First, Do No Harm: 
The Cure for Medical Malpractice 
by Ira E. Williams

Evelyn YeaTyng Tang*

Introduction

In his book, First, Do No Harm: The Cure for Medical Malpractice,1 Dr. Ira E. Williams evaluates the major issues that are central to the current medical malpractice crisis. Armed with many disturbing medical malpractice statistics and anecdotes, Williams focuses his analysis on the medical field's responsibility for the malpractice crisis. Williams scrutinizes the past and present "band-aids" of medical malpractice such as tort reform, alternative dispute resolution, and a no-fault system, and in the end offers Individual Responsibility Peer Review as a "radical yet practical" solution.

Dr. Ira E. Williams is a retired oral and maxillofacial surgeon and dental anesthesiologist with over 40 years of medical profession experience. For several years, he served as chairman of the dental department and as a member of the dental staff executive committee at Methodist Hospital in Madison, Wisconsin. Williams also spent five years as a clinical instructor in the ear, nose, and throat, and plastic surgery departments at the University of Wisconsin Medical School and Hospital. In 1970, Williams held the first one-week surgical refresher course in oral and maxillofacial surgery, which has since become a common event throughout the country. Williams, who continues his volunteer work with cancer patients, earned his D.D.S. in 1963 from the University of Tennessee Dental School.

* Evelyn YeaTyng Tang is a candidate for J.D., 2007, Suffolk University Law School, Boston, Massachusetts; B.Sc., Physiology, McGill University. She may be contacted at evelyn.tang@suffolk.edu.

An Overview of Medical Malpractice

Since the 1970s, the number and cost of medical malpractice cases have drastically increased.\(^2\) The impact of these increases has wreaked economic havoc in the medical field.\(^3\) Before the 1960s, only one in seven physicians would be sued during his or her lifetime.\(^4\) However, by the mid-1990s, one in seven physicians would be sued per year.\(^5\) Although the increase in number of malpractice suits has been slowed by tort reform, diagnostic testing, improved peer review, and better communication between the doctor and patient, the amount claimed per suit has continued to grow.\(^6\) In 2004, hospital liability claim costs were expected to reach $150,000 per claim, up from $79,000 in 1996, and the average claim against a physician, $178,000, up from $120,000 in 1996.\(^7\)

Consequently, physicians' insurance premiums have skyrocketed.\(^8\) In 2004, the Congressional Budget Office reported that national average premiums increased by 15% from 2000-2002.\(^9\) The range of increase for some physicians, in 2002 alone, was between 40% and 112%.\(^10\) In January 2005, the Greater New York Hospital Association reported an increase by almost 150% in the cost of medical malpractice insurance since 1999, in New York City and neighboring counties.\(^11\)

Three major effects on the medical field have surfaced due to the number of medical malpractice claims, the increasing amount claimed, and the increasing cost of malpractice insurance.\(^12\) First, some doctors are refusing to perform high-risk

---

\(^2\) WILLIAMS, supra note 1, at 88; see Amanda R. Lang, A New Approach to Tort Reform: An Argument for the Establishment of Specialized Medical Courts, 39 GA. L. REV. 293, 295 (2004). See generally Insurance Information Institute, Hot Topics and Issues Updates: Medical Malpractice, at http://www.iii.org/media/hottopics/insurance/medicalmal/ [hereinafter Hot Topics].

\(^3\) Lang, supra note 2, at 295; see also Deborah L. Rhode, Essay: Frivolous Litigation and Civil Justice Reform: Miscasting the Problem, Recasting the Solution, 54 DUKE L. J. 447, 458 (2004).

\(^4\) WILLIAMS, supra note 1.

\(^5\) Id.

\(^6\) See Hot Topics, supra note 2.

\(^7\) Id.; see also Melissa C. Gregory, Recent Developments in Health Care Law: Note: Capping Noneconomic Damages in Medical Malpractice suits is not the Panacea of the “Medical Liability Crisis,” 31 WM. MITCHELL L. REV. 1031, 1032 (2005).

\(^8\) Lang, supra note 2, at 295; see also Rhode, supra note 3.


\(^10\) Rhode, supra note 3., at 458.

\(^11\) See Hot Topics, supra note 2.

\(^12\) Lang, supra note 2, at 293, 295, 296.
Second, doctors are more inclined to perform defensive medicine where more tests are ordered and unnecessary precautions are taken by doctors to protect themselves against litigation.\textsuperscript{14} Third, the quality of health care that doctors are providing to patients is decreasing.\textsuperscript{15}

In response to these negative effects on the medical field, President Bush, in his 2006 State of the Union Address, renewed his appeal to Congress to pass the medical liability reform bill that the House passed but Senate did not in 2005.\textsuperscript{16} The reform bill allows the victim of medical negligence to “collect full economic damages, 100 percent of the cost of their medical and recovery, plus economic losses for the rest of their life.”\textsuperscript{17} Non-economic damages such as punitive damages, however, are capped at $250,000.\textsuperscript{18}

The “blueprint” for the reform bill is MICRA, the Medical Injury Compensation Reform Act, enacted in California in 1975 to “limit the frequency and severity of malpractice claims.”\textsuperscript{19} Major features of MICRA include the limiting of

\begin{footnotes}
\item[14] William P. Gunnar, Is there an Acceptable Answer to Rising Medical Malpractice Premiums?, 13 ANNALS HEALTH L. 465, 476 (2004); see also Lang, supra note 2, at 297. In 1993, a study indicated that defensive medicine accounted for between five and fifteen billion dollars of unnecessary medical costs. Id.
\item[15] Lang, supra note 2, at 293, 295-96; see also Humphrey Taylor, No. 22: Most Doctors Report Fear of Malpractice Liability has Harmed their Ability to Provide Quality Care: Caused Them to Order Unnecessary Tests, Provide Unnecessary Treatment and Make Unnecessary Referrals, THE HARRIS POLL (Harris Interactive, Los Angeles, Calif.), May 8, 2002, available at http://www.harrisinteractive.com/harris_poll/index.asp?PID=300. In a 2002 survey by Harris Interactive, Inc., 76% of physicians reported that their concerns over malpractice litigation hurt their ability to provide quality care to patients. Id.
\item[17] Medical Liability Reform Release, supra note 16.
\item[18] Id.
\item[19] Catherine M. Sharkey, Unintended Consequences of Medical Malpractice Damage Caps, 80 N.Y.U. L. REV. 391, 394 (2005); see also Gunnar, supra note 14, at 484.
\end{footnotes}
attorney fees and a $250,000 cap on non-economic damages.\textsuperscript{20} Although some states have adopted damage caps using MICRA as a model, MICRA and damage caps are criticized for unconstitutionality under the equal protection and due process clauses of the Fourteenth Amendment.\textsuperscript{21} Further, whether damage caps are actually effective is still questionable.\textsuperscript{22} For example, the Congressional Budget Office has noted that “[caps] on non-economic damages and a ban on punitive damages...would lower health care costs by only about 0.4 percent to 0.5 percent, and the likely effect on health insurance premiums would be comparably small.”\textsuperscript{23}

Medical malpractice stems from the medical field, is regulated by the legal field, and has economic consequences. Thus, medical malpractice liability has been blurred into the jargons of Economics, Medicine and Law. Williams decodes this resulting confusion using simple straightforward language along with illustrative stories to address a broad audience, including the parties directly affected by the malpractice crisis.

**A Synopsis of “First, Do No Harm”**

*First, Do No Harm: The Cure for Medical Malpractice* addresses the topic of medical malpractice in terms of standards of care and responsibility.\textsuperscript{24} Williams discusses issues that include the attribution of responsibility for the current medical malpractice crisis; the contradiction that medical malpractice is a medical problem but the law establishes the standard of care; the current systems for appeasing the malpractice crisis; and the “cure” for medical malpractice.

Williams’ book is organized into three major sections, and addresses medical malpractice systematically from how malpractice occurs to possible solutions to the malpractice crisis. In each section, Williams supports his arguments with engaging anecdotes of malpractice, disquieting statistics, and hypothetical situations. For example, he supports his contention that Medicine is failing patients with the anecdote of a surgeon who inserted a screwdriver into a man’s spine to stabilize a disc injury because the required titanium rod was not available.\textsuperscript{25} Using this technique, the author

\textsuperscript{20} Gunnar, supra note 14, at 484.
\textsuperscript{21} Sharkey, supra note 19, at 394; see also Gunnar, supra note 14, at 484.
\textsuperscript{22} Gunnar, supra note 14, at 489. In a recent $70.9 million jury award in San Francisco, the jury awarded only $500,000 in non-economic damages; $70.4 million was awarded for economic damages. Id.; see also Sharkey, supra note 19, at 395.
\textsuperscript{24} WILLIAMS, supra note 1, at 1-22.
\textsuperscript{25} Id. at 1. A recent study by the Agency for Healthcare Research and Quality [hereinafter
commands the readers’ attention and keeps them interested.

In the first section, Williams explores the history of the medical profession from trial and error to specialized medicine, its systems of public and private health care, and its organizations such as the American Medical Association (AMA) and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).26 The author’s focus falls upon the responsibilities of Medicine as a profession. Like the legal profession, the medical field has a responsibility to self-regulate.27 However, despite alarming medical malpractice rates, organized medicine has failed to establish any standard of care.28 For example, Williams recounts a story where the medical community ultimately “protected their own,” refusing to enforce any medical standard of care or discipline against a negligent physician.29 The patient was only able to receive compensation for his injuries through litigation.30 Because Medicine does not self-regulate, the Law must set the standards and guidelines to regulate Medicine.31

Section two is an evaluation of the problems with the current peer review system. According to Williams, lack of professional education on the peer review process, physician avoidance of unpleasantness associated with exposing a negligent colleague, and the unwillingness of review committees and JCAHO to respond to malpractice are three major factors which contribute to the demise of the peer review system.32 The author further explores organized medicine’s track record of futile attempts to control malpractice through grievance committees and programs such as PADFRAME, PEP, and PROs.33 For example, Williams suggests that these attempts failed because the system deteriorated almost immediately after initiation, the factors considered in the system were irrelevant, and the execution of the system was so

AHROQJ found that sponges or medical instruments are left inside more than 1,500 surgical patients each year. Id.

26 Id. at 23-45.
27 Id. at 45.
28 Id. at 3.
29 WILLIAMS, supra note 1, at 8-21.
30 Id.
31 Id. at 52-53.
32 Id. at 90, 92, 96.
33 Id. at 114, 121, 122. PADFRAME, the Planning and Development Framework, was a short-lived framework and process developed by a collaborative effort between the University of Colorado Medical Center and the Denver Medical Society for the reorganization of medical societies to increase Medicine’s positive effects; PEP, Performance Evaluation Procedure, was initiated by JCAHO and is based on length of hospital stay; PROs, Peer Review Organizations, were created by the 1982 Peer Review Improvement Act to monitor the quality of care within Medicare. Id.
enormously wasteful that it was a "legislative folly."\textsuperscript{34}

In section three, Williams evaluates the "band-aids" such as tort reform, Alternative Dispute Resolution (ADR), and the no-fault system currently used to appease the malpractice crisis.\textsuperscript{35} According to Williams, these solutions are only temporary because they do not act directly on medical negligence—they are mere attempts to clean up the aftermath.\textsuperscript{36} Instead, the author proposes the solution of Individual Responsibility Peer Review ("IRPR") by advocating the theoretical advantages of the system and explaining the process in detail in the book's Appendix section.\textsuperscript{37}

\textbf{Attributing Responsibility for the Current Medical Malpractice Crisis}

There has been much debate over who is responsible for the current medical malpractice crisis.\textsuperscript{38} For instance, health care practitioners blame a more litigious society than in the past.\textsuperscript{39} It has become easier to litigate, to find counsel, and to research information over the internet.\textsuperscript{40} Juries have become desensitized to large claims made by patients suing for negligence.\textsuperscript{41} Additionally, increasing media coverage of malpractice cases has exposed the vulnerability of physicians to malpractice suits and increased public distrust of the medical field.\textsuperscript{42}

In his book, Williams argues that the litigious nature of society is not to blame for the malpractice crisis.\textsuperscript{43} He asserts that a patient's decision to sue a physician is difficult; a patient must have the available funds, extensive clinical evidence of malpractice, a qualified medical expert, and many other components of the lawsuit.\textsuperscript{44} The author reminds the reader that in many cases, most of the monetary award covers

\textsuperscript{34} WILLIAMS, \textit{supra} note 1, at 121-122.
\textsuperscript{35} \textit{Id.} at 130-141.
\textsuperscript{36} \textit{Id.} at 132.
\textsuperscript{37} \textit{Id.} at 142-164, 174-197.
\textsuperscript{38} WILLIAMS, \textit{supra} note 1, at 109, 111; Lang, \textit{supra} note 2, at 302.
\textsuperscript{39} WILLIAMS, \textit{supra} note 1, at 109, 111; Lang, \textit{supra} note 2, at 302; Hot Topics, \textit{supra} note 2.
\textsuperscript{40} WILLIAMS, \textit{supra} note 1, at 109, 111; Lang, \textit{supra} note 2, at 302; Hot Topics, \textit{supra} note 2.
\textsuperscript{41} See \textit{Hot Topics, supra} note 2. According to research from Jury Verdict Research (JVR), although jury awards are stabilizing, the award range is climbing. \textit{Id.} From 2000-2002, the average jury award was around $1 million, ranging from $11,000 to $95 million. \textit{Id.}
\textsuperscript{42} See \textit{Hot Topics, supra} note 2. Media coverage disproportionately focuses on cases that have verdicts 4 to 34 times the average verdict. \textit{Id.; see also} Rhode, \textit{supra} note 3., at 464. Cases with exceptional recoveries or frivolous claims are also more memorable. \textit{Id.}
\textsuperscript{43} WILLIAMS, \textit{supra} note 1, at 3.
\textsuperscript{44} \textit{Id.} at 73-74.
little more than the legal expenses of the patient.\textsuperscript{45} Williams is not alone in the argument against society’s litigiousness. Research has indicated that “mass media claims that Americans will sue at the drop of a hat are false.”\textsuperscript{46} In fact, a Harvard study found that seven times as many patients are victims of malpractice as have filed a claim.\textsuperscript{47}

Instead, Williams blames health care practitioners for the current medical malpractice crisis.\textsuperscript{48} The author contends that the negligent medical practitioner ultimately delivers the substandard service, yet the medical field cannot, or will not, control medical malpractice without litigation.\textsuperscript{49} The Institute of Medicine of the National Academy of Sciences has estimated that 98,000 people die each year from medical errors occurring in accredited hospitals; twice as many as die in traffic accidents.\textsuperscript{50} The author points out that despite this prevalence of medical malpractice, the medical field has not required any standard of care and instead passes off this responsibility to the legal field.\textsuperscript{51}

An interesting proposition that Williams does not consider is the suggestion by many health law scholars that advances in technology have created more opportunity for malpractice.\textsuperscript{52} For example, Peter D. Jacobson, a professor of law and public health at the University of Michigan, suggests that the malpractice crisis may be linked to the light speed evolution of technology.\textsuperscript{53} The first medical lawsuits occurred between 1820 and 1850, fueled by technological advances in the treatment of bone fractures.\textsuperscript{54} Since then, this pattern of an “advancement creating an opportunity for injury” and suing when the advance fails has prevailed.\textsuperscript{55} The American “culture of technology” fosters extraordinary expectations for technology’s “healing powers.”\textsuperscript{56} For the physician, this means a pressure to use the new technology before adequate preparation, which may result in more incidents of negligence.\textsuperscript{57}

\textsuperscript{45} Id.
\textsuperscript{47} Id.
\textsuperscript{48} WILLIAMS, supra note 1, at 24, 45.
\textsuperscript{49} Id. at 73, 74.
\textsuperscript{50} Id. at 74.
\textsuperscript{51} Id. at 4, 52-53.
\textsuperscript{53} Id.
\textsuperscript{54} Id.
\textsuperscript{55} Id.
\textsuperscript{56} Snowbeck, supra note 52.
\textsuperscript{57} Id.
Therapy Versus Cure: Setting the Standard of Care

Tort reform, ADR, and a no-fault system like the one used in automobile accidents and divorce are only some of the systems that various states have used in attempts to ease the medical malpractice crisis. Williams, however, asserts that these systems are merely temporary "band-aids" because they cannot directly act upon the individual negligent practitioner with the effectiveness and efficiency that a medical standard can.

Williams urges that the only permanent solution for the malpractice crisis is for the medical community to self-regulate and discipline themselves through established medical standards of care. As a profession, the medical field is obligated to establish and enforce guidelines and standards for its members. In turn, each member is obligated to abide by these requirements and identify those who do not. The author contends that there is no self-regulation, no discipline, and no accountability in the medical field. For instance, Williams points out that the standard of care in many state statutes is "one used by a reasonably prudent practitioner"—a legal standard. Not only is this standard so vague it is meaningless, it has been developed by a [legal] field that has "very little knowledge about the practice of medicine."

The medical field, however, has been extremely reluctant to set a standard of care. The AMA has maintained in dictum that it is impossible to set one standard of care for any form of medical treatment. Each patient is different, and therefore the treatment varies. Although Williams concedes that there may be more than one technique for a medical procedure, he holds that two important imperatives can still be held constant in the standard of care, that: (1) the technique must be current and

58 WILLIAMS, supra note 1, at 134-135.
59 Id. at 130, 132-141.
60 Id. at 135.
61 Id. at 42.
62 WILLIAMS, supra note 1, at 42.
63 Id.
64 Id.
65 Id. at 24.
66 WILLIAMS, supra note 1, at 47. Some medical practitioners suggest that uncertainty cannot be separated from standard setting because it involves development, dissemination, application, and enforcement. Id.; see also Matt DeChamp, Editorial, Ethics in Standards of Care: The Joy of Doctoring, 6 VIRTUAL MENTOR (American Medical Assoc., Medical Ethics group, Chicago, Ill.), December, 2004, available at http://www.ama-assn.org/ama/pub/category/14276.html. At some level these four processes require good judgment, which in and of itself, involves uncertainty. Id.
67 WILLIAMS, supra note 1, at 47.
acceptable and, (2) the technique must be judged necessary based on the entire diagnosis, treatment plan, actual procedure, and follow-up.68

The AMA is also reluctant to establish national, over local, standards of care, since historically, rural doctors had less access to information regarding new techniques and equipment than urban doctors did.69 Although Williams argues that this disparity no longer exists, the federal government has recently considered reallocating residency slots to relieve doctor shortages in States such as Montana (2 medical residents/100,000 people) versus States such as New York (78 medical residents/100,000 people).70 It is difficult to imagine that despite such uneven distribution of physicians, there is no longer a disparity in funding, facilities, and accessibility to new techniques and equipment.

Set the Standard, Now What?

In his book, Williams contends that after the standards of care are established, they need to be enforced, and a good system of enforcement is through medical peer review.71 The medical peer review system, where a committee of physicians evaluates the performance of a fellow physician, dates back at least 50 years.72 Medical peer review “encompasses a wide range of professional activities, including the informal, collegial oversight and interaction that occur within medical group practices and hospital medical staffs.”73 Quality assurance, “an independent function of peer review,” serves to identify and control the negligent health care practitioner.74

As Williams suggests, although the medical peer review process exists and is actually required by Medicare and JCAHO, peer review has been ineffective in battling

68 Id. at 50.
69 Id. at 53.
71 WILLIAMS, supra note 1, at 90-93.
74 Id.
the malpractice crisis. First, physicians face impediments in the peer review process that include “fear of subsequent personal lawsuits, the effect on referrals, [and] the lack of compensation for participating physicians.”

Second, as of 2005, all but two states have statutes that protect the peer review participants and documents from potential liability. This privilege and immunity from potential liability contradicts and undermines the goal of the peer review process—to single out and discipline the negligent health care practitioner.

Third, the lack of uniformity among peer review programs and the statutes that regulate them cause confusion over whether protection under the programs exists and to what extent.

Fourth, no official body has conducted an “exhaustive study” to examine whether the peer review process actually works. Just because the process is required and exists does not necessarily mean that cases of malpractice will go through peer review.

Still, Williams contends, the framework for the solution to the malpractice crisis exists; all that needs to be added are some “teeth.” The author proposes, as an upgraded system, Individual Responsibility Peer Review (IRPR). Under IRPR, practitioners review themselves as a part of a systematic routine. Practitioners are held against standards of care they create for themselves for each procedure they practice.

---

75 See id.; Randall R. Bovbjerg & Laurence R. Tancredi, Liability Reform Should Make Patients Safer: “Avoidable Classes of Events” are a Key Improvement, 35 J.L. MED. & ETHICS 478, 478 (2005); WILLIAMS, supra note 1, at 99.
77 David L. Fine, The Medical Peer Review Privilege in Massachusetts: A Necessary Quality Control Measure or an Ineffective Obstruction of Equitable Redress?, 38 SUFFOLK U. L. REV. 811, 811 (2005). Congress has indicated support of this protection even though it is not “unequivocally” recognized by federal courts. Id.
78 Id.
79 Id.
80 Id.
81 See Bovbjerg et al., supra note 75, at 478.
82 WILLIAMS, supra note 1, at 135.
83 Id. at 143.
84 Id.
85 WILLIAMS, supra note 1, at 148.
Deviations from the standards could result in temporary suspension or a review of the physician’s entire practice. Ideally, practitioners would keep current and update their training as necessary, and be more cautious during each procedure as they now know exactly what standard of care they are being held against. Through IRPR, the medical field would be able to regulate and discipline practitioners from within the profession with very little legal participation.

Although Williams details his IRPR system very well, he does not address some very important issues such as the means required to support IRPR and if IRPR can actually work. First, Williams does not consider the extra time that medical practitioners must invest to execute the IRPR system. This is not simply a question of hours; medical practitioners must take the time to set their own individual standards, regularly review themselves, and deal with all the related paperwork. As it stands, physicians are already being overworked, and with dire consequences. In a recent Harvard Medical School study reported in the New England Journal of Medicine, physicians were found to work on-call shifts averaging 32 hours. Half of those physicians worked between 81 and 140 hours per week. In any month, each extended work shift increased the chances of a car crash by 15% on the physician’s commute home. If physicians are so overworked that they cannot be trusted to drive home safely, it is questionable whether they may be trusted to abide by a set standard of care.

Second, Williams does not address the likelihood that each practitioner will commit to the objective standards that they set. Williams states, “[i]n more than ten years of intense involvement regarding negligent care, I [Williams] never saw any practitioners participating in a peer review show the slightest concern for the patient... [t]heir concern was always for their colleague.” Thus, it is unlikely that anything will change under IRPR, especially when under IRPR the practitioner himself is the colleague.

86 Id. at 183.
87 Id. at 144.
88 Id. at 147. Williams does suggest that a strong medical entity such as the Mayo Clinic or Harvard can mandate such a system, admitting that implementing IRPR will be costly and require influence. Id.
90 Id.
91 Id.
92 Id.
93 WILLIAMS, supra note 1, at 168.
Third, Williams does not discuss alternative solutions to IRPR in the case that the medical field cannot or will not set a medical standard of care. Specifically, "enterprise liability" may be the most appropriate system to appease the malpractice crisis. In the "enterprise liability" approach, liability for medical injuries is shifted from individual health care practitioners to the organizations that they work for. "Enterprise liability" stems from the newer "patient safety" movement which realizes that practitioners make mistakes because they are human, not necessarily because they are insufficiently trained or incompetent. Thus, the rationale behind "enterprise liability" is that although individuals cannot be expected to perform perfectly all the time, systems may be brought closer to perfection.

A desirable effect of the shift of liability is that physicians may fear personal liability less and would be more inclined to report medical errors. After the error has been reported, the contributing factors may be identified, and new safeguards may be enforced to improve a hospital’s health care system processes. The Institute of Medicine has reported that there is some isolated success of "patient safety" innovations in anesthesia, drug errors, and post surgical infection. The most persuasive empirical evidence, however, comes from areas other than medical malpractice. Thus, more research still needs to be done to investigate the effects of "enterprise liability" in the medical field.

Conclusion

Williams engages the reader with horrifying statistics and anecdotes of medical malpractice, thus effectively conveying that there is a medical malpractice crisis. For

---

95 Id. at 370, 376. "Enterprise liability" stems from the newer "patient safety" movement which realizes that practitioners make mistakes because they are human, and not necessarily because they are insufficiently trained or incompetent. Id.
96 Id.
97 Id.
98 Bovbjerg et al., supra note 94, at 370. Practitioners should be punished for "ignoring a clear and important rule," not for ordinary human error; practitioners should be "praised, not chastised," for reporting medical errors. Id.
99 Id.
100 Id. at 373.
101 Id. Under "enterprise liability," workplace fatalities decreased from 38 per 100,000 workers in 1930 to 4 per 100,000 workers in 1995. Id.
102 WILLIAMS, supra note 1, at 3.
example, Williams’ cites that 98,000 patients every year are killed by medical errors in accredited hospitals—twice the number of people who die in traffic accidents. However, Williams could have benefited the reader more by evaluating the weaknesses of IRPR, responding to those weaknesses, and addressing alternative solutions such as “enterprise liability.”

The attractiveness of Williams’ solution, however, is not in the IRPR system that he discusses in only about ten percent of his book. The utility in his solution lies with where Williams identifies the malpractice crisis problem to be. If a physician’s negligence can be “cured,” there will be fewer malpractice claims and the malpractice crisis will be appeased. First, Do No Harm: The Cure for Medical Malpractice is thought provoking and generally educational in the area of medical malpractice. This book is well-tailored for the general public interested in the medical malpractice crisis and for practitioners and students within the medical and legal fields.

103 Id.