Prologue: The increasing frequency of physician liability claims and growth in size of awards prompted the American Medical Association’s (AMA’s) House of Delegates at its mid-winter 1984 meeting to characterize the situation as “a matter of extreme importance and high priority.” When organized medicine sought relief from its last malpractice crisis, which occurred in the mid-1970s, it sought reform of the nation’s tort law system through state legislative action. Many legislatures did act, but the measures they approved provided only temporary relief. For example, the St. Paul Companies, which provided professional liability insurance to 15 percent of the national medical market, reported 5,870 claims in 1983—2,757 more than in 1979, an increase of 88.6 percent. The AMA’s Socioeconomic Monitoring Service reported in mid-1983 that the average incidence of claims per 100 physicians increased from 3.3 claims per 100 prior to 1978 to eight claims during the years 1978-1983. Havighurst suggests in this essay that the time has arrived for medical care providers to recognize that longer lasting solutions may reside in private sector action, not simply in tort law reform. Havighurst is a professor of law at Duke University and a member of the National Academy of Sciences’ Institute of Medicine. Havighurst is a leading advocate of a medical care system that is based on decentralized, market-oriented solutions. He envisions a health sphere where individual consumers, armed with solid information, have the opportunity to select their medical care plans from an array of choices. Within Havighurst’s preferred conceptual framework, he views government’s proper place as rule-setter and referee of private sector action, not as the dictator of events.
After only a short absence from the policy agenda following the legislative and insurance reforms of the mid-1970s, the problems associated with medical malpractice litigation are once again the focus of national debate. This time around, however, if policymakers and industry observers are careful to view the situation in the context of overall health policy and in light of the new competitiveness of the health care industry, they will discover a promising new way in which the problem can be attacked. Specifically, the increased role of competition and consumer choice in health care, fostered through such federal policies as encouragement of prepaid health plans and aggressive antitrust enforcement, is opening exciting possibilities for private—as opposed to judicial and legislative—reform of the rules that govern liability for injuries suffered by patients in the course of medical treatment.

Although law professors and economists have frequently suggested that health care providers and consumers should be allowed to enter into contracts creating rights and remedies that differ substantially from those established by courts and legislatures, this way of attacking the malpractice problem has remained largely an academic idea. The time has now come, however, for the health care industry, and ultimately the courts, to recognize that tort law as laid down by courts and legislatures is not necessarily the final word. Instead, tort law should be seen as governing only in the absence of a negotiated arrangement.

Questions would arise, of course, about the enforceability of particular contracts altering patients’ rights, and courts should certainly hesitate before enforcing a liability-limiting contract that a patient—usually with the benefit of hindsight following some injury—later regrets having entered into. Nevertheless, a court should avoid being too hard to convince that such a contract was fairly negotiated and served the interests of consumers as well as providers. Because the new competitive environment gives consumers new opportunities for informed choice of health plans and providers and new help in bargaining with provider interests, the need for judicial vigilance against provider overreaching is lessened. I have argued recently that courts should have an open mind when asked to enforce a private contract that purports to alter the liability rules prevailing between health care providers and their patients.

In this article, I will first show how changes in industry conditions have made it feasible and acceptable to contemplate private initiatives to redefine rights and responsibilities associated with medical accidents. Then I will summarize some reasons for thinking that the legal system has not found the best, or even a satisfactory, way to protect consumers against the risk of injury and to motivate providers to provide care of appropri-
ate quality. Finally, I will suggest some ways in which health care providers and consumers might improve upon the legal system’s effort.

### Competition In The Health Care Industry

More than anything else, active competition in the health care sector is what makes it possible now to contemplate private solutions to the problems posed by tort law for medical care providers and their patients. In the era when the current law of medical malpractice took shape, consumers were seen as having no real options in the marketplace and no capacity to exercise choice. It was therefore natural for the law to prescribe duties and for courts to be suspicious of attempts to set aside the law’s prescriptions. Under the old assumptions, it was also natural for the law to look to the medical community for standards of care and to enforce professional norms of conduct without questioning their appropriateness or cost-effectiveness. Under the old circumstances, tort law was essentially prescriptive and regulatory, imposing substantial sanctions for departures from accepted processes whenever a bad result occurred.

The old situation was, of course, essentially monopolistic. Health care was generally thought of as the product of a unitary “system” in which consumers had little choice, professionals set their own standards, third-party payers unquestioningly supported professional habits, and tort law rigorously enforced adherence to the system’s norms. Recently, however, profound changes are occurring both in the structure of the industry and in our ways of thinking about health care. As we have begun to recognize that we live in an era of limits, even for medical care, alternatives to the previously dominant style and methods of practice have begun to seem acceptable. Although it is still hard to acknowledge it explicitly, we are gradually accepting the fact that we can’t have it all, that the highest quality is not necessarily worth its high cost, and that trade-offs must be made. The belief that the same high standards should prevail everywhere, though still widely professed, is seen more and more as unrealistic, and emphasis is placed instead on raising standards where they are unacceptably low. Decision making is becoming decentralized, thus opening up new innovation possibilities.

In these new circumstances, there is less reason to assume that there is one right way to treat patients. It should also appear that there may be more than one right way to redress medical injuries. Now that we have accepted alternatives to the dominant system of medical care, it seems a logical next step to look to health maintenance organizations (HMOs) and competitive medical plans of other kinds to offer consumers alternatives to the dominant legal system. Indeed, the key benefit of deregulating the health care industry, which more than compensates for the accompanying problems, is that it offers consumers a chance finally to escape the
burdens of professional monopoly—not only the physicians’ monopoly over the making of costly medical decisions, but also the lawyers’ monopoly over the costly business of making and administering rules governing liability for medical injury.

The Existing Legal System

There are not many good things that can be said about the existing legal system for handling medical malpractice. Its most apparent virtue is that it gives patients an opportunity they would otherwise lack to call doctors and hospitals to account for harms they cause through poor practice. It is at least arguable that the availability of this powerful grievance mechanism causes health care providers to be more careful than they would otherwise be and more attentive to their patients as human beings. Although the coming of competition has given consumers more opportunities for choice and effective complaint than they previously enjoyed, there is still a need for some public forum in which a patient can pursue his grievance to a decisive result and can see a meaningful sanction imposed on a negligent provider.

Almost certainly, the reluctance of legislatures to make more than marginal changes in the law of medical malpractice has been attributable to a sense that patients should not be deprived of their basic right to seek redress for the serious harms that providers do, sometimes through culpable neglect. This is not to say, however, that consumers may not voluntarily surrender some of their rights under the tort system in a contract with a provider. But by serving as the starting point for negotiations, the tort system gives consumers substantial bargaining power with which to induce price or other concessions in return for surrendering certain rights.

Everything else that can be said about the law governing medical malpractice is negative. The following brief specification of the legal system’s faults, summarizing what others have observed, adds up to a powerful indictment. Although these objections may not justify legislation that repeals or greatly restricts patients’ right to sue, they certainly suggest that both providers and patients could benefit substantially by entering into private contracts creating liability rules which differ from the rules created and administered by the legal system.

Very high legal and administrative costs. Judging negligence in the provision of medical care is often very difficult and expensive. As a result, much of the money paid as malpractice insurance premiums is absorbed, not in paying claims, but in deciding whether a particular loss should be shifted. Estimates of the portion of the premiums paid into the system that eventually goes to injured persons go no higher than 40 percent, meaning that at least 60 percent of the premiums collected go to pay lawyers and insurers for operating the system. (Costs of operating the
courts are an additional and hardly negligible factor.) One might easily judge that these high operating costs are not justified by any benefits the system yields in overcoming economic hardships and enforcing good medical practice. A system of compensation that was simpler to administer—that did not, for example, require a determination of fault in every case—could benefit many more injured patients without costing any more. Patients and providers might see an opportunity to cut out the lawyers and to use the savings to cover more injuries, to reduce fees or premiums, or to improve quality.

**High psychic costs.** The emotional toll taken on both providers and patients is unmeasurable but very high. The acrimony of trials, the tensions introduced into doctor-patient relationships, and the burdens on patients awaiting adjudication of their claims have been noted by many others. Many, though perhaps not all, individual providers and patients will see substantial value in escaping from such a system into one with fewer adversarial features.

**Haphazard compensation.** Many injured patients go uncompensated even when their injuries were actually caused by negligence; a few patients are compensated extravagantly. A review of the numerous reasons why some potential lawsuits are brought while many others are not leaves the impression that the system is not serving any clear function well. Instead, like lightning, it seems to strike almost at random. There is a great deal of room for improving patients’ financial security by increasing the number of patients compensated while reducing the level of payment to more closely approximate real economic losses.

**Perverse incentives.** Although the tort system is expensive to administer, there is always the possibility that its cost is justified by the behavior it induces. But there is good reason to believe that the liability system, whatever good it does, also promotes a great deal of uneconomic and undesirable behavior. Although “defensive medicine” is difficult to define and identify in practice, unnecessary testing and overutilization of health care resources do occur and in some degree seem to reflect providers’ desire to be protected against accusations of negligence. Moreover, tort law enforces a standard of care drawn primarily from customary practice—did the doctor do what other doctors would do? Unfortunately, this standard of care is almost certainly an inefficient standard because it is derived by observing a market in which third-party payers unquestioningly foot the bills and physicians seek not only absolute safety for their patients but also protection against lawsuits for themselves. By using customary practice as a reference point for imposing liability, the legal system appears to restrict opportunities for even the most responsible economizing, thus forcing the public to bear unnecessarily high health care costs. Private agreements altering liability rules seem to have great potential for improving the climate for efficient behavior.
Although the foregoing defects in the existing legal system are hard to compare to any benefits that the system may have in raising the quality of care to appropriate levels, they certainly provide a solid basis for thinking that there is room for improvement. Because legislative changes are inhibited by interest-group politics and uncertainty about precisely what to do, private avenues of change are worth exploring. Providers and consumers interacting in a competitive market appear to have an excellent opportunity to negotiate new arrangements that, by avoiding heavy legal and administrative costs and lifting the heavy penalties on responsible cost containment, could benefit everyone directly concerned. Only trial lawyers would have reason for complaint. Even patients who later suffer some injury that would have entitled them to a huge award may be seen as beneficiaries of the original decision to rule out such recoveries.

The following paragraphs suggest some specific ways in which private health care plans and individual hospitals and physicians might agree with consumers on a different set of rules governing what happens when a patient suffers an injury in the course of treatment.

**Changing the forum.** HMOs in California and elsewhere have already required arbitration of claims for medical malpractice.\(^4\) Such arbitration agreements may be entered into before an injury occurs, and plaintiffs have been bound by arbitration clauses negotiated by their employers on their behalf even when they did not actually know that their right to a jury trial had been restricted. In such cases, it appeared important that the employee also had the option (through “dual choice”) of choosing another form of financial protection which would have maintained his traditional legal rights.

In addition to arbitration clauses, one can also imagine contractual provisions that would limit the initiation of malpractice suits that had not been previously approved by a screening panel of some kind. Such methods for foreclosing frivolous claims are similar to those adopted in some state legislations and would provide some protection to providers without preventing clearly meritorious actions.

**Limiting recoveries.** Just as some states have sought to limit malpractice recoveries, private parties might do the same. Although the agreement might set a flat dollar limit, it is probably preferable to provide that a plaintiff could recover his full economic losses but not for pain and suffering or amounts reimbursed from collateral sources such as life, health, or disability insurance. A possible variation might provide an additional amount out of which the patient could pay his attorney’s fees.

Even though such limitations on recoveries might appear to benefit only the provider and not the patient, the provider’s lesser exposure to liability risks might well translate into lower fees and health plan premi-
ums. Because consumers do not customarily purchase insurance protection exceeding their potential out-of-pocket losses, it does not seem reasonable for courts to compel them, against their expressed will, to pay for duplicative or excessive protection through the tort system.

**Altering the standard of care.** Because malpractice law appears to require that physicians adhere to customary practice in their community, opportunities for responsible economizing are restricted. As a result, a health plan or provider might wish to specify by contract a commitment to abide by a different standard. For example, an HMO might contract to be bound, not by community standards, but by the standards of other HMOs. Alternatively, the HMO’s subscriber contract might preserve a right to depart from customary standards in good faith where medical literature supported the HMO’s judgment and its subscribers were consulted on the decision to adopt different methods. Avoidance of dubious claims might also be accomplished by contracting to limit liability to those cases in which gross negligence or an intentional act or omission could be proved.

**No-fault alternatives.** As a substitute for patients’ rights under the tort system, a provider or organized health plan might provide for automatic compensation for certain designated compensable events. Some years ago Laurence Tancredi and I proposed such a no-fault system that would be financed through provider-purchased insurance. A subsequent study by a commission appointed by the American Bar Association confirmed the desirability and feasibility of such a compensation system. Although a no-fault compensation system along these lines could be created by statute, it might also be implemented by private contract. In addition to protecting patients, a no-fault system can be structured to preserve strong incentives to avoid adverse outcomes.

**The Moore-Gephardt (O’Connell) strategy.** Private contracts might also provide for limitations on malpractice claims that are similar to those currently embodied in H.R. 5400, the Alternative Medical Liability Act introduced in the 98th Congress by Representatives Moore and Gephardt. This proposal, embodying ideas first advanced by Professor Jeffrey O’Connell, would permit a provider to foreclose a lawsuit for medical injury by tendering the patient’s net economic loss. Whatever the desirability of legislation implementing this interesting idea, it is worth recognizing that it or something like it might also be implemented privately.

**Exculpatory clauses.** The most extreme form of private agreement altering patients’ rights to compensation for medical negligence is an exculpatory clause, by which the patient entirely surrenders his right to sue. Although clauses of this type have been struck down by the courts from time to time, a case can be made for enforcing them. In any event, it should be clear that judicial reluctance to enforce contracts of this extreme type does not control the enforceability of agreements of other kinds.
Conclusion

This article has sought to highlight some new possibilities for relieving the serious burdens that are imposed on patients and providers alike by medical malpractice and the legal system’s current methods for dealing with it. The new competitiveness of the health care industry makes private solutions to this problem thinkable for the first time. Innovative providers and creative lawyers should begin considering how the private sector might initiate some responsible reforms of its own in this difficult area; public officials should seek ways of encouraging such private initiatives; and courts should be receptive to them when they occur.

NOTES

8. See, for example, Emory University v. Pomblansky, 282 S.E.2d 903 (Ga. 1981); and Epstein, “Medical Malpractice: The Case for Contract.”