

THE MALPRACTICE CRISIS TURNS 175: WHAT LESSONS DOES HISTORY HOLD FOR REFORM?

Robert I. Field*

ABSTRACT

The widespread perception of a medical liability crisis is anything but new. In fact, the emergence of malpractice litigation as a common feature of American jurisprudence and the sense of legal siege in the medical community date back more than 175 years to the 1830s. Several factors have been identified as possible causes. For the most part, these factors relate to changes in medicine and in society at large as America entered the Industrial Revolution. They can be grouped into three broad categories: advancing technology, greater standardization and oversight of practice, and expanded professional autonomy. Reform efforts to date have largely ignored this historical context. Perhaps such efforts would alleviate the perennial sense of crisis more effectively if they took these longstanding underlying features of American medicine into account. The first two factors have played instrumental roles in improving the quality of care, making them less than appealing targets for change. However, the third has led to a culture of entrepreneurship among physicians with no apparent clinical benefits. Therefore, the nature of professional autonomy, especially as it relates to the business structure of medical practice, may represent the most fruitful avenue for effectuating meaningful change in a perceived crisis that has persisted for almost two centuries.

TABLE OF CONTENTS

I. HISTORICAL PERSISTENCE OF THE MALPRACTICE CRISIS	8
II. ORIGINS OF THE MEDICAL MALPRACTICE CRISIS	10
A. The Start of the Litigation Explosion	12
B. Lawyers as Culprits	13
III. EXPLANATIONS FOR THE MALPRACTICE EXPANSION	14
A. Social and Economic Changes	14
B. Changes in the Medical Enterprise	16
C. Advances in Medicine	19
D. Evolution of Legal Doctrines	21
E. Liability Insurance	26

* Professor of Law, Earle Mack School of Law, and Professor of Health Management and Policy, School of Public Health, Drexel University. The author thanks Joanna S. Suder for her helpful research assistance in the preparation of this Article.

F. Expansion of Physician Autonomy	27
IV. OBSERVATIONS BASED ON HISTORY	29
V. LESSONS FOR REFORM	34
VI. CONCLUSION	37

I. HISTORICAL PERSISTENCE OF THE MALPRACTICE CRISIS

“Litigation, like legislation, was never so rampant as it is to-day.”¹ So cried a review of medical malpractice lawsuits published in *The Boston Medical and Surgical Journal* in 1911.² The article went on to bemoan the “craze for legal proceedings upon any and all occasions, however baseless the charges” and to condemn “the desire to seek revenge for injuries, real or imaginary.”³

The sense of a crisis in medical liability is palpable in these quotes. The author further warned that the flood of personal injury cases was consuming the courts.⁴ Reputable physicians faced “unjust charges” that not only imposed expenses, but were disheartening, aggravating, and demoralizing.⁵ He complained that the attitude of patients turned plaintiffs showed such callous disregard for a venerable profession that, “[w]ith no just cause for dissatisfaction, the most vindictive spirit is not infrequently shown toward one who has done his utmost, as much in fact as it was possible for any one to do, for his welfare.”⁶

Contemporary critics of the malpractice liability system echo these sentiments almost exactly. In 2010, the president of the American Medical Association described the system in striking similarity to his colleague of a century ago in stating, “The litigation lottery invites abuse, inefficiency and persecution of the blameless.”⁷ He went on to add a familiar theme in assigning blame: “Unfortunately, the liability system has failed patients, but it is extremely lucrative for trial lawyers, who receive the lion’s share of jury awards.”⁸

1. George W. Gay, *Suits for Alleged Malpractice*, 165 BOS. MED. & SURGICAL J. 353 (1911).

2. *Id.*

3. *Id.*

4. *See id.*

5. *See id.*

6. *Id.*

7. Cecil B. Wilson, Letter to the Editor, *Our Ailing Medical Malpractice System*, WASH. POST, Sept. 7, 2010, available at <http://www.washingtonpost.com/wp-dyn/content/article/2010/09/06/AR2010090603234.html>.

8. *Id.*

Clearly, the medical community's perception of a lawsuit crisis is not new. Even in 1911 it was already longstanding. Complaints of an inundation of malpractice suits had been expressed over half a century earlier. In 1852 an account of recent developments in *The Boston Medical and Surgical Journal* noted, "One case after another shows that the best operators in New England expose themselves to the hazard of a vexatious lawsuit, in every instance where the case is not in all respects satisfactory to the patient and his friends."⁹ The unfortunate result, it concluded, was "the ruin of the defendant's professional influence . . . even if his last dollar is not taken."¹⁰

As these historical references reflect, debates that rage today about the state of medical liability follow a long history.¹¹ They show that over the course of more than a century and a half, physician perceptions of an unjust burden imposed by malpractice litigation have changed little. Yet during this time, the profession and the environment in which it functions have hardly remained static. Medicine has evolved dramatically, so much so that practice in 1852 would be unrecognizable today.¹² Other aspects of the environment in which the profession operates, including its financing, regulation, and social context, have also undergone striking transformations.¹³ All the while, the legal doctrines behind malpractice liability have progressed considerably as well.

This persistent sense of a malpractice crisis through decades of change in medicine, law, and society suggests that fundamental underlying forces are at work independent of the trends at any given time. To endure for this long with such force, malpractice litigation must reflect factors that are deeply ingrained. Therefore, an accurate understanding of the system and of opportunities for truly effective reform requires an unraveling of the system's historical context and evolution. A tension has persisted for over a century and a half that

9. *Prosecuting Surgeons for Mal-practice*, 46 BOS. MED. & SURGICAL J. 264, 264 (J. V. C. Smith ed., 1852).

10. *Id.* at 265.

11. "[H]istorical data demonstrate that, contrary to the common perception, recent increases in physician liability are neither sudden nor dramatic." Reed Neil Olsen, *The Reform of Medical Malpractice Law: Historical Perspectives*, 55 AM. J. ECON. & SOC. 257, 258 (1996).

12. See generally PAUL STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE* 3-144 (1982) (describing the transformation of medicine in the United States over the course of the nineteenth and most of the twentieth centuries). Starr states that changes in medical practice that originated in the early nineteenth century, including technological advances, effectuated a new orientation that "was not simply a rearrangement of the elements within the traditional structure of medical thought; it transformed the structure itself." *Id.* at 55.

13. *Id.*

has stubbornly resisted resolution. The cause of achieving meaningful change would be well served by understanding it.

II. ORIGINS OF THE MEDICAL MALPRACTICE CRISIS

The earliest lawsuits for medical mistakes date back several centuries to the formative stages of the common law. The first reported case is that of *Stratton v. Swanlond*,¹⁴ decided in 1374 by Chief Justice John Cavendish of the Court of Kings Bench in England. The defendant in that proceeding, a London surgeon named John Swanlond, had treated the plaintiff, Agnes of Stratton, for a mangled hand.¹⁵ She claimed that he had guaranteed to cure her wound for a reasonable fee, but after his treatment the hand remained severely deformed.¹⁶ She and her husband sued for breach of contract.¹⁷ Although the surgeon escaped liability because of an error in the writ of complaint, the court set forth basic principles for cases arising from medical mishaps.¹⁸ Justice Cavendish declared that a physician should be held liable if a patient was harmed as a result of his negligence.¹⁹ However, if the physician diligently applied himself, liability would not ensue even if he did not succeed in effectuating a cure.²⁰

Cases continued to be brought, although infrequently, over the next several centuries.²¹ The word "malpractice" came to describe the underlying cause of action in the mid-eighteenth century. Its first use has been traced to Sir William Blackstone's *Commentaries on the Laws of England*, written in 1768.²² He applied the general concept of professional negligence to physician practice under the Latin term *mala praxis*, from which the word is derived.²³ In contrast to the basis for the claim in *Stratton*, he classified malpractice as a private wrong

14. Y. B. 48 Edw. 3, fol 6, pl. 2 (1375) (Eng.) (decided in 1374, but published in 1375) reprinted in Carlton B. Chapman, *Stratton vs. Swanlond: The Fourteenth-Century Ancestor of the Law of Malpractice*, 45 PHAROS 20-22 (1982).

15. See Chapman, *supra* note 14, at 20.

16. *Id.*

17. *Id.*

18. *Id.* at 20-21.

19. *Id.* at 21.

20. *Id.*

21. Additional rulings were issued in 1433, 1435, and 1472, and by the time the United States declared independence from England, the law of medical malpractice had become established in the common law. Allen D. Spiegel & Florence Kavalier, *America's First Malpractice Crisis, 1835-1865*, 22 J. CMTY. HEALTH 283, 286 (1997).

22. James C. Mohr, *American Medical Malpractice Litigation in Historical Perspective*, 283 JAMA 1731, 1731 (2000) (discussing 3 WILLIAM BLACKSTONE, COMMENTARIES *122).

23. *Id.*

rather than a breach of contract.²⁴ The offense occurred when a patient was injured by “the neglect or unskillful management of his physician, surgeon, or apothecary,” and it constituted a “great misdemeanor and offence at common law.”²⁵ *Mala praxis*, he noted, “breaks the trust which the party had placed in his physician, and tends to the patient’s destruction.”²⁶

While the concept of medical malpractice was recognized at common law and assigned a name by the end of the eighteenth century, lawsuits alleging it were extremely rare well into the early nineteenth century.²⁷ *The Boston Medical and Surgical Journal* reported only three cases between 1812 and 1835.²⁸ In the words of one author, “The years from 1790 to 1835 were a period of relative judicial safety for the physician, and only isolated cases presaged the menace on the horizon.”²⁹ In fact, lawsuits for malpractice were so rare that most American lawyers at the time would most likely not even have known how to draft a complaint.³⁰

During this era of relative legal comfort, some prominent physicians even regarded medical liability positively and the attorneys who brought such claims as their allies. Malpractice suits, they believed, helped to enforce quality standards in a profession that was poorly regulated.³¹ Two contemporary luminaries of medical education, Nathan Smith of Yale University and R. E. Griffith of the University of Pennsylvania, bemoaned the lack of vigilance by state and federal authorities against irresponsible physician behavior.³² They viewed lawyers who sought remedies in court for deficient care as important instruments for enforcing standards and improving practice.³³ However, this time of infrequent and selective suits turned out to be the calm before the storm.

24. Spiegel & Kavalier, *supra* note 21, at 286.

25. *Id.*

26. *Id.*

27. Mohr, *supra* note 22, at 1731.

28. Spiegel & Kavalier, *supra* note 21, at 283.

29. KENNETH ALLEN DE VILLE, *MEDICAL MALPRACTICE IN NINETEENTH-CENTURY AMERICA: ORIGINS AND LEGACY 2* (1990).

30. Mohr, *supra* note 22, at 1731.

31. See STARR, *supra* note 12, at 44–45, 58 (describing the ineffectiveness of attempts to impose licensing requirements on physicians in the late eighteenth century and describing the rescission of even these limited measures in the early nineteenth century).

32. See Mohr, *supra* note 22, at 1732.

33. *Id.*

A. *The Start of the Litigation Explosion*

The halcyon days of limited liability exposure for physicians came to an abrupt end in the 1830s.³⁴ Starting about 1835, malpractice claims began to arise with increasing frequency and soon were perceived to “inundate” the courts.³⁵ In just fifteen years, by 1850, the phenomenon of medical liability litigation as we know it today had emerged with full force.³⁶ Between 1840 and 1860, the number of appellate cases involving medical malpractice claims rose by 950%.³⁷ In 1860, one observer noted that most of the oldest physicians in almost every part of the country had by then either been sued or threatened with suit.³⁸

The proliferation of malpractice cases spread from state to state. It first appeared in western New York State.³⁹ By 1850, it had reached Pennsylvania and Ohio and, by the mid-1850s, Vermont, New Hampshire, and Massachusetts.⁴⁰ The change in legal climate in Massachusetts was particularly rapid.⁴¹ In 1847, a local commentator noted the state’s good fortune in remaining relatively immune from the spread of lawsuits that had reached as close as neighboring Vermont, and he opined that it would remain so.⁴² However, writing just five years later in 1852, another commentator complained that the state “is in a fair way of taking the lead in the persecution of surgeons.”⁴³ The following year, an observer saw Massachusetts as more litigious than both Vermont and western New York.⁴⁴

34. *Id.* at 1731–32.

35. Spiegel & Kavalier, *supra* note 21, at 283–84.

36. *Id.* The size of awards in malpractice cases also started to grow at this time. With the exception of a drop between 1860 and 1862, perhaps because of the Civil War, the mean and median awards grew each year, with a particularly dramatic increase of about 500% between 1870 and 1878. The median award during the period between 1843 and 1849 was \$382.15 in terms of the dollar value in year 1900. During the period between 1870 and 1878, it was \$1388.89. Overall, between 1843 and 1955, awards grew at an average annual rate of about 3%. Olsen, *supra* note 11, at 268, 269 tbl.3.

37. Mohr, *supra* note 22, at 1732. The number of appellate cases does not necessarily reflect the number of cases filed, since most verdicts are not appealed. However, this large increase strongly suggests that there was at least some significant increase in activity at the trial level, especially when considered in light of increases in the number of reports of malpractice suits in medical journals. Olsen, *supra* note 11, at 266.

38. DE VILLE, *supra* note 29, at 25.

39. *Id.* at 27.

40. *Id.* at 28–30.

41. *Id.* at 30.

42. *Surgical Malpractice*, 36 BOS. MED. & SURGICAL J. 283, 283–84 (J. V. C. Smith ed., 1847).

43. *Prosecuting Surgeons for Mal-practice*, *supra* note 9, at 264. The importance of New York as the origin of the practice of suing surgeons is also reflected in the commentary: “The State

B. Lawyers as Culprits

Along with the spread of lawsuits came the medical profession's identification of the culprit—lawyers. A deep rift developed between physicians and attorneys that has yet to heal.⁴⁵ One physician, writing in 1850, referred to areas with high numbers of lawsuits as “law-infested districts.”⁴⁶ Another, commenting in 1878, compared malpractice lawyers to sharks, an analogy that has proven to have considerable staying power.⁴⁷ In 1911, a commentary in *The Boston Medical and Surgical Journal* left no doubt as to where at least some physicians assigned fault for the steady flood of litigation: “A very important factor in many of these cases is the perniciously active attorney, who is constantly on the watch for opportunities to instigate and foment claims of all sorts with little regard to right and justice.”⁴⁸

One particularly unfortunate aspect of the way attorneys began bringing medical liability claims was their choice of targets. These tended to be physicians who were the most competent.⁴⁹ To be sued for deviating from standards of practice, accepted standards must exist. Highly educated physicians were trained to follow current standards through textbooks and manuals that were produced with increasing frequency by the mid-nineteenth century.⁵⁰ Alternative healers and amateur practitioners, on the other hand, claimed no widely recognized expertise and made no representations concerning the standards to which they adhered.⁵¹ Therefore, by promising to deliver higher quality medicine, mainstream physicians unwittingly offered ammunition to their legal adversaries. One observer ironically opined in 1849 that it would be safer for a physician to practice without a diploma.⁵²

of New York, greatly distinguished in that way, will soon be lost sight of in the more active career of this ancient commonwealth [referring to Massachusetts].” *Id.*

44. *Trials for Mal-practice*, 49 BOS. MED. & SURGICAL J. 270, 270 (J. V. C. Smith ed., 1853).

45. Mohr, *supra* note 22, at 1733.

46. *Medical Miscellany*, 42 BOS. MED. & SURGICAL J. 67, 67 (J. V. C. Smith ed., 1850).

47. Mohr, *supra* note 22, at 1734. Current allusions to lawyers as sharks include numerous jokes. See, e.g., SHARKS & LAWYERS, <http://sharksandlawyers.com> (last visited Dec. 5, 2011).

48. Gay, *supra* note 1, at 354.

49. Mohr, *supra* note 22, at 1732–33.

50. *Id.* at 1733 (stating that texts and manuals could be “used against [physicians] in court as codified norms from which they could be accused of diverging.”).

51. *Id.*

52. *Id.*

III. EXPLANATIONS FOR THE MALPRACTICE EXPANSION

An environment more conducive to medical liability claims was established by the mid-nineteenth century and continues through the present day. As contemporaneous observations indicate, the litigious atmosphere arose suddenly and took much of the medical profession by surprise. What forces could have brought about such a rapid and longstanding transformation?

Changes in many aspects of American society were occurring around the same time and may have influenced the malpractice litigation environment. Some changes were related to economic and social factors in the United States as it stood on the verge of the Industrial Revolution. Other changes were related to developments in medical practice, which was about to advance dramatically in technological sophistication. And some changes were related to developments in the law that opened more avenues for plaintiffs aggrieved by perceived professional misbehavior.

A. *Social and Economic Changes*

America entered an era of profound social and economic transformation in the early part of the nineteenth century. The economic base of the country was starting to undergo a tectonic shift from agriculture to industrial manufacturing.⁵³ This change brought with it greater standardization of goods and services and increased separation of consumers from producers.⁵⁴ Due to greater geographic and social distance, those who provided goods and services were less likely to be friends with and neighbors to their customers and more likely to be potential adversaries.

The most immediate change for many people was in the means of transportation, which underwent a technological revolution.⁵⁵ The first commercial steamship service in America began operation in 1807.⁵⁶ The first steam-powered railroad opened for passenger travel in 1830.⁵⁷ Easier transportation facilitated a more sophisticated medical profession, as practitioners could move from region to region to

53. CORONA BREZINA, *THE INDUSTRIAL REVOLUTION IN AMERICA: A PRIMARY SOURCE HISTORY OF AMERICA'S TRANSFORMATION INTO AN INDUSTRY SOCIETY* 4 (2005).

54. *Id.* at 8.

55. *Id.* at 4.

56. *Id.* at 6.

57. JAMES D. DILTS, *THE GREAT ROAD: THE BUILDING OF THE BALTIMORE & OHIO, THE NATION'S FIRST RAILROAD, 1828-1853*, at 80 (1993). The Baltimore & Ohio Railroad officially opened on May 22, 1830. *Id.*

see a wider range of patients.⁵⁸ Along with them, medical knowledge spread more readily, affording physicians and their colleagues easier access to recent advances. With a broader spread of information, standards of practice became easier to disseminate and to use in court proceedings for assessing liability.

These advances may also have promoted a more sophisticated patient base.⁵⁹ With improved travel, patients could more easily learn about medical developments and standards of practice across regions. They would also have found it easier to learn about trends in litigation as malpractice suits began to proliferate. Better-informed patients may have made more ready plaintiffs.

The spread of malpractice litigation also coincided with changes in philosophical and religious attitudes. During the 1820s and 1830s, views began to shift away from notions of religious fatalism, which held that adverse occurrences such as physical ailments were acts of divine providence, rather than of human fault.⁶⁰ In its place, there was a growing belief in religious perfectionism, the idea that human actions, not divine beings, determined the course of events.⁶¹ If people, rather than heavenly intervention, were responsible for medical outcomes, then those who practiced medicine could more readily be assigned responsibility if things went wrong.⁶²

The early nineteenth century was also a time of rising anti-elitist sentiment in the United States. Andrew Jackson assumed the presidency in 1829 as a populist, championing "honor in commonness."⁶³ He represented a rejection of the values of a more genteel and aristocratic Europe and the embodiment of a direct and simple American ideal.⁶⁴ Growing suspicion of elites applied to professionals,

58. STARR, *supra* note 12, at 68 (describing how, prior to the advent of mechanized transportation, "[t]he high costs of travel contributed to the individualism and isolation of medical practice").

59. Paul Starr notes of the late eighteenth and early nineteenth century, "Dispersed in a heavily rural society, lacking modern transportation, the great majority of the population was effectively cut off from ordinary recourse to physicians because of the prohibitive opportunity cost of travel." *Id.* at 66.

60. Mohr, *supra* note 22, at 1732.

61. *Id.*

62. "Malpractice suits were rare in the transition period of the 1820s and 1830s, before a large proportion of the population began to hold human agents responsible for human misfortune." DE VILLE, *supra* note 29, at 122. According to Paul Starr, "[A]n orientation was being established that regarded illness as a natural phenomenon not subject to magical or moral forces. The domestic medical guides, together with popular lectures on health and physiology, were one of many ways that rationalist ideas about disease and medicine were transmitted to the public and converted into attitudes and practices." STARR, *supra* note 12, at 36.

63. ANDREW BURSTEIN, *THE PASSIONS OF ANDREW JACKSON*, at xiii-xv (2004).

64. *Id.* at xiv-xv.

physicians included, who had long enjoyed special social status.⁶⁵ The value of commonness encouraged the belief that members of elite groups should only enjoy such privileges as they have earned.⁶⁶ For physicians, this meant being true to their representations of curative powers and their adherence to high standards. If they fell short, anti-elitist sentiment held that consequences should follow.

B. *Changes in the Medical Enterprise*

Some of the most important economic and social changes that affected physicians in the early nineteenth century involved the structure of the medical profession itself. In terms of economics, during the 1830s and 1840s, there was a proliferation of advertising for medical services, with claims of therapeutic wonders commonly appearing in newspapers.⁶⁷ Many patients took these representations at face value as promises of positive outcomes. However, wondrous results could be difficult for physicians to deliver. Advertising thereby engendered disappointed patients, who could point to a defendant physician's self-promotion as a standard against which his performance should be judged.

The medical profession was also undergoing its first major attempts at formal organization. The American Medical Association (AMA) was founded in 1847 to promote standardization in training and practice.⁶⁸ This effort supported a larger objective of enhancing the social and economic standing of the profession.⁶⁹ One of the AMA's specific goals was to improve the scientific base of medicine to make it more effective and respected.⁷⁰ However, standardization

65. "Jacksonian Democrats resented the pretension of physicians who endeavored to place themselves above other practitioners and the common people." DE VILLE, *supra* note 29, at 75.

66. Suspicion of professionals in the early part of the nineteenth century based on their special status gradually evolved, although resentments remained. "As Americans lost some of their antipathy toward professionals, a class-based resentment toward physicians gradually merged with the status-based resentment that had characterized attitudes of the first half of the century." *Id.* at 227.

67. Mohr, *supra* note 22, at 1732.

68. The AMA was founded on May 7, 1847. The organization lists the original goals as scientific advancement, standards for medical education, and improved public health. *The Founding of the AMA*, AM. MED. ASS'N, <http://www.ama-assn.org/ama/pub/about-ama/our-history/the-founding-of-ama.page> (last visited Dec. 5, 2011).

69. "From the Jacksonian period through the end of the nineteenth century, a medical career did not carry the prestige and guaranteed security it does today." STARR, *supra* note 12, at 82.

70. A notice in the *Boston Medical and Surgical Journal* in 1852 announced an organizational meeting of the Association in Richmond, Virginia, with the following encouragement: "Some excellent reports are preparing, and it is safe to predict that the transactions of this medical

of practice and aspirations of scientific rigor encouraged a public perception of heightened capabilities, which left the profession vulnerable to legal pushback when the quality of care fell short.

Standardization of medicine took many forms. Textbooks and treatises embodied compendiums of current scientific knowledge available to large numbers of practitioners.⁷¹ Medical schools offered common curricula and often hands-on training in hospitals.⁷² Licensure, implemented later in the century, effectuated more consistent oversight.⁷³ However, each of these forms of standardization may have served more as a stimulus to litigation than as a defense against it. Education and licensure discouraged practice by unqualified and untrained practitioners, who would be more likely to commit errors that could lead to lawsuits.⁷⁴ At the same time, they also created benchmarks by which physicians could be measured in court.⁷⁵

Perhaps the most important development in the medical enterprise during the early nineteenth century was an aggressive business posture adopted by many physicians.⁷⁶ In keeping with egalitarian sentiments of the time, professions in the United States were open to almost any practitioner who could convince people to use their services.⁷⁷ This paradigm of inclusiveness has been labeled “marketplace professionalism” because professionals competed for business in a relatively free and open market.⁷⁸

The rigors of the marketplace were magnified by the plethora of healers vying for business. Physicians competed with a range of alternative practitioners, including homeopaths, osteopaths, and herbalists, who sought to sell their services to the same pool of pa-

congress will demonstrate the progress of medical science in America.” *American Medical Association*, 46 BOS. MED. & SURGICAL J. 265, 265 (J. V. C. Smith ed., 1852).

71. See Mohr, *supra* note 22, at 1733–34.

72. During much of the nineteenth century, physician training tended to be haphazard. “A professional career had no fixed pattern. Whether or not a physician went to medical school and if he did, for how long and with what general education, were all variable. Apprenticeships had no standard content.” STARR, *supra* note 12, at 89. The reform of medical education to enforce higher standards and emphasize training in hospitals began around 1870. *Id.* at 112–16.

73. *Id.* at 102–06.

74. Mohr, *supra* note 22, at 1734.

75. *Id.*

76. *Id.* at 1732.

77. *Id.*

78. *Id.*

tients.⁷⁹ This market environment encouraged inflated claims and promises of cures that were certain to fall short, leaving many patients feeling frustrated and disappointed.⁸⁰

Of further importance for the burgeoning litigation enterprise, this business-oriented market environment for professionals also encompassed lawyers.⁸¹ Competitive pressures drove many of them to seek new income-generating opportunities. The emerging field of medical malpractice litigation served as a ready source.

The business structure of medicine that emerged in the United States stood in stark contrast to the profession's mode of organization in Europe. In the Old World, where a more elitist attitude toward the professions found greater acceptance, access to practice and standards of conduct were largely controlled by medical societies.⁸² They were permitted monopoly power to determine who could practice and under what terms. In this environment, physicians functioned less as independent businesses and more as participants in a larger social order. With individual practitioners exercising less autonomy, responsibility for mishaps could more readily be deflected to the profession as a whole.

All of these features of early nineteenth-century medicine in the United States served to raise public expectations of practitioners. Americans saw advertisements promising miracle cures, learned of medical practices in far away reaches, and heard boasts of uniform and rigorous scientific standards. At the same time, the public increasingly honored a value of egalitarianism in which social status was paired with responsibility. When expectations were not met and elite professionals fell short in fulfilling their obligations, the courts were available to serve as a great equalizer.

79. STARR, *supra* note 12, at 94-109 (describing competition between physicians and alternative "sects" in medicine). Starr states, "Of all the divisions that rent the profession, sectarianism was the most virulent." *Id.* at 94.

80. The political, social, and economic changes of the first half of the nineteenth century, however, transformed the American public view of the physician's role in society and threatened to alter fundamentally the grounds of the physician's personal and legal responsibility. By the 1830s a significant number of Americans were willing to treat medical practice as it if were a purely commercial enterprise.

DE VILLE, *supra* note 29, at 157.

81. See Mohr, *supra* note 22, at 1732.

82. See *id.*

C. Advances in Medicine

The early nineteenth century was also a time of dramatic change in medical technology. New discoveries were emerging that created a firmer scientific basis for the medical field. Along with them came a new mindset among physicians who started to see themselves as innovators in an evolving profession, rather than stewards of a static ancient wisdom.⁸³ However, advancing technology created new legal risks for physicians along with opportunities for greater effectiveness.⁸⁴

The double-edged sword that medical progress represented for practitioners was manifested most poignantly in the earliest spate of malpractice cases. In the years after 1835, when the proliferation of malpractice litigation began, the majority of suits involved patients who had been treated for fractures and dislocations of bones.⁸⁵ By one estimate, these represented 90% of all malpractice cases.⁸⁶ This litigation hotspot emerged from a technological revolution in the field of orthopedics.

Techniques to treat simple fractures had been known for thousands of years. Records document their use as far back as the Neolithic Age, and they were part of medical practice in many ancient civilizations.⁸⁷ However, compound fractures presented more of a challenge. Until the early nineteenth century, the only options were to let an injured limb heal in a deformed state or, more commonly, to amputate it.⁸⁸

Orthopedic treatment of compound fractures began to change in the early 1800s as physicians refined techniques for setting bones.⁸⁹ As late as 1819, a medical treatise opined that amputation was “the more justifiable practice” than trying to save a limb.⁹⁰ However, over the next several years, a range of innovative techniques was developed, and new instruments were invented.⁹¹ In 1835, a prominent surgeon observed that the state of practice had advanced to the

83. *Id.* at 1734.

84. *Id.*

85. DE VILLE, *supra* note 29, at 92.

86. Spiegel & Kavalier, *supra* note 21, at 293.

87. *Id.* Treatment of simple fractures with the use of splints and mechanical devices was practiced in ancient Egypt, Greece, and Rome, and for hundreds of years in Arab, Native American, and European societies. *Id.*

88. *Id.* at 294.

89. *Id.* at 295.

90. DE VILLE, *supra* note 29, at 95.

91. *Id.* at 97.

point at which amputation in cases of compound fractures would "be now deemed highly injudicious."⁹²

However, the results of treating compound fractures, and thereby saving limbs, were often less than perfect. Limbs could emerge deformed, shortened, or misaligned.⁹³ A review of fracture treatments in 1855 found such outcomes to be quite common.⁹⁴ The unfortunate patients in these cases faced a lifetime of limited functioning, and many turned to lawsuits for redress.⁹⁵

Disappointing outcomes from compound fracture treatments served as particularly powerful fuel for litigation for two reasons. First, the American economy depended heavily on manual labor, which was the cause of many injuries.⁹⁶ The economy was just emerging from its agrarian base in which hazardous farm work was a common occupation. It was starting a transition to an industrial base, in which many were employed in even more dangerous factory work.⁹⁷

Second, malformed limbs serve as ideal evidence in court. A jury can easily see the patient's harm, and functional limitations can be readily demonstrated.⁹⁸ Paradoxically, amputations can be the legally safer route because they rarely leave the indicia of an imperfect result. There is no limb for a jury or judge to examine in assessing whether the procedure was truly needed and whether it had been performed properly.⁹⁹ By developing an enhanced, though imperfect, treatment, surgeons had created a scenario ripe with new legal peril. In the words of one author, "In fact, physicians were left more vulnerable by medical progress that frequently provided patients with visible, bodily evidence for malpractice lawsuits."¹⁰⁰

Further medical advances later in the nineteenth century created additional grounds for lawsuits. In particular, x-ray technology, in-

92. *Id.*

93. Mohr, *supra* note 22, at 1733.

94. Spiegel & Kavalier, *supra* note 21, at 295-98.

95. Not surprisingly, the medical profession tended to see such plaintiffs in a less sympathetic light. As one physician observed in 1852,

Some of the most worthless men in the State, who have been kindly and skillfully attended, who neither had the means of paying, or the moral honesty to do so if they had, in repeated instances have made a fractured bone the stepping-stone to personal independence, without the least regard to the fair fame of their medical attendants.

Prosecuting Surgeons for Mal-practice, *supra* note 9, at 265.

96. DE VILLE, *supra* note 29, at 94.

97. BREZINA, *supra* note 53, at 5.

98. Mohr, *supra* note 22, at 1733.

99. *Id.*

100. DE VILLE, *supra* note 29, at 101.

roduced in 1895, represented a dramatic advance in medical imaging capabilities, but it also engendered new opportunities for mishaps. In the twenty years following their introduction, x-rays became the leading source of malpractice claims.¹⁰¹ Suits were based on allegations of overexposure to radiation and on missed diagnoses due to improper reading of films.¹⁰² X-rays also offered visual evidence of other kinds of medical mishaps that had been difficult to demonstrate without a means of internal imaging.¹⁰³

D. Evolution of Legal Doctrines

As with medicine and society in general, legal doctrines, including those that supported medical liability, evolved considerably during the nineteenth century. In particular, judges clarified the obligations of physicians toward their patients and also defined limits. Among the key principles that emerged during this time were that physicians must possess the skill and knowledge needed to provide treatment, must employ a reasonable level of care and skill in rendering care, and must apply common medical knowledge in their practice.¹⁰⁴ As limitations on liability, courts found that physicians are not required to have the highest level of qualifications, are not expected to avoid all injury to patients, are not responsible for errors if they exercised their best judgment, and need not effectuate an absolute cure of the patient's ailment.¹⁰⁵

Courts also entertained changes in the legal theory that supported malpractice liability. They did so in a way that tended to aid plaintiffs, with the unwitting complicity of the medical profession. Throughout much of the nineteenth century, judges differed on whether the basis for liability should lie in an implicit contract be-

101. Mohr, *supra* note 22, at 1734. In the late nineteenth century, a number of other new medical technologies arose that became frequent sources of malpractice claims. A particularly prominent one was obstetric and gynecological surgery. Suits arose from allegations of unnecessary operations and surgical complications. DE VILLE, *supra* note 29, at 217. Claims related to obstetrics continue to be a major source of malpractice litigation in the present day. See Steven L. Clark et al., *Reducing Obstetric Litigation Through Alterations in Practice Patterns*, 112 OBSTETRICS & GYNECOLOGY 1279, 1279 (2008) ("Medical malpractice claims in obstetrics continue to be a major driver of both the cost of medical care and physician dissatisfaction with obstetric practice.").

102. Mohr, *supra* note 22, at 1734.

103. *Id.*

104. Spiegel & Kavalier, *supra* note 21, at 289.

105. *Id.*

tween physician and patient or in tort.¹⁰⁶ Claims in contract suggested a business relationship in which the patient stands in the role of a customer and the physician in the role of a businessperson who works to produce an agreed-upon result. This approach was consistent with the prevailing notion of marketplace professionalism under which physicians functioned as entrepreneurs.¹⁰⁷ Under a contract theory of medical practice, physicians could have bargained with patients to limit claims in the event the engagement did not turn out as anticipated.¹⁰⁸

However, a physician-patient relationship that functioned as a purely business arrangement was inconsistent with the professional role that physicians sought to foster.¹⁰⁹ They saw their services as comprising something more than a mere commercial transaction into which any enterprise could enter. Physicians bring special knowledge and skills to bear in their work and enter into a relationship of trust with those whom they treat. This relationship does not fit within the parameters of an ordinary contract.

The alternative to basing malpractice liability in contract was to base it in tort. While contract claims can be measured against a promised outcome, tort claims assess a process. Tort liability for professional practice is based on the notion that the defendant failed to follow accepted procedures in the way a service was rendered.¹¹⁰ Since medicine, like most professions, is subject to many unknown and uncontrollable factors, a standard process does not necessarily produce a predetermined result. Rather, it reflects the way the defendant tried to achieve it. This approach to determining liability protects defendants from claims based purely on a failure to achieve a positive clinical outcome, but it is also more flexible and vague, and therefore easier for a plaintiff to plead.¹¹¹

106. Mohr, *supra* note 22, at 1736. In the early nineteenth century, “[j]udges and legal theorists had not yet molded the notions of tort and contract into discrete categories, and there was no need or basis upon which to classify malpractice under one abstract heading or the other.” DE VILLE, *supra* note 29, at 156.

107. Mohr, *supra* note 22, at 1732.

108. *Id.* at 1736.

109. *Id.*

110. See, e.g., Hall v. Hilbun, 466 So. 2d 856, 866 (Miss. 1985).

Medical malpractice is legal fault by a physician or surgeon. It arises from the failure of a physician to provide the quality of care required by law. When a physician undertakes to treat a patient, he takes on an obligation enforceable at law to use minimally sound medical judgment and render minimally competent care in the course of the services he provides. A physician does not guarantee recovery.

Id.

111. Mohr, *supra* note 22, at 1732.

Over the course of the nineteenth century, most courts came to accept the tort theory as the basis for medical liability claims.¹¹² This was a victory for the medical profession in some respects. With courts willing to see medical practice as distinct from the world of commerce, physicians were able to gain legal recognition of special status in a number of ways. These included licensure, which limited access to the profession by new practitioners, self-regulation in the areas of education and training, and rules restricting conventional employment relationships.¹¹³ However, in the sphere of liability, it solidified the position of physicians' adversaries by giving plaintiffs freer rein to construct theories of liability based on whatever deficiencies in physician adherence to standards of care they could demonstrate.

A second legal development that aided malpractice plaintiffs was the emergence of contingent fees arrangements for compensating attorneys.¹¹⁴ Under this method of payment, attorneys receive a percentage of any recovery they achieve for their client through verdict or settlement.¹¹⁵ If the attorney fails to recover anything, the client pays nothing. This outcome-based compensation structure eliminates the element of financial risk for the plaintiff in bringing a claim. An important potential impediment to initiating suits is thereby removed, especially for those with limited financial means.

Further support for malpractice claims came from the commitment to trial by jury, which remained ironclad in American jurisprudence through the nineteenth century.¹¹⁶ Juries composed of ordinary citizens are often sympathetic to injured patients, whose ranks they realize they could someday join.¹¹⁷ From the earliest stages of the proliferation of malpractice suits, some advocates of reform called for cases to be tried instead by panels of experts, whom they felt would weigh liability more dispassionately.¹¹⁸ Such proposals echo some contemporary reform initiatives, which for example, call

112. *Id.*

113. See discussion *infra* Part III.F.

114. Mohr, *supra* note 22, at 1735.

115. See JONATHON S. LYNTON, *BALLENTINE'S LEGAL DICTIONARY AND THESAURUS* 136 (1995).

116. Mohr, *supra* note 22, at 1735.

117. Plaintiffs' lawyers often appealed to anti-elitist sentiments to engender sympathy for their clients among juries. Spiegel & Kavalier, *supra* note 21, at 291. A review of jury verdicts across a range of tort cases in the nineteenth century found the overwhelming majority favored plaintiffs. Gary T. Schwartz, *Tort Law and the Economy in Nineteenth-Century America: A Reinterpretation*, 90 *YALE L.J.* 1717, 1764 (1981).

118. Mohr, *supra* note 22, at 1735.

for “health courts” or similar expert bodies to decide complex cases.¹¹⁹ Proposals to change the central role of juries were successfully resisted in the nineteenth century, and they continue to be resisted today.

Subsequent evolution of legal doctrines in the twentieth century further solidified the position of malpractice plaintiffs. During the early decades of the century, states began to recognize the doctrine of *res ipsa loquitur*, which gave some plaintiffs a powerful evidentiary advantage.¹²⁰ The term literally means “the thing speaks for itself,” and it relieves the plaintiff from having to prove fault when responsibility seems obvious but it is not possible to pinpoint what actually went wrong.¹²¹ For example, a sponge left in a patient after surgery could only have been the fault of someone participating in the operation, so the occurrence by itself demonstrates that there must have been negligence. Through use of this doctrine, a major impediment to meeting the burden of proof in certain circumstances is removed.¹²²

Later in the century, states began to move away from the locality rule, which held physicians to the standard of care in the location where they practiced.¹²³ The rule served to protect rural practitioners who did not keep up with medical developments in cities, where practice tended to be more sophisticated. In the 1960s, courts began to reject the rule in favor of one that applied national standards that measured all physicians by common norms.¹²⁴ In addition to raising the expectations for physician proficiency, the demise of the locality rule helped plaintiffs in presenting evidence of fault. To establish a

119. Recent proposals for health courts involve using panels of experts who would rule on whether an injury was avoidable. If it were, defendants would provide compensation according to a scale. Under some proposals, plaintiffs would choose this route in lieu of going to court, and in others, they could still file a suit if they were dissatisfied with the expert panel’s determinations. Michelle M. Mello & Thomas H. Gallagher, *Malpractice Reform—Opportunities for Leadership by Health Care Institutions and Liability Insurers*, 362 NEW ENG. J. MED. 1353, 1354–55 (2010).

120. Mohr, *supra* note 22, at 1736.

121. LYNTON, *supra* note 115, at 578.

122. *Res ipsa loquitur* is applied when “one or more of the various agencies or instrumentalities which might have harmed the plaintiff was in the hands of every defendant or of his employees or temporary servants. This, we think, places upon them the burden of initial explanation.” *Ybarra v. Spangard*, 154 P.2d 687, 690 (Cal. 1944).

123. Mohr, *supra* note 22, at 1736.

124. See, e.g., *Brune v. Belinkoff*, 235 N.E.2d 793 (Mass. 1968) (rejecting the locality rule in a malpractice case involving the administration of an anesthetic during childbirth). The court noted that the rule had been modified in several jurisdictions and that “[t]he time has come when the medical profession should no longer be Balkanized by the application of varying geographic standards in malpractice cases.” *Id.* at 798.

local standard of care, it was necessary to find expert witnesses who practiced in the same geographic area. These were likely to be the defendant physician's colleagues, who were often reluctant to testify.¹²⁵ To establish a national standard, in contrast, experts can be brought in from across the country. Practitioners from distant regions are less likely to fear the ire of a colleague in supporting a plaintiff's case.

Another important development that arose during the 1960s and 1970s was the emergence of the doctrine of informed consent as the basis for claims.¹²⁶ This doctrine required physicians to fully inform patients of the risks and benefits of medical procedures in advance and to obtain voluntary consent to perform them.¹²⁷ Failure to warn patients of a possible adverse outcome could engender liability if the adverse outcome came to fruition. Determinations of whether information was adequately provided and consent given voluntarily can be subjective, which gives plaintiffs substantial latitude in presenting evidence that the requirements of the doctrine were not met.

Finally, in the mid-twentieth century, courts discarded two important defenses to malpractice claims. One was the doctrine of charitable immunity, which barred suits against charitable organizations, including nonprofit hospitals.¹²⁸ The other was the "learned professions" doctrine, which protected physicians from antitrust suits.¹²⁹ The latter doctrine had held that because physicians are professionals with a fiduciary responsibility to their patients, their practice was distinct from an ordinary commercial endeavor and so exempt from liability.¹³⁰

125. STARR, *supra* note 12, at 111.

The courts, in working out the rules of liability for medical practice in the late nineteenth century, had set as the standard of care that of the local community where a physician practiced. . . . By adopting the 'locality rule,' the courts prepared the way for granting considerable power to the local medical society, for it became almost impossible for patients to get testimony against a physician who was a member.

Id.

126. David M. Studdert et al., *Medical Malpractice*, 350 NEW ENGL. J. MED. 283, 284 (2004).

127. TOM L. BEAUCHAMP & JAMES F. CHILDRESS, *PRINCIPLES OF BIOMEDICAL ETHICS* 77-78 (5th ed. 2001).

128. The demise of the doctrine of charitable immunity is discussed in Bradley C. Canon & Dean Jaros, *The Impact of Changes in Judicial Doctrine: The Abrogation of Charitable Immunity*, 13 LAW & SOC'Y REV. 969 (1979).

129. In the case of *Goldfarb v. Virginia State Bar*, the Supreme Court ruled that "learned professions," which include law and medicine, are not exempt from antitrust laws and should be treated as any other business in this context. 421 U.S. 773 (1975).

130. As the Supreme Court noted in *Goldfarb v. Virginia Bar*, "The public service aspect, and other features of the professions, may require that a particular practice . . . be treated differently." 421 U.S. at 788 n.17.

Along with these developments in legal doctrines, judicial treatment of medical liability claims responded to changes in social attitudes. During two periods in particular, support for social reform coincided with notions of patient empowerment, and concomitant increases in the number of malpractice suits are readily apparent. The first period was the decades of the 1920s and 1930s, which immediately followed the Progressive Era, a time of public support for, and congressional enactment of, several consumer protection measures.¹³¹ The second was the decade of the 1960s, when the value of consumerism gained further traction.¹³²

E. Liability Insurance

In addition to the threat to their reputations and disruption of their practices, the rise of malpractice litigation confronted physicians with the prospect of financial ruin in the event of an adverse outcome. In the early years of the twentieth century, the medical profession promoted the development of a mechanism to protect physicians against this peril in the form of liability insurance.¹³³ Under this financial arrangement, an external source is available to pay the cost of verdicts and settlements and, often more importantly, the expenses of defending a claim.¹³⁴

In its initial form, malpractice insurance was provided largely through medical societies, which offered access to affordable coverage as an inducement to membership.¹³⁵ One of the first to provide this benefit was the Massachusetts Medical Society starting in 1908.¹³⁶ In 1919, a review of this innovation on its tenth anniversary boasted that in addition to “camaraderie” and “one of the oldest and best medical journals in the country,” members of the society “now have the service of a mutual insurance against unjust suits for alleged malpractice.”¹³⁷

However, liability insurance proved to be a double-edged sword. It protects physicians from incurring personal expenses if they are

131. Mohr, *supra* note 22, at 1736.

132. *Id.*

133. *Id.* at 1734–35.

134. MICHELLE MELLO, ROBERT WOOD JOHNSON FOUND., UNDERSTANDING MEDICAL MALPRACTICE INSURANCE: A PRIMER 4 (2006), available at http://www.rwjf.org/pr/synthesis/reports_and_briefs/pdf/no8_primer.pdf.

135. STARR, *supra* note 12, at 111.

136. *Id.*

137. George W. Gay, *Ten Years' Experience with the Medical Defense Act*, 180 BOS. MED. & SURGICAL J. 597, 601 (1919).

sued, but it also turns them into more appealing targets for suits by assuring plaintiffs that financial resources will be available to cover a verdict or settlement.¹³⁸ The Massachusetts Medical Society admitted as much in the 1919 review, but concluded that the benefits justified the risk: "It is true that this practice may tend to encourage suits with the expectation of securing a settlement, yet it is difficult to see how this is to be avoided under the circumstances."¹³⁹ In the view of one observer, whether or not its adoption was avoidable, the emergence of liability insurance "all but guaranteed perpetuation of the existing system into the 20th century."¹⁴⁰

F. Expansion of Physician Autonomy

During the late nineteenth and early twentieth centuries, the medical profession came to enjoy legal recognition of considerable autonomy.¹⁴¹ This enhanced the business standing and clinical latitude of practitioners in a number of ways.¹⁴² However, it also increased the public's perception of physicians as insulated and privileged.¹⁴³

Three legal developments in particular served to protect and promote professional autonomy in medicine. The first was the manner in which state licensing requirements were effectuated.¹⁴⁴ With the active encouragement of the profession, every state adopted a law requiring licensure in order to practice during the late nineteenth and early twentieth centuries.¹⁴⁵ Most of these laws created boards to administer the process, which were dominated by members of the profession itself.¹⁴⁶ Critics have often complained that this system has amounted to self-regulation that exhibits minimal vigilance.¹⁴⁷ Had the policing of the profession been more rigorous, aggrieved patients might have more readily seen medical boards as

138. Mohr, *supra* note 22, at 1735.

139. Gay, *supra* note 137, at 601.

140. Mohr, *supra* note 22, at 1735.

141. STARR, *supra* note 12, at 104.

142. *Id.* at 140-42.

143. *Id.* at 85-88.

144. *Id.* at 104-05.

145. *Id.* at 102-04.

146. Timothy S. Jost, *Oversight of the Quality of Medical Care: Regulation, Management, or the Market?*, 37 ARIZ. L. REV. 828, 863 (1995).

147. A study by one consumer advocacy organization concluded that enforcement actions against physicians by state medical boards are extremely infrequent in light of the amount of malpractice that likely occurs. SIDNEY M. WOLFE ET AL., PUBLIC CITIZEN'S HEALTH RESEARCH GROUP RANKING OF THE RATE OF STATE MEDICAL BOARDS' SERIOUS DISCIPLINARY ACTIONS, 2008-2010 (2011), available at <http://www.citizen.org/documents/1949.pdf>.

a viable alternative to the courts for obtaining redress for perceived physician misbehavior.¹⁴⁸

The second development involved the role of physicians in the governance of hospitals. Toward the end of the nineteenth century, as hospitals acquired new technologies and capabilities, physicians increasingly came to dominate management.¹⁴⁹ The typical structure of American hospitals that emerged included an independent and self-governing medical staff with extensive power to control the provision of services within the institution and to police its own membership.¹⁵⁰ With this responsibility, physicians were the natural suspects in the event of substandard care.

The third is the corporate practice of medicine doctrine, which recognized practicing physicians as distinct from conventional employees in a business enterprise. The doctrine is based on the notion that as professionals bound by a code of ethics and licensing rules, physicians must honor a fiduciary duty to their patients, and as such, should be accountable not to the financial imperatives of a commercial employer but to their patients directly.¹⁵¹ This reasoning led to the legal principle that physicians should not render services as employees within corporate structures, but only in practices that they themselves controlled or that were controlled by professional colleagues.¹⁵² The doctrine thereby blocked the development of practice arrangements through corporations managed by non-physicians. This result granted the profession substantial leeway to adopt its own business structure free from outside interference.¹⁵³ However, once again, by gaining legal authority to control their ac-

148. Physicians "did not pursue any number of other possible ways to deal with malpractice (such as more vigorous state policing under the new licensing laws)." Mohr, *supra* note 22, at 1735.

149. See STARR, *supra* note 12, at 178-79, 220-21 (describing the rise of physician power in hospitals, which later waned as administrators gained importance, and efforts by physicians to maintain a "monopoly of competence" within hospitals).

150. BARRY R. FURROW ET AL., HEALTH LAW 850 (6th ed. 2008).

151. "As a practical and policy matter, rules against the corporate practice of medicine were intended to prevent 'commercial exploitation' of the health care field by organizations motivated more by a desire for profit than by a commitment to patients' well-being and quality of care." Arnold J. Rosoff, *The Business of Medicine: Problems with the Corporate Practice Doctrine*, 17 CUMB. L. REV. 485, 491 (1987).

152. The doctrine takes different forms in different states but has the same underlying rationale and general effect. See *id.* at 490.

153. "Lay and third-party interference in the traditional doctor-patient relationship was a concern even where the actual provision of care was to be left in the hands of physicians and other licensed health care providers." *Id.* at 492; see also STARR, *supra* note 12, at 204. However, exceptions to the doctrine have been carved out for hospital employment of physicians and for health maintenance organizations. Rosoff, *supra* note 151, at 494.

tions, physicians also positioned themselves as the only accountable parties when their services failed to meet expectations.

IV. OBSERVATIONS BASED ON HISTORY

As the history of the development of medical liability in the United States indicates, it is anything but a new phenomenon. In fact, the emergence of malpractice suits as a common feature of American jurisprudence dates back over 175 years to the mid-1830s. It has coincided with a perennial sense of crisis in the system and a view among physicians that they are under siege at the hands of rapacious lawyers. In other words, the perception of a “malpractice crisis” is as old as modern medicine itself. Despite countless efforts by the profession to stem the tide—including numerous proposals to reform the tort liability system in recent decades—the fundamental dynamics of medical liability and reactions to it have changed very little over time.

For the most part, observers over the past 175 years have viewed the malpractice environment of their time in isolation, ignoring its longstanding historical roots.¹⁵⁴ This pattern is poignantly illustrated by *The Boston Medical and Surgical Journal’s* observation in 1911 that litigation “was never so rampant as it is today.”¹⁵⁵ There has been no time since the 1830s when such a sentiment has not been expressed.¹⁵⁶ In their disregard of the larger historical context of medical malpractice, critics of the system miss the opportunity to explore its root causes. With little attention to underlying factors that have been at work over this long time frame, it is not surprising that effective solutions have proven so elusive. The medical profession may have condemned itself to repeating history by ignoring it.

Several elements of modern medicine, as it has evolved over the past 175 years, have been linked to an atmosphere of litigiousness. They can be grouped into three categories. The first is reliance on new technologies that have advanced steadily. The second is standardization and oversight of practice. The third is enhancement of the economic and social prerogatives of the profession.

154. Olsen argues, “[G]iven that neither malpractice litigation nor large growth rates in the frequency and severity of such litigation are recent phenomena, researchers should take a longer perspective than the 30-year time frame employed in most analyses.” Olsen, *supra* note 11, at 271.

155. Gay, *supra* note 1, at 353.

156. Olsen notes, “[I]f a medical malpractice crisis does exist, the available evidence suggests that the crisis has existed almost continuously since 1835.” Olsen, *supra* note 11, at 271.

Among the earliest manifestations of technological progress was the ability of orthopedists to treat compound fractures beginning in the 1830s and 1840s.¹⁵⁷ Subsequent developments in the nineteenth century included anesthesia, antisepsis, and x-ray imaging.¹⁵⁸ Over the course of the twentieth and early twenty-first centuries, the expansion of technological capabilities has been so substantial that it defies summary.¹⁵⁹ Indeed, technology has transformed medicine from its fairly primitive state at the start of the nineteenth century into a wholly different enterprise.¹⁶⁰

However, as orthopedists learned from their early work with compound fractures, the more that medicine tries to do, the more that can go wrong. Treatment of a broken limb can leave it healed but malformed. In the same way, advanced imaging available today increases the chance of missing a diagnosis that could have been found.¹⁶¹ Moreover, many treatments, from surgery to medical devices to pharmaceuticals, carry risks of adverse side effects that patients may not have fully anticipated.¹⁶² Each technological advance over the years has raised patient expectations but also multiplied the possibilities for mishaps—a perfect combination for encouraging lawsuits.

A more technologically sophisticated profession brought with it the need for greater standardization and oversight. Medical texts, formalized education, and professional societies, such as the AMA, served these functions during much of the nineteenth century.¹⁶³ These developments were reinforced by formal state licensing laws enacted at the end of the nineteenth century and the start of the twentieth.¹⁶⁴

157. Spiegel & Kavalier, *supra* note 21, at 293.

158. Mohr, *supra* note 22, at 1734 (noting the developments of x-ray imaging).

159. See, e.g., Peggy Peck & Lauren Cox, *The Top 10 Medical Advances of the Decade*, ABC NEWS, Dec. 17, 2009, <http://abcnews.go.com/Health/Decade/genome-hormones-top-10-medical-advances-decade/story?id=9356853> (a top ten listing of major medical advances since year 2000).

160. STARR, *supra* note 12, at 16 (“Undoubtedly the most influential explanation for the structure of American medicine gives primary emphasis to scientific and technological change and specifically attributes the rise of medical authority to the improved therapeutic competence of physicians.”).

161. DE VILLE, *supra* note 29, at 221–22.

162. TASK FORCE ON RISK MGMT., FOOD & DRUG ADMIN., *MANAGING THE RISKS FROM MEDICAL PRODUCT USE: CREATING A RISK MANAGEMENT FRAMEWORK* 24 (1999), available at <http://www.fda.gov/downloads/Safety/SafetyofSpecificProducts/UCM180520.pdf> (“When using a drug or other medical product, a patient runs the risk of experiencing [undesirable] reactions resulting from the product’s interaction with the body.”).

163. Mohr, *supra* note 22, at 1733–34; see also *supra* Part III.B.

164. See *supra* Part III.B.

Since then, regulation of medicine has grown considerably. Additional layers include specialty societies that certify competence in specific fields, hospital credentialing committees that review qualifications for membership on medical staffs, health maintenance organizations (HMOs) that enforce patterns of practice among participating physicians, and government health insurance programs, such as Medicare and Medicaid, which impose standards for participation.¹⁶⁵ In recent years, additional tools have emerged to standardize practice, including clinical protocols to guide professional decision-making and information technology that facilitates consistency in many aspects of practice, from recordkeeping to coordination of care.¹⁶⁶

Standardization and oversight serve to further reinforce patient expectations. By way of contrast, a disorganized profession typified by idiosyncratic practices discourages perceptions of consistent quality. Formal organization of the medical profession was intended, in part, to counter this characterization.¹⁶⁷ However, efforts to foster the public's acceptance of medicine as a reliable and trustworthy occupation could also engender disappointment when expectations were not met.

Along with greater technological capabilities and enhanced mechanisms for quality control, the medical profession fiercely guarded the independence of practitioners in clinical and business matters. Standardization and oversight of practice were accomplished, in large part, through various forms of professional self-regulation.¹⁶⁸ Medicine initially adopted the model of marketplace professionalism in which individual physicians competed as independent businesses in contrast to the European approach of organization through professional societies.¹⁶⁹ However, the profession also encouraged the belief that medicine is a special kind of business based on a fiduciary relationship between buyer and seller. As such, it gained exemptions from legal constraints that apply to conventional enterprises, including those governing employment relation-

165. See ROBERT I. FIELD, *HEALTH CARE REGULATION IN AMERICA: COMPLEXITY, CONFRONTATION, AND COMPROMISE* 19–40 (2007).

166. *Id.* at 237. For a discussion on clinical practice guidelines, see Arnold J. Rosoff, *The Role of Clinical Practice Guidelines in Health Care Reform*, 5 *HEALTH MATRIX* 369 (1995).

167. AM. MED. ASS'N, *supra* note 68; see also *supra* Part III.B (discussing formal organization and standardization of medical practice).

168. FIELD, *supra* note 165, at 19–40.

169. Mohr, *supra* note 22, at 1732; see also *supra* Part III.B.

ships.¹⁷⁰ The profession also discouraged the notion that commercial contracts, which underpin most business arrangements, should serve as the legal basis for relationships between physicians and patients.¹⁷¹

Physician autonomy has eroded to some extent in recent decades. Among the factors responsible is the rise of HMOs as a financing vehicle, which constrains physicians in the use of medical resources.¹⁷² Other factors include an increase in the number of physicians working as employees in hospitals and settings other than independent practice.¹⁷³ In addition, Medicare and many private insurers now encourage physicians to use standardized treatment protocols that constrict individual judgment.¹⁷⁴ Recent judicial opinions have also eroded the scope of the corporate practice of medicine doctrine in some states.¹⁷⁵

Nevertheless, physicians continue to enjoy a considerable measure of autonomy compared with members of most other professions. For example, they remain entitled to fair hearings when their

170. These exemptions are embodied in the corporate practice of medicine doctrine discussed *infra*. Adoption of the doctrine by courts and legislatures was encouraged by the medical profession. Rosoff, *supra* note 151, at 492 (“Undoubtedly, the influence of organized medicine was a factor in the adoption of laws prohibiting non-physicians from operating health care practices.”).

171. Mohr, *supra* note 22, at 1732; see also *supra* Part III.B.

172. HMOs use several techniques to control the use of medical resources by physicians. These include basing reimbursement of primary care physicians on a set monthly fee for each patient rather than on a payment for each service rendered (an arrangement known as *capitation*), requiring a referral from a primary care physician for visits to specialists, reviewing the necessity of diagnostic tests and procedures, and requiring preauthorization for hospital admissions. Kelly A. Hunt & James R. Knickman, *Financing Health Care*, in JONAS & KOVNER’S HEALTH CARE DELIVERY IN THE UNITED STATES 57, 68–69 (Anthony R. Kovner & James R. Knickman eds., 9th ed. 2008). The share of HMOs in the market for healthcare finance rose dramatically in the 1970s and 1980s. There were six million subscribers in 1976 and twenty-nine million in 1987. Lynn R. Gruber et al., *From Movement to Industry: The Growth of HMOs*, 7 HEALTH AFF. 197, 198 exhibit 1 (1998).

173. The percentage of physicians who practice independently has been declining for at least the past twenty-five years. Stephen L. Isaacs et al., *The Independent Physician – Going, Going . . .* 360 NEW ENG. J. MED. 655, 655 (2009). An example of Medicare’s encouragement of the use of treatment protocols is a proposal issued in 2004 to improve the treatment of chronic care, which promotes the use of care management plans that use “decision-support tools such as evidence-based practice guidelines.” Voluntary Chronic Care Improvement Under Traditional Fee-for-Service Medicare, 69 Fed. Reg. 22,065, 22,070 (proposed Apr. 23, 2004).

174. Large health insurers create guidelines and disseminate them to the providers with whom they contract to provide services. T. Allen Merritt et al., *Clinical Practice Guidelines in Pediatric and Newborn Medicine: Implications for Their Use in Practice*, 99 PEDIATRICS 100, 101 (1997).

175. For example, in the case of *Berlin v. Sarah Bush Lincoln Health Ctr.*, the Illinois Supreme Court held that the corporate practice of medicine doctrine does not apply to the employment of physicians by licensed hospitals. 688 N.E.2d 106, 106 (Ill. 1997).

hospital staff privileges are threatened with suspension or termination.¹⁷⁶ They enjoy the right—exclusive among healthcare professionals—to prescribe any approved prescription drug for any purpose they see fit.¹⁷⁷ They continue to have a tremendous say, through medical societies, in the regulation of their own profession, for example, through self-regulation of the accreditation of medical schools, certification of competence to claim expertise in a specialty, and majority membership on state licensure boards.¹⁷⁸

Moreover, many physicians function as entrepreneurs in the larger healthcare industry. Physician ownership interests in medical facilities are common, particularly in ambulatory surgery centers, specialty hospitals, diagnostic imaging centers, radiation therapy clinics, and clinical laboratories.¹⁷⁹ The extent of physician financial interests in these ancillary providers has become so widespread that it has engendered concerns that conflicts of interest between maximizing financial rewards and honoring clinical obligations could jeopardize patient care.¹⁸⁰ These concerns have led to the passage of

176. The Joint Commission, which accredits hospitals, requires that physicians be provided a fair hearing and appeal process regarding adverse staff privileging decisions. JOINT COMM'N, THE PHYSICIAN'S GUIDE TO THE JOINT COMMISSION'S HOSPITAL STANDARDS AND ACCREDITATION PROCESS 16 (2011), available at <http://www.jointcommission.org/assets/1/18/Physicians%20guide%20WEB1.PDF>.

177. Physicians are free to prescribe drugs that have been approved by the Food and Drug Administration for uses other than those encompassed in the approval based on their own clinical judgment, and this practice is common. See Randall S. Stafford, *Regulating Off-Label Drug Use – Rethinking the Role of the FDA*, 358 NEW ENG. J. MED. 1427, 1427 (2008).

178. See FIELD, *supra* note 165, at 26–38. Medical schools are accredited by the Liaison Committee on Medical Education, a nonprofit organization sponsored by the Association of American Medical Colleges and the AMA. *Id.* Specialty certification is controlled by private boards composed of members of the specialty. *Id.* State medical boards are composed largely of physicians. *Id.*

179. See generally Lawrence P. Casalino et al., *Focused Factories? Physician-Owned Specialty Facilities*, 22 HEALTH AFF. 56 (2003) (discussing physician ownership of ambulatory surgery centers and special hospitals); Brian E. Kouri et al., *Physician Self-Referral for Diagnostic Imaging: Review of the Empiric Literature*, 179 AM. J. ROENTGENOLOGY 843 (2002) (discussing physician ownership of diagnostic imaging centers); Elton Scott & Jean M. Mitchell, *Ownership of Clinical Laboratories by Referring Physicians: Effects on Utilization, Charges, and Profitability*, 32 MED. CARE 164 (1994) (discussing physician ownership of clinical laboratories). The extent of physician ownership of ancillary medical facilities is substantial. One study found that at least 40% of physicians in Florida who provide patient care have an interest in a facility to which they may refer patients. Jean M. Mitchell & Elton Scott, *New Evidence of the Prevalence and Scope of Physician Joint Ventures*, 268 JAMA 80 (1992).

180. Concerns that physician-investor conflicts of interest could adversely affect patient care are discussed in Morgan R. Baumgartner, *Physician Self-Referral and Joint Ventures Prohibitions: Necessary Shield Against Abusive Practices or Overregulation?*, 19 J. CORP. L. 313, 316 (1994); see also Ronald M. Green, *Physicians, Entrepreneurism and the Problem of Conflict of Interest*, 11 THEORETICAL MED. AND BIOETHICS 287, 288 (1990). Green states,

laws, such as the Stark Amendments, to restrict financial relationships between physicians and facilities to which they refer patients.¹⁸¹

In a sense, the medical profession has been able to have it both ways. On the one hand, it has safeguarded extensive autonomy for its members based on the proposition that physicians are bound by a special relationship of trust with their patients. On the other hand, it has protected its members' ability to engage in business ventures comparable to those in the broader commercial market, including investments in medical enterprises. By entering the business world, physicians function in a sphere in which disputes are routinely resolved by resort to the courts.¹⁸² It should not be surprising that this litigious atmosphere would spill over to the clinical side of their activities.

V. LESSONS FOR REFORM

These three aspects of medical modernization—technology, standardization and oversight, and business autonomy—developed in tandem with the expansion of medical liability. Each shapes important parameters of professional practice; however, each can also serve as an impetus for litigation.

Efforts to effectuate major changes in the medical liability system through tort reform began in earnest in the 1970s.¹⁸³ The first proposal to win passage was a law in California that limited the recov-

Nevertheless, despite this relative lack of attention, I wish to argue that the ethical problems created by the physician's new role as businessperson are far more serious than they first appear and may eventually prove more damaging to the medical profession than the problems associated with physicians' employment in for-profit organizations. Not only do physicians' new business activities have the potential for creating serious medical problems for patients, they also threaten to undermine the trust essential to the medical profession.

Id.

181. The Ethics in Patient Referrals Act, 42 U.S.C. § 1395nn (2006), commonly known as the Stark Amendments, bars reimbursement under Medicare and Medicaid for certain designated healthcare services when they are rendered based on a referral from a physician who has a financial relationship with the entity providing the services. In addition, the Medicare Act broadly prohibits paying or receiving anything of value in return for the referral of a patient for services covered by any government healthcare program. 42 U.S.C. § 1320a-7b (2006) (commonly known as the Anti-Kickback Statute).

182. See Ross E. Cheit & Jacob E. Gersen, *When Businesses Sue Each Other: An Empirical Study of State Court Litigation*, 25 LAW & SOC. INQUIRY 789, 790 (2000) (finding litigation among businesses to be quite common).

183. CAL. CIV. CODE § 3333.2 (West 2011) (enacted in 1975 and imposing a cap of \$250,000 on the damages plaintiffs can receive in lawsuits for medical malpractice for noneconomic losses).

eries that plaintiffs can receive in malpractice lawsuits.¹⁸⁴ Several states have adopted similar laws since then, and evidence suggests they have had some effect in reducing the size of recoveries.¹⁸⁵ However, despite these enactments, the sense of a crisis has not abated in these states or elsewhere.¹⁸⁶ Tort reform measures seem to have had little impact on the profession's perception that it is under a state of legal siege.¹⁸⁷

Perhaps tort reform enactments to date have failed to improve physicians' pervasive sense of unease because these measures have ignored important underlying aspects of the structure of medical practice. Their primary targets have been the structure of recoveries and the process for obtaining them in lawsuits.¹⁸⁸ Most initiatives have included measures such as limits on awards for noneconomic damages, restrictions on the contingent fees that attorneys can charge, shortening of statutes of limitations, and requirements for pre-trial mediation.¹⁸⁹ The inability of these laws to stem the sense of crisis suggests that these may not be the elements most in need of reform.¹⁹⁰

A more productive starting point for reform may lie among the defining aspects of modern medicine.¹⁹¹ However, reforms that address them would have to tread carefully, lest they adversely affect features of medical practice that have served to improve care. Of the three aspects discussed, the first two reflect forces that have proved beneficial to medical quality. Technology has saved and improved countless lives, and the future holds the promise of even more dra-

184. *See id.*

185. Allen Kachalia & Michelle Mello, *New Directions in Medical Liability*, 364 *NEW ENG. J. MED.* 1564, 1566 (2011). In fact, by 1980, almost every state had adopted at least one element of reform for medical malpractice claims. Olsen, *supra* note 11, at 264.

186. Kachalia & Mello, *supra* note 185, at 1564.

187. *Id.* As described in a 2011 report issued by the AMA, "The broken medical liability system remains one of the most vexing issues for physicians today." *AM. MED. ASS'N, MEDICAL LIABILITY REFORM NOW! 3* (2011), available at <http://www.ama-assn.org/resources/doc/arc/mlr-now-2011.pdf>.

188. Kachalia & Mello, *supra* note 185, at 1566.

189. *Id.*

190. An alternative possibility is that the medical malpractice system has functioned reasonably efficiently all along, that the sense of crisis is unwarranted, and that substantial reform is not warranted. Olsen, *supra* note 11, at 271.

191. After describing causes of the medical liability proliferation, Mohr notes, "Of the 6 principal factors that perpetuated and expanded the current system of medical malpractice litigation after its appearance around 1840, 5 remain powerfully in place." Mohr, *supra* note 22, at 1736.

matic advances.¹⁹² Similarly, standardization and oversight discouraged substandard treatment and unqualified practitioners. Reforms to these aspects of medicine could engender undesirable consequences.

However, the third aspect, business autonomy, stands apart. While technology and standardization may play essential roles in maintaining the quality of care, physician business autonomy does not do so in any apparent way. Technologically advanced care can be rendered in a standardized manner outside of an entrepreneurial setting. In fact, such care may be rendered more effectively in a less commercial environment, which can engender conflicts of interest between the dictates of financial gain and of optimal treatment.¹⁹³

Not only could this aspect of modern practice be altered without jeopardizing the quality of clinical care, it may represent the most important of the three in promoting litigation. By functioning in a commercial marketplace, medicine subjects itself to the strictures and public attitudes that apply to other businesses. Redress for injured parties when business relationships go awry is commonly obtained through the courts.¹⁹⁴ Such expectations of accountability are only magnified by medicine's claims of special standing as a privileged kind of business that relies on an ethical imperative of trust.¹⁹⁵

192. "It is also in the public interest that the best medical procedures become ever better prescribed and universalized, even though closely prescribed procedures render physicians vulnerable to charges of deviating from them." *Id.* Among the technological advances that are predicted to revolutionize medical care in the next few years is tailored medicine, which permits clinicians to customize treatments to each patient's genetic makeup. Andrew Smart et al., *Tailored Medicine: Whom Will it Fit? The Ethics of Patient and Disease Stratification*, 18 *BIOETHICS* 322, 337-40 (2004).

193. Green, *supra* note 180, 288-91.

194. Cheit & Gersen, *supra* note 182, at 790.

195. Reform proposals have been advanced to address the commercial side of medical practice. Most notable is the concept of enterprise liability. Under this approach, an organizational entity with supervisory responsibility for physician practice absorbs all liability for malpractice. William M. Sage et al., *Enterprise Liability for Medical Malpractice and Health Care Quality Improvement*, 20 *AM. J.L. & MED.* 1, 16 (1994). Such an entity could be a hospital, health system, clinic, or HMO. Physicians are held immune from direct liability because they are subject to oversight, and sanction if appropriate, by the supervisory organization. *Id.* at 27. Such an arrangement retains accountability and compensation for mishaps while buffering individual practitioners from the stresses and demands of the litigation process.

Enterprise liability was first articulated as an approach to products liability in the 1950s, although it built on intellectual strands that date back to the early 1900s. George L. Priest, *The Invention of Enterprise Liability: A Critical History of the Intellectual Foundations of Modern Tort Law*, 14 *J. LEGAL STUD.* 461, 465 (1985) (one such strand is the notion of society-wide risk distribution on a no-fault basis, which forms the basis for workers' compensation programs). It was first discussed as a possible approach to medical liability in the 1990s. See Sage et al. *supra*, at 9-10.

Of course, were the medical profession to function outside of the commercial sphere, it would still require a means of redress for the victims of substandard care. Litigation has persisted in part because few alternatives have emerged over time. Substitutes for litigation to provide financial compensation have been proposed, but implementation of them has been limited.¹⁹⁶ For the most part, patients who believe they have been wronged have had nowhere to turn but the courts.

Changing the business paradigm of medicine could afford an opportunity to institute a meaningful alternative for enforcing accountability and providing compensation. A new system would ideally grant redress to aggrieved patients while sparing practitioners the burden of drawn-out adversarial proceedings. While such an alternative arrangement might be unconventional in a traditional business context, a less entrepreneurial medical practice paradigm may offer it a more receptive environment.

VI. CONCLUSION

Medicine entered its modern era in America at the start of the Industrial Revolution. In the larger economy, the means of production were becoming more complex along with the commercial relationships that sustained them.¹⁹⁷ Medicine's trajectory was no different. As the profession grew in sophistication, it encountered new demands for accountability, which were manifested in a dramatic increase in the number of lawsuits. Neither the sophistication nor the lawsuits have abated since.

Another innovative reform approach is to promote apologies by physicians to injured patients when mishaps occur. Candor in acknowledging fault may reduce the likelihood that a patient will sue. Such proposals generally protect physicians who apologize by preventing the introduction of apologies in court as admissions of liability. The goal of this approach is to alter an aspect of the physician-patient relationship instead of addressing the structure of recoveries in lawsuits. It recognizes the bond between physicians and patients as a personal matter rather than a purely business-type arrangement. For a description and assessment of this reform approach, see Marlynn Wei, *Doctors, Apologies, and the Law: An Analysis and Critique of Apology Laws*, 39 J. HEALTH L. 107 (2006).

196. Several states have implemented alternative dispute resolution mechanisms for medical malpractice cases, for example, by providing for court-sponsored arbitration and mediation to try to resolve claims before they reach trial. However, such mechanisms still require the filing of a lawsuit. One example is described in CONG. BUDGET OFF., *THE EFFECTS OF TORT REFORM: EVIDENCE FROM THE STATES 8* (2004), available at <http://www.cbo.gov/ftpdocs/55xx/doc5549/Report.pdf>.

197. BREZINA, *supra* note 53, at 4.

Practitioners have bemoaned the burden of liability since the spread of lawsuits began. They have warned of its detrimental effect on care and proposed various kinds of reforms. However, little has changed over the years in the prevalence of these sentiments. In 1852, an observer rued that “juries have seemed to act with a determination to cripple the profession.”¹⁹⁸ In 2011, the American College of Emergency Physicians complained, “Frivolous lawsuits and billions of dollars in defensive medicine are driving up the costs of health care for everyone and harming patients.”¹⁹⁹

Tort reform initiatives have proliferated over recent decades. However, despite some effect in limiting the size of recoveries, they have left the perennial perception of a malpractice crisis largely intact. Perhaps these reform efforts have been misdirected. A sense of crisis that has endured for over 175 years suggests that more fundamental factors are at work than those that have been addressed. Instead of focusing on the process of litigation, reform might have been more effective had it targeted underlying features of the practice of medicine that have historically encouraged litigation.

Observers have identified several elements of modern medicine as possible drivers of the emergence and maintenance of litigiousness. For the most part, these fall into three categories. Advances in technology stretched medicine’s range of capabilities, but also expanded the expectations of patients and the opportunities for mishaps. Standardization and oversight improved quality, but created benchmarks against which professional behavior could be judged. Enhanced autonomy offered practitioners considerable leeway in structuring their practice arrangements, but fostered a more adversarial business atmosphere.

With these three aspects of modern medicine developing and expanding over the years, it is not surprising that litigation has kept pace. The public expects accountability from a profession that promises significant results while enjoying high economic and social standing. Lawsuits have historically offered the only viable means of achieving this accountability.

Reform seems unlikely to meaningfully alter the liability environment unless it addresses these fundamental structural aspects of medical practice. As targets for reform, technology and standardization are less than appealing because they are crucial to the effective-

198. *Prosecuting Surgeons for Mal-practice*, *supra* note 9, at 265.

199. *Medical Liability Crisis Fact Sheet*, AM. COLL. OF EMERGENCY PHYSICIANS, <http://www.acep.org/Content.aspx?id=25924> (last visited Dec. 5, 2011).

ness and quality of care. However, business autonomy adds no apparent value for patients while encouraging an adversarial mindset. If reformers seek to plumb the foundations of American medicine for elements susceptible to reform, they would do well to look there.

A history dating back 175 years teaches the fruitlessness of focusing reform efforts on malpractice trends at any given time. Modern medicine emerged into a world of growing intricacy in technology, economics, society, and law that has increased in complexity to this day. Developments in all of these areas have contributed fuel for litigation and fostered a perennial sense that the liability system is in a state of crisis. Perhaps, with history as a guide, an understanding of the underlying forces that shape the medical profession can lead to reforms that finally alter this dynamic.