Medical Errors: Causes, Cures, and Capitalism

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MEDICAL ERRORS: CAUSES, CURES, AND CAPITALISM

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_He that will not apply new remedies must expect new evils._

-Benjamin Franklin

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I. INTRODUCTION

Expenditures for healthcare consumed over thirteen percent of the United States gross domestic product in 1998, totaling over $1.1 trillion dollars.² A recent Institute of Medicine (IOM) report estimated that the number of deaths attributable to medical

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errors in the U.S. was as high as 98,000. This number represented hospital deaths only. Undoubtedly, additional deaths and injuries occurred in the outpatient setting. Whether the IOM estimate was exaggerated or not, the larger issue is whether the overall healthcare industry is operating at an acceptable error rate. If the error rate is unacceptably high, then what should it be? Are there legal impediments to detecting, reporting, analyzing, and improving error rates?

This article explores the causes of medical error, the medical profession’s responses to errors, and how the legal system responds to medical error through litigation and legislation. Part II discusses the definition of “medical error,” the frequency and pervasiveness of the problem, and the causes at the individual and system level. Part III considers how the culture of medicine has largely failed to address medical errors as a systems-based problem, and how the legal culture discourages admitting errors due to the threat of litigation. Focusing on systems, data must be collected and analyzed, and legal guidelines developed to encourage error reporting and develop standards, preferably at the state level. Part IV examines how both the legal and medical cultures might be reformed in order to reduce the rate of medical error, which would promote the ultimate goal of better quality healthcare. Legal barriers against error reporting need to be removed and liability theories re-evaluated, with appropriate legislation to foster these changes. Part V discusses the role of economic incentives which promoted the current state of affairs, and how these forces might effectively be employed to shape medical, legal, and legislative responses to medical error. It is clear that if medical error rates are unacceptably high, new approaches by doctors, lawyers, patients, and legislators are needed.

II. ERROR CLASSIFICATION

A. What is Medical Error?

A Jehovah’s witness is given a blood products infusion to reduce her risk of bleeding. A seven-year-old-boy dies after receiving the wrong medication from an...
unlabelled cup on an operating room tray. In the first case, the patient is unharmed and unaware that her caregivers have violated her religion-based treatment refusal. In the second case, a child is dead, and a family is devastated. Are these medical errors? It seems intuitively clear that the second case is, but what about the first?

The term “error” suggests an unintentional act or omission. By logical extension, the term “medical error” suggests an unintentional act that is related to the practice of medicine. Patient death or injury is thus not required to meet this definition. Rather, it is sufficient that patient safety is inadvertently threatened, whether actual or potential, or that a patient’s refusal for service is not obeyed. Note that patient errors might also be included in this definition if, for example, a patient commits a mistake with medication that proper education could have prevented.

Excluded from this definition of medical error are willful, reckless, and intentional acts or omissions, because these are outside the scope of “inadventent.” Even though a reckless act or omission may be unintentional, it falls so far outside of the realm of a reasonable standard of due care that it is not mere negligence. Rather, recklessness implies an indifference equivalent to willful behavior. Examples of such recklessness might include a surgeon who operates while intoxicated, or a doctor who treats a condition for which he is not trained despite the availability of referral for more appropriate care. Res ipsa loquitur, however, is a policy-based legal doctrine which creates an inference of negligence (in many jurisdictions), and is reasonably viewed as within the definition of medical error.

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11 See Loeben, supra note 9, at 80.
12 See Voelker, supra note 10, at 1537-38.
13 Webster’s Third New Int’l Dictionary 771 (1971) defines error as:
   1a: an act or condition of often ignorant or imprudent deviation from a code or behavior… b: …an unintentional deviation from truth or accuracy… c: an act that through ignorance, deficiency, or accident departs from or fails to achieve what should be done…
   3: something produced by mistake…
   6: a deficiency or imperfection in structure or function: DEFECT.
14 See Liang, Promoting Patient Safety, supra note 8, at 542.
15 See id.
16 See id
17 See id
18 See id. Conduct on this level also includes intentional torts such as battery, and criminal acts. Liang, supra note 8.
20 See e.g., Johnson v. Kokemoor, 545 N.W.2d 495 (Wis. 1996) (finding physician negligent for performing operation he was not trained to do).
B. The Scope of the Problem

A recent report by the Institute of Medicine (IOM) estimated that between 44,000 and 98,000 patients die each year in the U.S. from medical errors. The IOM arrived at this number by extrapolation from previous studies in New York, Utah and Colorado. Other prior studies also showed a substantial risk of death from medical error.

The IOM report has been criticized for its methodological flaws, and for possibly overestimating the actual number of deaths caused by medical error. Alternatively, the IOM report has been criticized for study design flaws that may have resulted in an underestimate of deaths. Of note is that the IOM report’s number of deaths estimate was derived solely from data on hospitalized patients. Certainly, outpatients also die from medical error, though the number of deaths is uncertain.

Adverse events and outcomes occur in the absence of medical error, and it may be important to make methodological or semantic distinctions between adverse events and medical errors. Regardless of these technical concerns and of the criticism of the IOM report, medical errors do occur at some rate. The major premise of this discussion is that this rate is too high. Further, there is a subgroup of errors causing patient harm which is preventable. For example, in the Utah and Colorado study the cost of preventable adverse events was nearly half of the total

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22 See IOM Report, supra note 3, at 31.
23 See id. at 30-31 (citing Troyen A Brennan et al., Incidence of Adverse Events and Negligence in Hospitalized Patients: Results of the Harvard Medical Practice Study, 324 ENG. J. MED. 370 (1991), and Eric J. Thomas et al., Cost of Medical Injuries in Utah and Colorado, 36 INQUIRY 255 (1999)).
24 See e.g., David C. Classen et al., Adverse Drug Events in Hospitalized Patients, 277 JAMA 301 (1997)(finding that adverse drug events caused an almost two-fold increased risk of death); David P. Phillips et al., Increase in U.S. Medication-Error Deaths Between 1983 and 1993, 351 LANCET 643 (1998) (finding 2.57-fold increase in medication deaths).
25 See e.g., Troyan A. Brennan, The Institute of Medicine Report on Medical Errors—Could it Do Harm?, 342 N. ENG. J. MED. 1123 (2000)(arguing that hospital care is actually becoming safer, distinguishing terms adverse event and error, and criticizing IOM methodology); Clement J. McDonald et al., Deaths Due to Medical Errors are Exaggerated in Institute of Medicine Report, 284 JAMA 93 (2000) (criticizing IOM methodology).
26 See Lucian L. Leape, Institute of Medicine Figures are Not Exaggerated, 284 JAMA 95 (2000) (arguing that IOM report may have underestimated number of deaths).
28 See supra note 23. Comprehensive estimates for overall outpatient deaths due to medical error are not available. Medication error seems to be the most studied outpatient medical error.
29 See Brennan, supra note 25, at 1123-25.
30 See Bodenheimer, supra note 7, at 488 (1999) (discussing healthcare quality, comparison with other industries, and organizations for monitoring quality).
31 See id. at 488-89.
costs attributable to adverse events. The physician’s credo *primum non nocerum* ("first do no harm"), thus suggests that it is incumbent upon medical doctors to lead the effort to reduce medical errors.

**C. Errors Occur at the Level of the Individual**

If medical error creates potential harm to a patient, when does it occur during the delivery of healthcare? The answer is that it can occur at any stage of medical care. Despite the complexity of healthcare as a “system,” actual delivery of care operates at the individual level. Thus, the common denominator for all healthcare is a one-on-one interaction between a provider and a patient. It is this interpersonal dynamic which exposes or creates error potential at various stages, such as examination, testing, diagnostic theorizing, or treatment, to name a few. Since healthcare is delivered at the human level, medical errors are ultimately attributable to a person and not to an institution or system. This fact does not mean that legal liability for errors rests solely at the individual level, for clearly organizations and hospitals may be found liable for medical errors.

If the endpoint or baseline source for all medical error is at the provider-patient level, then what can be done about it? Both sides of the care delivery equation, patients and providers, want to reduce medical error rates to the lowest feasible level. A reduction in medical error rates would be cost-effective through more efficient resource allocation, and the quality of care would improve. However, there are undoubtedly members of the plaintiff bar who fear economic harm if medical error rates are substantially reduced. This latter group has an incentive to maintain the status quo, or to allow error rates to increase, in order to flourish. Therefore, it is not so straightforward to claim that reducing errors is a universal goal.

32See id.
33See Liang, *Promoting Patient Safety*, supra note 8, at 563.
34See IOM Report, supra note 3, at 35-36.
35See CHARLES VINCENT & BAS DE MOL, SAFETY IN MEDICINE 233 (2000).
36See id.
37See IOM Report, supra note 3, at 35-36. Author’s note: A “computer error” might be blamed for a medical mistake by an automatic dose delivery machine. Even here, though, error would likely be traceable to the human who designed, built, or programmed the machine, or entered incorrect patient data.
38See Liang, supra note 8, at 542.
39See e.g., Jones v. Chicago HMO Ltd. of Illinois, 730 N.E. 2d 278 (Ill. 2000) (holding HMO potentially liable for doctor’s negligence because HMO assigned excessive number of patients to the doctor).
40See Bodenheimer, supra note 7, at 490-92.
41See id.
43See id.
D. System Errors

Although errors are committed by individuals and affect only one patient at a time, the provider-patient interaction does not occur in a vacuum. This interaction is influenced by the environment, an external force which increases or decreases the chance for inevitable human error. This outside force, in the context of a medical errors discussion, is labeled a system. A system may be defined as, “a complex unity formed of many often diverse parts subject to a common plan or serving a common purpose.” Alternatively, a system is defined as “an organized or established procedure or method or the set of materials or appliances used to carry it out.

A healthcare system may thus be viewed as an environmental force which is complex, establishes procedures and methods, and serves a common purpose. Because this force exerts an influence on the patient-provider encounter, it is necessary to examine whether the healthcare system promotes or can prevent medical errors.

One caveat is required: Systems exist in many forms and sizes. In the medical context, for example, a system may be a single doctor’s office, an operating room, or a large network of hospitals.

Regardless of the size or complexity of a system, research has consistently shown human error can be accounted for, measured, and reduced through proper organization and methodology. Medical systems are often compared with other industries, particularly aviation and nuclear energy. Research shows systems in these other industries, through proper design and monitoring, share the potential to reduce the likelihood of mishap caused by human error. For example, aircraft
manufacturers assume human error will occur, so the planes are designed with automatic and redundant features that effectively buffer or absorb pilot error.\(^{55}\) Individual and system errors may be distinguished by labeling them as “active” and “latent,” respectively.\(^{56}\) Active errors occur at the individual operator level, and usually have more immediate effects.\(^{57}\) Latent errors are system-based potential errors: Potential meaning that they trigger or promote error.\(^{58}\) Latent errors are removed from individual control, and because they are unrecognized in a complex system, pose a greater threat to safety.\(^{59}\) A latent error in a complex system can promote multiple active errors before someone recognizes the system’s flaw.\(^{60}\) Unfortunately, for the patient who is injured or killed prior to that moment of flaw recognition, any system fixes come too late.

### III. MEDICAL AND LEGAL INFLUENCES

#### A. Pathology of the Medical Culture

Physicians are taught to be compulsive and to attend to detail, which is an inarguably desirable feature of their training.\(^{61}\) They are also taught that mistakes are caused by individual failure.\(^{62}\) My personal experience as a medical student and internal medicine resident was entirely consistent with these observations.\(^{63}\) The medical culture persists in propagating the myth that the appropriate standard of medical care is error free.\(^{64}\) Any failure to uphold this standard is viewed as an individual failure, and the doctor alone is viewed as culpable.\(^{65}\)

Rather than admit that perfection is an unrealistic standard, medical training and practice persist in demanding error free practice.\(^{66}\) This fosters what one commentator labels the “shame and blame” mentality of the medical culture toward medical error.\(^{67}\) Physicians are taught to feel shame for any mistake, and to accept

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\(^{55}\) See Leape, supra note 49, at 1855.

\(^{56}\) See IOM Report, supra note 3, at 55-56.

\(^{57}\) See id.


\(^{59}\) See IOM Report, supra note 3, at 55-56.

\(^{60}\) See id.

\(^{61}\) See Liang, Promoting Patient Safety, supra note 8, at 545.

\(^{62}\) See Bates & Gawande, supra note 58, at 763.

\(^{63}\) M.D., University of Miami, 1987; residency, University of Hawaii, 1987-1990; Board Certified, Internal Medicine, 1990.

\(^{64}\) See Leape, supra note 49, at 1852.

\(^{65}\) See Bates & Gawande, supra note 58, at 763.

\(^{66}\) See Leape, supra note 49, at 1852.

\(^{67}\) See Liang, Promoting Patient Safety, supra note 8, at 545.
the entire blame. In some instances this approach may be entirely appropriate. Some who attend medical school or enter residency training are simply not up to the job. Others, upon clearing the hurdles of training, commit overt malpractice and deserve to be blamed and punished. However, unyielding reliance on the reactive shame and blame approach, rather than attempting some degree of a proactive systems based approach, has been criticized for failing to adequately self-regulate the medical profession or reduce error rates. Further, the reactive approach probably has little or no effect on latent errors, because these are not consistently admitted or reported.

In clinical terms, the medical culture’s traditional focus on individual culpability for error is pathological in the sense that such a mentality flatly ignores a reality that doctors are themselves clearly aware of: Humans make mistakes, and this includes doctors! If a patient so adamantly denied this reality despite objective evidence to the contrary, his doctor would diagnose him as having insane delusions. Also, the provider’s fear of blame and guilt for errors provides a disincentive to be forthright. The fear of being sued is a major deterrent to admitting or reporting errors. Loss of hospital privileges or insurance contracts, or sanctioning by medical boards provide additional disincentives to admit error. Thus, while no physician can objectively deny that errors happen to them or their colleagues, the culture of medicine exists in a state of suspended disbelief.

Although personal accountability is a desirable norm for any professional, the medical culture has traditionally overemphasized individual culpability at the expense of failure to truly explore the alternative explanations or mechanisms which promote error. Not until fairly recently has the medical culture realized that systems play a substantial, if not preeminent, role in promoting medical errors. This is a step in the right direction. The sad irony of the traditional approach is that it ignores fundamental medical diagnostics and treatment philosophy. Diseases are the underlying cause of symptoms, so find and fix the former to cure the latter. How many more patients must die due to faulty systems before the primum non nocerum clause is triggered?

68See id.

69See Joan Vogel & Richard Delgado, To Tell the Truth: Physicians’ Duty to Disclose Medical Mistakes, 28 UCLA L. Rev. 52, 58-59 (1980).

70See Voelker, supra note 10, at 1537-38.

71See id.


73See Jeffrey Ghannam, Goal to Reduce Medical Errors is Fraught With Difficulty, 86 A.B.A. J. 88 (2000); David Orentlicher, Medical Malpractice: Treating the Causes Instead of the Symptoms, 28 MED CARE 247, 247-49 (2000).

74See Leape et al., Preventing Medical Error, supra note 52, at 1444.

75See id.

76See VINCENT & DE MOL, supra note 35, at 70.

77See Voelker, supra note 10, at 1537-38 and, Leape, supra note 49, at 1852.
B. Legal Disincentives Error Reporting

Similar to the way the environmental forces of systems influence the endpoint provider-patient error rate, the medical profession’s perceived “wall of silence” does not arise in isolation from factors external to medicine. Aside from shame or guilt, physicians are reluctant to admit errors because of the perceived threat of litigation or other sanctions. Whether this threat is real or imaginary, the legal culture is a contributing cause of physicians’ reluctance to admit errors. Traditional malpractice claims for negligence, and the discoverability of voluntarily reported error data are the two primary sources of this reluctance. This section explores these roadblocks to error reporting or error-rate reduction attempts.

The concept of medical malpractice was described in Sir William Blackstone’s Commentaries on the Laws of England in 1768. In the United States, medical malpractice claims were uncommon until the mid-1800s. The rise in claims in that era paralleled the development of more standardized medical practice and education, and the use of innovative techniques by physicians. In response to the threat of suits, many physicians could purchase malpractice insurance by the end of the nineteenth century. Ironically, as innovation and standardization improved medical knowledge and quality, there arose identifiable “standards” of care which plaintiffs could allege were breached as the basis for a negligence claim. Also, the presence of liability insurance made physicians more desirable targets for plaintiff’s lawyers, a feature which persists in the current malpractice system.

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78 See Vogel & Delgado, supra note 69, at 52-54.
80 See id. at 1742-43; Liang, Promoting Patient Safety, supra note 8, at 555-59. Other sanctions affect government contracts, hospital privileges, or medical licensure. See Gostin, supra note 79, at 1742-43.
81 See Jeffrey Ghannam, supra note 73, at 88.
82 See id.
84 See Mohr, supra note 83, at 1731-43. According to Mohr, the social factors which promoted the rise of malpractice litigation included Americans’ less religiously fatalistic attitude about personal health, and the lack of government or self-regulation of medical practice. See id.
85 See id. at 1735-37.
86 See id. at 1736-37.
87 See id.
88 See Mohr, supra note 83, at 1731-43.
Two major goals of medical malpractice litigation are to compensate negligently injured patients, and to deter negligent behavior. Unfortunately, the present legal system is a very inefficient and inaccurate means of promoting these goals. Only a small percentage of injured patients actually attempt to sue their doctors. Many victims of medical negligence simply fail to realize that they were wrongfully injured, and fail to seek legal redress. Conversely, other patients who have adverse or suboptimal outcomes not caused by negligence file suit against their providers.

The legal system’s failure to consistently promote and enforce the injury-compensation and deterrence policies of medical negligence actions has thus failed to provide clear guidance to the medical community. One message is that if a doctor is negligent, he probably won’t be sued. The concurrent message is that providing non-negligent care is not clearly a shield from patients at least attempting to sue. Therefore, negligent practitioners are neither effectively punished nor deterred, and the more careful physicians are randomly punished in spite of their diligence.

As a result of the apparent randomness of negligence liability, doctors are faced with a disincentive to report medical errors. Additionally, the threat of litigation promotes defensive medical practices. Extra tests, procedures, and therapies are recommended by doctors in an attempt to avoid gaps where plaintiffs’ lawyers may

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89 See Troyen A. Brennan, Medical Malpractice Reform-The Long View, 11 J. CLIN. ANES. 265 (1999). A third social function of the tort system is to provide corrective justice, but this is “impossible to measure.” See id.

90 See id. at 265.

91 See Orentlicher, supra note 73, at 248. Indigent patients are the least likely to sue, though they are the patients most in need of compensation for injury. See id.

92 See Vogel & Delgado, supra note 69, at 56-57. With the prevalence of personal injury attorney advertising, patients today are probably more aware of their legal counseling options.

93 See e.g., Orentlicher, supra note 73, at 248 (stating that “most lawsuits are filed in the absence of negligence.” However, this is probably a reflection of patients’, rather than attorneys’, misperception of whether negligence occurred. Thus, even diligent pre-suit screening by attorneys does not adequately prevent such claims); Paul Weiler, The Case for No-Fault Medical Liability, 52 MBO. L. REV. 908, 913 (1993) (claiming lawyers have difficulty deciding whether to file a claim).


95 See e.g., Weiler, supra note 93, at 912-13 (finding only one-in-three likelihood of malpractice claims being paid to victims of serious injury caused by negligence).

96 See Liang, The Legal System and Patient Safety, supra note 94, at 609.

97 There is also undoubtedly what I would call a “hassle factor” threshold. This is the point where a non-negligent (from the physician’s viewpoint) physician is willing to settle a claim for an amount of money that represents the value of closure and ending the personal distress of litigation.

98 See Leape et al., supra note 52, at 1447.

99 See Weiler, supra note 93, at 916-17.
seek to establish a foothold. These defensive practices are costly in both economic and human terms. One study estimated the cost of defensive medicine at $18 billion annually. Aside from this economic waste, the mass effect of defensive medicine increases the risk of medical errors which result in patient injury. Thus, the legal system, or at least medicine’s reaction to it, has a causative role in the medical error rate. Also, malpractice insurers seem satisfied with the status quo, because of the actuarial stability it provides, as long as the insurers retain their ability to refuse coverage of high risk doctors.

Reducing medical errors should result in higher quality and more cost-effective care. The first step toward this end is error disclosure, and therein lies the rub. Given the already unpredictable nature of the medical malpractice tort process, doctors are unwilling to voluntarily disclose their errors for fear of discovery by plaintiffs. Admitting error so that it may be used against you is either foolish or masochistic. It’s tantamount to giving aid and comfort to the enemy. Although state laws may immunize certain mandated quality assurance monitoring or peer review processes from liability, they do not always protect the information from discovery. The information from these programs may be discoverable by plaintiffs under the traditional Hickman v. Taylor substantial need and undue hardship test. Also, reporting the information to third parties, such as consultants, private and federal quality monitoring agencies, or in cases tried in federal courts, immunity may not apply. Hence, absent better assurance that error disclosure will not be discovered by plaintiffs, the medical community remains reluctant to volunteer this information.

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100 See id., and, Liang, The Legal System and Patient Safety, supra note 94, at 610.
101 See Weiler, supra note 93, at 916-17.
102 See Liang, The Legal System and Patient Safety, supra note 94, at 610.
103 See Brennan, supra note 89, at 266.
104 See Liang, Promoting Patient Safety, supra note 8, at 55-59.
105 See e.g., FLA. STAT. § 395.0197(1) (2000) (requiring all licensed hospitals to establish an internal risk management program); MASS. ANN. LAWS ch.111, § 203(d) (West 2000)(same). These statutes provide for immunity of risk management data from discovery.
107 See Liang, supra note 8, at 55-59 and nn. 53-61.
108 See supra notes 90-98 and accompanying text.
IV. CURES FOR MEDICAL ERRORS

A. Adopt a Systems Approach

If medical errors are not being reduced by the traditional tort system, and individual physicians are operating at a level of efficiency that still produces an unacceptable error rate, then a new model for error reduction is necessary. This model, as previously mentioned, is the systems approach. The medical community has become increasingly aware of the need for such an approach, through studies of human error psychology and by examining other high-risk industries.

The medical profession, upon admitting its awareness of the systems-based influences and causes of medical error, is ethically compelled to pursue this approach if public opinion is to continue to grant physicians a foothold on the moral high ground. Despite obstacles, including the threat of litigation, the duty owed to patients is paramount. Besides, it would be foolish, and overtly self-destructive, if medicine waits until forces entirely outside of the profession dictate the terms of this endeavor. Medicine’s limited remaining capacity to self-regulate would evaporate. If nothing else, a better approach to reducing errors, and a good faith effort to implement this approach, is a matter of self-preservation.

Ironically, the threat of litigation has already led to some progress by medicine to incorporate a systems-based approach. In response to the rising malpractice insurance costs of the 1980s, the field of anesthesiology became a pioneer in the application of the systems approach to medical error reduction. By assessing the systems in which anesthesiologists delivered care, and implementing technological advances, the mortality rate from anesthesia was reduced by over ten-fold. The anesthesiology field’s success was attributable to improved information strategies, development of practice guidelines and standards, human factors evaluation, strong leadership, and a multidisciplinary approach. Extending this approach to other areas of medicine appears worthwhile, with adjustments and fine tuning for outpatient and individual provider settings.

109 See Bodenheimer, supra note 7, at 490-92.
110 See Liang, Promoting Patient Safety, supra note 8, at 544-45.
111 See id.; IOM Report, supra note 3, at 56.
112 Id. at 71-75; Leape, supra note 49, at 1854-55.
113 See Bates & Gawande, supra note 58, at 765-66.
114 See id.; Leape, supra note 49, at 1851.
115 Id. at 1856; IOM Report, supra note 3, at 164.
116 See IOM Report, supra note 3, at 164 (citing anesthesiology study where anesthesia mortality was reduced from one in 10,000 to 20,000 to less than one in 200,000 through the use of monitoring devices).
117 See id. at 144-45.
118 See Bodenheimer, supra note 7, at 491-92; Liang, Promoting Patient Safety, supra note 8, at 561-62; Leape, supra note 49, at 1856; IOM Report, supra note 3, at 173-74.
Leading medical and legal commentators have called for a systems approach to medicine which is modeled after those used in aviation and nuclear energy. These complex, high-risk industries have studied the causes of human error, and have implemented systems which reduce the influence of human imperfection. The common feature in these systems is that they expect and anticipate human error, and thereby integrate their systems to accommodate this reality. Given the complexity and variety of settings for healthcare delivery, there is no one size fits all approach. However, with some innovative thinking, leadership, and grassroots commitment, medicine can address the systems flaws it now is beginning to acknowledge.

B. Collect the Data and Encourage Error Reporting

Medical error reduction could lessen the unpredictability of the tort system by increasing the overall quality of care. Less patients will be injured, shrinking the pool of potential plaintiffs. To effect this change, errors need to be studied, which can only happen if they are more comprehensively reported. The ideal error detection-prevention process should: 1) identify errors by individual providers practicing substandard care, 2) identify deficiencies which increase the risk of error by providers within a system, 3) establish methods to reduce errors in both contexts, and 4) provide legal safeguards and market incentives for voluntary error reporting.

Licensing of individual physicians occurs at the state level. In the 1889 decision Dent v. West Virginia, the U.S. Supreme Court endorsed this system as proper to ensure that physicians had the “requisite qualifications” to practice medicine. In 1986, the Health Care Quality Improvement Act established the National Practitioner Data Bank (NPDB). The NPDB stores information about individual provider malpractice claims and decisions affecting clinical privileges. This information is used for credentialing and licensing purposes, and is protected from discovery by plaintiffs’ attorneys. Also, at the state level, statutes may require reporting of some adverse patient events. Together with traditional tort liability, state laws, licensing boards, and the NPDB provide checks on physician errors. However, they are post facto reactive checks that do not systematically address error types and

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120 See id. at 162-65.
121 See id.
124 129 U.S. 114, 123 (1889).
125 See id.
127 See IOM Report, supra note 3, at 121-22.
128 See id. at 122.
129 See e.g., FLA. STAT. § 458.351 (requiring physician reporting of “adverse incidents,” such as patient death or surgical complications).
causes, offering only the threat of punishment, which serves as a disincentive to voluntary error reporting.

A healthcare system can be virtually any level of complexity, but for the purposes of this analysis, the hospital will be considered as the standard example. Though no two hospitals are identical, and each department in a hospital represents a system within a system, they share some common features. Hospitals are accredited for the most part by the private, not-for-profit Joint Commission on Accreditation of Healthcare Organizations (JCAHO). Though JCAHO is a private entity, Medicare and many states require JCAHO accreditation as a condition of facility licensure or certification. JCAHO has a "sentinel event" policy which requires facilities to report certain bad outcomes. Hospitals are also commonly required by state statute to have an internal risk management program to investigate adverse patient incidents, and develop quality control and improvement programs. Thus, in the hospital context, there is at least some effort to identify and correct system errors.

A more sophisticated approach is needed for detecting errors in both office and hospital settings, though. Many proposals exist for collecting and analyzing this data in a way that will provide meaningful insight into the causes of individual and systems-based errors. One suggestion is for a “patient safety center” under the auspices of the National Institutes of Health. Under this proposal, error reporting by physicians and institutions would be mandatory, yet non-punitive unless errors are not reported as required. The data would be reported to a neutral third party which lacks sanctioning ability, similar to the Aviation Safety Reporting System.

130 For example, a large outpatient group practice has systems elements, such as practice protocols, nursing guidelines, or a central pharmacy, to name a few. Arguably, even a solo practitioner performs under a system, because he or she develops standardized approaches to common problems, approaches which may promote error if the approaches have latent defects.

131 Managed care organizations such as HMOs are accredited by the National Committee on Quality Assurance (NCQA), a private organization. See www.ncqa.org.


133 See Fla. STAT. § 395.0161. For example, Florida allows JCAHO accreditation in lieu of state periodic inspection.


135 See e.g., Fla. STAT. § 395.0197 (providing for, “a) the investigation and analysis of the frequency and causes of general categories of specific types of adverse incidents to patients.” and “b) the development of appropriate measures to minimize the risk of adverse incidents to patients. . .”).

136 See e.g., Timothy Stoltzfus Jost, Oversight of the Quality of Medical Care: Regulation, Management, or the Market, 37 ARIZ. L. REV. 825, 861-62 (1995) (suggesting that medical license boards have little effect on error rates).

137 See Liang, Promoting Patient Safety, supra note 8, at 561-62.

138 See id. at 561-64.
Other proposals include data collection by the National Patient Safety Foundation, or a federally funded Center for Quality Improvement in Patient Safety.

Assuming that a data collection center is established, one problem that the data collectors will have is deciding what data to gather. This is a technical issue beyond the scope of this paper. It is sufficient to note that merely collecting the data is a daunting task, subject to abstraction and interpretation bias.

Another concern with mandatory error reporting is liability exposure. Threatening to punish reporting failures may have some coercive influence, but does not efficiently promote the ultimate goal of simply obtaining the errors information for analysis and systems improvements. Fully anonymous reporting might provide raw data, but would not lead consistently to corrective measures at specific sites, because only widespread problems would be addressable. In the absence of anonymity then, what should be done to promote error disclosure information which is more useful to address problems at specific sites?

Granting liability immunity to those who provide error data is one solution. Many states already grant immunity to peer review and utilization review organizations. As noted earlier, such immunity does not extend to “administrative information,” such as certain safety data. For example, in *State ex rel. United Hospital v. Bedell,* the West Virginia Supreme Court held that a hospital’s incident report, made after a patient was injured in the hospital, was not immune from

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139 See id. at 561-62. The ASRS collects data and provides it to NASA rather than the FAA. Bypassing the FAA, which has the authority to sanction pilots and carriers, promotes voluntary error reporting. See id.

140 See Bodenheimer, supra note 7, at 490. The National Patient Safety Foundation was established in 1997 by the American Medical Association, and focuses on systems’ relations to medical errors. See id.


142 See UNDERSTANDING HEALTH OUTCOMES RESEARCH 214-217 (Robert L. Kane ed., 1997).

143 See Jost, supra note 136, at 851-54, for an in-depth discussion of these technical issues.

144 See id.

145 See Liang, Promoting Patient Safety, supra note 8, at 562-64.

146 See id. Professor Liang suggests federal legislation to protect “all safety analysis in continuous and ongoing safety programs.” He emphasizes that immunity is conditioned upon the provider’s making actual use of the collected data. See id.


148 See Liang, Promoting Patient Safety, supra note 8, at 556.

discovery because it was not a document prepared in anticipation of litigation.\textsuperscript{150} Other limitations on immunity may include the reports of peer review panels\textsuperscript{151} or information disclosed to third parties.\textsuperscript{152} If states wish to encourage error reporting, legislators may wish to extend immunity privileges to error data collecting activities. However, even if full immunity is not granted, some error data should be reportable without fear of litigation, such as when there has been no actual patient harm.\textsuperscript{153}

Instead of reporting medical errors directly to a national databank, I propose a different approach which is market-based and operates principally at the state level. A national databank would be unlikely to account for regional practice differences, and the solutions proposed would be aimed at a national lowest common denominator. It is preferable to collect data at the state level, where accountability and flexibility are more immediate.\textsuperscript{154} This would allow a variety of approaches, and states which evolve desirable systems more rapidly than other states could serve as models.\textsuperscript{155} State legislatures, insurers, regulators, and professional organizations could look to these leading states and incorporate reporting systems features most desirable for their own state. Market forces, such as funding decisions and insurance rates, would provide incentives not to be a laggard state. Similarly, states would also decide immunity issues for themselves. The data collected could still be passed on to a national databank, which could assess the data and make further recommendations.\textsuperscript{156} Rather than being used as a justification for new federal legislation, these recommendations could be used by market actors to provide incentives for states to evolve their own data collection process. In this way, desirable market forces and state autonomy would be preserved.

Instead of creating yet another federal bureaucracy,\textsuperscript{157} with all of the attendant inefficiencies, funding decisions for medical errors data collection and analysis, should occur using private resources at the state level. However, I do not suggest a state bureaucracy instead of a federal one. The data should be collected by a private company, which need not be confined to a state’s borders. The private company

\textsuperscript{150}See id.

\textsuperscript{151}See Bayfront Medical Center v. State, 741 So.2d 1226,1229 (Fla. Dist. Ct. App. 1999) (finding report of peer review process not privileged, though records of peer review process were) (emph. added).

\textsuperscript{152}See Liang, Promoting Patient Safety, supra note 8, at 557. “Nonhospital information” is, for example, information generated by the use of an outside safety expert. See id.


\textsuperscript{154}Florida established a Health Information Systems Council consisting of “executive-level managers for the state’s health-related entities.” See FLA. STAT. § 381.90(1) (2001). Minnesota law established a “[h]ealth outcomes data” collection process. See MINN. STAT. ANN. § 62J.301(a) (West 1996).

\textsuperscript{155}See e.g., Representative Jim Slatterly and Janet Murguia, The Role of the States in Health Care Reform, 3 KAN. J.L. & PUB. POL’Y 156, 161 (1993-94) (concluding that states are better able to implement healthcare reform measures than the federal government).

\textsuperscript{156}See supra notes 134-38, and accompanying text.

\textsuperscript{157}See id.
could contract directly with providers, who would incorporate the cost of collecting data into the cost of doing business. The state could allow one or more such private entities to collect the data along specified parameters, and then report their findings directly to the state.\footnote{An existing element of the state government, such as the Department of Health, could receive the data reports. The state could follow the recommendations of the private analysts, or formulate its own recommendations. The state’s role would be mainly that of oversight, which would not require much, if any, additional manpower.} Such a system would be cost-effective through the avoidance of fines and sanctions for failing to report errors, and ultimately through actual error reduction which results in lower liability insurance and litigation costs. Any void in the market which presently exists for a private errors data collecting entity will be more efficiently filled by a private information technology company than by a new government bureaucracy, and market competition would promote efficiency and results.

C. Standards of Care and the Use of Practice Guidelines

If a systems approach is adopted, and data collected, there remains the problem of how best to use the information in order to reduce errors. It may appear obvious that errors will decrease by applying the best known practices to each patient.\footnote{See Charles Marwick, Will Evidence-Based Practice Help Span Gulf Between Medicine and Law?, 283 JAMA 2775, 2776 (2000).} However, medicine is less well suited for standardization than certain purely mechanical tasks, because of individual patient diversity and complexity.\footnote{See id. at 2776. “Evidence-based medicine in practice defines the likelihood of something happening. It is never 100 percent. . . . the same evidence applied in one case may not apply in another. The circumstances of the individual patient may be different, or the circumstances may be the same, but patients may refuse one treatment in favor of another.”} Also, many medical problems can be successfully treated in more than one way, which suggests there is not always a ready applicable “best” method for a given patient or problem.\footnote{See Arnold J. Rosoff, Legal Implications of Clinical Practice Guidelines in Emergency Medicine, in LEGAL MEDICINE 1, 7 & n.11 (Cyril H. Wecht ed., 1995) (discussing “respectable minority” practice variations).} In spite of these difficulties, some standardization of medicine is possible to reduce patient risk. Clinical practice guidelines (CPGs) have thus emerged, and are developed continuously, with an emphasis on scientific evidentiary support.\footnote{See IOM Report, supra note 3, at 32 (citing anesthesia’s success in reducing operative mortality through the use of practice guidelines) available at http://books.rap.edu/books0309068371/html/.} This section discusses how these guidelines affect the legal standard of care.

Traditionally, the legal standard for medical negligence was based on the local practice custom established by the medical community.\footnote{Examples include the American Medical Association’s CLINICAL PRACTICE GUIDELINES DIRECTORY (1999) and the National Guidelines Clearinghouse’s website, available at www.guideline.gov.} As medical knowledge
and sophistication evolved, so did the legal standard in two main ways. First, a national standard of care applies to doctors practicing anywhere in the country, with some variation allowed to account for urban versus rural settings and resource availability. Second, regardless of a particular community’s customs, the objective standard of “skill and knowledge normally possessed by members of that profession in good standing in similar communities” applies. This objective standard may at times serve as a basis to impugn an industry-wide practice as negligent. A striking example was the Washington Supreme Court’s ruling in \textit{Helling v. Carey}, which declared that failure to screen a young patient for glaucoma was negligence, even though it was not usual practice for eye doctors to perform screening at that age. Thus, the law has forced medical standards of care to evolve, because the standard of care is ultimately a legal, rather than a medical, question.

Perhaps partly as a response to the law, medicine at the dawn of the 21st century is attempting to systematize and objectify standards of care through the establishment of CPGs based on scientific evidence. The Institute of Medicine defines CPGs as “systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances.” CPGs are generally developed by academic leaders and authoritative bodies for particular medical specialties. CPGs were initially promulgated as a quality improvement tool, but have also become cost-containment devices. Whether used to improve quality or lower costs, or both, a strong emphasis on evidence based medicine (EBM) is stressed as an underpinning for all CPGs. It is believed that a

\footnotesize{165}See \textit{Hall v. Hilbun}, 466 So.2d 856, 879 (Miss. 1985) (allowing out of state physician expert witnesses to testify regarding standard of care in Mississippi, so long as the experts were made familiar with with the local “facilities, equipment, personnel and general medical resources available”).

\footnotesize{166}Restatement (Second) of Torts § 299A, cmt. g (1965).

\footnotesize{167}519 P.2d 981 (Wash. 1974).

\footnotesize{168}See id. at 984. The Washington Supreme Court subsequently held that the state legislature intended to abolish the \textit{Helling} rule in \textit{Wash. Rev. Code} § 4.24.290 (1975). See Gates v. Jensen, 579 P.2d 374, 376 (Wash. 1978) (re-imposing traditional standard of “that degree of skill, care, and learning possessed by other persons in the same profession.”).

\footnotesize{169}See Rosoff, \textit{supra} note 161, at n.11.

\footnotesize{170}See AMA Clinical Practice Guidelines, \textit{supra} note 163.

\footnotesize{171}Institute of Medicine, Clinical Practice Guidelines: Directions for a New Program 8 (Marilyn J. Field & Kathleen N. Lohr eds., 1990).

\footnotesize{172}For example, CPGs have been promulgated by the American Colleges of Cardiology, of Pediatrics, and of Obstetrics and Gynecology. See IOM Report, \textit{supra} note 2, at 145-46.


\footnotesize{174}See e.g., Gordon H. Guyatt \textit{et al.}, Evidence Based Medicine: Principles for Applying the User’s Guide to Patient Care, 284 JAMA 1290, 1295 (2000) (discussing need for evidence data gathering to improve practice guideline development).
strong scientific evidentiary basis for CPGs will promote broader applicability and acceptance by practitioners in a variety of clinical settings.\textsuperscript{175}

In theory, well designed and widely followed CPGs will reduce medical error through better overall practice quality.\textsuperscript{176} However, the potential or actual use of CPGs as the legal standard of care in negligence actions has caused doctors to hesitate in accepting them.\textsuperscript{177} One solution to reduce physician apprehension is to allow CPG use as purely exculpatory evidence in a malpractice suit.\textsuperscript{178} Maine and Kentucky have enacted statutes which adopt this approach, at least to some degree.\textsuperscript{179} Ironically, such an approach may serve to reduce already low compliance with CPGs, because plaintiffs would not be able to introduce evidence of noncompliance.\textsuperscript{180} Thus, if CPGs are to function as effective error reduction mechanisms, they must be widely followed by doctors, so it may be important to allow plaintiffs to introduce evidence of CPG noncompliance.\textsuperscript{181} However, a catch-22 situation could result if the law encourages compliance with guidelines as a presumptive standard of care, since the more widespread the use of CPGs becomes, the more they can be used against providers, irrespective of the broader quality of care effects of a given CPG.\textsuperscript{182} In this respect, physician reluctance to accept CPGs is rational.

The goal of this discussion of CPGs is to emphasize caution by courts and legislators in adopting CPGs as legal standards of care. Medical errors will be

\textsuperscript{175}See id. But see John D. Ayres, The Use and Abuse of Medical Practice Guidelines, 15 J. LEGAL MED. 421 (1999). Ayres states that “the strength of the scientific data and expert judgment should be made explicit in the guideline.” See id. at 427. Further, he argues that guidelines may be no more authoritative than text books or learned treatises, and that guidelines often address controlled environments, like operating rooms. Also guidelines may be biased toward academic practice settings, failing to account for differences between urban and rural settings, and that guidelines are often outdated by the time they are published. See id. at 427-32.

\textsuperscript{176}See IOM Report, supra note 2, at 135-36.

\textsuperscript{177}See Rosoff, supra note 161, at 2. Rosoff cites other reasons besides litigation concerns which impact physicians’ acceptance of CPGs, including the fact that “doctors have been wary of “cookbook medicine” and, in general, any attempt to reduce complex professional judgments to standardized formulas. . .[CPGs] would tend to undermine professional autonomy,” and physicians’ perception that “third party payers will use them to deny payment for care that doctors believe should be provided to their patients.” See id.


\textsuperscript{179}See e.g., ME. REV. STAT. ANN. Title 24, § 2975 (West 1999) (restricting use of practice parameter compliance evidence to affirmative defenses by doctors or their employers); KY. REV. STAT. ANN. § 342.035(8)(b) (Michie 1999) (creating presumption that standard of care met by adherence to practice guidelines).

\textsuperscript{180}See Hyams, supra note 178, at 292.

\textsuperscript{181}See id. at 292-304.

\textsuperscript{182}See Wendy K. Mariner, Outcomes Assessment in Health Care Reform: Promise and Limitations, 20 AM. J.L. & MED. 37, 57 (1994) (expressing concern that guidelines “may inappropriately or inadvertently reduce the quality of care”) (emphasis added).
reduced by widespread application of what actually works best for a particular clinical scenario. However, blind adherence to CPGs may actually promote medical errors. CPGs must be developed with some inherent flexibility to allow for specific resource limitations, practice style differences, and individual patient variables and preferences. A per se approach that CPG conformity is not malpractice may unfairly prevent recovery by a patient who is injured by a physician’s negligent adherence to a CPG. Conversely, overly rigid CPGs might expose a doctor to liability when the reasonable and prudent approach is to not follow a CPG. A more workable legal approach is to incorporate CPGs as admissible evidence or as burden shifting devices in malpractice actions.

D. Enterprise Liability

If liability risks deter error reporting by physicians, perhaps the law can alleviate this concern. As individual practitioner liability laws have evolved, so has the law with respect to insurers and hospitals. Physicians have traditionally been the primary target of malpractice actions. Until the 1950s, hospitals were legally protected under the doctrine of charitable immunity, and doctors were usually viewed as independent contractors rather than agents or employees of the hospital. Insurers were also insulated by the system of fee-for-service retrospective payment, because they were not actively involved in patient treatment decisions. For various policy and economic reasons, the law began to accept hospital and insurer vicarious or direct liability theories to allow plaintiff recovery in malpractice cases. This section discusses these theories using the term “Enterprise Liability (EL)” to encompass hospitals, insurers, and managed care and health maintenance organizations (MCOs, HMOs).

183See Rosoff, supra note 161, at 2.

184See Ayres, supra note 175, at 442 (stating “[i]n some situations, adhering to guideline recommendations might increase the risk of an unfavorable clinical outcome.”).

185See Rosoff, supra note 161, at 381 (describing “respectable minority” practice variations).

186See id.

187See id. at 425.

188See supra note 179.


191See Abraham and Weiler, supra note 189, at 394-96. Insurers became more active participants in healthcare decisions under prospective payment systems, such as diagnosis-related groups (DRGs), implemented by Medicare in Private insurers, especially managed care, have followed suit with prospective payment systems. See id.

192See FURROW, supra note 190, at 238-44.
Enterprise liability is not a novel concept. Rather, it is derived from the theory of *respondeat superior*, a policy-based tort theory which shifts the risk of liability to a company for the acts of its workers acting within their scope of duty.\textsuperscript{193} The policy is based on the assumption that it is better to have companies insure consumers and others against losses than for potential tort victims to self-insure.\textsuperscript{194} The theory expanded to apply in the products liability context.\textsuperscript{195} EL has been extended to the medical malpractice context, albeit less thoroughly.\textsuperscript{196} Vicarious liability is straightforward when a provider is an employee of a health plan or hospital, but when the provider is an independent contractor, EL generally rests upon how much control the enterprise exerted in a particular clinical situation.\textsuperscript{197} Thus, if a hospital or other entity directly controlled a clinical decision,\textsuperscript{198} or owned and operated particular equipment,\textsuperscript{199} a plaintiff may have a viable EL claim. Also, EL may apply where a patient reasonably perceives and relies upon an apparent agency relationship between the provider and enterprise.\textsuperscript{200}

Besides vicarious liability, an enterprise may be directly liable for negligence. Mere cost-saving attempts are not negligent, as noted this year by the Supreme Court in *Pegram v. Hedrich*.\textsuperscript{201} However, an institution may be directly liable for failure to follow established protocols to provide an acceptable standard of care. For example, the Illinois Supreme Court held in *Jones v. Chicago HMO*\textsuperscript{202} that an HMO may be liable for enrolling too many patients with a single doctor.\textsuperscript{203} There is considerable jurisdictional variation in applying EL legal standards, though. State statutes may

\textsuperscript{193}See Abraham & Weiler, supra note 189, at 383-84.


\textsuperscript{195}See Priest, supra note 194, at 1535 (citing Greenman v. Yuba Power Products, 377 P.2d 897 (Cal. 1963) as a landmark decision applying enterprise liability).

\textsuperscript{196}See Abraham & Weiler, supra note 189, at 383-84.

\textsuperscript{197}See FURROW, supra note 190, at 240-45.

\textsuperscript{198}See e.g., Berel v. HCA Health Servs., 881 S.W.2d 21 (Tex. App. 1994) (controlling details of provider’s practice decisions could create EL).

\textsuperscript{199}This is known as the “inherent function test.” See FURROW, supra note 190, at 250-51 (citing Beeck v. Tucson Gen. Hosp., 500 P.2d 1153 (Ariz. Ct. App. 1972) (finding hospital liable for x-ray equipment malfunction which injured patient, because hospital owned and maintained the equipment)).

\textsuperscript{200}See e.g., Petrovich v. Share Health Plan, 719 N.E.2d 756, 775 (Ill. 1999) (finding HMO vicariously liable under apparent agency theory).

\textsuperscript{201}530 U.S. 211, 219 (2000).

\textsuperscript{202}HMO, 730 N.E.2d 1119 (Ill. 2000).

\textsuperscript{203}See id. at 1135.
govern whether an HMO or other insurance plan can be sued for negligence.\footnote{204} Another means of finding an enterprise liable is under a negligence \textit{per se} theory, where the institute violates a statute directly or by failing to establish and follow protocols required by statute. For example, in \textit{Edwards v. Brandywine Hospital},\footnote{205} the court concluded that a violation of a Health Department standard could be \textit{per se} negligence.\footnote{206}

Aside from state statutory preclusion of EL, another significant obstacle to plaintiffs is ERISA\footnote{207} preemption, which allows certain health plans to avoid state law claims for decisions that “relate to” health care plan administration.\footnote{208} Fortunately for some plaintiffs, and perhaps also for physicians who desire the risk-sharing of EL, some courts are excluding state law based tort claims from ERISA preemption. For example, the Tenth Circuit in \textit{Pacificare of Oklahoma v. Burrage}\footnote{209} held that a vicarious liability malpractice claim could be remanded to state court and was not preempted.\footnote{210} The Circuit Courts are divided with respect to state law tort claims and ERISA preemption.\footnote{211} The Supreme Court did not directly address the state law claims issue from \textit{Pacificare} and similar cases such as \textit{Pegram v. Hedrich}.$^{212}$ Thus, at least in some jurisdictions, health plans and other insurers face a
lesser risk of state law tort liability, which allows them to avoid blame or shift it to the individual provider. This risk avoidance tactic seems to lessen the incentive to reduce medical error through cooperative quality improvement efforts between plans and providers.

As noted earlier, the current tort system does not effectively or efficiently deter malpractice by individual providers. If one accepts the premise that malpractice is causally related to the rate of medical errors, then reducing malpractice would reduce errors. To enhance the deterrence effect and efficiency of the tort system, it makes sense to extend the liability risk to the enterprises on the delivery side of health care. Although moral and ethical considerations should prompt efforts to reduce negligence and the resultant errors which harm patients, economic motivation will create a more practical necessity for change. Sharing liability with providers will force enterprises to foster an effective partnership with providers to reduce the costs of medical errors by improving healthcare quality at all levels. Part of the enterprise’s burden should ideally include informing patients with quality of care and error data, so that enterprises will face additional market pressure to improve care.

E. Alternatives to the Standard Negligence Approach

As noted in the preceding section, enterprise liability may encourage efforts to reduce medical errors by creating a shared risk-benefit between providers and hospitals and hospitals or insurers. Enterprise liability theory still operates under a standard negligence model, though, because it merely extends duty to the enterprise through a vicarious or direct mechanism. There are alternative liability theories which focus on other ways to reduce medical errors and their negative impacts or resultant liability risks. The theories this section discusses are: apology; no-fault; and strict liability.

id. at n.9. The Court may be asked to resolve the meaning of “inextricably mixed” in a future case. Does it mean a negligence claim must be preempted for any ERISA plan?

211 See Peter D. Jacobson & Scott D. Pomfret, ERISA Litigation and Physician Autonomy, 283 JAMA 921 (2000). The authors point out that ERISA-based plans cover 125 million Americans (citing Department of Labor estimates). See id. at 921.


215 See Sage, supra note 214, at 1-3.

216 See Stuart Speiser et al., THE AMERICAN LAW OF TORTS §1:30 (1983).

218 See Priest, supra note 194, at 1537. “It is well accepted that the optimal level of accident prevention will be attained if incentives are created for both the provider and consumer to make additional safety investments up to the point at which the marginal costs of such investments equal their marginal benefits.” See id. But see Clark C. Havighurst, Vicarious Liability: Relocating Responsibility for the Quality of Medical Care, 26 AM. J.L. & MED. 7, 14-15 (2000). Havighurst suggests that “the market alone cannot provide appropriate incentives to maintain quality because consumers cannot, in most cases, reliably assess the value of the services they receive. The policy problem therefore, is to narrow the extent to which consumer ignorance allows providers to give less than optimal care. . .” See id.
It seems like an ethical no-brainer that physicians who err should inform the patient of this fact as soon as the doctor learns it, regardless of actual harm.\(^\text{219}\) This is consistent with the highest form of professional ethics.\(^\text{220}\) However, there may be instances where error disclosure might harm the patient through adverse psychological effects.\(^\text{221}\) If this is the learned and reasonable judgment of a physician, then it seems ethical to not disclose an error to certain patients.\(^\text{222}\) Conversely, error disclosure could actually increase a patient’s confidence in a provider.\(^\text{223}\) By admitting error, the physician exposes his own humanity, which a patient may not only empathize with but be reassured by, because they perceive their doctor as someone who is honest and will strive to protect the patient’s interests.\(^\text{224}\) The default ethical position should be to disclose the error to the patient, unless it is clear that the patient will be harmed by the disclosure.\(^\text{225}\)

Unfortunately, a doctor’s decision to admit error and apologize for it is not, at least psychologically, just a straightforward ethical question. Doctors fear being sued if they admit errors.\(^\text{226}\) In some instances, there is actual patient harm from a medical error, and the doctor will settle a claim or lose in court, irrespective of whether the doctor admits any error. Most doctors probably agree that professional standards are maintained at higher levels by punishing certain negligent providers.

Are there situations where doctors can admit their errors without risking a lawsuit?\(^\text{227}\) Certainly, if a patient isn’t harmed, then there may be no damages to

\(^{219}\)See Loeben, supra note 9, at 81 (stating “on one side are individuals who feel strongly that patients should be told.”). In fact, it is conceivable that the primary doctor should honestly address errors made by nurses or other providers. See id. See also Vogel & Delgado, supra note 69, at 94 (concluding that physicians should have a legal duty to admit errors, “because the medical profession does not regulate itself effectively, discourages the reporting of malpractice to patients, and erects formal and informal barriers to patients’ access to information.”) (emphasis added).

\(^{220}\)See Rosner et al., supra note 153, at 2092 (concluding that “truth telling should not be the mark of the heroic physician but rather a distinguishing feature of all decent physicians.”).

\(^{221}\)See Loeben, supra note 9, at 81.

\(^{222}\)See id.

\(^{223}\)See id. at 83 (stating “patients can understand and accept medical error much easier than they can understand and accept medical dishonesty.”).

\(^{224}\)See Steve S. Kramer & Ginny Hamm, Risk Management: Extreme Honesty May be the Best Policy, 131 ANNALS INTERNAL MED. 963 (1999) (citing study which showed 43 percent of families were motivated to sue in part because of a suspicion of a cover-up, betrayal of trust, or desire for revenge).

\(^{225}\)See id. at 967.

\(^{226}\)See Bates & Gawande, supra note 58, at 764-66. The authors point out that failure to admit error is ethically contradictory to physicians’ “fierce ethic of individual responsibility.” See id. at 764.

\(^{227}\)See Cohen, supra note 72, at 1473-74. The Lexington VA Hospital experience has been positive in this respect, both economically and ethically. In addition, telling the truth may improve morale by allowing providers to do the “right thing.” Besides morale boosting, apology may have positive effects on business goodwill and reputation. Cohen uses the
interest a plaintiff’s attorney. However, the patient could fire the doctor, or somehow impugn the doctor’s reputation, so the doctor may still have an economic incentive to remain silent. Perhaps, though, there is a human tendency to forgive that is being overlooked by doctors (or hospitals and insurers).\footnote{But see Philip G. Peters, The Quiet Demise of Deference to Custom: Malpractice Law at the Millennium, 57 Wash. & Lee L. Rev. 163, 196 (2000) (citing studies which show declining public confidence in medical practitioners).} It is doubtful that doctors are widely actually dishonest or are perceived as dishonest.\footnote{In my personal experience as a physician, patients seem quite willing to forgive mistakes, such as medication side effects, when I apologize to them and emphasize my willingness to continue to help them fix their problem. In another context, perhaps President Clinton could have avoided impeachment if he had been promptly honest and apologetic for his sexual indiscretions. In that context, though, unwillingness to be honest may reflect a more fundamental character trait, which is arguably selected by the political process.} Unfortunately, it is the medical culture itself which inhibits a more optimal level of honesty with respect to medical errors.\footnote{See Bates & Gawande, supra note 58, at 763; Leape et al., Preventing Medical Error, supra note 51, at 1444.} Fortunately, medical leaders are realizing that admitting errors is one step toward fixing the overall problem, and is a better ethical approach.\footnote{See Leape et al., Preventing Medical Error, supra note 52, at 1447.}

Apology presents a cost-effective and ethical approach to medical errors in a context like a Veterans’ Administration Hospital, partly because providers are insulated from individual liability.\footnote{See Kraman & Hamm, supra note 224, at 965. VA providers do not pay malpractice premiums, and are not named individually in malpractice claims. They are reported to the National Practitioner Data Bank for actual malpractice payouts. See id. Malpractice insurers also contribute to physicians’ reluctance to admit errors, but if the insurers realized a net savings from honest error admission, they would probably be more receptive to this approach. See id. at 965-67.} In the private sector context, the applicability of apology may be limited to the enterprise’s willingness to accept or share the liability risk with the individual provider.\footnote{See id.} One approach that automatically imposes risk on the enterprise is a no-fault system of medical injury liability, which focuses on causation rather than duty.\footnote{See e.g., Abraham & Weiler, supra note 189, at 432-36 (promoting no-fault approach to medical malpractice); Randall R. Bovbjerg & Frank A. Sloan, No-Fault for Medical Injury: Theory and Evidence, 67 U. Cin. L. Rev. 53, 99-120 (1998) (analyzing pros and cons of no-fault system); Paul C. Weiler, supra note 93, at 950 (1993) (favoring no-fault approach).} The proponents of various no-fault systems argue that such systems reduce administrative costs and improve compensation to injured patients.\footnote{See e.g., Weiler, supra note 93, at 923-35 (discussing benefits of no-fault compensation to injured patients, and decreased administrative costs).} Florida already has a limited no-fault medical liability system,
which applies to Workers’ Compensation and brain-damaged newborns.\textsuperscript{236} Data indicates that administrative costs are lower and patients are compensated faster than in the traditional tort system, though overall costs are not lower.\textsuperscript{237}

Strict liability has also been proposed as a method to reform the current malpractice system.\textsuperscript{238} Strict liability theory is a policy based cost-shifting mechanism which is applied to promote public safety through injury prevention.\textsuperscript{239} Strict liability has yet to be applied to medical services, but is applicable to certain medical devices under products liability laws.\textsuperscript{240} For example, in \textit{Porter v. Rosenberg}, Florida’s Fourth District Court of Appeals acknowledged that strict liability applied to silicone breast implant manufacturers and distributors.\textsuperscript{241} However, the surgeon in the case was not strictly liable for selecting and using the implant.\textsuperscript{242} The \textit{Porter} court left open the possibility of strict liability for a service provider where the “essence of the transaction” between the patient and the provider was akin to a business-customer relationship.\textsuperscript{243}

\section*{V. Capitalism}

\subsection*{A. The Entitlement Mentality}

This discussion of the causes and potential solutions to medical errors is incomplete without at least a brief analysis of the roles of patients as consumers, and the economic forces which have fostered and perpetuated the current healthcare market in the United States.\textsuperscript{244} As discussed in section II.C of this article, healthcare

\textsuperscript{236}See Bovbjerg & Sloan, \textit{supra} note 234, at 82-83 (citing Fl. A. STAT. §§ 766.305, 766.315, and describing a similar approach in Virginia).

\textsuperscript{237}See id.

\textsuperscript{238}See Barry Furrow, \textit{Defective Medical Treatment: A Proposal For the Application of Strict Liability to Psychiatric Services}, 58 B.U. L. REV. 392, 434 (concluding strict liability should apply to “defective medical treatment” in a manner similar to products liability).

\textsuperscript{239}See id. at 410-411.

\textsuperscript{240}See \textit{Furrow}, \textit{supra} note 190, at 265-70. The \textit{Restatement (Second) of Torts} § 402A (1965), provided the traditional rule of products liability. \textit{See David W. Robertson et al., Cases and Materials on Torts} 558 (1998). There is now a \textit{Restatement (Third) of Torts} (1997) devoted specifically to products liability. \textit{See id.}

\textsuperscript{241}650 So.2d 79 (Fla. Dist. Ct. App. 1995).

\textsuperscript{242}See id. at 81.


\textsuperscript{244}See \textit{Porter}, 650 So.2d at 83.

\textsuperscript{245}A detailed discussion of either is beyond the scope of this article. \textit{See generally} Weiler, \textit{supra} note 93, at 950 (favoring no-fault); Bovbjerg & Sloan, \textit{supra} note 234, at 99-120 (discussing pros and cons); Mark F. Grady, \textit{Why Are People Negligent? Technology, Nondurable Precautions, and the Medical Malpractice Explosion}, 82 NW. L. REV. 293, 306-310 (1988) (discussing strict liability, effects of technology, and transaction costs).
delivery ultimately occurs at the individual patient level. Patients’ perceptions, and their willingness or ability to pay for their own medical care influence the rate of medical errors. The law operates in this context to support, propagate, or even expand error rates.

At this point in our nation’s history, universal healthcare is not a fundamental right. The U.S. Supreme Court has acknowledged a right to healthcare under the Eighth Amendment for prison inmates, and under the Fourteenth Amendment for confined mental patients, due to these groups’ “special relationship” with the government. In other cases, the U.S. Supreme Court has expressly refused to grant healthcare the status of a fundamental right. In Harris v. McRae, the Court rejected a right to state funded abortions. In Youngberg v. Romeo, the Court stated that it was an “established principal” that “[a]s a general matter, a State is under no constitutional duty to provide substantive services within its border.” The Youngberg Court did find a due process right to minimally adequate training to ensure safety and freedom from undue restraint for a severely retarded patient who was involuntarily committed. Thus, the U.S. Supreme Court has refused to grant constitutional right status to healthcare for the general population, suggesting a proper deference to the political process and legislature.

In every state, though, there already exists broad access to medical care through Medicaid and Medicare programs. Medicaid, a federally assisted state program, provides coverage to needy children and adults. Medicare, also federally funded, provides coverage for the disabled and for persons over age sixty-five. Thus, even though there is not an absolute right to healthcare, benefit programs already exist for those patients willing to declare and substantiate their need for assistance.

Patients not covered by Medicaid or Medicare rely upon employer provided insurance benefits, or must purchase their own coverage out-of-pocket. This still

246 See supra notes 234-44 and accompanying text.
247 See supra note 246.
248 See e.g., Van M. Halley, The Right to Health Care: Key Policy Issue or Useless Concept, KAN. J.L. & PUB. POL’Y at 101, 120 (1993) (stating that absent a “special relationship” between the state and a patient, healthcare is not a constitutional right).
249 See Estelle v. Gamble, 429 U.S. 97, 103-104 (1976) (stating it would be “cruel and unusual punishment” to deny prisoners adequate healthcare).
252 Youngberg, 457 U.S. at 320.
253 See id. at 324-25.
254 See id.
255 42 U.S.C.S. § 1396 (2000) et seq. Established in 1965, Medicaid provides, “(1) medical assistance on behalf of families with dependent children. . . whose income and resources are insufficient to meet the costs of necessary services,” and “(2) rehabilitation and other services to help such families attain of retain capability for independence or self care. . .”
256 42 U.S.C.S. § 426 (2000) et seq. Also established in 1965, Medicare provides for healthcare for individuals over age 65, and disabled individuals. See id. at §§ 426(a)-(b).
leaves as many as forty-four million Americans without health insurance. Proponents of universal health insurance emphasize these uncovered millions when such plans are debated. What such proposals ignore, though, is the dynamic nature of this uninsured group. Most are young and between jobs, and many have simply chosen to not purchase insurance. Many of those between jobs could have elected to continue employer-sponsored coverage under the Consolidated Omnibus Budget Act of 1985 (COBRA) for at least eighteen months. In contrast, less than one percent of the elderly are without insurance. Therefore, those who need insurance the most, the poor, disabled, and elderly, already have access to it through existing programs. It may be that younger people without insurance have simply accepted a certain risk in exchange for saving money not spent on insurance.

Even if universal healthcare attained legal right status, there would remain the fact that medical services must be paid for. This is where the entitlement mentality rears its ugly head, because too many patients insist upon a scope of services which they are unable or unwilling to pay for. Patients are too often not aware of the true costs of coverage and services, creating what one commentator describes as a “moral hazard.” Instead of using health insurance for the usual insurance function as protection against unpredictable loss, people tend to “over-insure” themselves for healthcare. They do so in large part because the law promotes employer and government sponsored insurance. Patients are thereby encouraged to assume that their care is or should be paid for by their employers or the government.

The economic reality, which such a mindset ignores, is that neither the government nor employers actually pay for healthcare. The government creates no wealth, it can only confiscate and redistribute it through what Frederic Bastiat

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258 See e.g., James E. Dalen, Health Care in America: The Good, the Bad, and the Ugly, 160 ARCH. INT. MED. 2573, 2575 (2000) (citing figure of 43 million uninsured Americans, and advocating employer mandated health insurance); Frank Davidoff, The 28th Amendment, 130 ANN. INT. MED. 692-94 (1999) (suggesting constitutional amendment to provide universal health insurance).

259 See supra note 257, HHS website data (describing uninsured as commonly between ages 21 and 24, and workers who experienced “some unemployment”).


261 See supra note 257.

262 See Clark C. Havighurst, American Health Care and the Law—We Need to Talk!, 19 HEALTH AFFAIRS 84, 86-88 (2000).

263 See id. at 88.

264 See id. at 87-88.

265 See id.
accurately labeled as “legal plunder.” The government does not pay for anything, the productive citizens do. Employers also do not pay for healthcare, because the costs are passed on to consumers through higher prices, and to employees through wages adjusted for the expense of insurance. Therefore, what those who claim is an entitlement to healthcare are really demanding is the property of their fellow citizens, and they must rely on the coercive power of the government to take it for them.

Perhaps before patients insist upon an entitlement to the fruits of their fellow citizens’ labor, they should pause to consider the consequences of such a mentality. For example, a prominent feature of the 2000 presidential campaign was each candidate’s prescription drug plan for Medicare patients. The premises of such plans were flawed in at least two major ways. First, the vast majority of Medicare patients are over age sixty-five, a segment of the population which is wealthier on average than the younger people who will pay the lion’s share of the cost. Second, these proposals for prescription drugs create a disincentive for younger people to save for their retirement needs. Plans like these only reinforce the entitlement mentality by passing along costs to those who bear the burden of paying for others’ healthcare. Do the Medicare beneficiaries of such plans properly view their desire for prescription drugs as a burden on their children and neighbors?

The impact of the entitlement mentality on medical errors should be self-evident. At some point, freedom of choice is restricted by the strings attached to entitlement programs. For example, only certain doctors or hospitals will accept Medicare or Medicaid. The patient is thus less able to effectively provide the economic incentives to reduce medical error by seeking care from competing providers. Thus, shielding selected providers from full-fledged market competition reduces the threat that patients will shop elsewhere for a lower error-rate doctor or hospital. Without such an economic threat, providers have less incentive to improve quality through reduced error rates.

B. Contractual Freedom

Suppose the federal government, responding to “the high price of automobiles,” enacted legislation to provide universal automobile purchasing insurance. An insurance policy, provided by the government or the employer, allows each citizen to purchase a car from a participating auto maker. Each insured person purchases the car he or she wants, as long as the purchase is pre-approved. This creates an


267 See id.


269 See id.


271 Analogous to the prospective payment system for healthcare. See generally, Abraham & Weiler, supra note 189, at 393-96 (describing prospective payment system). This analogy is perhaps tenuous with respect to emergency medical care, because people do not have the
incentive for each person to use the insurance and purchase the most expensive car allowed by the policy, regardless of need or ability to pay. At some point, the program becomes too costly, and a limit is placed on car prices. It is illegal for the seller to exceed the price limits, or to allow any covered person to pay the seller directly for amounts that exceed coverage limits. Participating car sellers would then attempt to maximize profit by reducing production costs, motivated to improve quality only to the extent of the buyers’ ability to choose between participating sellers.

It is hard to imagine Americans accepting such restrictions on their choice of what car they can buy, yet such a system already exists to limit individual choice for healthcare, arguably a more personal choice than choosing a car. The providers of healthcare, primarily doctors and hospitals, though private insurers may also be included here, are similarly restricted in their choices of what care to provide. Contractual freedom to choose either the care received or the care provided is restricted. If freedom to choose is restricted by non-market forces, then incentives to improve quality are reduced to the extent competition is discouraged. This translates into a suboptimal climate for medical error detection, admission, and reduction. Therefore, both patients and providers must have greater contractual freedom if market efficiencies are to affect medical error reduction.

One example on the provider side of healthcare contracts is “without cause” termination clauses. Professor Liang calls for an end to these clauses in provider contracts.
contracts with HMOs and other managed care entities. This will encourage physicians to report errors without fear of backlash. Unfortunately, Professor Liang’s remedy is federal legislation, thus further entangling the government in our healthcare system. This is like Socrates asking for more hemlock. Physicians should admit they are in their current situation precisely because they have lobbied for federal involvement in healthcare, and they helped get Medicare and Medicaid passed in the first place. Now physicians lament the fact that the market has reacted to restrict their contractual freedom. A sounder approach by physicians to obtain contractual freedom is to reject these contracts up front, or argue in court that they should not be enforced for policy reasons. Otherwise the medical community is further abdicating its position as a market player to the federal government. The result can only be increased dependency on government for subsequent solutions.

On the patient side of healthcare contracts, contractual freedom needs to be enhanced as well. As with physicians, though, patients are also to blame for the

279 See Liang, Promoting Patient Safety, supra note 8, at 564.

280 See id.

281 See id. Unsurprisingly, lawmakers have politicized the medical errors problem. See e.g., Chad Bowman, Medical Errors Proposals Proliferate As Lawmakers Seek Reporting Systems, 68 U.S. LAW WEEKLY 2643-44 (2000) (describing various legislative proposals by Republicans and Democrats in the House and Senate to require or promote medical errors reporting, such as the Medical Error Reduction Act, sponsored by Arlen Spector, (R-PA) and Tom Harkin (D-IA)). But see Michael Pretzer, Congress Backs Away From Mandatory Medical Errors Reporting, 77 MED. ECON. 25, 25-26 (2000) (describing successful lobbying efforts by physician and managed care organizations who opposed mandatory reporting).

282 See PAUL J. FELDSTEIN, THE POLITICS OF HEALTH LEGISLATION: AN ECONOMIC PERSPECTIVE, 204-5, 243-45 (1988) (explaining how “economic self-interest” was used by physicians to affect legislation which benefited physicians).

283 See Liang, supra note 8, at 564.

284 The antitrust implications here are worth fighting on ethical grounds, but cannot be easily disregarded. See e.g., American Medical Ass’n. v. United States, 317 U.S. 519, 534-36 (1943) (finding Sherman Act violations and restraint of trade by medical organizations). Medical leaders should use the literature to voice how this process could occur in a non-collusive and ethical manner. The recent case of Harper v. Healthsource of New Hampshire, Inc., 674 A.2d 962 (N.H. 1996), should provide some reassurance that courts are willing to view without cause termination clauses as counter to public policy. That is the decision of the Harper court, even in the absence of federal legislation. See id. The California Supreme Court also found a without cause contract termination clause invalid in Potvin v. Metropolitan Life Insurance Co., 997 P.2d 1153, 1167-68 (Cal. 2000). The Potvin court found that the contract unfairly restricted the doctor’s common law right to fair procedure, and impaired the doctor’s ability to practice in a particular geographic area, because the insurer had such a large market share. See id. at 1167-68. The medical community should pursue the without cause contractual issue at the state rather than the federal level.

285 Cf. Roger Pilon, Freedom, Responsibility, and the Constitution: On Recovering Our Founding Principles, 68 NOTRE DAME L. REV. 507, 546 (1993) (arguing that the law has evolved away from founding principles, and concluding, “the time has come to recover these principles and to take responsibility for our lives. . .for nothing less will free us as a people.”).

286 See Havighurst, supra note 262, at 97.
clearly, not all patients have voted to involve the federal government in financing healthcare. However, the political process continues to operate under the premise that one group of voters, particularly the elderly with respect to healthcare, can organize to redistribute the wealth of other citizens to pay for the elders’ healthcare. Politicians fall in line because their main goal is re-election. While it is true that this disparity cannot progress indefinitely, the concept of medicine and other entitlement programs must be addressed realistically. Either patients must accept greater responsibility for their family’s healthcare, or they must accept choice limitations along with the money redistributed from others. The causal chain of events for the latter is less choice, less competition, and less pressure to improve quality and reduce medical errors.

It should be clear that neither providers nor patients can have their cake and eat it too, when the assertion is made that medical error reduction will be enhanced by contractual freedom. Doctors, patients, and politicians will continue to be motivated by their own self-interest. In general it is just such self-interest which enhances market efficiency. However, the redistribution mentality of healthcare thwarts this efficiency, because too few people are actually aware of what their own healthcare costs. Thus, there is less bargaining in the traditional contract sense. Both sides of the bargain need to acknowledge that by asking the government to get involved in healthcare financing, they have relinquished their bargaining power. Unless the provider-patient transaction occurs in a more arms-length fashion, without the

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287 See Feldstein, supra note 282, at 242-45.
288 Enough voters obviously did convince their representatives. See id. at 242-44. Feldstein describes this as the “Self-Interest Paradigm,” where “individuals act according to self-interest, not necessarily the public interest,” and “organized groups seek to achieve through legislation what they cannot achieve through the marketplace.” See id. at 3.
289 As Feldstein succinctly stated, “Legislation is a means of transferring wealth to those with political power from those without.” See id. at 181.
290 See id. at 3.
291 See Feldstein, supra note 282, at 248-49 (describing a “self correcting element” to redistribution inequities). See also id. at 182 (criticizing Medicare as “designed to be both inequitable and inefficient.”).
292 See Havighurst, supra note 262, at 97.
293 See id.
294 See Feldstein, supra note 282, at 3.
296 See Havighurst, supra note 262, at 97.
297 See e.g., Oliver Wendell Holmes, The Common Law 230 (Mark DeWolfe Howe ed., 1963) (stating . . . “it is the essence of a consideration, that, by terms of the agreement, it is given and accepted as the motive or inducement of the promise.”) (1881).
298 See Havighurst, supra note 262, at 97.
government middleman, contractual freedom, and thus its ability to lower medical error rates, will continue to be limited.  

C. Economic Rationale

Just as a systems approach should be taken with respect to the detection, analysis, and reduction of medical errors, a fundamental reassessment of the healthcare financing system is urgently needed. The market efficiencies of capitalism should be embraced, rather than restricted, by policy makers. Legislators, patients, providers, and even lawyers must acknowledge resource limitations, rather than make unsustainable promises through programs which pass costs along to taxpayers and succeeding generations. Sooner, rather than later, the notion that “you get what you pay for” must be emphasized. If the system continues to tell patients that they get what others pay for, it will collapse of its own weight, because those who are actually paying will lose the incentive to be productive.

As noted earlier, healthcare is not a fundamental right, but most Americans have health insurance through their job or a government program. Others elect to pay out-of-pocket for insurance or direct costs. Still others freely elect to forgo care or insurance. The minority of Americans left wanting for care or insurance will benefit from market solutions. For example, self-employed individuals and small businesses can form risk pool alliances which allow them to negotiate better insurance rates. Florida created just such a program in the Florida Health Care and Insurance Reform Act of 1993, which established community based health purchasing alliances. Another approach is to reconsider the purpose of health insurance, which is to prevent unpredictable costs. Many people can probably afford to trade-off between a higher deductible in exchange for lower premiums, as is done for home or auto insurance. Paying directly for certain small incidental costs would encourage true consumerism, while catastrophic losses would be avoided.

People should not be forced to buy what they don’t want or need, yet that is exactly what is happening with many current policies through a one size fits all

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299 See id.

300 See e.g., Daniel J. Murphy, Medicare In Urgent Need of Reform as Population Ages, Costs Skyrocket, INVESTOR’S BUS. DAILY, Oct 23, 2000, at A26 (describing accelerating medical costs, especially those related to Medicare, which consumed $213.6 billion, or 13.3 percent, of the federal budget in 1998. The high costs prompt the government to cut doctor reimbursements, which doctors respond to by cutting back on care).

301 See supra notes 257-58.


303 FLA. STAT. ANN. § 408.702(1) (1999).

304 See Havighurst, supra note 262, at 88.
approach. Why should a fifty year old man have the same plan as a twenty-five year old woman? Employer sponsored plans could offer a greater menu of choices for a better custom fit for each employee. This allows employees flexibility to pay only for what they need or want. What the employee “saves” in benefits could thereby be realized as increased wages. Ideally, the tax code would equalize treatment for this variety of individual expenses, but a discussion of how this could be done is beyond the scope of this article.

The free market, and not the government, is the most efficient solution to increase access to healthcare, control costs, and improve quality through error reduction. A free market “gives people what they want instead of what a particular group thinks they ought to want.” As a critical corollary to this notion, the free market promotes individual responsibility by emphasizing that consumers get what they actually pay for. Government and the law play an important role in adjusting to and promoting competition, by enforcing contracts, and preventing fraud and deception. This creates an awareness by consumers, who in turn vote with their wallets when the market fails to meet their needs. In the recent case of Pegram v. Hedrich, the Supreme Court acknowledged that cost-control measures are necessary, and are influenced by market forces and negligence risks. Socialized medicine, on the other hand, will reduce market incentives to lower medical error rates, because consumer choice will be restricted. The economic incentives to produce a safer product will be blunted by reduced consumer choice and cost awareness.

Healthcare should remain a service, and not a right. Businesses who provide the service of healthcare, whether for profit or not, must still attend to the bottom line. That bottom line requires them to control costs while still offering a product that consumers demand. A business must face the threat that a competitor will create a more desirable product, either because it’s cheaper, safer, or better in other ways. What the market will bear requires constant vigilance and adaptation by the business that wishes to remain viable. If what consumers ultimately desire is safer healthcare, then politicians, lawyers, insurers, and providers should honor that choice as promoting the essence of our liberties. Medical error rates will then fall as a necessary predicate for providers’ market survival. The magic of capitalism’s “invisible hand” will always create a niche for the able entrepreneur.

306 See Havighurst, supra note 262, at 87-89.
308 See F. A. HAYEK, THE ROAD TO SERFDOM 102 (1944).
310 See ADAM SMITH, supra note 295, at 421, (describing how individuals intend only their own security when they interact with producers, but the result is an overall promotion of the public interest. “… and by directing that industry in such a manner as its produce may be of the greatest value, [the individual] intends only his own gain, and he is in this, as in many other cases, led by an invisible hand to promote an end which was never his intention.” (emphasis added)).