LIABILITY IN MEDICINE AND PUBLIC HEALTH

Marcia M. Boumil
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LIABILITY IN MEDICINE AND PUBLIC HEALTH

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Preface

In 1991 the editors, with two colleagues, created a specialized casebook that they called *Medical Liability.* It was designed to support courses on medical malpractice taught by specialists in the field. Many teachers would be practicing lawyers bringing their trial expertise to the academic arena. The casebook supplemented the teachers' practical experience by providing up-to-date cases from every region of the United States. This new casebook, *Liability in Medicine and Public Health,* keeps the foundation and expands the coverage.

Part I, *Liability in Medicine,* retains the format and topics of *Medical Liability,* but more than 80% of the cases represent twenty-first century law. Part I maintains the practice orientation as it looks at medical liability through the eyes of litigators and clients rather than administrators and planners. As educators the editors are not oriented toward plaintiffs or defendants; rather the editors seek to demonstrate the interplay of the primary contenders, as the United States law of medical liability has evolved over the past 50 or more years.

Part II, *Public Health,* adds new materials to support public health law courses, whether in law schools, schools of public health, or other professional degree programs. Part II changes the orientation, from compensation and private law to compliance and public law. In most of the public health cases one antagonist is a city, municipality or governmental official, and the target of litigation is an ordinance, regulation or private nuisance. The cases show the competing concepts of judicial activism and restraint in the development of public health law.

For courses that offer a broad scope of health law, Part I contains traditional medical liability materials, including cases on ERISA and quality control regulation, and Part II contains materials on reproductive health, end-of-life issues, domestic violence, infectious disease, and public safety.

The editors caution users not to quote the casebook in place of actual law reports. Brackets indicate omitted citations. The editors have taken some liberties with editing the cases so as to enhance readability without altering meaning.

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Introduction to Liability in Medicine

In 1994 a landmark research effort, the Harvard Medical Practice Study (Leape, 1994), documented the large number of "adverse medical events" suffered by hospital patients. Error was documented throughout all areas of medical practice, with the largest number of errors resulting from drug complications. The Harvard Study suggested that 2.9% of hospitalizations resulted in an adverse event attributable to erroneous medical management. Nearly a decade later the Institute of Medicine issued its own alarming report, "*To Err is Human,*" which publicized the issue and unsettled the medical community. The IOM report suggested that as many as 98,000 preventable deaths per year are due to medical mishaps. Further, since most health care takes place in outpatient settings, it is reasonable to assume that the problem is substantially larger. Significant progress in eliminating the systemic issues that result in errors has been painfully slow.

Though neither the medical nor legal communities deny the gravity of the problem, they differ dramatically on proposed solutions. Most lawyers believe that the current liability system is necessary to keep physicians accountable for the quality of their practices. Under this theory, a system that divorces error from liability creates a disincentive for physicians to observe the highest standards of practice. Many physicians, on the other hand, believe that the key to resolving the problem of error in medicine is to implement an improved data collection system that documents mishaps and allows physicians to learn from their mistakes. They believe that fear of medical liability has hindered the reporting process and thus the ability to learn from errors. Their solution is to develop ways of unhinging medical liability from the reporting of adverse medical events. Only then can there be meaningful progress in reducing the error rate. They point to the dramatic improvement that other industries—most notably the airlines industry—have managed to achieve by implementing a confidential reporting system for "near misses" to benefit from mistakes.

Part One of this casebook focuses on medical liability. It addresses legal issues and theories, defenses, immunities and harms. It also addresses quality control and efforts toward malpractice reform. For the most part these are matters that few physicians and practicing lawyers will agree upon. Indeed, the terminology itself is a matter of contention: a physician would look at this material and see medical error, while a lawyer would see the same material and consider it medical malpractice. Is this merely a matter of semantics, or do the two professions genuinely disagree on the fundamental nature of medical liability? In medicine, an honest mistake still can be medical malpractice notwithstanding the good intentions of the physician.

Part Two of this casebook focuses on public health. It is noteworthy that these two subjects are contained under the same cover. In 2004, medical error was documented as the 8th leading cause of death in the United States. Clearly the sheer numbers of medical mistakes make it a matter of grave public health concern. Both medical error and medical liability truly result in issues affecting the health of the public, and it is good to see this matter finally cast as a serious public health issue.

A further complicating factor is the escalating medical malpractice insurance crisis, with premiums for some physicians in excess of $200,000 per year. Once again, physicians and lawyers disagree as to the cause of the crisis. Many physicians believe that fear of malpractice lawsuits leads to the practice of so-called defensive medicine, which increases the cost of medical care. Additionally, it is intuitive that large malpractice judgments would increase the cost of medical practice, as physicians pass on the costs of exorbitant insurance premiums. Malpractice lawyers point out, however, that empirical data suggest that less than one per cent of total health care costs are directly attributable to malpractice judgments.

Nevertheless, reports of doctors leaving practice in states where insurance premiums have risen dramatically fill the newspapers. The public is rightfully concerned about access to needed care, as the supply of crucial primary care physicians and specialists dwindles. Although many states have tried to deal with the perceived medical liability crisis by reforming the tort system, the real issue—eliminating the errors that result in liability claims—remains largely untouched. Though several states have mandatory reporting of medical errors, physicians and lawyers agree that fear of provoking claims undermines the reporting of adverse events.

There are no obvious solutions to the problems of medical error in the United States or around the world. The incidence of malpractice and the collateral issues of exorbitant insurance premiums and scarcity of affordable care make medical error a true public health crisis. It is not entirely clear whether a meaningful reduction in errors can be achieved through various proposed tort reform measures, or whether a fault-based system is needed to maintain accountability. Compensation to victims must also be addressed. The purpose of this text is to train students of the law and other graduate disciplines to function within the parameters of the present legal system and at the same time search for strategies to improve the quality of health care delivery.

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