Chapter X

MALPRACTICE REFORM: FIVE STEPS TO LIABILITY BY CONTRACT

In the mid-1980s, University of Chicago law professor Richard Epstein argued for replacing the tort-law malpractice system with a system in which liability would be determined by contract.[1] One drawback of Epstein's proposal was the lack of an institutional mechanism that would make such contracts palatable. As explained below, courts have been reluctant to accept contracts signed in the hospital admissions office, let alone in the emergency room, as a true meeting of the minds.

In 1993, Emory University professor Paul Rubin extended Epstein's idea by describing a reasonable institutional environment for contracts.[2] Insurance companies would contract with providers and then offer people insurance governed by different legal regimes. In return for waiving the right to sue for pain and suffering and settling for economic damages only, people would be able to purchase lower-priced insurance.

While Rubin's contribution is important and moves in the right direction, it does not go far enough. In general, market-based (contract) solutions should be encouraged for all medical malpractice claims — both economic and noneconomic. The following discussion shows how most malpractice issues could be resolved better in the marketplace.

Step No. 1: Reform the Tort System.

A reformed tort system is one that is governed by the 10 principles of a rational tort system, discussed above. This is the default system, and all cases of malpractice will be tried in this system unless patients and providers contract out prior to the occurrence of the alleged malpractice.

Step No. 2: Free the Patients.

Under the traditional system, most hospitals and doctors ask their patients to sign a form at the time of treatment releasing the provider from any legal liability in case of negligence. In malpractice suits, the defendants point to the form and claim the plaintiff (victim) has waived her right to sue by contract, as a condition of treatment. Courts have routinely dismissed such arguments, however, on the grounds that they do not really constitute informed consent. After all, how can a patient who is ill, frightened and intimidated by the health care system make rational decisions about complex legal liability issues?

The position of the courts is understandable, but it has had an unfortunate side effect: Doctors and patients are unable to avoid the costs of the malpractice system through any contract whatsoever. In other words, we have thrown the baby out with the bathwater.

How can the system give patients and doctors other options, while at the same time protecting patients from making unwise decisions when they are least able to negotiate contracts? One answer is for the legislature

(or a body designated by the legislature) to decide in advance what will constitute an enforceable contract. Patients would not be required to agree to such contracts as a condition of treatment; however, if they voluntarily signed the agreement, it would be binding.

Here are some provisions that should be considered for inclusion in such contracts.

Compensation without Fault. This provision obligates the provider to compensate the patient (or family of the patient) in the case of unexpected death or disability. In the case of an unexpected death, the amount could be set in advance and generally known to all patients. In the case of an unexpected disability, the contract might use the provisions of the state Worker's Compensation system — reformed along the lines outlined in Chapter VIII.

How much compensation should be paid in the case of an unexpected death? Any number would be somewhat arbitrary. The amount could be varied by patient characteristics, including the patient's age, the age of any surviving spouse and children, the patient's income and so forth. In other words, the amount could be based on some of the same criteria the current malpractice system uses — but without judges, jurors, lawyers and courtroom costs.

Other factors the current system ignores could be considered. For example, the existence of social insurance programs is relevant here — including workers' compensation, Social Security retirement and survivor's insurance. For disabilities, the existence of Social Security disability insurance, as well as Medicaid and Medicare, would be considered. Either the amount of compensation should be reduced by the existence of collateral social insurance benefits, or part of the compensation should go to government agencies to defray the added costs to them of the unexpected death or injury.

Adjustments for Risk. Not all medical cases are the same. Even if the probability of an unexpected death is low, complications in one patient

may create risks twice as high as for another. There must be a way of adjusting for this, or providers would try to avoid all the harder cases. One possibility is to reduce the amount of compensation for the riskier patient. A more attractive alternative is to ask the patient (or the patient's health insurer) to pay the extra premium needed to insure the event. (See the discussion below.)

Full Disclosure. As a condition of waiving the patient's legal rights to pursue liability claims under traditional tort law, providers should be required to make certain quality information public. For routine surgeries, for example, hospitals and doctors should post (case-adjusted) mortality rates, readmission rates, hospital acquired infection rates and so forth. Providers should also be required to disclose the use of safety measures, including electronic medical records, computer software designed to reduce errors and procedures designed to prevent hospital acquired infections. Additionally, in the case of unexpected death or disability, providers should be required to fully disclose all facts to appropriate investigative bodies so that steps can be taken to prevent future recurrences.

The patient should also be required to provide full disclosure. Even such routine information as when the last meal was consumed or what other drugs are being taken, if undisclosed, can lead to adverse medical outcomes.

Patient Compliance. Even for simple surgery, patients must comply with certain provider directives, including diet restrictions, full disclosure of medications being taken and so forth. For maternity cases, compliance in the form of prenatal care is more involved and extends over a longer period of time. Failure to comply in all these cases would result in a reduction in the amount of compensation and perhaps no compensation at all.

Additional Insurance Options. As explained above, legislatures will set minimum requirements for liability contracts. In most cases, insurance companies will then insure those contracts. However, once premiums for a doctor, patient and procedure are set, patients could increase the coverage

by paying an additional out-of-pocket premium. For example, if the legislature requires a minimum payout of $500,000 for an unexpected death, and the providers have to pay $X of premium for the insurance, patients should be able to pay an additional $X to obtain $1 million of insurance coverage (or any other multiple).

These are only a few provisions that seem reasonable. Other people will no doubt think of additional items. The list should not be long, however. If too many burdens are placed on the contract, there will be no contracts. The reason for the restrictions is to promote good social policy and avoid unconscionable outcomes.

Advantages. A liability-by-contract system along these lines would have a number of compelling advantages, including the following:

Advantage No. 1: Insurers rather than patients would become the primary monitors of health care quality.

Under this proposal, a great deal of quality information would be available to patients that is currently unavailable. However, patients would not be the primary monitors of quality. That role would fall to insurers. If doctors could escape the costs and burdens of the liability system by compensating patients for unexpected outcomes, they would naturally want to insure against such payments. So instead of buying malpractice insurance, they would be purchasing what amounts to short-term life insurance on all patients, say, undergoing surgery.

In the current system, there are no life and disability insurance products specifically tied to episodes of medical care. However, if the contract system becomes widely used, such products are likely to emerge.

As noted above, under the current system there is very little relationship between actual malpractice and malpractice lawsuits. As a result, malpractice premiums do not reflect the likelihood that doctors will commit malpractice. Instead, premiums reflect the likelihood that doctors will be sued. Under the liability-by-contract system, however, compensation

would be based on objective phenomenon, that is, death and disability. In pricing these policies, insurers would have a strong interest in monitoring how doctors practice medicine. The market, rather than bureaucratic bodies, would determine who is a good surgeon and who is a bad one, and those determinations would be reflected in insurance premiums.

Advantage No. 2: Medical providers would face strong financial incentives to improve quality.

In addition to the fact that malpractice premiums are not closely related to the actual incidence of malpractice, premiums charged to doctors rarely reflect the quality of medicine being practiced.[3] In the reformed system, insurance premiums should be closely related to actual outcomes. Surgeons with high mortality rates will pay higher premiums to insure against unexpected outcomes, other things being equal. These higher premiums, in turn, will constitute a strong financial incentive to find safer ways to perform surgery.

Advantage No. 3: Multiple parties on the medical side would have strong incentives to cooperate in improving quality.

Under the current system, a patient undergoing surgery typically is not dealing with a single doctor who is responsible for the entire procedure. Instead, the patient is (implicitly) contracting with several doctors, each as an independent contractor. For example, there is the surgeon, the anesthesiologist, the radiologist, the pathologist and the hospital itself. Because each of these entities is independent of the other, none bears the full cost of his or her bad behavior and none reaps the full benefits of good behavior.

Some have proposed making the hospital fully responsible for all malpractice claims. But that doesn't work very well when none of the other parties to the medical incident are hospital employees. Under the proposal envisioned here, all parties to a surgical event, for instance, would have strong incentives to contract with each other and cooperate with each other on error-reducing, quality improving changes (including electronic medi-

cal records and hospital infection reduction procedures). The incentives would be to avoid the current tort system, to offer the patient a contract insured by a single insurer and to minimize the cost of that insurance.

Advantage No. 4: Patients will receive cash compensation for unexpected outcomes without the stress or expense of a lawsuit.

The loss of a loved one is a traumatic event. The prospect of filing a malpractice lawsuit is also inherently stressful and traumatic. A better way of facing grief is to be given a check, without the need to talk to doctors or lawyers and endure unpleasant confrontations with an opposing party in litigation. The compensation system envisioned here would put doctors and patients on the same side, with only one obligation — completing the paperwork needed to collect from an insurance company.

Advantage No. 5: Patients and their families could self-insure for additional compensation.

How much should a surviving spouse receive for the death of a loved one? The decision will, to a certain extent, be arbitrary — especially if made by a legislative body. However, if the amount is publicized in advance and broadly known, families can make adjustments to meet their expected needs. If the amount is too low, for example, families could buy additional life or disability insurance on their own — including (as described above) insurance under the provider's insurance contract.

Advantage No. 6: The social cost of a liability-by-contract system is likely to be much lower than the cost of the current system.

As noted above, according to the Institute of Medicine, as many as 98,000 people die each year because of errors and mistakes in our health care system — primarily in hospitals.[4] We also acknowledged that the estimate is probably excessively high. But suppose, for the sake of argument, we accept it; and suppose that the surviving family members of these patients each received a check for $500,000.[5] The total cost would be less than $50 billion. To put that number in perspective, note that the total cost of the

current malpractice system is estimated to be as much as $200 billion, or four times as much.[6] If the average compensation were $250,000, the total cost would equal one-eighth the cost of the current system.

Moreover, the current system involves a huge use of real resources — lawyers, judges, court rooms and so forth. By contrast, the check-writing solution involves very few real resources — other than monitoring and administration costs; it primarily involves moving money from some people to others, leaving real resources to be used in more productive ways.

Further, if hospitals were required to pay $500,000 per unexpected death, on the average, the health care system would not continue to sustain 98,000 deaths from medical errors each year. Hospitals would quickly find ways of reducing their error rates.

Advantage No. 7: Health care costs for patients would likely be reduced.

Ultimately, the cost of any compensation system primarily will be paid by patients and potential patients. Just as the cost of malpractice premiums is embedded in the patients' cost of care, the cost of a liability-by-contract system will also be passed on to patients (and their insurers) in the form of higher prices. However, if the proposed system is socially more efficient, patients will see an overall reduction in health care costs (as well as an increase in quality and better personal protection against untoward events).

Advantage No. 8: Liability by contract is a socially better way of handling sympathetic cases.

Some of the most heart-wrenching cases in malpractice law involve newborns facing the prospect of a lifetime of care. Even if the doctors and hospital personnel committed no error, the parents are confronted with an enormous burden — in terms of both time and money. The tendency on the part of jurors, therefore, is to have great sympathy for the plaintiffs. One reason OBGYN malpractice premiums are so high is that the system is inching ever closer to a system of liability without fault. But if this is the

case, why not move there directly and dispense with the lawyers, judges and juries? The reformed system would take care of the sympathetic cases in an efficient, responsible way.

Step No. 3: Free the Doctors.

A system of liability by contract will not work in all cases. Many patients have a high probability of death or disability. Doctors are unlikely to want to pay the cost of those adverse outcomes, and it would be unreasonable to expect them to do so. Further, when patients seek care at emergency rooms, no one has time to evaluate the likelihood of death or permanent injury prior to the delivery of care. Even in these cases, however, an alternative to the current system would seem to be desirable.

Accordingly, medical providers who offer their patients the opportunity to escape the current malpractice system by contract should have the chance to escape the system themselves in cases where contracts are impossible or impractical. In particular, these providers would be able to insist as a condition of treatment that all malpractice claims must be submitted to binding, unappealable arbitration. (The exception would be cases of gross negligence, discussed below.)

Two questions immediately arise: Who would the arbitrators be? What criteria would they use to make decisions?

Many people already serve as arbitrators, including former judges. They are selected and agreed upon by plaintiff lawyers and defense lawyers in cases where the parties want to avoid the costs, burdens and risks of trial by subjecting their cases to a respected, impartial third party. Since these arbitrators are already in the business and have reputations for integrity and good judgment, they are an ideal source for malpractice arbitration.

If there is a shortage of suitable arbitrators, other options exist. For example, a case could have two arbitrators — one with a history of representing plaintiffs, the other with a history of representing defendants.

The two arbitrators must agree on a final resolution; if they cannot agree, neither gets paid and two more arbitrators replace them.

What criteria should arbitrators use in deciding cases? Basically, it is the same criteria that would be relevant in a reformed tort system. However, unlike the liability-by-contract system, here the paramount issue is one of fault. Doctors (and their insurers) pay nothing unless they are found to be at fault, and the amount they would pay would be based on the degree to which they are at fault.

As in the case of liability by contract, doctors would be freed from the burden of the traditional malpractice system, provided they do certain things. For example, they must make their quality data available to all patients; they must cooperate with all safety bodies; and they must (in arbitration cases) make all relevant data available to the patient without costly discovery.

Step No. 4: Free the Experts.

All too often, expert witnesses in tort cases are "hired guns." The same witnesses appear time and again for one side or the other. They are selected as witnesses precisely because their testimony can be counted upon to be overly generous to one of the two sides. Further, these witnesses are often handsomely paid, which gives them an incentive to continue the practice and become "professional witnesses."

These witnesses would have no role in a properly run system of arbitration. The arbitrators would be free to call on real experts who would be agents of the arbitrator rather than agents of one of the two parties.

A model for the arbitrators is the so-called "vaccine court," a branch of the U.S. Court of Federal Claims in Washington. The vaccine court was created in 1986 as Congress' response to a liability crisis. In rare cases, vaccines were being blamed for catastrophic injuries and even death. Manufacturers were threatening to quit the business, which in turn threat-

ened the vaccine supply. The National Vaccine Injury Compensation Act shielded the industry from civil litigation by instituting a system of no-fault compensation. Under the law, aggrieved families file petitions, which are heard by special masters in the vaccine court. Successful claims are paid from a trust fund fed by a 75-cent surcharge per vaccine dose. The U.S. Department of Health and Human Services oversees the fund, with the Justice Department acting as its lawyer.[7]

Step No. 5: Free the Courts.

The reformed system described above should be available in all cases except gross negligence. Medical practitioners should be able to contract away responsibility for mistakes. They should also be able to insure against the consequences of their mistakes. There seems to be no socially defensible reason, however, to allow them to contract out of the consequences of gross negligence.

Notes

1 Richard Epstein, "Medical Malpractice, Imperfect Information, and the Contractual Foundation for Medical Services," *Law and Contemporary Problems*, Vol. 49, No. 2, spring 1986, pages 201-212.

2 Paul H. Rubin, *Tort Reform by Contract* (Washington, D.C.: American Enterprise Institute, 1993).

3 Malpractice insurance premiums are commonly community rated, meaning all physicians in a particular specialty or geographic area pay the same rate. Community rating shifts the cost of errors (higher premiums) and the financial reward of avoiding errors from the individual to the group. This reduces the financial incentive of doctors to invest in quality-improving measures (such as electronic medical recordkeeping).

4 Linda T. Kohn, Janet M. Corrigan and Molla S. Donaldson, *To Err is Human: Building a Safer Health System* (Washington, D.C.: National Academy Press, 1999).

5 As noted above, not every patient should receive the same amount of money.

6 In making this comparison, we are temporarily ignoring the cost of nonfatal malpractice injuries.

7 The vaccine compensation law requires that petitions be filed within three years of the first sign of injury. Under the law, petitioners who have gone more than 240 days without a ruling in the vaccine court can opt out and file a civil suit. More than three dozen families who've waited long enough have opted out, and more are sure to follow.