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The U.S. Medical Malpractice System: Issues, Perspectives and Alternatives

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The commonly accepted notion that "you can't place a dollar value on a human life" has ironically resulted in multimillion-dollar medical malpractice judgments against doctors, driving many out of business and creating acute shortages in some areas of the United States, especially in high-risk specialties, such as obstetrics.

The current practice of obstetrics resembles a game of Russian roulette, with modest rewards, accompanied by the ever-present threat that the next pregnant woman in the delivery room holds the loaded chamber with a defective baby or high-risk delivery that endangers the mother's life and the doctor's career.

But if it's true that "you can't place a dollar value on a human life," then shouldn't doctors also be rewarded with similar multimillion-dollar bonuses for intervening and saving a life? How would the health care system work if the incentives for patients, doctors, lawyers and juries were reversed? Since patients contend—and juries eagerly agree—that one cannot place a dollar value on a human life and the burdens of pain and suffering are incalculable, should doctors be equally—and disproportionately—rewarded when they save a life or relieve physical pain and suffering?

If the incentives were reversed, obstetrics would be equivalent to a high-stakes lottery where doctors could buy as many tickets as they wanted, and be virtually assured of hitting a multimillion-dollar payoff at some point in their career, just as lawyers do today. These two extremes illustrate one of the great economic and legal mysteries of our age. Why does the U.S. legal system prevent patients and doctors from entering contracts to exchange money for vital goods and services?

Actuarial and Economic Factors

From the actuarial and economic perspectives, there are multiple problems with the medical malpractice system in the United States, including:

- ***Risk Assessment:*** *estimating the inherent risk of the insured entity to determine the insurance premium.* Patients with complex and dangerous conditions that pose greater medical malpractice liability risk are not charged proportionally higher fees by doctors.

- ***Insurable Interest:*** *where insured parties have invested the equivalent of the economic value of the items they purchase insurance for.* Patients make no defined investment in their health (such as when they buy insurance for a house or car they own), nor do they place a predetermined value on their health (such as when they purchase life insurance to cover their financial obligations).

- ***Morale Hazard:*** *when insured parties lack incentives to take reasonable precautions to prevent losses they are insured for.* Patients are often noncompliant and exhibit self-destructive behaviors that undermine the best efforts of doctors to treat them.

- ***Incompetent Decision Mechanism:*** *when judges and juries make the wrong decisions because they are unable to assess the facts.* Jurors, who have been selected specifically for their lack of medical knowledge, decide innocence or guilt and award monetary damages.

- ***Depreciation and Inevitable Failure:*** *when the natural inevitable outcomes of disease and death are bundled with the potential man-made risks of medical malpractice.* While people recognize that some babies will be born with genetic defects and that everyone will die, the practice of medicine and the law often ignore these realities. Car owners rationally accept these facts when repair costs exceed the value of the vehicle. Aging,

disease and death are ultimately beyond the powers of medical science and inevitable for everyone. Emotionally, people don't think of human life this way, even if logically they know they should.

- ***Moral Hazard:*** *when insured parties have an incentive to engage in malicious destructive behavior to profit from the proceeds of their insurance policies.* The practice of medicine dictates that the best heart surgeon in town should attract the most difficult and severe cases. However, the medical malpractice system provides increasing pressure to avoid them and the additional malpractice risks they pose.

Notice that none of these insurance problems are solved by reversing the incentives in the mirror-image scenario, except that doctors—instead of lawyers—would be chasing ambulances. (Presumably, patients in ambulances have a more pressing need for a doctor than for a lawyer.)

Dilemmas for Doctors

Dr. Shelby Wilbourn, an OB/GYN in Las Vegas, Nev., faced a doubling of his malpractice premiums, causing him to move across the country, where his premium dropped by more than 90 percent.[1] For the privilege of delivering 200 babies in 2002, his malpractice insurer charged him $56,000, or $280 per delivery, equating to a 20 percent surcharge. This would have jumped to $108,000, $540 per delivery, or a 40 percent surcharge in 2003.

Since patients never see malpractice premiums itemized on medical bills, to understand this from the customer's perspective, imagine paying $25,000 for a new car, only to have the salesman say, "for an extra $10,000, we'll guarantee that it works." Like having a baby, the cost of the warranty contract (malpractice insurance) for a new car is included in the purchase price. However, few products or services have warranty costs that approach even 5 percent of the purchase price, let alone the 40 percent malpractice tax on having a baby in Las Vegas. In the auto industry, the standard three-year warranty comprises less than 1.5 percent of the cost of the vehicle for Japanese automakers, and about 3 percent for U.S. automakers.[2]

Dr. Wilbourn was sure his malpractice premium was grossly overpriced, but he didn't know what the market price should be. Even worse, actuaries responsible for calculating the cost of his malpractice premium don't know what that price should be either, because incompetent and unpredictable juries compound the risk assessment problem.

Alternatives

The basic actuarial calculation for an insurance premium is the *odds of an event occurring* multiplied by the average *value of the loss*. The problem for actuaries is that both of these previously predictable variables have become unpredictable. First, when juries make the wrong decision by routinely assigning fault to the doctor—irrespective of the facts—actuaries are unable to calculate the true *odds of an event occurring* for the risks they are attempting to price. Second, when juries assess randomly large and unrealistic damages with their guilty verdicts, actuaries don't know what amount to use for the *value of the loss* for the second variable in their equation. Thus, a reasonably stable system of predictable outcomes is transformed into an unstable system of unpredictable outcomes.

Increasing the *odds of an event occurring*, or increasing the *value of the loss*, will naturally increase an insurance premium. This is exacerbated by another actuarial principle which holds that increased uncertainty further increases insur-

[1] "Fed-Up Obstetricians Look for a Way Out," by Rita Rubin, *USA Today*, June 30, 2002: *http://www.usatoday.com/news/health/healthcare/2002-07-01-malpractice.htm.*

[2] "Auto Warranty vs. Quality," *Warranty Week,* June 20, 2006: *http://www.warrantyweek.com/archive/ww20060620.html.*

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ance premiums. The less certain an actuary is about either the odds of an event occurring or the value of the loss, the higher the premium should be. In other words, premiums for incompetent predictable juries will be lower than premiums for incompetent unpredictable juries.

One alternative to our current medical malpractice system frequently discussed is a no-fault, "bad outcomes" insurance policy purchased by the patient prior to surgery to protect her financially from an undesirable result. It exists today in the form of flight insurance, where the customer purchases a policy prior to traveling for a predetermined amount at risk. It appears to solve all six problems with the medical malpractice system by assigning values to the two primary insurance variables, which the patient consents to pay.

Travelers purchasing flight insurance assess their risks in advance when they buy the policy. They define their insurable interest, paying proportionally more for higher levels of coverage. There is no morale hazard because airlines don't know who purchased flight insurance. The incompetent decision mechanism is eliminated, because the question is no longer, "Who was at fault?" but rather, "Did the passengers arrive safely?" The inevitable failure of death is acknowledged and valued in advance, and the moral hazard is removed because travelers cannot affect the outcome of the flight, and thus contract disputes rarely result.

With no-fault bad-outcomes malpractice insurance, patients define in advance how dearly they value their life and health and how much a bad outcome is worth to them. Actuaries have ample statistics on maternal and infant mortality rates to calculate reasonably accurate and competitive premiums with a high degree of confidence. Insurers will charge arithmetically more for policies with a higher face value, and exponentially more for policies covering patients with high-risk pregnancies versus routine ones.

The cost of the risk of the patient's condition is properly transferred from doctors, who cannot control it, to patients, who cannot escape it. Doctors can focus their efforts on achieving optimal outcomes for the patient, rather than on minimizing legal liability. In the event something goes wrong, the legal issue is no longer the difficult and subjective question of, "Who was at fault?" but instead the simpler and objective question, "What was the outcome?"

Warranty contracts for consumer products are routinely written with similar provisions, which limit the seller's liability to the purchase price. For example, if someone buys a refrigerator for $1,000, which becomes defective, he is legally entitled to a $1,000 refund. However, the seller is not liable for the value of food that spoiled when the unit failed. But if a restaurant serves poultry products tainted with salmonella, customers can recover both the cost of their "defective" meal and monetary damages for the illnesses they suffer.

Legal and Economic Barriers to Change in the Malpractice System

The restaurant example also illustrates four legal and economic barriers which prevent implementation of "no-fault" bad-outcomes medical malpractice contracts:

- ***Inalienable rights.*** People cannot waive their rights to their physical bodies.

- ***Personal responsibility.*** People cannot absolve themselves of responsibility for the consequences of their actions.

- ***Unequal bargaining power.*** Doctors have vastly more knowledge and experience of the risks involved with (a) the patient's condition, (b) their recommended course of treatment and (c) their professional competence, than their patients.

- ***Economic efficiency.*** It's more economically efficient and socially advantageous for the knowledgeable and responsible parties to bear the cost of the risks of routine implicit contracts of daily social intercourse.

The first problem with no-fault bad-outcomes medical malpractice insurance is that, while it defines in advance the exchange of money based on possible outcomes, it ignores the legal liability for bodily harm. While doctors and patients can agree to ignore this liability, the U.S. legal system will not. The laws of economics also make it inefficient to do this, as illustrated by the failures of no-fault auto insurance.

A fundamental principle of the U.S. legal system is that a citizen generally cannot waive or be denied his rights, which are deemed to be inalienable. For example, a person can agree to sell himself into slavery to a master, and even sign a contract to codify the terms. However, if the slave decides to quit and run away, and the master files a lawsuit against him for breach of contract, the courts will not enforce it.

The practical application to medical malpractice means that patients cannot waive their rights to sue their doctors for bodily harm. If a patient signs a contract with a surgeon that waives his right to sue, it is not enforceable in the courts. In cases of incompetence or negligence, the malpractice problem would not go away, because the insurer of the no-fault bad-outcome policy would then sue the doctor to recover its losses, just as an auto insurer might sue the driver of the car that hit one of its policyholders to recover its losses.

Another fundamental principle of the U.S. legal system is that a citizen—in most cases—cannot be absolved of the responsibility for the consequences of his actions. When parking lot owners post signs that read, "Not responsible for damaged or stolen vehicles," this is generally valid because they are stating the contract terms are for providing a parking space, and not for security. However, a person cannot extend this legal principle by putting a bumper sticker on his car that reads, "Not Responsible for My Reckless Driving," and then claim immunity for crashing into another vehicle because the other drivers on the road were properly informed of this in advance.

Third, doctors know a great deal more about the risks their patients face than the patients. Patients trust their doctors' medical expertise and make decisions based on their doctors' professional recommendations. When contractual disputes arise in cases of asymmetric knowledge of the parties involved, legal precedent holds that ambiguities and unforeseen circumstances are interpreted against the party with the superior knowledge, because it is in a much better situation to be aware of such potential outcomes, and is assumed to be able to take unfair advantage of the other party in such a contract.

Even if these legal barriers did not exist, the best argument against no-fault medical outcomes insurance is economic. The practical economic reality is that it's much more efficient for ***one*** doctor—knowledgeable about the risks of medical conditions, treatment options and surgical procedures—to sign ***one*** contract for medical

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malpractice at the optimum price, than for ***many*** patients—with little or no knowledge of the risks involved—to negotiate, pay for and sign ***many*** contracts at inflated prices because insurers were able to take advantage of their unfamiliarity with the situations they face.

All other forms of insurance operate on this principle. Drivers purchase a single insurance policy against the risk of a collision with anyone, not individual policies covering the risk of colliding with each other car. Similarly, building owners purchase liability insurance against the risks of structural failures, rather than everyone who enters a building negotiating and purchasing a separate insurance contract for the same risk.

When the Hyatt Hotel walkway in Kansas City collapsed in 1981, killing 114 people, none of the victims had thought to purchase insurance against such an unforeseen event. The property owner and architect were legally liable. It would be practically, legally and economically absurd for every person contemplating walking into a hotel lobby to consider negotiating and purchasing such insurance. And when someone doesn't think to, or bother to, purchase such insurance in advance, it does not mean either that (a) they place no value on their life, or (b) that injuring or killing them should not result in legal liability.

Reducing all this to one sentence: *The economics of the U.S. malpractice insurance market are efficient, but the U.S. legal system—as applied to medical malpractice—is not effective.* The proposal for no-fault bad-outcomes medical contracts attempts to sacrifice the economic efficiencies of medical malpractice insurance in exchange for the privilege of circumventing the ineffective U.S. medical malpractice legal system.

To illustrate why this is generally undesirable, consider the legal precedents that would be set—and the resulting social consequences—if people were able to avoid or severely restrict their liability for the consequences of their actions. Men would have incentive to coerce women they date—or even marry—to sign contracts stating they are not liable for child support should they get them pregnant. Projecting this scenario into other areas of routine social discourse will generate sufficient examples that would shake the foundation of our legal system and ultimately our civilization.

The lynchpin of the problem with the U.S. medical malpractice system is the defective decision mechanism. Fixing this problem will generally solve the others. Success will be measured when malpractice premiums are reduced to 2 percent to 3 percent of the costs of a doctor's practice, instead of the current 20 percent to 30 percent. ■