

Malpractice

Health Economics Lecture 11

Outline

- Goals of Malpractice System
- Law and Economics Framework
- Economic Perspectives
 - ▶ Coase Theorem
 - ▶ Deterrence
 - ▶ Defensive Medicine
 - ▶ Experience Rating
- Cyclic Crises

Definitions

- **Adverse outcome:** bodily harm, mental harm, deception, battery
 - ▶ Not all adverse outcomes caused by acts of commission or omission
 - ▶ Commission worse than omission
 - Dying from “inoperable disease” better than dying on the operating table

Definitions

- **Error**: (*medical term*) failure of planned action to be executed properly, or selection of wrong plan of action
- **Negligence**: (*legal term*) preventable adverse outcome caused by failure to follow standard of care
 - ▶ Local community standard giving way to national standard

Case 1: Error

- Mrs. G's feeding tube becomes dislodged. Dr. Q inserts a new one, but it doesn't go into her stomach
 - ▶ A nurse at the nursing home gets an X-ray prior to using the tube and finds that the tube is in the lungs
 - ▶ The tube is repositioned successfully



Case 2: Adverse Outcome

- Mrs. G's feeding tube becomes dislodged. Dr. Q inserts a new one, but it doesn't go into her stomach
 - ▶ When she is fed she chokes and coughs because the tube is in her lungs
 - ▶ She experiences 24 hours of fever, responds to antibiotics, and is discharged 2 days later in good health

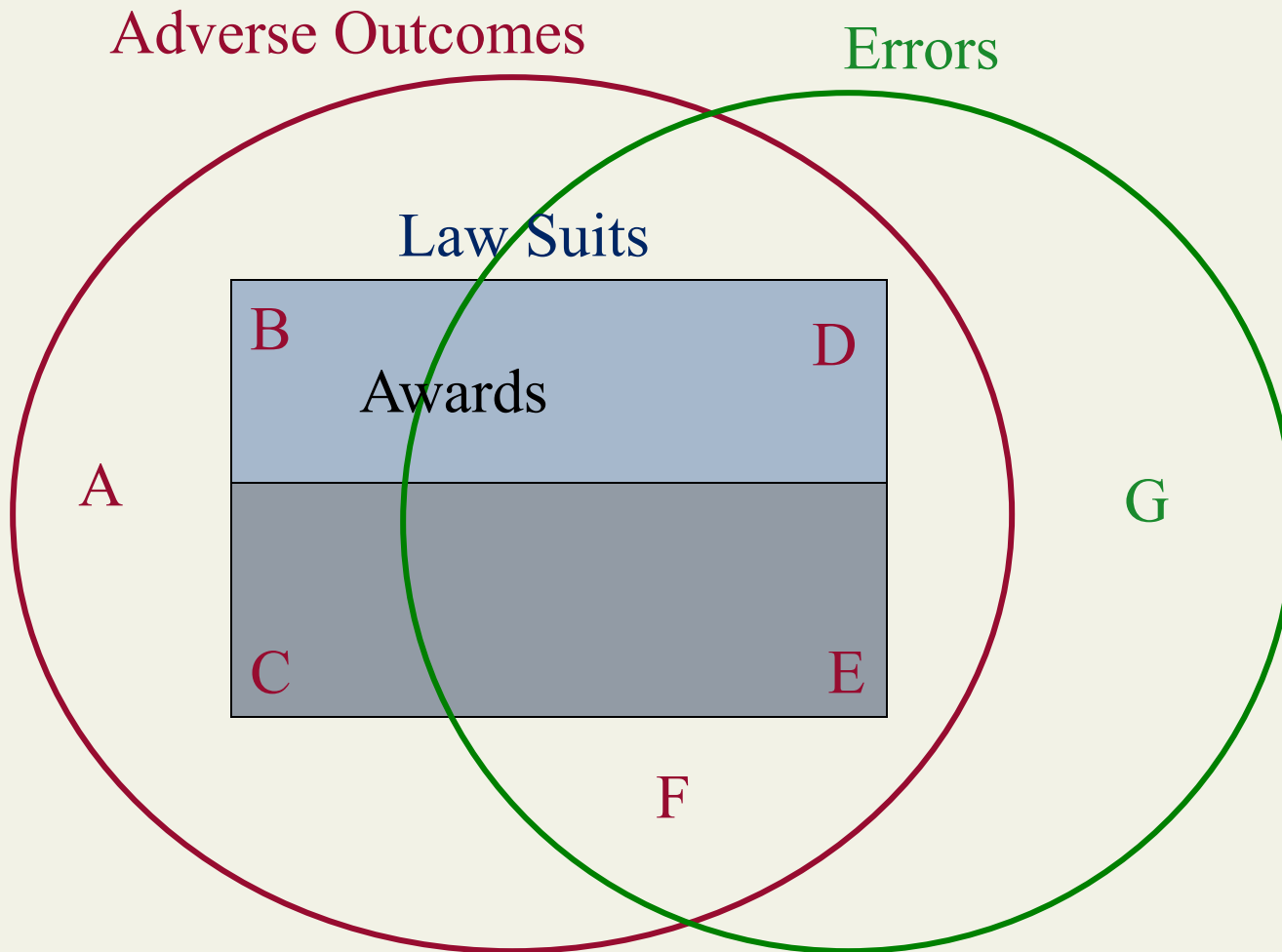


Case 3: Negligence

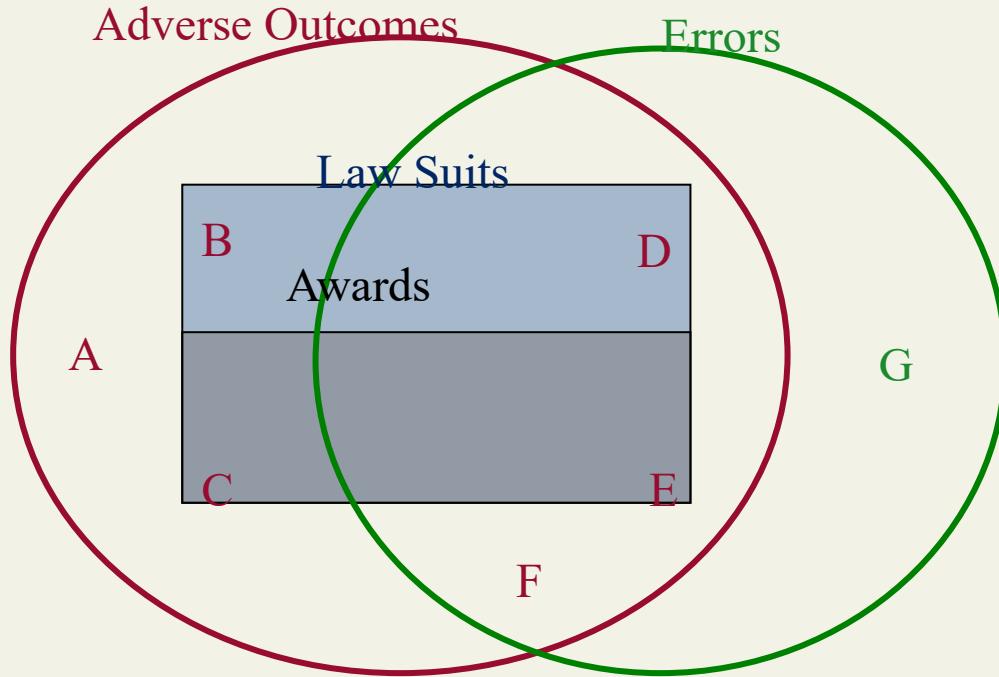
- Mrs. G's feeding tube becomes dislodged. Dr. Q inserts a new one, but it doesn't go into her stomach
 - ▶ When she is fed she chokes and coughs because the tube is in her lungs
 - ▶ She dies of aspiration pneumonia 1 week later
- Is the negligence malpractice?
 - ▶ Yes if court finds that Dr. Q violated accepted standards of care
 - ▶ No if Mrs G's family never sues
 - ▶ No if Mrs G's family sues and loses



Map of Malpractice

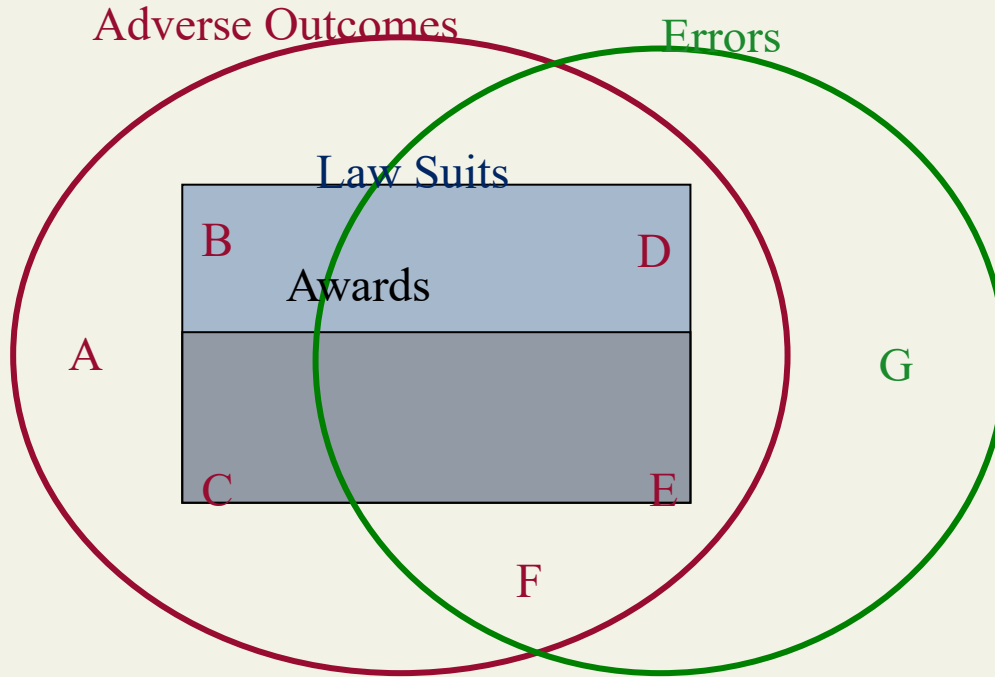


Map of Malpractice



- A. Adverse outcomes+No error+No suit
- B. Awarded suit +No error
- C. Dismissed suit +No error
- D. Awarded suit + Error
- E. Dismissed suit + Error
- F. Adverse outcome+Error+No suit
- G. Error+No adverse outcome

Goals of Malpractice System Improvement



- 1. Fairness to Doctors → Make B small
 - 2. Fairness to Patients → Make E small
 - 3. Deter errors → Make F small, G small
 - 4. Compensate injured → Make ACEF small
 - 5. Lawyer's interest → B and D big
 - 6. Doctor's interest → BCDE small
 - 7. Patient's interest → DEFG small
 - 8. Society's interest → Mitigate catastrophic consequences to patients of ABCDEFG at lowest costs
-
- Which lawsuits generate economic waste from a societal perspective?

Goal of Malpractice System

- Deter errors
 - But!
 - Providers are insured and don't bear full costs
- Compensate victims
 - Why?
 - Remedy an unfair loss
 - Damage property remedied by restored property
 - Lost health remedied by money (?)
 - Special form of insurance
 - Revenge (“Eye for an eye”)



Error deterrence: Other Options

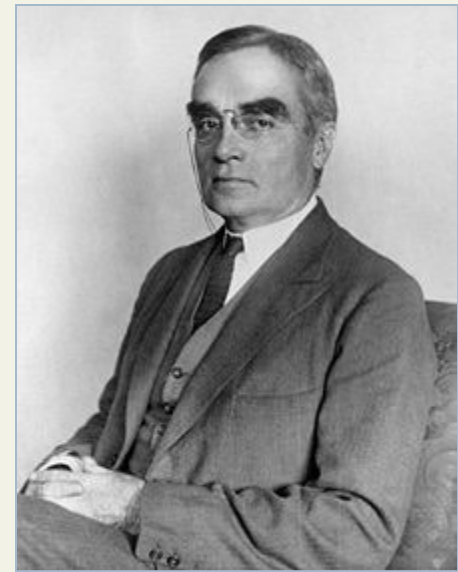
- Systems of care
 - Total quality management
 - Feedback loops
- Peer review
- Informed consumers

Victim compensation

- No fault insurance
- Arbitration
- Soften revenge motive
 - Perception that provider didn't care motivates many lawsuits
 - Disclosure protocols now appearing for error management

Learned Hand Criterion for optimal negligence

- If reductions in the error rate are costly, the optimal error rate is not zero
- Learned Hand Criterion
 - Spend money controlling errors until $C = P(C) \square D(C)$
 - C is cost of harm reduction
 - P is probability of harm
 - D is damage



Judge Learned Hand

Economic criterion for optimal negligence

- Welfare Econ Criterion
 - Social cost=Pr(Damage) x Damage +Cost of harm reduction
 - Social Cost=[P(C) ×D(C)]+C

- Minimize by finding derivative with respect to C

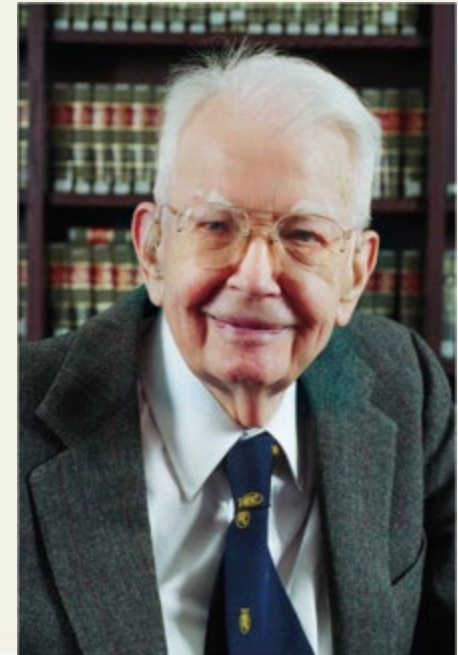
$$p \frac{dD}{dC} + D \frac{dP}{dC} + 1 = 0$$

$$pdD + DdP = -dC$$

- Spend until value of next dollar spent on harm reduction equals (Value of Marginal Damage Reduction + Value of Marginal Probability Reduction)

Coase Theorem

- Optimal Outcome Defined
 - Optimal rate of externalities is not zero
 - Optimal rate is defined by $dC = PdD + DdP$
 - Marginal social cost of pollution abatement = Marginal social benefit
- Coase: Optimal Outcome is Available if:
 - 1. All rights are assigned
 - 2. Transactions costs are zero
- *It doesn't matter HOW you assign rights!*



Corollary to Coase Theorem

- If there are externalities then:
 - A. Property rights have not been assignedAND/OR
 - B. High transactions costs are impeding injurers and victims from reaching social optimum

Who owns malpractice insurance costs?

- Premiums reflect prior claims of a specialty
 - Increases incentives to practice caution
 - Death spirals from adverse selection
- Malpractice premiums are experience rated across specialties
- Community rated within specialty
 - Good doctors subsidize bad doctors within specialty
- Do community rated premiums enhance or defeat the assignment of ownership of consequences of negligence?

Premiums

- Obstetricians: \$45,000
- GPs: \$10,000
- Internists: \$12,500
- Pediatricians: \$12,500

Experience Rating

- Insurers could get data on claims per MD and experience rate
 - They don't. Why?
- Perspectives
 - It's a victim compensation system not a deterrent.
 - Skepticism that incentive of a lower malpractice rate would improve caution
 - Power of medical lobbies

Weak Incentives to Supply Caution

- Selfish doctors, fully insured against malpractice
- Pass through malpractice premium to patient
 - Single doctor's caution will never lower malpractice premium
- → No incentive to supply caution

- PARADOX : Doctor's say they are over incentivized to supply caution, that they practice costly defensive medicine



Resolve Paradox

- Real doctors are not indifferent to being sued because there are uninsurable emotional costs and lost leisure time spent defending suits
- The emotional costs may lead to defensive medicine

Defensive Medicine: Evidence

- Kessler and McClellan
 - Tort reforms of 1984-1990 lowered expected damages in lawsuits
 - Total hospital expenses per heart attack patient fell in this period more so in states with tort reform
 - Outcomes no worse
 - Effects in states timed to occur with tort reform
 - No effects in states that did not do tort reform
 - Technology improvements would not have been disseminating just to tort reform states

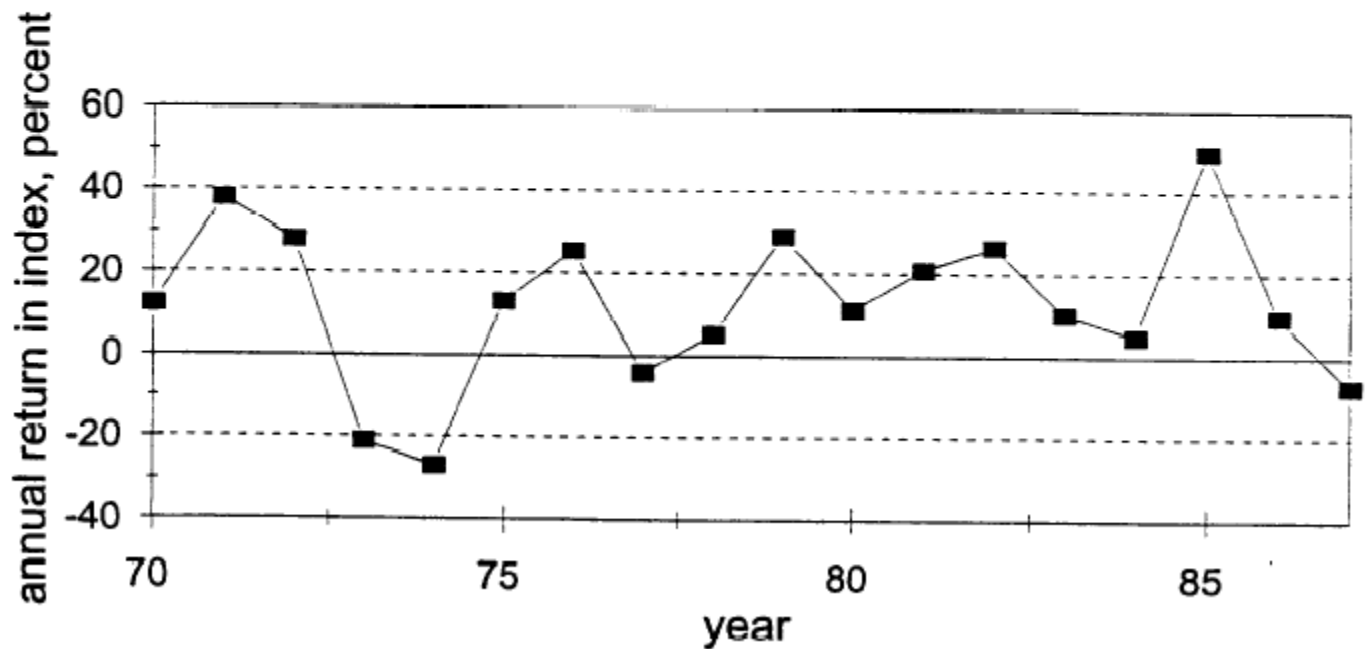
Bad Apples

- California
 - 46 of 8000 doctors made 10% of the claims
 - 30% of the awards
- What to do?
- For the other 90% claims feel like random bad luck.

Cycles of Crisis

Property-Casualty Stock Returns

1970-1987





Insurance Companies

- Collect lots of money
 - Invest it and lend it to make more money
 - Hope few casualties
- Cyclicity based on business cycles
 - Low interest rates are unfavorable to insurers
 - Downturns create shortages
- Cyclic high premiums
 - A) Due to exit of firms
 - B) To cover losses in capital markets

Cyclic malpractice crises

- Rises in malpractice premia lead to cyclic tort reforms
 - “Tort reform” is typically a cap in pain and suffering damages at \$250,000
- Public debates often spurred by price hikes that weren’t caused by an epidemic of malpractice payments for pain and suffering
- Tort reform is the classic doctors vs. lawyers showdown and will keep recurring



Summary

- Malpractice has multiple objectives
 - Compensation
 - Deterrence
- Economic perspectives stress
 - Lower transactions costs between injurer and victim
 - Incentives to reduce errors