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Adaptation of Tort Law to Modern Health Care Delivery in the Restatement of Medical Malpractice

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7.1 INTRODUCTION

Prior to the mid-1960s, with the advent of Medicare and Medicaid, health law looked predominantly to various sources of private law – principally branches of common law – to address major issues at the time. Naturally, that legal landscape has changed a great deal, but common law still undergirds many of the classic components of the field. This chapter explores the extent to which common law remains capable of adjusting itself to evolving structures and dynamics in health care finance and delivery. It does so in the particular context of medical liability.

As we begin the inquiry, it helps to recognize that common law has two core but conflicting, features: stability and adaptability. Stability arises through stare decisis. Adaptability is inherent in the judge-made quality of common law doctrine. As the landscape changes that gives rise to common law, so too can the judicial outlook that applies the law's principles, generating not only different rulings under established principles but also revision of governing principles at both second-order and higher levels of conceptualization.[1] Such doctrinal evolution or revolution can be slow and fitful, but many successful examples can be given of this innate adaptability.[2] At the same time, the common law's precedential inertia can create impatience among scholars, regulators, and reformers eager to modernize hidebound legal principles.

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[1] Countless discussions of these themes can be found, but each owes its intellectual debt to the classic work of Oliver Wendell Holmes Jr., The Common Law (1881).

[2] My co-reporters, for instance, canvass a number of such examples in their review of a companion Restatement project called Torts: Miscellaneous Provisions. See Nora F. Engstrom & Michael D. Green, Tort Theory and Restatements: Of Immanence and Lizard Lips, 14 J. Tort Law 333 (2021).

The American Law Institute's (ALI or Institute) first-ever project to restate medical liability law provides a fitting occasion to explore these tensions and themes in the context of tort law's application to medical care delivery. Tort law has been a principal focus of the ALI from its beginning a century ago.[3] This medical liability project arose at the concluding phase of the Institute's quarter-century work to issue its third Restatement of Torts law. Previous Restatements addressed medical malpractice only briefly, as a leading example of a more general concept of professional liability, discussed in just a single section.[4] In solipsistic contrast, the Restatement of the Law Governing Lawyers devotes eleven sections to legal malpractice.

A review of various provisions reveals that judicially determined common law is capable, to some extent, of evolving with the health policy times; however, there are significant points of inertia that may be hindering useful health policy developments. Surveying this landscape may help lawmakers and public policy officials identify where regulatory nudges or overt overrides can be helpful in freeing up precedential logjams.

Medical malpractice law arose in the nineteenth century, at a time when medical care could be described in its best light as primitive.[5] Importantly, treatment relationships then were almost entirely dyadic (with just a single provider) and episodic, addressing primarily acute issues. Also, patients paid entirely out-of-pocket and providers delivered care mostly in noninstitutional settings, either at home or in the doctor's office. As common law is expected to do, it reflected, and thus was premised on, these essential features. As I have written elsewhere, the private law features of health law in particular are especially adept at recognizing and responding to the essential features of illness, vulnerability, trust, professionalism, and other core attributes of health care delivery and finance.[6]

Obviously, it greatly understates things to say that much has changed in medicine over the past 200 years. Thus, we might expect that critical doctrinal elements and principles have shifted dramatically over time. However, many or most of the core essentials of the medical enterprise – the ontological assault of illness, the vulnerability a treatment relationship entails, the complexity and unpredictability medical practice, the fundamental existential stakes of the enterprise – inhere in the human condition and thus remain true today. But, for essential features that are more contingent, the common law's precedential inertia might stunt doctrinal evolution. The emerging Restatement of Medical Liability provides an opportunity to learn the

[3] John C. P. Goldberg, Torts in the American Law Institute, in The American Law Institute: A Centennial History (Andrew S. Gold & Robert W. Gordon eds., 2023).

[4] Restatement (Second) of Torts § 299A (Am. Law Inst. 1969).

[5] For historical accounts, see, e.g., Kenneth A. DeVille, Medical Malpractice in Nineteenth-Century America (1990); Iain Hay, Money, Medicine, and Malpractice in American Society (1992); James C. Mohr, American Medical Malpractice Litigation in Historical Perspective, 283 JAMA 1731 (2000).

[6] Mark Hall, The History and Future of Health Care Law: An Essentialist View, 41 Wake Forest L. Rev. 347 (2006).

extent to which these competing features of private law affect the Institute's ability to bring coherence to the common law of medical liability.[7]

7.2 THE TREATMENT RELATIONSHIP

When does a physician or other care provider enter the realm of medical professional responsibility? According to tort law, this occurs when the provider forms a treatment relationship, that is, begins to undertake the care of a patient. Undertaking care is the critical point at which a provider leaves the zone of generic negligence law, which holds actors responsible only for risks they create judged by a general reasonableness standard and assumes the more affirmative responsibilities defined by professional standards.

A treatment relationship's timeline – its beginning and ending – is defined largely by contractual principles. Sometimes overt agreements to start or end a treatment relationship can be identified, but often they cannot. A physician simply starts to engage with a patient and then stops engaging, or they engage in ways that can be ambiguous as to the nature and scope of the engagement. Thus, the Restatement of Medical Malpractice begins by addressing the foundational contours of a treatment relationship.[8]

At the threshold, one visible indication of common law adaptation is the modernizing of the rules around formation of the treatment relationship. Historically, courts have tended to apply what might be called a "hair trigger" test for relationship formation, by finding that contractual elements are met with only a slight indication of potential intent by the provider to assume responsibility. Thus, in various circumstances, courts have found that a treatment relationship formed when a patient made an appointment, or when a provider discussed the patient's situation and needs only briefly, or only with a colleague.

The quick trigger approach stands in sharp contrast to lawyers undertaking client representation. Lawyers commonly consult with a potential client before launching representation, and that launch rarely occurs without an explicit understanding about its basic scope and terms.

When patients are sick and in need of immediate attention, there are obvious reasons to dispense with formalities. Recognition, however, that greater complexities and subtleties can legitimately arise in the modern setting, coupled with the emergence of a more overtly "consumerist" ethos in medicine, led the Restatement to endorse a moderating stance. Based on limited, but sufficient, case

[7] This analysis is based on the current version of the project's drafting, which is not yet completed.

[8] As with other Restatements, this one addresses only the common law, and not statutory law. Many states, however, have statutes that codify medical liability essentials. In doing so, statutory law embraces common law concepts and thus decisions interpreting and applying these statutes often employ common law reasoning.

law, the Restatement advises that, "in appropriate nonemergency circumstances, medical providers should have leeway, similar to that in legal representation, to first assess a patient's condition and to discuss potential courses of treatment and costs before initiating a patient-care relationship."[9] That passing sentence is a small but instructive example of common law adaptation.

The unhelpful aspect of inertia in the common law can be seen, however, in its episodic conception of treatment relationships. Following well-established case law, the Restatement declares that a treatment relationship ceases "once the particular condition or conditions that gave rise to treatment no longer need attention, unless the patient has reason to believe that the provider intends to continue the relationship." As it notes, this "captures what is sometimes referred to as a 'spell of illness' demarcation of treatment relationships."[10] The Comment acknowledges, however, that "patients as well as providers often think of themselves as having an established and ongoing relationship that bridges episodes of illness."

Here, the Restatement urges courts to better adapt the law to modern practice. The Comment instructs that medical liability law should attempt "to shape itself to the actual contours of patient-provider interactions and understandings." Further, it notes that "several modern developments support, in appropriate circumstances, embracing a more continuous rather than episodic conception of patient-care relationships." An obvious example is chronic illness with episodic flare-ups. Another, which is more institutionally contingent, is the contemporary emergence of primary-care "medical home" arrangements, "in which a primary-care provider is paid to manage a patient's needs on an ongoing basis across a range of providers and conditions." The Comment prompts courts to recognize that these (or similar) arrangements "can form an ongoing patient-care relationship that transcends spells of illness."[11]

This type of small-bore, stepwise evolution is a hallmark of the common law and thus is comfortably within the bounds of the Institute's guidelines and practices for how Restatements justifiably may guide further legal development.[12] The Restatement embraces a similarly less transactional and more relational view in its section on informed consent. There, it keys the informed consent duty to a "course of treatment" rather than to a specific intervention, recognizing (again without much explicit precedent) that "it is typical, and permissible, to obtain informed

[9] § 2 cmt. k. Unless otherwise noted, section numbers refer to the current version of the Restatement (Third) of Torts: Medical Malpractice.

[10] § 2 cmt. n. As an example, the Reporters' Note mentions the classic decision in Hurley v. Eddingfield, 59 N.E. 1058, 1058 (Ind. 1901), which absolved a general practitioner from refusing to aid a former patient who ended up dying during childbirth. Although the court noted that the doctor "had been decedent's family physician," the court (without discussion) treated this as a refusal to initiate, rather than to continue, a treatment relationship.

[11] § 2 cmt. n.

[12] See Goldberg, supra note 3 for additional discussion.

consent in a manner that bundles a variety of discrete items of treatment."[13] In these several respects, we see a somewhat successful, but still limited, ability of common law to adapt to basic changes in treatment relationships.

7.3 SHARING RESPONSIBILITY AMONG MEDICAL PROFESSIONALS

Common law has been somewhat less successful, however, in adapting to changes in how medicine is practiced. Tort law has frequently had to determine the scope of an individual provider's professional responsibility in the context of multiple professionals working together as part of a treatment team.[14] This first arose in the surgical operating arena. Cases a century ago asked whether a surgeon is responsible for errors that surgical assistants make, such as nurses charged with counting sponges to ensure none are left behind. As surgical techniques advanced, subsequent courts were asked to determine a lead surgeon's responsibility for another physician's error in, for instance, administering anesthesia.[15]

Initially, courts adopted a strong version of vicarious liability known as the "captain of the ship" doctrine, which held the lead surgeon responsible as a matter of law for any negligence under their "command," regardless of the surgeon's actual control over the team member.[16] One rationale at the time for this small-scale form of enterprise liability was that, with respect to nurses, if the surgeon were not liable then there would be no adequately sized pocket from which to seek recovery, given that almost all hospitals at the time were immune from liability, either as charitable or governmental institutions.

In many cases, modern courts have appropriately backed away from this literal-absolutist application of the captain-of-the-ship metaphor, in favor of a more fact-based inquiry, now referred to as the borrowed "employee" doctrine.[17] This modern version appropriately adapted to changing circumstances in the profession and applies more conventional vicarious liability principles to inquire whether a surgeon, in a particular situation, controls, or has the right to control, "the manner and means" by which a colleague performs their work. Recognizing that in modern practice, the training and oversight of nurses is typically the hospital's responsibility, this more

[13] § 12 cmt. k.

[14] In addition to the examples discussed in text, also relevant is the long-standing doctrine that, in applying *res ipsa loquitor* to mishaps in surgical settings, courts rule that it is sufficient if anyone on the surgical team was probably at fault, rather than requiring the plaintiff to identify which particular actor was most likely responsible. § 7 cmt. b. In essence, this variation in the doctrine holds the entire team responsible for any member's mistake, unless evidence emerges about which particular team member was at fault.

[15] See Stephen H. Price, The Sinking of the "Captain of the Ship": Reexamining the Vicarious Liability of an Operating Surgeon for the Negligence of Assisting Hospital Personnel, 10 J. Leg. Med. 323 (1989).

[16] See §15 reporters' note cmt. e.

[17] § 15 cmt. g.

nuanced doctrine nevertheless allows a finding based on the facts of a particular case that a surgeon assumed temporary control of a team member's action.

But the story isn't all a positive one. Variability remains in how these principles play out in recurring scenarios, including the original scenario of sponges, clamps, or other foreign objects accidentally left behind during surgery.[18] Some courts look to how providers themselves allocate responsibility, recognizing that "operating room personnel have specialized tasks to perform during surgery, … [and] that it [may] not [be] practical for [surgeons] to exercise control of the nurses in their sponge-counting task."[19] Other courts, however, continue to hold surgeons responsible as a matter of law.[20] They do so without resuscitating an explicit and free-ranging captain-of-the-ship notion; instead, they embrace the more limited common-sense notion that when a surgeon inserts a foreign object, the surgeon remains responsible for ensuring its proper removal. That line of thinking is more appropriately considered to be a straightforward recognition of a nondelegable duty.[21]

These established strands of doctrine have not matured, however, into more general principles of shared professional liability when errors occur in team-based care settings. The Reporters' Note to the Comment on borrowed employees explains that, "[a]lthough such team-care arrangements are increasingly common, courts continue to resist viewing them as a basis for vicarious liability among individual medical professionals, as long as none of the providers actively supervises or controls his or her counterpart. Instead, courts apply a highly compartmentalized view of shared physician responsibility." The Note continues in an editorial vein to say:

> This highly compartmentalized view is subject to the criticism that it fails to reflect the increasing emphasis in modern medicine on caring for patients through coordinated teams, as seen, for instance, in the rise of "accountable care organizations" and "care coordination teams" based with multidisciplinary primary care medical homes that monitor and coordinate care patients receive from a range of providers.[22]

[18] As summarized by Restatement (Third) of Agency § 7.03 cmt. d(2) (Am. Law Inst. 2006), owing to the highly fact-intensive nature of the inquiry, "[e]ven within the same jurisdiction, it may be difficult to predict whether a given set of indicia will demonstrate that a special employer has assumed the right of control." The associated Reporter's Note points in particular to "examples drawn from medical-malpractice cases [to] illustrate the fact-specificity of borrowed-servant cases [and hence their unpredictable outcomes], regardless of the doctrinal formulation a court applies."

[19] Holger v. Irish, 851 P.2d 1122, 1127–28 (Or. 1993).

[20] § 15 reporters' note cmt. e.

[21] As another example, under-informed consent law courts hold the principal physician solely responsible for making necessary disclosures even though physicians, following institutional policies, often delegate such tasks to subordinates employed and supervised by hospitals. § 15, cmt. e. See also note infra.

[22] Similarly, the § 1 Reporters' Note to comment g observes that the Restatement only partially and thus inadequately accounts for the fact that "many bad outcomes result from poor system design or multiple reinforcing mistakes rather than primarily from individual error" and that, accordingly, "it is widely accepted that a systems approach is needed to improve medical quality and reduce medical error."

These sentiments are those only of the Reporters, however, and do not speak for the Institute. The ALI's official position is expressed in Comments recognizing that "much of this Restatement addresses a simple one-on-one relationship between provider and patient, even though much medical care, especially in hospital settings, is in fact provided by teams that share and assign responsibilities in complex ways," and noting that the "Restatement only partially accounts for this complexity."

Here, then, we see a glaring example of the limits of common law tort principles, rooted in an anachronistic framing of medical care delivery. Despite dramatic changes in how modern medicine structures care delivery, tort law can struggle to fully adapt to modern conditions.

Partly accounting for this doctrinal rigidity, however, is that medical professionals themselves hold on to a bounded view of their own responsibilities. Thus, when providers collaborate across disciplines or fulfill supervisory roles, they form explicit understandings about the nature of limits of their separate but dovetailing responsibilities.[23] In honoring these understandings, tort law is not so much stubborn to change, as it is compliant with professional norms. Thus, the common law is more subject to the criticism of declining to push for overarching structures of responsibility, than of failing to recognize professional and institutional realities.[24]

7.4 INSTITUTIONAL RESPONSIBILITY

Common law's rigidity can be seen in the failure of institutional liability to fully adapt to modern circumstances. A few years before work began on the Third Restatement of Torts, the Institute commissioned a project, led by a group of eminent torts scholars, to restate institutional responsibility for personal injury. The group's work proved too scholarly and lacked grounding in existing case law. The Institute therefore downgraded what was originally intended as a Restatement to simply a "Reporters' Study,"[25] meaning that it spoke only for the reporters and not the Institute.[26] For similar reasons, this Restatement attempts no bold move toward sweeping enterprise liability for medical institutions.[27] That move would require

[23] Various examples the Restatement gives and documents include medical examinations for purposes of employer or insurance, physicians who supervise nurse practitioners or physician assistants, consulting and on-call arrangements. See also Mark A. Hall et al., Liability Implications of Physician-Directed Care Coordination, 3 Ann. Fam. Med. 115, 115–20 (2005) (discussing the limited legal exposure of physicians who coordinate care in managed care settings).

[24] Possibly, this reluctance to push harder is informed by a concern that doing so may deter professionals from assuming new responsibilities that, if they were not professionally controllable, would carry unknown liability risks.

[25] Am. Law Inst., Reporters' Study on Enterprise Responsibility for Personal Injury (1991).

[26] Recounting this history, see Engstrom & Green, supra note 2, at 341; Goldberg, supra note 3, at nn. 104–17.

[27] Indeed, that term purposefully does not appear in the official Comments, but only in the § 15 Reporters' Note to comment f. For further discussion of potential enterprise liability for

fairly dramatic legislation action. Short of that, however, this Restatement recognizes a number of doctrinal advancements that, potentially, form building blocks for more sweeping enterprise liability.

First, the Restatement's institutional liability ambit is substantially broader than just hospitals and nursing homes. The institutions subject to some form of medical liability are "entities that arrange for or furnish medical care through the services of medical professionals," including: "medical facilities that treat patients, such as hospitals, clinics, and nursing homes; entities, such as managed care insurance plans, that arrange medical care for their customers; and newly emerging arrangements such as 'accountable care organizations.'"[28] This Section is explicit, however, that all such institutions do not have the same set of duties. Instead, different duties apply according to whether the institution directly delivers care or instead merely helps to arrange for care.

Ample precedent exists to articulate the basic duties owed by institutions engaged in direct medical care. Precedent is limited, though, for other forms of institutions – those that merely arrange for or influence patient care rather than act as a provider. Managed care insurers are the primary example, but, owing to preemption by the Employee Retirement Income Security Act (ERISA), relevant precedents are scarce.

Despite this absence of precedent, the Section is able to state based on general principles that any such medical institution owes a "duty of reasonable care" to the extent that it "select[s] and retain[s] the medical professionals who furnish care under its auspices," or that it "make[s] or actively review[s] medical decisions."[29] Comments explain that this structure and wording does not require institutions to engage in such activities unless they actually deliver care; if not, the Section tailors medical duties to the functions that particular institutions choose to undertake.[30] These principles provide appropriate room for flexible development both of different types of medical institutions and different attendant duties, rather than embracing a "one size fits all" rule.

The Institute is especially careful to avoid insisting that medical institutions actively supervise medical professionals in a manner that requires institutions to regularly inject themselves directly into medical decision-making as it occurs (rather than reviewing decisions more retrospectively). If institutions choose to do so,

hospitals or managed care insurers, see generally Kenneth Abraham & Paul Weiler, Enterprise Liability and the Evolution of the American Health Care System, 108 Harv. L. Rev. 381 (1994); Kenneth Abraham & Paul Weiler, Enterprise Medical Liability and the Choice of the Responsible Enterprise, 20 Am. J.L. & Med. 29 (1994); Clark C. Havighurst, Making Health Plans Accountable for the Quality of Care, 31 Ga. L. Rev. 587 (1997); Philip G. Peters, Resuscitating Hospital Enterprise Liability, 73 Mo. L. Rev. 369, 369–97 (2008); William Sage, Enterprise Liability and the Emerging Managed Care Health Care System, 60 Law & Contemp. Probs. 159 (Spring 1997).

[28] § 14 cmt. a.

[29] § 13(a), (c).

[30] See, e.g., §13 cmts. a, i, & j.

naturally they assume a more exacting duty of care, but requiring institutions to take on this responsibility would contravene public policies that seek to minimize untoward institutional influence in professional judgment. In these ways, the Section aims to set a doctrinal stage for the ongoing development of a wide variety of different types and forms of medical institutions.

The Restatement also addresses institutional liability through vicarious liability doctrine. In particular, the Restatement discusses the substantial body of case law that has developed under the "apparent (or ostensible) agency" doctrine.[31] In developing and applying this and other aspects of vicarious liability, the Comments emphasize that courts are especially attentive to public policy consideration, such as:

> (1) patients' reasonable understandings about who is responsible for their care; (2) medical professionals' and institutions' reasonable understandings about how roles and responsibilities are assigned, shared, and allocated; and (3) society's broader interest in promoting safe, efficient, and high-quality care.[32]

Because these policies can point in different directions or can be given differing weights, there is notable variability in the extent to which different courts, sometimes from the same jurisdiction, assess whether an adequate manifestation of authority exists to invoke institutional vicarious liability.

Nevertheless, the Restatement is explicit that doctrinal articulation and application of vicarious liability should change in response to changes in health care delivery and finance. Thus, Comments note that the classic model – of independent physicians on a hospital medical staff having no other contractual relationship with the hospital – no longer predominates. Instead, physicians who treat hospital patients increasingly either work for the hospital or are part of a group that contracts, or is affiliated, with the hospital or a parent organization. Legal precedents from the pure independent-practice era may not necessarily be a good fit with these more complex "integrated delivery systems."[33]

Institutional liability for hospital-based specialists that a hospital does not employ is the leading example of doctrinal evolution that reflects several of these public policy considerations. Conventionally, when a professional (or other actor) is not an actual employee or agent of an institution, the institution assumes no vicarious liability unless the injured party (here, a patient) detrimentally relies on the institution representing that the professional is acting on its behalf as its agent.[34] Courts increasingly have relaxed these doctrinal demands of actual reliance and overt representation. They have held, for instance, that patients need not show reliance in the form that a different understanding about agency would have caused them to

[31] § 15(2) & cmt. i.
[32] § 15 cmt. a.
[33] Id. cmt. c.
[34] Restatement (Third) of Agency § 7.03, supra note 18.

seek care elsewhere. Instead, patients need only show simply that they assumed the doctor was working for the hospital. Moreover, in many jurisdictions, patients need not point to a specific holding out or representation of agency; instead, it suffices that the patient's assumption was reasonable in the circumstances.

The Restatement makes ample room for these doctrinal liberalizations but does not insist on their adoption, recognizing that doing so appropriately requires taking account of factual circumstances. Noting the variability that remains among decisions, as well as the fact-sensitivity of these standards, the relevant Comment sets an outer limit of apparent agency only at the point where "a patient establishes a relationship with an independent physician prior to hospital treatment."[35] Then, "the patient cannot convincingly claim that the independent physician is the hospital's apparent agent, simply because the physician is on the hospital's medical staff or is entitled to work on the hospital's premises." Otherwise, for hospital-based specialists, "various circumstances can give rise to a patient's reasonable belief that the physician is acting and has authority to act on behalf of the hospital when, in fact, the physician is an independent contractor."[36]

Beyond this expansion of apparent agency, tort law has not gone much further toward possible full-scale enterprise liability for hospitals or other medical institutions, nor does this Restatement encourage doing so, recognizing that Restatements are not an overt law-reform initiative.[37] In this respect, basic institutional liability remains much as it was a half-century ago. It remains to be seen whether dramatic innovations such as artificial intelligence – allowing much more detailed real-time interaction with professional decision-making – will push institutional roles and legal doctrine to a tipping point of more encompassing liability.

In the meantime, this Restatement does contain limited doctrine that may become seeds for future development of more encompassing enterprise liability. It notes that, in emergency room settings, where public policy considerations loom especially large, more courts are willing to curtail or dispense with the factual issues that might complicate a finding of apparent institutional agency. These courts, for instance, tend to adopt a presumption of reasonable impression of agency status, and they decline for obvious reasons to honor disclaimers of agency contained in form paperwork presented to emergency patients.

[35] § 15 cmt. i.
[36] Id.
[37] Indeed, it endorses one particularly retrograde position that, based on substantial case law, absolves hospitals from responsibility for ensuring that patients' informed consent is obtained for physician treatment – despite the fact that hospitals routinely take measures to ensure that physicians comply with their informed consent obligations. § 12 reporters' note cmt. e. The reason courts give for abnormally limiting institutional responsibility is in order to keep the central focus of responsibility for informed consent on the treating physician. Although scholars find this reason unconvincing, case law currently is too consistent for the Restatement to reject it outright. See id.

The relevant Comment takes an important further step, pointing courts to the availability of a more straightforward, but still limited, embrace of nondelegability as a matter of law. Building from decisions that presume apparent agency, the Comment notes that, "for certain core hospital functions, such as nursing care, it may be unacceptable as a matter of law to permit a medical institution to disavow vicarious liability for the negligence of independent contractors – even if it furnishes patients clear and timely notice of the contractors' independent (nonemployee) status."[38]

The extent to which courts take up this invitation remains to be seen. But, even with some uptake, wholescale enterprise liability for independent physicians remains inconceivable in the short or medium term. More likely, continuing integration among facilities and professionals will diminish the practical importance of any major doctrinal reform regarding independent physicians.

7.5 CONCLUSION

This chapter presents several examples of tort law's ability to thoughtfully adapt to changes in health care delivery at a measured pace – a pace that does not attempt to anticipate changes before they become widespread but also does not lag too terribly far behind important changes. The new Restatement of Medical Malpractice dutifully reflects where such changes have already taken hold and points to other changes that are primed to occur or to become more mature. Considering how rapidly health care delivery has changed, tort law appears by this assessment to be performing acceptably well on the adaptability score.

In some respects, however, this assessment highlights challenges to tort law governing and shaping modern health care delivery. Because the DNA of tort law adapts to practices, structures, and norms as they are, it is not well suited to leading or pushing for reform. Because a Restatement is, at its core, a synthesis of existing doctrine rather than a law-reform enterprise, Restatements have very limited ability to force tort law to improve or modernize. Nevertheless, embedded in the Restatement are a number of key passages that point in potentially constructive directions that future evolution of tort doctrine might take. Other points of doctrinal rigidity, however, might require more overt law-reform efforts to overcome.

[38] § 15 cmt. i.