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Tom Baker
University of Pennsylvania Carey Law School

Timothy D. Lytton
Albany Law School

Author ORCID Identifier:

Tom Baker 0000-0002-0876-2312

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Essays

ALLOWING PATIENTS TO WAIVE THE RIGHT TO SUE FOR MEDICAL MALPRACTICE: A RESPONSE TO THALER AND SUNSTEIN

Tom Baker[*] *& Timothy D. Lytton*[**]

INTRODUCTION

In their recent book, *Nudge: Improving Decisions About Health, Wealth, and Happiness*, Richard Thaler and Cass Sunstein offer a variety of public policy reforms based on behavioral economics and what they call "libertarian paternalism."[1] Behavioral economics identifies common patterns of thinking that influence perception and conduct and often lead individuals to make poor choices. Examples include reliance on stereotypes, overconfidence, preference for immediate gratification over long-term well-being, and susceptibility to peer pressure.[2] Thaler and Sunstein's reforms are designed to take these patterns into account to help individuals make better choices. Their commitment to libertarian paternalism leads them to advocate against government mandates that restrict choice and in favor of policies that subtly guide, or "nudge," individuals in the direction of options that will make them better off.[3]

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[*] William Maul Measey Professor of Law and Health Sciences, University of Pennsylvania Law School.

[**] Albert and Angela Farone Distinguished Professor of Law, Albany Law School. The authors thank Martin Bienstock, Ray Brescia, Bernard Lytton, Greg Mandel, Peter Siegelman, and Katherine Zeiler for comments on an earlier draft.

[1] RICHARD H. THALER & CASS R. SUNSTEIN, NUDGE: IMPROVING DECISIONS ABOUT HEALTH, WEALTH, AND HAPPINESS 4–6 (2008).

[2] *Id.* at 17–80.

[3] *Id.* at 5–6.

In the area of healthcare, Thaler and Sunstein advocate allowing patients to waive their right to sue physicians for medical malpractice, claiming that "patients and doctors should be free to make their own agreements about that right."[4] Under this theory, the resulting "increase in freedom is likely to help doctors and patients alike, and to make a valuable, even if modest, contribution to the health care problem."[5] Waivers would, they explain, give patients more choice and reduce healthcare costs. This is so primarily because Thaler and Sunstein view a right to sue for medical malpractice that cannot be waived as a form of compulsory insurance. Liability exposure leads physicians to purchase medical malpractice insurance, the cost of which they pass on to their patients in the form of higher fees. Allowing patients to waive their right to sue would eliminate much of the need for medical malpractice coverage and, they argue, thereby enable patients, either directly or through their health insurance carriers, to negotiate lower fees with physicians.[6]

While Thaler and Sunstein claim that allowing patients to waive the right to sue for medical malpractice will enhance patient choice and reduce healthcare costs, their analysis does not support this claim. To begin with, behavioral economics offers reasons to think that, given a choice to waive the right to sue for medical malpractice, patients will often make choices that are not in their best interest. For example, the preference for immediate gratification will lead patients to overvalue the immediate gains offered by fee reductions, and overconfidence will lead them to underestimate the risk of medical negligence. Moreover, Thaler and Sunstein's assertion that waiving the right to sue will reduce healthcare costs is based on an assessment of medical malpractice liability that omits serious consideration of the current system's benefits. Before touting the cost savings of waiving the right to sue, one ought to pay careful attention to its effects on not only doctors' fees but also the quality of care. Finally, and perhaps most egregiously, Thaler and Sunstein's analysis is framed by polemical rhetoric and outlandish examples, a form of discourse characteristic of popular tort reform advocates and widely discredited among scholars.[7] Comparing the civil justice system to a "lottery" and analogizing lawsuits for injuries resulting from medical negligence to sour grapes over a bad haircut does not advance our understanding of the costs and benefits of tort litigation.[8]

In their defense, undertaking a rigorous cost–benefit analysis of medical liability would be an extraordinarily difficult task.[9] For that reason, it

[4] *Id.* at 207.

[5] *Id.*

[6] *Id.* at 208–09.

[7] *See, e.g.*, Marc Galanter, *Real World Torts: An Antidote to Anecdote*, 55 MD. L. REV. 1093 (1994).

[8] THALER & SUNSTEIN, *supra* note 1, at 209, 211–12.

[9] *See* Tom Baker, Herbert M. Kritzer & Neil Vidmar, Jackpot Justice and the American Tort System: Thinking Beyond Junk Science 9–11 (July 1, 2008) (unpublished manuscript, http://ssrn.com/abstract=1152306).

might seem unfair to complain that they did not accomplish that task in a short chapter in a book that otherwise has nothing to do with medical malpractice. Nevertheless, this criticism is necessary given the circumstances. *Nudge* has the potential to be an extraordinarily influential book, both because of the strength of the underlying behavioral research and because of Professor Sunstein's prominent position within the Obama Administration as head of the Office of Information and Regulatory Affairs and Professor Thaler's own ties to Obama's economic team.[10] Indeed, medical liability reform has already begun to play a prominent role in the national health care reform debate.[11]

Ours is far from a wholesale criticism of *Nudge*. Indeed, we applaud the behavioral turn and many of the authors' other policy prescriptions. Moreover, behavioral economics may well offer insights that can improve the current medical malpractice system, but Thaler and Sunstein's waiver proposal is, unfortunately, a poor example.

In the first Part of this Essay we show that the behavioral insights that undergird *Nudge* do not support the waiver proposal. In the second Part we demonstrate that Thaler and Sunstein have not provided a persuasive cost–benefit justification for their proposal. In the third Part we argue that their liberty-based defense of waivers rests on misleading analogies and polemical rhetoric that ignore the liberty and other interests served by patients' tort law rights.

I. THE EFFECTS OF COGNITIVE BIAS ON PATIENTS' DECISION TO WAIVE THE RIGHT TO SUE

Thaler and Sunstein survey a number of common patterns of thinking that bias perception and lead individuals to make poor choices. Rather than supporting their waiver proposal, these cognitive biases raise concerns about the ability of patients to make good decisions about waiving their right to sue for medical malpractice. Consider, for example, optimism and overconfidence. "Unrealistic optimism," the authors explain, "is a pervasive feature of human life" that leads people to "overestimate their personal immunity from harm."[12] With regard to healthcare decisionmaking, Thaler and Sunstein suggest:

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[10] *See, e.g.*, Allegra Stratton, *'Nudge' Economist Richard Thaler Joins Conversative Camp*, GUARDIAN, Oct. 6, 2009, http://www.guardian.co.uk/politics/2009/oct/06/richard-thaler-conservative-party (noting that Thaler is "close to Obama's economic team"); Noam Scheiber, *The Audacity of Data*, NEW REPUBLIC, March 12, 2008, http://www.tnr.com/article/the-audacity-data ("Thaler is revered by the leading wonks on Barack Obama's presidential campaign. Though he has no formal role, Thaler presides as a kind of in-house intellectual guru . . . .").

[11] *See* Sheryl Gay Stolberg & Robert Pear, *Obama Open to Reining in Medical Suits*, N.Y. TIMES, June 15, 2009, at A1 ("Mr. Obama has been making the case that reducing malpractice lawsuits . . . can help drive down health care costs, and should be considered as part of any health care overhaul . . . .").

[12] THALER & SUNSTEIN, *supra* note 1, at 33.

> Unrealistic optimism can explain a lot of individual risk taking, especially in the domain of risks to life and health. Asked to envision their future, students typically say that they are far less likely than their classmates to . . . have a heart attack or get cancer . . . . Gay men systematically underestimate the chance that they will contract AIDS, even though they know about AIDS risks in general. Older people underestimate the likelihood that they will be in a car accident or suffer major diseases. Smokers are aware of the statistical risks, and often even exaggerate them, but most believe that they are less likely to be diagnosed with lung cancer and heart disease than most nonsmokers.[13]

These findings raise concerns that patients given the option to waive their right to sue will underestimate the risk of medical negligence in their particular case, even if informed about such risks in general. Few people, even doctors, adequately appreciate how frequently medical mistakes occur,[14] and, even if they did, the optimism bias would lead people to think, "It won't happen to me."

The temptation of immediate gratification is another source of bias that, according to Thaler and Sunstein, results in "a series of bad outcomes for real people."[15] They note as examples the millions of Americans who continue to smoke, the two-thirds of the U.S. population that is overweight or obese, and the failure of many people to save for retirement even when their employers offer heavily subsidized retirement plans.[16] Thaler and Sunstein explain that competitive markets cater to the bias in favor of immediate gratification, thereby exacerbating its distorting effects:

> Even when we're on our way to making good choices, competitive markets find ways to get us to overcome our last shred of resistance to bad ones. At O'Hare Airport in Chicago, two food vendors compete across the aisle from each other. One sells fruit, yogurt, and other healthy foods. The other sells Cinnabons, sinful cinnamon buns that have a whopping 730 calories and 24 grams of fat . . . . Care to guess which of the two stores always has the longer line?[17]

This bias might lead patients to overvalue the immediate gains of fee reductions offered in exchange for waiving their right to sue.

Other sources of cognitive bias could further distort patients' perceptions of the benefits and risks of waiving their right to sue for medical malpractice. According to Thaler and Sunstein, the "availability heuristic" leads individuals to "assess the likelihood of risks by asking how readily examples come to mind."[18] Information about medical negligence is closely guarded by doctors, hospitals, and insurers; victims rarely publicize their

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[13] *Id.* at 32–33.

[14] *See* TOM BAKER, THE MEDICAL MALPRACTICE MYTH 2, 22–24 (2005).

[15] *See* THALER & SUNSTEIN, *supra* note 1, at 44.

[16] *Id.*

[17] *Id.* at 49.

[18] *Id.* at 25.

experiences. Media coverage of medical malpractice is heavily weighted in favor of the rare, very egregious error rather than more frequent, routine mistakes.[19] Thus, for lack of available examples, patients may underestimate the risk of more ordinary and more frequent kinds of malpractice. In addition, successful media campaigns by tort reform advocates have spread factually inaccurate stereotypes of undeserving plaintiffs with outlandish claims brought against innocent defendants.[20] Reliance on such stereotypes—what Thaler and Sunstein call the "representativeness heuristic"[21]—may make patients reluctant to envision themselves as tort plaintiffs or to imagine suing their doctor.

The way that choices are framed also influences the options that individuals select. Thaler and Sunstein frame the choice of whether to waive the right to sue for medical malpractice as a choice between a real discount in doctors' fees and "a kind of lottery ticket, one that might be worth anything from millions of dollars to nothing, but that is, on average, worth no more than 60 cents for every dollar spent (the rest going to lawyers)."[22] If independent scholars are inclined to frame the choice in terms so clearly aimed at encouraging waiver, one should be concerned about how healthcare providers with financial interests would frame it.

In justifying the need for government-sponsored "nudges" that will improve individual choices that might otherwise be distorted by cognitive bias, Thaler and Sunstein observe that "in some cases, companies have a strong incentive to cater to people's frailties and to exploit them."[23] Individuals are most vulnerable to this type of manipulation, they explain, when choices offer immediate benefits and deferred costs; involve a high degree of complexity; occur infrequently; provide inadequate feedback to increase knowledge and experience over time; and when people have a hard time predicting how choices will impact their lives in the future.[24] Decisions to waive the right to sue for medical malpractice leave patients vulnerable to manipulation for all of these reasons. Waiver offers fee reductions now and defers financial risk until later; it involves complex issues of risk assessment; it is made infrequently and without any feedback (because if medical negligence occurs, patients are unlikely to learn of it in the absence of a

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[19] *See* BAKER, *supra* note 14, at 99–105 (reviewing egregious medical malpractice cases reported in the news media); WILLIAM HALTOM & MICHAEL MCCANN, DISTORTING THE LAW: POLITICS, MEDIA, AND THE LITIGATION CRISIS 155–56 (2004) (documenting that media reporting is biased in favor of outlier cases); David A. Hyman & Charles M. Silver, *The Poor State of Health Care Quality in the U.S.: Is Malpractice Part of the Problem or Part of the Solution?*, 90 CORNELL L. REV. 893, 942–47 (2005) (summarizing research showing that medical providers do not disclose errors). Of course, media outlets perhaps understandably only take interest in unusual cases, as there is no news value in ordinary cases.

[20] HALTOM & MCCANN, *supra* note 19, at 174–78.

[21] THALER & SUNSTEIN, *supra* note 1, at 26–27.

[22] *Id.* at 211–12.

[23] *Id.* at 77.

[24] *Id.* at 72–76.

lawsuit); and it is difficult to predict how the inability to sue for medical negligence will affect the patient's life in the future. The superior bargaining power of physicians over patients based on asymmetry of information, high demand for healthcare services, and the status of the physician as healer add to the risk of exploitation.

Thaler and Sunstein see the risk of exploitation in the market as a reason to nudge patients to reflect consciously on their decision to waive by making nonwaiver the default option.[25] They also propose that waivers be part of employer-purchased healthcare coverage, in the "hope that employers would help their employees make informed choices."[26] "[W]e are libertarian paternalists, not libertarians 'full stop,'" they explain. "We recognize that patients might find it hard to understand the nature of medical malpractice liability and the consequences of waiver. Waiving liability should not be done lightly or impulsively."[27]

Embedding the waiver in an individual's healthcare coverage, however, hardly seems to mitigate the effects of cognitive bias. A patient's single decision when enrolling in a healthcare plan to waive the right to sue for medical malpractice would apply to all her future medical care within the plan. It would thereby aggregate multiple fee reductions into a single insurance premium reduction and lump doctor-by-doctor risk analysis into a single decision to waive that covers all doctors. This aggregation increases immediate benefits while making future risks less specific and more remote. It also increases the complexity of the choice to waive and reduces the frequency with which patients face it, thus reducing opportunities for feedback. And it makes it harder to predict future implications of the choice since it covers multiple medical procedures. Exacerbating these problems is the fact that doctors, insurance companies, and most employers[28] will likely perceive a benefit in reducing consumers' access to medical malpractice litigation and thus will almost certainly frame choices about medical malpractice waivers in a way that exploits people's biases.[29]

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[25] *Id.* at 213.

[26] *Id.*

[27] *Id.* at 212.

[28] We suspect that employers would generally favor waivers to an extent that may not be in the best interest of their employees. Ths is because employers would not receive the benefits that their employees receive from liability, but employers would have to pay part of the cost of higher premiums.

[29] Recent work by Michael Barr and his colleagues extends this insight. They explain how some markets help consumers compensate for behavioral biases while other markets exploit those biases. The difference lies in the degree to which the biased decisionmaking produces profits or other benefits for the organizations with the power to shape consumers' decisions. For example, the immediate gratification bias leads consumers to underestimate the power of compound interest, with the result that they fail to appreciate the benefits of saving and the costs of borrowing. Banks, insurance companies, mutual funds, and other organizations that benefit from consumer saving have developed lots of ways to help consumers overcome this bias. Credit card companies, on the other hand, benefit from consumer borrowing and, thus, tend to exploit this bias, such that too many consumers are over their heads with credit card debt. ELDAR SHAFIR, MICHAEL S. BARR & SENDHIL MULLAINATHAN, NEW AM. FOUND.,

Thaler and Sunstein's concern for protecting patients from exploitation seems even less convincing when they suggest that

> [f]or those who are especially skeptical of malpractice lawsuits, we have an even more ambitious proposal: patients should be presumed to be permitted to sue only for intentional or recklessness wrongdoing—and not for mere negligence . . . . Under this approach, patients would be offered a right to "buy" a stronger liability right, but it would cost them a bit. This approach would undoubtedly mean that waivers would be common. The offer to "buy" should be accompanied by relevant information, so that people know what they are effectively losing if they fail to accept that offer.[30]

Given Thaler and Sunstein's view that "the default option usually sticks," this proposal makes it highly unlikely that patients would retain their right to sue for negligence.[31] Moreover, "relevant information" about the costs and benefits of medical malpractice liability is hard to come by. Thaler and Sunstein's own slanted account of the system is typical of popular perceptions based on incomplete and inaccurate information (more on this below).[32] There is ample reason to be skeptical that healthcare providers and insurance companies with financial interests in limiting liability would be likely to promote truly informed decisionmaking by patients about waiving the right to sue. In public discourse about medical malpractice reform, they have hardly been unbiased sources of information.[33]

BEHAVIORALLY INFORMED FINANCIAL SERVICES REGULATION, 3–5, 12–13 (2008), *available at* http://www.newamerica.net/publications/policy/behaviorally_informed_financial_services_regulation.

[30] THALER & SUNSTEIN, *supra* note 1, at 213.

[31] *Id.*

[32] *See* BAKER, *supra* note 14, at 1 (discussing popular misconceptions of the medical malpractice system). *See generally* HALTOM & MCCANN, *supra* note 19 (discussing the way media, reform groups, and individualistic values have led to popular misconceptions of the tort system).

[33] One case in point comes from the American Medical Association's response to a landmark medical malpractice closed claim study published in the *New England Journal of Medicine* in May 2006. *See* David M. Studdert, Michelle M. Mello, Atul A. Gawande, Tejal K. Gandhi, Allen Dachalia, Catherine Yoon, Ann Louise Puopolo & Troyen A. Brennan, *Claims, Errors and Compensation Payments in Medical Malpractice Litigation*, 354 NEW ENG. J. MED. 2024 (2006). The study concluded: "Claims that lack evidence are not uncommon, but most are denied compensation. The vast majority of expenditures go toward litigation over errors and payment of them." *Id.* at 2024. In other words, the tort system weeds out the meritorious claims so that most of the claim payment dollars go to people who deserve them. The AMA press release responding to the study ignored this result (which was consistent with prior studies) and seized upon the one statistic in the article that supported the AMA's tort reform agenda. The press release led with a headline stating that forty percent of medical malpractice claims are meritless and included a statement from an AMA board member, Dr. Cecil Wilson, that drew an entirely unsupported conclusion: "The costs of these meritless lawsuits are borne by patients who have decreased access to care as physicians are forced to spend significant time and money defending against meritless lawsuits." Press Release, AMA, Harvard Study Shows 40 Percent of Medical Liabilty Claims Filed Without Merit (May 10, 2006) (copy on file with authors). The AMA "line" on the study and Dr. Wilson's quote was picked up in newspapers across the country, obscuring the study's true findings. *See, e.g.*, Associated Press, *Many Medical Malpractice Cases Groundless*, MSNBC.COM, May 10, 2006, http://www.msnbc.msn.com/id/12723303.

If, as Thaler and Sunstein suggest, the danger of healthcare providers exploiting patients' cognitive bias justifies making nonwaiver the default, it would seem also to justify making the right to sue nonwaivable altogether. Thus, it appears that behavioral economics does not justify allowing patients to waive their rights.

So what is really driving Thaler and Sunstein's proposal? One possibility is welfarism.[34] Perhaps their argument is simply that the costs of medical malpractice liability outweigh its benefits, so reforms should be instituted that will reduce liability. Thaler and Sunstein suggest that, insofar as waivers would reduce medical malpractice litigation, they would reduce overall healthcare costs. A second possibility is libertarianism "full stop," notwithstanding the authors' claim to be libertarian paternalists. Thaler and Sunstein argue that the duties of care imposed by medical malpractice liability restrict the liberty of doctors and patients to contract freely.[35] The move from tort to contract increases individual liberty.

As the next Part shows, Thaler and Sunstein's welfarist justification is based on an incomplete and inaccurate review of the available empirical evidence. In the final Part, we argue that their libertarian justification amounts to little more than a rhetorical polemic against tort litigation.

II. TAKING THE BENEFITS OF MEDICAL MALPRACTICE LITIGATION INTO ACCOUNT

Thaler and Sunstein's framing of waivers as a means of reducing healthcare costs suggests that they are motivated by welfarism.[36] An underlying welfarism is also reflected in their otherwise inexplicable endorsement of no-fault compensation schemes that "dramatically reduce administrative burdens from an often laborious litigation process."[37] Thaler and Sunstein's praise for caps on noneconomic and punitive damages similarly reveals their welfarist concern for cost savings.[38]

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[34] Welfarism is the view that rules should be evaluated on the basis of their social utility and consequences for human welfare.

[35] THALER & SUNSTEIN, *supra* note 1, at 207.

[36] *See id.*

[37] *Id.* at 213. Compulsory no-fault compensation schemes such as worker's compensation or the New Zealand accident system are odd policies for libertarians to advocate since such systems are classic examples of command and control administrative regulation that limit individual choice in the service of social welfare.

[38] *Id.* There is scholarly disagreement about the effect of damage caps on healthcare costs. *Compare* Ronen Avraham & Max M. Schanzenbach, *Impact of Tort Reform on Private Health Insurance Coverage* (Northwestern Pub. Law Research Paper No. 07-16, Dec. 17, 2007), *available at* http://papers.ssrn.com/sol3/papers.cfm?abstract_id=995270 (finding that some tort reforms are effective in reducing healthcare costs, though not to a substantial extent), *with* Michael A. Morrisey, Meredith L. Kilgore & Leonard (Jack) Nelson, *Medical Malpractice Reform and Employer-Sponsored Health Insurance Premiums*, 43 HEALTH SERVICE RES. 2124 (2008) (finding no evidence that damage caps reduce the cost of employer-sponsored health insurance).

Thaler and Sunstein's welfarist defense of waivers rests on their claim that the costs of medical malpractice litigation outweigh the benefits. After offering cost figures that they admit "are controversial and may be exaggerated," they conclude that "no one doubts that many billions of dollars must be paid each year to buy insurance and to fend off liability."[39] They also cite unquantified costs of "defensive medicine" and the reluctance of doctors and hospitals to report medical errors for fear of liability.[40] Contingent fees—constituting "about 40 percent" of awards—add to the cost of the system.[41] In addition, Thaler and Sunstein decry erratic jury awards for pain and suffering and punitive damages.[42]

As for the purported benefits of medical malpractice liability, Thaler and Sunstein assert that "the deterrent effect of tort liability is overstated" since malpractice insurance premiums are not experience-rated, meaning that a physician's premiums are the same regardless of the level of care he or she exercises.[43] Deterrence is also undermined, they continue, by "the stunningly poor fit between malpractice claims and injuries caused by medical negligence. To put it bluntly, most patients don't sue even if their doctor has been negligent, and many of those who do sue, and end up with favorable settlements, don't deserve the money."[44] Moreover, the authors cite findings that an admission of fault and apology by the physician often leads patients not to file a lawsuit. "If an apology prevents a lawsuit, then the deterrent effect of the right to sue is further reduced."[45] Thus, Thaler and Sunstein argue that, insofar as waivers would reduce medical malpractice litigation, they will reduce overall healthcare costs.

Careful consideration of empirical findings regarding medical malpractice litigation, however, reveals serious problems with Thaler and Sunstein's analysis. To begin with, they understate the benefits of medical malpractice litigation. Their claim that liability does not deter medical negligence rests on a highly selective review of the empirical research.[46] Thaler

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[39] THALER & SUNSTEIN, *supra* note 1, at 209.

[40] *Id.* The term "defensive medicine" is used in two different ways. It can mean any change in response to concern about liability, in which case, like "defensive driving" some of the changes may be beneficial. Or it can mean only wasteful responses to concerns about liability. Our sense is that Thaler and Sunstein are referring to the latter.

[41] *Id.* at 211.

[42] *Id*.

[43] *Id.* at 210. "Experience rating" refers to the practice of adjusting insurance premiums according to the experience of the person or entity insured. In theory, this could include adjusting premiums up or down according to observations of the level of care. But, in practice, the level of care cannot be observed, so "experience rating" in the liability insurance context means adjusting premiums up or down according to the number and severity of claims or, possibly, complaints made against the insured.

[44] *Id*.

[45] *Id.* at 211.

[46] For an example of research reaching contrary conclusions, see Patricia Danzon, *Liability for Malpractice, in* 1 HANDBOOK OF HEALTH ECONOMICS 1339, 1341 (A.J. Culyers & J.P. Newhouse eds., 2000). Danzon concludes that "[t]he limited empirical evidence of provider response to liability and the

and Sunstein cite a well-regarded review of the empirical literature reporting that the deterrent impact of medical liability is difficult to document.[47] But they do not mention the numerous case studies demonstrating that medical malpractice litigation does in fact improve patient safety. The strongest evidence comes from the long-term effort of the American Society of Anesthesiologists to systematically study and learn from malpractice claims, and there are many individual cases outside the anesthesia context in which medical malpractice claims led to safer practices.[48] In addition, concern about medical liability motivated the now voluminous research on medical malpractice—research that led directly to the patient safety movement that promotes safe practices in hospitals today.[49] Some of the most recent research has used medical malpractice claims to identify ways to improve patient safety in hospitals.[50] The Harvard hospitals' captive insurance company, for example, has developed a risk management consulting group that uses medical malpractice claims experience to improve patient safety in hospitals.[51]

Second, Thaler and Sunstein's characterization of apologies by physicians as undermining the deterrent value of malpractice litigation overlooks the significant personal and social value of apologies. A primary goal of many tort plaintiffs is to make defendants accountable for their wrongful behavior and the harm that it has caused.[52] Potential release from liability offers doctors a powerful incentive to take responsibility for their mistakes

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deterrent effect of claims suggests—but cannot prove—that the net benefits of the medical malpractice system may plausibly be positive." *Id.* Also see Janet Currrie & W. Bentley MacLeod, *First Do No Harm? Tort Reform and Birth Outcomes* 22–23 (Nat'l Bureau of Econ. Research, Working Paper No. 12478, 2006), for research finding a correlation between caps on damages and birth-related complications consistent with the hypothesis that liability serves a deterrence function.

[47] THALER & SUNSTEIN, *supra* note 1, at 211 (citing Michelle M. Mello & Troyen A. Brennan, *Deterrence of Medical Errors: Theory and Evidence for Malpractice Reform*, 80 TEX. L. REV. 1595, 1619–20 (2002)).

[48] BAKER, *supra* note 14, at 98–105, 108–10.

[49] *See* Tom Baker, *Medical Malpractice Insurance Reform: 'Enterprise Insurance' and Some Alternatives*, *in* MEDICAL MALPRACTICE AND THE U.S. HEALTH CARE SYSTEM 267, 278–79 (William M. Sage & Rogan Kersh eds., 2006).

[50] *See* Allen Kachalia, Tejal K. Gandhi, Ann Louise Puopolo, Catherine Yoon, Eric J. Thomas, Richard Griffey, Troyan A. Brennan & David M. Studdert, *Missed and Delayed Diagnoses in the Emergency Department: A Study of Closed Malpractice Claims from 4 Liability Insurers*, 49 ANNALS EMERGENCY MED. 196 (2007); Selwyn O. Rogers, Atul A. Gawande, Mary Kwaan, Ann Louise Puopolo, Catherine Yoon, Troyen A. Brennan & David M. Studdert, *Analysis of Surgical Errors in Closed Malpractice Claims at 4 Liability Insurers*, 140 SURGERY 25 (2006); Hardeep Singh, Eric J. Thomas, Laura A. Petersen & David M. Studdert, *Medical Errors Involving Trainees: A Study of Closed Malpractice Claims from 5 Insurers*, 167 ARCHIVES INTERNAL MED. 2030 (2007).

[51] *See* RMF Strategies, http://www.rmfstrategies.com (last visited March 17, 2010) (website of RMF Strategies, a division of Risk Management Foundation of the Harvard Medical Institutions, Inc.).

[52] *See, e.g.*, TIMOTHY D. LYTTON, HOLDING BISHOPS ACCOUNTABLE: HOW LAWSUITS HELPED THE CATHOLIC CHURCH CONFRONT CLERGY SEXUAL ABUSE 182–84 (2008) (discussing plaintiffs' desire for public accountability and apology in clergy sexual abuse litigation).

and to share information about the nature of what went wrong.[53] Beyond vindication of individual plaintiffs' claims, such admissions of liability on the part of physicians can provide other potential patients with information about the quality of care provided by particular physicians and could be a valuable source of aggregate information about medical errors more generally.

In addition, Thaler and Sunstein overstate the argument that insurers' failure to experience-rate doctors' medical malpractice premiums undermines the deterrent value of medical malpractice litigation. In fact, at least some insurers do drop doctors if they have too many claims against them, which is a form of experience rating.[54] Moreover, the concern that medical malpractice insurance is not experience-rated had more force ten or twenty years ago than it does today. Hospitals and other large health care provider organizations commonly "self-insure" to a very substantial extent and therefore experience the full deterrent impact of settlements or judgments of up to $5 million or more—and the excess insurance that these organizations purchase to cover payments above this amount is experience-rated.[55] Also, an increasing number of doctors obtain their medical malpractice insurance through hospitals, medical schools, and other large organizations.[56] As a result, the fact that the medical malpractice insurance sold to individual doctors is not experience-rated has less impact with each passing year.

As for Thaler and Sunstein's assertion of a "poor fit between malpractice claims and injuries caused by medical negligence," the empirical research overwhelming shows that people who receive medical malpractice payments deserve the money.[57] Although it is true that most people who are

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[53] *See* Jennifer K. Robbenalt, *Attorneys, Apologies, and Settlement Negotiations*, 13 HARV. NEGOT. L. REV. 349, 352–63 (2008) (presenting the most recent review of the literature on the role and impact of apologies in litigation); *see also* Lee Taft, *Apology Subverted: The Commodification of Apology*, 109 YALE L.J. 1135, 1146–54 (2000) (suggesting that laws protecting apologies turn these sincere expressions into strategic commodities for civil mediations).

[54] *See, e.g.*, BARRY WERTH, DAMAGES 201, 207–09 (1998) (reporting the difficulty that an obstetrician had obtaining insurance because of her claims history).

[55] *See* Michelle M. Mello, *Understanding Medical Malpractice Insurance: A Primer*, 8 SYNTHESIS PROJECT 1, 1 (2006), *available at* http://www.rwjf.org/pr/product.jsp?id=15091 (last visited March 18, 2010) (reporting that hospital liability insurance is experience-rated); e-mail from medical malpractice insurance broker to author (Oct. 6, 2009) (on file with the author) (stating that a hospital's deductibles, known as self-insured retentions (SIRs), are "generally linear to size of facility" with hospitals of less than 200 beds carrying SIRs from $10,000 to $100,000 and large hospitals carrying SIRs from $1 million up to $5 million or more).

[56] *See generally* Baker, *supra* note 49, at 268–69 (applauding this trend and advocating that such "enterprise liability insurance" be made available to all doctors practicing in hospitals or other large organizations); *see also* Mello, *supra* note 55, at 3 (reporting a trend toward hospitals buying insurance for doctors).

[57] *See, e.g.*, Philip G. Peters, *What We Know About Medical Malpractice Settlements*, 92 IOWA L. REV. 1783, 1831–33 (2007). The only study that reports a contrary finding was poorly constructed to assess the accuracy of medical malpractice claims and could easily be reinterpreted to support what is otherwise the consensus view. *See* Tom Baker, *Reconsidering the Harvard Medical Practice Study*

injured by medical malpractice do not bring a claim, that fact reflects the considerable procedural hurdles and financial costs of bringing suit. It does not mean that judgments in the medical malpractice cases that do arise are erroneous.[58]

Thaler and Sunstein's accounting of the costs of medical malpractice litigation similarly rests upon a selective review of the empirical research. Their claim about the high costs of defensive medicine cites the only study that suggests a significant amount of wasteful defensive medicine exists.[59] They fail to cite a later study by the same researchers showing managed care to be much more effective than tort reform at reducing unnecessary expenditures.[60] Moreover, fear of liability is *supposed* to change doctors' behavior and, therefore, what might seem to be defensive medicine is likely to be beneficial in many, if not most, cases. Scholars who have conducted serious research on defensive medicine universally acknowledge that it is extraordinarily difficult to determine whether the changed behavior is good or bad for patients.[61] Among other problems, "one cannot handle accurately the issues involved in defensive medicine without having first established epidemiologically the soundness of medical procedures as they relate to specific outcomes in patients."[62] Separating the beneficial aspects of defensive medicine from its wasteful aspects requires a better understanding of medical practices than medical science research has attained in many, if not most, cases.[63] Thaler and Sunstein's assertion that a large percentage of liability-influenced treatments are "unnecessary" simply reflects their intuitions, not empirical research.

The authors' other assertions about the costs of medical malpractice litigation are equally unsupported. The claim that medical malpractice liability discourages error reporting has never been documented by empirical research, and a recent, careful review has thoroughly discredited this con-

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Conclusions About the Validity of Medical Malpractice Claims, 33 J.L. MED. & ETHICS 501, 502–06 (2005).

[58] *See* Steven P. Croley, Civil Justice Reconsidered 80–116 (Oct. 10, 2008) (unpublished manuscript, on file with the authors) (cataloguing the procedural hurdles and financial costs of bringing tort claims).

[59] *See* Daniel Kessler & Mark McClellan, *Do Doctors Practice Defensive Medicine?*, 111 Q.J. ECON. 353 (1996).

[60] Daniel Kessler & Mark McClellan, *Malpractice Law and Health Care Reform: Optimal Liability Policy in an Era of Managed Care*, 84 J. PUB. ECON. 175 (2002); *see also* BAKER, *supra* note 14, at 126–32 (explaining that, taken together, the two Kessler and McClellan articles point toward managed care as a more promising approach to reducing wasteful defensive medicine).

[61] *See, e.g.*, David Klingman, A. Russell Localio, Jeremy Sugarman, Judith L. Wagner, Philip T. Polishuk, Leah Wolfe & Jacqueline A. Corrigan, *Measuring Defensive Medicine Using Clinical Scenarios*, 21 J. HEALTH POL. POL'Y & L. 185, 188 (1996); *see also* Mello, *supra* note 55, at 4 ("There are no reliable estimates of the national costs of defensive medicine.").

[62] Laurence R. Tancredi & Jeremiah A. Barondess, *The Problem of Defensive Medicine*, 200 SCIENCE 879, 881 (1978).

[63] BAKER, *supra* note 14, at 120–22.

ventional wisdom.[64] Among other points, this research documents that physicians who are not exposed to liability are no more likely to report errors than physicians who are exposed to liability.[65] In reality, fear of medical malpractice liability is the reason that we know what we know about medical malpractice. As already mentioned, nearly all of the existing research on medical malpractice was motivated by liability concerns.[66] Fear of liability has also produced a new health care profession—the health care risk manager—responsible for helping hospitals and other institutions collect information about medical errors and improve patient safety.[67]

Finally, Thaler and Sunstein's criticism of high contingency fees fails to take into account the benefits of the contingency fee system. Contingent fees provide people with access to the courthouse that they otherwise could not afford and represent a kind of litigation insurance in which successful plaintiffs defray the costs of the unsuccessful. Indeed, a recent study conducted for the Civil Justice Council in Great Britain concluded that contingent fees improve access to justice and that "restricting the levels of fee has a significant detrimental effect on access to justice."[68] The benefits of medical malpractice litigation in terms of improving patient care—by deterring carelessness, encouraging doctors to take responsibility for their mistakes, generating information about medical errors, and motivating patient safety reforms—all depend upon patients' access to lawyers who can help them file lawsuits.[69]

In sum, Thaler and Sunstein make no effort to systematically evaluate the costs and benefits of medical malpractice liability in arguing that medical malpractice waivers will reduce healthcare costs by diminishing liability exposure and litigation. Instead, they provide an impressionistic and one-sided review of the imperfections of the current medical liability system, vaguely concluding that "even if the risk of liability for negligence actually

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[64] *See* Hyman & Silver, *supra* note 19, at 909–47.

[65] *Id.* at 893.

[66] *See* Baker, *supra* note 49, at 278–79.

[67] *See* BAKER, *supra* note 14, at 107; Margo Schlanger, *Operationalizing Deterrence: Claims Management (In Hospitals, a Large Retailer, and Jails and Prisons)*, 2 J. TORT L. 1, 24–40 (2008).

[68] Richard Moorhead & Peter Hurst, Contingency Fees: A Study of Their Operation in the United States of America 36 (Nov. 17, 2008) (unpublished manuscript, http://ssrn.com/abstract=1302843).

[69] We should note that others have also criticized the high fees earned by some contingency fee lawyers. *See* Lester Brickman, *Effective Hourly Rates of Contingency-Fee Lawyers: Competing Data and Non-Competitive Fees*, 81 WASH. U. L.Q. 653 (2003). Whether the contingency fee lawyer market is competitive is open to debate. *Compare id.* (arguing that returns from contingency fee practice are inordinately high and that the current system suffers from collusion among contingency fee attorneys to prevent competition) *with* Herbert M. Kritzer, *The Wages of Risk: The Returns of Contingency Fee Legal Practice*, 47 DEPAUL L. REV. 267 (1998) (surveying they contingency fee system and arguing that the returns from contingency work are only slightly better than hourly work, and that this system benefits potential clients by offering eased access to the justice system). In this debate no one has claimed that eliminating contingency fees would improve access to the tort system for medical malpractice plaintiffs.

does reduce the frequency of injuries caused by doctors, these gains could easily be offset by the losses of those who are unable to afford treatment at all."[70] This is hardly a rigorous welfarist defense of waivers.

In contrast, Professor Jennifer Arlen has recently completed a rigorous welfarist analysis of waivers.[71] She concludes that waivers are likely to *decrease* social welfare. Professor Arlen explains that individual patients or their insurance companies would receive the full reduction in price that would be attributable to a waiver, but they would not suffer the full costs that waivers impose on society. Medical liability leads medical providers to make expensive and durable investments in safety that benefit all of their patients. As a result, an individual patient has a strong incentive to waive liability, because that waiver does not have a large effect on the provider's incentive to make those expensive and durable investments.[72] In other words, waivers present a classic free rider or collective action problem, in which individually rational decisions lead to a collectively irrational result.[73]

III. LIBERTARIAN PATERNALISM OR LIBERTARIAN POLEMICISM?

Thaler and Sunstein also view waivers as a way of "increasing freedom of contract in the domain of medical malpractice."[74] Their argument for waivers based on the libertarian value of freedom of contract unfortunately relies on polemical rhetoric that trivializes the problem of medical negligence, compares medical malpractice litigation to a lottery, and characterizes noncontractual legal rights to sue as unnecessary, state-imposed obligations. This rhetorical strategy does little to advance understanding about the complex issue of civil justice reform or the merits of contract over tort approaches to medical negligence.

Thaler and Sunstein offer the following analogy:

> Suppose, for example, that people had the right to sue their hairdressers if a haircut went badly wrong, and that the cost of this insurance raised the price of haircuts by $50 after someone who had received a particularly gruesome haircut won a $17 million judgment. Would you be interested in saving $50 per

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[70] THALER & SUNSTEIN, *supra* note 1, at 211.

[71] Jennifer Arlen, *Contracting over Malpractice Liability* (N.Y.U. Law & Econ. Research Paper Series, Working Paper No. 08-12, 2008), *available at* http://ssrn.com/abstract=1105368.

[72] *Id.* at 21.

[73] *See also* Jennifer Arlen & W. Bentley MacLeod, *Malpractice Liability for Physicians and Managed Care Organizations*, 78 N.Y.U. L. REV. 1929, 2000–04 (2003) (first suggesting this point); *cf.* Abraham L. Wickelgren, *The Inefficiency of Contractually-Based Liability with Rational Consumers*, 22 J. L. ECON. & ORG. 168 (2005) (presenting a formal economics model to make a similar point in the products liability context). It is worth noting that, as required by her formal economic approach, Arlen assumes that individuals are rational and that medical providers will not frame the decision in a way that takes advantage of cognitive limitations. Considering the behavioral economic insights addressed in the first part of this Essay makes her conclusions even stronger.

[74] THALER & SUNSTEIN, *supra* note 1, at 214.

> haircut to give up the right to sue if you got a bad one? Would you be angry if you were prevented from doing so?[75]

The authors' immediate qualification, "We know, we know, the analogy isn't perfect," hardly does justice to the inaccuracy of the comparison.[76]

First, many medical malpractice claims involve permanent injuries or death, not temporary disappointments.[77] Second, medical malpractice claims are based on negligence, not merely bad outcomes. Third, adding $50 to the $21 cost of the average American haircut would mean that liability insurance premiums comprised, on average, seventy percent of the cost of a haircut.[78] This is hardly comparable to the less than two percent that medical malpractice liability insurance and self-insurance adds to the cost of the average medical procedure.[79] Fourth, evidence from a number of states suggests that medical malpractice awards over $1 million are rare and usually occur in cases involving death, serious injury, or egregious wrongdoing.[80] Trial judges and appellate courts frequently reduce multimillion dollar jury verdicts as excessive, although the news media tend to report only the jury verdict, not the reduction.[81] Moreover, even when courts do not reduce jury verdicts, defendants are often able to avoid paying the plaintiffs the full amount of the verdict.[82] Thaler and Sunstein's hypothetical award

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[75] *Id.* at 209. For a similarly polemical analogy, see Thaler and Sunstein's discussion of holding university professors liable for teaching "something that turned out to be wrong." *Id.* at 208.

[76] *Id.* at 209.

[77] *See, e.g.*, Neil Vidmar, Paul Lee, Kara MacKillop, Kieran McCarthy & Gerald McGwin, *Uncovering the "Invisible" Profile of Medical Malpractice Litigation: Insights from Florida*, 54 DEPAUL L. REV. 315, 339–42 (2005) (presenting data that over fifty percent of paid claims in Florida from 1990 to 2003 involved permanent injuries).

[78] *See* Rachel Lehmann-Haupt, *The $800 Haircut*, MSN MONEY, June 14, 2007, http://articles.moneycentral.msn.com/Investing/HomeMortgageSavings/haircut.aspx (stating that the average cost of a haircut in America is $21).

[79] This figure is obtained by dividing the $30 billion medical malpractice tort costs for 2007 reported in the *2008 Update on U.S. Tort Cost Trends* from Towers Perrin into the $2.2 trillion total U.S. health care expenditures estimated by the Centers for Medicare and Medicaid Services for 2007. *See* TOWERS PERRIN, 2008 UPDATE ON U.S. TORT COST TRENDS 15, *available at* http://www.towersperrin.com/tp/getwebcachedoc?webc=USA/2008/200811/2008_tort_costs_trends.pdf (last visited March 17, 2010); CENTERS FOR MEDICARE & MEDICAID SERVICES, NATIONAL HEALTH EXPENDITURE PROJECTIONS 2007–2017, at 3 tbl.1 (2007). For an explanation of why the Towers Perrin number may be exaggerated, see Baker et al., *supra* note 9, at 4.

[80] *See* THOMAS H. COHEN & KRISTEN A. HUGHES, U.S. DEP'T OF JUSTICE, MEDICAL MALPRACTICE INSURANCE CLAIMS IN SEVEN STATES, 2000–2004, at 1, 4–6 (2007), *available at* http://bjs.ojp.usdoj.gov/content/pub/pdf/mmicss04.pdf (last visited March 18, 2010) (reporting that "few medical malpractice insurance claims resulted in payouts of $1 million or more" and reporting a correlation between the severity of the injury and the size of the payment); *see also* Vidmar et al., *supra* note 77, at 338, 346 (reporting a median payment of $150,000 in 2003, that only 3.8% of paid claims from 1990–2003 were $1 million dollars or greater, and that over 80% of those million dollar payments were made in cases involving a permanent major injury or worse).

[81] *See, e.g.*, HALTOM & MCCANN, *supra* note 19, at 212–13.

[82] *See* David A. Hyman, Bernard Black, Kathryn Zeiler, Charles Silver & William M. Sage, *Do Defendants Pay What Juries Award? Post-Verdict Haircuts in Texas Medical Malpractice Cases, 1988–*

of $17 million thus seems designed more for shock value than to reflect the reality of medical malpractice awards.[83] In sum, the choice to "sav[e] $50 per haircut to give up the right to sue if you got a bad one" is worse than an imperfect analogy. It is downright misleading.

Thaler and Sunstein also compare medical malpractice to a lottery based on the assertion that many plaintiffs who suffer no harm or have not been treated negligently nonetheless receive compensation. They point to the variability in pain and suffering and punitive damages awards as further support for the comparison.[84] According to this view, even if erroneous findings of liability and high awards are rare (as the weight of empirical evidence seems to suggest),[85] they nevertheless make litigation into a game of chance. Leading tort reform advocate Ted Frank explains:

> The nature of a litigation lottery is that the availability of potentially huge damages justify bringing a meritless claim, so long as there is some small chance that the combination of an outlier judge and an outlier jury will produce a jackpot that compensates for the risk that the judge/jury combination will get it right.[86]

Yet the possibility of erroneous outcomes and variable awards does not make tort litigation a lottery. Indeed, the very possibility of identifying some outcomes as erroneous fundamentally distinguishes litigation from a lottery. Winners in litigation are determined, not by chance, but by applying the law to the facts of a case. Of course, there is always the possibility of an erroneous outcome when a judge misapplies the law or the jury misconstrues the facts. But this is quite different from the process of random selection whereby lottery winners are selected. It makes no sense to argue that a randomly selected lottery winner should not have won. In contrast, it is certainly possible to criticize litigation outcomes as erroneous—to argue that the prevailing party should not have won—precisely because litigation, unlike a lottery, is governed by the rule of law. Suggesting that the error rate of a decision procedure makes it a lottery is a category mistake since the very possibility of identifying an erroneous outcome by definition makes the procedure nonrandom and therefore not a lottery.[87]

2003, 4 J. EMPIRICAL LEGAL STUD. 3, 5–6 (2007) (reporting that 75% of plaintiffs in medical malpractice cases received a payout of less than the jury verdict amount, and that 98% of plaintiffs with a verdict of $2.5 million or more received a reduced payout with a mean reduction of 56%).

[83] Of note, Vidmar et al., *supra* note 77, at 348, reports that from 1991 through 2003 the maximum paid medical malpractice award in Florida—a medical liability tort crisis state according to the American Medical Association—exceeded $17 million in only one year, 2000.

[84] THALER & SUNSTEIN, *supra* note 1, at 211–12.

[85] BAKER, *supra* note 14, at 77–92.

[86] Posting of Ted Frank to Pointoflaw, http://www.pointoflaw.com/archives/001307.php (July 11, 2005, 18:31 EST).

[87] Of course, one could criticize the outcome of a lottery on the basis that it was not random—for example, where the lottery is "fixed"—but that would render it no longer a lottery.

Of course, for practical purposes, the error rate of a decision procedure could be so high as to render outcomes practically random. But no one, not even the most ardent advocates of tort reform, has suggested that high damage awards based on erroneous findings of liability are anything but statistical outliers.[88] One might argue that there is a randomness as to whether an individual who files a false claim of medical malpractice will be lucky enough to draw the rare judge or jury who will produce an erroneous judgment in his favor. But this random distribution of errors does not make a flawed process into a random one. Those who cheat on their taxes stand some random chance of avoiding detection, but this hardly makes the tax system a lottery. Similarly, while bank depositors stand a random chance of an accounting error in their favor, this does not make depositing one's money in a bank tantamount to playing a lottery.

Comparing medical malpractice litigation to a lottery is, at best, unhelpful for understanding the sources, frequency, and magnitude of error in the tort system. At worst, it is a rhetorical strategy aimed at undermining public confidence in the civil justice system in order to strengthen popular support for tort reform.

Thaler and Sunstein similarly frame waivable rights to sue in tort as a form of compulsory insurance that restricts liberty. This metaphor is not as egregious as that of the lottery, but it is also a rhetorical move that inhibits careful analysis. The ability to waive one's rights is, no doubt, a form of liberty. At the same time, it should be remembered that the right to sue is also a form of liberty—it gives victims of negligence a voluntary option to enforce their substantive rights to compensation. If the concerns over cognitive bias and unequal bargaining power discussed earlier are valid, then the liberty of waiver could be used as a tool to deprive patients of their liberty to sue. Whether allowing waiver increases the liberty of patients depends upon how waivers would be negotiated, not by ideal economic agents, but by real physicians and patients subject to cognitive bias and the unequal distribution of market power. We should, as Thaler and Sunstein argue throughout their book, base policy on predictions about how imperfect humans, not idealized rational actors ("econs"), will behave.[89]

Note also that Thaler and Sunstein's framing of non-waivable rights as coercive has more general application. One might, for example, view rights to workplace safety, race and sex equality, and due process as forms of compulsory insurance that restrict the liberty of workers. While such a perspective is certainly coherent, the history of these rights suggests that the need for them arose precisely out of the failure of contract to secure them.[90] Far from being a new idea, Thaler and Sunstein's desire to transform tort

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[88] *Id.*; *see also* BAKER, *supra* note 14, at 83–92.

[89] For the distinction between humans and "econs," see THALER & SUNSTEIN, *supra* note 1, at 6–8.

[90] *See* 2 MELVIN I. UROFSKY & PAUL FINKLEMAN, A MARCH OF LIBERTY: A CONSTITUTIONAL HISTORY OF THE UNITED STATES 509–11, 518, 545–71 (2002).

and other nonwaivable rights to sue into contract rights might be viewed as a return to the laissez-faire ideology that preceded the twentieth century's progressive reforms in common law, statutory law, and constitutional law. Unfortunately, the authors' proposed reform of medical malpractice offers no new reasons to swing the pendulum back in the direction of contract.

CONCLUSION

Thaler and Sunstein's proposal for medical malpractice waivers does not seem to rest on insights from behavioral economics. Nor does their cost–benefit analysis of the current malpractice system support their call for change. And for all of their discussion of libertarian paternalism, in the end they appear motivated by the classical libertarian commitment to individual choice. Perhaps their argument is simply the following: (1) we know that medical malpractice liability is expensive in terms of insurance premiums, litigation costs, and awards; (2) there is a great deal of uncertainty as to this costly system's benefits in terms of improving the quality of care; (3) so why not let individuals make their own choices about whether they want to pay for the system? Those who believe it benefits them can retain their right to sue for medical malpractice, and those who do not can opt out and obtain lower cost medical services.

We offer several responses to this characterization of Thaler and Sunstein's argument. First, this is classical libertarianism, not some more moderate libertarian paternalism that promises a "third way" that "might serve as a viable middle ground in our unnecessarily polarized society."[91] In other words, Thaler and Sunstein are partisans, not peacemakers, in the highly polarized debate over medical malpractice reform. Second, Thaler and Sunstein's claim that choice will make individuals better off does not adequately consider people's vulnerability to exploitation, which behavioral economics suggests would be common and would not be mitigated by nudges designed to encourage waiver. Third, while one could argue that individuals should have the right to waive regardless of the social costs, one should not, as Thaler and Sunstein do, trivialize those costs. Scholarly research points to benefits of medical malpractice litigation in terms of error reduction and physician accountability, and advocates of reform should not pretend that individual choice in this arena comes at no one's expense. Finally, insofar as Thaler and Sunstein argue that, on balance, the benefits of allowing individual choice outweigh the costs, they fail to provide adequate evidence for this claim. To be clear, we are open to the possibility that the costs of malpractice litigation outweigh the benefits; we simply suggest that the case has not yet been made.

Our criticisms are not meant to imply that some real nudges might not improve the performance of medical malpractice litigation. Procedural re-

[91] *Id.* at 252.

forms can temper cognitive biases that lead to inefficiency and waste. For example, offer of judgment rules counteract overconfidence by giving both plaintiffs and defendants an incentive to make and accept reasonable settlement offers without incurring the additional costs of litigating a case all the way to a final judgment. Under offer of judgment rules, if a party rejects a settlement offer and through further litigation obtains a judgment that is less favorable than the settlement offer, the rejecting party is subject to certain penalties, such as paying part or all of the litigation costs of the other party.[92]

Nudges might also be useful in addressing the poor fit between malpractice claims and injuries caused by medical negligence. Insofar as existing evidence suggests that too few victims of medical malpractice bring claims, one might institute nudges designed to encourage victims to sue. Government might find ways to reduce the up-front costs of filing suit, perhaps by reducing filing fees or subsidizing legal representation in cases where potential awards are not enough to support a contingency fee arrangement.[93] Such a reform might reduce the tendency to overvalue the present costs and undervalue the future benefits of filing a lawsuit. Government might also improve the quality of information available to patients so that they can make more informed choices about bringing claims. This goal might be accomplished by providing incentives to healthcare providers to be more open about medical negligence when it occurs, perhaps by imposing additional liability for active concealment of relevant information or limitations on liability for early disclosure.[94]

There are, to be sure, many ways in which nudges could be part of reforming medical malpractice litigation and improving the quality of medical care. Thaler and Sunstein's use of behavioral economics to explore new ways of addressing persistent problems is an invitation to innovative and meaningful policy reform. Our criticisms of their medical malpractice waiver proposal are designed not to disparage this effort, but to remind policymakers of the importance of careful consideration of the facts before choosing a path for change.

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[92] *See, e.g.*, FED. R. CIV. P. 68. For discussions of offer of judgment rules, see BAKER, *supra* note 14, at 162–63, 169–72, and Croley, *supra* note 58, at 218–24.

[93] *See* Croley, *supra* note 58, at 230–52.

[94] *See, e.g.*, BAKER, *supra* note 14, at 168–72 (proposing disclosure and enforcement regime and a liability limiting incentive for apologies).