Enterprise Medical Liability and the Choice of the Responsible Enterprise

by Kenneth S. Abraham† and Paul C. Weiler‡

I. INTRODUCTION

During the last year, the proposal of "enterprise" liability for medical malpractice became a major issue in debates about health care and malpractice reform. The idea, however, was not new. In scholarly work over an extended period, we have been developing the systematic case for the concept of enterprise — or, as we originally termed it, "organizational" — liability for medical malpractice.[1] After several years of debating the critics of our proposal to shift the focus of liability for medical injury from individual physicians to the organizations that deliver health care,[2] we were naturally gratified that the idea was now on the national agenda.

In particular, we recommended adoption of enterprise liability to President Clinton's Health Care Task Force. The Task Force did embrace a version of the idea as its own, but then encountered stiff resistance from a number of special interests. Finally, however, a proposal for enterprise liability demonstration projects was included in the legislation submitted to Congress last Fall. The Article in this issue by William Sage, Kathleen Hastings, and Robert Berenson ("SH&B"),[3] who headed the Administration's malpractice reform working group, makes an eloquent case for imposing enterprise liability for medical malpractice on the "Health Plans" that would be the vehicle for assuring health care under the Administration's proposal.[4]

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[1] One of us had considered a version of the idea almost two decades ago, under the label "channelling." *See* Kenneth S. Abraham, *Medical Malpractice Reform: A Preliminary Analysis*, 36 MD. L. REV. 489, 520-22 (1977). Weiler served as Chief Reporter for the AMERICAN LAW INSTITUTE REPORTERS' STUDY, ENTERPRISE RESPONSIBILITY FOR PERSONAL INJURY (1991), with special responsibility for medical liability, and Abraham was Associate Reporter, with special responsibility for the insurance side of the tort system. That Study analyzed and endorsed the concept of organizational liability for medical malpractice. *See* 2 AMERICAN LAW INSTITUTE REPORTERS' STUDY, ENTERPRISE RESPONSIBILITY FOR PERSONAL INJURY 113-26 (1991). Finally, one of us authored a book on medical malpractice in which the concept was explored in detail. *See* PAUL C. WEILER, MEDICAL MALPRACTICE ON TRIAL 122-32 (1991).

[2] These proposals have appeared in various forms. *See, e.g.*, 2 AMERICAN LAW INSTITUTE REPORTERS' STUDY, *supra* note 1, at 113-26; WEILER, *supra* note 1, at 122-32; Kenneth S. Abraham et al., *Enterprise Responsibility for Personal Injury: Further Reflections*, 30 SAN DIEGO L. REV. 333, 355-58 (1993); Kenneth S. Abraham & Paul C. Weiler, Organizational Liability for Medical Malpractice: An Alternative to Individual Health Care Provider Liability for Hospital-Related Malpractice (March 1993) (on file with author).

[3] William M. Sage et al., *Enterprise Liability for Medical Malpractice and Health Care Quality Improvement*, 20 AM. J. L. & MED. 1 (1994).

[4] Sage et al., *supra* note 3, at 11-12.

Once an affirmative answer is given to the question whether some form of enterprise medical liability, "EML," is preferable to the traditional system of individual physician liability, the most important issue to be addressed is the choice of the responsible enterprise. In this Article we outline our views on that issue,[5] contrasting our position, favoring imposing liability on hospitals and similar health-care delivery organizations, with the SH&B proposal to impose such liability on Health Plans.

Ultimately, the choice of the responsible enterprise turns on the social objectives that tort liability is designed to serve. In our view delivery-based liability of the sort we have proposed would best serve the multiple criteria a sound tort system must satisfy. Delivery-based liability would most effectively promote the goals of medical injury prevention and quality assurance that SH&B themselves believe to be the major advantage of enterprise liability. In addition, delivery-based enterprise liability would be a superior approach to the provision of insurance against and compensation for medical injury, and would outperform any other form of medical liability in reducing the administrative burdens of the tort system. Along each of these dimensions our proposal would mesh more closely than other alternatives with the underlying goals of tort liability: promoting optimal prevention, providing reasonable compensation to accident victims, and minimizing the administrative costs of a fault-based liability system. Importantly, from the point of view of past and future victims of medical injury, delivery-based enterprise liability also would improve upon the protective benefits of tort liability, rather than merely shrink the burdens of that regime now experienced by physicians.

I. THE CASE FOR DELIVERY-BASED LIABILITY

The affirmative case for imposing EML on hospitals and similar enterprises directly involved in the delivery of health care is straightforward. Precisely because the function of these enterprises is to deliver health care, they are in the best position to make decisions about how to optimize the mix of potential risks and benefits associated with treatment of any particular patient's medical condition. By comparison, neither the individual physician,[6] who increasingly is merely a component (though admittedly a key one) of a health-care delivery team, nor an organization (such as a "Health Plan") that is primarily a vehicle for financing or facilitating the delivery of care, is as well-situated to make the critical decisions about how to systematically improve the quality of medical treatment. In our view the delivery-based approach to EML would result in a more sensible system of insurance at somewhat more economical administrative costs, and would best channel the legal incentives for prevention of medical injury and negligence.

A. Sensible Insurance

The flaws of individual liability as an insurance/compensation system are well-known. Because of the small pools of physicians in each specialty that insurers use to fashion risk classes, physicians face the threat of substantial fluctuations in their premiums for medical malpractice liability insurance.[7] At the same time, reliance on individual liability creates the risk for the occasional claimant with a tragic injury and enormous damages that the individual physician's insurance will be insufficient to

[5] We are currently at work on a lengthy study of this and many other issues associated with the concept of enterprise liability, entitled, *Enterprise Medical Liability and the Evolution of the American Health-Care System.*

[6] Although the proposals we discuss are generally designed to apply to physicians and other individual health-care providers, for convenience we will refer in the remainder of this Article to "physicians" alone.

[7] *See* Weiler, *supra* note 1, at 123-24.

HeinOnline -- 20 Am. J.L. & Med. 30 1994

satisfy the entire judgment against her. In contrast, a shift to delivery-based liability would impose liability on enterprises with much larger claims experience for insurers to employ in setting premiums and with much more capacity than physicians to deal with fluctuations in the insurance market. Moreover, in the rare but important cases in which large damages are appropriate compensation (for example, for a permanently and seriously injured young patient), the automatic availability of a financially solvent defendant such as a hospital would assure full compensation in a way that physician liability financed by individually-purchased malpractice insurance simply cannot do.[8]

As we note below, it is possible that Health Plans will have similar (though not greater) insurance and compensation capacities; but the nature of Health Plans under any new system is uncertain. In contrast, delivery-based enterprises such as hospitals are both mature and have long shouldered a share of liability for medical malpractice. They are therefore in a much better position than Health Plans to move immediately into an EML system.

B. Administration

The costs of administering a system of individual liability could be reduced significantly by delivery-based EML. The cost of separate attorney representation of individual defendants would be eliminated, as would at least some of the finger-pointing among multiple defendants that now occurs and impedes settlement and exacerbates litigation. A system that imposed enterprise liability on Health Plans would capture many of these benefits as well. The question, however, is which approach would avoid such costs most effectively.

There have already grown up a variety of forms of hospital tort liability for treatment-related injuries — vicarious liability for employed physicians (including residents), ostensible agency liability for emergency, radiology, and other physician services that hospitals directly offer patients, and corporate liability for negligent credentialing and monitoring of surgeons, obstetricians, and other physicians with hospital affiliations. In addition, hospitals are currently liable in their own right for torts committed by non-medical personnel — nurses, technicians, and others. It is not at all clear whether, under the SH&B approach, Health Plans would bear liability for *all* tortiously-caused patient injuries, or only liability for patient injuries caused by *physician* malpractice. Under the former approach, administrative costs are likely to be as low as under delivery-based EML because there would never be more than one defendant. However, for reasons we discuss below, there would then be a serious sacrifice of the injury-prevention potential of EML. In contrast, if Health Plan liability were confined to physician malpractice (perhaps even excluding physicians employed or deployed by hospitals) litigation and other administrative costs would continue to be high. Disputes would frequently arise about which personnel (and therefore which enterprise) were legally responsible for the injury in question, and thus it would be appropriate for the patient to make claims against multiple defendants.

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[8] We are aware that a shift to enterprise liability would risk an increase in the magnitude of tort awards because of a "deep-pocket" effect resulting from the substitution of enterprise defendants for individual physicians. For this reason (among others) we have argued elsewhere that a variety of tort reforms, including enterprise liability, should be accompanied by sensible reform of the law of tort damages — in effect, through damage guidelines — rather than the adoption of absolute (and thence regressive) fixed dollar caps on tort awards. *See, e.g.*, 2 American Law Institute Reporters' Study, *supra* note 1, at 161-316; Weiler, *supra* note 1, at 45-69; Abraham et al., *supra* note 2, at 340-47.

HeinOnline -- 20 Am. J.L. & Med. 31 1994

Moreover, even if the former approach (imposing liability for all tortiously-caused patient injuries on Health Plans) were preferred as a matter of principle, as a matter of practice it would likely be difficult—and certainly it will prove to be complicated—for a system of Health Plan liability to eliminate all forms of hospital liability for patient injuries under authorizing legislation. Thus, litigation over the extent to which such liability has been eliminated, with all its attendant costs, is likely to continue for some time under Health Plan enterprise liability.

All of these unnecessary administrative costs would be saved under delivery-based EML, because under this approach the hospital enterprise would bear all liability for both malpractice and other patient causes of action against the hospital. Consequently, the question of which forms of hospital liability had survived the adoption of EML would be rendered irrelevant, and the cost of litigating these questions would be saved.[9]

C. Quality Assurance and Injury Prevention

Hospitals and other enterprises that deliver care, such as day-surgery clinics, are the site of the vast majority of injuries resulting from medical malpractice.[10] These enterprises also are typically responsible for supplies, facilities, and equipment, and for almost all of the non-physician health-care providers involved in the delivery of care. Hospitals control resources and they grant and withdraw admitting privileges to physicians. The hospital consequently is best placed to make decisions about how to assure medical quality and prevent patient injury, by adjusting one or more of the factors that affect quality of care and injury. Moreover, hospitals—especially teaching hospitals—are in the best position to conduct serious research and development in the field of quality assurance. Finally, given their base of claims experience, hospitals are suitable vehicles for experience-rating malpractice insurance premiums or for use of self-insurance mechanisms, both of which generate far more injury prevention incentives than malpractice insurance purchased by individuals.[11]

It is no surprise, therefore, that most of the developments in quality assurance over the past decade have designated the hospital as both the focus of and the institution responsible for quality assurance,[12] and that common law developments in tort liability have been evolving toward greater and greater liability on the part of hospitals for malpractice that occurs under their auspices.[13] For all these reasons, hospitals and the other enterprises responsible for the actual delivery of care are the appropriate focus of EML.

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[9] In addition, as we explain below in Part II, under both our proposal and the SH&B proposal, the enterprises rendered liable in the first instance would be authorized in certain circumstances to shift liability by contract: under our approach hospitals could contract with Health Plans for the latter to bear liability, and under the SH&B approach the converse could occur. Since contracting is not costless, the extent to which liability shifting would occur under these models is highly relevant to the administrative costs that would be incurred under each. Because delivery-based liability is more nearly optimal than its alternatives, less liability-shifting would occur under this approach and correspondingly lower administrative costs would be incurred.

[10] Paul C. Weiler et al., A Measure of Malpractice 39 n. 11 (1991).

[11] *See* Weiler, *supra* note 1, at 78-80.

[12] *See, e.g.*, Emmett B. Keeler et al., *Hospital Characteristics and Quality of Care*, 268 JAMA 1709 (1992); Stephen Kritchevsky & Bryan P. Simmons, *Continuous Quality Improvement: Concepts and Applications for Physician Care*, 266 JAMA 1817 (1991).

[13] Diane M. Janulis & Alan D. Hornstein, *Damned If You Do, Damned If You Don't: Hospitals' Liability for Physicians' Malpractice*, 64 Neb. L. Rev. 689 (1985); Arthur F. Southwick, *Hospital Liability: Two Theories Have Been Merged*, 4 J. Leg. Med. 1 (1983).

HeinOnline -- 20 Am. J.L. & Med. 32 1994

II. THE UNCERTAIN CHARACTER OF HEALTH PLAN LIABILITY

The extent to which the SH&B proposal relies on an essentially new institution—the Health Plan ("HP")—to make EML work effectively is striking. HPs are the centerpiece of the Clinton Administration's proposed American Health Security Act.[14] But there is virtually no description of them in the Administration's 239 page September 1993 narrative "summary" of its proposal[15] and little in the actual legislation submitted to Congress.[16] SH&B are nearly as silent about the character of HPs. They simply say that over "the last two decades the marketplace has created an organizational unit that integrates the bearing of insurance risk with the provision of clinical services" and then cite to the Clinton proposal.[17]

Organizational units that integrate the bearing of insurance risk with the provision of clinical services, however, vary widely in their character. For example, some Health Maintenance Organizations and Preferred Provider Organizations are owned and operated by health insurers. In such cases the organization that would bear liability under the SH&B proposal would in essence be a financer of the delivery of health care rather than an actual deliverer of care. Although we would regard this form of enterprise liability as preferable to traditional individual liability for medical malpractice, it would nevertheless be less suitable than delivery-based EML whose advantages we explained in Part I.

A. The Deficiencies of Finance-Based EML

Adoption of an approach that would, in effect, be financing-based EML would tacitly reinforce the view that we rejected in first proposing the move away from individual liability. This traditional view is that at the heart of the medical injury problem is the individual carelessness of the isolated practitioner, rather than the organization, coordination, and technology of the health care system that delivers treatment to patients. Failure to focus liability on the enterprises that actually provide health care would preserve the separation of individual physicians from care-delivering institutions that has always characterized the malpractice litigation morality play — a play about whether a physician's "mistake" precipitated an adverse outcome for an unfortunate patient.

It is true that some of the Health Plans that have emerged in recent years are free-standing enterprises that are directly responsible for the delivery of health care. To the extent that these enterprises are integrated networks of individual providers and hospitals rather than commercial health insurers, imposing liability on them might serve the purposes of delivery-based EML. But at this point it is impossible to tell what form HPs will generally take under the Clinton proposal, even if the President's program is enacted in some form. Indeed, we can't be sure whether the HPs envisioned by that proposal will all look the same once they are actually in operation. SH&B implicitly acknowledge this uncertainty when they suggest that some HPs may not be immediately ready to undertake enterprise liability.[18]

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[14] *See* S. 1775, 103d Cong., 1st Sess., § 140 (1993) [hereinafter Health Security Act].

[15] *Clinton Administration Description of President's Health Care Reform Plan, "American Health Security Act of 1993,"* BNA, Special Supp., Sept. 13, 1993, at 74.

[16] Subtitle E of Title I of the Health Security Act, *supra* note 14, is labelled "Health Plans," but most of the provisions it contains pertain to other issues. The most direct description of a "Health Plan" in the entire Subtitle is the definition embodied in § 1400 indicating that the term means "a plan that provides the comprehensive benefit package that meets the requirements of parts 1, 3, and 4." Health Security Act, *supra* note 14, § 1400(a). In other words, a Health Plan is an entity that provides health benefits.

[17] Sage et al., *supra* note 3, at 10.

[18] Sage et al., *supra* note 3, at 25-26.

More importantly, in a system in which health care providers (including hospitals) will treat patients belonging to different Health Plans, the capacity of these Plans to coordinate their efforts at influencing the quality of care provided by these individuals and enterprises is likely to be very limited. Conceivably a Health Plan that furnished all of a single hospital's patient population could monitor that hospital's quality of care and suggest or demand improvements that would optimize quality and cost. In the world envisioned by SH&B and the Administration's proposed legislation, however, hospital patients could be insured by one of several different Plans. As a consequence, any given Health Plan would have only partial data about the quality of the hospital's performance. Coordination among Health Plans would thus be required to assure that they possessed complete data and did not make inconsistent demands regarding quality improvement goals and methods. We are not optimistic that a diversity of Health Plans will be able to act together to train consistent incentives on hospitals and other health care providers.

B. Getting the Best of Both Worlds with Delivery-Based EML

Even setting aside the foregoing deficiencies of finance-based EML as envisioned by SH&B, that approach has no greater potential than delivery-based EML to achieve the benefits SH&B enumerate. Given the way in which Health Plans are likely to operate, delivery-based EML could create incentives for the responsible enterprise to compare the costs of care with its benefits in much the same way that SH&B describe for Health Plans. No doubt if a Health Plan were made liable for both the costs of over-providing care and the malpractice-caused costs of under-providing or mis-providing care, such an enterprise would have the incentive to optimize these costs. But it does not follow, as SH&B imply it does,[19] that because hospitals and other delivery-based enterprises would automatically be liable under our approach only for the latter costs, defensive medicine (and other excesses) that occur under the current system of individual malpractice liability would continue. On the contrary, our approach has just as much potential to eliminate defensive medicine as does SH&B's.

SH&B assume that the incentive for HPs to optimize the quality of care provided to patients resulting from the payment to HPs of capitated premiums would be sacrificed by a delivery-based EML system. There is no reason, however, to make this assumption. It is entirely possible that Health Plans will find it in their interest to contract with hospitals and even individual physicians on a similar capitation basis. Thus, if a hospital found itself under contract with an HP to treat coronary patients for a specified dollar amount per patient, the hospital would have the same incentive as the HP to optimize the mix of treatment quality and cost. Hospitals subjected to enterprise liability would therefore bear the costs of both over-utilization and under- or mis-utilization, as SH&B elaborate. It is easy to envision such contractual relationships with hospitals under either system, since they currently exist in the form of Diagnosis Related Groups (DRG's) under Medicare[20] and in much managed care provided under private health insurance contracts.

At the same time, although SH&B's analysis can be as easily confirmed in our proposal as their own, that analysis is somewhat overdrawn. Neither approach can completely optimize the mix of health care overutilization and under- or mis-utilization. Under either proposal, the responsible enterprise does not internalize the full cost of under- or mis-utilization, because EML is imposed only for *malpractice-related*

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[19] *Id.* at 12.

[20] *See* Bruce C. Vladeck, *Medicare Hospital Payment By Diagnosis Related Groups*, 100 Annals of Internal Med. 576 (1984).

HeinOnline -- 20 Am. J.L. & Med. 34 1994

injury. The responsible enterprise will bear the health care costs of treating non-malpractice-related iatrogenic injury only to the extent that it is contractually obligated to do so,[21] and it will bear none of the other costs associated with such injury — e.g., wage loss and loss of life or its enjoyment. Thus, while SH&B's optimality thesis supports our EML version as much as it does theirs, the point is much weaker in either context than they surmise.

As our discussions with physician organizations have brought home to us, physicians are concerned that under either version of EML, "economic credentialing" will increase. Whether the HP or the hospital bears liability, the enterprise will have far more incentive than it now has to assure that affiliated physicians do not increase their malpractice burden. From the point of view of patients, the intended beneficiaries of medical liability, that is precisely the point. A different form of economic credentialing would, however, be reduced by adoption of delivery-based EML. To the extent that hospitals now credential physicians more because of their ability to fill beds with patients than to provide high quality treatment, adoption of EML will force hospitals to balance potential malpractice costs resulting from poorer patient care against the business-attracting capacity of their affiliated physicians.

In contrast, HPs dominated by insurance companies are much more likely than hospitals to feel and to give in to the attraction of pure economic credentialing. Although hospitals increasingly behave like businesses, their culture still is heavily influenced by the physicians who serve on their boards, maintain a separate power base in medical staff organizations, and interact frequently with management. Economic and quality credentialing are thus naturally contending forces even within for-profit hospitals. In contrast, HP management is likely to be physically and culturally separate from physicians and hospitals, and prone to view the HP mission in *exclusively* economic terms. Certainly that is less true of hospital executives who still conceive their mission as a blend of traditional medical service and modern economic considerations. Thence our concern about quality of patient care if HPs are tempted to use economic credentialing as a substitute for quality assurance through systematic attention to the patient injury problem.

III. A DEFAULT-RULE APPROACH TO DELIVERY BASED EML

Our preferred approach, then, is to impose liability on hospitals and similar enterprises whose raison d'etre is the delivery of health care, rather than on HPs whose predominant function is to finance care that is actually delivered by others. Of course, many HPs are contractually obligated to their insureds to provide care. However, if HPs fulfill this obligation by contracting with those who are actual health care providers, then the latter enterprises should bear legal responsibility for medical malpractice.

Nonetheless, we recognize that the enterprises that increasingly dominate the American health care scene are far from homogeneous. Both hospitals and HPs vary in their character and structure and will continue to do so. At the same time, the other enterprises that participate in the delivery of care are evolving, and may also be appropriate objects for the imposition of liability for medical malpractice. In general, delivery-based EML would best serve the objectives of modifying the traditional system of individual liability. But it would be imprudent, and probably impossible, to

[21] In the case of HP liability the HP would probably bear the medical costs of non-malpractice-related iatrogenic injury only until the patient became a member of a different HP, although conceivably a comprehensively-legislated approach would dictate that the first HP continue to bear these costs.

specify by inflexible rule the precise allocation of liability among the various enterprises that are to deliver health care now and in the future.

Instead, the best approach would be to use what the contract law literature labels the "default-rule" approach.[22] Enterprise liability would initially be imposed on hospitals, but contractual transfer of such EML would be permissible between hospitals and the other enterprises that deliver health care to patients. In the absence of such a contract, liability would remain with hospitals. Since hospitals will, more often than not, be the optimal enterprises to bear malpractice liability, this approach would minimize the cost of contracting. In the majority of cases where the hospital is in fact the optimal risk-bearer, no contracting costs would be incurred. However, in those situations in which some other enterprise would be a superior risk-bearer and risk-avoider, the initial allocation of tort liability could be shifted by contract to that other enterprise.

Thus, if certain HPs were sufficiently involved in the delivery of health care that they could more effectively manage the risk of patient injury and legal liability than could the hospitals where patients were being treated, the approach advocated by SH&B could then be adopted by contract. The hospital enterprises to whom liability was initially assigned would transfer that legal charge to HPs that found it in their economic interest to accept a tort burden in return for lower patient care charges to these HPs by their hospitals. In all probability, however, only those HPs that were sufficiently involved in the actual delivery of care to be able to control its quality directly would be willing to enter into such a liability exchange. We note that while SH&B enumerate at length what they view to be the advantages of HP liability, they also appear to be proposing a default-rule scheme that would entitle HPs to contract out of their liability by shifting it to hospitals or physician group practices.[23] But the costs of contracting under their proposal would far exceed the costs under ours, because for the foreseeable future hospitals are much more likely to be the appropriate vehicles for bearing EML. The default rule selection in a "market for liability" must reflect this comparative liability advantage.

IV. CONCLUSION

Of course, the proof of the pudding is in the eating, and the pudding whose recipe we are debating with SH&B has not even been cooked, let alone served. In situations such as this, policymakers must make their best estimate of the approach that will maximize the benefits of reform. We commend SH&B for their effort within the Health Care Task Force to see the concept of enterprise liability incorporated into the Administration's proposals, and we recognize the force of the arguments they marshal in favor of imposing liability on Health Plans. In the end, however, we must part company with them regarding the choice of the responsible enterprise. Hospitals and other enterprises that deliver care are much more likely than Health Plans to be the optimal bearers of liability for medical malpractice. Subject to the default-rule approach we have both endorsed, hospitals — still the major institution actually delivering health care to patients — should be the institutions responsible for patient injuries in a new regime of enterprise medical liability.

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[22] For discussions of the default-rule concept in contract law generally, see Jason S. Johnston, *Strategic Bargaining and the Economic Theory of Contract Bargaining Rules*, 100 YALE L.J. 615 (1990); Richard Craswell, *Contract Law, Default Rules, and the Philosophy of Promising*, 88 MICH. L. REV. 489 (1989); Charles J. Goetz & Robert E. Scott, *The Limits of Expanded Choice: Analysis of the Interactions Between Express and Implied Contract Terms*, 73 CAL. L. REV. 261 (1985).

[23] Sage et al., *supra* note 3 at 23, 25-26.

HeinOnline -- 20 Am. J.L. & Med. 36 1994