alternatives to medical malpractice liability. The first involves causation judgments, and the second, the injury-prevention effects of a no-fault system. Adoption of EML would facilitate comparative evaluation of the desirability of the fault and no-fault approaches to medical-injury compensation in each of these respects.

A. EML and the Possible Transition to Cause-Based Compensation

By making medical causation rather than medical fault the predicate to recovery, no-fault medical compensation would expand the uni-

\(^{168}\) Any disputes regarding the hospital's obligation to provide such coverage would be submitted to binding arbitration. Because this provision would entail additional cost to the hospital beyond the amount of the fees paid to it by physicians, the federal funds or research grant that would support the demonstration project would have to contain sums sufficient to reimburse the hospital for this potential expense.

\(^{169}\) See Paul C. Weiler, The Case for No-Fault Medical Liability, 52 Md. L. Rev. 908 passim (1993) (discussing the broader promise and pitfalls of this more profound transformation of the medical liability regime).
verse of those entitled to compensation. At the same time, this shift of emphasis from fault to cause would simplify certain aspects of the compensation decision and thereby reduce administrative costs.

Because not only the patient's recovery but also the physician's reputation is riding on the malpractice verdict, litigation about medical fault is bound to be more intense and costly than administrative determinations of causation. Current malpractice law requires that both conditions, fault and cause, be satisfied before the plaintiff can collect damages. Determining whether a patient's illness or injury was caused by medical treatment rather than by her underlying medical condition is admittedly more difficult than determining whether a claimant has suffered an injury arising out of employment or driving — the other two fields in which the no-fault alternative to tort liability has worked effectively. However, the Harvard Medical Practice Study documented that scientific judgments about medical causation were only about one-quarter as difficult to make as judgments about medical fault. This discovery certainly makes adoption of medical no-fault appear more feasible than many observers previously have supposed.

Nonetheless, determination of medical causation would inevitably be more complicated and costly if, in addition to deciding whether the condition for which a patient claims compensation was caused by medical treatment, it was also necessary to identify the particular individual — physician, nurse, technician — who provided the treatment. Under an "enterprise medical no-fault" regime this latter determination would be unnecessary. The only causal determination required would be whether a patient's illness or injury was the result of the course of treatment provided under the auspices of the hospital — a far simpler and less costly question to answer.

Moreover, whereas moving directly from the current regime to enterprise medical no-fault would constitute a very considerable leap, a change to that kind of no-fault system from an enterprise medical liability regime would be far less revolutionary — certainly much less so than the shift from individual fault to no-fault that the latter's proponents typically have recommended. In short, once the current re-

170 The current malpractice regime provides compensation to only a tiny fraction of the actual victims of medical injury but awards substantial sums to the "lucky" winners in the litigation lottery. See generally Weiler, Haft, Newhouse, Johnson, Brennan & Leape, supra note 1, at 4-5, 73-76 (noting that only a small fraction of patients with potentially valid tort claims ever file a malpractice claim and that among those who do file such a claim, only about half ultimately receive some payment).

171 See id. at 54-55.

gime's obsession with individual fault is replaced by a system-wide focus through the adoption of EML, shifting from a fault-based to a no-fault-based regime is likely to seem far more natural than it does at present.

B. The Enterprise Role in Injury Prevention: A Necessary Component of the No-Fault Debate

The evolution in the legal culture reflected by the adoption of EML would also facilitate more sensible consideration of the comparative injury-prevention effects of fault-based and no-fault liability. The focus of the traditional tort system on individual liability for malpractice has obscured the potential of an enterprise liability system, also based on malpractice, to improve quality of care and to promote injury prevention. Once liability for medical malpractice becomes focused on the enterprises in the best position to assure injury prevention, we will be in a better position to evaluate proposals for shifting the basis of liability from fault to no-fault. Our own view is that an enterprise-based no-fault system holds out substantial promise as an injury-prevention regime, both with respect to medical injuries that do and those that do not result from malpractice.

i. Injuries Caused by Malpractice. — In the eyes of tort liability's defenders, no-fault's superiority as a sensible mechanism for compensating past patient injuries is outweighed by its deficiency as an instrument for preventing future patient injuries.\(^{173}\) We disagree. That critique may be valid as against a social-insurance brand of medical injury compensation; it does not apply to a no-fault liability approach. This version of medical no-fault retains legal incentives for injury prevention because it imposes liability for compensating claimants upon the institutional providers responsible for patient care.

It is true that, by contrast with enterprise liability based on malpractice, no-fault sacrifices the injury-prevention potential of litigation focusing on individual blame, substituting instead the imposition of purely financial incentives on an institution made responsible for patient safety. This shift in the focus of liability, however, offers considerable promise for better prevention of future injury. Under a malpractice regime it is difficult for patients to discover and demonstrate the occurrence of malpractice, and defendants have a strong incentive to resist any such claims because of the high financial and reputational stakes in such litigation. As a result, only a small proportion of potentially actionable malpractice suits are even filed, let alone paid. Because no-fault offers patients compensation for medical injury without requiring proof of malpractice, this regime would sharply increase the odds that such claims would be made and paid. More ex-

\(^{173}\) See, e.g., DANZON, supra note 73, at 216 ("With respect to prevention, the elimination of fault would reduce useful incentives to avoid negligence.").
tensive legal and financial liability would be imposed on the treating institution, thereby providing an incentive for the institution to intensify its efforts to control careless behavior of individual providers.

2. Medical Injuries Not Caused by Malpractice. — With respect to medical injuries not resulting from malpractice, a no-fault system also could have considerable advantages over the current system, which does not impose any legal responsibility for medical injuries that are not a result of demonstrable negligence. A natural objection, of course, is that if an injury occurred even in the absence of malpractice, then the patient’s injury was not reasonably avoidable and liability for its consequences should not be imposed. But tort law theory has understood for decades that this view reflects a static vision of the activities regulated by the threat of liability. In contrast, a dynamic view of the potential for medical injury prevention recognizes that the threat of liability without fault can in fact create incentives to reduce the hazards of medical treatment.

The practice of medicine is constantly evolving under the impetus of newly developed diagnostic and treatment techniques. Many medical injuries that were accepted as inevitable just a decade or two ago — heart block during cardiac surgery, for example — are now considered avoidable as a matter of course. A no-fault program could create economic incentives for health care enterprises to undertake research and innovation into more advanced and safer medical techniques for avoiding currently “unavoidable” adverse outcomes. In the meantime, incorporation of at least some of the cost of “unavoidable” adverse outcomes in the prices charged for particular modes of treatment would permit increasingly informed judgments about the total cost and benefit of one mode of treatment as compared with another that, while less promising as a cure, is also less hazardous to the patient’s health.

In short, enterprise medical liability could prove to be something of a half-way house between the current malpractice regime and a dramatically different no-fault alternative. Making hospitals and other health care enterprises liable for all malpractice-related injuries suffered by their patients would fit comfortably within the current fault-based tort regime, which makes virtually all other business enterprises responsible in tort for negligently inflicted injuries resulting from the enterprise’s activities. At the same time, the case for enterprise liability rests on a vision of tort law as an instrument for more efficient injury prevention and insurance, rather than as a morality play about individual culpability. A society that takes this new vision seriously might well decide that no-fault liability offers an even more promising

174 See, e.g., Guido Calabresi & Jon T. Hirshoff, Toward a Test for Strict Liability in Torts, 81 YALE L.J. 1075, 1071 (1972); Steven Shavell, Strict Liability Versus Negligence, 9 J. LEGAL STUD. 1, 2–3 (1980).
blend of compensation, administration, and deterrence than a system ultimately basing medical liability on a provider’s fault.

CONCLUSION

The current ferment over reform of our health care system has led to a rethinking of the relations between this country’s health care and civil justice systems. Since the time when the traditional individual liability approach to malpractice crystallized, the manner in which health care is delivered has changed enormously. From a group of isolated individual practitioners who used hospitals as workshops for themselves and hotels for their patients, the system has evolved to the point where care is now delivered mainly under the auspices of large enterprises such as health insurers, hospitals, and HMOs. Yet the liability regime has remained geared to an older world of individual delivery of health care, a world that is on the verge of disappearing. The time has come to renovate our system of liability to make it better suited to a new world dominated by health care enterprises. The enterprise liability model we have developed is designed for precisely this purpose.