WORKING PAPER

Reforming Medical Malpractice Liability through Contract

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This paper discusses the medical malpractice "crisis" and the potential of contract liability to reduce overall malpractice costs as well as improve the quality of and access to care. First, the paper describes the current medical malpractice liability "system" and some of the more common reforms offered. It then discusses the economic rationale of allowing patients and providers to agree in advance of treatment on how the patient will be compensated in the event of simple negligence on the part of providers, explaining how contract liability may offer improvements in the areas of costs, patient preferences, the pursuit of more efficient liability rules, and quality of care. The paper then critiques select objections to contract liability – those based on the superior bargaining power of providers, the lack of information available to patients, and possible reductions in quality – and forwards possible limitations on the right to contract that may allay such concerns.

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I. Introduction

Patients typically have little information about the quality of medical care in advance of seeking treatment. One way the law seeks to overcome that information problem is by allowing patients injured by sub-standard care to recover from the responsible health care provider through an action for negligence. Rules for medical malpractice liability are determined by the courts and legislatures and are uniform within a state. That is, the medical malpractice "system" requires the same level of protection for all patients.

There is near-universal agreement that the current medical malpractice system does not achieve its aims. In theory, that system is supposed to encourage providers to deliver high-quality care by transferring to negligent providers a large portion of the costs that their negligence imposes on patients. Insofar as that system makes the provider suffer financially when her negligence injures her patient, it aligns the incentives of the provider with the needs of the patient. In practice, however, the medical malpractice system achieves that goal rather imperfectly. Research suggests that only a small fraction of patients injured by provider negligence actually recover and that many who do recover from providers are not victims of negligence.[1] Such imprecision is one reason why a recent study estimates that in 2002, the medical liability system provided benefits of $33.0 billion, but carried far greater costs of $113.7 billion, thereby imposing a net loss of $80.7 billion on society.[2]

The costs of the medical liability system are passed on to patients through higher prices for medical care, which can make care unaffordable for those with below-average incomes

[1] Mark A. Hall et al., *Health Care Law and Ethics* 270 (6th ed 2003). *See also* Patricia Danzon, *Liability For Medical Malpractice*, in HANDBOOK OF HEALTH ECONOMICS (Anthony J. Culyer & Joseph P. Newhouse eds., 2000) at 1354, 1358.

[2] Christopher Conover, *Health Care Regulation: A $169 Billion Hidden Tax* (Cato Institute, 2004).

and/or above-average medical expenses. The above-mentioned study further suggests that the net cost of the medical liability system made health insurance unaffordable for over three million individuals in 2002.[3] Physicians and other providers – who have seen often dramatic increases in malpractice insurance premiums – have intermittently declared the medical liability system to be in "crisis" for over 30 years.[4]

This "crisis" has spawned numerous proposals to reform medical malpractice liability rules. The American Medical Association (AMA) advocates a nationwide cap on non-economic damages similar to the $250,000 cap enacted in California. The AMA claims that three-quarters of the public favor such a limit on non-economic damages.[5] Other proposals include legislative limits on contingency fees for plaintiffs' attorneys; "no-fault" compensation systems for medical injuries, such as the limited programs adopted in Florida and Virginia; alternative forms of dispute resolution, such as arbitration and special medical courts; the English rule of costs; and reform of the collateral source rule. Each of these reforms has the characteristic that it would leave some plaintiffs better off – typically by reducing prices for medical care – at the cost of leaving other plaintiffs worse off. For example, a cap on non-economic damages would reduce health care costs for non-injured patients, but at the expense of leaving some injured patients with uncompensated losses. Likewise, limits on contingency fees would reduce costs for non-injured patients, but at the cost of denying compensation to injured patients whose cases plaintiffs' attorneys deem too expensive to pursue.

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[3] *Id*.

[4] *See generally* Richard A. Epstein, *Medical Malpractice: The Case for Contract*, 1 AM. BAR. FOUND. RESEARCH. J., 87, 87-89 (1976). *But see* Bernard S. Black et al., *Stability, Not Crisis: Medical Malpractice Claim Outcomes in Texas, 1988-2002*, 2 JOURNAL OF EMPIRICAL LEGAL STUDIES, 207 (2005) ("We do not find evidence in claim outcomes of the medical malpractice insurance crisis that produced headlines over the last several years and led to legal reform in Texas and other states.").

[5] American Medical Association, *Medical Liability Reform: Q&A* (March 2006), *available at* http://www.ama-assn.org/ama1/pub/upload/mm/399/mlr_tp.pdf (last visited Nov. 29, 2006).

An alternate approach to medical liability reform would allow patients and providers to determine in advance the rules that govern how patients will be compensated in the event they are injured by simple negligence. Contractual liability rules could employ greater or lesser protections than current tort liability rules crafted by the judiciary and legislatures. For instance, a patient and provider could agree to some combination of caps on non-economic damages, the English rule of costs (or "loser pays"), and so forth. The contract could also alter the standard of care used to determine negligence. Alternatively, the contract could specify greater protections against negligence than are currently available through tort liability. A patient could demand a higher standard of care than customary practice within a region and specialty, or a California patient could insist on being able to collect more than the $250,000 statutory limit on non-economic damages.

The economic appeal of contract liability is that competent adults vary in their preferences for risk and their ability to pay for medical care. Requiring all patients to accept a uniform level of protection against negligence may price health care out of the reach of low-income patients and force others to "purchase" more malpractice protection than they would prefer. The opportunity to contract around tort liability rules could enable providers to lower their prices, thereby enabling more low-income patients to afford medical care, as well as reducing the cost of care for patients who demand less protection against negligence than tort rules require. At the same time, contract liability would allow risk-averse patients to bargain for greater protection from negligence than current tort rules offer. As discussed further in Section II, the ability to vary malpractice protections could also provide patients with a useful tool for judging the quality of different providers.

Despite this appeal, contractual limitations on providers' liability for malpractice are largely unenforceable. The main criticisms will be touched on here, and discussed at greater length below. Scholars and courts, in particular the court in *Tunkl v. Regents of the University of California*, consider such agreements to be contracts of adhesion due to the lopsided nature of the relationship between provider and patient. Some contend that such contracts violate vertical equity by suggesting that low-income individuals are due a lesser standard of care than those with greater means. Others maintain that allowing some individuals to accept less protection against malpractice would harm those who prefer higher levels of protection, in that a net loss of liability exposure could encourage providers to reduce their investments in quality.

This paper proceeds in the same fashion as the foregoing discussion. Section II presents the arguments for moving control over liability protections from tort law, the courts, and legislatures, to contract law, where liability protections may be determined by the market. Section III presents and evaluates select criticisms of contract liability that appear in the literature and case law. Section IV offers possible limitations on the right to contract around tort liability rules that might assuage the major concerns of critics. Section V concludes.

II. Contractual Liability for Medical Malpractice

This section provides the economic rationale for enforcing contracts between patients and providers that specify malpractice protections different from those available in tort. It then examines possible contract terms, as well as areas where tort liability should continue to govern provider misconduct.

Though tort law has traditionally governed medical malpractice liability, the relationship between a patient and a health care provider may be distinguished from the relationships in many actions for tort. The classic tort suit typically involves two individuals who were unknown to each other prior to the tort; for example, the pedestrian struck by a falling barrel when walking past a warehouse owned by another.[6] In contrast, patients and health care providers are typically known to one another and form a contract before the provider plies her trade. Before any negligence can occur, patient and provider typically have the opportunity to negotiate the various aspects of their relationship, in particular the quality guarantees offered by the provider. The protection that a patient enjoys against negligence by the provider is one component of quality assurance. Thus, those protections often could be one of the contractual terms negotiated by the two parties.[7]

Given the amenability of the patient-provider relationship to negotiating liability protections as one aspect of quality assurance, there are several reasons *why* a patient and provider would want to negotiate over those terms. First, patients vary in their ability to pay for medical care and their preferences for risk. As noted above, the cost of the medical malpractice "system" is widely considered to be one reason behind the rising cost of medical care and health insurance.[8] Insofar as existing tort liability rules make medical care more expensive, they likely make medical care unaffordable for those with below-average incomes. Patients who have difficulty affording medical care might wish to contract for a reduced level of protection against

[6] Epstein, *supra* note 4 at 92, 140, citing *Byrne v. Boadle*, 2 H. & C. 722, 159 Eng.Rep. 299 (Court of Exchequer, 1863).

[7] *Id.*

[8] PricewaterhouseCoopers' Health Research Institute, *Top Seven Health Industry Trends in '07* 2 (2006) *available at* http://pwchealth.com/cgi-local/hregister.cgi?link=reg/topseven.pdf (last visited Dec. 1, 2006) (finding that 61 percent of consumers believe medical malpractice costs are a "big factor" behind rising health care costs, and a further 31 percent of consumers believe them to be "somewhat of a factor").

negligence if doing so enables them to obtain a greater degree of protection against illness. Indeed, that tradeoff could leave many patients much better off, particularly if the alternative is a high degree of protection against negligence in the delivery of medical care that they cannot afford. Distinct from issues of affordability, patients differ in their preferences for risk. Put differently, some patients value the protection against medical negligence offered by tort liability much less than other patients do. Such patients would prefer additional income in the here-and-now to the marginal reduction in risk provided by tort liability, and therefore would benefit from the opportunity to contract for a lower level of malpractice protection. By the same token, some patients may prefer *more* protection against medical malpractice than is afforded by the tort liability rules in their state. Although such patients may currently purchase additional protection in the form of disability or life insurance, they may also benefit from being able to contract with providers for an even greater level of malpractice protection. (There does not seem to be any judicial impediment to contracts that provide more protection than tort liability rules do. Nevertheless, judicial impediments to contracts providing less protection undoubtedly suppress the practice, and therefore may leave patients ignorant of that option.)

A second reason why patients and providers may prefer contract liability to tort liability is that the former would allow greater experimentation with different liability rules, which could lead to more efficient sets of rules. The political pressure currently expressing itself in state capitols and in Congress for reforms such as caps on non-economic damages is a manifestation of pent-up demand for different malpractice liability rules, at least on the part of health care providers, purchasers, and insurance companies. At present, the search for more efficient rules proceeds only in fits and starts as legislatures alter the rules of tort liability. Once new rules are enacted, it again becomes difficult for those who are dissatisfied to make alterations. Doing so

again requires judicial or legislative intervention. In contrast, contract liability would allow dissatisfied patients and providers to make instant corrections. That agility makes it more likely that disfavored rules would be discarded under contract liability than under tort liability, where interest groups can pressure the legislature to preserve their preferred rules.

A third appeal of contract liability is that it could improve the quality of care. To differentiate themselves from low-quality providers, high-quality providers must offer patients credible signals of quality. That is, high-quality providers must signal the quality of their services in a way that low-quality providers cannot emulate. For instance, both high- and low-quality providers can make unsupported claims about the quality of their services, making such claims not credible. An example of a credible quality signal is a high rating from an independent organization, such as the web site HealthGrades or *Consumer Reports*, although at present such organizations have little quality information to offer regarding individual providers. Another credible quality signal would be an enforceable contract wherein high-quality providers agree to furnish more protections against malpractice for the same price that low-quality providers charge, or identical liability protections at a lower price.

In the current system of tort liability, providers who are less likely to injure patients through negligence have little ability to convey that information in a credible manner. There are a number of reasons. First, the fact that a provider has been sued for malpractice, whether successfully or not, appears to be a poor indicator of the quality of care. The incidence of malpractice claims appears to bear little relation to the incidence of injuries due to negligence. It is estimated that some 98 percent of potentially valid malpractice claims are never filed; some 80 percent of those claims that are filed are invalid; and nearly 50 percent of filed claims result in a

payout, which implies that many invalid claims result in payouts.[9] Second, because providers insure against malpractice claims, and insurers tend not to vary malpractice premiums according to the quality of care, high- and low-quality providers tend to pay the same malpractice premiums. Thus high-quality providers cannot differentiate themselves by offering the same level of liability protection at a lower cost. Liability rules that prevent (only) invalid claims could enhance the ability of insurers to price malpractice coverage according to an individual provider's risk of injuring a patient through negligence. However, uniform tort liability frustrates the discovery and adoption of such rules.

In contrast, contract liability offers considerable flexibility to experiment with liability rules designed to reduce frivolous claims, such as the English rule of costs, which requires the losing party in litigation to pay some or all of the litigation costs of the winning party. Insofar as contract liability would allow discovery and implementation of rules that discourage frivolous claims, the share of claims that are valid would grow. That in turn should enhance malpractice liability insurers' ability to price coverage according to a provider's risk of being sued for negligence. In such an environment, high-quality providers would have a credible way of signaling quality. They would face smaller malpractice insurance premiums, and thus could differentiate themselves from low-quality providers by offering more liability protections for the same price, or identical liability protection for a lower price. By providing the freedom to experiment with different liability rules, contract liability presents an opportunity to improve the quality of care by rewarding high-quality providers and punishing low-quality providers.

Contract liability could facilitate quality improvements in other ways as well. Many providers are reluctant to collect or release data on medical errors for fear that those data could

[9] Hall et al., *supra* note 1 at 270. *See also* Danzon *supra* note 1 at 1358 ("Overall, only 43 percent of claimants receive any payment").

expose providers to greater liability. As a result, a potentially important tool for measuring and improving quality may go under-utilized. Allowing providers and patients to create contractual safe harbors for medical error data could encourage its collection.

What liability rules might providers and patients adopt if they knew that courts would enforce such contracts? Early candidates would include the very rules that interest groups currently seek to impose legislatively: caps on non-economic damages, limits on contingency fees, mandatory arbitration, medical courts, the English rule of costs, and changes to the collateral source rule. Those who lobby for caps on damages for pain and suffering could insist on such limits in their own contracts with health care providers.[10] Caps on damages could be set as low as $0 for the indigent faced with the prospect of otherwise receiving no medical care. Simply capping overall damages would provide a variant of collateral source rule reform for those who are elsewhere insured against disability. Contract liability could employ all, some, or none of the above-mentioned rules. The ability to experiment would generate novel combinations of these rules and even novel rules. Insofar as these innovations leave both patient and provider better off, they would be retained, while rules that proved intolerable to either side would be discarded.

Enforcing contractual limitations on providers' liability for medical malpractice would not obviate the need for tort liability. Contract liability is well-suited to supplant tort liability for many injuries caused by simple negligence. Tort liability could still deter and punish acts of gross negligence, and would still be necessary to deter and punish willful misconduct, which should vitiate any contract where a provider promises to exercise reasonable care. Moreover, contract liability is not an option for some patients. This group includes incompetents and those

[10] *But see* Frank Cornelius, *Crushed by My Own Reform*, NEW YORK TIMES (October 7, 1994) (former lobbyist for caps on damages is left with uncompensated losses after suffering injuries from medical negligence).

who choose not to contract. Tort liability could and should provide a set of background rules around which patients and providers may contract if they are able and willing.

III. Obstacles to Contract Liability

When advocating an idea that has no hope of being adopted, it is customary to blame those dim prospects on powerful vested interests rather than the idea itself. Certainly, there are organized interests who might suffer financially were patients and providers able to make binding ex ante agreements that limit the frequency and/or size of liability payouts. The trial bar comes to mind. Yet contract liability also meets resistance from open-minded skeptics. Nevertheless, such arguments against contract liability still fall short of demonstrating that tort liability affords patients greater overall protection than contract liability would. This section critiques three arguments against contract liability: that such agreements constitute contracts of adhesion due to providers' superior bargaining power; that patients are too poorly informed about different liability rules for such agreements to be upheld; and that contract liability would reduce investments in quality.

A leading case regarding contract liability for medical malpractice is *Tunkl v. Regents of the University of California*.[11] Tunkl was a charity patient at the University of California at Los Angeles Medical Center. Upon admission, he was asked to sign and did sign a document that waived his right to recover from the Regents or the hospital for injury due to the negligent acts of the hospital's employees. Tunkl was subsequently injured by the negligence of two physician employees. At trial, the jury upheld the release, reasoning that even though the plaintiff was in

[11] *Tunkl v. Regents of the University of California*, 60 Cal.2d 92, 383 P.2d 441, 32 Cal.Rptr. 33 (Cal. 1963).

pain and sedated when he signed, Tunkl "either knew or should have known the significance of the release."[12] On appeal, the Supreme Court of California invalidated the release as contrary to public policy. The court gave the following test for deciding when contracts that relieve an actor of liability for his own negligence affect the public interest, and are thus invalid:

> [T]he attempted but invalid exemption involves a transaction which exhibits some or all of the following characteristics[:]
>
> [1.] It concerns a business of a type generally thought suitable for public regulation.
>
> [2.] The party seeking exculpation is engaged in performing a service of great importance to the public, which is often a matter of practical necessity for some members of the public.
>
> [3.] The party holds himself out as willing to perform this service for any member of the public who seeks it, or at least for any member coming within certain established standards.
>
> [4.] As a result of the essential nature of the service, 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.
>
> [5.] 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.
>
> [6.] 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 agents…
>
> In this situation, the releasing party does not really acquiesce voluntarily in the contractual shifting of the risk, nor can we be reasonably certain that he receives an adequate consideration for the transfer.[13]

Though *Tunkl* does not provide a precise rule for when an exculpatory contract is invalid, this passage illustrates that the court was concerned primarily with contracts of adhesion, where the

[12] *Id*. at 95.

[13] *Id*. at 98-101 (formatting added).

provider wields "superior bargaining power" over the patient and can therefore compel the patient to waive protection against negligence contrary to the patient's own interest. This is consistent with the courts' handling of exculpatory contracts in other circumstances.[14]

That focus suggests that the reasoning in *Tunkl* need not invalidate all contractual limits on liability for malpractice. Certainly there are many transactions where the patient has ample time to choose from between a number of providers, drastically reducing the bargaining power of each provider and correspondingly increasing the patient's bargaining power. One can think of cosmetic surgery or any of a number of other elective procedures. If provider offers patient a range of protections against negligence (including traditional tort liability) from which to choose, as competition might force providers to do, the *Tunkl* court's fears are further assuaged.[15] If the patient ultimately agrees to a limit on recovery for non-economic damages equal to 80 percent of the state's cap on such damages, or to no changes to tort liability rules save the English rule of costs, the public's interest in the contract shrinks further.[16]

Even in the situations the court most fears, however, *Tunkl* fails as an argument against contract liability. First, the court expresses understandable reservations about allowing a patient to contract away liability protections right before she submits to complete vulnerability at the hands of a provider or multiple providers. The court's language evokes feelings of vulnerability before a careless and possibly malevolent provider who, exculpatory contract in hand, may do

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[14] *See* 175 A.L.R. 8 (1948) at § 9 ("Validity is almost universally denied to contracts exempting from liability for its negligence the party which occupies a superior bargaining position").

[15] *See Id*. at § 10 ("In some instances an artificial equality of bargaining power has been produced so far as agreements to exculpate are concerned by giving the party occupying the inferior bargaining position the option to secure the other's unlimited liability at a price set by governmental regulation at a 'reasonable' level, and where this has been done, exemption provisions have been held valid").

[16] *See Id.* at § 3, citing 2 AM L INST RESTATEMENT, CONTRACTS, § 574 ("A bargain for exemption from liability for the consequences of negligence *not falling greatly below the standard established by law* for the protection of others against unreasonable risk of harm, is legal except in the cases stated in § 575," emphasis added). *But see Id*. at § 3 ("No such clear-cut rule can be deduced from the various decisions of the courts").

with the patient as he wishes. But of course this is not the case. As noted in the previous section, honoring contractual limitations on liability for simple negligence would still leave in place tort remedies for gross negligence and willful misconduct. Contract liability could reduce the patient's ability to recover in the event of slight but not egregious deviations from the standard of care. Moreover, in cases where a contract limits recovery for simple negligence, judges and juries would police more carefully the boundary between simple and gross negligence just as they have used other tools at their disposal to invalidate exculpatory contracts.[17]

Yet the fatal flaw of *Tunkl* is that the court assumes that liability protection it mandates for indigent patients either has no cost, or that the cost is not passed on to those patients (e.g., through higher prices or by discouraging providers from practicing in low-income areas). The former is obviously not true, and the latter is almost certainly not true. In effect, *Tunkl* raises the cost to providers of delivering care to indigent patients above what it otherwise might be. If the resources available to provide care to the indigent are finite, the additional liability costs prevent providers from caring for additional indigent patients.[18] Thus the *Tunkl* court thoughtlessly dictates that some indigents must go without medical care so that others may receive medical care plus protection against the small probability of injury from substandard care. An attempt to protect the poor from negligence thus leaves them more vulnerable to illness.

Rather than adopt an inkblot-like test for determining the validity of exculpatory contracts, the courts should afford patients and providers the certainty that comes with a bright-line test. Where that line should be drawn can be found in the history of *Tunkl* itself. Courts

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[17] *See e.g., Id*. at § 11 ("Where there is no, or no great, disparity of bargaining power between the parties, contracts limiting liability for negligence will, as a rule, be upheld on the theory of freedom of contract. As stated before, *this fundamental rule, while correct in theory, has been changed in nearly all cases which do not expressly mention negligence, into the opposite rule through the principle of strict construction of exculpatory clauses against the person seeking to exculpate himself*," emphasis added).

[18] Richard A. Epstein, *Market and Regulatory Approaches to Medical Malpractice: The Virginia Obstetrical No-Fault Statute*, 74 VA. L. REV. 1451, 1460-1461 (Nov. 1988).

should uphold contractual liability rules agreed to by competent patients and should continue to invalidate limits on liability agreed to by incompetent patients. This is how the *Tunkl* jury approached the question at trial, before the California Supreme Court invalidated as violating public policy a contract that Tunkl's peers considered valid.

A related objection to contract liability is that patients lack sufficient information to bargain with providers over liability protections.[19] That patients lack such information today is undeniable, but that's because information about the value of alternate liability rules is of little use – and thus is seldom supplied – to consumers who cannot legally contract for non-standard rules. Able to choose alternate rules, consumers' demand for such information would increase markedly, creating profit opportunities for those in a position to supply such information. Markets could route the information to consumers as it does information about other products. To reduce patient confusion, providers may offer a small number of standardized contracts, perhaps drafted or approved by medical societies or independent groups. Employers, unions, and even health insurers[20] could act as the patient's agent in negotiations with providers, recommending or even demanding certain liability protections. Independent organizations such as *Consumer Reports* could evaluate the importance of discrete liability protections and standardized contracts, including the liability protections offered by corporate entities such as Kaiser Permanente and HCA.

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[19] *See, e.g.*, P.S. Atiyah, *Medical Malpractice and the Contract/Tort Boundary*, 49 LAW & CONTEMP. PROBS. 287, 295 (Spring 1986). *See also* Jennifer Arlen, *Private Contractual Alternatives to Malpractice Liability*, in MEDICAL MALPRACTICE AND THE U.S. HEALTH CARE SYSTEM: NEW CENTURY, DIFFERENT ISSUES (William M. Sage & Rogan Kersh, ed.) (Cambridge University Press, 2006).

[20] Provided a health insurer has an arm's length relationship with (1) the provider and (2) the carrier from whom the provider purchases malpractice liability insurance.

Moreover, at the same time critics of contract liability exaggerate the information problems confronting patients,[21] they ignore the information problems facing judges and legislators. Legislators obtain information on malpractice liability rules from groups that are relatively easy to organize and have a large stake in their preferred rules (e.g., the trial bar, providers, employers, etc.). Legislators tend not to receive information from those whose stake is relatively small and who are more difficult to organize (i.e., individual patients, particularly the indigent). For the individual patient, the costs of obtaining information about the potential effects of legislative reforms, organizing, and conveying one's views to the legislature would overwhelm the expected benefits of a given rule. Courts have a distinct advantage over legislatures in crafting tort liability rules, in that courts are better equipped than legislatures to collect information from individuals adversely affected by a legal rule, are less subject to political influence, and have more opportunities to experiment with and revisit a legal rule.[22] Nevertheless, as *Tunkl* illustrates, the indigent patient is privy to information that courts and lawmakers are not. Specifically, the patient who agrees to waive liability may know – in a way that a court cannot appreciate – that the cost of the court's preferred rule could require the patient to forgo medical care. Judges, much less legislators, should not dismiss the possibility that the indigent possess information that lawmakers do not.

A third objection to contract liability is that such a system could not generate the investments in quality that a functional tort liability system would generate. This case is made

[21] Indeed, critics of contract liability have used the information problems caused by the effective prohibition of contractual liability to dismiss the appeal of contract liability. At the same time Atiyah argues that consumers are poorly informed about different liability rules, he notes a "marked lack" of evidence that consumers demand reform of existing liability rules. Atiyah, *supra* note 19 at 295-296, 298. Yet a lack of demand for reform is meaningful only if consumers are well-informed about reform options.

[22] *See generally* John Hasnas, *What's Wrong with a Little Tort Reform?*, 32 IDAHO L. REV. 557 (1996).

forcefully by Jennifer Arlen of New York University School of Law.[23] Arlen argues that a uniform tort liability system that forces providers to bear the cost of their negligence encourages providers to invest in quality – in both human and physical capital, and both before and after forming a contract with a particular patient. Under a system where the parties can bind themselves to a lower level of liability protection, providers would face diminished incentives to invest in quality. Quality investments would thus fall, to the detriment of patients who preferred the level of quality investment spurred by uniform tort liability rules. Even if those patients were to contract for the same level of malpractice protection previously afforded under tort liability, they could not replicate the incentives for providers to invest in quality that come from exposing providers to that degree of liability for all patients. As a result, even if all patients were fully informed, those patients would be worse off under contract liability.

As an argument against contract liability, Arlen's analysis fails for two reasons. The first reason is that it faults markets for doing something that markets are supposed to do. Insofar as there are patients who would be worse off under contract liability than under an optimal tort liability system, that means that uniform tort liability confers subsidies on those patients – subsidies extracted from patients who would prefer less liability protection, but whose right to contract for less protection has been denied by the courts. The monetary and autonomy losses suffered by that latter group of patients must be entered in the ledger along with the losses borne by the indigent who are denied medical care. An important function of markets is to eliminate such cross-subsidies, particularly those that travel up the income scale, as these subsidies appear to do. Moreover, patients who lose these cross-subsidies are certainly not without recourse. They could obtain their preferred level of quality the old-fashioned way: by paying for it.

[23] *See* Arlen *supra* note 19.

Demanding even greater liability protections than tort liability currently provides would encourage some providers to make the desired investments in quality.

The second reason is that Arlen demonstrates that contract liability would be inferior only to an idealized, "optimal" system of tort liability. Though Arlen adds much to our understanding of how contract liability would affect the health care sector, her critique compares contract liability only to an optimal system of tort liability, which she acknowledges does not exist. Nor does Arlen articulate a strategy for moving our actual tort liability system toward optimality, or compare such a strategy to the process of experimentation and learning that contract liability would provide. As a result, Arlen does not show contract liability to be any more flawed than our current tort liability system, or any other human institution. It is hardly a damning criticism to say that contract liability fails in comparison to an ideal.[24] Most human endeavors do.

It is that process of experimentation with different rules that gives contract liability its greatest advantage in the pursuit of optimality. Indeed, the process by which liability rules are selected is likely more important than which rule will be tried next. Presumably, Arlen would prefer to retain the current system's uniformity while pushing toward optimality through judicial and/or legislative intervention. However, an optimal selection process would reduce the cost of gathering and making use of new information. The fact that contract liability reduces the cost of adopting and discarding liability rules – including rules designed to deal with the problems Arlen identifies – gives contract liability a distinct advantage over experimentation by courts and legislatures. A full appraisal of the information problems under the three available reform processes – contract, judicial, and legislative – suggests that contract provides the least-imperfect route toward optimality.

[24] *See generally* Harold Demsetz, *Information and Efficiency: Another Viewpoint*, 12 J.L. & ECON. 1, 1 (1969).

IV. Allaying Concerns with Contract Liability

Limitations on the right of competent adults to contract for protection against medical negligence are likely to be either unnecessary (because no patient and provider would choose the prohibited terms) or harmful (because the limitation would foreclose a preferred option). Yet the dim prospect that courts will begin to enforce such contracts suggests that some limitations might be tolerated in order to reduce the harm currently imposed by complete prohibition. What contracts might courts or legislatures be persuaded to declare valid? One possibility is to enforce only those contracts produced by someone other than providers themselves. Requiring that contract liability rules will only be enforced when written by those at arms-length from providers, and only when offered as a part of a menu of standardized contract liability protections, would provide a much needed, if ultimately inadequate, dose of experimentation and relief. Alternatively, legislatures could permit patients and providers to negotiate within boundaries set by other legislatures, such as by enforcing only those contracts that employ limits on malpractice liability enforceable in one of the other 49 states. Legislatures could overcome concerns that patients would forgo all malpractice protections by setting a lower bound on maximum awards, such as $250,000 for non-economic damages. Concerns about uninformed patients signing away their rights could be remedied by initially confining the right to contract only to those patients who are judges, lawyers, physicians, statisticians, actuaries, high-income earners, or who carry third-party insurance against such injuries. As *Tunkl* suggests, courts have not developed a clear rule to decide which contracts will be upheld and which invalidated. That

indeterminacy suggests courts are not hostile to all exculpatory contracts,[25] and opens the door to limited reforms such as these.

V. Conclusion

Public policy currently allows patients to assume the very large risks involved with forgoing treatment for fatal yet treatable diseases.[26] It further permits patients to select different liability protections by traveling abroad for medical care.[27] Judges and lawmakers respect the right to refuse treatment even when the risks are large, but deny the right to limit one's ability to recover for negligence even when the risks are small. Patients already have the right to choose different malpractice liability protections, but only if they are willing to travel out-of-state or out-of-country. If consumers are too poorly informed to allow them to bind themselves to different liability rules, a consistent approach to contract liability would have to prohibit traveling abroad for medical care.[28]

Proponents of uniform tort liability argue that the provider owes a duty to the patient upon the two forming a special legal relationship.[29] Yet the problem of malpractice protection has a positive economic component as well as a normative legal component. That is, where shall we invest resources: in protection from negligence, or in protection from illness? Certainly, society should not completely sacrifice either in pursuit of the other. Ignoring the tradeoff,

[25] *See* A.L.R. at § 3.

[26] *See, e.g., Matter of Conroy*, 98 N.J. 321, 486 A.2d 1209, 53 USLW 2372, 48 A.L.R.4th 1 (N.J. 1985) at 353 ("On balance, the right to self-determination ordinarily outweighs any countervailing state interests, and competent persons generally are permitted to refuse medical treatment, even at the risk of death").

[27] *See, e.g.*, Michael F. Cannon and Michael D. Tanner, *Healthy Competition: What's Holding Back Health Care and How to Free It*, (Cato Institute, 2005) at 8-9, 141-143.

[28] One hesitates to give the legislature ideas.

[29] Atiyah *supra* note 19, at 296-297.

however, is dangerous precisely because in doing so we may inadvertently reduce protection overall, particularly for the poor. The threat posed by our current system of tort liability for medical malpractice is that we have struck a balance that demands greater protection from simple negligence than many patients would prefer, that is uniform and inescapable, that reduces protections against illness, and that may only be altered through Herculean efforts in a process that guarantees that some voices will not be heard.

Where, then, to strike the balance? As the foregoing discussion suggests, that question is subordinate to the threshold question: who decides?[30] It is here that contract liability offers advantages that tort liability cannot. Contract liability offers a means to drive the imperfections out of the medical malpractice liability system through a process that selects liability rules based on their ability to deliver improvements in both cost and quality. Our present system of uniform and rigid tort liability offers no such process, and thus provides less overall protection than we could achieve.

[30] Epstein, *supra* note 18, at 1451-1452.