MEDICAL-MALPRACTICE REFORM: IS ENTERPRISE LIABILITY OR NO-FAULT A BETTER REFORM?

Abstract: This Note compares two medical-malpractice reforms: enterprise liability and no-fault. The Note compares the reforms for their relative ability to compensate injured patients and deter malpractice. The Note also examines the reforms' economic and sociopolitical feasibility. The Note concludes that a no-fault medical-malpractice system would better compensate patients and deter malpractice, but enterprise liability is a more feasible reform that policymakers should pursue more aggressively.

INTRODUCTION

In November 2000, a man was admitted to the hospital for a broken hip.[1] The doctor on duty inserted a feeding tube to ensure that the patient received proper nutrition.[2] The doctor accidentally inserted the tube into the patient's lung, which began to fill with liquid.[3] Despite being transferred to the hospital's critical care unit, the patient never recovered.[4] A jury found that medical malpractice caused his death.[5]

In the fall of 2004, a senior partner of an OB/GYN clinic in Chicago sent her patients letters informing them she would be moving to Madison, Wisconsin where medical-malpractice insurance premiums are lower.[6] Although, a lifelong resident of Chicago, who had found the practice of medicine to be challenging and rewarding, the malpractice environment in Illinois made it a hostile place for the doctor to work.[7]

Medical malpractice harmed this patient and doctor, but in two very different ways.[8] One story illustrates that real lives are lost or ru-

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[1] Lagerstrom v. Myrtle Werth Hosp.-Mayo Health Sys., 700 N.W.2d 201, 206 (Wis. 2005).

[2] *Id.*

[3] *Id.*

[4] *Id.* at 207.

[5] *Id.* at 206.

[6] Amelia Buragas, *Priced Out*, CAPITAL TIMES (Madison, WI), Sept. 27, 2004, at 8A.

[7] *Id.*

[8] *See Lagerstrom*, 700 N.W.2d at 206–07; Burages, *supra* note 6, at 8A.

ined because of medical malpractice.[9] The other story paints a picture of a litigious America hurting the doctor-patient relationship by driving doctors out of business.[10] Ideally, medical malpractice law compensates injured patients and deters doctors from injuring their patients.[11] Although medical-malpractice law has helped raise the standard of care in the medical profession, it has become a source of frustration for physicians and inadequate protection for patients.[12]

The problems with the current medical-malpractice system are numerous.[13] Doctors are sued much more often than in the 1950s.[14] Medical-malpractice liability insurance is less available and less affordable, forcing some physicians to leave the profession as a result.[15] Those doctors continuing to practice sometimes provide unnecessary treatment to protect themselves from liability.[16] This "defensive medicine" is dangerous and costly; 44,000 to 98,000 people die each year because of medical error.[17] There are many more injuries caused by compensable medical errors than there are malpractice claims.[18]

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[9] *See Lagerstrom*, 700 N.W.2d at 207; *see also* Watkins v. Cleveland Clinic Found., 719 N.E.2d 1052, 1057–59 (Ohio Ct. App. 1998) (involving a patient in a persistent vegetative state due to surgery to fix a deviated septum in her nose).

[10] *See* Burages, *supra* note 6, at 8A; *see also* David A. Hyman, *Medical Malpractice and the Tort System: What Do We Know and What (If Anything) Should We Do About It?*, 80 TEX. L. REV. 1639, 1639 (2002); Paul C. Weiler, *The Case for No-Fault Medical Liability*, 52 MD. L. REV. 908, 909–10 (1993); Patrick B. Massey, M.D., *Despite Top-Notch Physicians, Medical Field Showing Signs of Illness*, CHICAGO DAILY HERALD, Jan. 5, 2004, at Health & Fitness 4.

[11] *See* STEVEN E. PEGALIS & HARVEY F. WACHSMAN, AMERICAN LAW OF MEDICAL MALPRACTICE 2D § 2:10 (1992).

[12] *See* Helling v. Carey, 519 P.2d 981, 985 (Wash. 1974) (making glaucoma tests standard practice for ophthalmologists); *Lagerstrom*, 700 N.W.2d at 206–07; Burages, *supra* note 6, at 8A.

[13] *See* INST. OF MED., TO ERR IS HUMAN 1 (2000); PEGALIS & WACHSMAN, *supra* note 11, § 2:7; Weiler, *supra* note 10, at 912.

[14] In the late 1950s, there was approximately one malpractice claim per hundred physicians in a year. Weiler, *supra* note 10, at 912. By the early 1990s, there were more than ten claims per hundred physicians per year. *Id.*

[15] *See* REPUBLICAN NAT'L COMM., 2004 REPUBLICAN PARTY PLATFORM: A SAFER WORLD A MORE HOPEFUL AMERICA 59 (2004), *available at* http://www.gop.com/media/2004platform.pdf.

[16] *See* Weiler, *supra* note 10, at 916–17.

[17] *See* INST. OF MED., *supra* note 13, at 1; PEGALIS & WACHSMAN, *supra* note 11, § 2:7 (defining defensive medicine as "the alternation of modes of medical malpractice, induced by the threat of liability, for the principal purpose of forestalling the possibility of lawsuits by patients as well as providing a good and legal defense in the event such lawsuits are instituted"); Weiler, *supra* note 10, at 942(estimating the cost of defensive medicine at $20 billion per year).

[18] *See* Hyman, *supra* note 10, at 1643; Weiler, *supra* note 10, at 913.

These problems demonstrate the need for reform.[19] The public should not have to bear the cost of an arguably ineffective and inefficient medical-malpractice system that inadequately distributes costs and hinders patient safety.[20]

Medical-malpractice reforms have been enacted over the past thirty years, but complaints continue about the medical-malpractice system.[21] The most popular reforms include damage caps, attorney contingency fees caps, installment payments for damages, screening boards, and shorter statutes of limitation for malpractice actions.[22] Where enacted, the damage caps have reduced the number of suits, the amount of damages, and, therefore, the overall cost of medical malpractice.[23] Unfortunately, malpractice-insurance rates remain high.[24] The savings, although real, are small in comparison to the overall cost of healthcare in the United States.[25] As a negative consequence of these reforms, patients with legitimate claims and severe injuries face greater difficulties when bringing medical-malpractice suits.[26] Thus, despite these tort reforms, problems persist.[27]

In light of the futility of popular tort reform efforts, and with an eye toward improving patient safety, some reformers have suggested

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[19] *See* Randall R. Bovbjerg et al., *U.S. Health-Care Coverage and Costs: Historical Development and Choices for the Future*, 21 J.L. MED. & ETHICS 141, 142 (1993); Weiler, *supra* note 10, at 916–17.

[20] *See* Barry R. Furrow, *Enterprise Liability and Health-Care Reform: Managing Care and Managing Risk*, 39 ST. LOUIS U. L.J. 79, 100–08 (1994); Weiler, *supra* note 10, at 908–09.

[21] *See* AM. MED. ASS'N., MEDICAL LIABILITY REFORM—NOW! 2–22 (2004), *available at* http://www.ama-assn.org/go/mlrnow (describing the recurring problem of medical-malpractice liability and the reforms in states); Steve Lohr, *Bush's Next Target: Malpractice Lawyers*, N.Y. TIMES, Feb. 27, 2005, at BU1 (illustrating current interest in medical-malpractice reform).

[22] *See* Randall R. Bovbjerg, *Legislation on Medical Malpractice: Further Developments and a Preliminary Report Card*, 22 U.C. DAVIS L. REV. 499, 513, 522–31 (1989); Weiler, *supra* note 10, at 908–09.

[23] *See* AM. MED. ASS'N., *supra* note 21, at 23; Bovbjerg, *supra* note 22, at 546–53.

[24] *See* REPUBLICAN NAT'L COMM., *supra* note 15, at 59.

[25] Weiler, *supra* note 10, at 909; *see* NAT'L CTR. FOR HEALTH STATISTICS, HEALTH, UNITED STATES, 2004 WITH CHARTBOOK ON TRENDS IN THE HEALTH OF AMERICANS 14, 326 (2004) (stating national healthcare expenditures totaling more than $1.5 trillion in 2002 have been growing); KAISER FAMILY FOUND., TRENDS AND INDICATORS IN THE CHANGING HEALTH CARE MARKETPLACE 2004, Exh. 1.1: National Health Expenditures and Their Share of Gross Domestic Product, 1960–2003, http://www.kff.org/insurance/7031/ti2004-1-set.cfm.

[26] *See* ASS'N OF TRIAL LAWYERS OF AM., *Ten Reasons to Oppose Medical Malpractice "Reform"*, http://www.atlanet.org/ConsumerMediaResources/Tier3/press_room/FACTS/medmal/tenreasons0504.aspx (last visited Apr. 7, 2005).

[27] *See* AM. MED. ASS'N., *supra* note 21, at 2–22 (describing the recurring problem of medical-malpractice liability and the reforms in states).

changing the medical-malpractice system.[28] One such proposed reform, enterprise liability, would shift liability entirely away from individual healthcare providers to hospitals or similar institutions.[29] Even more aggressive reformers have suggested replacing the fault based negligence system with a no-fault strict liability system that would compensate injured patients even if the provider was not negligent in causing the injury.[30] Acknowledging the hurdles related to enactment, both enterprise liability and a no-fault strict liability system offer the possibility of improving the affordability and quality of healthcare delivered in the United States.[31]

To better understand the utility and feasibility of these systemic medical-malpractice reforms, this Note compares enterprise liability and no-fault.[32] Enterprise liability retains the fault requirement of the negligence based medical-malpractice system, but limits the liability to the hospital or equivalent enterprise.[33] The no-fault reform takes enterprise liability a step further by eliminating the fault requirement.[34] Part I describes the history of medical-malpractice law and the development of enterprise liability and no-fault as potential reforms.[35] Part II addresses the question of which is the better reform model.[36] Because medical-malpractice reform is a frequent topic of public debate, the theoretical models of reform should be weighed against one another before investing limited resources in implementation.[37] Part II

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[28] *See* Kenneth S. Abraham & Paul C. Weiler, *Enterprise Medical Liability and the Evolution of the American Health Care System*, 108 HARV. L. REV. 381, 398–400 (1994); Weiler, *supra* note 10, at 919–21.

[29] *See* Abraham & Weiler, *supra* note 28, at 398–400; John V. Jacobi & Nicole Huberfeld, *Quality Control, Enterprise Liability, and Disintermediation in Managed Care*, 29 J.L. MED. & ETHICS 305, 305 (2001).

[30] David M. Studdert & Troyen A. Brennan, *Toward a Workable Model of "No-Fault" Compensation for Medical Injury in the United States*, 27 AM. J.L. & MED. 225, 227–29 (2001); Weiler, *supra* note 10, at 919–21.

[31] *See* Abraham & Weiler, *supra* note 28, at 382–84; Jacobi & Huberfeld, *supra* note 29, at 305; Studdert & Brennan, *supra* note 30, at 227–29; David M. Studdert et al., *Can the United States Afford a "No-Fault" System of Compensation for Medical Injury?*, 60 LAW & CONTEMP. PROBS., Spring 1997, at 1, 33; Weiler, *supra* note 10, at 919–20.

[32] *See infra* notes 178–386 and accompanying text.

[33] Exclusivity determines whether the enterprise would be the only party a patient/plaintiff could sue. *See* HEALTH-CARE LAW AND ETHICS 458 (Mark A. Hall et al. eds., 6th ed. 2003). Under an exclusive enterprise liability system, a patient may only sue the hospital or other comparable enterprise for an injury. *Id.* Under a nonexclusive enterprise liability system, a patient may sue the hospital as well as individual providers. *Id.*

[34] Studdert & Brennan, *supra* note 30, at 227–29; Weiler, *supra* note 10, at 919–21.

[35] *See infra* notes 39–173 and accompanying text.

[36] *See infra* notes 174–386 and accompanying text.

[37] *See* Lohr, *supra* note 21, at BU1.

concludes that no-fault better serves the goals of compensation and deterrence, but enterprise liability is a better model for reform in the United States because enterprise liability is more economically, socially, and politically appropriate.[38]

I. Background

A. *History of Medical Malpractice*

To understand how either no-fault or enterprise liability might improve the healthcare system, it is helpful to understand the history and evolution of the U.S.'s current negligence-based medical-malpractice system.[39] In the early part of the 19th century, actions against physicians for medical malpractice were rare.[40] As the century progressed, people began to demand more from their healthcare providers.[41] Additionally, the medical profession became populated with doctors toting a wide range of treatments, not all of which were scientifically sound or effective.[42] As a result, patients increasingly held doctors accountable for inadequate care.[43] By 1850, medical-malpractice suits had become a fixture of the American healthcare system.[44]

In the late 1950s, there was approximately one malpractice claim per 100 physicians in a year.[45] By the early 1990s, there were more than ten claims per 100 physicians in a year.[46] The increased number of malpractice claims has caused financial and emotional strain on the healthcare system.[47] These strains reached their height in the malpractice "crises" of the mid-1970s and mid-1980s.[48] These crises were charac-

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[38] *See infra* notes 376–86 and accompanying text.

[39] *See* Furrow, *supra* note 20, at 80–100 (discussing the evolution of the health system and liability).

[40] James C. Mohr, *American Medical Malpractice Litigation in Historical Perspective*, 283 JAMA 1731, 1731 (2000).

[41] *See id.* at 1732.

[42] *Id.*

[43] *Id.*

[44] *Id.* at 1731–32.

[45] Weiler, *supra* note 10, at 912.

[46] *Id.*

[47] *See id* at 908–10. Although the healthcare system has been strained by medical-malpractice claims, it is also important to note that medical-malpractice law has improved healthcare and patient safety. *See* Paul A. Sarlo, *Shining a Light on Malpractice*, N.Y. Times, Feb. 15, 2004, at 14NJ. Although this Note focuses on the problems of the medical-malpractice system, it does not discount the positive effect medical-malpractice law has had on healthcare. *See id.*

[48] *See* Studdert & Brennan, *supra* note 30, at 225.

terized by a surge in malpractice claims with corresponding increases in malpractice insurance rates.[49] In 1974 and 1975, major insurers refused to continue writing coverage for medical-malpractice liability.[50] In the 1980s, businesses of all kinds were struggling to find affordable liability insurance.[51] These insurance crises resulted in frustration with the tort system, which prompted legislative interest in general tort reform, and in particular in medical-malpractice reform.[52] The 1970s and 1980s reforms included insurance reforms, limiting attorney contingency fees, damage caps, and instituting pretrial screening panels.[53]

In the 1990s, no similar insurance crisis materialized, but pressure from medical practitioners fueled continued interest in reform.[54] More states enacted damage caps and similar federal legislation came close to passage.[55] Despite intense debate over healthcare reform during the Clinton Administration, the Administration's comprehensive reforms were not enacted.[56] The Clinton plan considered moving the nation toward an enterprise liability system, but the American Medical Association (the "AMA") strongly opposed giving hospitals more control over physicians.[57]

Without any reforms enacted in the 1990s, medical-malpractice reform continues to be a topic of national debate.[58] The 2004 Republican Party Platform specifically advocated non-economic damage caps as a reform, and it attacked Democrats for curtailing reform efforts and siding with trial lawyers instead of doctors and patients.[59] During the 2004 presidential debates, President George W. Bush highlighted medical-malpractice reform as a means to alleviate healthcare costs and improve the quality of healthcare in America.[60] Democratic presidential candidate Senator John Kerry conceded that

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[49] Am. Med. Ass'n., *supra* note 21, at 2–3; Studdert & Brennan, *supra* note 30, at 225.

[50] Bovbjerg, *supra* note 22, at 502–03.

[51] *See id.* at 503.

[52] *See id.* at 503–04.

[53] *See id.* at 513.

[54] Randall R. Bovbjerg, Medical Malpractice: Problems & Reforms (1995), *updated and reprinted in* Health-Care Law and Ethics, *supra* note 33, at 480.

[55] *Id.*

[56] *See* Abraham & Weiler, *supra* note 28, at 382–83. *See generally* Theda Skocpol, Boomerang: Health-Care Reform and the Turn Against Government (1997).

[57] *See* Abraham & Weiler, *supra* note 28, at 383.

[58] *See* Lohr, *supra* note 21, at BU1.

[59] Republican Nat'l Comm., *supra* note 15, at 59. For comparison, the 2004 Democratic Party Platform is available at http://www.democrats.org/pdfs/2004platform.pdf.

[60] *See* Comm'n on Presidential Debates, Debate Transcripts (Oct. 8, 2004), http://www.debates.org/pages/trans2004c.html.

the medical-malpractice system needed reform, but he considered tort reforms, like damage caps, to be an inadequate approach to reducing healthcare costs or improving care.[61] Their limited exchange exemplifies the heated debate being waged in Congress and in state legislatures throughout the country.[62]

The debate is largely waged in state legislatures by two factions, one typically led by physicians, and the other by plaintiffs' attorneys.[63] The physicians and their supporters lobby for reforms that limit patients' ability to bring suits and recover damages.[64] This school of thought believes that by reducing the number of suits and the amounts plaintiffs recover, insurance rates will fall, doctors will be happier and more effective, thereby curbing healthcare costs.[65] Reforms advocated by physicians include damage caps, limiting attorney contingency fees, installment payments for damages, screening boards to filter claims, and shorter statutes of limitation to reduce the time a patient would have to file a claim.[66] These reforms have been selectively adopted in many states.[67]

On the other side of the debate, plaintiffs' attorneys, patients' rights advocates, and like-minded supporters oppose these reforms and argue that such reforms unfairly limit plaintiffs' rights and do little to improve healthcare.[68] They stress that by making it more difficult for plaintiffs to bring suit, these reforms limit patients' ability to demand quality care.[69] For example, this school of though alleges that damage caps disproportionately harm the most severely and grossly injured victims of medical malpractice.[70] Furthermore, plaintiffs' attorneys and patients' rights advocates argue that tort reforms are futile efforts to

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[61] *See id.*

[62] *See* AM. MED. ASS'N., *supra* note 21, at 24–45; Lohr, *supra* note 21, at BU1.

[63] *See* 2004 REPUBLICAN NAT'L COMM., *supra* note 15, at 59; Abraham & Weiler, *supra* note 28, at 383; Daniel Costello, *Asking Patients to Help Shoulder Malpractice Costs*, L.A. TIMES, Oct. 25, 2004, at F1.

[64] *See* AM. MED. ASS'N., *supra* note 21, at 23–45; Lohr, *supra* note 21, at BU1.

[65] *See* AM. MED. ASS'N., *supra* note 21, at 23.

[66] *See id.* at 23–24.

[67] *See id.*

[68] *See* John Gibeaut, *The Med-Mal Divide*, 91 A.B.A. J. 38, 40 (2005); Lohr, *supra* note 21, at BU1.

[69] *See* Lohr, *supra* note 21, at BU1.

[70] *See* WASHOE COUNTY REGISTRAR OF VOTERS, WASHOE COUNTY 2004 GENERAL ELECTION SAMPLE BALLOT *Rebuttal to Argument in Support of Question No. 3* and *Argument Against Question No. 3*, S6-E to S7-E (2004).

contain costs.[71] They contend that limitations on patients' rights are not justified by an imperceptible reduction in healthcare costs.[72]

As long as healthcare providers continue to feel unfairly burdened by the medical-malpractice system, debate over reform proposals will probably remain on the state and national agendas.[73] The AMA is a powerful lobbying force, and the stories of doctors being forced out of practice by prohibitively high costs of medical-malpractice-liability insurance has potent political force.[74] Voters and legislators, while sympathetic to doctors, are quick to see plaintiffs and attorneys as greedy and litigious.[75] Until this changes, medical malpractice promises to remain a salient issue of public debate.[76]

Any reforms that are implemented should thus improve the healthcare system.[77] Some scholars argue that typical tort reform has not significantly improved the healthcare system over the past three decades and it is difficult to see how more of these same reforms will make a difference in the future.[78] These scholars have proposed more novel and

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[71] *See* Comm'n on Presidential Debates, *supra* note 60 (statement of Senator John F. Kerry) ("Now, ladies and gentlemen, important to understand, the president and his friends try to make a big deal out of it. Is it a problem? Yes, it's a problem. Do we need to fix it, particularly for OBGYNs and for brain surgeons and others? Yes. But it's less than 1 percent of the total cost of health care."). Empirical evidence shows that medical malpractice only accounts for a small proportion of total healthcare costs. Weiler, *supra* note 10, at 909. In 1992, the total cost of healthcare in the United States was $840 billion. *Id.* A generous estimate of the cost of medical malpractice at that time was $9 billion. *Id.* This figure may have underestimated the full cost of the malpractice system, however, because it does not include the cost of defensive medicine. *See id.* at 909, 916, 942. Medical malpractice is blamed for causing doctors to order unnecessary tests and procedures to protect themselves from liability. *See id.* at 909, 916–17. Such "defensive medicine" was estimated to cost the healthcare system another $18 billion in 1992, bringing the total cost of medical malpractice to $27 billion. *See id.* Even this $27 billion figure is small relative to the total cost of $840 billion. *See id.* These numbers have only continued to grow. *See* Bovbjerg, *supra* note 15, at 45. In 2001, the cost of healthcare in the United States was 14.1% of the country's gross domestic product, and it has been steadily rising. *See id.* In 2002, the total cost of healthcare was nearly $1.6 trillion. KAISER FAMILY FOUND., *supra* note 25. Although the relatively small cost of medical malpractice tempers the urgency with which the nation needs to tackle malpractice reform, the medical-malpractice system does cause meaningful problems for healthcare providers and patients alike. W. John Thomas, *The Medical Malpractice "Crisis": A Critical Examination of a Public Debate*, 65 TEMP. L. REV. 459, 464 (1992); Weiler, *supra* note 10, at 916–17.

[72] *See* Comm'n on Presidential Debates, *supra* note 60.

[73] *See e.g.*, Abraham & Weiler, *supra* note 28, at 383; Gibeaut, *supra* note 68, at 40; Lohr, *supra* note 21, at BU1.

[74] *See* Abraham & Weiler, *supra* note 28, at 383.

[75] *See* Weiler, *supra* note 10, at 910.

[76] *See* Lohr, *supra* note 21, at BU1.

[77] *See* INST. OF MED., *supra* note 13, at 3.

[78] *See* Studdert & Brennan, *supra* note 30, at 225–26.

systemic reforms including enterprise liability and no-fault systems.[79] The following two sections describe these reforms and their history in greater detail.[80]

B. *Enterprise Liability*

Advocates first proposed enterprise liability as a systemic reform for the medical-malpractice system in the 1970s.[81] The reform proposal evolved out of the steady development of caselaw holding hospitals liable for patient injuries.[82] Not long ago, the idea of holding a hospital liable for the torts of its physicians was far-fetched.[83] Early American hospitals were charitable institutions where the sick and poor would go to die.[84] Those who could afford healthcare treatment stayed home and had doctors come to them.[85] Courts dismissed the idea of holding a charitable hospital vicariously liable for the negligent acts of a physician.[86] At that time, hospitals simply provided a venue for doctors to perform their duties.[87] Hospitals exercised little or no control over doctors, leading courts to distinguish easily the hospital-doctor relationship from the typical employer-employee relationship that gives rise to vicarious liability.[88] Additionally, these early hospitals may not have been able to keep their doors open to the sick and poor if they had been shouldered with vicarious liability.[89] Therefore, courts established a doctrine of charitable immunity for hospitals, which clearly exempted hospitals from vicarious liability for physicians' acts and from most direct liability for errors in treatment.[90]

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[79] *See* Abraham & Weiler, *supra* note 28, at 436; David M. Studdert & Troyen A. Brennan, *No-Fault Compensation for Medical Injuries*, 286 JAMA 217, 222 (2001); Weiler, *supra* note 10, at 947–948;

[80] *See infra* notes 81–173 and accompanying text.

[81] Abraham & Weiler, *supra* note 28, at 384.

[82] *Id.* at 385–94.

[83] *See* Michael v. Hahnemann Med. Coll. & Hosp. of Phila., 172 A.2d 769, 786 (Pa. 1961) (Musmanno, J., dissenting).

[84] *See id.*

[85] *See id.*

[86] *See id.*; *see also* McDonald v. Mass. Gen. Hosp., 120 Mass. 432, 434–36 (1876), *overruled by* Colby v. Carney Hosp., 254 N.E.2d 407 (Mass. 1969); Abraham & Weiler, *supra* note 28, at 385–86.

[87] *See* HEALTH-CARE LAW AND ETHICS, *supra* note 33, at 421–23.

[88] *See id.*; *see also* Schloendorff v. Soc'y of N.Y. Hosp., 105 N.E. 92, 94 (N.Y. 1914), *abrogated by* Bing v. Thunig, 143 N.E.2d 3 (N.Y. 1957).

[89] *See Schloendorff*, 105 N.E. at 94; HEALTH-CARE LAW AND ETHICS, *supra* note 33, at 421–23.

[90] *See McDonald*, 120 Mass. at 434–36; *Schloendorff*, 105 N.E. at 94; Abraham & Weiler, *supra* note 28, at 385–86.

The doctrine of charitable immunity lasted until the 1950s when the law began to adjust to the changing world of healthcare.[91] By the 1950s, hospitals were less like charitable institutions and more like sophisticated centers of healthcare delivery.[92] Although physicians were still independent contractors of hospitals, their relationship with hospitals became increasingly like an employer-employee relationship.[93] As a result, charitable immunity dissolved, causing hospitals to be held vicariously liable for the negligent acts of physicians when there is apparent authority or when the hospital negligently hired or supervised the physician. [94]

Currently, hospitals can be held liable for physician negligence when physicians are held out as hospital employees.[95] If the relationship appears sufficiently similar to that of an employer and employee, the tort doctrine respondeat superior applies, exposing a hospital to liability for a physician's negligent acts.[96] As hospitals have become more involved in the delivery of healthcare, including doctor-patient relationship and treatment decisions, courts have become more willing to hold them liable for treatment-related injuries, regardless of the hospital's fault.[97] Now, hospitals can be liable for healthcare related injuries through vicarious liability and corporate liability.[98]

With hospitals assuming more responsibility for both the provision and liability of healthcare, reformers and academics began to consider the state of the healthcare system if hospitals were to assume all malpractice liability.[99] Under an enterprise liability system, a hospital is liable for all malpractice regardless of whether the culpable individual healthcare provider is an employee, independent contractor, or

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[91] *See Bing*, 143 N.E.2d at 8; Abraham & Weiler, *supra* note 28, at 385–86.

[92] *See Bing*, 143 N.E.2d at 8; Abraham & Weiler, *supra* note 28, at 385–86.

[93] *See* Adamski v. Tacoma Gen. Hosp., 579 P.2d 970, 978–79 (Wash. Ct. App. 1978); Abraham & Weiler, *supra* note 28, at 386–92.

[94] *See* President & Dirs. of Georgetown Coll. v. Hughes, 130 F.2d 810, 823–24 (D.C. Cir. 1942); Abraham & Weiler, *supra* note 28, at 386–92. Some states still maintain a diluted system of charitable immunity where the amount a patient can recover from a nonprofit hospital is capped. *See* Note, *The Quality of Mercy: "Charitable Torts" and Their Continuing Immunity*, 100 HARV. L. REV. 1382, 1398 (1987) (arguing charitable immunity should be eliminated where it remains).

[95] *See Adamski*, 579 P.2d at 978–79; Abraham & Weiler, *supra* note 28, at 386–89.

[96] *See Adamski*, 579 P.2d at 978–79; Abraham & Weiler, *supra* note 28, at 386–89.

[97] *See* Darling v. Charleston Cmty. Mem'l Hosp., 211 N.E.2d 253, 260 (Ill. 1965); *Adamski*, 579 P.2d at 978–79.

[98] Abraham & Weiler, *supra* note 28, at 393. A hospital could be found liable under a theory of corporate liability when it, for example, negligently grants staff privileges to an inadequate physician. *See id.* at 381, 389, 393.

[99] *See id.* at 393–94.

holder of admitting privileges.[100] An exclusive enterprise liability system would allow patients to sue only hospitals, thus insulating individual providers from liability.[101] By limiting the liability to hospitals, medical-malpractice suits would appreciably simplify, as there would be only one defendant available to potential plaintiffs.[102]

Enterprise liability had a brief moment in the spotlight in the spring of 1993 when the Clinton Administration began vetting its proposals for healthcare reform.[103] The original Clinton plan included a national system of enterprise liability.[104] The AMA and the Physician Insurer Association of America ("PIAA") aggressively opposed this proposal.[105] Although one might expect a physicians' lobbying group to support legislation that would immunize physicians from medical-malpractice liability, the AMA believed that by making hospitals exclusively liable for malpractice, physician autonomy would be curtailed by hospitals and administrators.[106] The lobbying effort of the AMA and PIAA succeeded, and the final Clinton proposal only suggested pilot programs to test enterprise liability.[107] The Clinton reforms ultimately died in Congress, but enterprise liability has remained a tantalizing idea for systemic reform to many health-policy experts.[108]

An enterprise liability approach to medical malpractice in the United States would maintain most of the infrastructure and legal norms of the current medical-malpractice system.[109] Liability would still be based on a finding of fault.[110] The key change would make

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[100] *See id.* at 393.

[101] *See id.* at 393–94. A non-exclusive system would still allow patients to sue individual providers. *See id.* Individual providers could continue to insure against personal liability as they do under the current system. *See id.*

[102] *See* Jacobi & Huberfield, *supra* note 29, at 307.

[103] *See* Abraham & Weiler, *supra* note 28, at 382–84; William M. Sage, *Unfinished Business: How Litigation Relates to Health Care Regulation*, 28 J. HEALTH POL. POL'Y & L. 387, 410 (2003).

[104] *See* William M. Sage, *Medical Malpractice Insurance and the Emperor's Clothes*, 54 DEPAUL L. REV. 463, 466 n.13, 473 n.44 (2005); Sage, *supra* note 103, at 382–83; Paul C. Weiler, *Reforming Medical Malpractice in a Radically Moderate—And Ethical—Fashion*, 54 DEPAUL L. REV. 205, 223 (2005). *See generally* Symposium, *Starting Over?: Redesigning the Medical Malpractice System*, 54 DEPAUL L. REV. 203 (2005).

[105] *See* Abraham & Weiler, *supra* note 28, at 383; Sage, *supra* note 104, at 437 n.44; Sage, *supra* note 103, at 410.

[106] *See* Abraham & Weiler, *supra* note 28, at 383; Sage, *supra* note 104, at 437 n.44; Sage, *supra* note 103, at 410.

[107] Abraham & Weiler, *supra* note 28, at 384; Weiler, *supra* note 104, at 223.

[108] *See* Abraham & Weiler, *supra* note 28, at 394–95; Weiler, *supra* note 104, at 223.

[109] *See* Abraham & Weiler, *supra* note 28, at 393.

[110] *See id.* at 434.

hospitals assume the legal liability of individual providers, even those with off-site facilities.[111] Doctors would need to submit themselves to additional control and supervision from hospitals in exchange for immunity from personal liability for malpractice.[112] An enterprise liability system would funnel all malpractice claims to hospitals without changing the applicable law of negligence.[113]

C. *No-Fault Liability*

No-fault also emerged as a possible systemic reform for medical-malpractice law in the 1970s.[114] During the malpractice crisis of the 1970s, reformers suggested creating a no-fault system of liability for medical malpractice similar to the workers' compensation scheme being developed at the time.[115] In general terms, a no-fault system would eliminate the need for courts to find doctors or other healthcare providers negligent for an injured patient to receive compensation.[116] Instead, a patient would automatically recover for injuries caused by medical care through an administrative system in which an injured patient would fill out a form and then a review board would process the claim.[117] With the medical-malpractice crisis subsiding and scholars predicting that a no-fault system would be more costly due to higher compensation rates, interest dissipated.[118]

In the last ten years, interest in creating a no-fault medical-malpractice system has resurged because of its potential to reduce medical error and improve patient safety.[119] In 2000, the Institute of Medicine issued a report citing that between 44,000 and 98,000 deaths are caused every year by medical error.[120] This report highlighted a pressing need to improve the way the U.S. healthcare system

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[111] *See id.* at 393–94; Furrow, *supra* note 20, at 109; Weiler, *supra* note 104, at 224.

[112] *See* Furrow, *supra* note 20, at 109, 112.

[113] *See* Abraham & Weiler, *supra* note 28, at 434; Weiler, *supra* note 104, at 224.

[114] Weiler, *supra* note 10, at 910.

[115] Weiler, *supra* note 10, at 910–11; *see* Eleanor D. Kinney, *Administrative Law Approaches to Medical Malpractice Reform*, 49 ST. LOUIS U. L.J. 45, 48 (2004).

[116] Studdert et al., *supra* note 31, at 6; Weiler, *supra* note 104, at 227; Weiler, *supra* note 10, at 919–20.

[117] *See* Studdert et al., *supra* note 31, at 6; Weiler, *supra* note 10, at 919–20.

[118] *See* Weiler, *supra* note 10, at 910–11.

[119] *See* Mark A. Hall, *Can You Trust a Doctor You Can't Sue?*, 54 DEPAUL L. REV. 303, 309 (2005); Studdert & Brennan, *supra* note 79, at 217; Weiler, *supra* note 104, at 227; Weiler, *supra* note 10, at 912.

[120] INST. OF MED., *supra* note 13, at 1.

identifies and manages error.[121] Currently, there is not enough incentive for healthcare providers to report errors.[122] Consequently, valuable information is being lost.[123] A system that encourages providers to report errors would provide opportunities to identify recurring errors and ways to correct them.[124] The fault-based medical-malpractice system provides the opposite incentive because admitting errors is an invitation to a lawsuit.[125] Recognizing this tension between fault-based liability and the need to gather information to limit medical error, reformers have a renewed interest in creating a no-fault system.[126]

Under a no-fault system, hospitals would have a strong financial incentive to gather information about errors and reduce them because hospitals would be compensating patients for their injuries.[127] Regardless of whether the error was an act of negligence or a mistake that did not breach the standard of care, the hospital would have to compensate patients for injuries caused by the error.[128] Physicians would be more willing to discuss cases candidly, including errors, because they would not be subject to individual liability, and their fault would not affect the hospital's liability.[129] Thus, a no-fault system could be a catalyst for significant improvements in patient safety and care.[130]

Although the medical-malpractice system is largely based on a negligence theory of liability, the tort system has pockets of strict liability that could serve as models for a no-fault medical-malpractice system.[131] Strict liability has deep roots, dating to English common law.[132] Before negligence became the norm in tort law, tortfeasors

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[121] *See id.*; David A. Hyman & Charles Silver, *The Poor State of Health Care Quality in the U.S.: Is Malpractice Liability Part of the Problem or Part of the Solution?*, 90 CORNELL L. REV. 893, 896 (2005) (acknowledging the influence of the Institute of Medicine report on malpractice reform).

[122] *See* Lawrence Gostin, *A Public Health Approach to Reducing Error*, 283 JAMA 1742, 1742–43 (2000). *But see* Hyman & Silver, *supra* note 121, at 893.

[123] *See* Gostin, *supra* note 122, at 1743.

[124] *See* Hall, *supra* note 119, at 309; Studdert & Brennan, *supra* note 79, at 219.

[125] *See* Studdert & Brennan, *supra* note 79, at 218–19.

[126] *See id.* at 218; Weiler, *supra* note 104, at 229–30. *See generally* Randall R. Bovbjerg & Frank A. Sloan, *No-Fault for Medical Injury: Theory and Evidence*, 67 U. CIN. L. REV. 53 (1998).

[127] *See* Studdert & Brennan, *supra* note 79, at 221.

[128] *See id.*

[129] *See id.*

[130] *See id.*

[131] *See* DAN B. DOBBS & PAUL T. HAYDEN, TORTS AND COMPENSATION 556 (4th ed. 2001); Weiler, *supra* note 10, at 910–11 (discussing worker's compensation as a strict liability model for no-fault).

[132] DOBBS & HAYDEN, *supra* note 131, at 590–92.

were held strictly liable for injuries they caused regardless of their fault.[133] As long as tortfeasors caused an injury, they were liable for damages.[134] Over time, negligence emerged as a fairer approach to distributing the costs of risks and injuries, but strict liability did not entirely disappear.[135]

Workers' compensation is a contemporary example of no-fault liability in the U.S. legal system.[136] Under workers' compensation statutes, when an employee is injured in the course of employment, the employer compensates the employee for the injury regardless of the employer's fault in causing the injury.[137] All states and the federal government enacted workers' compensation statutes, most by 1920.[138] These programs, administered by states or private insurers, hold employers strictly liable for injuries arising in the course of employment.[139] An employer is liable for fixed amounts that are set out for specific injuries in the statutes.[140] The employee can recover medical expenses and lost wages, but cannot recover for pain and suffering.[141] Injured employees are entitled to immediate and periodic payments as long as the disability exists.[142] Disputes are settled by an administrative agency.[143] The system is funded through insurance that employers are required, or strongly encouraged, to purchase through the workers' compensation statutes.[144] A no-fault medical-malpractice system might resemble the administrative system of workers' compensation, though a no-fault medical-malpractice system would probably have a narrower range of compensable injuries.[145]

Products liability is another area of strict liability in tort law.[146] A seller of a product may be strictly liable for injuries caused by the product if: (1) the seller is in the business of selling the product, (2) the product is expected to and does reach the user without substantial change, and (3) the product was sold in a defective condition unrea-

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[133] *Id.*
[134] *Id.*
[135] *See id.*
[136] *Id.* at 822.
[137] DOBBS & HAYDEN, *supra* note 131, at 822.
[138] *Id.*
[139] *Id.* at 822, 827.
[140] *Id.* at 822.
[141] *Id.*
[142] DOBBS & HAYDEN, *supra* note 131, at 822.
[143] *Id.* at 822–23.
[144] *Id.* at 823.
[145] *See id.* at 822–23; Studdert et al., *supra* note 31, at 5–9.
[146] DOBBS & HAYDEN, *supra* note 131, at 626.

sonably dangerous to the consumer.[147] Products liability is already a part of health law.[148] Pharmaceutical and medical device companies are subject to products liability suits, and the experiences of these industries provide insight into how to design a no-fault medical-malpractice system in light of the special needs and issues of healthcare.[149]

There even exists a small pocket of no-fault liability in current medical-malpractice law.[150] Virginia and Florida implemented no-fault systems to provide compensation for babies who suffer neurological injuries during delivery regardless of fault.[151] The programs provide compensation for these limited injuries regardless of the fault of healthcare providers.[152] The no-fault models in Virginia and Florida may offer additional guidance for developing a comprehensive no-fault system.[153]

A comprehensive no-fault system liability could use a wide range of recovery schemes.[154] The most liberal models allow for recovery for all kinds of injuries with no regard for causation, but this would be expensive and impractical.[155] Therefore, a no-fault system should only allow compensation for limited injuries.[156] Furthermore, any feasible no-fault system would also offer compensation based on the level of causation.[157]

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[147] *See* RESTATEMENT (SECOND) OF TORTS § 402(A) (1965); *see also* RESTATEMENT (THIRD) OF TORTS: PRODUCTS LIABILITY § 1 (1998) ("One engaged in the business of selling or otherwise distributing products who sells or distributes a defective product is subject to liability for harm to persons or property caused by the defect.").

[148] *See* Laura Pleicones, Note, *Passing the Essence Test: Health Care Providers Escape Strict Liability for Medical Devices*, 50 S.C. L. REV. 463, 464–65 (1999) (discussing a decision of the South Carolina Supreme Court to hold healthcare providers not strictly liable for defective medical devices).

[149] *See* Walker v. Johnson & Johnson Vision Prods., Inc., 552 N.W.2d 679, 687 (Mich. Ct. App. 1996) (holding that common law products liability claims can be brought against Class III medical device manufacturers).

[150] *See* Studdert et al., *supra* note 31, at 1–2; Weiler, *supra* note 10, at 936 n.87.

[151] *See* Studdert et al., *supra* note 31, at 1–2; Weiler, *supra* note 10, at 936 n.87; *see also* Maxwell J. Mehlman, *Bad "Bad Baby" Bills*, 20 AM. J.L. & MED. 129, 129 (1994); Peter H. White, *Innovative No-Fault Tort Reform for an Endangered Specialty*, 74 VA. L. REV. 1487, 1487 (1988).

[152] *See* Weiler, *supra* note 10, at 936 n.88.

[153] *See id.*

[154] *See* Studdert et al., *supra* note 31, at 10–11.

[155] *See id.* at 6–10.

[156] *See id.*

[157] *See id.*; Weiler, *supra* note 104, at 227 (suggesting compensation only be provided to injuries that last at least two months).

The Swedish system provides a working example of what a no-fault system could look like in the United States.[158] Sweden uses a no-fault model that compensates injuries caused by treatment that could have been avoided.[159] In Sweden, if a patient believes an injury was a result of medical care, the patient fills out an application for compensation, usually with the assistance of a physician.[160] After the patient files the claim, the treating physician fills out a report.[161] Then, adjustors and physicians working for a national central claims office decide whether the injury was caused by treatment and whether the injuries could have been avoided.[162] Only patients with injuries caused by treatment that could have been avoided receive compensation.[163] Although the causation and avoidability test does not clearly indicate exactly which treatment injuries deserve compensation, the structured judgments of the claims office seem to be more predictable and objective than judgments of negligence.[164] In addition to requiring avoidability to merit compensation, Sweden also instituted a disability threshold to control costs.[165] To be eligible for no-fault compensation, the patient must have spent at least ten days in the hospital or have used more than thirty sick days.[166] The Swedish process usually takes six months from filing a claim to receiving a decision.[167]

A no-fault system in the United States would not be exactly like Sweden's system, but three characteristics of their system can be used to compare no-fault with enterprise liability as reforms for the United States.[168] First, a no-fault system would require hospitals to pay for medical errors.[169] In this respect, a no-fault system would be similar to an enterprise-liability model.[170] Second, a no-fault system would not inquire whether treatment was negligently provided.[171] Rather, an inquiry would be made as to whether the injury was avoidable to deter-

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[158] Studdert et al., *supra* note 31, at 8.

[159] *See id.*

[160] *See id.* at 6.

[161] *See id.*

[162] *See id.* at 7.

[163] Studdert et al., *supra* note 31, at 7.

[164] *See id.*

[165] *See id.* at 8.

[166] *Id.*

[167] *Id.* at 6.

[168] *See, e.g.*, Abraham & Weiler, *supra* note 28, at 434; Studdert et al., *supra* note 31, at 5–9; Weiler, *supra* note 10, at 919–20.

[169] *See* Weiler, *supra* note 10, at 919–20.

[170] *See* Abraham & Weiler, *supra* note 28, at 434.

[171] *See* Weiler, *supra* note 10, at 919–20.

mine liability.[172] Third, a no-fault system would use an administrative body to process claims and make compensation decisions rather than a court of law.[173]

II. Analysis

A. *Framework for Analysis*

Enterprise liability and no-fault are both sweeping models of reform for medical-malpractice law.[174] The two share many characteristics; in fact, enterprise liability is part of the foundation of no-fault.[175] Although enterprise liability and no-fault have each been discussed in existing literature, the two have not been explicitly compared to determine which would be a better reform.[176] This Part compares enterprise liability with no-fault to determine which would be the better reform model.[177]

This Note compares the two models on the basis of four factors.[178] The four factors are: (1) the goal of compensation, (2) the goal of deterrence, (3) the requirement of economic feasibility, and (4) the requirement of sociopolitical feasibility.[179] Each of these factors are discussed individually in turn in greater detail, leading to the conclusion that enterprise liability is the better model for reform because it is significantly more feasible.[180]

The first two factors, deterrence and compensation, are often described as the twin goals of tort law.[181] Medical-malpractice law similarly serves to prevent injuries and compensate injured patients.[182] Medical-malpractice law deters healthcare providers from harming patients, and compensates patients for injuries.[183] Thus, any evalua-

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[172] *See* Studdert et al., *supra* note 31, at 7.

[173] *See id.* at 6.

[174] *See* Abraham & Weiler, *supra* note 28, at 436; Weiler, *supra* note 10, at 947–48.

[175] *See* Studdert & Brennan, *supra* note 30, at 227–29; Weiler, *supra* note 10, at 919–21.

[176] *See e.g.*, Abraham & Weiler, *supra* note 28, at 432–36; Studdert et al., *supra* note 31, at 32–34; Weiler, *supra* note 10, at 947–48.

[177] *See infra* notes 181–386 and accompanying text.

[178] *See infra* notes 181–95 and accompanying text.

[179] *See infra* notes 181–95 and accompanying text.

[180] *See infra* notes 181–386 and accompanying text.

[181] *See* Pegalis & Wachsman, *supra* note 11, § 2:10.

[182] *See id.*

[183] *See id.*

tion must consider how the alternatives serve deterrence and compensation.[184]

In addition to evaluating how an alternative medical-malpractice system serves deterrence and compensation, the system must also be feasible.[185] A system's feasibility should be evaluated by its cost and economic efficiency.[186] Alternative medical-malpractice systems must be cost-sensitive because the already expensive U.S. healthcare system cannot afford a more costly malpractice system.[187] A malpractice system also should be efficient.[188] Efficiency in this context measures what percentage of medical-malpractice costs actually compensate patients and how quickly malpractice claims are resolved.[189]

Feasibility also should be measured by how well the system fits the prospective cultural and political environment.[190] A systemic reform of medical-malpractice must rally support and gain political momentum to be enacted.[191] In addition to political demands, an alternative medical-malpractice system must meet social and cultural needs.[192] Healthcare is a unique realm of public policy where questions about life, mortality, and human frailty are ever-present.[193] Health problems can be intensely personal, complicated, and consuming for patients.[194] Systemic changes in medical-malpractice law will have ramifications that extend far beyond the courtroom.[195]

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[184] *See id.*

[185] *See* Studdert et al., *supra* note 31, at 3.

[186] *See id.*

[187] *See* NAT'L CTR. FOR HEALTH STATISTICS, *supra* note 25, at 14, 326 (stating that healthcare spending in the United States was $1.5 trillion in 2002, 14.9% of the GDP).

[188] *See* Weiler, *supra* note 10, at 926 (stating the cost of malpractice litigation consumes fifty-five to sixty percent of every claims dollar).

[189] *See id.*

[190] *See* SKOCPOL, *supra* note 56, at 173–78 (discussing the failure of the Clinton Administration's Health Security proposal and the important role social and political forces played in bringing about this failure); Weiler, *supra* note 10, at 947–48.

[191] *See* SKOCPOL, *supra* note 56, at 173–78; Weiler, *supra* note 10, at 947–48.

[192] *See* SKOCPOL, *supra* note 56, at 173–78; Weiler, *supra* note 10, at 947–48.

[193] *See* ATUL GAWANDE, COMPLICATIONS: A SURGEON'S NOTES ON AN IMPERFECT SCIENCE 4 (2002).

[194] *See id.* at 8; Gibeaut, *supra* note 68, at 44.

[195] *See* Abraham & Weiler, *supra* note 28, at 436; Studdert et al., *supra* note 31, at 32–34; Weiler, *supra* note 10, at 947–48.

B. *Goal of Compensation*

1. Enterprise Liability

A medical-malpractice system should compensate patients for injuries caused by malpractice.[196] An enterprise-liability system would make compensation more frequent, consistent, and predictable.[197] The current medical-malpractice system compensates few patients relative to the amount of injuries sustained.[198] Additionally, compensation varies significantly from case to case.[199] Enterprise liability would improve patient compensation by streamlining medical-malpractice claims and by making outcomes more predictable.[200] More injured patients would be able to receive compensation because malpractice actions would be simpler and less expensive in so far as plaintiffs would only bring a claim against one defendant, the hospital.[201]

Enterprise liability also promises to improve compensation by making claims more predictable.[202] Hospitals would become more experienced with medical-malpractice claims and would be able to distinguish legitimate claims from frivolous claims more easily.[203] Hospitals might settle more valid claims because their reputations would not be as vulnerable as the reputations of individual physicians who are motivated to fight every claim.[204] Hospitals might focus their resources on fighting frivolous and weak claims and settling stronger claims.[205] Thus, claims would become more predictable and compensation would reflect actual injuries more closely.[206]

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[196] *See* PEGALIS & WACHSMAN, *supra* note 11, § 2:10; Weiler, *supra* note 104, at 227.

[197] *See* Abraham & Weiler, *supra* note 28, at 401–06; Edward P. Richards & Thomas R. McLean, *Administrative Compensation for Medical Malpractice Injuries: Reconciling the Brave New World of Patient Safety and the Torts System*, 49 ST. LOUIS U. L.J. 73, 89 (2004) (stating that an enterprise liability system would increase money available to patients and would compensate patients more often because corporate defendants are less sympathetic to juries); Sage, *supra* note 104, at 476.

[198] *See* Hyman, *supra* note 10, at 1643.

[199] *See id.* at 1643-44.

[200] *See* Abraham & Weiler, *supra* note 28, at 406.

[201] *See id.* at 403, 406; Weiler, *supra* note 104, at 224–25.

[202] *See* Abraham & Weiler, *supra* note 28, at 403; Furrow, *supra* note 20, at 101, 109.

[203] *See* Abraham & Weiler, *supra* note 28, at 403.

[204] *See id.* at 404; Weiler, *supra* note 10, at 916.

[205] *See* Abraham & Weiler, *supra* note 28, at 404, 406 (discussing how damages might be standardized by an enterprise liability system).

[206] *See id.* at 403, 406; Mark Geistfeld, *Malpractice Insurance and the (Il)legitimate Interests of the Medical Profession in Tort Reform*, 54 DEPAUL L. REV. 436, 459–60 (2005) (comparing damage caps with enterprise liability and finding that enterprise liability would make malpractice premiums more representative and fairer).

Enterprise liability would improve compensation, but maintaining the fault requirement should limit compensation to the same kind of injuries and claims that are successful under the current system.[207] Enterprise liability would improve compensation largely through making the litigation process more efficient and cost-effective.[208]

2. No-fault

An enterprise liability system would improve compensation through gains in efficiency.[209] A no-fault system would couple these improvements with an expansion of compensation to more injured patients.[210] A study in 1997 tested the economic feasibility of a no-fault system like Sweden's in Colorado and Utah.[211] The study found that, even by conservative estimates, two to three times the number of patients would be compensated in Utah and Colorado respectively, while only modestly increasing the cost relative to the negligence-based malpractice system.[212] A dramatic increase in compensation like this would alleviate the problem of deserving patients not receiving compensation.[213]

Potential economic problems temper the advantages of the no-fault system.[214] A larger number of claimants might spread compensation resources too thin.[215] Although more patients would be eligible for compensation, there may not be adequate funds to compensate these patients meaningfully.[216] Because of limited resources, it may be better to limit compensation to cases where there has been a judicial finding of negligence.[217] The goal of compensation would not be well

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[207] *See* Abraham & Weiler, *supra* note 28, at 432–33.

[208] *See id.* at 406; Weiler, *supra* note 104, at 224–25.

[209] *See* Abraham & Weiler, *supra* note 28, at 406; Bovbjerg & Sloan, *supra* note 126, at 71; Weiler, *supra* note 104, at 224–25.

[210] *See* Abraham & Weiler, *supra* note 28, at 406; Bovbjerg & Sloan, *supra* note 126, at 70; Weiler, *supra* note 10, at 919–20.

[211] *See generally* Studdert et al., *supra* note 31 (describing the study and presenting its results).

[212] *Id.* at 29–30.

[213] *See* Barbara Brill, *An Experiment in Patient Injury Compensation: Is Utah the Place?*, 1996 UTAH L. REV. 987, 1003; Studdert et al., *supra* note 33, at 29–30.

[214] *See* Mary Ann Kupeli, Survey, *Tort Law = No Fault Compensation: An Unrealistic Elixir to the Medical Malpractice Ailment*, 19 SUFFOLK TRANSNAT'L L. REV. 559, 568–71 (1996).

[215] *See* Bovbjerg & Sloan, *supra* note 126, at 73; Studdert et al., *supra* note 31, at 29 (estimating that no-fault liability in Colorado and Utah would have a higher direct cost than the existing negligence system).

[216] *See* Bovbjerg & Sloan, *supra* note 126, at 73; Studdert et al., *supra* note 31, at 29.

[217] *See* Kupeli, *supra* note 214, at 560. *But see* Studdert et al., *supra* note 31, at 33.

served if a no-fault system opened the door for recovery so wide that all patients, especially the most severely injured and deserving, would not be adequately compensated for their losses.[218]

3. Which System Is Better?

A no-fault system would be a more effective way to compensate injured patients than enterprise liability.[219] No-fault promises to compensate a greater number of injured patients more consistently and appropriately.[220] A no-fault system runs the risk of casting the net too wide and compensating undeserving patients, but because there are limited resources available to compensate patients, it is likely that only legitimately injured patients would be compensated.[221] The social advantages of assisting people with injuries caused by medical treatment, even if the injuries were caused by mistakes rather than negligence, are high.[222]

In addition to increasing the number of compensable injuries and parties, a no-fault system would also serve to standardize compensation.[223] Currently, the fault-based medical-malpractice system creates the possibility that one injured patient could hit the metaphorical jackpot with their medical-malpractice claim and be awarded huge punitive damages in addition to compensatory damages.[224] This would not change in a fault-based enterprise liability system.[225] These large awards are designed to serve deterrence goals rather than compensation.[226] By standardizing compensation under a no-fault system, the punitive damages would be spread across many injured parties, thus providing more people with compensation and having compensation better reflect the nature of the injuries sustained.[227] Compensation is not well-served when so few patients recover for their injuries, nor is it served by having like patients receive different amounts.[228]

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[218] *See* Studdert et al., *supra* note 31, at 29.

[219] *See id.* at 33; Weiler, *supra* note 104, at 227; Weiler, *supra* note 10, at 921–22.

[220] *See* Studdert et al., *supra* note 31, at 29; Weiler, *supra* note 10, at 921–22.

[221] *See* Bovbjerg & Sloan, *supra* note 126, at 70, 73; Studdert et al., *supra* note 31, at 29–31; Weiler, *supra* note 10, at 921–22.

[222] *See* Studdert et al., *supra* note 31, at 29–31; Weiler, *supra* note 10, at 921–22.

[223] *See* Bovbjerg & Sloan, *supra* note 126, at 70–71; Weiler, *supra* note, 10 at 922.

[224] *See* Weiler, *supra* note 10, at 922.

[225] *See id.*

[226] *See id.*

[227] *See* Bovbjerg & Sloan, *supra* note 126, at 70–71; Weiler, *supra* note 10, at 922.

[228] *See* Randall R. Bovbjerg et al., *Administrative Performance of "No-Fault" Compensation for Medical Injury*, 60 LAW & CONTEMP. PROBS., Spring 1997, at 71, 71–72.

Enterprise liability would not improve compensation nearly as much as a no-fault system because enterprise liability would continue to compensate roughly the same inadequate number of patients.[229] An enterprise liability system would only improve compensation relative to the current system by giving hospitals more experience with malpractice claims, thereby helping them more easily and consistently settle legitimate claims and oppose weak claims.[230] Although these improvements should not be overlooked, relative to a no-fault system, enterprise liability does not serve compensation goals as well.[231]

C. *Goal of Deterrence*

1. Enterprise Liability

A medical-malpractice system should deter physicians from committing malpractice and encourage them to provide the best possible care.[232] Enterprise liability would deter physicians from committing malpractice more effectively than the current system, and improve patient safety.[233] An enterprise liability system would give hospitals added incentive to gather more data about medical errors, which might reveal patterns, revealing potential ways to eliminate errors.[234] Additionally, the hospital would have additional incentive to correct or remove inadequate physicians.[235] Currently, peer review boards are not effective because there is too much professional courtesy.[236] By imposing liability on hospitals for all medical-malpractice, hospitals would have a heightened financial incentive to identify physicians providing substandard care, correct their treatments, or stop the physicians from practicing.[237] Defensive medicine also would be curbed since physicians would no longer fear being held personally

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[229] *Compare* Abraham & Weiler, *supra* note 28, at 401–06 (discussing the ability of enterprise liability to provide compensation), *with* Weiler, *supra* note 10, at 922–24 (discussing how a no-fault system could compensate more patients more equitably than the current system).

[230] *See* Abraham & Weiler, *supra* note 28, at 403, 406.

[231] *Compare* Abraham & Weiler, *supra* note 28, at 401–06 (discussing the ability of enterprise liability to provide compensation), *with* Weiler, *supra* note 10, at 922–24 (discussing the ability of no-fault to provide compensation).

[232] *See* Pegalis & Wachsman, *supra* note 11, § 2:10.

[233] *See* Abraham & Weiler, *supra* note 28, at 407–14; Furrow, *supra* note 20, at 101.

[234] *See* Abraham & Weiler, *supra* note 28, at 413; Furrow, *supra* note 20, at 110.

[235] *See* Abraham & Weiler, *supra* note 28, at 413–14; Furrow, *supra* note 20, at 110.

[236] *See* Pegalis & Wachsman, *supra* note 11, § 2:10.

[237] *See* Abraham & Weiler, *supra* note 28, at 413–14; Furrow, *supra* note 20, at 110.

liable for malpractice.[238] Because defensive medicine can result in unnecessary care, which puts patients at higher risk of iatrogenic injury, a reduction would improve patient safety.[239]

Another advantage of an enterprise-liability system would be that, unlike individual physicians under the current system, hospitals' medical-malpractice insurance would become experience-rated.[240] This would mean that hospitals with better safety records would have access to less expensive insurance.[241] This would give hospitals a financial incentive to improve patient safety by looking for systemic improvements and by pressuring their individual providers to provide better, safer care.[242]

The major drawback to an enterprise liability system with respect to deterrence is that it would lessen the responsibility of individual physicians to give their patients the best possible care.[243] Deterrence is sacrificed at the individual level in hopes of making gains in patient safety by providing greater incentives to gather and analyze data about medical error.[244]

2. No-fault

A no-fault system of liability should also facilitate efforts to improve patient safety.[245] A no-fault system would encourage hospitals to educate individual providers more aggressively about patient safety and to discipline them for providing inadequate care.[246] A no-fault system would magnify the incentives for hospitals to improve patient safety.[247]

A no-fault system would hold hospitals liable for a broader range of injuries caused by medical care than a negligence system.[248] This increased liability would encourage hospitals to find more ways to re-

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[238] *See* Abraham & Weiler, *supra* note 28, at 407–14.

[239] *See id.*; Sage, *supra* note 104, at 475–76.

[240] *See* Abraham & Weiler, *supra* note 28, at 403–04; Weiler, *supra* note 10, at 914–15.

[241] *See* Abraham & Weiler, *supra* note 28, at 403–04, 409–11; *see also* Geistfeld, *supra* note 206, at 460 (stating that enterprise liability would replace individual premiums with enterprise premiums, which would be fairer).

[242] *See* Abraham & Weiler, *supra* note 28, at 403–04, 409–11; Furrow, *supra* note 20, at 110.

[243] *See* Kupeli, *supra* note 214, at 570.

[244] *See* Abraham & Weiler, *supra* note 28, at 407–14; Furrow, *supra* note 20, at 110.

[245] Studdert & Brennan, *supra* note 31, at 227–29; Weiler, *supra* note 10, at 937–39.

[246] *See* Studdert & Brennan, *supra* note 31, at 227–29; Weiler, *supra* note 10, at 937–39.

[247] *See* Studdert & Brennan, *supra* note 31, at 227–29; Weiler, *supra* note 10, at 937–39.

[248] *See* Weiler, *supra* note 104, at 227; Weiler, *supra* note 10, at 919–20.

duce medical error, including error not caused by negligence.[249] Physicians might have less reason to be hesitant about sharing their concerns about potential errors because their fault would not affect the liability of the hospital.[250] The advantages of an enterprise liability system would be heightened by a no-fault system, which would further relieve individual providers from their unproductive fear of liability and give hospitals greater incentive to reduce medical error.[251]

Like enterprise liability, no-fault also has the problem of potentially reducing the accountability of individual providers by shifting liability to hospitals.[252] An enterprise liability system would remove the accountability from individuals and shift it to a hospital, but hospitals would still only lose cases when a provider is found to be at fault.[253] Under an enterprise liability system, the law would still focus on the individual actions of providers.[254] This focus pressures physicians to provide perfect care.[255] A shift to a no-fault system would reduce this pressure and might allow physicians to be careless without fear of retribution from the legal system.[256]

Alternatively, a no-fault system might make doctors more careful because they would know that their errors, even errors that were not the result of negligence, would still merit compensation.[257] Individual providers would have incentive to keep their hospitals happy by doing everything they could to keep their error rates as low as possible.[258] In a profession steeped with moral and ethical obligations, this may be the more likely effect of a no-fault system.[259]

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[249] *See* Hall, *supra* note 119, at 309–10; Weiler, *supra* note 10, at 939.

[250] *See* Weiler, *supra* note 10, at 939.

[251] *See* Weiler, *supra* note 104, at 228–30; Weiler, *supra* note 10, at 939.

[252] *See* Kupeli, *supra* note 214, at 570.

[253] *See* Abraham & Weiler, *supra* note 28, at 383.

[254] *See id.*; Furrow, *supra* note 20, at 109.

[255] *See* Abraham & Weiler, *supra* note 28, at 383.

[256] *See* Kupeli, *supra* note 214, at 570. *But see* Weiler, *supra* note 104, at 223 (noting that individual providers are already distanced from personal liability because insurance almost always pays the costs of malpractice suits).

[257] *See* Weiler, *supra* note 10, at 938.

[258] *See id.*

[259] *See* PEGALIS & WACHSMAN, *supra* note 11, § 2:8 (listing some of the ethical guidelines of the practice of medicine); Weiler, *supra* note 10, at 938. The AMA Principles of Medical Ethics are available at http://www.ama-assn.org/ama/pub/category/2512.html (last visited Aug. 14, 2005).

3. Which System Is Better?

Enterprise liability and no-fault would both facilitate improvements in patient safety, but a no-fault system has the potential to better serve the goal of deterring healthcare providers from injuring their patients.[260] Under a no-fault system, efforts to improve patient safety could thrive because individual providers could disclose errors without fear of individual liability.[261] Additionally, a no-fault system would provide hospitals with more incentive to improve care than under an enterprise liability system because hospitals would have to compensate patients even if there was no negligence and even if a patient did not file a lawsuit.[262] By forcing hospitals to pay for more adverse medical outcomes, hospitals would have a larger incentive to improve safety.[263]

A no-fault system would do a better job of reducing the practice of defensive medicine than an enterprise-liability system.[264] No-fault relieves the pressure of legal liability from individual physicians more than enterprise liability.[265] The less fear physicians have of malpractice claims, the less likely they are to prescribe unnecessary care simply to shield themselves from liability.[266] No-fault takes an additional step in reducing defensive medicine because medical errors that stem from defensive care will merit compensation, even if there was no fault.[267] Thus, no-fault makes defensive medicine even more unnecessary and risky because defensive medicine would expose hospitals to greater liability by increasing the opportunity time for medical error to occur.[268]

D. *Requirement of Economic Feasibility*

For a medical-malpractice reform to compensate patients better and deter malpractice, it must be feasible.[269] For purposes of this Note, economic efficiency considers the total cost of a system: the administra-

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[260] *Compare* Abraham & Weiler, *supra* note 28, at 407–14 (discussing how enterprise liability would work as an injury-prevention system), *with* Studdert & Brennan, *supra* note 79, at 220 (discussing how no-fault could prevent error).

[261] *See* Weiler, *supra* note 10, at 916–17, 942.

[262] *See* Studdert & Brennan, *supra* note 79, at 220; Weiler, *supra* note 10, at 937–39.

[263] *See* Studdert & Brennan, *supra* note 79, at 220; Weiler, *supra* note 10, at 937–39.

[264] *See* Bovbjerg & Sloan, *supra* note 126, at 72; Weiler, *supra* note 10, at 916–17, 942.

[265] *See* Weiler, *supra* note 10, at 916–17, 942.

[266] *See* Bovbjerg & Sloan, *supra* note 126, at 72; Weiler, *supra* note 10, at 916–17, 942.

[267] *See* Weiler, *supra* note 10, at 938–39.

[268] *See id.* at 938–39, 942.

[269] *See* Eleanor D. Kinney, *Malpractice Reforms in the 1990s: Past Disappointments, Future Success?*, 20 J. HEALTH POL. POL'Y & L. 99, 99, 123–25 (1995); Studdert et al., *supra* note 31, at 2–3.

tive costs relative to compensation and the amount of time necessary to resolve medical-malpractice claims.[270]

1. Enterprise Liability

An enterprise-liability system would save costs relative to the current medical-malpractice system.[271] The range of compensable events would not necessarily increase.[272] Lawsuits would be more straightforward because patients would simply sue hospitals, not individual providers involved in treatment.[273] Increased efficiency would reduce the costs and time spent defending and bringing malpractice claims.[274] An enterprise-liability system would also realize savings if improvements in patient safety materialize; thus, reducing the actual incidence of medical malpractice and compensable events.[275] Finally, doctors would no longer need the costly individual malpractice insurance that is driving some physicians out of their practices.[276]

Enterprise liability also has some financial risks.[277] Implementing an enterprise-liability system might be difficult for hospitals, especially nonprofit hospitals or those hospitals in poor areas already operating on a tight budget.[278] Some hospitals are struggling to pay for emergency medical care they must provide regardless of whether patients can pay for it.[279] Giving hospitals the increased responsibility of physicians' medical-malpractice liability may prove to be too much for some hospitals.[280] For this reason, any attempt to institute enterprise liability should begin with hospitals that have the financial strength to test the economic feasibility of the system.[281]

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[270] *See* Weiler, *supra* note 10, at 926.

[271] *See* Abraham & Weiler, *supra* note 28, at 403–04; Jacobi & Huberfeld, *supra* note 29, at 307; Weiler, *supra* note 104, at 224–25.

[272] *See* Abraham & Weiler, *supra* note 28, at 403–04.

[273] *See* Abraham & Weiler, *supra* note 28, at 403–06; Weiler, *supra* note 104, at 224–25.

[274] *See* Abraham & Weiler, *supra* note 28, at 403–04; Jacobi & Huberfeld, *supra* note 29, at 307.

[275] *See* Abraham & Weiler, *supra* note 28, at 407–14.

[276] *See id.* at 383; Geistfeld, *supra* note 206, at 459–60; Burages, *supra* note 6, at 8A.

[277] *See* Abraham & Weiler, *supra* note 28, at 423, 426.

[278] *See id.* at 423–27.

[279] *See id.*

[280] *See id.*

[281] *See id.*

2. No-fault

A no-fault approach to medical-malpractice liability would probably be more expensive than the current negligence-based model.[282] With healthcare costs rising, any systemic change that increases the cost of healthcare should be carefully scrutinized.[283] A no-fault scheme may begin a slippery slope towards excessive compensation.[284] Currently, few of the potentially compensable claims are actually brought as medical-malpractice actions.[285] In the negligence-based medical-malpractice system, a large investment of time and money is required to bring a suit, and a favorable outcome for patients is far from guaranteed.[286] If barriers to compensation were lowered, a floodgate of claims could be opened.[287] If a no-fault system was not carefully designed to contain costs, the surge in claims could overwhelm the financial stability of the system.[288]

Despite valid concerns about the risk of increasing the cost of healthcare by creating a no-fault system, there may be some cost advantages relative to the current system.[289] A no-fault system might prove to be an easier system and fairer way to manage costs.[290] Although tort reform efforts such as capping punitive damages or limiting the contingency fees of attorneys have been successful in reducing the number of malpractice claims, the effects of the reforms are not equitably spread throughout society.[291] They tend to limit options for poor plaintiffs and for plaintiffs with difficult cases.[292]

A no-fault system might make the effects of cost control mechanisms more predictable and equitable.[293] For example, to reduce the

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[282] *See* Bovbjerg & Sloan, *supra* note 126, at 73; Studdert et al., *supra* note 31, at 31–32.

[283] *See* NAT'L CTR. FOR HEALTH STATISTICS, *supra* note 25, at 14, 326 (2004) (stating national healthcare expenditures totaled more than $1.5 trillion in 2002).

[284] *See* Bovbjerg & Sloan, *supra* note 126, at 73; Kupeli, *supra* note 214, at 570 (expressing concern about how a no-fault system would be funded).

[285] *See* Hyman, *supra* note 10, at 1643; Weiler, *supra* note 10, at 913.

[286] *See* Weiler, *supra* note 10, at 913.

[287] *See* Kupeli, *supra* note 214, at 570; Studdert et al., *supra* note 31, at 2–3; Weiler, *supra* note 10, at 913.

[288] *See* Kupeli, *supra* note 214, at 570; Studdert et al., *supra* note 31, at 2–3; Weiler, *supra* note 10, at 913.

[289] *See* Studdert et al., *supra* note 33, at 30–31.

[290] *See id.*; Weiler, *supra* note 10, at 927.

[291] *See* Studdert & Brennan, *supra* note 32, at 225; Weiler, *supra* note 10, at 910.

[292] *See* Weiler, *supra* note 10, at 910; Lohr, *supra* note 23, at BU1.

[293] *See* Bovbjerg & Sloan, *supra* note 135, at 71 (stating that no-fault would make compensation more efficiently delivered, better tailored to individuals, and better managed); Weiler, *supra* note 10, at 921–23. *But see* Kupeli, *supra* note 229, at 569.

costs within a no-fault system, one might consider increasing the disability threshold necessary to receive compensation.[294] This would control costs by eliminating some of the more minor claims, and it would favor people with the most severe injuries.[295] Because damages in a no-fault system would be dispersed in a regulated and controlled fashion, it would be easier to anticipate the effect of changes in the compensation requirements.[296] In the current torts system, the unpredictable nature of damage awards makes it difficult to anticipate how much will be saved by cost-cutting measures and who will be affected.[297]

A no-fault system could be even less expensive than the existing negligence system.[298] If the system were carefully designed to control costs and limit payments, it does have the potential to reduce the costs of the healthcare system.[299] A no-fault system could produce savings by greatly reducing physician malpractice insurance, by reducing defensive medicine, by increasing patient safety, and by more efficiently compensating claimants.[300] These savings combined with careful design might make the cost of a no-fault system an advantage instead of a weakness.[301]

The current system spends about fifty-five to sixty cents on the dollar to compensate patients for medical malpractice.[302] This is not very efficient.[303] More patients would be compensated for the same amounts of money under an administrative system like no-fault.[304]

A no-fault system of liability might run into problems of efficiency to the extent that it would be a much more bureaucratic system than the negligence model.[305] Paper work, regulations, and review boards could potentially choke the system with red tape.[306] The

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[294] *See* Studdert et al., *supra* note 31, at 10–11 (discussing how the Swedish no-fault system controls cost); Weiler, *supra* note 104, at 227 (suggesting a two month injury threshold).

[295] *See* Studdert et al., *supra* note 31, at 10–11; Weiler, *supra* note 104, at 227.

[296] *See* Studdert et al., *supra* note 31, at 12–13 (explaining cost control in Sweden's no-fault system).

[297] *See* Weiler, *supra* note 10, at 914.

[298] *See* Bovbjerg & Sloan, *supra* note 126, at 70–73; Weiler, *supra* note 10, at 926–27.

[299] *See* Studdert et al., *supra* note 31, at 33.

[300] *See* Weiler, *supra* note 10, at 926–27.

[301] *See* Studdert et al., *supra* note 31, at 33.

[302] Weiler, *supra* note 10, at 926.

[303] *See id.*

[304] *See* Studdert et al., *supra* note 31, at 30; Weiler, *supra* note 10, at 926.

[305] *See* Kupeli, *supra* note 214, at 570–71; Weiler, *supra* note 10, at 926.

[306] *See* Studdert et al., *supra* note 31, at 9–10 (describing Sweden's more administrative no-fault system).

initial system, subsequent statutes, and regulations would have to be attentive to streamlining the administrative system in order to maximize funds for patient compensation.[307]

3. Which System Is Better?

Although no-fault serves the goals of compensation and deterrence well, an enterprise liability system is more economically feasible.[308] An enterprise liability system has two key advantages over a no-fault system.[309] First, an enterprise liability system would not drastically expand the number of patients or injuries meriting compensation like a no-fault system would.[310] This characteristic may be a weakness of enterprise liability's capacity to serve the goal of compensation, but it is an economic advantage.[311] A no-fault system probably would increase the cost of the medical-malpractice system.[312] Enterprise liability, in contrast, should save money through increased efficiency.[313] Malpractice claims should become more predictable and lawsuits should become streamlined and less expensive under an enterprise-liability system.[314]

The second economic advantage enterprise liability has over no-fault is that it should have fewer initial start-up costs.[315] A no-fault system would require all initial costs of an enterprise liability system plus the cost of establishing an administrative body to review and process

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[307] *See id.* at 5–10.

[308] *Compare* Abraham & Weiler, *supra* note 28, at 406 (discussing how enterprise liability would be less expensive than the current system), *with* Studdert et al., *supra* note 31, at 29–32 (discussing the affordability of no-fault).

[309] *Compare* Abraham & Weiler, *supra* note 28, at 406 (discussing how enterprise liability would be less expensive than the current system), *with* Studdert et al., *supra* note 31, at 29–32 (discussing the affordability of no-fault).

[310] *Compare* Abraham & Weiler, *supra* note 28, at 393 (discussing how malpractice would still be a requirement for imposing liability), *with* Studdert & Brennan, *supra* note 79, at 219 (explaining how a no-fault system eliminates the need to find negligence to impose liability).

[311] *Compare* Abraham & Weiler, *supra* note 28, at 406 (discussing how enterprise liability would be less expensive than the current system), *with* Studdert et al., *supra* note 31, at 29–32 (discussing the affordability of no-fault).

[312] *See* Studdert et al., *supra* note 31, at 29–32.

[313] *See* Abraham & Weiler, *supra* note 28, at 406.

[314] *See id.*

[315] *See id.* at 432.

claims.[316] Since enterprise liability is a less radical change, it should be easier and less expensive to implement enterprise liability.[317]

E. *Requirement of Sociopolitical Feasibility*

1. Enterprise Liability

Enterprise liability has sociopolitical appeal because it would relieve physicians from individual liability.[318] Physicians are a sympathetic group to the electorate, and the success of recent tort reforms at the state level indicates the political will to relieve the burden of malpractice from physicians.[319] Also, more attention is being dedicated to the problem of medical error and the startling number of injuries and deaths it causes.[320] As enterprise liability promises to identify and reduce medical error more effectively, it could gain political momentum.[321]

At the same time, enterprise liability may face substantial sociopolitical challenges.[322] Enterprise liability fell flat as a proposed reform in 1996, and if anything, the interest groups that opposed the reforms are even more powerful now.[323] Enterprise liability may be viewed as a step too close to socialized medicine to be viable in the United States.[324] Enterprise liability focuses the medical-malpractice system on hospitals.[325] Although this focus would streamline the malpractice system, it would also make hospitals more involved in the provision of care.[326] The American people seem averse to socialized medicine, and attempts to institute an enterprise liability system may, to some, look like an attempt to enact socialized medicine.[327] By fo-

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[316] *See id.*; Studdert et al., *supra* note 31, at 30.

[317] *Compare* Abraham & Weiler, *supra* note 28, at 406, 432 (discussing how enterprise liability could be less expensive than the current system and a bridge to later reforms), *with* Studdert et al., *supra* note 31, at 29–32 (disucussing the costs of a no-fault system).

[318] *See* Abraham & Weiler, *supra* note 28, at 382.

[319] *See* AM. MED. ASS'N, *supra* note 21, at 24–41; GAWANDE, *supra* note 193, at 11.

[320] *See* Studdert & Brennan, *supra* note 79, at 217. *See generally* INST. OF MED., *supra* note 14.

[321] *See* Abraham & Weiler, *supra* note 28, at 407–14.

[322] *See id.* at 383.

[323] *See id.*

[324] *See id.* at 383–84; Keith Myers, *Medical Errors: Causes, Cures, and Capitalism*, 16 J.L. & HEALTH 255, 288 (2002) (arguing that socialized medicine would reduce incentives to reduce medical error).

[325] *See* Abraham & Weiler, *supra* note 28, at 382–83.

[326] *See id.* at 383.

[327] *See* SKOCPOL, *supra* note 56, at 6–8, 174; Myers, *supra* note 324, at 288.

cusing malpractice on hospitals, doctors would become less autonomous and more like employees of the hospitals.[328] Patients seem to want their doctors to direct their care and treatment, rather than an administrative unit such as a hospital.[329]

Involving the hospital more deeply in the provision of care seems to compromise the intimacy and trust of the doctor-patient relationship.[330] These effects and perceptions of an enterprise liability system are important because if they are not addressed, the system may never be instituted.[331] American culture focuses a great deal on individualism, and enterprise liability is more concerned with systems than personal relationships.[332] The existing fault-based medical-malpractice system is focused on the individual patient and individual providers.[333] A move toward enterprise liability would sacrifice some of this individualism.[334]

An enterprise liability system also faces design challenges.[335] As an example, how would the system deal with a malpractice claim against a rural solo practitioner where the injury happened in the doctor's office?[336] Is it fair to assign liability to a far-off hospital that essentially has no control over the rural physician?[337] How would you choose which hospital should pay for an injury at a doctors' office when the doctor has staff privileges at multiple hospitals?[338] These design questions are not easy to answer.[339] The fact that enterprise liability will be challenging to design does make it less politically and culturally feasible.[340]

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[328] *See* Abraham & Weiler, *supra* note 28, at 383.

[329] *See* GAWANDE, *supra* note 193, at 11–12; Abraham & Weiler, *supra* note 28, at 383.

[330] *See* GAWANDE, *supra* note 207, at 11–12; Abraham & Weiler, *supra* note 28, at 383. *But see* Hall, *supra* note 119, at 309–10 (suggesting that a system that encourages doctors to disclose errors to patients might improve trust).

[331] *See* SKOCPOL, *supra* note 56, at 178–83; Abraham & Weiler, *supra* note 28, at 383.

[332] *See* James A. Henderson, Jr., *Why Negligence Dominates Tort*, 50 UCLA L. REV. 377, 404–05 (2002).

[333] *See* PEGALIS & WACHSMAN, *supra* note 11, § 2:10.

[334] *See* Abraham & Weiler, *supra* note 28, at 382–83; Henderson, *supra* note 332, at 404–05.

[335] *See* Abraham & Weiler, *supra* note 28, at 415; Weiler, *supra* note 104, at 226 (urging states to experiment with enterprise liability).

[336] *See* Furrow, *supra* note 20, at 112.

[337] *See id.*

[338] *See id.*

[339] *See id.*

[340] *See* SKOCPOL, *supra* note 56, at 178–79 (referring to the political volatility of a complex, expensive, and bureaucratic system).

2. No-fault

A no-fault system may have significant cultural appeal because it would be more accepting of the fact that doctors make mistakes, and the system would nurture forthrightness in the doctor-patient relationship.[341] Americans care a great deal about their healthcare.[342] This is reflected by how much Americans spend on healthcare.[343] The doctor-patient relationship is the cornerstone of healthcare provision, and doctors and patients might both be well-served if the relationship did not become so adversarial when invoking the law.[344]

Despite a no-fault system's cultural appeal as a more accepting and generous way of dealing with medical error, a no-fault system would face serious political and cultural roadblocks.[345] A no-fault system would be more bureaucratic and administrative—adding another layer of paperwork to an already complex system.[346] This added bureaucracy may also prompt cries of socialization, which may make a no-fault system politically unrealistic.[347]

Perhaps more critical than its bureaucratic and socialistic characteristics, a no-fault system may not have an organized interest group to champion it.[348] Doctors seem convinced that they want damage caps and similar medical-malpractice reforms.[349] Plaintiffs' attorneys would probably oppose a no-fault system because they would be largely cut out of the claims process.[350] Like the AMA, the Association of Trial Lawyers of America ("ATLA") is a powerful lobbying force.[351] Attorneys who bring medical-malpractice claims probably stand to lose the

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[341] *See* Furrow, *supra* note 20, at 122–23 (making the same argument with respect to enterprise liability); Studdert & Brennan, *supra* note 30, at 227–28.

[342] *See generally* GAWANDE, *supra* note 193 (illustrating the human side of medicine).

[343] *See* NAT'L CTR. FOR HEALTH STATISTICS, *supra* note 25, at 14.

[344] *See* Studdert & Brennan, *supra* note 30, at 227–28. *See generally* Hall, *supra* note 119 (discussing the importance of trust in the doctor patient relationship).

[345] *See* Kinney, *supra* note 269, at 123–25; Kupeli, *supra* note 214, at 569–70; Chandler Gregg, Comment, *The Medical Malpractice Crisis: A Problem with No Answer?*, 70 MO. L. REV. 307, 311 (2005) (stating that reforms like no-fault have received little support).

[346] *See* Weiler, *supra* note 10, at 931–32.

[347] *See* SKOCPOL, *supra* note 56, at 174 (discussing "Reagan's Revenge" and Americans' distaste for big government and bureaucracy).

[348] *See* Abraham & Weiler, *supra* note 28, at 383; Kinney, *supra* note 269, at 123–25 (stating that physicians are skeptical of no-fault, consumer groups are silent, and the trial bar prefers the status quo); Gregg, *supra* note 345, at 311.

[349] *See* AM. MED. ASS'N, *supra* note 21, at 23–24.

[350] *See* Kinney, *supra* note 269, at 124–25; ASS'N OF TRIAL LAWYERS OF AM., TEN REASONS TO OPPOSE MEDICAL MALPRACTICE "REFORM", http://www.atlanet.org/ConsumerMediaResources/Tier3/press_room/FACTS/medmal/tenreasons0504.aspx.

[351] *See* Abraham & Weiler, *supra* note 28, at 383.

most if a no-fault system were implemented.[352] Attorneys would no longer be needed for patients to receive compensation for medical errors.[353] Thus, some attorney groups probably would fight a no-fault system aggressively.[354] Given how potent their current opposition is to medical-malpractice reforms like damage caps, a system that largely cuts out attorneys could be expected to generate even more opposition.[355] Without strong political momentum, it is difficult to imagine an extensive reform like no-fault being enacted.[356]

3. Which System is Better?

Because an enterprise liability model more closely resembles the current medical-malpractice system, it would alienate fewer interest groups if implemented and be more politically feasible.[357] A no-fault system has the cultural misfortune of being an inherently more bureaucratic and administrative approach to compensating injured patients.[358] It would thus be vulnerable to claims that it would further clog the healthcare system with paperwork and complicated rules.[359] The lawsuit-based enterprise liability system would not be vulnerable to these kinds of attacks.[360]

No-fault's greatest political weakness is that it would not have a powerful interest group to champion it.[361] An enterprise liability system would not alienate attorneys nearly as much.[362] In fact, attorneys may even profit from an enterprise liability system.[363] Hospitals have

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[352] *See* Brill, *supra* note 213, at 1005.

[353] *See* Bovbjerg & Sloan, *supra* note 126, at 73; Brill, *supra* note 213, at 1005;.

[354] *See* Bovbjerg & Sloan, *supra* note 126, at 73; Brill, *supra* note 213, at 1005; Ass'n of Trial Lawyers of Am., Health Care Resource Center, http://www.atlanet.org/ConsumerMediaResources/Tier3/press_room/FACTS/health/index.aspx (including links to articles such as *The Truth About Medical Malpractice in America, Debunking the Top 5 Myths About Medical Malpractice*, and *Ten Reasons To Oppose Medical Malpractice 'Reform'*).

[355] *See* Kinney, *supra* note 269, at 124–25; Ass'n of Trial Lawyers of Am., *supra* note 354.

[356] *See* Skocpol, *supra* note 56, at 6–8, 174; Kinney, *supra* note 269, at 225; Kupeli, *supra* note 214, at 569–70.

[357] *See* Skocpol, *supra* note 56, at 6–8, 174; Abraham & Weiler, *supra* note 28, at 432; Kupeli, *supra* note 214, at 569–70; Ass'n of Trial Lawyers of Am., *supra* note 354.

[358] *See* Skocpol, *supra* note 56, at 174; Studdert et al., *supra* note 31, at 29–31.

[359] *See* Studdert et al., *supra* note 31, at 5–10.

[360] *See generally* Ass'n of Trial Lawyers of Am., *supra* note 26.

[361] *See* Abraham & Weiler, *supra* note 28, at 383; Kinney, *supra* note 269, at 123–25.

[362] *See generally* Ass'n of Trial Lawyers of Am., *supra* note 354.

[363] *See* Abraham & Weiler, *supra* note 28, at 403–06 (discussing improvements in patient compensation).

deep pockets and would probably settle legitimate claims more often than doctors would.[364]

Although it would probably be more difficult to enact a no-fault system, it is worth noting that enterprise liability already fizzled as a reform during the Clinton administration.[365] Enterprise liability faced opposition from the AMA and the PIAA.[366] Doctors may prefer a no-fault system to enterprise liability because it eliminates the fault requirement and its culture of blame.[367] If this difference is sufficiently enticing to doctors, the AMA may support no-fault reforms.[368]

It is probably more likely that the AMA would oppose both enterprise liability and no-fault because doctors are unwilling to submit themselves to additional control from hospitals.[369] The AMA will continue to lobby for damage caps and similar reforms.[370] The AMA will not feel pressured to compromise and support alternative reforms like enterprise liability or no-fault because the Bush administration and Republican Congressional majorities support damage caps and similar reforms promoted by the AMA.[371]

Enterprise liability and no-fault both face daunting political challenges.[372] Enterprise liability is probably more feasible because it does not alienate attorneys.[373] No-fault may have no champions if both physician and plaintiff attorneys' lobbies oppose it.[374] Without a determined and well-financed lobby, it is hard to imagine a dramatic change like no-fault overcoming political opposition and realizing the improvements it was designed to create.[375]

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[364] *See id.*

[365] *See id.* at 383.

[366] *Id.*

[367] *See* Weiler, *supra* note 10, at 913.

[368] *See* AM. MED. ASS'N, *supra* note 21, at 4–8; Abraham & Weiler, *supra* note 28, at 383; Weiler, *supra* note 10, at 913.

[369] *See* Abraham & Weiler, *supra* note 28, at 383; Kinney, *supra* note 269, at 123 (stating that physicians feel enormous personal responsibility for their patients, contributing to their discomfort with no-fault).

[370] *See* AM. MED. ASS'N., *supra* note 21, at 23–45.

[371] *See* Lohr, *supra* note 21, at BU1.

[372] *See e.g.*, SKOCPOL, *supra* note 56, at 174; Kupeli, *supra* note 214, at 569–70.

[373] *See* Brill, *supra* note 213, at 1005; ASS'N OF TRIAL LAWYERS OF AM., *supra* note 26.

[374] *See* Brill, *supra* note 213, at 1005; Kinney, *supra* note 269, at 223–25; ASS'N OF TRIAL LAWYERS OF AM., *supra* note 26.

[375] *See* Brill, *supra* note 213, at 1005; Kinney, *supra* note 269, at 225; ASS'N OF TRIAL LAWYERS OF AM., *supra* note 26.

F. *Aggregate Weighing: Which Model Is Better?*

Having evaluated enterprise liability and no-fault in terms of how well each satisfies the goals of compensation and deterrence and meets the requirements of economic and sociopolitical feasibility, the question becomes which is the better reform.[376] No-fault offers greater promise that it will serve the goals of compensation and deterrence, but enterprise liability is more feasible both economically and in the current sociopolitical context.[377]

Although no-fault is a promising reform because it has so much potential to improve compensation and deterrence, enterprise liability is a better reform because it is more feasible than no-fault.[378] The theoretical virtues of no-fault cannot do good if the system cannot be enacted.[379] Because enterprise liability does promise to streamline compensation and significantly improve patient safety, it is a valuable reform that could be enacted.[380]

Enterprise liability also has the advantage of being a potential step toward no-fault liability.[381] Enterprise liability could be an end in itself or a stepping-stone for a no-fault system.[382] Because enterprise liability is a more feasible reform, it should be implemented first.[383] Enterprise liability is a more moderate reform that leaves open the possibility for a more radical change like no-fault.[384] At this time, no-fault has many theoretical virtues, but its implementation remains unlikely.[385] Enterprise liability also has great promise for improving healthcare and is a more realistic option for reform.[386]

CONCLUSION

Enterprise liability is the better reform for the medical-malpractice system because it is more economically, socially, and po-

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[376] *See supra* notes 196–375 and accompanying text.

[377] *See supra* notes 196–375 and accompanying text.

[378] *Compare* Abraham & Weiler, *supra* note 28, at 434–36 (summarizing the promise of enterprise liability and its role as an incremental reform), *with* Studdert et al., *supra* note 31, at 32–34 (summarizing the value and affordability of no-fault).

[379] *See* Studdert et al., *supra* note 31, at 3.

[380] *See* Abraham & Weiler, *supra* note 28, at 436.

[381] *See id.* at 434.

[382] *See id.*

[383] *See id.*

[384] *See id.*

[385] *See* SKOCPOL, *supra* note 56, at 6–8, 174; Abraham & Weiler, *supra* note 28, at 434; Kupeli, *supra* note 214, at 569–70.

[386] *See* Abraham & Weiler, *supra* note 28, at 434–36.

litically feasible than a no-fault system. An enterprise liability system also promises to serve the goals of compensation and deterrence better than the current fault based system that targets individual providers. Although a no-fault system may better compensate patients and deter malpractice, an enterprise liability system would be less costly and easier to implement. An enterprise liability system could be a step toward a no-fault system if experience indicates no-fault would further improve medical-malpractice law and the healthcare system.

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