THE MEDICAL MALPRACTICE MYTH

THOMAS BAKER (University of Chicago Press, Chicago, Illinois, 2005), 214 pages, $22.50.

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Professor Thomas Baker's new book, *The Medical Malpractice Myth*, consists largely of a deconstruction of the beliefs that undergird the call for tort "reform" and impede the ability of the polity to focus on, and respond constructively to, the real problems of health care in twenty-first century America. This deconstructive project is very persuasively carried out. Professor Baker also offers some positive proposals for reform, designed to open a dialogue. Rising to this invitation, I suggest below some modifications to his proposals that might make them more politically feasible.

DECONSTRUCTING THE MALPRACTICE MYTH

The primary strands of the malpractice myth are the following: that many malpractice lawsuits are frivolous; that many plaintiffs obtain large judgments or settlements although the defendants did nothing wrong; and that, as a result of these lawsuits, doctors have been driven to waste substantial resources on defensive medicine, insurance premiums have skyrocketed, and good doctors have been driven out of the practice of medicine. The overall result: worse care for patients, demoralized doctors, higher costs of medical care, with no one

benefiting but a few greedy plaintiffs and – the favored villain for this Administration, apart from terrorists – trial lawyers. [1]

Baker proceeds systematically, persuasively, often eloquently, to dismantle each of these myths, showing either that the alleged problem does not exist or its severity is overblown. Sometimes the alleged causal link between medical malpractice litigation and the problem is false or wildly exaggerated. The evidence cited in support of the myth is generally far weaker than its proponents acknowledge or is countered by other data.

As for ”frivolous’ lawsuits, Baker concedes that many suits are dismissed by the plaintiff before trial but argues that such suits are not frivolous but, rather, are a consequence of health professionals’ refusal to meet their obligation when things go wrong to discuss with the patient or his family what happened. Patients may believe the best way to pierce the “white wall of silence” is through use of the discovery processes permitted when a lawsuit is filed.[2] If the facts thus unearthed indicate that there was no malpractice, the suit is dropped. Furthermore, multiple studies have indicated that the number of adverse events and even of malpractice[3] far outweigh the number of malpractice lawsuits.[4] Baker concludes the real problem is one of too much malpractice rather than too much malpractice litigation.

When lawsuits do reach trial, malpractice plaintiffs are relatively less successful than plaintiffs in other kinds of litigation, undermining the claim that juries and judges unduly favor them. When plaintiffs do recover, through trial or by settlement, the amount of the recovery is best predicted by two factors: the

seriousness of the injury and the assessment by the malpractice insurance company's experts of the quality of the plaintiff's case.[5] The legal system, then, works as it should in most cases.[6] Its apparatus for truth-finding is different from that of the healthcare system – so that doctors are often angered or discomfited by the process[7] -- but the outcomes are generally consistent.[8]

With regard to defensive medicine, Baker first notes the difficulty of defining this term. Changes in medical practice in response to malpractice litigation are most clearly a problem if they provide no medical benefit to the patient.[9] As Baker points out, the Office of Technology Assessment informed Congress that they could not "distinguish in any quantitative way between the good and bad effects of medical malpractice lawsuits." [119] Only two studies seemed to indicate that states' tort law was significantly related to additional treatment that did not lead to improved health care outcomes in the relevant population. But, Baker argues, there are reasons to think that the benefits of tort reform found by Professors Kessler and McClellan, the authors of the most widely cited study,[10] are relatively slight and short-lived; and, more important, the attempt to generalize the result to other treatments and other populations is an implausible extension of the study results. More broad-based studies did not find evidence that the malpractice litigation system induces defensive medicine -- perhaps because the shift from fee-for-service to managed care provides a strong counter-force by restricting payment for practices that cannot be justified by the patient's health needs. Baker notes that, to the extent there is a problem with the use of tests and procedures that have little or no benefit, the right

solution is evidence-based medical management, not curtailment of patients' rights to seek redress for iatrogenic incidents. [130-32]

Professor Baker provides a particularly careful and nuanced study of the malpractice insurance market.[11] He notes that the periodic appearance of "hard markets," in which insurance rates rise rapidly, is an artifact of the inherent volatility of those markets. Insurance regulations require companies to adjust their reserves annually to reflect their assessment of predicted losses. The "long tail" (the lengthy time from an act of alleged malpractice to final resolution), the relatively large amounts at stake in many claims, and the inflation in health care costs that can increase the potential damages going forward make it difficult for insurance companies to accurately predict their ultimate exposure. These uncertainties, coupled with the need for actuarial conservatism, periodically lead to sharp increases in required reserves and a consequent spike in premiums.

The supply of doctors in general responds much more to focused incentives, such as financial support for medical school education, than to indirect effects of the litigation system. [142-43]. There is a problem of too few doctors in rural areas because the potential income for such doctors is so much lower than elsewhere. Any significant cost, including malpractice premium increases, will exacerbate this problem. There may be a similar marginal effect for those, such as older doctors, whose commitment to continuing in practice is less strong in any event, or younger doctors making choices of location and practice specialty. The one area, Baker acknowledges, where malpractice seems to affect substantially physician's practice decisions is obstetrics. Some

doctors leave obstetrics, concentrating the practice in the hands of a smaller number of physicians. However, this may improve the quality of care, since the remaining physicians will be more experienced. [147] As Baker notes, there is anecdotal but little hard evidence of any significant decrease in access to care as a result of malpractice litigation.[12] As with malpractice insurance premiums and defensive medicine, there is a real problem, though less severe than presented by the proponents of the myths. More important, changing the rules for medical malpractice litigation is, at best, a highly inefficient way of responding to these problems and distracts from the need to find and develop political support for real solutions.

None of this is likely to be news to the readers of this journal. But readers of this journal are not the primary audience for the book. Rather, Baker describes his goal as "reframing the public discussion about medical malpractice lawsuits" by "shin[ing] so much sunlight on the . . myth that doctors and other people who care about health care cannot help but see what a misleading picture it presents." [19] Thus it would seem that one significant audience is those politicians and opinion leaders who have simply accepted the myths that he challenges.

IS BAKER'S PROJECT LIKELY TO SUCCEED?

It is difficult to predict what effect this book might have in the "real world" of policy development. I sense a tension between two Tom Bakers. One, an earnest optimist, writes this book in the hope that those pushing misdirected tort

reforms might be turned around by the truth. The other, more realistic and cynical, whom I find more persuasive, recognizes that politicians and the leaders of special interest groups propagate and use these myths knowingly.[13] I also doubt that many in the general public will read this book, be shaken out of their strong but erroneous beliefs,[14] and pressure the politicians to abandon their tort reform agenda. Nor does it seem likely that the medical profession can be moved. Physicians, too, have entrenched views that are unlikely to be changed merely by the provision of contradictory facts.[15] However, if fact-based argument were combined with proposed reforms that resonate better with the concerns of the medical profession, it might be possible to displace the bad "reforms" that the institutional medical profession has been supporting.[16]

As Professor Baker recognizes, there are a number of reasons why the medical profession has accepted so much of the myth. First, malpractice litigation itself is experienced as upsetting in ways that are not true for other forms of litigation. "[D]espite its veneer of scientific precision," medicine is a field in which "success depends largely on experience and judgment."[17] Physicians find it difficult to acknowledge the uncertainties of medical choices and the unavoidability of what turn out to be bad choices or true mistakes.[18] Baker terms the processes that project these anxieties outward onto the tort system "blame displacement" and "fear displacement." [15-16] Perhaps because of this hostility, physicians readily believe the myths about the harms that malpractice litigation causes. These beliefs are reinforced by their colleagues and their professional associations; and doctors, like the rest of us, tend to absorb most readily from the

media those stories that confirm their worldview. While Baker acknowledges that "doctors' fear and anxiety deserve our attention, even if they are out of proportion to what the research shows," [17] I think we need to pay more attention to the genuine, if not wholly rational, reasons for physicians' hostility if we are to get traction for more effective reform.

THE CONFUSIONS OF TERMINOLOGY

Among the most difficult, but important, issues we must confront, both to make the patient safety movement effective and to reduce physician hostility, is terminology. Numerous writers have recognized the difficulty of carefully defining and distinguishing among such concepts as "bad outcome," "adverse event," "medical error," and negligence.[19] Failure to do so makes it very difficult to collect the kind of data that allows for effective change or to compare the results of different studies, as Baker notes in discussing the various studies on which he relies to demonstrate the extent of the problem of medical error. Despite his care to speak precisely,[20] Professor Baker sometimes uses the term "malpractice" as his shorthand for this congeries of issues or otherwise writes in ways that are likely to evoke the ire of physician readers, such as when he asserts that "[t]he problem is not that there are too many claims; the problem is that there are too few." [157]

There is no simple answer here; the concepts for which we seek descriptive language are inherently slippery. One problem is that we generally consider an "adverse event" to be an "error" only if it is preventable. However,

hindsight bias makes it difficult to determine if a bad outcome was reasonably foreseeable and thus preventable. Second, we use the same terminology to talk about a series of actions prospectively, for purposes of possible corrective action, and retrospectively, to decide if a particular outcome was the result of error. Finally, concepts like adverse event are statistical, yet lay readers may translate them to proof that this particular bad outcome could have been avoided. I have no answer to these problems; I only note that we should be sensitive to the potential for misuse of such language as mistake or error or adverse event by the media and others,[21] and to the foreseeable and not unreasonable sensitivity of the medical profession to the conflation of different concepts through the confusions of terminology.

MAKING BAKER'S REFORMS MORE PALATABLE

In light of the above concerns, I want to briefly examine three of the reforms that Professor Baker proposes and suggest how they might be modified to increase their acceptability to the medical profession (and thus their political plausibility), their effectiveness in advancing patient concerns, or both.[22]

Professor Baker's reform proposals include mandatory disclosure of medical misadventures to patients and to state agencies. Baker tends to blend the two, using the same standard to define what should be disclosed in both contexts. I think, however, that for both substantive and political reasons, they should be carefully distinguished.

Mandatory Disclosure to Patients

Baker's proposed disclosure obligation to patients is extensive and the sanctions for failure severe. Every adverse or possibly adverse healthcare event must be disclosed to the patient orally and in writing, including: what happened, what the preferred outcome would have been, how what happened differed from this, and what the provider making the disclosure or others could have done differently to increase the chance of getting the preferred outcome. Any provider who does not disclose or get written proof that another person had done so and that the patient received and understood the disclosure would be deemed negligent in any subsequent lawsuit. [159-60] Baker correctly notes that his mandate for full disclosure is consistent with and reinforces the medical profession's ethical edict to "inform the patient of all the facts necessary to ensure understanding of what has occurred, [regardless of] legal liability which might result following truthful disclosure."[23] [166] He also recognizes that the disclosure may provide the basis for the patient, presumably together with his or her attorney, to decide what steps to take. [167]

As Baker and others have noted, effective communication between physician and patient is essential, at all stages of the relationship. Indeed, key predictors of whether someone will bring a malpractice claim are patient dissatisfaction with physicians' communication and interpersonal skills.[24] Apart from the normal human reluctance to admit error or to talk about things that go wrong for which one feels some responsibility, physicians have understandable reason to avoid any obligation to disclose. Many of them lack the natural ability

or the training to effectively communicate difficult, complex information, especially to patients who are likely to be both medically unsophisticated and under stress.[25] Partly because of the complexities of terminology noted above, there is a legitimate concern that the communication will be misunderstood. Might patients misconstrue their expressions of concern as apologies for error? Might they misconstrue the term "adverse event" as a synonym for "negligence," even if the complication experienced resulted from an inherent risk of a reasonable treatment choice? Before we reach for the heavy stick of presumptive liability, we should provide health care workers with the communication tools to minimize such misunderstandings, through special training or the support of hospital staff who are themselves better able to avoid these linguistic landmines.

Mandatory Disclosure to State Agencies

Professor Baker would require that the same data be disclosed to whatever state agency is, in effect, the patient safety organization, including a "serious auditing requirement" to ensure such disclosure. [160-61] He calls for strong enforcement measures on the reasonable assumption that disclosure will not occur simply from the good will of providers or "a desire to improve the accuracy of claims of medical malpractice."[26] [168]. However, effective disclosure for patient safety purposes cannot be defined *ex post* by the consequences. The key is *risk-creating* behavior, not *harm-causing* behavior.

Patient safety advocates realize that evidence-based analysis of systems failures requires consideration of near-misses as well as adverse events.[27]

Furthermore, confidentiality and insulation from discovery – not mentioned by Professor Baker -- are needed to induce such disclosure. Steps have been taken, including the recent Patient Safety and Quality Improvement Act of 2005,[28] to provide such protection. Baker is correct that disclosure will not reliably occur without a positive obligation of some sort,[29] but I believe that it also will not reliably occur without the "carrot" of confidentiality. The widespread belief among health care professionals and institutions that such disclosures are dangerous is itself a fact that must be taken into account.[30]

Enterprise Liability

Professor Baker also proposes the adoption of enterprise insurance, a scaled-down version of enterprise liability. He argues that the health care facility should provide liability insurance that would cover the physicians who practice there, as well as its own employees. This would directly affect only the insurance market (by providing the benefits of larger pools of insureds and experience rating), not the structure of subsequent tort litigation.[31] [67, 164]

However, enterprise insurance will also almost surely create an incentive for hospitals (who are paying the premiums) to control physician behavior that threatens to increase the number and severity of compensable events. Indeed, Professor Baker recognizes this when he mentions that his proposal "might make hospitals choosier about which doctors they allow to use their facilities. That

would be a very good thing." [177]. It is unlikely to signficantly reduce the intense resistance of the medical profession to enterprise liability.[32]

This might suggest that the only politically feasible position would be to oppose both enterprise liability and enterprise insurance. I think, however, that there may be an opportunity to move the medical profession by persuading them of how different tort litigation might be, with the shift to an enterprise liability system as the first step in such a transformation.[33] There has been a presumption that the patient safety movement and the medical malpractice system are "conflicting cultures." As David Studdert presents the received wisdom, "the punitive, individualistic, adversarial approach of tort law" is antithetical to the "systems-oriented, non-punitive, cooperative strategies" of the patient safety movement.[34]

If one assumes this conflict is inevitable, the question becomes deciding which system is best. But the choice is not this stark; the two approaches share some common ground. Perceptive proponents of the tort system recognize that its deterrence effects are necessarily indirect and rely on system changes of the sort the patient safety movement promotes, while perceptive proponents of patient safety acknowledge that the changes they advocate have often come in response to malpractice litigation.[35]

The received wisdom assumes that the current structure of medical malpractice, with its focus on individuals, is inevitable. Consider, however, what malpractice litigation might look like if the defendants were healthcare institutions. The plaintiff's claim in most lawsuits would be not that doctor X

harmed me by failing to behave as a competent doctor should, but that institution Y failed to take the steps that a reasonable institution would take to train its staff or to institute systems (that the patient safety movement has shown are practicable) to sever the link between inevitable mistakes and harm to patients. Refocusing litigation on the institution largely eliminates the challenge to the reputation of individual physicians and thus can reduce the hostility of the medical profession generally and the resistance by individual physician-defendants to the current system.[36] It would also reinforce the patient safety system.

Such a modified malpractice system, focused largely on challenging failures to implement patient safety systems,[37] might better advance all the goals of the tort system: to provide compensation for those who have been injured by medical error, to induce changes in the health care system (the "deterrent" effect of tort law), and to provide corrective justice between the injured patient and the system that failed him or her. It also can draw on deep parallels to another area of tort law, products liability, in which the focus is not on individuals and frequently not on particular, blameworthy behavior but, rather, on the institutional decisions that unreasonably risk the safety of consumers.

CONCLUSION

The debates over what to do about medical malpractice are complex andlongstanding. I hope that Professor Baker's analysis and proposals, and my own responses to them, will be seen as offering some fresh ideas and perspective, but the problems will not readily be solved and the debate will go on.

The key value of Professor Baker's book, in my view, is that it can elevate the debate and make it more rational and reality-based by chipping away at the myths that obscure understanding and block meaningful collaboration on solutions. If we can move toward debates in which lawyers, doctors, insurance professionals, economists, scholars, and others with a genuine interest in improving the system talk among ourselves rather than shouting impossibly conflicting positions at each other, perhaps some real progress can be made. Not only will the medical and legal systems be improved but, more important, patients who come in contact with these systems will benefit. It is a goal both Professor Baker and I share.

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1 While a variety of groups have promulgated these myths, Baker uses as a framing device a speech by President Bush in January 2005 presenting a number of these myths as facts and citing them as the basis for the need to "fix a broken medical liability system." [13] [**Ed. Note:** Numbers in brackets herein refer to pages in the Baker text.]

[2] [81-87] Baker here relies significantly on Henry Farber & Michelle White, *Medical Malpractice: An Empirical Examination of the Litigation Process*, 22 RAND J. ECON. 199 (1990).

[3] See note 19 *infra* and accompanying text.

[4] *See* DON HARPER MILLS, ED., REPORT ON THE MEDICAL INSURANCE FEASIBILITY STUDY (1977); Troyen Brennan et al., HARVARD MEDICAL PRACTICE STUDY, PATIENTS, DOCTORS, AND LAWYERS: MEDICAL INJURY, MALPRACTICE LITIGATION AND PATIENT COMPENSATION IN NEW YORK (1990); Ross Wilson, William Runciman et al., *The Quality in Australian Health Care Study*, 163 MED. J. AUSTRALIA 458 (1995); Lori Andrews, *Studying Medical Error in Situ: Implications for Malpractice Law and Policy*, 54 DEPAUL L. REV. 357 (2005).

[5] Recoveries in cases where the defense experts believed care was appropriate were generally small and, thus, cheaper than the costs of litigation, while even in cases assessed as strong on the evidence, insurance companies generally settled only after plaintiffs hired lawyers and pressed for such compensation. [78-81]

[6] Baker persuasively demonstrates the defects in the one contrary study. *See* Thomas Baker, *Reconsidering the Harvard Medical Malpractice Study: Conclusions about the Validity of Medical Malpractice Claims*, 33 J. L., MED. & ETHICS 501 (2005).

[7] The negative reaction is not irrational. Legal practice, unlike medicine, does not purport to be a search for abstract truth but, rather, for a plausible, supportable story that is consistent with one's client's position. *See, e.g.*, Professor Baker's recounting that the visiting lawyers in a medical malpractice case told his torts class that, for strategic reasons, they had constructed their case as one in which the hospital, not the delivering doctor, was liable but, "if we had to prove she caused the harm, we could have." Baker, *supra* note 1, at 89-90.

[8] Academic studies have shown a high degree of agreement between juries and medical experts presented with the same information. *See* Catherine Struve, *Doctors, The Adversary System, and Procedural Reform in Medical Liability Litigation*, 72 FORDHAM L. REV. 943, 983-86 (2004).

[9] A practice is also undesirable, defensive medicine, if the costs clearly outweigh the potential benefits, but this calculation is still more complicated.

[10] Daniel Kessler & Mark McClellan, *Do Doctors Practice Defensive Medicine?*, 111 Q'TLY. J. ECON. 353 (1996)(describing a study of treatments for heart disease in elderly patients in states with and without tort reform). There was also some evidence of a modest effect on C-section rates from perceived malpractice litigation risks. A. Russell Localio et al., *Relationship between Malpractice Claims and Cesarean Delivery*, 269 J.A.M.A. 366 (1993).

[11] His analysis here draws on his excellent and more detailed article, Thomas Baker, *Medical Malpractice Insurance and the Insurance Underwriting Cycle*, 54 DEPAUL L. REV. 393 (2005).

[12] Baker relies here on an earlier version of Katherine Baicker & Amitabh Chandra, *Defensive Medicine and Disappearing Doctors?*, 28 REGULATION 24 (2005).

[13] This is, after all, an Administration that faulted its critics for living in "the reality-based community," because, it asserted, "when we act, we create our own reality." Ron Suskind, *Without a Doubt*, N. Y. TIMES MAG. 44 (Oct. 17, 2004) (available at http://www.truthout.org/docs_04/101704A.shtml, last visited Mar. 8, 2006)..

[14] Baker notes part of the problem is the phenomenon of "cognitive dissonance." [42-43] Once we believe something is true, we tend to perceive and believe those things that reinforce what we already "know" and overlook, dismiss, or undervalue contradictory inputs. *See* LEON FESTINGER, A THEORY OF COGNITIVE DISSONANCE (1957).

[15] *See, e.g.*, William Sage, *Reputation, Malpractice Liability and Medical Error, in* VIRGINIA SHARPE, ED. ACCOUNTABILITY: PATIENT SAFETY AND POLICY REFORM 159, 159 (2004). Professor Sage observes: "[O]pposition to malpractice litigation has been a litmus test for membership in the medical profession. . . Eliminating malpractice suits takes precedence over every other political objective …for the

AMA and state medical societies. No contradictory belief, however well-reasoned, empirically based, or sincerely held, succeeds in crowding out antipathy toward malpractice from physicians' minds."

[16] Such a shift is particularly important, given the ways in which politicians and special interests -- as Baker recognizes, when he describes President Bush as speaking surrounded by doctors in white coats -- are using the medical profession as a "front group," to rally public support for protecting not just doctors, but also pharmaceutical companies, medical device manufacturers and business in general from effective accountability through the tort system. [11]

[17] Sage, *supra* note 15, at 165. Physicians' sense of being unfairly targeted may be exacerbated by the recognition that one factor driving increased malpractice litigation over time has been precisely the improvements in health care that make it easier to prove that a particular action caused harm, that increase economic damages, and that create rising expectations that, when disappointed, can lead to litigation. *See* David Studdert, Michelle Mello, & Troyen Brennan, *Medical Malpractice*, 350 NEW ENG. J. MED. 283, 286 (2004); Sage, *supra* note 15, at 169.

[18] He relies in part on the insights of ATUL GAWANDE, COMPLICATIONS: A SURGEON'S NOTES ON AN IMPERFECT SCIENCE (2002).

[19] *See, e.g.*, Maxine Harrington, *Revisiting Medical Error: Five Years After the IOM Report, Have Reporting Systems Made a Measurable Difference?*, 15 HEALTH MATRIX 329 (2005); Troyen Brennan, *The Institute of Medicine Report on Medical Errors – Could It Do Harm?* 342 NEW ENG. J. MED. 1123 (2000).

[20] I think Baker's failures in this regard are somewhat overstated in the review of his book by Peter Hammer, *Slaying Dragons: Malpractice Beyond Myth*, 25 HEALTH AFFAIRS, 289 (2006).

[21] Harrington, *supra* note 19, at 344: "[M]any people, including professionals, equate medical error with negligence." Insofar as our focus is prospective, we need a broad concept that will encourage development of tools that would make bad outcomes that appear to be the inevitable risks of appropriate medical care preventable. *Cf.* David Leonhardt, *Why Doctors So Often Get it Wrong*, N.Y. TIMES (Feb. 22, 2006) (http://www.nytimes.com/2006/02/22/business/22leonhardt.html, last visited Mar. 8, 2006) (describing a computer system that allows diagnosis of rare conditions that even well-trained physicians might otherwise overlook).

[22] Baker also includes two other proposals, which I do not deal with here. First, he suggests an administrative, no-fault compensation system, modeled on worker's compensation. The proposal is attractive in some ways, but its acceptability to the medical profession may be undermined by the same characteristic that makes it acceptable to the trial bar: It is consciously designed "to minimize interference with

the current tort approach" (164). He also proposes a variation of the "early offer" procedure in which a health care provider who believes he or she is at fault can acknowledge that fault and offer restitution "within a reasonable time" after he or she is aware of the extent of the patient's injuries. There are financial consequences that make both offer and acceptance attractive. Baker stresses, however, the therapeutic benefits to all parties of apology and restitution [171-72], citing Lee Taft, *Apology and Medical Mistake: Opportunity or Foil?,* 14 ANNALS OF HEALTH L. 55 (2005). Here, as in his disclosure requirements, Baker would permit use of the physician's statements in subsequent litigation.

[23] American Medican Association Council on Ethical and Judicial Affairs, Code of Medical Ethics § 8.12

[24] Studdert et al., *supra* note 17, at 284.

[25] Consider the literature examining parallel problems in the context of informed consent. *See, e.g,* Alan Meisel & Lorne Roth, *Toward an Informed Discussion of Informed Consent: A Review & Critique of the Empirical Studies*, 25 ARIZ. L. REV. 265 (1983); JESSICA BERG ET AL., INFORMED CONSENT: LEGAL THEORY & CLINCIAL PRACTICE, 2D ED. (2001). These problems are often exacerbated by the need of both physician and patient to see the doctor as infallible. *See* JAY KATZ, THE SILENT WORLD OF DOCTOR AND PATIENT (1986), Lucian Leape, *Can We Make Health Care Safe?* in ACCELERATING CHANGE TODAY, REDUCING MEDICAL ERRORS AND

IMPROVING PATIENT SAFETY 2 (Report from the National Coalition on Health Care and the Institute for Health Care Improvement 2000).

[26] Professor Baker's strong views on the desirability of tort litigation as a necessary incentive to safety as well as a means for compensation are evident here. Others would assume the appropriate desire would be to improve the safety of the health care system.

[27] Harrington, *supra* note 19, at 339. Unfortunately, the Institute of Medicine similarly distinguished between harm-causing events, for which it would make disclosure mandatory, and harm-risking events, for which only voluntary disclosure was advocated.

[28] Codified at 42 U.S.C. §§ 299b-21-299b-26.

[29] *Cf.* David Hyman & Charles Silver, *The Poor State of Health Care Quality in the United States: Is Malpractice Liability Part of the Problem or Part of the Solution?* 90 CORNELL L .REV. 893, 985-90 (2005) (advocating financial incentives to health-care workers who report errors to an outside body, such as The Leapfrog Group, that can analyze them and make safety assessments).

[30] *See, e,g.*, Studdert et al, *supra* note 17, at 287; Harrington, *supra* note 19, at 354-55 (making the argument that medical malpractice fears deter disclosure absent such protections).

[31] Baker notes that legislation requiring such insurance coverage may be necessary to avoid the anti-kickback law, 42 U.S.C. §1320a-7b(b).

[32] This resistance was manifested in the response to this aspect of the Clinton health plan. *See* Kenneth Abraham & Paul Weiler, *Enterprise Medical Liabiilty and the Evolution of the American Health Care System*, 108 HARV. L. REV. 381, 383 (1994).

[33] For more traditional arguments regarding the value of enterprise liability, see, e.g., Studdert et al, supra note 17; Abraham & Weiler, supra note 33, *See also* Hyman & Silver, *supra* note 29, at 975 (noting that the current tort system "emits a weak and inconsistent signal for quality improvement").

[34] Studdert et al., s*upra* note 17, at 287.

[35] *See, e.g.*, Hyman & Silver, *supra* note 29, at 971 (discussing the actions of the American Society of Anesthesiology in response to rising malpractice premiums); William M. Sage, *Understanding the First Malpractice Crisis of the 21st Century*, in HEALTH LAW HANDBOOK 1, 19 (ALICE GOSFIELD, ED. 2003) ("innovation that

improves safety often happens in the shadow of liability"); and the book under review.

[36] *See* Sage, *supra* note 15, at 160.

[37] Personal injury lawyers who take seriously their claims that they are seeking to improve health care by making errors costly, should support this as well. The patient safety system is already beginning to have positive impacts, though the adoption of these changes is slower than one might hope. *See, e.g.*, Accelerating Change Today, *supra* note 25 (setting out examples of changes that have occurred in certain segments of the health care industry); Daniel Longo, John Hewett, Bin Ge & Shari Schubert, *The Long Road to Patient Safety*, 294 J.A.M.A. 2858 (2005) (describing the slow progress in implementing such changes across a wide range of hospitals).