Medical Education and Malpractice: What's the Connection?

Lars Noah

Follow this and additional works at: http://scholarlycommons.law.case.edu/healthmatrix

Recommended Citation
Lars Noah, Medical Education and Malpractice: What's the Connection?, 15 Health Matrix 149 (2005)
Available at: http://scholarlycommons.law.case.edu/healthmatrix/vol15/iss1/9

This Article is brought to you for free and open access by the Student Journals at Case Western Reserve University School of Law Scholarly Commons. It has been accepted for inclusion in Health Matrix: The Journal of Law-Medicine by an authorized administrator of Case Western Reserve University School of Law Scholarly Commons.
MEDICAL EDUCATION AND MALPRACTICE: WHAT’S THE CONNECTION?

Lars Noah†

Researchers recently published a study finding an association between frequency of malpractice claims and the school where physicians had received their medical education.¹ Imagine the reaction of an enterprising plaintiff’s attorney: in the event of a patient injured by substandard health care, a lawsuit might name the physician’s alma mater alongside the negligent physician, alleging some relevant shortcomings in the primary tortfeasor’s training. Although it has happened only rarely in the past, such a response would fit squarely within the increasingly common pattern of naming hospitals and health insurers as additional parties in medical malpractice litigation. This essay discusses the prospects for pursuing claims for medical educational malpractice – call it “(m)ed-mal” for short.

The question presented in my title has both empirical and doctrinal facets. This essay will reference some of the existing research and commentary on shortcomings in medical education, but it largely sidesteps these pedagogical questions in favor of asking whether and how the law should take account of any arguable failings in the ways that we train physicians.² Although many of the rationales against

† Research Foundation Professor of Law, University of Florida.

¹ See T.M. Waters et al., Medical School Attended as a Predictor of Medical Malpractice Claims, 12 QUALITY & SAFETY IN HEALTH CARE 330 (2003); see also David Behling et al., Problem Based Learning and Medical Malpractice: Does How You’ve Been Trained Make a Difference?, 62 HAW. MED. J. 73 (2003); Myrle Crossdale, Higher Lawsuit Risks Tied to Some Schools, AM. MED. NEWS, Nov. 17, 2003, at 13 (reporting that the results were “greeted with skepticism by medical school administrators”); cf. Maxine A. Papadakis et al., Unprofessional Behavior in Medical School Is Associated with Subsequent Disciplinary Action by a State Medical Board, 79 ACAD. MED. 244, 248-49 (2004). But cf. Frank A. Sloan et al., Medical Malpractice Experience of Physicians: Predictable or Haphazard?, 262 JAMA 3291, 3296-97 (1989) (finding no correlation between malpractice claims experience and “prestige of medical school attended”).

² In an earlier article, I posed similar questions about the ways that physicians learn after they graduate and how various legal institutions might take these
recognizing (m)ed-mal claims are not terribly compelling, and one can imagine unusual cases that might justify an award of damages, ultimately I conclude that the consequences of ever allowing such litigation to proceed might imperil academic medical centers.

Medical schools, like other parts of a university, regularly deal with questions about the quality of education that they provide and periodically face efforts at reform. With regard to pedagogy, some observers have criticized an excessive emphasis on memorization at the expense of fostering critical thinking skills during the first few years of medical school, though commentators have bemoaned the scant efforts at validation research designed to measure outcomes associated with innovations in physician training. The practical training offered during the clinical programs in the latter half of medical school and the residencies required after graduation suffer from a different set of shortcomings, captured in part by the famous joke about lessons into account. See Lars Noah, Medicine's Epistemology: Mapping the Haphazard Diffusion of Knowledge in the Biomedical Community, 44 ARIZ. L. REV. 373 (2002).


6 See David Blumenthal et al., Preparedness for Clinical Practice: Reports of Graduating Residents at Academic Health Centers, 286 JAMA 1027, 1027-28,
how physicians learn to perform new medical procedures: "See one, do one, teach one."  

With regard to course offerings, a number of commentators have complained about various gaps in coverage.  

Although a few of these may represent nothing more than curricular fads, certain seemingly important subjects may not receive the attention that they deserve, including genetics, pain management and palliative care, professional ethics, and communications training. One recurring curricu-
lar battle involves the teaching of abortion procedures and related subjects that have generated political controversy.\textsuperscript{14}

As a doctrinal matter, claims of educational malpractice rarely succeed. Initially pursued against elementary and secondary schools, courts generally reject such tort claims,\textsuperscript{15} and, for the most part, they also do not recognize lawsuits for breach of contract in this context.\textsuperscript{16} This pattern recurs in lawsuits brought against colleges and universities,\textsuperscript{17} including law schools,\textsuperscript{18} though a few courts have entertained

\textit{in US Medical Schools}, 276 JAMA 1676, 1677-78 (1996); Herbert M. Swick et al.,\textit{ Teaching Professionalism in Undergraduate Medical Education}, 282 JAMA 830, 832 (1999); see also Frederic W. Hafferty & Ronald Franks,\textit{ The Hidden Curriculum, Ethics Teaching, and the Structure of Medical Education}, 69 ACAD. MED. 861, 869-70 (1994).


\textsuperscript{14} See, e.g., Rebecca S. Dresser,\textit{ Freedom of Conscience, Professional Responsibility, and Access to Abortion}, 22 J.L. MED. & ETHICS 280, 281-83 (1994) (discussing declines in residency programs that provide training in the procedure); Helene Cooper,\textit{ Medical Schools, Students Shun Abortion Study}, WALL ST. J., Mar. 12, 1993, at B1; see also Editorial,\textit{ A De-Facto End to Abortion in USA?}, 347 LANCET 1055 (1996) (explaining that changes in accreditation standards designed to remedy this problem were watered down as a result of political pressure).


\textsuperscript{18} See, e.g., Miller v. Loyola Univ., 829 So. 2d 1057, 1060-62 (La. Ct. App. 2002) (holding that student could not pursue tort claim against law school alleging incompetence in the teaching of a professional ethics course); Bittle v. Okla. City
breach of contract claims as more plausible in the higher education setting.\(^9\)

Courts make a number of points when they reject educational malpractice claims.\(^20\) First, they recognize the range of views about pedagogy, which would make it difficult to define a standard of care. Second, judges anticipate that plaintiffs will face insurmountable obstacles in proving causation and damages in cases, for instance, where a student graduates from high school without basic skills. Third, courts express concerns about becoming entangled in the administration of local schools, preferring a stance of "abstention" in the academic setting. Finally, they fear that allowing dissatisfied parents and graduates to pursue educational malpractice claims, and in turn allowing juries composed of possibly disgruntled members of the local community to award damages in such cases, portends ruinous liabil-

---


ity, which ultimately redirects already scarce resources from the core mission of educating students.

Each of these arguments suffers from obvious flaws. For instance, a similar diversity of views may exist about appropriate medical care in many situations, but courts have managed to define the standard of care in ways that take this disagreement into account (e.g., the "respectable minority rule"). Although causation and damages questions may loom large in the illiteracy cases, courts also have disallowed claims involving school psychologists who negligently misdiagnose students in ways that unmistakably cause injuries no less concrete than damages allowed in other types of tort litigation. The concern about undue entanglement seems somewhat curious given the long-running involvement of the courts in, for instance, supervising desegregation decrees—perhaps that experience has made courts more cautious about the matter, but permitting litigation against any type of institutional tortfeasor will involve judges and jurors in the affairs of that business or organization.

Schools do not deserve special solicitude in this regard unless, of course, rules of sovereign immunity come into play, yet courts have rejected educational malpractice claims lodged against private schools as well. Conversely, courts routinely allow tort claims against public schools for physical injuries to students. For these and other rea-

26 See, e.g., Wyke v. Polk County Sch. Bd., 129 F.3d 560, 571-74 (11th Cir. 1997); Hoyem v. Manhattan Beach City Sch. Dist., 585 P.2d 851, 853-57 (Cal. 1978);
sons, commentators continue to question the nearly universal judicial resistance to claims of educational malpractice.  

In the health care context, a growing chorus of experts has called for a shift of attention from individual failures to systemic causes of errors. In its recent reports, the Institute of Medicine has recommended improvements in the training of health professionals as one method for reducing medical errors. Tort doctrines already have begun to move in the direction of holding institutions accountable for negligence in the provision of medical services. For example, injured patients have recovered damage awards from hospitals on claims that these institutions failed to ensure the competency of physicians granted staff privileges, either in connection with the original Fallin v. Maplewood-North St. Paul Dist. No. 622, 362 N.W.2d 318, 321 (Minn. 1985); Ernest v. Red Creek Cent. Sch. Dist., 717 N.E.2d 690, 693 (N.Y. 1999); Univ. Prep. Sch. v. Huit, 941 S.W.2d 177, 180 (Tex. App. 1996); see also Kleinknecht v. Gettysburg Coll., 989 F.2d 1360, 1367-69 (3d Cir. 1993) (student-athlete at private college).


See INST. OF MED., TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM 3-5, 49 (Linda T. Kohn et al. eds., 2000); Lucian L. Leape et al., Editorial, Promoting Patient Safety by Preventing Medical Error, 280 JAMA 1444, 1445 (1998); Gregg Meyer et al., To Err Is Preventable: Medical Errors and Academic Medicine, 110 AM. J. MED. 597 (2001); Mark A. Schuster et al., How Good Is the Quality of Health Care in the United States?, 76 MILBANK Q. 517, 557 (1998); Sandra G. Boodman, No End to Errors, WASH. POST, Dec. 3, 2002, at F1.

See INST. OF MED., HEALTH PROFESSIONS EDUCATION: A BRIDGE TO QUALITY 5, 23, 134-36 (Ann C. Greiner & Elisa Knebel eds., 2003); INST. OF MED., CROSSING THE QUALITY CHASM: A NEW HEALTH SYSTEM FOR THE 21ST CENTURY 209-14 (2001); see also Mark R. Chassin, Is Health Care Ready for Six Sigma Quality?, 76 MILBANK Q. 565, 578-80 (1998); id. at 580 ("Medical education must emerge from the old, and now bankrupt, model of experts teaching facts, to a new model in which facilitators train young physicians in the skills they will need for a lifetime of knowledge acquisition, analysis, and continuous quality measurement and improvement.").

credentialing decision, during periodic quality reviews, or in the wake of incident investigations.\textsuperscript{31}

Courts have encountered only a handful of educational malpractice claims against institutions that train health care professionals, and these have fared no better than other such lawsuits.\textsuperscript{32} One of the earliest reported judicial efforts to scrutinize a (m)ed-mal claim, \textit{Swidryk v. Saint Michael’s Medical Center},\textsuperscript{33} appeared just two decades ago. In his first month as a resident in obstetrics and gynecology, Dr. Swidryk participated in the delivery of a child who suffered severe brain damage, allegedly the result of negligence. During the pendency of the patient’s lawsuit against him, Dr. Swidryk filed a claim for educational malpractice, alleging that the director of his residency program had provided inadequate instruction and supervision, which proximately caused him to commit medical malpractice.\textsuperscript{34} The New Jersey Superior Court granted the defendants’ motion for summary judgment.

The opinion in \textit{Swidryk} details the early and nearly uniform rejection of educational malpractice claims in other jurisdictions.\textsuperscript{35} The court recognized that the available case law dealt entirely with elementary and secondary school pupils, but it decided that the rationales for rejecting those lawsuits applied equally well to a physician’s negligence claim against his or her medical school or residency program.\textsuperscript{36} In particular, the court emphasized the extensive state regulation of medical education through accreditation bodies,\textsuperscript{37} and it feared

\begin{footnotes}


34 See id. at 642. Although not an effort to implead these parties as additional defendants in the patient’s lawsuit, the physician evidently pursued his separate lawsuit in order to secure contribution in the event that the patient ultimately secured a judgment against him.

35 See id. at 642-43 (declining to differentiate between tort- and contract-based claims).

36 See id. at 643-44. Somewhat curiously, the court reserved for another day the question of whether educational malpractice claims brought by elementary or secondary school students might succeed. See id. at 644 n.2.

37 See id. at 644-45 ("The Legislature has vested the board of medical examiners, the board of higher education and the advisory graduate medical education council with the authority to ensure that a proper medical education is delivered within New Jersey. It would be against public policy for the court to usurp these functions . . .").}

the potential difficulties of having to decide the medical malpractice question within the lawsuit for educational malpractice. This latter concern makes little sense, however, and it would fall away entirely once the underlying medical negligence action has concluded. Moreover, the patient probably could have named the director of the residency program as a joint tortfeasor in the first lawsuit if his negligent supervision contributed to her child's injuries.

(M)ed-mal claims fare no better when asserted directly by an injured patient against a school. In Moore v. Vanderloo, the Iowa Supreme Court held that a patient who suffered a stroke allegedly caused by her chiropractor's negligence could not also assert claims against the school from which he had graduated four years earlier. The plaintiff had asserted that the school negligently failed to instruct its students about the risk of strokes from manipulations of the neck, but the court—in accord with the holding in Swidryk just one year earlier—declined to recognize an educational malpractice claim in this con-

38 See id. at 645 ("To allow a physician to file suit for educational malpractice against his school and residency program each time he is sued for malpractice would call for a malpractice trial within a malpractice case.").

39 It arises whenever someone named as a defendant in tort litigation anticipatorily files a contribution claim against someone not named in the underlying case, and a court worried about inconsistencies or inefficiencies from the duplication of effort could direct the defendant to use impleader instead, hold the claim in abeyance pending the conclusion of the first lawsuit, or issue a declaratory judgment recognizing a contingent right of contribution if the defendant later faces a liability judgment to the patient.

40 In a factually similar case, a California court allowed the settling malpractice defendant—in that instance, a public hospital—to seek contribution from the medical school that had sponsored a residency program at the hospital. See County of Riverside v. Loma Linda Univ., 173 Cal. Rptr. 371, 378-80 (Ct. App. 1981); see also id. at 379, 379 n.7 (observing that "the university owed a duty to patients who were under the care and treatment of residents to see that the residents received proper education and training in their specialty and proper supervision over the clinical aspect of their training," but noting that the university's duty to the patient—based on its contract with the hospital—distinguished the case from an educational malpractice claim).


42 386 N.W.2d 108 (Iowa 1986).
The court doubted that it could find an appropriate standard of care to apply, that it could manage to resolve the inherent uncertainties surrounding the question of causation, that it could prevent an ensuing flood of litigation, and that it could avoid intruding unduly in school administration and legislative judgments about professional licensure.

---

See id. at 113-15; id. at 114 ("Although the factual context in the present case varies slightly from those educational malpractice cases previously cited, the public policy considerations raised in them also apply in Iowa as to a third party patient of a former student."); cf. Moss Rehab v. White, 692 A.2d 902, 905-09 (Del. 1997) (refusing to entertain a third-party educational malpractice claim against a special driving school when one of its former students caused a fatal accident). Another stroke victim unsuccessfully sued the same chiropractic school more than a decade earlier. See Salter v. Natchitoches Chiropractic Clinic, 274 So. 2d 490, 494 (La. Ct. App. 1973) (affirming the dismissal of a negligence claim against the school for lack of personal jurisdiction, emphasizing the potentially unreasonable burden that out-of-state schools would face if forced to defend themselves wherever their graduates have decided to practice).

See Moore, 386 N.W.2d at 114 ("[W]e are not prepared to determine what . . . reasonable chiropractic institution[s] should or would have taught to [their] students."). The court does not entirely articulate its hesitation in this regard: assuming that the school should have known of this serious risk associated with a common chiropractic procedure that it teaches to students, why would a court doubt its ability to define the standard of care any more so than in closely related medical malpractice or products liability contexts? After all, such a question goes to issues of curricular content rather than teaching methodology.

See id. ("This reason is particularly persuasive in the present case involving a third party claim against an institution for what it allegedly did not teach a student, four years after that student graduated."). What if the injury occurred shortly after the student graduated? The passage of time alone would not make negligence too remote as a matter of law, though perhaps no reasonable jury could regard it as a proximate cause after a decade or more has elapsed. If the court means that a reasonable chiropractor should have learned of the risk after graduation (e.g., through continuing education programs or by staying abreast of the professional literature), then a jury could allocate a smaller causal share to the school’s antecedent negligence, but, as pharmaceutical manufacturers have learned in defending against products liability litigation, a physician’s independent failure to learn of a reported drug risk would not exonerate an entity that failed to satisfy its separate duty to warn of a non-obvious risk. See, e.g., Garside v. Osco Drug, Inc., 976 F.2d 77, 80-83 (1st Cir. 1992); Walls v. Armour Pharm. Co., 832 F. Supp. 1467, 1484-93 (M.D. Fla. 1993); cf. May v. Dafoe, 611 P.2d 1275, 1277-78 (Wash. Ct. App. 1980) (distinguishing drug manufacturers from suppliers of hospital equipment).

See Moore, 386 N.W.2d at 114-15 ("[I]f a cause of action for educational malpractice is recognized . . ., a doctor or attorney sued for malpractice by a patient or client might have an action over against his or her educational institution for failure to teach the doctor or attorney how to treat or handle the patient or client’s problem."). This concern stands in some tension with the prior pair of fears insofar as it fails to credit requirements that a plaintiff prove breach of duty and causation as erecting hurdles to frivolous negligence claims.

See id. at 115.
The plaintiff in Moore also had asserted a claim for breach of an express warranty, but the court rejected this theory: "If we held there was a warranty created by a school upon issuance of a diploma or advertisements, absent reliance or privity, we would be opening the door to unlimited liability for all educational institutions . . . ." Even if a patient first inquired about a health care professional's credentials and relied on that information in either selecting among physicians or agreeing to undergo a procedure, it seems implausible that this court would have decided the warranty claims differently given its refusal to entertain negligence-based (m)ed-mal claims.

Nonetheless, courts in some jurisdictions have allowed third parties (incidental beneficiaries) to press tort claims in analogous situations. For instance, the California Supreme Court decided that a student sexually assaulted by a public school employee could pursue a negligent misrepresentation claim against four other school districts where the molester previously had worked because agents for these districts had given him positive job recommendations even though they were aware of his tendencies. An intermediate appellate court

---

48 Id. at 112; see also id. at 112-13 (adding that the state still would have to issue a license before a graduate could engage in practice).

49 Cf. John G. Culhane, Reinvigorating Educational Malpractice Claims: A Representational Focus, 67 WASH. L. REV. 349, 412 (1992) (agreeing with the decision, but conceding that, "[w]hile reasonable patients rely on their doctors, in some cases reasonable doctors may, in turn, have relied on their medical schools to provide them with the basic tools of 'literacy' for their profession"). In a related vein, some informed consent cases pose questions about the duty to disclose provider characteristics. See Hales v. Pittman, 576 P.2d 493, 500 (Ariz. 1978); Johnson v. Kokemoor, 545 N.W.2d 495, 504-10 (Wis. 1996); see also Aaron D. Twerski & Neil B. Cohen, The Second Revolution in Informed Consent: Comparing Physicians to Each Other, 94 NW. U. L. REV. 1, 12-14 (1999). But see Ditto v. McCurdy, 947 P.2d 952, 958-59 (Haw. 1997) (no duty to disclose lack of special credentials); Duttry v. Patterson, 771 A.2d 1255, 1258-59 (Pa. 2001); Whiteside v. Lukson, 947 P.2d 1263, 1265 (Wash. Ct. App. 1997) ("In theory, . . . even medical school grades could be considered material facts . . . . [W]e conclude that a surgeon's lack of experience in performing a particular surgical procedure is not a material fact for purposes of finding liability predicated on failure to secure an informed consent.").

50 Similarly, in a decision that had endorsed the theory of corporate liability when hospitals make negligent credentialing decisions, one court refused to allow a claim for an offsite injury premised solely on the argument that the patient had relied on the physician's admitting privileges at that facility: "The hospital does not hold itself out as an inspector or insurer of the private office practices of its staff members." Pedroza v. Bryant, 677 P.2d 166, 172 (Wash. 1984) ("The delineation of staff privileges by the hospital can only affect the procedures used by staff members while they are inside hospital walls. The public cannot reasonably expect anything more.").

in Oregon allowed a student injured during football practice to bring a negligence claim against the entity that accredited high school athletic programs in the state.\textsuperscript{52} Similarly, organizations that certify product quality have faced liability for negligence when consumers suffer injuries.\textsuperscript{53} One federal court allowed claims to proceed against the National Hemophilia Foundation for publishing some allegedly inaccurate information about blood factor concentrates intended for distribution to patients,\textsuperscript{54} and a few commentators have argued that injured patients should get to assert similar claims against medical societies responsible for drafting clinical practice guidelines.\textsuperscript{55}

Even more so than the rationales opposed to traditional educational malpractice claims, the arguments against allowing (m)ed-mal claims do not stand up well to close scrutiny.\textsuperscript{56} Unlike the variability

\textsuperscript{52} See Peterson v. Multnomah County Sch. Dist. No. 1, 668 P.2d 385, 393 (Or. Ct. App. 1983); see also Peter H. Schuck, Tort Liability to Those Injured by Negligent Accreditation Decisions, LAW & CONTEMP. PROBS., Autumn 1994, at 185, 187-97 (exploring this theory in both the educational and health care delivery context, but doubting whether courts will or should entertain such claims). But see Ambrose v. New Eng. Ass'n of Schs. & Colls., Inc., 252 F.3d 488, 493-99 (1st Cir. 2001) (rejecting tort claims against regional accreditation body brought by former college students pursuing associate degrees to become medical assistants).


\textsuperscript{56} But see Deanne Morgan, Commentary, Liability for Medical Education, 8
among elementary and secondary school pupils, only high achieving students of roughly comparable abilities and prior undergraduate course work will make it into medical school.\textsuperscript{57} Moreover, at least when claims of medical malpractice target younger physicians,\textsuperscript{58} the nexus between alleged inadequacies in training and the provision of substandard care may be close enough to satisfy causation requirements. Licensure examinations do not reliably screen out students who performed poorly during medical school.\textsuperscript{59}

Although courts have shown substantial deference to decisions made by medical schools,\textsuperscript{60} the recognition of (m)ed-mal claims need

\textit{J. LEGAL MED.} 305, 330-38 (1987) (concurring with all of the rationales offered against recognizing such claims, particularly the difficulties in defining a standard of care for instruction by medical school faculty and in proving causation for subsequent patient injuries).


\textsuperscript{58} Studies suggest that the frequency of malpractice claims gradually increases until a physician reaches mid-career. See E. Kathleen Adams & Stephen Zuckerman, \textit{Variation in the Growth and Incidence of Medical Malpractice Claims}, 9 J. HEALTH POL. POL'Y & L. 475, 485 (1984); Mark I. Taragin et al., \textit{Physician Demographics and the Risk of Medical Malpractice}, 93 AM. J. MED. 537, 541 (1992).


\textsuperscript{60} See Regents of the Univ. of Mich. v. Ewing, 474 U.S. 214, 225 (1985) ("When judges are asked to review the substance of a genuinely academic decision . . ., they should show great respect to the faculty’s professional judgment."); Bd. of Curators of the Univ. of Mo. v. Horowitz, 435 U.S. 78, 89-90 (1978) (deferring to the presumed expertise underlying a medical school’s decision to expel without a prior hearing a student on academic grounds); see also Shaboon v. Duncan, 252 F.3d 722, 730-32 (5th Cir. 2001) (upholding dismissal of a medical resident); Gupta v. New Britain Gen. Hosp., 687 A.2d 111, 117-18, 120-21 (Conn. 1996) (same, rejecting educational malpractice claim); Frederick v. Nw. Univ. Dental Sch., 617 N.E.2d 382,
not threaten excessive judicial intrusion into the administration of these institutions. As with elementary and secondary schools, medical students who suffer physical injuries while engaging in school-sponsored activities have successfully brought tort claims against their institutions.61 Even if courts recognized (m)ed-mal claims, public universities would enjoy some protection by virtue of the rules of sovereign immunity prevailing in their particular state.62 Concerns about ruinous liability do, however, resonate in this context insofar as academic medical centers have encountered serious financial problems during the last decade.63

Anticipating that courts may encounter an increasing number of educational malpractice claims against medical schools when patients suffer injuries at the hands of recent graduates, this essay has sketched the contours of several overlapping debates in law and medicine. Such lawsuits will pose difficult questions, and they fall at the intersection of two divergent litigation trends — namely, a greater willingness to impose duties on health care institutions (and also to extend tort duties to third party beneficiaries in various contexts), and a longstanding unease with claims of educational malpractice. It is difficult to predict which of these tendencies will predominate when courts resolve future (m)ed-mal claims. Such lawsuits may well falter after a thorough analysis of the evidence and competing policy arguments, but judges should carefully articulate their reasons for declining to


63 See David Blumenthal & Gregg S. Meyer, The Future of the Academic Medical Center Under Health Care Reform, 329 NEW ENG. J. MED. 1812, 1813 (1993); Lelia B. Helms et al., Litigation in Medical Education: Retrospect and Prospect, 11 J. CONTEMP. HEALTH L. & POL'Y 317, 374 (1995); id. at 323 ("In such a resource-constrained environment, the costs of litigation will loom ever larger as medical education is forced, for the first time, to cope with the twin challenges of increased regulation and reduced resources."); Samuel Thier & Nannerl Keohane, How Can We Assure the Survival of Academic Health Centers?, CHRON. HIGHER EDUC., Mar. 13, 1998, at A64.
recognize these sorts of cases rather than simply parroting the weak rationales used to reject tort claims asserted by public high school students who graduate with inadequate basic skills. The characteristics of medical education – and the foreseeable consequences of doing a poor job of training future health care professionals – demand a closer evaluation of the possible benefits and burdens of holding medical schools accountable for failing in their mission.