

MEDICAL MALPRACTICE: EFFICIENCY OF THE NEGLIGENCE
STANDARD OF PHYSICIAN LIABILITY

by

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CHAPTER ONE

INTRODUCTION

The Problem

Medical malpractice litigation represents perhaps the most loathsome extra-professional problem confronting physicians today. The problem of malpractice litigation had become so severe nearly a decade ago that, in 1971, President Nixon convened a commission on medical malpractice to investigate the situation. In its final report the Commission reported a significant increase in the number and size of malpractice suits being brought against medical personnel and institutions delivering health care services; but the Commission also concluded that malpractice was far less pervasive than it was assumed to be and that, contrary to popular opinion, most patients actually receive high quality health care. The majority of physicians, the report continued to note, go their entire careers without being sued.¹

Since the publication of these findings, the situation concerning medical malpractice in the United States has changed dramatically. In the more recent past, patient initiated malpractice claims have increased at an extraordinary rate. For example, the St. Paul Fire and Marine Insurance Company, which insures physicians in forty-four

¹Report of the Secretary's Commission on Malpractice (Washington, D.C.: Government Printing Office, 1973), pp. 1-4.

states, estimated that malpractice claims against the doctors it insures is running at a rate of about 4000 per year in 1975. This represents a 225 percent increase over the 1538 claims filed against this insurance company in 1970. Between 1970 and 1973, there was an eighty percent increase in the number of malpractice suits brought against physicians in New York State--564 in 1970, 1064 in 1973, and by June 1974, there were about 3000 suits pending. Nationwide, there were over 20,000 malpractice claims settled involving as many as 40,000 defendants settled between July 1975 and June 1976, with many more suits still pending.

The probability of a doctor going an "entire career without being sued" is much less today than it was five years ago. Not only has the total number of claims increased, but the frequency of claims per physician has also been on the rise (See Table 1). In 1969, for example, one out of every twenty-three (4.3%) doctors covered by the St. Paul Fire and Marine Insurance Company was involved in a malpractice suit; by 1974, one of ten (10.0%) of the company's covered physicians was being sued for alleged malpractice. A study by the Baltimore Sun in 1974 of Maryland doctors found that one in every three orthopedic surgeons and one out of every four obstetricians/gynecologists and anesthesiologists were involved in malpractice litigation.² In a January 7, 1975, report in the Los Angeles Times, medical sources

²Malpractice In Focus (Chicago: American Medical Association, August 1975) p. 13.

Table 1

Annual Number of Paid Claims and Claim Frequency for
Physicians' and Surgeons' Professional Liability Insurance

Policy Year Ending	Paid Claims (number)	Claim Frequency*
12/31/66	n.a.	1.741
12/31/67	n.a.	1.925
12/31/68	n.a.	1.835
12/31/69	6,606	2.105
12/31/70	7,067	2.125
12/31/71	7,354	2.469
12/31/72	8,135	3.229
12/31/73	10,151	4.149

*Paid claims per 100 insured doctors

SOURCE: Mark C. Kendall, "Expectations, Imperfect Markets, and Medical Malpractice Insurance," in The Economics of Medical Malpractice, ed., Simon Rottenberg (Washington, D.C.: American Enterprise Institute for Public Policy Research, 1978), p. 188.

estimated that the average Los Angeles physician is sued once every seven years.

In addition to facing a greater probability of being named in a malpractice case, and being named more often, physicians have seen settlements against them increase at a disturbing rate. In 1970, the average jury award for malpractice cases, excluding one million dollar awards, was approximately \$100,000; just three years later this average had risen to about \$350,000.³ In 1976, the average settlement for all claims paid was over \$20,000, more than double the average in 1970. These increases in the number and size of malpractice settlements has created a rapid acceleration in insurance premiums in many states (See Tables 2 and 3); and this increase in malpractice insurance has alarmed the medical profession, the insurance industry, and state legislatures and regulatory agencies.

In light of these developments, one hears frequent reference to a so-called "medical malpractice crisis," although it is unclear as to what exactly the crisis is about. Some contend that the high and rising cost of malpractice liability insurance is the basic problem. Many believe that the refusal of some companies in certain states to issue new or renew existing liability policies is the crisis. Still others point to the responses of doctors to rising insurance costs as the cause of concern.⁴

³"The Malpractice Crisis," Newsweek, February 10, 1975, p. 41.

⁴For example, many doctors have become self-insurers or judgement proof, restricted their practices or change specialization, or sought

Table 2
 Price Index For Malpractice Coverage,
 Selected Groups and U.S. Average, Selected Years
 (1966 = 100)

Year	Group I	Group III	Group VII	Group IX	U.S. Average
1955	90.7	58.4	39.0	37.9	57.9
1960	81.5	84.0	55.6	55.1	67.8
1962	93.1	93.9	62.7	62.6	76.8
1964	87.0	87.2	87.4	87.1	87.1
1966	100.0	100.0	100.0	100.0	100.0
1967	100.1	125.2	111.9	110.9	114.0
1968	103.4	129.3	144.4	114.8	126.9
1969	189.6	230.7	259.5	210.7	230.2
1970	289.9	475.5	533.3	423.2	435.4
1971	327.7	538.0	602.2	478.2	491.5
1972	359.5	590.3	662.2	524.9	538.8
1973	372.5	754.8	844.9	669.6	655.7
1974	483.9	772.1	1388.0	894.1	809.8
1975	954.3	1221.5	2146.5	1379.4	1329.2
1976	3171.8	4039.1	7133.3	4482.7	4414.7

Note: Group I: physicians, no surgery; Group III: physicians who perform major surgery, for example, ophthalmologists and proctologists; Group VII: orthopedists and neurosurgeons; Group IX: general and cardiac surgeons.

SOURCE: Patricia Munch, "Causes of the Medical Malpractice Insurance Crisis: Risks and Regulation," in The Economics of Medical Malpractice, Rottenberg ed., p. 127.

Table 3
 Medical Malpractice Insurance Premiums Paid by
 Dentists, Physicians, Surgeons, and Hospitals, 1960-1974
 (in millions of dollars)

Year	Dentists	Physicians	Surgeons	Hospitals	Total
1960	5.1	7.6	19.7	28.7	61.1
1961	5.3	7.9	22.4	30.3	65.9
1962	5.4	8.1	25.2	31.1	69.8
1963	5.6	8.9	30.3	32.2	77.0
1964	5.8	9.6	35.5	33.2	84.1
1965	6.4	10.5	38.5	35.1	90.5
1966	7.0	11.4	43.7	33.2	95.3
1967	7.4	15.2	51.7	35.7	110.0
1968	7.7	19.0	59.7	38.1	124.5
1969	8.9	30.2	110.5	63.0	212.6
1970	11.0	48.7	206.7	104.2	370.6
1971	11.7		272.7	113.3	397.7
1972	12.5		291.2	123.1	426.8
1973	13.4		310.9	133.8	458.1
1974	14.3		332.0	145.5	491.8

SOURCE: 1960-1970 from Mark Kendall and John Haldi, "Medical Malpractice Insurance Market," Report of the Secretary's Commission on Medical Malpractice, Department of Health, Education, and Welfare (Washington, D.C., 1973), Appendix, p. 509. The 1974 figures for physicians, surgeons, and hospitals are estimates by the Insurance Services Organization based on a survey of member firms, in U.S. Congress, Senate, Subcommittee on Health of the Committee on Labor and Public Welfare, Continuing Medical Malpractice Insurance Crisis, 1975, 94th Congress, 1st session, April and December 1975, p. 603. The 1971-1973 figures are interpolations. The 1971-1974 figures for dentists are estimated as a constant share (based on 1970) of the figures for physicians and surgeons.

The fact that medical malpractice settlements and insurance premiums are rising does not, in and of itself, necessarily constitute a problem or crisis for society as a whole. The high and rising costs of any particular system must be considered in light of any offsetting benefits which may result. For example, if higher insurance premiums lead to a cost justified reduction in iatrogenic injuries, or if society on the average becomes increasingly risk averse (i.e., prefer more loss spreading and insurance), then the increase in premiums and subsequent responses to higher insurance costs would merely reflect the cost of these improvements.

All of the above aspects of a malpractice crisis stem originally from our common law system of jurisprudence which adjudicates disputes arising from the physician-patient relationship, since the willingness of the judiciary to permit patients to sue (and recover damages from) physicians has engendered the present system of private action litigation and the nearly billion dollar malpractice insurance industry. It would appear, therefore, that any evaluation of recent changes in the area of medical malpractice must begin with an analysis of the justification for private action litigation and judicial intervention. Alternatively, one may ask whether or not the concept of medical malpractice litigation is the appropriate means for achieving a desired outcome.

employment in immune sectors of the medical profession (e.g., research and the armed forces), or retired prematurely.

Scope and Purpose of the Analysis

Any analysis of medical malpractice must be limited in scope. Indeed, an entire volume, containing thirteen separate articles and totaling 293 pages, on medical malpractice was recently published.⁵ The "economics of medical malpractice" necessarily encompasses more issues than any single study could adequately cover. Accordingly, this analysis is neither definitive nor all inclusive. The purpose of this study is to address a single question concerning medical malpractice: Is the present system of private action litigation the appropriate organizational arrangement for exploiting potential gains from trade that arise from the interaction of patients and physicians?

Such an evaluation may be pursued through two distinct approaches. On the one hand, one could answer this question by analyzing the present system of malpractice law in terms of its ability to satisfy some predetermined criteria based upon various concepts of economic efficiency or optimality: that is to say, one could specify certain goals or objectives to be achieved and then evaluate the ability of an existing institutional or organizational arrangement to fulfill these goals. For example, one may evaluate the present system in terms of its ability to generate the appropriate incentives to produce the "optimal" level of precaution, to spread losses efficiently, or to achieve certain results at the least cost. On the other hand, this question could

⁵The Economics of Medical Malpractice, Simon Rottenberg, ed. (Washington, D.C.: American Enterprise Institute for Public Policy Research, 1978).

be answered by analyzing a public policy's ability to facilitate mutually beneficial exchanges, or, within the Wicksellian tradition, to generate changes which meet with unanimous agreement. In order to uncover potential gains from trade, however, one must occasionally rely upon certain criteria of more or less normative nature. Third party observers must occasionally employ modern value theory as a benchmark for evaluation. Moreover, certain features of the real world operations of a system or policy must be taken into account if a theoretically prescribed policy is to be evaluated completely. This is not to say that some second-best approach should be followed; rather, it is to recognize the fact that simplistic notions of what satisfies certain efficiency standards are not to be pursued blindly and at the expense of other considerations.

The succeeding analysis is a hybrid of the two approaches mentioned above, although the primary emphasis is within the Wicksellian tradition. Towards this end the analysis will proceed as follows. Chapter Two will discuss the development of important legal issues pertinent to medical malpractice. The first part describes tort law in general and the fault system in particular. Included in the discussion are traditional interpretations of the shift to the negligence standard. The final portion of the second chapter traces the development of tort law as it applies to medical practitioners.

Chapter Three integrates the legal and economic concepts of property rights, externalities, liability rules, and public policy. The discussion begins with an analysis of market failure and alternative

organizational arrangements to deal with relevant externalities. The relationship between property rights, allocative efficiency, and the courts is developed with special attention given to the problems confronting the courts as they try to assign and enforce property rights in the area of bodily integrity and personal injury. The final part of Chapter Three analyzes the economic role of liability rules and the conditions under which the rule of liability will effect resource allocation and facilitate mutually beneficial gains.

The fourth chapter will discuss some of the allocative effects of physician liability. The analysis will describe, to the extent data are available, the magnitude of medical malpractice, the costs and consequences of this form of private action litigation, and the possibility of court error.

The final chapter will summarize the preceding analysis and present some tentative conclusions concerning the ability of the present system of physician liability to promote allocative efficiency and exploit potential gains from trade. Also included in the fifth chapter is a discussion of alternative solutions to the problems of medical malpractice which have emerged as a result of the present legal system.

CHAPTER TWO

LEGAL FOUNDATIONS OF MEDICAL MALPRACTICE

Introduction

Medical malpractice (mala praxis) is a broad legal term describing situations under which health care suppliers (usually physicians and surgeons, but occasionally nurses, dentists, and hospitals) are held accountable for their professional actions. Generally speaking, there are four distinct and separate situations that are referred to as "medical malpractice cases."¹ A medical care supplier can be charged with criminal violations while performing in a professional capacity. Although there is no such crime as "criminal malpractice," physicians are subject to statutory constraints. For example, an abortion performed in a state which has laws prohibiting such operations subjects the surgeon to possible criminal charges. Moreover, an increasing number of indictments have been handed down charging physicians with fraudulently obtaining money under the Medicaid and Medicare programs. Other criminal charges that may arise from the practice of medicine include narcotics law violations, wrongful death, and battery. These types of malpractice cases are relatively few and usually not controversial because what is at issue is the criminal nature of the offense and not the practice of medicine; hence the criminal law and its

¹C. L. Cusumano, Malpractice Law Digested for Quick Grasping (New York: Medicine-Law Press, 1962), p. 22.

application to medical practitioners will not be analyzed in this dissertation.

The remaining three types of malpractice cases are of a civil nature. The predominate legal issue in some cases is the failure to perform a contract. In these instances, a physician or surgeon has agreed explicitly to achieve a definite result or to perform a particular operation. Failure to comply fully with the agreement by the physician constitutes a breach of contract. Medical services rendered under such terms are governed by the law of contracts; and, as a result, the remedies available to the non-breaching party (plaintiff-patient) are more limited than those under tort action. Malpractice cases which stem from a breach of contract usually allow the plaintiff to recover only payments made to the defendant physician. Excluded from compensable damages, in most cases, are indemnities for physical and mental injuries, loss of past and expected earnings, pain and suffering, and medical expenses to treat injuries the defendant may have caused. Although medical cases alleging breach of contract do not require expert witnesses and are usually easier than negligence cases for the plaintiff to prove, very few malpractice suits fall into this category. During the last twelve month period for which data are available, less than one-half of one percent of all malpractice "incidents" involved breach of contract as the legal issue at suit. This is apparently so for two reasons. Few doctors will enter into such agreements; and, given the litigation costs to the plaintiff, the

limited recovery discourages many from filing suit. For these reasons, breach of contract cases will not be included in this study.

The remaining two types of malpractice cases are of a civil nature and fall under the rubric of the law of torts. The first of these two involves cases of tort action brought against physicians which are not based upon alleged negligence but involve so-called intentional interferences with person. Examples include battery, false imprisonment, and libel, slander and defamation. Malpractice litigation rarely is based upon such allegations. During the period of July 1, 1975, through June 30, 1976, only 216 out of 12480 (1.7 percent) legal issues reported in 8431 medical malpractice incidents involved intentional interferences with person (abandonment and false imprisonment). Apparently few medical injuries are premeditated or the result of physician malevolence. Because these cases are relatively infrequent and do not have a noticeable effect upon the medical care industry, they too will be excluded from the analysis.

The fourth situation from which most medical malpractice cases arise is instances where tort action is founded upon negligence--the failure to exercise due care. In other words, there exists what is known as a tort obligation for the physician to protect others (i.e., his patients) from unreasonable risks of injury, in which case liability for injuries resulting from the failure to exercise due care is placed upon the tortfeasor. It is this basis upon which most of the controversy surrounding medical malpractice arises. This assignment of liability will be the major focus of this dissertation.

The Law of Torts

Although many legal scholars have lamented the fact that a comprehensive and concise definition of what is a tort has not been articulated, most agree that torts "consist of the breach of duties fixed and imposed upon the parties by the law itself, without regard to their consent to assume them, or their efforts to evade them."² Unlike criminal law, which is concerned with protecting the interest of the public at large, and contract liability, which is for the protection of a single, well defined interest, tort law attempts to define generally the circumstances under which an obligation to protect others exists and to specify how losses resulting from human interaction will be allocated. As one author put it:

Arising out of the various and ever-increasing clashes of the activities of persons living in a common society, carrying on business in competition with fellow members of that society, owning property which may in any of a thousand ways affect the persons or property of others--in short, doing all the things that constitute modern living--there must of necessity be losses, or injuries of many kinds sustained as a result of activities of others. The purpose of the law of torts is to adjust these losses, and to afford compensation for injuries sustained by one person as the result of the conduct of another.³

As a product of the common law, tort obligations and liability assignments are truly dynamic. As Prosser observed: "New and nameless torts are being recognized constantly, and the progress of the common

²William L. Prosser, Law of Torts (St. Paul, Minn.: West Publishing Company, 1964), p. 4.

³J. Wright, "Introduction to the Law of Torts," 8 Cambridge Law Journal, 1944, p. 238.

law is marked by many cases of first impressions, in which the court has struck out boldly to create a new cause of action, where none had been recognized before."⁴ Whenever the courts find conflicting interests which are not adequately governed by existing law, they are generally free to create and impose new obligations to fit the situation. The introduction and widespread use of the automobile, for example, have created a relatively new set of duties and liabilities upon drivers. Furthermore, the courts attempt to define as objectively and disinterestedly as possible what constitutes a reasonable (i.e., judicially acceptable) standard of care, and impose liability upon those who breach this duty in instances where an obligation exists. It is this dynamic nature of the law of torts which has extended liability to the medical profession in general.

Although the law of torts is applicable to nearly every human endeavor, it can be divided into essentially two distinct categories. On the one hand, tort obligations and remedies can arise from intentional interferences with property or person. Examples of these intentional interferences include trespass, battery, assault, false imprisonment, abandonment, and conversion.

A second, and more common, type of situation creating a tort obligation and imposing liability upon the tortfeasor involves unintentional (i.e., accidental) injuries. In other words, the injuries were a result of individuals engaging in legal, socially useful

⁴Prosser, Law of Torts, p. 3.

activities. The primary legal basis for unintended torts became known as negligence and has been the dominant standard of civil liability for accidental injuries since about 1825.⁵

Before discussing the development of the negligence concept, it would be useful to digress briefly on the different liability rules commonly employed by the courts. Generally speaking there are only two fundamental liability rules--liability without fault and liability based upon fault. The essential difference between the two stems from the role blameworthiness plays in allocating losses. Liability without fault, as the name implies, assigns losses among individuals on some criteria other than who "caused" the loss. Liability based upon fault says that the individual who caused an accident or failed to prevent it will be liable for the losses.

Liability without fault is sometimes subdivided into no-fault liability and strict liability, but this is a distinction without a difference. So-called no-fault liability is simply strict victim liability, while that which is usually referred to as strict liability actually means strict non-victim liability. The current system of workmen's compensation and the concept of recently enacted no-fault automobile insurance schemes are examples of the no-fault concept while products' liability typifies strict liability.

Negligence (and the defense of contributory negligence) is the general term used to describe liability based upon fault. The essential

⁵Richard A. Posner, "A Theory of Negligence," Journal of Law and Economics, Vol. 1, 1972. p. 29.

feature of liability based upon fault is that those who do not take "reasonable or ordinary" care to protect others from loss or injury are liable for the losses that may result from one's action. In other words, those individuals who are in a position to undertake cost-justified precautions are expected to bear the burden of loss avoidance and any losses that may ensue if certain precautions are not taken. These comments on the different forms of liability are merely introductory. The specific issues regarding liability assignment will be developed in more detail later.

Negligence: Reassignment of Liability

The modern day concept of negligence generally was not considered a separate tort until the early part of the nineteenth century.⁶ The traditional view is that prior to about 1825, a person was liable for harm caused to another person irrespective of the actor's blameworthiness. In other words, "A rule of strict liability prevailed at the early stages of development of the common law, usually rendering an actor liable if he in fact caused injury to another."⁷ The negligence standard is recognized as an independent basis of liability and quite apart from intentional torts and instances where strict liability applies.

⁶Charles O. Gregory, "Trespass to Negligence to Absolute Liability" 37 Virginia Law Review, 1951, p. 359.

⁷Cornelius J. Peck, "Negligence and Liability without Fault in Tort Law," Washington Law Review, Vol. 46, No. 2, 1971, p. 226.

It is interesting to note that what appeared early in the development of our common law, and today goes by the name of negligence, concerned itself with the liability of those who claimed to be competent in particular professions.⁸ In particular, maritime shippers and innkeepers were held liable under the law while other industries were not judged by the same legal standards. In other areas of commerce, such as blacksmiths and surgeons, the law similarly regarded the practitioner as being under an obligation to be competent and render his services competently. These "public callings" were under an obligation to be competent and render his services competently. These "public callings" were under an obligation to exercise a higher standard of care with respect to their professional conduct to protect others from the risk of injury or loss. Perhaps this form of quasi-industrial regulation was economically justifiable in a pre-industrial revolution society with very limited communications and lower quality information. In any case, certain professionals were "regarded as holding [themselves] out to the public as one in whom confidence might be reposed, and hence as assuming an obligation to give proper service, for the breach of which, by any negligent conduct, he might be liable."⁹

Finally, around the year 1825, amid an ever increasing number of industrial machinery related personal injury cases, the courts relaxed the previously held assumption that "a man acted at his peril." In

⁸Prosser, Law of Torts, p. 142.

⁹Ibid., p. 142.

essence, the courts said that an individual was not to be held liable for injuries he caused if he conformed to a certain standard of conduct for the protection of others against unreasonable risks of injury or harm. An individual was judged blameless and escaped liability if he conducted himself in such a way as to take reasonable precautions against likely or foreseeable harm to others. The precedent handed down in Brown v. Kendall¹⁰ had the immediate effect of reducing the case loads of the courts. As the standard of care became more clearly defined, many cases involving personal injuries in the absence of negligence were of little value to the injured party. Individually the members of society were held increasingly responsible for certain inevitable injuries that are a natural by-product of a modern, industrially complex society. The courts recognized that perhaps it was better socially to permit certain accidents to occur and enjoy the benefits from human interaction and development than to avoid these accidents altogether. The courts apparently also believed that where there was no gain from shifting a loss, there is no reason to try to shift it. In other words, certain foreseeable, but highly unlikely, accidents will always occur; and if shifting liability does not generate any social gains, there is no reason to pay the costs of reallocating the losses.

Compensation for these accident losses gave rise to the first-party accident insurance industry. In general the courts said that

¹⁰1850, 6 Cush. 292, 60 Mass., 292.

individuals should recognize the unpredictable and uncertain nature of the future and to expect to become victims of these unfortunate occurrences. Against these risks and expected losses, the individual can purchase private insurance to indemnify against these losses in the event they occurred.

Elements of a Case

In place of strict liability (i.e., liability without fault) the negligence standard gradually took hold. Although some areas of strict liability remain today (e.g., blasting operations and keeping vicious animals), the majority of personal injury cases are governed by the negligence standard.

A legal cause of action arising from alleged negligence involves more than the failure to comply with a prescribed standard of conduct. The elements of a negligence case which must be met in order to shift liability include the following:

- 1) An obligation or duty to protect others from unreasonable risk must exist. This duty arises from a contract, public policy, or an implied or explicit relationship.
- 2) A breach of duty must have occurred--failure to exercise due care.
- 3) The injured must show actual loss.
- 4) There must exist a causal connection between the breach of duty and the loss.
- 5) The plaintiff must be free from contributory negligence.

Although the law frequently mentions "avoidable accidents" as the predominant basis for unintended torts, one must recognize that all accidents are entirely avoidable to the extent that they result from voluntary action. All unintended injuries could, of course, be avoided if society were to forego nearly all human interaction. What the law usually regards as an avoidable accident, however, is an occurrence which was not intended and which, under all the circumstances, could have been foreseen or prevented by the exercise of reasonable precautions.¹¹

The next issue which must be resolved is what constitutes "unreasonable risk of harm or injury?" The courts, in their unique way, recognize that risk is a matter of degree. The courts usually define risk as an apparent danger or a danger which should be apparent to the actors. In deciding the magnitude of risk, the law takes into account two factors. First, the foreseeability of an injury must be considered in each case. Some accidents are so rare that there are insufficient observations upon which one could estimate the probability of the event happening. In other words, the injuries are essentially unimaginable. Beyond these nearly unforeseeable accidents are those endeavors where accidents are known to occur, but where the probability of anyone sustaining an injury is extraordinarily small. For example, a soft drink bottler can estimate the frequency of bottle explosions; however, the chance of any given container bursting is so small that the only

¹¹Prosser, Law of Torts, p. 143.

feasible way of avoiding the accident (and accompanying injuries) is to halt all soft drink sales. A tire manufacturer can expect some structurally defective tires to be produced and sold. Technical limitation, however, may prevent the manufacturer from keeping off the market all defective automobile tires.

Against these probabilities the courts require the actors to take into account the possible magnitude of the injuries. Lightning strikes more or less arbitrarily; but if the consequences of a strike are large (say, explosives are stored), then a higher standard of precaution is required by the law. As passenger aircraft become larger and larger, the law requires air carriers to take into account the greater potential damages in the event of a crash. The standard of care required of a trucker hauling inflammables is clearly greater than that incumbent upon someone transporting milk.

The exact type of conduct which the courts expect remains to date a mystery. As previously mentioned, individuals are under an externally imposed obligation to protect others from unreasonable risks of harm and injury. The standard of due care does not require people to be careful or to act circumspectly; rather, the courts set a standard for all to follow and be judged. The important point here is that the standard is not usually an individualistic one. A person in a position to cause others harm is, instead, supposed to exercise that level of precaution which a "reasonable man of ordinary prudence"¹² would

¹²First mentioned in Vaughan v. Menlove, 1738, 8 Bing. H.C. 468, 132 Eng. Rep. 490.

undertake. The maladroit and impatient alike are afforded no exemptions, except perhaps at the Gates of St. Peter.¹³ The individual who is exceptionally perspicacious and foresighted is not under a higher standard. Nearly everyone, then, is judged by a more or less uniform standard of behavior. Allowances are made, however, for the risk apparent to the actor and the circumstances under which he must act. As a uniform standard, the law requires individuals to act as if they actually knew the expected loss. As Prosser noted:

... the standard imposed must be an external one, based upon what society demands of the individual, rather than upon his own notions of what is proper. An honest blunder, or a mistaken belief that no damage will result, may absolve him from moral blame, but the harm to others is still as great, and the actor's individual standards must give way to those of the public. In other words, society may require of him not to be a fool.¹⁴

In light of these two factors (foreseeability and the losses in the event of an accident) the courts set the appropriate standard of precaution which the actor is obligated to undertake. Somehow the disutility of taking precautions is to be weighed against the expected loss.

Traditional Interpretations

As noted earlier in the discussion, a significant change occurred in the law around the turn of the 19th century concerning personal

¹³The blind, insane, and juvenile are granted, as usual, sympathetic treatment before the law.

¹⁴Prosser, Law of Torts, p. 142.

injury liability. In light of this change, legal analysts have attempted to explain this reassignment of liability. What factors can justify the shifting of accidental losses to some faultless victims?

Many have noted that the change occurred simultaneously with early stages of industrialization and the introduction and widespread use of hazardous machinery. An increasingly complex society lead to an unprecedented increase in personal injury litigation. Some claim that the court's caseload simply became overburdened and the change was necessary to ameliorate judicial congestion.¹⁵ This explanation for the change appears to be untenable for at least two reasons. First, it seems unlikely that our court system would turn its back on the public when it is needed most. The intent and purpose of the law is to adjudicate disputes which cannot be settled voluntarily. Undoubtedly the law is willing to change for the sake of administrative and procedural convenience; however, for the courts to ignore an increasing amount of injury and suffering for the express purpose of reducing its workload is contrary to the spirit and design of the law. Second, it is not obvious that a change from strict liability to negligence would reduce the court's workload. To be sure, the caseload of the courts was reduced; but since it is more difficult and time consuming, because of a lack of precedent, to decide each case, the courts may have invited upon itself more, rather than less, work.

¹⁵Ibid., p. 143 and Peck, "Negligence and Liability Without Fault in Tort Law," pp. 229-230.

Posner presents and rejects three orthodox views justifying the adoption of the negligence standard (i.e., the abandonment in some cases of strict injurer liability):

"Justification for the shift, in the orthodox view, can perhaps be found in a desire to subsidize the infant industries of the period but any occasion for subsidization has long passed, laying bare the inadequacy of the negligence standard as a system for compensating accident victims. The need for compensation is unaffected by whether the participants in the accident were careless or careful and we have outgrown a morality that would condition the right to compensation upon a showing that the plaintiff was blameless and the defendant blameworthy."¹⁶

Posner's interpretation and rejection of the traditional views warrant additional edification and support.

The industrial subsidy argument has no application today as a basis for preferring the negligence standard over any other liability rule. For one thing, if society wanted to subsidize industry efficiently, it could achieve this goal best with direct cash payments. Freeing from liability the losses of industrial accidents seems to be rather arbitrary and unpredictable in terms of the magnitude of any subsidy granted. Nor is it a very effective mechanism for promoting the principle of rationality of public choice--the ability of a fiscal system to enable voters to compare the costs and benefits of a collective decision. Even if this subsidy argument were appropriate in the nineteenth century, the long run effects upon the distribution of wealth today appears to be unchanged. In other words, changes in liability rules may temporarily redistribute incomes; but once the

¹⁶Posner, "A Theory of Negligence," p. 29-30.

market has had time to resell the newly created wealth (and absorb the new losses), the final distribution is unlikely to be markedly different from the distribution of income if no shift had occurred.¹⁷ It should be recognized, moreover, that the precedent in Brown v. Kendall, which Chief Justice Shaw used to change the law, "involved not industry, but instead the actions of private persons engaged in separating two fighting dogs. It seems unlikely that [the Chief Justice] shrewdly selected the case in order to disguise the ends to be served by changing the law..."¹⁸

As a system of compensation, adoption of a negligence standard does not score very highly. The determination of fault and indemnity settlements are problematic and costly. Even the late Justice Holmes rejected the compensation argument: "Universal insurance, if desired, can be better and more cheaply accomplished by private enterprise."¹⁹ Liability reassignments do not produce any net compensation for accident losses. There is little reason today to believe that loss spreading cannot be effectively handled with the extensive availability of first party accident insurance. Such policies are neither novel nor expensive to administer.

¹⁷Harold Demsetz, "When Does the Rule of Liability Matter," Journal of Legal Studies, Vol. 1, No. 1, 1972, p. 13.

¹⁸Peck, "Negligence and Liability Without Fault in Tort Law," p. 229.

¹⁹Oliver Wendel Holmes, Jr., The Common Law (Boston: Little, Brown and Company, 1881) p. 96.

Finally, the change to the negligence standard is said to be rooted in a change in moral philosophy during the nineteenth century. A so-called individualistic philosophy took hold. As the negligence standard further replaced strict liability, the courts were saying, in effect, that the members of society were to assume individually a greater share of the risk and responsibilities of living in an increasingly complex and uncertain world. People should not expect the courts to remain a mechanism for shifting all of the misfortune which may befall an individual. This view may offer an explanation, but it does not necessarily provide a justification.

At the same time, the adoption of the negligence standard necessitated the creation of the "reasonable man." And it is against this reasonable man that people were to be judged. Those who failed to undertake reasonable precautions to protect others were to be held responsible for the losses sustained. There can be no doubt that a ruling against the defendant imparted blameworthiness or fault. To be sure, the negligence standard is referred to alternatively as the faulty system which some extol because it has the twin "virtues" of punishing the wrong-doer while compensating the victim. This punitive view was supported by Associate Justice Holmes, who wrote: "In other words, vengeance on the immediate offender was the object of Greek and and early Roman process, not indemnity from the master or owner"²⁰ ...

²⁰Ibid., p. 10.

My aim and purpose have been to show that the various forms of liability known to modern law spring from the common ground of revenge."²¹

The vagueness and lack of specificity of these moralistic interpretation neither advances analysis nor provides us with an objective guide to evaluate the allocative and distributive effects of the law. As a moral concept, it seems unlikely that all would agree upon the adequacy and equity of the negligence standard. Philosophically and morally, it is difficult and perhaps impossible to choose between different liability assignments when one is confronted with genuine accidents. Both parties to an incident could be totally blameless, or equally capable of avoiding an accident; but, ultimately, the law must decide upon whom the loss will finally rest. As a related matter, we must recognize that the courts can never achieve the elusive absolute justice in spite of its moral attractiveness. To resolve the issue on normative considerations is, of course, an impossibility.

The economic interpretation of the negligence standard and the justification for its adoption will be discussed later.

Professional Negligence: Tort Law and Medical Practitioners

The development of the law of torts which governs the practice of medicine is somewhat unusual and unclear. It is generally agreed among legal scholars that the basis for most of what is today commonly called medical malpractice stems from an allegation of negligence. Although

²¹Ibid., p. 37.

the precedent for the negligence standard was handed down in 1825, it was not generally applied in this country to the medical profession until the 1930's.²² The more frequent basis for tort action prior to the Great Depression was the "public calling" doctrine. Liability and the standard of care imposed upon certain professionals did not stem from an explicit contractual agreement; rather, public policy and an implied relationship created the tort obligation. As noted earlier, the general requirement was that those who held themselves out as being competent in certain occupations were under a tort obligation to render their services competently. The professional was expected to exercise his calling with the knowledge and skill commonly possessed by those engaged in it.

The earliest known case of medical malpractice in Anglo-American law involved a surgeon, J. Mort,²³ who in 1374 "...undertook to treat a wounded hand and allegedly acted in such a negligent manner as to maim the hand."²⁴ Although the court dismissed the case on a technical interpretation of trespass, it held that the standard of care suggested in the Hippocratic Oath was sufficient to exculpate the surgeon.

During the eighteenth and early nineteenth century, the English courts further defined the obligation physicians, and particularly

²²Allan H. McCoid, "The Care Required of Medical Practitioners," in Professional Negligence, T. G. Roady and W. R. Anderson, eds. (Nashville: Vanderbilt University Press, 1960) pp. 39-40).

²³Y. B. Hill. 48 Edw III, f. 6, pl. 11 (1374).

²⁴McCoid, "The Care Required of Medical Practitioners," p. 14.

surgeons, were under, drawing frequently upon the statements of Blackstone concerning the implicit contract of "...everyone who undertakes any office, employment, trust or duty... to perform it with integrity, diligence and skill. And if by his want of either of these qualities any injury accrues to individuals, they have therefore their remedy in damages...."²⁵

In the United States, the courts were quick to adopt similar standards. The first recorded case in American law involving alleged malpractice was decided in 1794. A Connecticut court in Cross v. Guthery ruled in favor of the plaintiff charging the physician "...performed such operation in the most unskilled, ignorant and cruel manner, contrary to all the well known rules and principles of practice in such cases."²⁶ Finally in 1853, the New Hampshire court handed down its landmark decision which was to become the precedent governing medical malpractice cases for nearly a century. In its ruling in Leighton v. Sargent the court more clearly defined the duties imposed upon physicians and surgeons:

1. That he possesses that reasonable degree of learning, skill and experience which is ordinarily possessed by the professors of the same art or science, and which is ordinarily regarded by the community, and by those conversant with that employment, as necessary and sufficient to qualify him to engage in such business....

²⁵₃ Blk. Comn. *163.

²⁶₂ Root 90 (Conn. 1794).

2. That he will use reasonable and ordinary care and diligence in the exertion of his skill and the application of his knowledge, to accomplish the purpose for which he is employed.²⁷

The primary role of the courts prior to the 1930's, therefore, was to rule on the competency of medical practitioners in instances where a patient was injured. The courts became, in effect, an extra-professional agency for censuring medical malefactors and charlatans. It should be noted in passing that this judicially imposed standard usually did not call into question the physician's choice of treatment, nor did it deal with errors of omission that could possibly have been made. The emphasis appeared to be on positive acts, or misfeasance, rather than on nonfeasance.

Under the standards set forth in Leighton v. Sargent medical malpractice litigation was infrequent and seldom controversial. As one report noted: "...a medical malpractice suit was a relatively rare occurrence. Seldom did physicians and other health care providers find themselves the targets of suits by dissatisfied patients. During the 19th Century and the first two or three decades of the 20th, there was essentially no such thing as a malpractice 'problem' in the United States."²⁸ Whether or not the infrequency of medical malpractice litigation during this period was a result of patient

²⁷ 27 N.H. 460, 469-72 (1853).

²⁸ Report of the Secretary's Commission on Malpractice, p. 3.

attitudes and expectations or the seemingly low standard of care required by the law is unclear. It has been argued that, compared to present conditions, serious illness and death were more easily accepted by the family. Pneumonia, diphtheria, and childbirth were common sources of death and disability. A doctor visit was rare, and the cure rate comparatively low. For whatever reason, professional liability of physicians and surgeons posed no serious problems for the courts or medical practitioners until the middle of the 1930's.

The number of malpractice suits began to rise sharply in this country during the 1930's. Although California ranked only sixth in population during the decade, it experienced more malpractice litigation than any other state. Similarly large increases in malpractice suits soon followed in Ohio, Texas, Minnesota, and the District of Columbia. The Second World War halted temporarily the rise in malpractice suits but the pace resumed shortly thereafter.

The explanations for this sudden increase in litigation are varied. Some claim that patients' expectations concerning the success of treatment increased as significant advances were made in medicine.²⁹ It is alleged that patients increasingly viewed unsuccessful treatments as the result of physician error rather than limitations of the medical arts. If such a change in attitudes did occur at the time, we would, of course, expect to observe an increase in such litigation. Unfortunately, such an explanation is hard to quantify without being tautological.

²⁹David S. Rubsamen, "Medical Malpractice" Scientific American, Vol. 235, No. 2, August 1976, p. 18.

Another explanation for the sudden increase in malpractice litigation is that during the 1930's and 1940's more people were visiting physicians more often.³⁰ No data, however, have been produced to support this view. It is not necessarily true that more people were seeing physicians more often. If the demand for physician services is income elastic, then the largest increase in doctor visits should have occurred during the period 1880 through 1929 rather than during the 1930's. One would expect also that improvements in public health would actually reduce the "illness induced" demand for physician visits; indeed, such significant advances in general health conditions did occur during the first three decades of this century.³¹

It has been suggested more recently that an increasing knowledge of medical matters by the general public and a "depersonalization" of the doctor-patient relationship have increased the willingness of patients to sue when treatment is unsuccessful.³² This view, as with the previously mentioned interpretations, may explain an increase in suits filed but not necessarily an increase in the number of cases ruled in favor of the plaintiff if the law had been interpreted consistently along prevailing precedent.

³⁰Report of the Secretary's Commission on Malpractice, p. 13.

³¹Erwin H. Ackerknecht, M.D., A Short History of Medicine (New York: Ronald Press Company, 1968) pp. 219-239.

³²C. Dornette, "Medical Injury Insurance--A Possible Remedy for the Malpractice Problem," Journal of Legal Medicine, March-April 1973.

The first emergence of a "malpractice problem" also occurred during a time when the law governing medical practitioners changed considerably. Recall that the duty of care since about 1850 required a physician to possess the skill and knowledge of the average physician in the same or similar localities and to exercise a corresponding average level of skill and diligence. During the 1930's, however, tort law governing the medical profession changed markedly. The courts began imposing additional standards of care, beginning with the establishment of the "duty to keep abreast of progress in the profession." This duty apparently arose as a result of the introduction of X-ray technology. In several cases,³³ the courts ruled against the defendant on the grounds that the physician was negligent for not making use of X-ray analysis in treating broken bones. Additional affirmative duties were soon placed upon physicians where none existed previously.³⁴

Another significant development occurred in California in 1944. The State Supreme Court in Ybarra v. Spangard³⁵ firmly entrenched the doctrine of res ipsa loquitur.³⁶ The effects of this doctrine

³³ For example: Agnew v. City of Los Angeles, 82 Cal. App. 2d 616, 186 p. 2d 450 (1947); DeHaan v. Winter, 258 Mich. 293, 241 N.W. 923 (1932); and Willett v. Rowekamp, 134 Ohio St. 285, 16 N.E. 2d 457 (1938).

³⁴ Other duties include "duty to inform or disclose facts," "duty to refer to specialist," and more recently in California, "duty to report abused child."

³⁵ 25 Cal. 2d 486, 154 P. 2d 687, 162 A.L.R. 1258 (1944).

³⁶ Literally "the thing speaks for itself," first mentioned in Byrne v. Boadle, 1862, 2 H. & C. 722, 159 Eng. Rep. 299.

essentially were to obviate expert testimony as part of the plaintiff's burden of proof and to make circumstantial evidence admissible. In other words, the burden of the plaintiff's proof was reduced significantly and the courts permitted an inference, rather than a proof, of negligence in some cases.³⁷ Needless to say, the number of malpractice suits filed soon followed and an increasing number of cases were ruled in favor of the plaintiff.

At the present, the law of torts has moved fully to the point where medical practitioners are accountable equally for their acts of professional misfeasance and nonfeasance. Physicians not only have to possess adequate skill and knowledge and exercise reasonable care to protect their patients from injury but they also are expected to take into account the effects of not undertaking an alternative or additional treatment. No longer are physicians expected only to perform skillfully; they must also choose the proper treatment, operation, or level of testing.

Medical malpractice cases today very rarely involve a sponge left in a surgery patient, removal of the wrong organ, or lack of informed consent. Currently, medical practitioners are sued most for "failure to prevent an abnormal condition" and "failure to accomplish intended result." During a twelve month period of 1975 and 1976, for instance,

³⁷Some contend, "...that the doctrine of res ipsa loquitur is applied, in many cases, to impose liability upon defendants who in reality have not been negligent at all." William Prosser, "The Assault Upon the Citadel," Yale Law Journal, Vol. 69, (1960) p. 119.

failure to prevent an abnormal condition was alleged in sixty percent of all reported malpractice incidents.³⁸

It seems clear that the recent increase in malpractice litigation is mainly the result of the expanded duty of care physicians are under. As the burden of proof for the plaintiff is reduced, more of the patients' losses can and will be shifted to the physician or other health care provider. The important question concerning this matter is: Do the gains from shifting more liability of physicians outweigh the costs associated with such a change?

The Case for Physician Liability

Before analyzing in detail the economic function of accident liability in general, it would be useful to review briefly the purported advantages or benefits of physician liability in particular. Apart from the requirements of justice, there are three basic arguments for holding physicians liable for some of their patients' unintended personal injuries and losses.

The first of these arguments is the view first advanced by Calabresi³⁹ and further developed by Posner⁴⁰. Their view is simply that the goal of tort liability (e.g., the negligence standard) is to

³⁸Malpractice Claims, National Association of Insurance Commissioners, Vol. 1, No. 4, 1976, p. 16.

³⁹Guido Calabresi, The Costs of Accidents: A Legal and Economic Analysis (New Haven: Yale University Press, 1970), p. 26.

⁴⁰"A Theory of Negligence." For additional detail, see Chapter Three, pp. 57-64.

promote allocative efficiency. This can be achieved when the sum of the costs of accidents and the costs of avoiding accidents are minimized. In the absence of tortfeasor liability, it is argued, accident losses would be "externalized" from the injurer to the victim. If the injurer were not held liable for the victim's losses, then there would be no incentives for the tortfeasor to take actions which would protect potential victims. This line of reasoning concludes that negligence or strict injurer liability is necessary to create incentives so that potential injurers would undertake cost justified precaution (i.e., the burden of taking precautions that would avert the accident is less than the expected accident losses). Fault liability thus attempts to "internalize" accident costs and thereby encourages potential injurers to take cost justified accident avoidance and results in the efficient level of accidents and safety. Although the popular concept of medical malpractice is that it discourages physician "misconduct," this form of liability can be interpreted in economic terms as a way of internalizing the costs of economically avoidable injuries.

There are several reasons to believe that physician liability is unnecessary in order to promote this efficiency goal. In the first place and most importantly, the externality analogy is not applicable because the parties involved in a medical malpractice suit are not brought together only as a result of a chance-encounter mishap. This is to say, the externality analogy holds only in instances where pre-accident bargaining is not feasible because of prohibitively high transaction costs (e.g., in the case of automobile accidents). As

Demsetz⁴¹ and Stigler⁴² correctly pointed out, when pre-accident bargaining is possible (i.e., relatively low transaction costs), the rule of liability "does not matter." When potential tort feors and victims have the opportunity to agree upon each party's responsibilities and liability, as far as promoting optimal resource allocation, it does not matter whether the courts enforce strict victim, negligence, or strict tort feor liability; in all instances, physicians and patients will agree upon the appropriate level of care and precaution. Physicians would be willing to "sell" as much precaution and treatment as their patients value. In other words, so long as the patients' expected benefits from additional precaution or treatment exceed the physician's marginal cost of treatment, both will agree upon further treatment or additional care. The result of this market-like process is to lead to the optimal level of treatment and precaution and to avoid uneconomical accidents.

There is a second argument that weakens the case for negligence liability as a way of discouraging physician misconduct. Even if physician liability encourages doctors to practice carefully, the nature of physician liability insurance attenuates these incentives. This is so because medical malpractice premiums are seldom based upon the experience rating of the individual physician. They are, instead,

⁴¹"When Does the Rule of Liability Matter."

⁴²George Stigler, "Edited Transcript of AALS-AEA Conference on Products Liability," in The Economics of Legal Relationships, Henry G. Manne, ed. (St. Paul: West Publishing Company, 1975), pp. 279-281.

usually determined exclusively by the physician's regional location and type of practice. The individual doctor therefore, is unlikely to have to pay higher insurance premiums or experience personal financial hardships as a result of his negligence. The moral hazard problem becomes particularly troublesome with this type of insurance system and undoubtedly undermines the ability of the law to promote better quality health care. In the long-run, most and perhaps all of these insurance premiums are borne by patients.

There are other extra-legal factors that limit physician misfeasance. Foremost among these is a doctor's desire to establish and maintain a good reputation. Physicians who have a good record of successful treatment are more likely to have a profitable practice or to be able to charge more for his services. The business concept of "goodwill" and competition among physicians are strong incentives to practice in the best interest of a patient. Although nearly every state restricts physician advertising, doctors do, in fact, have reputations among their colleagues and the public.

The second major argument in favor of physician liability is that it provides injured parties with a system of accident compensation. As to be discussed, this aspect of tort law is probably its weakest. The transaction costs associated with third-party liability are extraordinarily high. These high costs are illustrated by the fact that only about twenty-five percent of malpractice premiums paid is ultimately received by injured patients. It should be obvious that using the courts to determine compensation eligibility and the amount of

compensable damages is a resource consuming process because each dispute must be decided upon on a case basis. The adversary system results in an over investment in the decision making process (i.e., fault determination and compensable losses). As compared with private, no-fault systems of accident insurance, the process of litigation is a very costly and unpredictable system. To be sure, some injured patients receive relatively large sums of money as a result of malpractice litigation; but, the percentage of patients who file suit and who receive compensation is small and payments are usually made only after years of legal maneuvering. Moreover, some studies⁴³ estimate that attorneys accept only one out of eight cases. Many injured patients are rejected because the amount of the claim is too small for the lawyer to recover what he considers to be an adequate fee. The result of the present system is to provide no coverage for patients sustaining relatively small injuries.

Another argument in support of the present system of medical malpractice liability is that there is an inherent inequality of information or knowledge between the doctor and his patient which gives the physician "superior bargaining power" over the lay public. Undoubtedly doctors possess considerably more knowledge about medical matters than the general public--this is precisely why they are practicing physicians and why there is a market for health care.

⁴³An Overview of Medical Malpractice, Committee on Interstate and Foreign Commerce, U.S. House of Representatives, 94th Congress, 1st Session, p. 23.

The issue of differential information has generated two important legal doctrines in civil law, and both of these doctrines are applicable to medical malpractice. In some instances the courts have invoked the concept of duress or unconscionability as a defense to suit on a contract. In general these cases do not involve fraud or misrepresentation; rather, the courts void the contract after one party has learned that the terms of the sale are much less favorable than originally perceived. Since many contracts are standardized and, consequently, offered only on a take-it-or-leave basis:

(T)he purchaser can sign it or not as he pleases, but there is no negotiation over terms. It is an easy step from the premise that there is no negotiation to the conclusion that the purchaser lacked a free choice and therefore should not be bounded by onerous terms.⁴⁴

Posner continues his analysis of this concept of duress by offering two explanations why a seller might adopt a take-it-or-leave-it policy--one is innocent and the other is sinister.

The innocent explanation is that he wishes to avoid the costs involved in negotiating and drafting a separate agreement with each purchaser. These costs are likely to be very high for a large organization that engages in so many transactions that it must adopt routine procedures for the guidance of its line personnel. The sinister explanation is that the seller refuses to negotiate terms with each purchaser because the purchaser has no choice but to accept his terms.... The sinister explanation is in general implausible

⁴⁴Richard A. Posner, Economic Analysis of Law, 2nd edition (Boston: Little, Brown and Company, 1977) p. 84.

because it implicitly assumes the absence of competition.⁴⁵

Thus, there are few economic reasons to prohibit contracting based upon this rather dubious interpretation of duress.

The other, and more important, legal doctrine arising from the inequality of information between buyers and sellers deals with the judicial imposition of seller's liability and the invalidation of waivers of liability. The rationale for the court's position on this matter is unclear and cannot be justified on economic grounds. Consider, for example, the following view expressed recently in a footnote by a law professor:

"We disregard the thought that the patient should ask information before the physician is required to disclose. Caveat emptor is not the norm for the consumer of medical services. . . . The patient may be ignorant, confused, overawed by the physician or frightened by the hospital, or even ashamed to inquire. . . . Perhaps relatively few patients could in any event identify the relevant questions in the absence of prior explanation by the physician. Physicians and hospitals have patients of widely divergent socio-economic backgrounds, and a rule which presumes a degree of sophistication which many members of society lack is likely to breed gross inequalities.⁴⁶ (emphasis added)

This line of reasoning is interesting but incomplete and unconvincing.

In the first place, the argument does not specify what the "gross inequalities" are or why they are objectionable. Moreover, it is

⁴⁵ Ibid.

⁴⁶ John Bines, "Medical Malpractice Problems," unpublished manuscript, University of Virginia School of Law, 1975, pp. 20-21.

not obvious that replacing caveat emptor with the rule of caveat venter is likely to result in fewer inequalities. The application of caveat vendor is likely, in fact, to exacerbate the information disparity since it establishes few incentives for the patient to become informed about the consequences of alternative treatment.

This view also ignores the fact that in a medical malpractice case, the same (unsophisticated) laymen are required as jurors to decide whether or not a physician negligently treated a patient. One would normally assume that the layman would be more inquisitive and attentive to medical issues as a patient than as a juror. This argument is ironic in that it suggests that laymen cannot be trusted to acquire information and make decisions intimately related to his personal health and well-being as a patient but is entrusted with the power as a juror to pass judgement on the professional conduct of medical practitioners.⁴⁷ The logical conclusion of this argument is to reject trial by jury in malpractice cases. The asymmetry here is difficult to reconcile.

Another example of the court's reasons for invalidating private efforts to contract out the judicially mandated liability rules for medical malpractice was expressed by a California court. In the case of Tunkl v. Regents of University of California the court voided the contractual provision in which a charitable research hospital sought to exempt itself from malpractice liability:

⁴⁷ See also, Chapter Four, "Court Error" pp. 82-85.

". . . , in the economic setting of the transaction, the party invoking exculpation possesses a decisive advantage of bargaining strength against any member of the public who seeks his services. In exercising a superior bargaining power the party confronts the public with a standardized adhesion contract of exculpation, and makes no provision whereby a purchaser may pay additional reasonable fees and obtain protection against negligence. Finally, as a result of the transaction, the person or property of the purchaser is placed under the control of the seller, subject to the risk of carelessness by the seller or his agent.⁴⁸

It is interesting to note that the court objected to the standardized contract form. Apparently the court suspected the "sinister" explanation for the take-it-or-leave-it contract adopted by the hospital. Finally, the opinion seems to ignore the fact that such exculpation was in exchange for a lower cost to the patient. In other words, the purchaser was apparently willing to exchange a waiver of liability (i.e., subjected to the risk of carelessness) for a reduced cost of treatment. As previously discussed, there are no compelling economic reasons for prohibiting rational individuals from assuming such risks.

⁴⁸60 Cal. 2d 92, 32 Cal. Rptr. 33, 383, P. 2d 441 (1963).

CHAPTER THREE
ECONOMIC ROLE OF LIABILITY RULES

Introduction

The purpose of this section is to integrate the economic and legal concepts of property rights, externalities, liabilities rules, and allocative efficiency. The analysis is developed along the following lines. First, it is assumed that an efficient outcome is achieved when all of the gains from trade have been exhausted, or, within the Buchanan-Stubblebine framework, there are no relevant marginal external economies or diseconomies, i.e., Pareto equilibrium has been attained.¹ Second, the analysis explicitly recognizes the difficulty of assigning completely and fully all (present and future) property rights. This difficulty is especially significant with respect to intangible property rights such as a political right or a right to freedom from bodily harm. The discussion will analyze the role of the judicial system as an extra-market institution to protect these property rights in a world where assigned rights are not always honored or respected. The analysis will also develop some limits to the extent rights can be socially assigned and guaranteed. Finally, the efficacy of various liability rules to protect these rights will

¹James M. Buchanan and William G. Stubblebine, "Externality," Economica, Vol. 29, No. 116, pp. 372-376.

be discussed with special consideration given to their comparative abilities to facilitate the attainment of a Pareto equilibrium.

Market Failure and Public Policy

The general theoretical justification for public intervention in the economy is founded primarily upon the concept of "market failure." Since Alfred Marshall (and especially beginning with A. C. Pigou), modern value theory has engendered a school of welfare economics that has criticized the market for its failure to achieve the economic efficiency claimed for it. The "new" (post-Robbins) welfare economics has employed microeconomic theory to develop the necessary conditions that must exist in product and factor markets to achieve a so-called social optimum. At base, the private market has been attacked because of its alleged inability to reflect full (private and social) costs and benefits in market prices. If market determined prices do not include total costs and benefits, then decentralized decisions based upon observed prices will lead to an inefficient allocation of resources.

The factors that account for the inability of decentralized private markets to achieve economic efficiency are numerous, and many attempts to reduce the variety of conditions to some common elements have been made.² The essential and common characteristic of market

²For examples of different approaches to the classification problem, see: J. E. Meade, "External Economies and Diseconomies in a Competitive Situation," Economic Journal, March 1952, pp. 54-67; Tibor Scitovsky, "Two Concepts of External Economies," Journal of Political

failures, however centers upon the existence of Pareto relevant marginal external economies and diseconomies.

Various institutional arrangements are available to deal with these Pareto relevant externalities. These include, but are not limited to:

- 1) public provision (e.g., national defense and public safety);
- 2) direct regulation (e.g., transportation and utilities);
- 3) fines, taxes, and subsidies (e.g., traffic tickets and housing subsidies);
- 4) private action litigation (e.g., environmental protection and personal injury);
- 5) voluntary, private arrangements (e.g., shopping centers and condominiums).

All five have in common an ability to reallocate resources among competing uses and alter relative prices. They differ in terms of their comparative abilities to correct market failures because of the inherent differences in the characteristics of each situation. In

Economy, April 1954, pp. 143-151; Francis M. Bator, "The Anatomy of Market Failure," Quarterly Journal of Economics, August 1958, pp. 351-379; John G. Head, "Public Goods and Public Policy," Public Finance, No. 3, 1962, pp. 197-221; James M. Buchanan, "Joint Supply, Externality, and Optimality," Journal of Political Economy, November 1966, pp. 404-415; James M. Buchanan, The Supply and Demand for Public Goods (Chicago: Rand McNally, 1968); and Kenneth Arrow, "The Organization of Economic Activity: Issues Pertinent to the Choice of Market versus Nonmarket Allocation," in J. Margolis and R. H. Haveman, eds., Public Expenditures and Policy Analysis (Chicago: Markham, 1970), pp. 59-73.

other words, given the degree of indivisibility or consumption jointness and the size of the interacting group, the appropriate organizational arrangement for correcting observed market failures will depend upon the relative advantage of each to achieve the optimal level of market failure at the least cost.³ Public policy towards personal injury arising from medical treatment traditionally has favored private action litigation, although this does not preclude other approaches nor does it necessarily mean that the observed policy allows all potential gains from trade to be realized.

In all cases, however, the notion of property rights and their enforcement are at the core of nearly all instances of market failure. It is nearly universally agreed that resource ownership is a necessary, but not sufficient, condition to the attainment of economic efficiency.⁴ Given the importance of property rights, the assignment and enforcement of resource ownership constitutes a public good in its purest sense. Generally speaking our judicial system is the institution

³ Monopoly and antitrust policy represent a case in point. Currently, each of the first four arrangements are used to deal with the market failure associated with monopoly. Some have argued that the optimal degree of competition can be most effectively achieved by using a simple system of fines rather than the present private action litigation involving treble damages. See, Kenneth G. Elzinga and William Breit, The Antitrust Penalties: A Study in Law and Economics (New Haven: Yale University Press, 1976).

⁴ See, for example, Posner, Economic Analysis of Law, pp. 27-34, Harold Demsetz "Toward a Theory of Property Rights," American Economic Review Proceedings Issue, May 1967, p. 347, and Milton Friedman, Capitalism and Freedom (Chicago: University of Chicago Press, 1962), Chapter 2.

usually responsible for such enforcement. As with nearly all other organizational arrangements, there are alternative "rules" that can be used to assign and protect property rights and to encourage efficient resource use. As previously noted, our present system of civil law is empowered with alternative liability rules to assign and protect property rights.⁵ The judicial system can facilitate efficient resource use by performing two important functions: First, the courts can compel individuals to fulfill the voluntary agreements they have entered into; and second, the courts can establish property rights entitlements by adjudicating disputes over resource transfers that occur in the absence of an agreement, and consequently, provide information to guide future interaction among society's members. These two functions constitute the economic role of the judiciary concerning property rights enforcement necessary to allocative efficiency.

Property Rights and Resource Allocation

About two decades ago economists renewed their analysis of the economic effects of alternative systems of assigning property rights.⁶ Property rights and liability assignments are similar economically

⁵For more details, see Guido Calabresi and A. Douglas Melamed, "Property Rules, Liability Rules, and Inalienability: One View of the Cathedral," Harvard Law Review, April 1972, pp. 1089-1128.

⁶See, for example, Ronald Coase, "The Federal Communications Commission," 2 Journal of Law and Economics 1, 1959, and S. Gordon, "The Economic Theory of a Common-Property Resource: The Fishery," Journal of Political Economy, Vol. 62, April 1954.

insofar as nonmarket institutions can be employed to convey and guarantee to particular individuals the exclusive ownership of a particular asset in an effort to facilitate efficient resource allocation.

If ownership of all scarce resources were universally assigned and honored, then the need for other forms of market intervention are obviated. Put differently, a necessary and sufficient condition for allocative efficiency is that resource ownership must, at zero transactions costs, be completely assigned and freely exchangeable. If ownership rights are respected, then private, voluntary exchange will tend to transfer efficiently resources to their most valued use. Or, as Posner noted:

By a process of voluntary exchange, resources are shifted to those uses in which the value to consumers, as measured by their willingness to pay, is highest. When resources are being used where their value is highest, we may say that they are being employed efficiently.⁷

The important conclusion from the property rights analysis is straightforward and intelligible to the economists: In the absence of negotiation costs, and assuming universal and well defined private property, the observed allocation of resources is Pareto optimal. In other words, "If people are rational, bargains are costless, and there

⁷Posner, Economic Analysis of Law, p. 10. The efficiency criteria are developed rigorously in F. M. Scherer, Industrial Market Structure and Economic Performance (Chicago: Rand McNally and Company, 1970) Appendix to Chapter 2, pp. 543-550.

are no legal impediments to bargains, transactions will ex hypothesis occur to the point where bargains can no longer improve the situation...."⁸ This, of course, is merely a restatement of Coase's important conclusion in his seminal Journal of Law and Economics article in 1960.⁹ It is interesting to note how long it took, nearly a decade, before the now famous Coase theorem was understood and accepted generally.¹⁰

It appears currently that the proper synthesis of externalities and property rights has occurred. In light of this recognition, recent developments have offered a more sophisticated integration of these contractual rules and efficient resource allocation. In sum, it is not the failure of the market to allocate scarce resources efficiently, but rather nonoptimal allocations are frequently the failure of incomplete or disregarded property rights assignment. It has been

⁸Guido Calabresi, "Transaction Costs, Resource Allocation and Liability Rules--A Comment," Journal of Law and Economics, Vol. II, (1968), pp. 67-73.

⁹Ronald Coase, "The Problem of Social Cost," Journal of Law and Economics Vol. III, October 1960, pp. 1-44.

¹⁰For example, "The Coase theorem thus asserts that under perfect competition private and social costs will be equal. It is a more remarkable proposition to us older economists who have believed the opposite for a generation, than it will appear to the young reader who was never wrong, here." George J. Stigler, The Theory of Price, 3rd ed., (London: The Macmillan Co., 1966), p. 113 and "Various writers ... accepted that conclusion (the Coase theorem) for the short run, but had doubts about its validity in the long run situation.... Further thought has convinced me that... Coase's analysis must hold for the long run as well as the short run." Calabresi, "Transaction Costs, Resource Allocation, and Liability Rules."

recognized also that the market is allocatively efficient given the presence of positive transaction and enforcement costs.¹¹

It is relatively easy to uncover examples of inefficient resource allocation given positive negotiation and protection costs as compared with some idealized yet unattainable world. It is merely the limited technology of exclusion (positive enforcement costs) and imperfect information which forestall the attainment of the necessary marginal conditions for Pareto optimal resource allocation.

Property Rights Enforcement

Impediments to allocative efficiency do exist, however, in the real world for two basic reasons. First, it is unrealistic and grossly optimistic to rely upon only voluntary transfers. Involuntary transfers have been, and continue to be, pervasive. Liability rules, like property law, can be devised to overcome some of these problems. Second, technical and institutional limitations may prevent the complete assignment of ownership rights, especially in instances where price exclusion is impossible or enforcement costs are prohibitively high. Institutionally imposed restrictions on exchange in the absence of relevant externalities may also forestall the efficient allocation of resources.

Within our system of jurisprudence, civil law is used to deal with most involuntary or coerced private transfers. If someone either

¹¹See George Stigler and Harold Demsetz in "Edited Transcript of AALS-AEA Conference," Henry G. Manne, ed., in The Economics of Legal Relationships (St. Paul: West Publishing Co., 1975), pp. 279-281.

unilaterally destroys or reduces the value of an asset, or denies the rightful owner use of his property (thus creating Pareto relevant external diseconomies), the courts are empowered to compel compensation. In the welfare economist's terminology, by requiring indemnification the courts are attempting to internalized the Pareto relevant external diseconomies associated with these involuntary, unilateral transfers.

To efficiently internalize these external diseconomies which result from involuntary transfers the courts must not only require restitution but also award settlements equal to the payment which would have been made voluntarily.¹² The courts are thus in the unenviable position of having to infer ex post the ex ante intentions of the individuals involved in a dispute. Personal injury litigation is by the far the most complex area of civil law that deals with this matter. Unlike real property, the right to bodily integrity is difficult to enforce for numerous reasons and warrants additional consideration. First and foremost, it is extraordinarily difficult, given the absence of an active private market for such rights, to determine accurately the monetary value of "bodily property." Second, it must be recognized that a right to bodily integrity or freedom from bodily harm cannot be guaranteed absolutely. For example, the courts seldom protect or enforce property rights from self-destruction or from losses resulting from "acts of God."

¹²See Calabresi and Melamed pp. 1106-1110 and Posner, Economic Analysis of Law, pp. 97-98.

Placing a monetary value on bodily integrity poses two problems for the courts which may hinder efficient transfers. First, personal injury may entail substantial nonmonetary costs (e.g., pain and suffering, disfigurement, and alienation of affection). Being purely psychological and nontransferable it is impossible to calculate cardinally or compare interpersonally the extent of such personal injuries although they are real losses to the individual. Within the context of externalities, the courts are assigned the impossible task of determining how much loss in "utility" the victim has suffered. In essence the subjective value of the Pareto relevant external diseconomies must be derived without the aid of an ordinary market to assist in supplying some information about their values.

In addition to the valuation problem, it is again impossible to determine which injuries are unavoidable or unforeseeable "acts of God." Another way of putting the same thing is to recognize the impossibility of everyone in society eliminating or escaping the costs of some bodily injury. Absolute freedom from bodily harm cannot be guaranteed in the aggregate. Within the Knightian framework we can expect, but cannot avoid, the uncertainty of an unpredictable future. We know that some losses will occur, but we do not know exactly when or to whom misfortune will befall. As a consequence of an uncertain future, a decision must be made as to how these risks will be assigned among society's members. The decision could be either a formal, collective choice (e.g., legislation) to spread losses in a predetermined way or the implicit choice not to intervene and let the victim bear the loss. In

either case, the courts cannot in any meaningful sense guarantee to every member of society the right to enjoy the full value (utility) of one's total wealth.

This point can be clarified by way of an example. Assume the familiar Robinson Crusoe isolated individual case. His standard of living or level of utility will be directly related to his productivity, given the available resources. It is incorrect, however, to assume that all of Crusoe's income (production) will be available for current and future consumption. An earthquake may destroy his fort, or insects may invade his food bins. A moment's reflection will uncover the obvious fact that there is no such thing as a natural right to complete bodily integrity or an absolute freedom from misfortune. Some reduction in utility as a result of misfortune can be viewed as an infra-marginal diseconomy.¹³ Although it is possible in any particular case to re-allocate the losses from "acts of God," in the aggregate the burden of these unavoidable mishaps cannot be shifted (i.e., someone ultimately will bear the loss).

Two other significant obstacles to allocative efficiency are the technical limitation that preclude zero enforcement and protection costs and institutional constraints that prohibit voluntary transfers even in the absence of Pareto relevant marginal diseconomies. In other words, in some cases the costs of protecting an assigned property right may well exceed the value of that right. As a result most people

¹³ See Buchanan and Stubblebine, "Externality," p. 373.

rationally do not enforce their rights even though the externality is relevant to the injured party. In this case positive bargaining costs may render an otherwise potentially relevant external diseconomy irrelevant. These involuntary transfers remain uncompensated. Such transfers may offend our sense of justice, but pragmatic considerations tell us their protection is not justifiable.¹⁴

In some instances, of course, the aggregate value to the victims of these involuntary transfers may exceed the costs of enforcement by a central or collective agency. This is of little importance here because the purpose of the analysis is not to improve the technology of bargaining or enforcement. The allocative inefficiencies which supposedly stem from free-rider and nonexclusion problems (so-called sources market failure) disappear when we assume zero transactions costs and complete ownership. Potentially relevant externalities become irrelevant, not because of a failure or inadequacy of the market to accommodate mutually beneficial trades, but rather because of the technical limitations that result in positive costs of enforcing the assigned property rights.

Institutional constraints may also forestall Pareto efficient movements. In some instances not all property rights are assigned or recognized by the enforcement agency of a society. Pareto efficient changes will result only when the parties involved have legitimate

¹⁴See Harold Demsetz, "The Exchange and Enforcement of Property Rights," Journal of Law and Economics, Vol. II, 1964.

claims over the resources they desire to exchange. The agencies responsible for assigning and protecting property rights frequently do not or cannot grant control over these rights to any particular individual. It would be highly unlikely that resources would be efficiently utilized in the absence of exclusive control. Common property "abuse" is typical. In other cases, Pareto efficient movements are not observed because judicial restraints prohibit certain exchanges. So-called inalienable rights or acts which are judged mala prohibita are examples. By no stretch of the imagination could the unrealized gains from trade be blamed on market failures.

Economic Interpretation of Negligence

Within our system of jurisprudence, many disputes over property rights arising from intentional interferences with property or violations of one's bodily integrity are adjudicated under criminal law. In other instances, civil law is the formal institution designed to settle conflicting claims among individuals over ownership rights. Commercial transactions are generally governed by the common laws of contract and property. The unintentional interferences with person and property are usually handled under the law of torts. Tort Law also governs disputes between interfering activities or simultaneous claims to divisible (private) resources. The economic function of tort law can be viewed as the same as in property and contract law--to define and enforce property rights so that resources will be efficiently used.

If we assume that accident (i.e., unintentional) losses and the burden of preventing accidents are undesirable yet unavoidable and cannot be adequately handled by private agreement, then the economic role of tort law would be to minimize these costs. Conversely, the appropriate liability rule would be that one which maximized the joint value of potentially conflicting activities.

Although many factors effect the ability of a particular system to achieve this cost minimizing result, one must begin with an analysis of the basic incentives created under various liability rules. Later other relevant factors (such as the cost of administering a system or decision making costs) can then be introduced in an effort to evaluate the overall ability of a given system to facilitate a desired outcome.

As discussed in the preceding section, the adoption of the negligence standard in this country has been interpreted along several different lines. Only until recently has an effort been made to explain in economic terms the change from liability without fault to the fault standard. Perhaps moral considerations concerning blameworthiness and fault and the punitive nature of the law have obfuscated the economic consequences of changing liability assignments.

Nearly a hundred years ago, Oliver Wendel Holmes, Jr. alluded to an economic argument for not reassigning accident losses when he wrote "... the prevailing view is that its (the government's) cumbrous and expensive machinery ought not to be set in motion unless some clear

benefit is to be derived from disturbing the status quo. State interference is an evil, where it cannot be shown to be a good."¹⁵ It appears that the late Supreme Court Justice was saying, in effect, that where there is no gain from shifting a loss, there is no reason to shift it.

Despite its brevity, this interpretation is economically very sophisticated. If we ignore distributional consequences, then an efficiency criterion for reassigning losses through judicial interference would be to shift losses only when it can be shown there exist net gains from doing so. From the economist's perspective, we would want to know if the gains, somehow measured, from a given reassignment outweigh the costs associated with implementing the change. Unfortunately, Mr. Holmes did not provide any guidance for determining when "some clear benefit is to be derived from disturbing the status quo."

Detailed analysis of the allocative effects of various liability rules has progressed rapidly within the past several years.¹⁶ With respect to the negligence standard in particular, Richard Posner was

¹⁵The Common Law, p. 96.

¹⁶For example, see: Prosser, "Assault Upon the Citadel"; Walter J. Blum and Harry Kalven, Jr., Public Law Perspectives on A Private Law Problem--Auto Compensation Plans (Boston: Little, Brown and Company 1965); Guido Calabresi, "Fault, Accidents and the Wonderful World of Blum and Kalven," Yale Law Journal, 75 (1965); Walter J. Blum and Harry Kalven, Jr., "The Empty Cabinet of Dr. Calabresi," University of Chicago Law Review 34 (1967); Roland N. McKean, "Products Liability: Some Implications of Some Changing Property Rights," Quarterly Journal of Economics (1970), and Demsetz, "When Does the Rule of Liability Matter?"

one of the first to develop "... a theory to explain the social function of the negligence concept and of the fault system of accident liability that is built upon it."¹⁷ Although Posner's analysis is not completely correct throughout,¹⁸ he does offer a testable hypothesis about the social function of the negligence concept to facilitate the attainment of "the efficient--the cost-justified--level of accidents and safety."

Posner begins by restating Judge Learned Hand's famous interpretation of what constitutes reasonable or ordinary care in a negligence case: If the probability of an accident occurring times the magnitude of the loss if an accident occurs is greater than the burden of taking precautions that would avert it, then the injurer's failure to take the precaution constitutes negligence. This interpretation coupled with a defense of contributory negligence (the victim was in a position to undertake cost-justified precautions at a lower cost than the injurer could) would, assuming zero transaction costs and complete information, generate the efficient (cost-justified) level of accident and accident avoidance. Under such a system of liability a potential injurer will

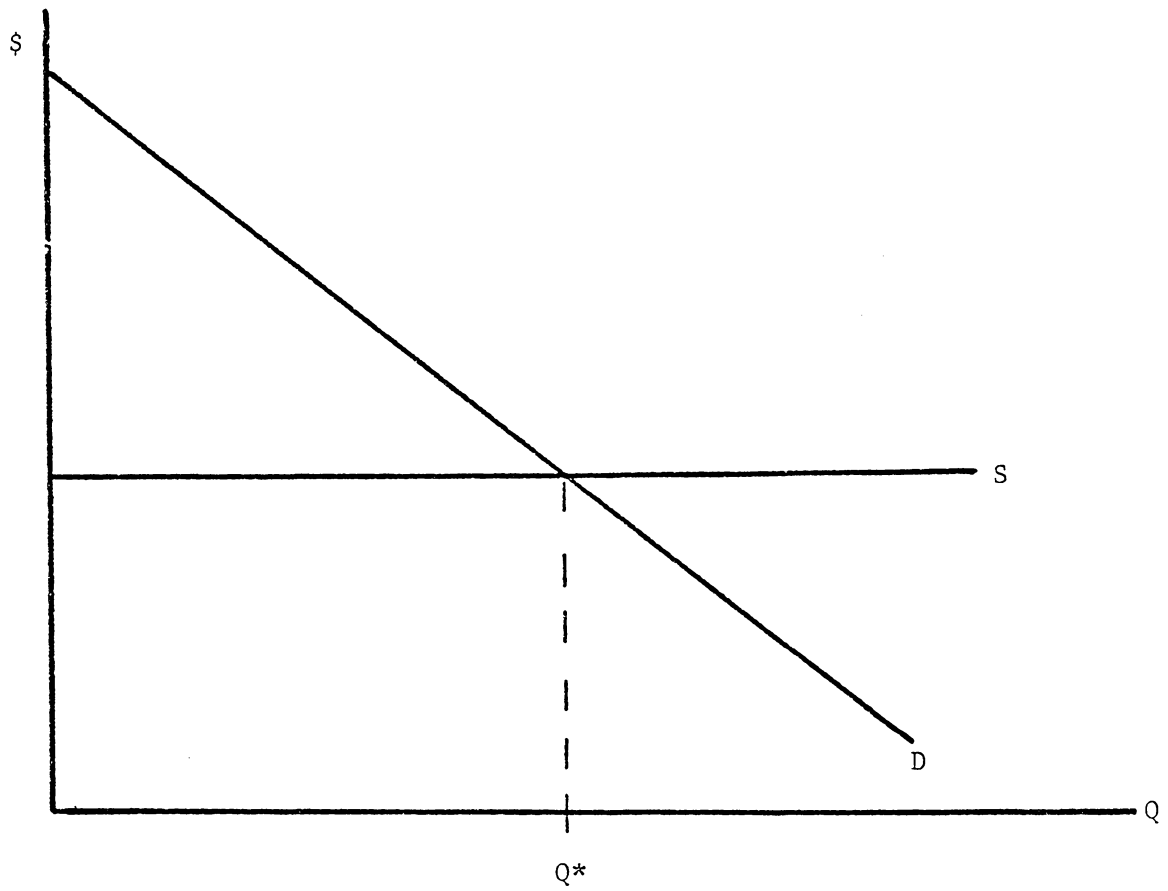
¹⁷Posner, "A Theory of Negligence," p. 29.

¹⁸For example, he states early in the article that a result of relaxing strict liability upon the injurer and adopting the negligence rule, "was that accident costs were 'externalized' from the enterprise that caused them to workers and other individuals injured as a by-product of their activities" (p. 29). As we will see, wage and product price changes render these externalities between the enterprise and its employees and customers Pareto irrelevant. The only relevant externality would be between the enterprise and those effected individuals with whom no pre-encounter agreement could be reached, i.e., strangers.

take into account the "accident cost" associated with a particular undertaking or action. In the absence of negligence liability, these accident costs would be externalized from the injurer to the victim only in instances where the injurer and victim are unable to reach private agreement over who is to undertake precaution and how the losses will be spread among the affected parties. In economic terms, then, a negligence liability rule constitutes a social contract governing the ultimate distribution of accident losses when private agreement is not feasible. According to Posner¹⁹ the negligence standard in its idealized form creates the correct set of incentives to generate the efficient level of accidents and safety.

The standard of due care is depicted graphically in Graph 1. Units of precaution or accident prevention are given along the abscissa while the ordinate measure costs and benefits. For simplicity it is assumed that units of precaution can be supplied at constant cost and is depicted as S. The benefits from accident avoidance are shown as D, which is equal to the marginal productivity of additional units of precaution to reduce the probability of an accident times the loss in the event the mishap occurs. The optimal quantity of accident avoidance is at the intersection of D and S and labeled Q*. Failure to provide at least Q* precaution constitutes negligence and if an accident results, the individual who is in a position to take the precautions is liable for the accident loss.

¹⁹Ibid., and "Strict Liability: A Comment," Journal of Legal Studies, Vol. 2, No. 1, 1973, p. 205.



Graph 1

Optimal Level of Precaution

Calabresi envisions a nearly identical economic role for tort liability; specifically, he states, "Apart from the requirement of justice, I take it as axiomatic that the principal function of accident law is to reduce the sum of the costs of accidents and the costs of avoiding accidents."²⁰ Both Posner and Calabresi agree that in the absence of transaction and decision making costs and assuming perfect information, the negligence standard is capable of minimizing the costs of accidents and precaution.

The conclusions of Coase, Posner, and Calabresi have been corroborated in a more formal, theoretical analysis by John P. Brown. He begins by stating, "(T)he social optimum we shall define as that combination of avoidance measures which minimizes the sum of the costs of the controls and the expected cost of the accident."²¹ He concludes that in most instances the rule of liability has little or no effect upon the attainment of efficient resource allocation.

The exception to this conclusion are accidents involving individuals who are brought together only by chance-encounter mishaps. These situations involve accidents among strangers and consequently, the circumstances preclude any opportunity for the effected parties to agree voluntarily upon how to avoid the mishap or share the resulting losses. More formally, accident prevention may be under the control of two or more noncooperating individuals (i.e., strangers). Under

²⁰ Calabresi, The Costs of Accidents, p. 26.

²¹ John P. Brown, "Toward A Theory of Liability," Journal of Legal Studies, June 1973, p. 325.

these circumstances, the affected parties cannot feasibly agree upon how the socially optimum level of accident avoidance will be supplied. As a result, the fault standard is allocatively superior to liability without fault only in instances where accident preventers are unable to bargain before the mishap brings them together. The absence of pre-encounter bargaining will prevent the full exploitation of the gains from trade that would have resulted had negotiation been possible. The allocative effect of assigning liability on a fault basis is to provide incentives for accident preventers to undertake cost justified precautions.

Summary

To summarize the economic role of liability rules, several important points must be considered. First, it should be realized that imposing liability for personal injuries is simply a means by which the courts attempt to define and protect an individual's limited right to bodily integrity (human capital). The right to bodily integrity, or freedom from bodily harm, cannot be protected absolutely; consequently, the individual by necessity must assume some responsibility for preventing accidental losses or be willing to bear the losses in the event of a mishap. Bodily integrity is also a scarce resource, and if it is to be employed efficiently, it must be priced appropriately. The protection of human capital is similar conceptually to the case for protecting the ownership rights of non-human assets.

In all instances in which the individual is not interacting with others, the individual actor is in the best (only) position to undertake

accident avoidance. The observed level of precaution that the isolated individual chooses is, ex hypothesis, the optimal level of prevention since the individual is both the supplier and consumer of human capital protection. Moreover, the individual actor is in the best (again, only) position to place a value on the loss. Under such conditions, there is no role or justification for judicial intervention.

When an individual interacts with others, accident avoidance becomes a joint venture in which both the potential injurer's and victim's behavior determine the level of prevention supplied. If the interacting individuals are cooperating, (i.e., able to bargain and reach agreement over the level of accident avoidance each is to provide), then the observed outcome is again optimal. Based upon the differences in risk preference, value of losses, and cost of supplying prevention, the negotiated outcome will exploit all potential gains from trade. In these cases, the only function of the courts is to enforce the private agreements.

In still other instances accident avoidance is a joint venture involving noncooperating individuals. The situation is noncooperative when the interacting parties cannot, for whatever reasons, bargain and agree upon the level of precaution each will supply. The nature of chance or infrequent encounters renders pre-encounter agreement impossible. Under these circumstances private agreement is precluded or prohibitively costly. In place of private agreement it is possible to substitute other institutional arrangements in order to achieve outcomes of an efficient, market-like nature.

One such alternative is the application of the negligence standard of liability (with the defense of contributory negligence) to allocate accident (unintentional) losses. The negligence standard can create the correct set of incentives such that potentially interacting parties will undertake the cost justified level of precaution and thus minimize the cost of accidents and the costs of avoiding accidents. Specifically, the courts could promote this efficient result by imposing accident losses on those individuals who fail to take cost-justified precaution. Cost justified accident avoidance would be all precautions up to the point where the expected accident costs (probability of a mishap occurring times the loss in the event of an accident) equal the costs of accident prevention. The economic role of the judicial system is expanded in the noncooperating setting. In this situation, the courts are required not only to define and protect property rights but also to reallocate some accident losses from the victim to the injurer. The reallocation of these losses will lead to an efficient outcome only if the courts can decide accurately whether or not the interacting parties undertook the efficient levels of precaution. In order for the courts to answer these questions accurately, they must know at a minimum the value of a loss, the costs of prevention, and the probability of the accident occurring given the level of precaution undertaken. The purported superiority of the negligence standard over liability without fault to promote efficiency in the noncooperating situation must, therefore, take into account aspects other than the theoretical possibility of creating the proper set of incentives. Court error and the

malincentives they engender may attenuate the ability of the negligence standard to generate an efficient reduction of accident losses and the costs of avoiding accidents.²² Furthermore, if the cost of using the courts to transfer liability far outweigh the losses caused by the incorrect incentives which are inherent in a no-fault scheme, then the case for imposing the negligence standard is weakened considerably.

²²For more details, see Warren Schwartz and Gordon Tullock, "The Costs of A Legal System," Journal of Legal Studies, Vol. IV, No. 1, January 1975, pp. 75-81.

CHAPTER FOUR

ALLOCATIVE CONSEQUENCES OF PHYSICIAN LIABILITY

Introduction

The discussion to this point has analyzed the present legal basis for medical malpractice litigation in particular and the economic purpose and effects of tort law in general. The purpose of this section is to discuss some important characteristics of recent medical malpractice litigation. Specifically, the analysis will present a description of the nature and magnitude of malpractice claims, the costs of this form of private action litigation, and other relevant economic consequences of physician liability.

Magnitude of Medical Malpractice

Chapter One reported some trends in the number and size of malpractice claims during the recent past. In the aggregate, the number of cases settled in 1975-76 was nearly twice that of 1970, while the total indemnity paid increased three-fold during the same period (see Table 4). These data, however, report only a part of the actual extent and nature of malpractice litigation.

Given the types of medical malpractice cases which receive media coverage, one might conclude that typical malpractice settlements are impressively large and stem from significant disabilities, or even death, caused by a physician's or surgeon's carelessness or incompetence.

Table 4
 Number of Malpractice Claims
 Settled and Indemnity Paid, 1970 and 1975-76

Year	Number of Settled Cases	Total Indemnity Paid (Millions)
1970	12,000	\$ 80.3
1975-76	20,857	\$224.3

SOURCE: 1970, Report of the Secretary's Commission on Malpractice, Chapter 2; 1975-76, NAIC, Malpractice Claims.

This impression, in light of available data, however, is inaccurate and applies to very few malpractice cases.

In fact, most malpractice cases involve injuries that are temporary or, if permanent, only insignificantly so. Table 5, for example, reports the distribution of injuries by severity for 20,785 malpractice claims settled between July 1975 and June 1976--the latest year for which nationwide, comprehensive data are available. Nearly two-thirds (64.3 percent) of all reported injuries were classified as temporary--major or less severe. Over three-fourth (76.7 percent) of the reported claims were permanent--minor or less severe. Only 15.3 percent of the settled claims resulted from death.

Although physician negligence has the potential to inflict great harm upon patients, the evidence suggest that the lion's share of malpractice claims involve neither catastrophic nor permanently significant injuries. Physician negligence, therefore, does not appear to have generated an epidemic of disability or death. Given the fact that there are annually about one billion patient-physician contacts, the rate and severity of iatrogenic injuries are infinitesimal.

Another perhaps unexpected finding concerning the extent of medical malpractice is the relatively small losses patients suffer. For example, of the 5196 malpractice claims which were indemnified between July 1975 and June 1976 and where the patient's economic losses¹ were

¹Economic losses, as defined by the NAIC, include corrective medical expenses, lost wages, and other relevant costs to the patient.

Table 5
Severity of Malpractice Injuries, 1975-76

Severity of Injury	Total No. Claims	% of Total	Cumulative %
No Injury	280	1.3	1.3
Emotional Only	1,702	8.2	9.5
Temporary-Insignificant	2,249	10.8	20.3
Temporary-Minor	6,620	31.8	52.1
Temporary-Major	2,536	12.2	64.3
Permanent-Minor	2,586	12.4	76.7
Permanent-Significant	882	4.2	80.9
Permanent-Major	448	2.2	83.1
Permanent-Grave	309	1.5	84.6
Death	3,173	15.3	99.9
Total	20,785		

SOURCE: Derived from NAIC, Malpractice Claims, p. 75.

reported, over one-half (53.1 percent) of the cases involved economic losses averaging less than \$2400 per incident. These same cases and most other claims, furthermore, were indemnified well in excess of the patients' reported economic losses. For whatever reasons, the data suggest that the majority of indemnified patients suffering small economic losses were generously overcompensated (see Table 6). As a result, it appears that in most every case a successful malpractice claim represents a substantial financial windfall to the patient and his or her attorney. With rare exceptions, these overpayments do not facilitate the efficiency promoting role of tort law because they encourage cost-justified accidents to be avoided by increasing the plaintiff's expected settlement.²

Although it is exceedingly difficult, and perhaps impossible, to quantify physician "competence," there is tentative evidence to suggest that malpractice litigation does not efficiently identify (much less rehabilitate) incompetent doctors. To the contrary, it seems that physicians most likely to become embroiled in a malpractice suit are not the inexperienced, foreign-trained, senile, or general practitioner attempting to perform a specialist's duties. The defendant in a malpractice suit is more likely than not to be a highly trained specialist performing vital surgery.³

²Posner, Economic Analysis of Law, p. 143.

³For example, "...it is generally the good doctor who is sued; the less adequate practitioner, who is likely to have a stable practice in a small community will escape law suits regardless of his mistakes....

Table 6
 Distribution of Economic Losses
 of Injured and Indemnity Paid, 1975-76

Average Economic Loss of Injured	No. of Paid Incidents	Average Indemnity Paid
\$ 377	1,482	\$ 4,414
1,405	786	12,027
2,394	495	16,325
3,412	390	17,668
4,377	254	15,694
5,351	191	23,164
6,347	140	32,381
7,378	110	23,675
8,401	93	36,968
9,323	73	29,739
13,792	452	40,990
24,245	171	60,109
34,156	74	67,008
43,706	54	73,884
54,487	40	97,360
64,499	33	76,272
75,197	19	86,713
82,943	16	88,209
93,532	12	53,054
144,893	135	137,551
237,658	86	166,626
342,512	32	168,549
433,073	16	193,425
655,923	34	271,517
1,920,232	8	474,297

SOURCE: NAIC, Malpractice Claims, p. 103.

Cost of Medical Malpractice Litigation

One thing concerning medical malpractice litigation is for certain: It is an extremely expensive system of compensation and accident control. Some of the costs are direct and relatively easy to calculate, while others are more subtle and difficult to quantify.

Direct Costs

The very nature of private action litigation under the adversary system is always costly and frequently inefficient.⁴ One reason medical malpractice litigation is expensive is that it requires not only lawyers for both parties, but also physicians as expert witnesses and consultants. In other words, both the defendants and plaintiffs must invest substantial resources to settle the dispute thereby resulting in large transaction costs.

The best physicians are likely to be in charge of the most difficult cases and so may be the target of a number of claims." David S. Rubsam, "Medical Malpractice," Scientific American, August 1976, p. 23. Also, "Seven chairmen of neurosurgery departments in leading New York hospitals have a combined total of twenty-five malpractice suits filed against them, seeking an aggregate total of \$6.3 million." R. H. Brooks, R. L. Brutoco, and K. N. Williams, "The Relationship Between Medical Malpractice and Quality of Care," Duke Law Journal, Vol. 1975 (January) No. 6, p. 1197.)

⁴For a detailed discussion of the institutional inefficiencies associated with the adversary system of jurisprudence, see Gordon Tullock, "On the Efficient Organization of Trials," Kyklos, Vol. 28, (1974), pp. 745-761. For comments and Tullock's reply, see: Fred S. McChesney, "On the Procedural Superiority of a Civil Law System: A Comment"; J. A. Ordover and Phillip Weitzman, "On the Efficient Organization of Trials: A Comment"; and G. Tullock, "Reply to McChesney, and Ordover and Wertzman," Kyklos, Vol. 30 (1977), pp. 507-519.

For the plaintiff, the contingency fee system reduces his or her settlement by 25 to 50 percent. The smaller the settlement, in general, the larger will be the plaintiff's attorney's fee. This means that on average "transaction costs" (e.g., attorneys' fees) are about one-third of a successful plaintiff's award. For the defendant, claim expenses⁵ average 17.5 percent of total indemnity paid or about \$1900 per malpractice claim.⁶

For the 9.0 percent of malpractice claims settled during or by trial, the defendant's average claim expense is about \$6200 (see Table 7). In the aggregate, claim expenses equal over 80 percent of indemnity paid in suits settled during or by trial. These averages understate the cost of malpractice as a system of compensation as compared with other systems. To underscore the high cost of medical malpractice litigation it is interesting to note the small percentage of malpractice premiums that end up being paid to injured patients. Although definitive conclusions are unavailable, estimates report that only between 16 and 35 percent⁷ of all malpractice premiums are paid to

⁵"...Include all defense counsel plus all other expense of the insurance company which can be specifically allocated to a particular claim. There is also a substantial amount of internal expenses related to the companies' claims activity which cannot be assigned to specific claims and has not been included in this study." NAIC, Malpractice Claims, p. 9, (emphasis added).

⁶Ibid., p. 75.

⁷See, American Medical Association, Malpractice In Focus, p. 15.

Table 7

Malpractice Claim Expenses, by Manner of Disposition

(1) Manner of Disposition	(2) % of Claims Paid	(3) Average Indemnity Per Paid Claim*	(4) Expected Indemnity Per Claim**	(5) Average Defense Claim Expense
By/or During Trial	20.0	\$26,786	\$5,357	\$6,203
Pre-Trial	36.4	\$12,136	\$4,416	\$1,158

*Total Indemnity paid divided by the number of paid claims.

**Columns (2) times (3).

SOURCE: Derived from NAIC, Malpractice Claims, p. 75.

plaintiffs. This enormous disparity is due to a large extent to the very large administrative costs of determining physician negligence and settling claims. The high administrative costs associated with this form of third-party liability can be more clearly understood if one compares similar pay-out ratios of other systems of accident compensation. For example, the automobile insurance system, which is a combination of both first-party accident and third-party liability insurance, pays out approximately 50 percent of total premiums. First-party health and accident insurance, on average, returns between 80 and 90 percent of premiums paid.⁸ It should be clear that systems of third-party liability insurance are costly to administer as compared with first-party accident insurance schemes.⁹

Another consequence of costly defendant litigation is to encourage patients to file nonmeritorious claims in hopes of receiving a pre-trial settlement. In other words, relatively small, but nonmeritorious, claims would not be pursued by the defense in order to avoid

⁸Manne, Economics of Legal Relationships, p. 296.

⁹It is interesting to note that systems of third-party liability are becoming a thing of the past. For example, around the turn of this century, all states replaced the previous system of employer negligence liability for job related accidents with first-party workmen's compensation. More recently, several states have adopted no-fault automobile liability in place of negligence (fault) liability. The predominate reasons given for these changes are high administrative costs and delays in payment associated with fault liability.

costly litigation.¹⁰ Available empirical evidence supports this conclusion. The NAIC report on medical malpractice clearly shows that defendants' expenses for settling cases by trial are more than four times that of pre-trial costs. Moreover, the expected indemnity cost for pre-trial settlements are less than the expected indemnity cost for claims resolved by trial (see Table 7).

In sum, loss spreading under negligence liability is very costly. The contingency fee system reduces considerably the amount of indemnity plaintiffs receive. Physicians (and their insurance companies) must also devote considerable resources towards their defense. Because malpractice cases involve complicated and difficult medical issues, determination of fault and loss shifting are problematic and time consuming.¹¹

Indirect Costs

The fact that so few malpractice premiums are received ultimately by patients attests to the high transaction costs associated with loss

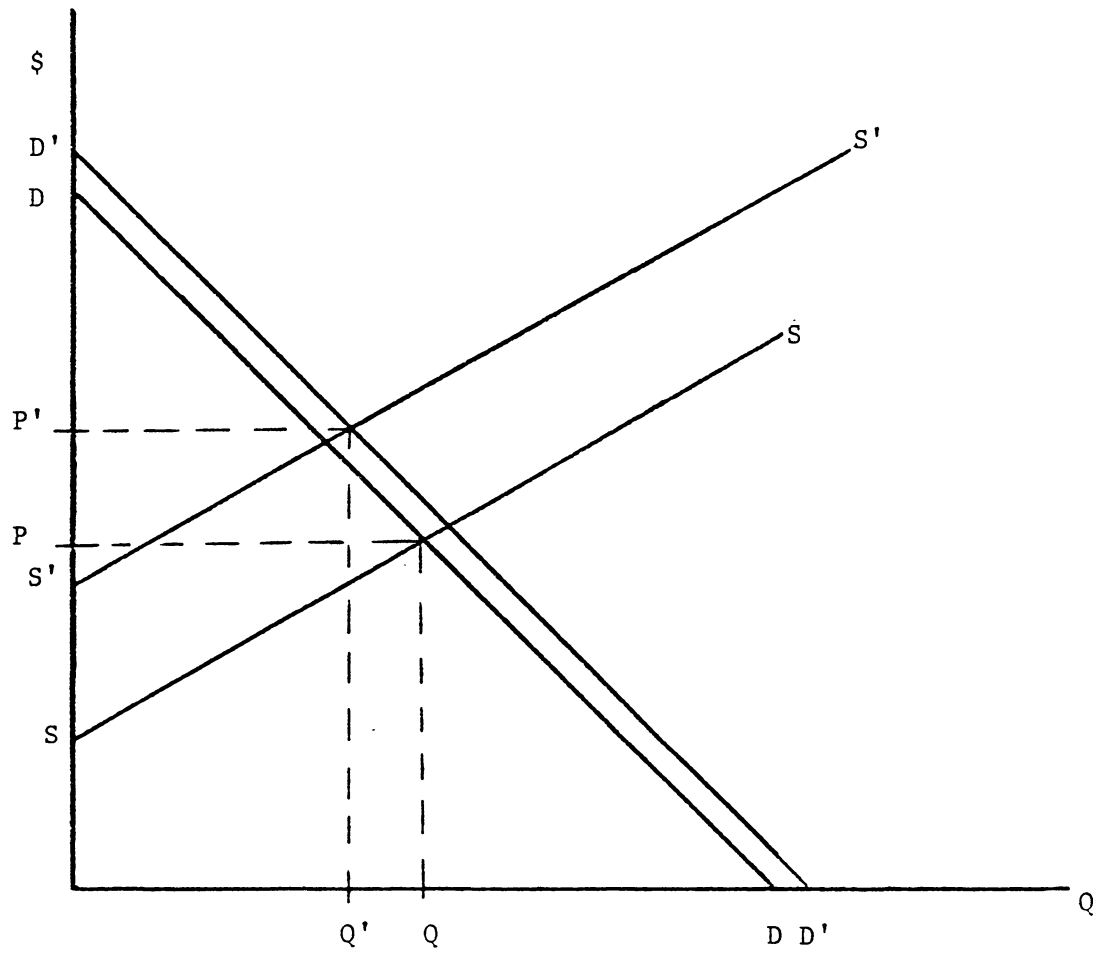
¹⁰ For example, "An element in the apparent increase in malpractice awards is the unwillingness of hospitals, physicians, and insurers to contest small claims, even when their merits are dubious, because of the costs of prolonged litigation." David Mechanic, "Some Social Aspects of the Medical Malpractice Dilemma," Duke Law Journal, Vol. 1975 (January) No. 6, pp. 1182-1183.

¹¹ According to NAIC, only 40 percent of all settled claims are indemnified. The average time between when a claim is filed and indemnified is three years. Malpractice Claims, pp. 101 and 75.

spreading under negligence liability. Other significant, but less obvious, costs are also associated with the present system of fault liability. Medical malpractice litigation has important effects upon the price and quantity of medical care available to patients. Furthermore, the jury trial system and the decision errors associated with determining fault liability also effect the attainment of efficient iatrogenic accident avoidance.

The allocative inefficiencies created by very high loss spreading costs are illustrated in Graph 2. For simplicity, assume (not unrealistically) that under physician liability 25 percent of malpractice premiums are paid to patients. In the graph, DD and SS represent the demand and supply curves, respectively, for medical care in the absence of physician liability (implicitly a system of patient liability for iatrogenic injuries). Now assume liability is shifted to physicians; as a consequence, physicians must bear \$x in liability costs. This causes the supply curve to shift vertically by \$x to S'S'. Since patients are no longer liable for the costs of treatment related injuries, the demand for medical care shifts vertically by only \$x/4 to D'D'.¹² Clearly there has been a reduction in both consumers'

¹²This analysis assumes that the level of medical precaution is the same under either liability assignment--an assumption first introduced in the preceding chapter and discussed further in the following chapter.



Graph 2

Effects of Shifting Liability with Positive
Transaction Costs

and sellers' surplus as a result of the high costs of loss shifting under negligence liability.¹³

Another important consequence of holding physicians liable for iatrogenic injuries is the practice of so-called "defensive medicine." Defensive medicine is simply the practice of administering additional tests and treatments, which costs more than the expected reduction in injury costs, in an effort to forestall malpractice litigation.¹⁴

Although it is difficult to prove quantitatively that physicians practice defensive medicine, it seems reasonable to assume that the present system of malpractice liability does, in fact, encourage such practices. Much like the regulatory bureaucrat, doctors can make two basic allocative "mistakes" with respect to conducting further testing. The physician can either: (1) order further treatment and tests which are not cost-justified (i.e., the expected gain in diagnostic accuracy is less than the cost of the tests) in cases where the additional tests do not increase the probability of successful treatment; or (2) not administer additional treatment which is not cost-justified in instances where further treatment would have favorably affected the outcome. Rarely is a physician held liable for making the first type of mistake; on the other hand, errors of the second type are likely

¹³Total decrease in consumers' and sellers' surplus is equal to $x[(Q'/4 + \Delta Q/8) + (Q' + \Delta Q/2)]$, where $\Delta Q = (Q - Q')$.

¹⁴See also, Report of the Secretary's Commission on Malpractice, Chapter 2, p. 6.

to arouse controversy and result in litigation. Given the patient's costs and expected gains from litigating the first type of mistake, one would expect to observe very few cases of this type of "malpractice" (i.e. allocative inefficiency). Although the plaintiff's costs are higher to litigate the second type of error, the patient's potential gains can be very large. It is not surprising, therefore, to find considerably more of the second type of mistake resulting in law suits. The incentives facing the physician with respect to which type of error to make are clear--when in doubt, order more tests and render additional treatment.¹⁵

Court Error

Perhaps the most difficult aspect of medical malpractice litigation is the accurate determination of what exactly constitutes physician negligence. It has been shown in Chapter Two that negligence, in general, is the failure to take cost-justified precautions to protect others from risk of harm or injury. In particular, an individual in a position to protect others from injury is expected to provide that level of accident prevention where the marginal cost of loss avoidance is equal to the expected accident cost. In a medical malpractice case the plaintiff must show that the defendant

¹⁵Estimates vary; but the cost of defensive medicine during 1974 was reported to have been between one and seven billion dollars. J. Hassard, "Change Tort System?: Pro," Medical World News, September 8, 1975, p. 60.

physician rendered a degree of treatment below the cost-justified level. To determine this accurately, three things must be known by the court: (1) the marginal cost of accident avoidance; (2) the marginal productivity of additional treatment to forestall losses; and (3) the value of the loss in the event an accident occurs. Needless to say, these concepts are unusually abstract and in most cases exceedingly difficult to determine ex ante by a physician or by the court (i.e., judges and juries).

As a consequence of the difficulties, one would expect a relatively high incidence of decision error by the court. Posner, for example, recognized the potential for such errors when he observed:

The analysis of error costs has many interesting applications to problems of civil procedure. Consider the preponderance-of-the-evidence standard which governs civil cases. This standard directs the tier of facts to find in favor of the party who has the burden of proof on an issue if that party's version of the disputed facts is more probably true than the other party's version; thus, to prevail, the party hearing the burden of proof need only establish the validity of his claim by a probability infinitesimally greater than 50 percent. This implies that of cases decided erroneously, about half will be won by undeserving plaintiffs and about half lost by deserving plaintiffs.¹⁶

Tullock reached a similar conclusion earlier when he noted succinctly:

It is only the man who sues when he has no case... who can hope to profit from miscarriages of justice. Between the just and the unjust, court errors always favor the wrong undeserving side.¹⁷

¹⁶Posner, Economic Analysis of Law, p. 336.

¹⁷Gordon Tullock, The Logic of the Law, (New York: Basic Books, Inc., 1971) p. 40.

With these factors in mind, one would expect a relatively high incidence of error in malpractice cases in particular because of the technical medical issues which are typically involved in each case. Indeed, Oliver Wendall Holmes, Jr., earlier recognized these difficulties in general when he wrote:

The trouble with many cases of negligence is that they are of a kind not frequently recurring so as to enable any given judge to profit by long experience....¹⁸

As another example, consider cases involving the accurate determination of fault in automobile accidents. One of the primary reasons for abandoning negligence liability in favor of no-fault liability in automobile accidents is the difficulty juries have in determining negligence.¹⁹ Given the fact that most jurors are more likely than not to have had extensive driving experience,²⁰ with well established rules-of-the-road, and still are viewed as incapable of deciding with a tolerable degree of accuracy the tier of facts, it is even more likely that jurors cannot determine whether or not a physician has undertaken the proper level of precaution or the correct type of treatment. To be sure, within a medical setting, patients seeking

¹⁸Holmes, The Common Law, p. 129.

¹⁹See Peck, "Negligence and Liability Without Fault in Tort Law," p. 242.

²⁰According to the 1977 Statistical Abstract of the U.S., over 86 percent of the total population 18 years old and over are or were licensed drivers.

treatment almost invariably have something "wrong" with them to begin with, and it is frequently difficult to distinguish correctly improper treatment from complications resulting from pre-existing ailments.

The preceding discussion of court error is significant because the social usefulness of the judiciary system is predicated upon its ability to render accurate decisions. That is to say, the superiority of the courts, instead of voluntary, private exchange, to promote allocative efficiency in some circumstances rests upon its ability to render informed and accurate choices. If, as the analysis suggests, the judicial system is incapable of making correct allocative decisions, then the alleged superiority of such extra-market intervention is greatly reduced. Thus, one may impugn the ability of tort law to facilitate allocative efficiency when disputes arise between the interaction of patients and physicians because of its inherent inability to decide issues accurately and shift losses with a respectable degree of certainty.

CHAPTER FIVE
SUMMARY AND CONCLUSIONS

Summary

The vast majority of medical malpractice cases are adjudicated under our common law of torts and are governed by the negligence standard of civil liability. The law of tort liability imposes upon physicians a duty to protect patients from unreasonable risk of harm or injury. Moreover, this obligation cannot be escaped or altered by private, voluntary agreement. In the area of medical malpractice, this duty arises from judicial public policy based upon an implied, contractual relationship between patients and physicians.

The standard of due care in medical treatment is frequently ambiguous and always changing. The exact legal standard varies from state to state; in general, a physician is supposed to possess a reasonable (average) degree of skill and experience and to use reasonable care and diligence to accomplish the purpose for which he is employed. Beyond this, however, the courts decide each case on an individual basis and possesses wide latitude in determining whether or not the defendant was negligent.

Medical malpractice litigation under our present system of jurisprudence is a source of concern for medical care suppliers and their insurers directly and patients ultimately. During the past decade, the courts have placed medical care suppliers under increasingly

higher standards of liability. The result of this has been initially to shift the cost of some treatment related injuries from patients to physicians. In the long run, of course, some (and perhaps most or all) of these costs are ultimately borne by medical care consumers.

The increase in the number and size of malpractice claims paid cannot be attributed solely to a sudden increase in physician carelessness or incompetence. Rather, it appears that the courts are either requiring physicians to exercise higher standards of care, or, in many cases, imposing liability upon defendant physicians who have not been negligent in an economic sense. The law governing the final allocation of iatrogenic injuries appears to have changed significantly and unexpectedly in favor of patients.

The purpose of the preceeding analysis was not to explain the observed increase in medical malpractice litigation; rather, the focus of attention was to describe the economic consequences of such forms of professional liability. Although medical malpractice law includes such noneconomic principles as equity, retribution, and justice; our common law governing such disputes cannot avoid economic consequences and effects. Our common law system of civil liability can, however, be used to promote the economic goal of allocative efficiency. The courts, in other words, can be an instrument of public policy capable of correcting instances of market failure. It appears that the important economic question concerning civil liability deals with the social usefulness of such judicial intervention.

That is to say: What improvements in allocative efficiency does such loss shifting produce?

The economic purpose of shifting accident losses is to create that set of incentives which minimizes the costs of accident avoidance, the costs of accidents, and the costs of shifting these losses. In a world of zero transaction, all liability rules, ex hypothesi, result in optimal resource allocation in the long run. In instances where bargaining costs are so prohibitively high that pre-encounter agreement is impractical, affirmative liability on the tortfeasor (e.g. the negligence or strict injurer standards) creates the correct set of incentives to minimize these costs. However, such liability rules necessitate loss shifting and fault determination costs. Without additional empirical evidence, it is impossible to conclude definitively whether or not the cost of using the courts to transfer liability is less than the losses caused by the incorrect incentives which are inherent in victim liability.

Assuming zero transaction costs and perfect information, only under strict physician liability would the cost of economically unavoidable accidents be nominally shifted from patients to physicians. If physicians behave rationally and the law is enforced consistently, then doctors would be expected to avoid uneconomical injuries regardless of the liability rule in effect. This is so because the direct buyer-seller relationship between patients and physicians provides the appropriate setting for the full exploitation of mutually

beneficial gains from trade. Pre-encounter bargaining is possible and not so prohibitively costly as to prevent such bargaining.

Under physician liability, the cost of loss shifting, both in the aggregate and in each case, is very high. In the aggregate, significant administrative costs reduce both seller's and consumer's surplus. Industry output is below the allocatively efficient level and price is above the social optimum. At the individual case level, each patient is "overtreated."

Jury trials and adversary proceedings do not appear to be the most efficient means for determining fault; consequently, one would expect these proceedings to result in a high rate of decision error. The precise affects of these errors is unknown, but they certainly do encourage some additional nonmeritorious litigation.

Most malpractice injuries are not very severe, and the rate of iatrogenic injury is miniscule. Without more data, there is no way of knowing whether or not these injury rates are optimal. It is possible that physician liability has established the correct set of incentives to minimize accident losses and the cost of avoiding accidents. On the other hand, the observed practice of defensive medicine tends to indicate that physicians are, at best, preventing economical accidents or, more wastefully, rendering additional treatment without significantly increasing the effectiveness of treatment.

Finally, it should be noted that under nearly all forms of physician liability insurance, premiums are based upon the doctor's geographical location and type of specialty rather than the individual

physician's past malpractice experience. Hence, it could be argued that the moral hazard element attenuates considerably the incentives for physicians to practice with the due care prescribed by the courts.

Alternatives

The above discussion and the analysis presented in the preceding chapter severely impugn the social usefulness of the current system of medical malpractice law. It appears also that this aspect of tort law is of dubious value to physicians and their patients. The advantages or benefits of malpractice litigation seem minimal and are offset by the high cost of the system.

The fundamental economic problem associated with the current system of physician liability is the extraordinarily high transaction costs associated with fault determination and loss shifting. Although a large number of changes are possible, there are three general alternatives or solutions to the problems of medical malpractice. All three of these involve institutional changes designed to reduce some of the sources of inefficiency of the present system.

The first suggested solution would retain the basic system of fault liability, but introduce changes in the law designed to reduce both the number and size of cases handled by the courts. Such reductions could be accomplished by legislatively: (1) shortening the statute of limitations and eliminating the discovery rule¹;

¹The discovery rule states that the time period for initiating a tort liability suit begins when the patient discovers the injury

(2) making the requirements of informed consent² more definite and limited; (3) rescinding the doctrine of res ipsa loquitar³; (4) reducing the contingent fee charged by attorneys; (5) prohibiting recovery of losses which have been paid by insurance or other collateral sources⁴; and (6) establishing a schedule of the amount of payments to be made for various types of injuries and losses. Any or all of these legislative changes would probably achieve a reduction in the size and number of malpractice claims; however, "they will probably prove to be too little and too late to solve the problem."⁵ Since the reforms just discussed do not change the substantive nature of medical malpractice law, they are unlikely to reduce significantly the inherently high transaction costs of using the judicial process to adjudicate malpractice disputes. Physician negligence must still be proved and the courts would have to determine losses on a case-by-case basis.

rather than when the act or omission which allegedly caused the injury occurred.

²Liability based upon lack of informed consent is a new theory of tort liability that has been applied only in medical malpractice cases. It permits damages to be awarded even though an injury was not caused by physician negligence.

³See Chapter 2, "Professional Negligence."

⁴Currently the fact that such costs or losses have already been paid cannot even be disclosed to the jury which awards the damages.

⁵Richard A. Epstein, "Medical Malpractice: Its Cause and Cure," in The Economics of Medical Malpractice, p. 254.

A second, and more radical, approach to the problems of malpractice would be to replace the present system of negligence liability with no-fault physician liability. The essence of these proposals is to obviate the need to establish the negligence or the fault of the physician in order for the patient to receive compensation.⁶ Under the no-fault approach the patient is eligible to recover damages if he can show that his injury or loss resulted from the provision of health services. The patient would waive his right to tort action in exchange for guaranteed, but more limited, coverage. The effect of the no-fault approach to medical related injuries (like other such schemes, e.g. no-fault automobile and workmen's compensation) is to expand the number of cases in which physicians must compensate their patients. Many of the non-negligently caused injuries or losses that the common law currently refuses to treat as compensable would become compensable under the proposed system. No-fault insurance, in other words, would eliminate the need to distinguish between unavoidable and

⁶Numerous schemes have been suggested recently. The more frequently cited ones include: Clark C. Havighurst and Laurence Tancredi, "Medical Adversity Insurance--A No-Fault Approach to Medical Malpractice and Quality Assurance," The Insurance Law Journal, Vol. 613 (1974); Guido Calabresi, "The Problem of Malpractice--Trying to Round Out the Circle," in The Economics of Medical Malpractice, pp. 239-243; and Richard A. Epstein, "Medical Malpractice: The Case for Contract," American Bar Foundation Research Journal, Vol. 1, No. 1, (January 1976), pp. 119-28. Proposals for a Federal government plan along these lines have also emerged in the form of bills S. 215, 94th Cong., 1st Sess. (1975) and H.R. 4881, 94th Cong., 1st Sess. (1975).

avoidable injuries by regarding both types as compensable. Thus, causation, rather than negligence, would be the test for compensation.

The alleged advantage of the no-fault approach over the negligence standard is that it would eliminate (or at least reduce significantly) the costs associated with the determination of physician negligence. Although these no-fault systems may not reduce malpractice insurance premiums, advocates of the no-fault approach claim that a much larger percentage of premiums paid will be returned to injured patients.

Even though the no-fault approach is capable of improving the efficiency of the compensation function of tort law, there are reasons to believe it possesses important disadvantages also. Perhaps the most objectionable feature of the no-fault concept is that it is compulsory insurance. The effect of this is to force many who may not desire insurance to be covered. In other words, those individuals who would prefer to bear some additional risk are prevented from doing so.

A second, more practical, consideration is that over time the courts will again become extensively involved in the decision making process. Although the issue of negligence is no longer to be considered, the courts would have to become more involved in deciding causation and eligibility. Simply put, this means eventually more and more resources will be devoted to deciding each injury on a case-by-case basis. This is precisely what has happened under so-called no-fault workmen's compensation. Within the context of

malpractice, the courts would have to decide whether an injury was the result of medical treatment or was caused by pre-existing complications. The likely result of expanded coverage and high decision making costs is to return to the situation as it exists today.⁷

The final alternative to the present system of negligence liability is a radical change from judicial domination to private contracting. This would require first a fundamental change in the law from negligence liability to strict victim (i.e., patient) liability. Under this system the patient would be free to contract voluntarily for insurance to cover the risks of injury or loss from medical treatment.

This system has two distinct advantages. First, it would allow patients to choose individually the type and level of coverage they desire. Risk averse patients could voluntarily shift the risk by expanding their accident, death, and disability insurance, they could pay higher physician fees in exchange for doctor supplied coverage, or they could insure themselves to cover possible losses on a treatment-by-treatment basis. The primary advantage of such private contracting is that it allows individuals to assume voluntarily the level of risk they desire and to decide the level of coverage that is appropriate. The possible private schemes to provide this type of insurance are numerous and beyond the scope of this analysis.

⁷For specific examples, see Epstein, "Malpractice: Causes and Cures," pp. 257-267; and Calabresi, "The Problem of Malpractice," pp. 239-243.

Second, loss shifting through first-party accident insurance would require significantly lower administrative costs. Although some cases will go to court as a matter of contract disputes, they are likely to be minimal compared to the present level of litigation.⁸

The important conclusion of the preceding analysis and discussion is that the judicial system, as a matter of public policy, has imposed upon the medical industry the inappropriate standard of liability. The courts continue to preclude more flexible and efficient private solutions to the problem. Apparently the courts have not considered the objections to or the problems of the present system, or they have rejected the notion of private solutions in this area. At a minimum, the courts should begin to question the social usefulness of medical malpractice law as it now exists and to begin to view the issue as largely a private matter more effectively resolved by imaginative and efficient private institutions.

Conclusions

The purpose of the preceding analysis was to determine the economic function of using the court system to shift losses which arise from the interaction of patients and physicians. What economic justification, in other words, is there for using our current system of civil law to adjudicate disputes and injuries arising from medical treatment?

⁸For more details of the advantages of contracting, see Epstein, "Medical Malpractice: The Case for Contract."

Allocatively, there is no economic justification for choosing negligence liability over victim liability because the interacting parties are not brought together by chance-encounter accidents. Rather, they are engaged in most cases in a direct buyer-seller exchange situation that does not produce any relevant externalities. Under these circumstances, competition among buyers and sellers, motivated by self-interest, will tend to generate the cost-justified level of medical precaution and injury avoidance.

The very high transactions costs associated with the judicial process appears to benefit neither patients nor physicians. In economic terms, the high transactions costs that are characteristic of medical malpractice litigation reduce both seller's and consumer's surplus. The primary beneficiary from malpractice litigation appears to be the legal profession. The use of the court system to adjudicate disputes increases the demand for lawyers generally. Such proceedings create employment opportunities for lawyers in the malpractice insurance industry and provide income for defense attorneys through the contingency fee system.

If the preceding conclusions concerning the inefficiencies of physician liability are correct, then there must also exist unexploited gains from trade. Currently there is evidence to suggest that in the real world unexploited gains exist and that efforts are being made to reallocate resources to the extent that institutional

constraints permit.⁹ By 1976, every state had enacted or was considering legislation to limit medical malpractice litigation.

Perhaps when more data are available to quantify the magnitudes of the costs and inefficiencies associated with the present system, more action will be undertaken to limit judicial intrusion into an essentially private matter. The preceding analysis, as a first step, has attempted to call into question the efficacy of our common law to fulfill a socially useful role. Until more persuasive arguments are advanced and further analysis can demonstrate the usefulness of such judicial intervention, there is little or no reason to believe that the gains, if any, created by the incentives associated with physician liability outweigh the transactions costs of loss shifting.

In place of the present system, the evidence and analysis suggest that direct and explicit contracting is the appropriate alternative. More generally, it appears that patient (i.e. first-party) liability is preferable. A more efficient public policy would be to permit voluntary loss shifting by private agreement. Patients, if they so desired, could then augment their existing medical and disability insurance coverage to include iatrogenic injuries. It has been clearly and repeatedly shown that first-party insurance

⁹See, for example, "Justice Department Readies Bill to Curb Malpractice Claims," Wall Street Journal, January 4, 1978, p. 8.

requires substantially lower transaction costs than does third-party liability. In any case, voluntary agreement would more likely be capable of generating allocatively superior outcomes.

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MEDICAL MALPRACTICE: EFFICIENCY OF THE NEGLIGENCE
STANDARD OF PHYSICIAN LIABILITY

by

William T. Harris

(ABSTRACT)

During the past decade medical malpractice litigation has created problems and concern within the medical and legal professions, the malpractice insurance industry, and for healthcare patients. The purpose of this dissertation was to analyze and evaluate the ability of the negligence standard of civil liability to facilitate efficient resource allocation between physicians and their patients. The analysis also attempted to determine whether or not the negligence rule of liability is an effective means of ensuring that cost-justified levels of precaution will be undertaken and that the efficient levels of iatrogenic injuries will result.

The negligence standard is not the appropriate liability assignment for activities involving direct contact between buyers (patients) and sellers (physicians). Transaction and negotiation costs are not so high as to engender significant negative externalities and to result in inefficient resource allocation. Tort liability is a problematic and costly system of victim compensation.

The study concluded that most personal injuries arising from medical treatment should be allocated contractually between physicians

and patients. Assigning more liability for adverse outcomes to patients would not likely reduce the quality of health care while allowing the parties involved to assume voluntarily the appropriate level of risks.