Hospital-level liability could revive the dormant deterrent power of tort liability.

Making Hospitals Accountable

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Medical errors are far too common. Yet, researchers have found that the threat of tort liability currently does little to discourage them. Shifting liability from individual physicians to the hospitals in which they work would change that. In fact, a robust regime of hospital vicarious liability has more potential than any other medical malpractice reform to realign the deterrent power of tort law with the goal of patient safety.

In most industries, tort law makes an economic actor, like the corner pharmacy, legally responsible for all tortious injuries inflicted by its workers. This threat gives the organization a powerful incentive not only to select and supervise its workers carefully, but also to create workforce rules and workplace environments that minimize the risk of harm to customers and bystanders.

American hospitals have historically been insulated from this responsibility because physicians working within their walls were deemed to be independent contractors rather than employees. This conceptual model made sense in the late 19th and early 20th centuries, when medicine was practiced by solo practitioners and hospitals were little more than hospices where patients too poor for home-based care came to be quarantined or to die. Today, however, hospital care is delivered by large teams of highly trained physicians, nurses, technicians, and allied health professionals in a complex web of interactions that demand coordination, oversight, and overall accountability. As a result, patient safety advocates now call for greater accountability at the hospital level. Yet, today's tort law stands in the way of greater attention to organizational oversight. It is time for a legal regime crafted in the 19th century to be replaced by one fashioned to respond to the realities of the 21st century.

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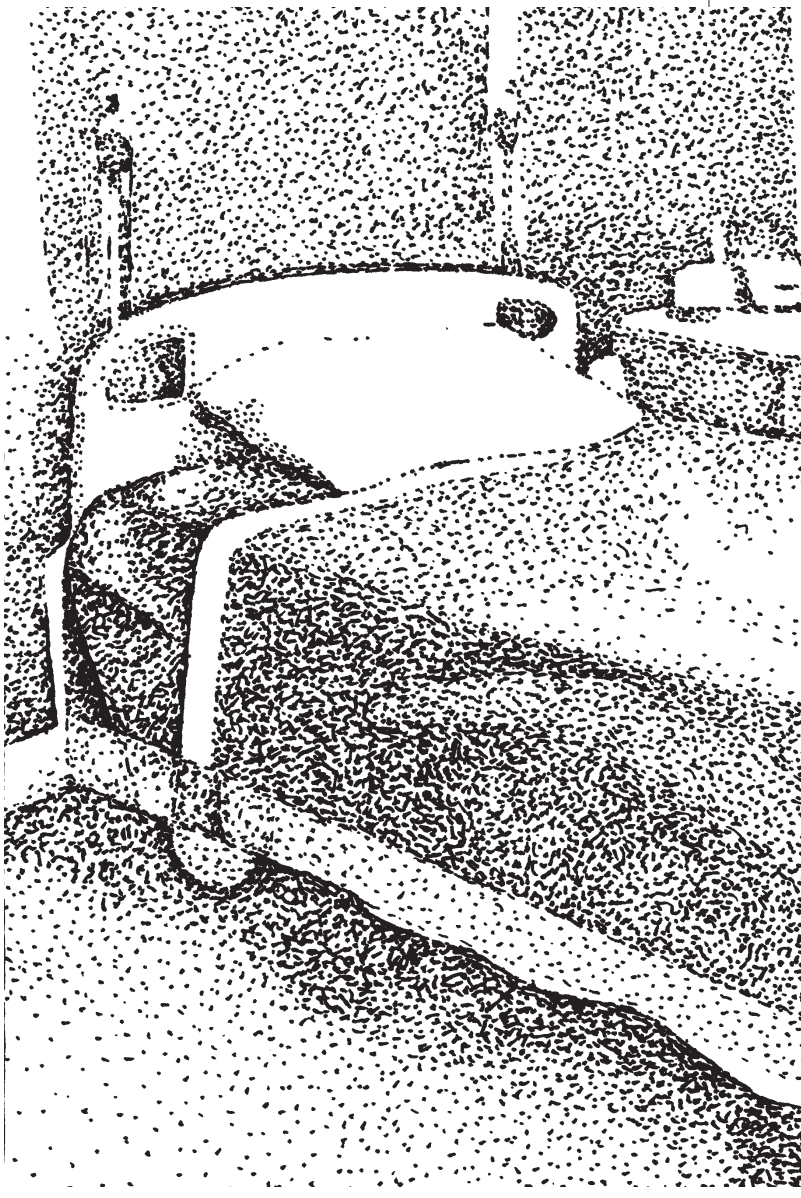
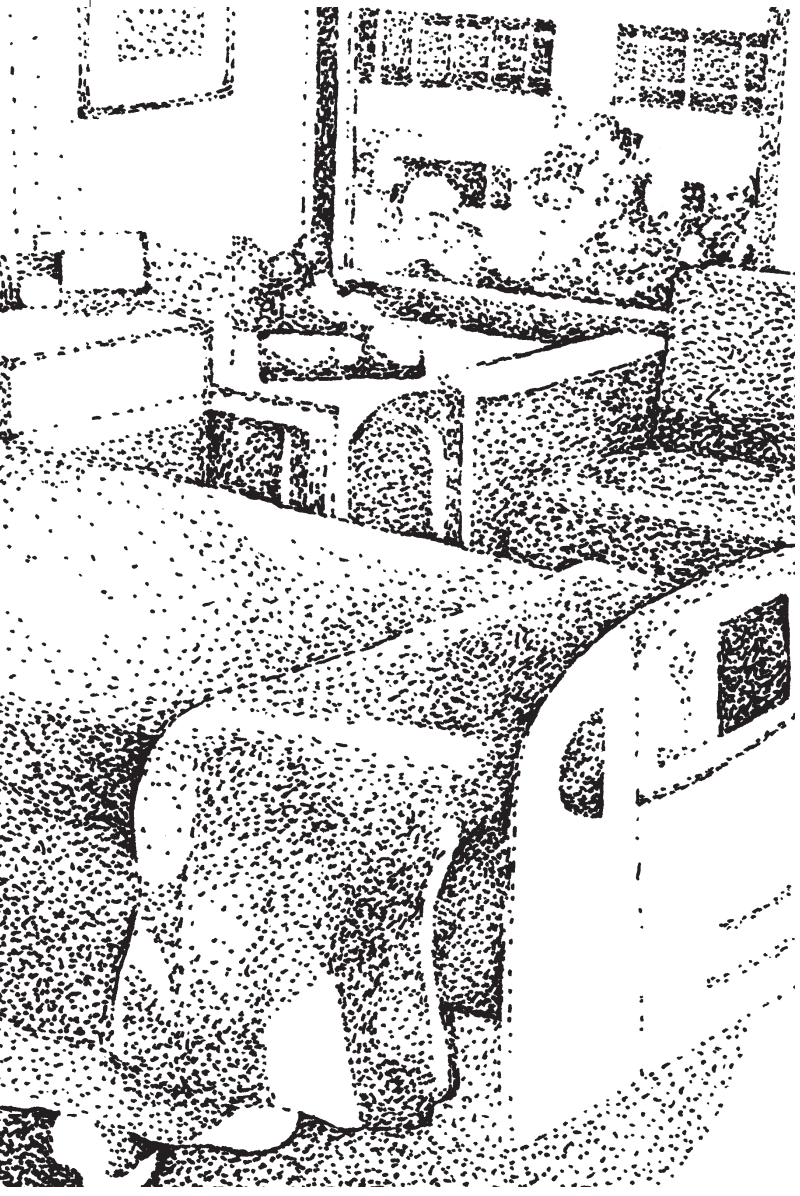


MORGAN BALLARD

The modern hospital has far more power than its individual physicians to improve the quality of care received inside its walls. Unlike individual physicians, hospitals possess both the system-wide vantage point needed to identify the high-risk stages of the delivery system and the resources needed to implement systematic improvement. Yet, tort law continues to place the responsibility for rational accident avoidance exclusively on individuals rather than on systems.

Over the past three decades, many respected legal scholars have called for expanded vicarious liability. In the past, however, advocates for an increased emphasis on enterprise responsibility found few allies in the health care community. That is now changing.

Today, hospital safety experts emphasize the need to shift our focus from the blaming of individual wrongdoers to the design of systems that anticipate and prevent human error. They have been joined by market-oriented health law scholars who also call for greater organizational-level accountability in health care. Those scholars advocate the use of "pay-for-performance" plans to improve health care quality and they, too, tend to focus on organizational outcomes as the preferred level of accountability.



Legislative adoption of hospital "enterprise" liability would align the deterrence incentives of tort law with the patient safety and pay-for-performance movements. Each sensibly recommends the shifting of greater accountability for system performance away from individuals and onto health care organizations, like hospitals and managed care organizations, with better information and greater resources — the actors best positioned to respond rationally to legal and economic incentives to reduce patient injuries.

Hospital enterprise also offers several other advantages over current legal doctrine, the most significant of which is its potential to dampen the extraordinary fear and anger that practicing physicians feel toward tort law. Their near-hysterical bitterness has negatively affected the way that they see their patients and has led them to seek and win a number of unfortunate tort reforms, like draconian damage caps, that have made the civil justice system less fair on balance than it was before. Those legislative victories pose a serious threat to the credibility of the civil justice system. The "exclusive" form of hospital enterprise liability has the potential to lessen the pressure to enact still more dysfunctional reforms because it places legal responsibility exclusively on the hospital and, unlike conventional vicarious liability, eliminates the liability of individual physicians and nurses.

TREATMENT BY BUSINESSMEN?

Physicians are generally skeptical about hospital enterprise liability because it has the potential to reduce their clinical independence. In 1965, for example, physicians vocally criticized the notorious Illinois case of *Darling v. Charleston Community Memorial Hospital* because it suggested that hospitals could be liable for failure to supervise the clinical decisions of their physicians.

However, hospital enterprise liability would not be as intrusive as the regime suggested in the *Darling* dictum. Hospital enterprise liability would not, for example, give hospital executives with business degrees an incentive to rewrite the emergency room protocols. No jury would accept that. Instead, vicarious liability for all negligently inflicted injuries would give hospital executives a strong reason to make sure that duly appointed groups of hospital physicians review the protocols on a regular basis and test them against current best practices. It also means that the work of those separate physician groups will need to be synthesized and coordinated so that the processes being put into place in each corner of the hospital are compatible with, and ideally build upon, the safety systems adopted in other hospital departments. Finally, enterprise liability will give hospitals a legal incentive, lacking in the current system, to invest in systemic safety improvements, like electronic medical records, that reduce the mistakes made by individuals. In all of those respects, the new regime is likely to resemble that of the airline industry, in which an airline's vicarious liability for the mistakes of its pilots gives the airline a strong incentive to work with its pilots to fashion state-of-the-art guide-

lines for safe takeoffs and landings.

As a result, hospital enterprise liability is less likely to lead to a shift in power from physicians to MBAs, than it is to shift power from individual physicians to committees of physicians. At the same time, it will shift authority from individual instincts to research findings. Health quality experts believe that a shift to evidence-based guidelines will improve patient safety, not impair it.

ROOM FOR IMPROVEMENT

Health care quality experts have several good reasons to believe that hospital-level accountability will improve patient outcomes. First, clinical practices, like the readiness to do caesarean sections, vary substantially and inexplicably from place to place. John Wennberg, the pioneer in this field, found that 8 percent of the population in one Vermont town had surgery to remove their tonsils, while 70 percent of the people in another Vermont community underwent the procedure. His research showed that such variations are the norm rather than the exception, and that they are not explained by patient condition or associated with better outcomes

Second, we know that individual physicians are often slow to change their habits or adopt new procedures. One study found that only half of the patients who should be receiving beta-blockers to prevent recurrence of myocardial infarctions were receiving them many years after the drugs' effectiveness had been demonstrated and even after the American College of Cardiology had adopted a guideline recommending their use. Other studies found that rates of use varied across the country from 5 percent to 92 percent. Again, those findings are common.

Third, physicians are not immune to the temptations of enhanced income. Physicians who own a lab or test facility order far more of the tests than physicians who do not. Physicians are much more likely to recommend an invasive procedure if they can do it themselves than if it requires a referral; if you visit a cardiologist who does invasive procedures, you are more likely to end up getting one than if you first visit a primary care physician or a cardiologist who does not perform the procedure. Physicians more often prescribe drugs sold by companies that have provided them with favors than drugs sold by competitors.

Finally, a large body of evidence demonstrates that avoidable medical injuries are surprisingly common. The landmark Harvard Study of New York Hospitals conservatively estimated that one of every 100 hospital patients leaves the hospital with an injury caused by medical negligence. Four of every 100 are injured by avoidable medical mistakes. Many more experience "near misses." Those discouraging findings have now been confirmed by studies in Colorado and Utah and, in fact, were presaged by a physician-sponsored California study in the 1970s that was quietly buried. As a result, the Institute of Medicine estimates that avoidable mistakes cause about 100,000 deaths annually — more than automobile accidents and breast cancer combined.

The lesson is plain. While current clinical practices are often exemplary, they leave substantial room for further improvement.

DETERRENT POWER

Medical malpractice law is intended to provide physicians with an incentive to reduce errors. Regrettably, there are two good reasons to doubt that it currently does a credible job. First, researchers have been unable to detect a significant deterrent effect. Second, physicians simply do not believe that tort law rewards improved quality.

None of the studies that have attempted to detect the magnitude of malpractice law's deterrent effect have been able to ascertain any reliable evidence of reduced patient injuries. Although the subject presents difficult methodological barriers, the failure of even one study to glean reliable evidence of deterrence is very disappointing. Although some supporters of existing tort law argue that the dramatic improvements in anesthesiology outcomes at the end of the 20th century were attributable to existing tort liability, I explain below why those improvements are best explained by the arrival of de facto enterprise liability at the Harvard teaching hospitals.

The findings that tort has little effect on error rates are consistent with the existence of several factors thought to impede malpractice law's deterrent signal. For example, only 2–3 percent of the patients who are injured by medical negligence ever file a legal claim, thereby diluting the deterrent signal. In addition, physician liability insurance premiums generally are not experience-rated. As a result, good and bad physicians suffer alike. Furthermore, the nonbinding nature of case-specific jury decisions deprives physicians of reliable *ex ante* guidance about the applicable standard of care.

Furthermore, the very audience intended to receive the deterrent signal does not believe that raising the quality of their services will reduce the risks of tort liability. Most physicians believe that tort claims and tort outcomes are largely random events. As long as individual physicians believe that tort

> Hospital enterprise liability would shift authority from individual physicians to teams of physicians and from individual instincts to research findings.

law operates this way, then the threat of individual tort liability is unlikely to prompt improvements in patient safety.

Some patient safety advocates believe that the shortcomings of existing tort law run even more deeply. They believe not only that tort law fails to reduce accidents, but also that it stands in the way of industry efforts to improve patient safety. The threat of individual tort liability, they argue, makes physicians too afraid to discuss their accidents and near misses. Their reluctance greatly impedes efforts to gather the information needed to design hospital environments and processes that will reduce the risk of foreseeable accidents in the future. The patient safety experts' arguments are credible and their frustration is palpable. As a result, it is safe to conclude that the threat of tort liability currently does little to make patients safer.

SAVING LIVES Exclusive hospital enterprise liability is the key to unlocking the dormant deterrent power of tort liability. Unlike individual physicians, hospitals are experience-rated repeat players who have both the vantage point and the resources to make systematic improvements in the delivery of health care. Enterprise liability would give them an incentive to use that vantage point to improve patient safety.

There are several reasons to believe that hospital enterprise liability would add a powerful and beneficial deterrent effect. First, today's hospital care typically involves multiple physicians, nurses, diagnosticians, and therapists. Experts in medical error believe that advances in patient safety are most likely to come from improvements in the coordination of those activities — from the study and redesign of the processes through which inputs are delivered. They reasonably argue that injuries could be reduced markedly if we devote greater effort to identifying the places in the system where errors are most common and redesign those weak stages so that foreseeable mistakes are prevented or else detected before serious harm occurs. This shift in emphasis from individual workers to entire systems has already been employed successfully in the automotive and aviation industries.

Consistent with this growing attention to system design, all of the reforms proposed by an important 2007 study of errors in the emergency department involved the improvement of departmental systems rather than greater attention to physician talent, training, or discipline. The study found that virtually all misdiagnoses involved a system weakness, usually in combination with individual cognitive error and sometimes contributing to the individual error. System failures included problems in handoffs, excessive workload, breakdowns in supervision, and failures of test results to reach the proper clinician.

Even when patient injuries were caused by individual cognitive errors, the authors often concluded that prevention required a systemic response. Errors caused by excessive workload, for example, have a systemic origin. Similarly, the researchers concluded that many common clinical mistakes would be prevented by the adoption of explicit clinical algorithms — treatment protocols adopted by the hospital through its departments. They also suggested that hospitals recommend second opinions in circumstances where errors are historically most common. In effect, they concluded that absolute deference to the "professional judgment" of individual physicians is often detrimental to their patients.

Consequently, the largest unused opportunity to improve patient safety lies at the systems level. Enterprise liability would give hospitals a reason to identify the instances in which this is most likely to occur, to adopt appropriate algorithms, and to weather the pushback of individual physicians who are reluctant to yield authority to their peers

The second reason to believe that enterprise liability will greatly improve tort law's deterrent signal is that hospitals and their medical committees occupy a much better position than individual physicians to identify the most dangerous practices in the hospital's many delivery systems and act on them. The care of today's hospital patient typically involves multiple physicians, nurses, diagnosticians, and therapists, and no single player can monitor the entire process the way that the hospital itself can. Only the hospital occupies the vantage point needed to see this "big picture." Enterprise liability would motivate hospitals to collect the data needed to identify the most dangerous loci in the delivery system and to refine the system to reduce those risks

Third, hospitals are more likely than physicians to possess the financial and organizational resources needed to accomplish the necessary systemic changes. Improvements such as better information systems will require the collective resources of the entire hospital organization. So will the creation of quality improvement programs that collect and analyze data about patient outcomes and identify high-risk events.

Fourth, hospital liability insurance premiums are adjusted each year to reflect their payout experience in the prior years. Because their insurance is experience-rated, hospitals know that they will benefit concretely from the reduction of medical mishaps. As a result, hospital enterprise liability could produce the same kind of safety improvements that workers' compensation liability has brought to the workplace.

Greater hospital-level accountability is also a central component in most health care industry proposals for improving the quality of medical care. Dartmouth's Elliot Fischer argues that "policy initiatives should be judged at least in part on the degree to which they strengthen accountability and collaboration at the level of the hospital and its medical staff." Hospital-level accountability makes sense as a matter of industry practice for the same reasons that enterprise liability makes sense as a matter of legal policy. Furthermore, hospital-level accountability carries several additional advantages of great interest to medical safety experts. Compared to the collection of data on individual physician outcomes, hospital outcomes data provide a larger sample size, easier data management, and less physician resistance. As a result, efforts to rate providers with "report cards" and to reward quality via "pay-for-performance" arrangements tend to focus on hospital-level outcomes. Adoption of hospital enterprise liability would bring the incentives of tort law into alignment with the norms, accountability systems, and organizational structures emerging within the industry.

REDUCING PHYSICIAN ANGER

Physicians are frightened and bitter. They see the so-called civil justice system as Kafkaesque. Punishment, they believe, is as likely to be inflicted upon the innocent as the guilty. No malpractice reform, short of the complete abolition of tort liability for medical negligence, has as much potential as exclusive enterprise liability to dampen the extraordinary fear and anger practicing physicians feel toward legal remedies for medical negligence.

Reducing this anger is important because physician anger and cynicism produce decidedly negative consequences for both the delivery of quality health care and for the legal system. Fear of liability has transformed the way many physicians see their patients, converting them from partners into potential adversaries. Their fear and anger have also prompted physicians to lobby for many tort reforms that have made the civil justice system less fair to patients, like caps on compensatory damages.

The "exclusive" form of hospital enterprise liability has the potential to reduce the bitterness because it places legal responsibility exclusively on the hospital and eliminates the liability of individual physicians and nurses. Physicians and nurses would not be jointly liable with the hospital under this liability regime.

Superficially, this step would differentiate hospital enterprise from the traditional version of organizational vicarious liability because employees are usually jointly liable with their employer for any injuries caused by their negligence. However, most vicariously liable organizations, like manufacturers and retail stores, have created de facto versions of exclusive enterprise liability. They purchase liability insurance for the entire enterprise and, when found liable, hold their employees harmless. As noted in a report from the American Law Institute, "no one expects that pilots or machinists working for an airline firm would personally pay a substantial premium for insurance against their own instances of careless behavior." Exclusive hospital liability would create a similar arrangement for the hospital industry.

In an exclusive liability regime, physicians would not be served with papers naming them as defendants. When settlements are reached, they would be paid by hospitals, not physicians. In fact, hospitals, rather than physicians, would buy the liability insurance.

Exclusive hospital liability would also free physicians from the fetters of an existing system of insurance and privileges renewal in which the mere filing of a claim, even if later found to be frivolous, creates a paper record that follows the physician for the rest of her professional life. It resurfaces each time she applies for licensure, hospital privileges, liability insurance, or managed care participation. Dr. Elliott Perlman describes the experience this way:

> The lawyers advised me to forget it, but it's not that simple. Every year I have to fill out forms from my malpractice insurer, hospital staff, and state licensing boards. I'm asked whether I've ever been convicted of a felony and whether a malpractice claim has ever been brought against me. So it's OK to have been accused of murder — but not of malpractice.

Under the current regime of individual tort liability, the mere filing of a claim against an individual physician leads automatically to a lifelong punishment that is imposed on both the innocent and the guilty. Exclusive hospital liability will free physicians from that fate.

By eliminating individual liability, exclusive enterprise liability will also make it easier for hospitals to institute a "blame-free" culture that encourages open discussion of errors. The Institute of Medicine believes that existing malpractice law discourages physician cooperation with patient safety initiatives. Patient safety advocates reasonably believe that open discussion of errors is a necessary precursor to systematic safety improvements. They believe that fear of lawsuits discourages doctors from disclosing their own errors and participating in those discussions. Those realities have prompted most patient safety advocates to conclude that malpractice reform is an essential predicate to fundamental improvement in patient safety. Exclusive enterprise liability answers this plea without depriving negligently injured patients of compensation for their injuries.

The likelihood that enterprise liability will free physicians to discuss errors and near misses more freely is suggested by common sense. It is also suggested by studies that have found that independent practicing physicians who buy their own malpractice insurance are less likely to support the disclosure of errors than physicians who work for an institution that provides insurance for them, such as a veteran's hospital or teaching hospital. Private practice physicians are more likely to see disclosure proponents as naïve; they are "reluctant to do anything that might precipitate a lawsuit." This attitude is a predictable consequence of their personal exposure to malpractice liability, a risk that physicians don't face when they are protected by large insured institutions. Little wonder that the leaders in the movement for greater disclosure were large, self-insured institutions whose physicians had much less concern about malpractice insurance availability and premiums.

At the same time, it would be foolish to overestimate the effect that insulation from liability will have on physician disclosure. Disclosure of personal error is painful. Even physicians in countries with much lower litigation rates balk at disclosure. Nonetheless, insulation from individual liability would mark a sea change in the medical environment and would lift many costs from the shoulders of physicians. It seems reasonable to believe that this change will have a liberating effect on physicians and will improve their willingness to participate in quality improvement initiatives.

WILL IT REALLY WORK?

In theory, exclusive hospital enterprise liability is likely to spur significant improvements in the quality of patient care. It strengthens the deterrent signal to the actor with the greatest capacity to improve the quality of hospital-based health care while freeing physicians to cooperate with efforts to

improve patient outcomes. Clinically, however, the evidence is still thin.

Some day, researchers will compare the quality of care provided at hospitals that already operate under a system similar to exclusive hospital enterprise liability with the outcomes at hospitals that operate under the more traditional model. University teaching hospitals and Veterans Administration hospitals commonly have an employer-employee relationship with most of their physicians and, as a consequence, are vicariously liable for physician negligence. Those hospitals also provide malpractice liability insurance for their staff and protect them from individual liability. In theory, those hospitals should respond to this institutional liability with greater attention to safe delivery processes.

Unfortunately, this hypothesis has not been tested, perhaps because it poses serious methodological difficulties; teaching hospitals and VA hospitals systems treat a materially different mix of patients than community hospitals. Instead, we have only a few pieces of circumstantial evidence, the most exciting of which is the transformation of anesthesiology during the last few decades. It happened because the physicians in Harvard Medical School's Department of Anesthesia were insured by Harvard's own medical malpractice insurance company. Anxious to bring down the payouts made for injuries from anesthesia, the insurer's risk managers asked the anesthesiologists to investigate why they had so many injured patients. In response, the group devised new techniques and equipment to lower the risk of mishap. Their research helped spur efforts across the country to study the causes of anesthesia-related injuries and to develop better protocols. Mortality rates in anesthesia dropped from one in 10,000–20,000 to one in about 200,000, a 10–20-fold improvement. Liability insurance premiums for the specialty of anesthesiology went from being among the highest in medicine to among the lowest. This transformation was prompted in significant part by the de facto system of exclusive enterprise liability operating at the Harvard medical facilities.

Of course, the adoption of a universal regime of exclusive enterprise liability will not have an equally dramatic effect on every hospital or department. However, it will put in place a system that encourages the search for better ways to deliver care. Some hospitals and departments will respond to that incentive and their efforts will improve the delivery of health care for all of us.

This prediction is consistent with the history of the patient safety movement. Hospitals and managed care organizations that already operate under a system of de facto exclusive enterprise liability play a disproportionate role in innovative safety initiatives. For example, the *Wall Street Journal* recently reported that the VA and managed-care giant Kaiser Permanente are leading an effort to improve diagnostic accuracy by using new tools, like computer decision-support systems, to help order correct tests, institute proper follow-up plans, obtain complete medical histories, and perform adequate physical exams. Both employ and insure their physicians. Similarly, the two hospitals at the forefront of the movement to voluntarily disclose errors — the VA hospital in Lexington, Ky., and the teaching hospital at the University of Michigan — employ and insure their attending physicians.

OTHER ADVANTAGES Exclusive enterprise liability also has advantages unrelated to patient safety. For example, exclusive enterprise liability would save litigation costs by consolidating the defense of the hospital and all its providers. According to one report, about 25 percent of all medical malpractice cases have two or more defendants.

Second, exclusive enterprise liability places the burden of purchasing liability insurance on a corporate entity that is more likely than an individual physician to plan ahead for the peaks and troughs of the insurance cycle and to weather them relatively smoothly. More than any other single factor, the periodic spikes of the insurance cycle precipitated the malpractice political crises of the 1970s, the 1980s, and 2001. Any malpractice reform that hopes to end this series of crises must temper the effect of inevitable premium spikes on individual physicians. Exclusive enterprise liability will do that.

Third, enterprise liability removes the unfair penalty currently imposed on physicians who practice in a high-risk specialty, like obstetrics, neurosurgery, or emergency medicine. Physicians who practice in those specialties play a vital role in our health care system, yet they pay far higher premiums than their colleagues in lower-risk specialties. As a result, some reformers have suggested that the state or other providers give those specialties financial assistance. Enterprise liability provides an even more elegant solution. It shifts to the hospital the burden of insuring against injuries that occur in the hospital and its clinics, and removes the financial penalty currently associated with high-risk practice. Once again, this is a lesson learned decades ago in other industries; neither airline pilots nor fuselage welders are required to buy their own liability insurance.

The reduction in anesthesiology mortality rates was prompted largely by the de facto system of enterprise liability at the Harvard medical facilities.

POSSIBLE SHORTCOMINGS Enterprise liability has its own set of potential disadvantages. For example, the elimination of individual physician liability could reduce safety precautions by physicians. Yet, tort's deterrence signal is already badly diluted by the availability of liability insurance that is not experience-rated and by physician disbelief that the malpractice system rewards competence.

Second, enterprise liability introduces the problem of defining the boundaries of the hospital's vicarious liability. Would hospitals be liable for injuries occurring in a hospital's outpatient facilities or during private office visits following hospitalization? Nevertheless, the task of defining those legal boundaries will be no more troublesome than countless others that lawmakers regularly address.

Third, the federal anti-kickback laws, as currently written, may make it illegal for hospitals that do not employ their treating physicians to voluntarily adopt a de facto system of enterprise liability by purchasing insurance to cover all of the physicians on their staff. However, that has yet to be determined. Furthermore, state legislation mandating enterprise liability would eliminate the kick-back issue.

Finally, exclusive enterprise liability will insulate negligent physicians from personal legal responsibility to the patients whom they have harmed. Although this erosion of corrective justice is a serious cost, the cost is one worth enduring because the patient's right to compensation for those injuries is protected and because the new regime offers the promise of safer medical care. The current use of liability insurance that lacks experience-rating has already weakened the link between victim and tortfeasor, so the step to exclusive enterprise liability is smaller than it would otherwise be.

Because the benefits of enterprise liability far outweigh its disadvantages, many respected health law scholars recommend enterprise liability in health care. They include Duke Law's Clark Havighurst, Harvard Law's Paul Weiler, Aetna senior vice president Troyen Brennan, Harvard's Michelle Mello and David Studdert, the University of Connecticut's Tom Baker, and the University of Texas's William Sage. Although they differ on some issues, like the choice between hospitals and managed care organizations as the responsible "enterprise," they agree on the need for institutional, rather than individual, responsibility.

Why then is enterprise liability missing from the package of reforms bundled together in the current health courts proposal? The answer almost certainly lies in the anticipated opposition of hospital associations and physicians groups. While hospitals have an obvious financial reason to resist the transfer of legal responsibility entirely onto their shoulders, the issue is more complex for physicians. On the one hand, exclusive enterprise liability would take them out of the shadow of tort liability and permit them to focus on their patients. On the other hand, physicians have traditionally opposed the expansion of hospital vicarious liability because they fear it will bring greater interference with their medical decision making. Yet, this objection, as the American Law Institute notes, "evokes a health care world that has long since passed." With rare exceptions, physicians already function as part of complex systems. Surely, physicians understand the importance of building those systems carefully. Furthermore, the evidence reviewed above strongly suggests that the care of patients will improve if physicians join their hospitals in the design of better delivery processes. Furthermore, Tom Baker rightly notes that enterprise liability has existed in university hospitals and staff-model health maintenance organizations for many years without revolt.

CONCLUSION

Sooner or later, medical malpractice law must adapt to the modern era. In hindsight, it is now obvious that the law's delay in doing so has been bad for both physicians and patients, keeping individual physicians on the front line of malpractice litigation and depriving patients of the safety systems that enterprise liability will produce.

The time has come to revisit the individualistic model of malpractice law. Modern medicine is far more complex than it was when that model was adopted. Today, health care is delivered by large teams of highly trained individuals in a complex web of interaction that demands coordination and oversight. The industry's own experts on quality improvement have recognized this new order. It is time for the law to join them. R

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