ANATOMY OF A MEDICAL MALPRACTICE LAWSUIT

Presented by the
American Bar Association
Health Law Section,
Section of Litigation,
Tort Trial and Insurance Practice Section and
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   Philip G. Peters, Jr.

Anatomy of a Medical Malpractice Lawsuit

Wednesday, September 21, 2016 | 12:00 PM Eastern
Sponsored by the ABA Health Law Section, Section of Litigation, Tort Trial and Insurance Practice
Section and the ABA Center for Professional Development

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Overview

- Discussion Will Include:
  - The Impact of Damage Caps and Other Tort Reform Measures on Medical Malpractice Litigation
  - Why Final Settlement Authority Often Lies with the Doctor, and How This Affects Your Handling of the Case
  - Malpractice or Not? How To Tell Known Risks from Negligent Care
  - Strategies for Successfully Selecting Medical Experts
  - Effective Preparation of Expert Witnesses for Deposition/Trial Testimony
  - Key Considerations in Jury Selection

Tort Reform

- Impact of Damage Caps on Medical Malpractice Litigation from the Perspective of Plaintiff’s Counsel
  - Affect on Ability to Accept Certain Representations
    - Potential Clients with No Expected Future Medical Treatment
    - Potential Clients with Expected Future Medical Treatment that Is Significant
    - Potential Clients with Expected Disfigurement Damages
  - Affect on Litigation Strategy
  - Affect on Selection of Expert Witnesses
  - Affect on Settlement Strategy
Tort Reform (continued)

- **Impact of Damage Caps on Medical Malpractice Litigation from the Perspective of Defendant’s Counsel**
  - Affect on Litigation Strategy
    - Potential Clients with No Expected Future Medical Treatment
    - Potential Clients with Expected Future Medical Treatment that Is Significant
  - Affect on Selection of Expert Witnesses
  - Affect on Decision to Defend Through Trial
  - Affect on Settlement Strategy

Tort Reform (continued)

- **Impact of Tort Reform with Regard to Governmental Entity Defendants**
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  - Affect of Absolute Limit of Liability from Perspective of Defendant’s Counsel
  - Punitive Damages
Tort Reform (continued)

• **Pre-Filing Requirements**
  - Affect of Requirement that Claim Be Certified by an Expert Prior to Filing Suit
  - Affect of Requirement that Claim Be Certified by a Medical Review Panel Prior to Filing Suit

Tort Reform (continued)

• **Notice Requirements**
  - Majority of States Now Require Minimum Notice Periods Before Suit May Be Filed (Typically 60-90 Days)
  - If Suit Is Filed Without Proper Notice, the Claim Will Be Subject to Dismissal
  - Dismissal Often Leads To Statute of Limitations Defense
  - Form of the Notice – Many Jurisdictions Require the Notice to Contain Specific Information and, If Deficient, the Claim Will Be Subject to Dismissal
Final Settlement Authority

- Final Settlement Authority Often Lies with the Physician
  - Difference from Typical Lawsuits where Insurer Maintains Final Settlement Authority
  - Affect on Perspective of Plaintiff’s Counsel
  - Affect on Perspective of Defendant’s Counsel
  - Practical Realities that Impact Handling of Medical Malpractice Lawsuits
  - The National Practitioners Databank – How Physicians and Insurers View the Reporting Requirement and Interplay with Consent

Selecting Medical Experts

- Strategies for Successfully Finding Medical Experts
  - Start with the Medical Literature Relevant to the Issues of the Care and Causation in Your Case:
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    - Google Scholar
    - Uptodate.com
  - Last Named Author Is Often the Senior Physician on the Article
  - Legal Network for Both Sides of the Bar Handling Malpractice Cases
  - Dangers of Testifying Expert Services
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Selecting Medical Experts

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Selecting Medical Experts (continued)

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- **Designating Medical Expert Testimony**
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  - Allowing for Multiple Levels of Attack/Defense – Parties Often Are Constrained to the Designation
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  - Finality of Designation vs. Supplementation of Designation
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Informed Consent

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  - What are Known and Accepted Complications/Risks?
  - Can a Plaintiff Prevail Even If His Injury Is the Result of Known and Accepted Risks and/or Complications?
  - How To Distinguish Between Known and Accepted Complications/Risks and Care that Is Negligent
  - Examples:
    - Post-operative Infection Diagnosed 3 Days After Discharge
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Informed Consent

- **Defending a Medical Malpractice Lawsuit Based on Informed Consent**
  - Identify the Known and Accepted Complications/Risks of the Procedure
  - Demonstrate the Patient Has Signed Releases Assuming the Risks
    - Practice Tip Defendants – Have Clients Utilize Release Forms that Leave Additional Blanks for Physicians to Identify Known Risks Tailored to the Procedure
    - Practice Tip for Defendants – Discover Whether the Plaintiff Has Executed Releases Assuming the Risks of Prior Procedures – Demonstrate Awareness
    - Practice Tip for Defendants – Always Plead Assumption of the Risk and Informed Consent as Affirmative Defenses

- **Avoiding the Informed Consent Defense**
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    - “No One Can Consent To be Malpracticed Upon”
Expert Preparation

- Effective Preparation of Expert Witnesses for Deposition/Trial Testimony
  - In Many Instances, Cases Are Won or Lost at This Stage of the Litigation
  - Spending Time in Preparation with Medical Experts
  - Discussing the Standard of Proof with Medical Experts
  - Practicing Cross Examination with Medical Experts
  - Know the Stats
  - Know the Medical Literature
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Daubert

- Challenging Expert Testimony Under the *Daubert* Standard
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  - If Not, the Jury Should Not Be Allowed To Consider the Theory
  - Whether To Challenge the Expert’s Testimony at the Pretrial Stage or During Trial
Client Testimony

- Your Client’s Testimony Is of Vital Importance
  - Client’s Testimony Must Appear Truthful – Experts Are Paid, and the Jury Knows It
  - Your Client Must Be Likable To the Jury – The Client Must Look Good and Sound Good

Jury Selection

- Key Considerations in Jury Selection
  - Know Your Venue
  - Diverse Jury vs. Non-Diverse Jury
  - Identification of Preferable Jurors from the Plaintiff’s Perspective
    - Outside of Medical Industry
  - Identification of Preferable Jurors from the Defendant’s Perspective
    - Detailed Oriented Jurors
    - Scientific Minded
    - Macro vs. Micro
    - Non-Emotional
Jury Selection

- **Sample Voir Dire Questioning**
  - Have You Ever Lost a Loved One Due to Malpractice?
  - Have You Ever Had a Medical Problem?
  - Have You or a Loved One Been Treated at the Defendant Facility?
  - What Is Your Opinion of Medical Care in the Local Community?
  - Does Anyone Feel That Even If They Were Seriously Injured Due To Medical Negligence, They Would Not Bring a Claim Because of Their Feelings About Malpractice Lawsuits?

Questions?

All attendees can submit questions via the chat feature on the webinar interface.
Additional Resource

Influence Your Verdict by Changing Jurors' Perceptions of Expert Witnesses, Part Two
By Joseph M. Hanna – December 14, 2011

Part One of “Influence Your Verdict by Changing Jurors' Perceptions of Expert Witnesses” appeared in the summer 2011 issue of Minority Trial Lawyer.

Expert Characteristics: Credibility, Credentials and Motives
The “Jurors’ Evaluations of Expert Testimony” study reported that jurors’ comments about experts’ credibility could be classified into two major types: comments about personal characteristics of the expert and comments about the testimony. Sanja Kutnjak Ivkovic & Valerie P. Hans, "Jurors’ Evaluations of Expert Testimony: Judging the Messenger and the Message," 28 Law & Soc. Inquiry 457–58 (2003). In terms of personal characteristics, jurors’ comments were categorized as relating to the expert’s credentials, motives, or general impressions. Id. at 458. As for testimony, the jurors’ comments were categorized as those pertaining to the expert’s content and style.

The jurors’ associated the following characteristics with credible testimony: good credentials; lack of bias; a pleasant personality; a clear, objective, focused, not overly long presentation that utilizes diagrams and models; use of lay terms; a presentation that is complete, consistent, and not too complex; knowledgeable in the area of expertise; and familiarity with the case.

Jurors can be influenced by experts’ credentials, such as professional activity (e.g., presenting papers at conferences and seminars), their formal education, and their research activity. Id. at 461. Typically, the jurors who used credentials as the basis for their judgment of the experts’ credibility thought that the experts with good credentials were credible witnesses. Having an expert witness with a long list of credentials, however, is not an automatic guarantee of credibility. The jurors mostly mentioned credentials and used this as a factor when jurors compared the credibility of experts from the same field. Id.

Jurors can be influenced by perceived motives. Many jurors attempt to determine the motives that an expert may bring to the witness stand. Id. at 464. The jurors in the study focused primarily on characteristics that reduced an expert’s credibility, such as an expert’s potential motive for bias, the magnitude of his fees, the frequency with which he testified, and the expert’s relationship to a party.

Jurors’ General Impression of Expert Witnesses
Also instructive were jurors’ comments about expert witnesses that were outside the categories of credibility, credentials, and motive. Id. at 468. The authors called this category “general impressions of expert witnesses,” and it included comments about age (“He was an older doctor.”), gender (“the lady doctor”), nationality (“I believe he was the Irishman.”), physical appearance (“He’s a tall man with blonde hair.”), and dress of expert witnesses (“One of them wore bow ties. Which one was that?”). Other factors that were included in the general category by the authors included the expert’s personality and attitude, as well as any personal acquaintance with the expert, and jurors’ judgments about these factors did appear to influence their assessment of expert credibility. Id. at 469.

The jurors surveyed not only judged the experts as individuals but also the presentation of technical material during testimony. Jurors clearly preferred live testimony by experts over the reading of depositions. Moreover, jurors’ assessments appeared to be influenced by how experts presented their information. Id. at 470. It was noted that the
jurors appreciated the use of some forms of technical aid as part of the expert’s presentation, whether it was a model, a chart, a diagram, or an x-ray. Finally, jurors found it challenging where the pace was tedious or the presentation too long. *Id.* at 471. The authors concluded that jurors noticed the way the testimony was given and the facts presented, and they preferred clear presentation in lay terms, paced well, not too long, given enthusiastically, and supported with technical aids. *Id.* at 472.

Ivkovic and Hans concluded their study by looking at how jurors remarked about the content of the testimony of the expert witness. When the jurors examined the content of the testimony, they considered many factors, such as completeness, consistency, and complexity. *Id.* at 477. The jurors concluded that with everything else being equal, the clearer the presentation, the better they understood the evidence.

One study noted that “when there are competent experts on both sides, and they offer contradictory or confusing opinions, jurors may resolve the differences by relying on general impressions of character and veracity.” Dennis J. Devine, “Jury Decision Making: 45 Years of Empirical Research on Deliberating Groups,” 7 Psychol. Pub. Pol’y & L. 622, 624 (2001).

### The Education Factor
Saks and Wissler found that as a juror’s educational level rose, he or she was less likely to believe expert witnesses. Michael J. Saks and Roselle L. Wissler, “Legal and Psychological Bases of Expert Testimony: Surveys of the Law and Jurors,” 2 Behavioral Sci. & L. 361, 435 (1984). The authors attributed their test findings to the fact that a more educated juror was more likely to have a critical appraisal of an expert’s competence. *Id.* at 445. A different study found that the more educated a mock juror is, the more likely the juror is to participate actively in deliberations and to recall evidence accurately. Reid Hastie, *Inside the Jury*, 137–38 (1983).

### The Gender Factor
Saks and Wissler reached no clear conclusion about the relationship between juror perceptions of expert testimony and gender. See Saks and Wissler at 446. Ivkovic and Hans’s study concluded that 82 percent of male jurors compared to 64 percent of female jurors agreed that lawyers could always find a compliant expert. See Ivkovic and Hans at 453.


It has been reported that male jurors approach decision making with a win-lose attitude not present in female decision-making. See Hastie at 142. It was found that male jurors were more vocal about factual and legal issues, while female jurors focused more on the verdict. This same study also concluded that women were more defense-orientated than men. *Id.* at 128.

### The Age Factor
One study did not find a strong correlation between age of the prospective juror and a tendency to believe or disbelieve expert testimony. See Saks & Wissler at 448. However, the authors observed that younger prospective jurors tended to find psychologists and psychiatrists more credible than older jurors did, while older jurors tended to believe expert witnesses more than younger jurors did.

Another study indicated that mock jurors between the ages of 34 and 57 took a more active role in the decision-making process. Jurors who were older than 57 tended to take the legal process more seriously than younger jurors did; however, they failed to recall the information as accurately. See Hastie at 142.

### The Occupation Factor
In the late 1970s and early 1980s, Arthur D. Austin analyzed the role of two juries that heard complex expert
evidence and arguments in the same Cleveland antitrust suit. Arthur D. Austin, “Jury Perceptions on Advocacy, a Case Study,” 8 Litigation 15 (1982). The first trial ended in a hung jury, and the second trial ended in a verdict for the defendant. Austin had attended both trials, and, at the end of each, interviewed the jurors. After interviewing the jurors and analyzing their comments, Austin’s premise was that both juries were rather skeptical of the experts from both trials. The jurors from the first trial, comprised of primarily blue-collar individuals, were quite suspicious of management. Moreover, the jurors felt that the experts were “talking down to them” and the fact that the experts’ qualification were repeated over and over again to them was “needless and tasteless self-praise.” Id. at 16.

The members of the second jury were also “blue-collar” employees; however, this group was employed in supervisory jobs. Id. at 15. The members of this jury showed more of an inclination to support a more “management-oriented perspective.” It is important to note that although Austin’s conclusions about the impact of jurors’ occupations is interesting, it relates only to the analysis of the jury and the experts from only one case.

An unrelated juror study compared and contrasted the ratings given by jurors to assess different classes of witnesses and different categories of jurors in 50 trials. David Linz and Steven Penrod, “The Use of Experts in the Courtroom” (1982) (paper presented at the annual meeting of the Academy of Criminal Justice Sciences). The jurors reported that policemen and women appearing as witnesses were the most believable, honest, likeable, confident and understandable. The study went on to note that these experts were the least likely to be discredited as opposed to the other types of witnesses.

Interestingly, another study of potential jurors’ opinions of expert witnesses found that the respondents ranked physicians, chemists, and firearms experts as the most believable, honest, and experienced type of experts, followed by accountants, psychiatrists, psychologists, and eyewitnesses. Saks and Wissler, supra. Police officers, handwriting experts, and polygraph experts were ranked the lowest. Id. at 442. It is important to note that the respondents answered hypothetical questions and did not view any of the experts on the witness stand.

An Expert’s Independent Involvement
In 1989, the American Bar Association Special Committee of Jury Comprehension conducted an in-depth study of jury decisions involving four highly complex cases—three of which included expert evidence. ABA Special Committee on Jury Comprehension, “Jury Comprehension in Complex Cases” 40, 42 (1989). The ABA committee concluded that the most believable experts had an “independent involvement” with the issue on which they were testifying. However, the jurors rejected experts who seemed to be “hired guns.” Thirty-five percent of the juror respondents stated that payment of the expert by the lawyers meant that the expert could not be trusted to be unbiased. Id.

One study explored the importance of testimony’s complexity by varying the testimony’s actual content and the strength of the experts’ credentials. Joel Cooper, Elizabeth Bennett, and Holly Sukel, “Complex Scientific Testimony: How Do Jurors Make Decisions?,” Law and Human Behavior 20: 379–94 (1996). Interestingly, the study found that the personal characteristics of the experts, such as their credentials, played an important role only when the evidence was complex and the mock jurors had a difficult time evaluating it.

These studies confirm what the authors have learned during the course of their trial careers. A skillful cross-examination coupled with exposing an expert’s bias, weak credentials, and inconsistencies in his testimony is the recipe to successfully debunking the plaintiff’s expert witness. It is well known that jurors tend to decide for the plaintiff or the defense early in the trial, with a majority of jurors making up their minds after the opening statements. With the exception of the opening statements, the cross-examination of plaintiff’s expert witness is often the first instance that the defense has to challenge the expert’s opinion.

The Decision-Making Process for Jurors
“[T]he most widely adopted approach to juror decision making process is the ‘story’ model, wherein jurors attempt to assemble the evidence into a coherent whole that is consistent with the facts of the case and makes sense given their existing knowledge.” See Devine at 624. In other words, members of the jury are more apt to gather as much
information as possible from the facts of the case, the parties, and expert-witness testimony and will create a story that provides them with an understanding of what happened and why.

“Storytelling is one of the most powerful ways of communicating with other people. . . . Since the time we were babies, storytelling has been the fundamental way for us to learn about life.” Richard C. Waites, “Courtroom Psychology and Trial Advocacy,” 535–37, 535 (2003). Every story is composed of facts. Therefore, undermining the plaintiff’s “story” can be critically important for success at trial.

The story model asserts that jurors do not approach the trial with a blank slate. Rather, they utilize their past experiences to filter and understand the various pieces of evidence as the evidence is presented and to develop alternative interpretations, or “stories,” about the events that led to the dispute now on trial. Nancy Pennington and Reid Hastie, “A Cognitive Theory on Juror Decision Making: The Story Model,” 13 Cardozo L. Rev. 519, 523–24 (1991). These alternative stories are then weighed against one another to determine which one is most consistent and logical. The preferred story is then considered under the instructions about the law provided by the trial judge. Id. at 530–31.

Pulling It All Together

The story model is widely accepted as a general description of how jurors process information and reach their decisions. It has many implications that bear on juror decision making. It is important to note that the various parts of trial evidence, including the testimony of experts, are not viewed in isolation. Instead, they are integrated into “stories” derived from preexisting cognitive frameworks and from the other trial evidence, including the testimony of plaintiffs, defendants, and other witnesses.

Experts who are willing to reach a firm conclusion about the issue on which they are testifying are deemed more readily believable and add credibility to the story. However, the expert’s lack of independence in the discipline in which he or she is involved, for example, performing independent research, can raise significant credibility issues. It is important to undermine the appearance that plaintiff’s expert has the expertise and objectivity to justify the jurors’ trust. Finally, establishing that the expert’s methodology/opinions are not generally accepted in the discipline involved can be decisive at the trial level and/or appeal. The cross-examination of plaintiff’s experts should seek to capitalize on this body of information concerning jurors’ decision making and receptivity to expert testimony.

Attacking Witness’s Credentials

As noted earlier, one of the primary methods of impeaching an expert witness is to cast doubt on his or her qualifications. Demonstrating that the expert is a professional witness or potentially biased will undoubtedly cause the jury to wonder whether the witness is a “gun for hire.”

It is possible to shatter the expert’s facade by raising the inference during the cross-examination that the expert is:

- testifying outside the scope of his or her qualifications
- using methodology that is not generally accepted
- giving opinions that are generally not accepted
- giving opinions that lack independent research

Conclusion

There is no room for speculation or conjecture in connection with expert testimony under Frye. Indeed, speculation, surmise, and conjecture are the logical antitheses of reliable and valid premises. The “average juror” may not be able to fully appreciate subtle cross-examination concerning complex scientific principles; the juror will, however, be able to recall a concession from an expert witness that his testimony is speculative. The buzz words here are surmise, conjecture, and speculation. It should, therefore, be a primary goal of the cross-examiner to elicit from the witness that at least some component of his testimony is speculative, conjectural, uncertain, or unreliable. Whether the defense is trying the case to a jury or attempting to convince a trial court or appellate court that the expert’s testimony fails to meet Frye, simple admissions elicited from plaintiff’s experts may irrevocably debunk his testimony.
Keywords: juror perception, expert witness, expert credibility, credible testimony

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Doctors & Juries

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http://ssrn.com/abstract=929474

DOCTORS & JURIES

Philip G. Peters, Jr.*

Physicians widely believe that jury verdicts are unfair. This Article tests that assumption by synthesizing three decades of jury research. Contrary to popular belief, the data show that juries consistently sympathize more with doctors who are sued than with patients who sue them. Physicians win roughly half of the cases that expert reviewers believe physicians should lose and nearly all of the cases that experts feel physicians should win. Defendants and their hired experts, it turns out, are more successful than plaintiffs and their hired experts at persuading juries to reach verdicts contrary to the opinions of independent reviewers.

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INTRODUCTION

Legislation is pending in both houses of Congress to transfer medical malpractice cases from civil juries to administrative health courts. The Institute of Medicine also wants to take malpractice cases away from juries and endorses experiments with both health courts and a system of binding early settlement offers. Each of these proposals is premised in part on the intuitive assumption that juries lack the capacity to resolve medical malpractice disputes fairly. This Article evaluates that premise. It collects and synthesizes three decades of empirical research on jury decision-making, updating the seminal review done by Neil Vidmar over a decade ago.

Four important findings emerge from the data. First, negligence matters. Weak cases rarely win, close cases do better, and cases with strong evidence of medical negligence fare best. Second, the agreement rate between juries and experts is very high in the class of cases that most worries critics of malpractice litigation, that is, cases with weak evidence of negligence. Juries agree with expert reviewers in eighty to ninety percent of these cases. That is a better agreement rate than physicians typically have with each other. Third, the agreement rate is much lower in cases with strong evidence of negligence. Doctors consistently win about fifty percent of the cases that experts believe the plaintiffs should win. Fourth, the consistently low success rate of malpractice plaintiffs in cases that expert reviewers feel they should win strongly suggests the presence of one or more factors that systematically favor medical defendants in the courtroom, such as better litigation teams or pronounced jury reluctance to find doctors liable. From the perspective of defendants at least, jury performance is remarkably good.

This Article proceeds as follows. Part I reviews the widespread criticism of jury performance and the range of views on this issue held by academic experts. Part II examines the data showing that defendants win most medical
malpractice jury trials. It compares those findings with the data indicating that most trials involve cases with weak evidence of negligence.

Part III synthesizes the studies which have compared jury verdicts with the opinions of expert reviewers. These studies have consistently found a direct correlation between the strength of the plaintiff’s case as evaluated by an expert and the likelihood of a plaintiff’s verdict. However, the studies also show that jury performance is not perfect, especially in cases with strong evidence of negligence.

Part IV reviews the reasons why juries and reviewers sometimes reach different conclusions about the same case and then identifies the factors most likely to explain the unique pattern of disagreement found in medical malpractice cases. Those factors are (1) the normal variation that occurs when multiple individuals are asked to evaluate the same conduct (inter-rater variability), (2) the superior litigation resources sometimes available to one of the parties, usually the defendant, (3) jury antipathy toward people who sue their physicians, and (4) jury reluctance to find a doctor liable when the proper outcome is unclear. At present, we lack the data needed to estimate the relative influence of each of these factors.

The studies reveal that juries treat physicians very favorably, perhaps unfairly so. The data also justify the surprising conclusion that juries are more likely to defer to the judgment of a physician defendant than other physicians are. As a consequence, politicians and critics of jury performance in medical malpractice cases should think twice before concluding that doctors will be treated more favorably in health courts.

I. JURIES

Hapless juries have become the symbol of a civil justice system run amok. Critics claim that juries render irrational and unjust verdicts. The jury trial, claims critic Peter Huber, is really “a generous sort of charity.”


5. Peter W. Huber, Liability: The Legal Revolution and its Consequences 12 (1988). President George W. Bush stated the charge this way:

Doctors and hospitals realize . . . . it’s expensive to fight a lawsuit, even if it doesn’t have any merit. And because the system is so unpredictable, there is a constant risk of being hit by a massive jury award. So doctors end up paying tens of thousands, or even hundreds of thousands of dollars to settle claims out of court, even when they know they have done nothing wrong.
According to this account, malpractice insurers are frightened into paying substantial sums to settle frivolous lawsuits because they dread the “lottery” of a jury trial. Those settlements then spawn a new wave of frivolous claims. Through this domino effect, jury incompetence poisons the entire civil justice system.

Even respected legal scholars are skeptical of the jury’s capacity to decide malpractice cases fairly. Clark Havighurst, for example, has said that “realism compels recognition that juries are often poorly positioned to choose reliably between the well argued, but often highly confusing, theories of the two sides’ experts” and “often fall back on such irrelevancies as the witnesses’ demeanor and style of presentation or sympathy for the plaintiff’s plight or the defendants’ reputation.” Stephen Sugarman also doubts the ability of jurors to choose between competing experts “whose scientific credibility the jurors are unlikely to accurately appraise.”

Is that picture accurate? The most recent extended review of the literature appears in Neil Vidmar’s classic 1995 book Medical Malpractice and the American Jury. In this book, Vidmar summarizes some of the empirical studies, including his own, that compared jury verdicts to the ratings given to the plaintiff’s medical care by independent physicians. From this body of data, he concludes “that there is reasonable concordance between jury verdicts and doctors’ ratings of negligence. On balance, juries may have a slight bias in favor of doctors.”

For some scholars, however, empirical evidence of a statistically significant relationship between jury verdicts and expert opinion is too thin a basis for concluding that juries do their job well. Mark Hall rightly notes that “[f]inding a statistical association between jury results and expert opinions means only that jury verdicts as a whole are not entirely random or unpredictable.” Thomas Metzloff used similar caution in 1993 to describe the empirical evidence then available, noting only that jury verdicts were not...
Based on his own empirical research, he concluded that “[m]ost of the time, jury outcomes represent a fair resolution of the claim, but the risk that the result will not be fair is real and troubling.”

If that is the best that can be said in defense of jury performance, then critics of jury decision-making have a powerful basis for complaint. However, the body of empirical data currently available offers insights into jury behavior that are both more complex than the public rhetoric and, at least for physicians, more reassuring.

II. Plaintiff Win Rates

Although juries are widely believed to be biased against physicians, patients lose twice as many medical malpractice verdicts as they win. Does this refute the charge that juries favor injured claimants? Not necessarily. Standing alone, win rates tell us very little about the fairness of jury verdicts. According to a convincing body of empirical research on medical malpractice trials, weak claims dominate the mix of cases that go to trial. The poor quality of the pool of cases that go to trial means that it is inappropriate to expect a fifty-fifty split in verdicts.

Yet the intuitive appeal of this benchmark is so powerful that the Supreme Court and prominent legal scholars have employed it to evaluate the fairness of adjudicative processes. That is a mistake. Although the poor success that malpractice plaintiffs have in front of juries does place a ceiling on the magnitude of any proplaintiff bias that might exist, the low plaintiff win rate does not tell us whether the right claims win or even whether the right fraction does.

A. The Fifty Percent Hypothesis

The belief that a fair adjudicatory process will produce a roughly even split in verdicts is widely held, even by sophisticated observers. Harry Kalven, for example, believed that the fifty-five percent plaintiff win rate that he found in his large study of personal injury cases showed that juries are not “monolithically pro-plaintiff.” Similarly, the Supreme Court inferred that a disability benefits process was procedurally fair from the fact

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13. Metzloff, supra note 6, at 115.

14. Id. Metzloff called for “meaningful procedural reforms within the context of the current system.” Id.


16. Harry Kalven, Jr., The Dignity of the Civil Jury, 50 VA. L. REV. 1055, 1072 (1964); cf. Shari Seidman Diamond & Mary R. Rose, Real Juries, 1 ANN. REV. LAW & SOC. SCI. 255, 262 (2005) (noting favorably that plaintiffs win about half of the time, but also acknowledging that “it is not clear what the win rate ought to be”).
that nearly fifty percent of the benefits denials were reversed.\textsuperscript{17} Win rates are an appealing measure of substantive fairness. The more balanced the outcomes, the more evenhanded the process seems.

The intuition that a fair process will produce an even split in verdicts also has powerful theoretical support. According to the “fifty percent hypothesis” of negotiation theory,\textsuperscript{18} the cases most likely to settle are those in which liability is either clearly present or clearly absent.\textsuperscript{19} Because these “easy” cases are likely to settle, the cases that go to trial will tend to be “close” cases.\textsuperscript{20} In the trials of those toss-up cases, plaintiffs and defendants should win a roughly equal number of verdicts.

The fifty percent hypothesis also has empirical support. In their landmark study of the settlement process, George Priest and Benjamin Klein gathered data on all civil jury trials in Cook County, Illinois from 1959 through 1979. The overall plaintiff win rate stayed in the vicinity of the fifty percent mark for virtually the entire period.\textsuperscript{21} Although other scholars have questioned the applicability of this model to individual fields of litigation,\textsuperscript{22} the fifty percent hypothesis retains considerable vigor. Consistent with the hypothesis, for example, a 2001 survey by the Bureau of Justice Statistics found a win rate in all tort trials of fifty-two percent.

Surprisingly, the fifty-fifty split anticipated by negotiation theory should be present even in courts that are systematically biased against one side. As long as the bias is foreseeable, the parties can be expected to take this bias into account when they make their settlement decisions.\textsuperscript{24} The “close” cases

\begin{thebibliography}{10}


\bibitem{18} See George L. Priest & Benjamin Klein, \textit{The Selection of Disputes for Litigation}, 13 J. Legal Stud. 1, 17–25 (1984) (predicting that win rates will converge to fifty percent as the parties’ abilities to predict trial outcomes improve).

\bibitem{19} See Metzloff, supra note 6, at 63.

\bibitem{20} Priest & Klein, supra note 18, at 14–15 (predicting that the vast majority of the cases which go to trial will be the borderline cases); Frank A. Sloan et al., \textit{Suing for Medical Malpractice} 168 (1993) (treating this as an accepted premise). Over time, the parties will become adept at predicting trial outcomes and the win rate will converge to fifty percent. \textit{See} Priest & Klein, supra note 18, at 17–25.

\bibitem{21} Priest & Klein, supra note 18, at 32 tbl.4 (showing a win rate between forty-five and fifty-five percent in all but two years, 1972 and 1977).

\bibitem{22} E.g., Theodore Eisenberg, \textit{Testing the Selection Effect: A New Theoretical Framework with Empirical Tests}, 19 J. Legal Stud. 337, 339–40, 352 (1990) (stating that the fifty percent hypothesis is a plausible description of tort litigation, but not of all civil litigation and also producing data suggesting that the fifty percent hypothesis may only apply to overall tort rates that are an amalgam of deviant win rates in the respective subfields). Priest and Klein themselves had found that some fields of litigation departed from the fifty percent prediction (including medical malpractice litigation). Priest & Klein, supra note 18, at 38–39.


\bibitem{24} \textit{See} Priest & Klein, supra note 18, at 5, 7 & n.24.
\end{thebibliography}
in those jurisdictions will be the cases that the parties believe could go either way in front of a biased fact-finder.\footnote{25} As long as the court’s bias is foreseeable, the plaintiff win rate at trial should still hover around fifty percent.\footnote{26} Although the tribunal’s bias will produce unjust outcomes, that unfairness will not be evident from the bare win rate.\footnote{27} Instead, the unfairness will be reflected in the terms of the pretrial settlements and in the fate of cases that ought to prevail at trial.

Conceivably, the low win rate in malpractice cases could be attributed to the predominance of weak cases in the overall pool of lawsuits. According to negotiation theory, however, the fifty percent hypothesis should survive this imbalance in the initial pool of claims. The weak claims should still settle more frequently than the toss-up cases because the parties have a relatively easy time estimating the expected value of these cases and agreeing on a settlement.\footnote{28} As a result, the “selection effect” of the settlement process should wash out asymmetries in the underlying pool of disputes and yield a trial win rate close to fifty percent.\footnote{29}

\section{B. The Win Rate in Malpractice Cases}

The win rate in medical malpractice trials consistently departs from the fifty percent hypothesis and has done so for decades. In an exhaustive review of decades of research and dozens of empirical analyses, Valerie Hans and Neal Vidmar concluded that medical malpractice plaintiffs win roughly 30\% of their jury trials.\footnote{30} The most recent comprehensive review of the data comes from the Bureau of Justice Statistics, which systematically sampled malpractice jury verdicts in 1992, 1996, and 2001 from the seventy-five

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\item \footnote{25} Initially, prediction errors might result in win rates that depart materially from a fifty-fifty split, but the size of this departure should diminish as the parties become better at predicting the jury’s decisions. \textit{Id.} at 18–19.
\item \footnote{26} \textit{Id.} at 5 (“[P]laintiff victories will tend toward 50 percent whether the legal standard is negligence or strict liability, whether judges or juries are hostile or sympathetic.”).
\item \footnote{27} The settlement data strongly suggest that defendants have superior bargaining power, but provide no clues about the contribution of anticipated prodefendant jury bias to that bargaining power. \textit{See Philip G. Peters, Jr., What We Know About Malpractice Settlements, 92 Iowa L. Rev. (forthcoming July 2007) (manuscript at 40–53), available at http://ssrn.com/abstract=891120.}
\item \footnote{28} \textit{See Priest & Klein, supra note 18, at 17–20. By settling, each party saves the costs of preparing for and participating in a trial.}
\item \footnote{29} \textit{See Eisenberg, supra note 22, at 340. While an extraordinary number of weak claims in the initial pool could theoretically produce a trial mix dominated by weak cases simply by virtue of their raw numbers, even though they settle at a higher rate than closer cases, this probably does not explain the low win rate in malpractice cases. Indeed, meritless claims actually settle less regularly than strong claims and, as a result, are overrepresented in the trial mix. The 2006 findings of David Studdert and his colleagues are typical. Claims lacking merit constituted thirty-seven percent of their total sample of claims, but fifty-six percent of the cases that went to a jury verdict. \textit{See David M. Studdert et al., Claims, Errors, and Compensation Payments in Medical Malpractice Litigation, 354 New Eng. J. Med. 2024, 2030 tbl.2 (2006).}}
\item \footnote{30} \textit{Valerie Hans & Neil Vidmar, Judging the Jury} (1986).}

\end{itemize}
most heavily populated counties in the United States.\textsuperscript{31} Over that period of time, the plaintiff win rate dropped from 30\% to 27\%.\textsuperscript{32} In the 2001 sample of 1,038 trials, “[t]he overall win rate for medical malpractice plaintiffs (27\%) was about half of that found among plaintiffs in all tort trials (52\%).”\textsuperscript{33} A number of studies have found that malpractice cases have the lowest plaintiff success rate of any category of tort litigation.\textsuperscript{34}

The poor success rate of malpractice plaintiffs is made even more evident when cases with contested damages, but admitted liability, are excluded from the calculation.\textsuperscript{35} In his study of North Carolina malpractice verdicts, Thomas Metzloff found that plaintiffs received a significant award of damages in only 11\% of the cases in which liability was genuinely at issue.\textsuperscript{36} In her earlier landmark study, Patricia Danzon also found that the win rate shrank materially when uncontested cases were excluded.\textsuperscript{37}

C. Selection Effect

Opponents of tort reform often argue that the very limited success of malpractice plaintiffs at trial proves that juries are neither biased against wealthy physicians nor readily manipulated into rendering verdicts based on their sympathy for badly injured patients. Some have even suggested that the difficulty of obtaining a plaintiff’s verdict demonstrates that juries are

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\item \textsuperscript{31} Cohen, supra note 23; Carol J. DeFrances & Marika F.X. Litras, Bureau of Justice Statistics, Civil Trial Cases and Verdicts in Large Counties, 1996 (1999); Carol J. DeFrances et al., Bureau of Justice Statistics, Civil Jury Cases and Verdicts in Large Counties (1995).
\item \textsuperscript{32} See Cohen, supra note 23, at tbls.1 & 3. Materials from the Jury Verdict Research website show win rates between 29\% and 38\% for each year between 1995 and 2000. http://www.juryverdictresearch.com/Press releases/medmal_01.html (May, 10 2002). However, jury verdict reporting services tend to oversample significant plaintiffs’ victories and, thus, to overstate both plaintiff success rates and average verdict size. Frank Sloan and Chee Ruey Hsieh, for example, found an actual win rate of 22\% in the trials of the claims they studied in Florida, where a jury verdict reporting service had reported that plaintiffs won 66\% percent of their verdicts. Frank A. Sloan & Chee Ruey Hsieh, Variability in Medical Malpractice Payments: Is the Compensation Fair?, 24 Law & Soc’y Rev. 997, 1007 (1990).
\item \textsuperscript{33} Cohen, supra note 23, at 1. Those rates are consistent with the findings of the most recent small-scale study, published in 2006, which found a win rate of twenty-one percent for medical malpractice plaintiffs. Studdert et al., supra note 29, at 2026.
\item \textsuperscript{34} E.g., DeFrances & Litras, supra note 31, at 6 tbl.5; Stephen Daniels & Lori Andrews, The Shadow of the Law: Jury Decisions in Obstetrics and Gynecology Cases, in 2 Medical Professional Liability and the Delivery of Obstetrical Care 161, 173–75 & tbl.3 (Victoria P. Rostow & Roger J. Bulger eds., 1989) (finding that the plaintiff success rate for malpractice was below the overall rate in all but two of forty-six counties surveyed and that those two counties had few malpractice verdicts); Priest & Klein, supra note 18, at 38 tbl.7 (finding malpractice cases had the lowest success rate among the categories of tort litigation analyzed).
\item \textsuperscript{35} See Diamond & Rose, supra note 16, at 262 (noting that the usual figures on plaintiff win rates are “inflated because liability is either uncontested or only partially contested in some percentage of the cases counted as plaintiff wins”).
\item \textsuperscript{36} Metzloff, supra note 6, at 52.
\end{itemize}
prejudiced against people who sue their doctors, a bias suggested by research showing that potential jurors are skeptical of medical malpractice plaintiffs. However, the data suggest an equally plausible alternative: weak claims dominate the trial docket.

Taragin’s study of 976 malpractice verdicts is by far the largest. He and his colleagues found that only 10% of the trials involved negligent care and eleven percent were too close to call. Thus, 78% of the trials involved weak claims. The weak claims outnumbered the strong ones 8 to 1.

The other studies are considerably smaller, but they, too, have found that weak claims outnumber strong ones at trial. In Thomas Metzloff’s study of 48 trials, the defense insurer believed that only 23% of the tried cases had sufficient evidence of negligence to support a jury verdict, while 42% did not, and the remaining 35% were unclear. As a consequence, Metzloff concluded that the trial pool consists “of a solid core of marginal claims in which the insurers routinely prevail.” Danzon reached the same conclusion in her study of malpractice litigation, stating that the cases that go to trial are “a small, atypical subset” in which the evidence for the plaintiff is weak.

Other studies are in agreement. In their analysis of 26 malpractice trials, Henry Farber and Michelle White found that 57% involved good care while only 19% involved poor care. In a separate study of thirteen trials, they found that 69% of the trials involved good care and only 8% involved poor care. Ralph Peeples, Catherine Harris, and Metzloff found a similar imbalance in their examination of 19 trials—there were over 5 times as many weak claims as strong.

However, other studies have failed to find a substantial imbalance in the trial mix. A study of 37 Florida jury verdicts by Frank Sloan and his

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38. See, e.g., Vidmar, supra note 4, at 182 (“The evidence in fact indicates that . . . [o]n balance, juries may have a slight bias in favor doctors.”); Metzloff, supra note 6, at 83 (noting that a possible explanation for defendants beating the odds more often than plaintiffs is the operation of a jury bias in favor of doctors).


40. See Metzloff, supra note 6, at 69 tbl.6.

41. Id. at 76–77.

42. Danzon, supra note 37, at 51 (“[Malpractice] cases that are actually litigated to verdict constitute a small, atypical subset, ‘self-selected’ to that stage of disposition precisely because the outcome was unpredictable to the litigants, the potential award was large, and the evidence for the plaintiff was weak.”).


45. Ralph Peeples et al., The Process of Managing Medical Malpractice Cases: The Role of Standard of Care, 37 Wake Forest L. Rev. 877, 899 tbl.6 (2002) (recording eleven weak claims versus two strong claims). Care quality was largely determined from the opinions of physician consultants. Id. at 884–85.
colleagues found an equal number of strong and weak claims.\textsuperscript{46} And a 2006 study by David Studdert and his colleagues found only 1.3 weak cases in the trial sample for each strong claim.\textsuperscript{47}

Taken together, the studies show a wide variety of trial mixes. The weak cases outnumber the strong in every study but one, but the ratios range from 1.3-to-1 to 9-to-1. As a result, the exact ratio of weak to strong claims remains in considerable doubt. Our inability to calculate this ratio with more specificity makes it impossible to determine from this data whether the thirty percent plaintiff win rate typically observed in medical malpractice cases is too high, too low, or exactly right. In order to make that determination, the verdicts in specific cases must be matched against the strength of the evidence of negligent conduct. Fortunately, several studies have tried to collect that data. They are reviewed in Part III.

The obvious theoretical question raised by these findings is why the mix of malpractice cases taken to trial departs so substantially from the predictions of the fifty percent hypothesis. Although scholars have offered several promising hypotheses, the study of this question is still in its infancy. It is hampered, no doubt, by the difficulty and expense of obtaining detailed data about private settlement outcomes and strategies.

At present, several factors seem especially likely to account for the unusual preponderance of weak cases in the set of malpractice disputes that reach a jury. Most obviously, malpractice litigation may not conform to one or more of the simplifying assumptions on which the fifty percent hypothesis is built. The hypothesis incorporates assumptions that the parties have an equal tolerance for risk,\textsuperscript{48} that the stakes for both parties are identical,\textsuperscript{49} and that they have equal access to the skills and information needed to predict the likely outcome at trial.\textsuperscript{50} Each of these assumptions has been challenged by at least one legal scholar and the failure to conform to that assumption has been identified as the most likely cause of the low plaintiff win rate in malpractice litigation.\textsuperscript{51} Other factors that could skew the trial mix include a

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  \item \textsuperscript{46} Sloan et al., \textit{supra} note 20, at 167 tbl.8.2 (showing that thirty percent of the trials that resulted in a verdict involved poor care and twenty-seven percent involved good care; the rest were "uncertain").
  \item \textsuperscript{47} Studdert et al., \textit{supra} note 29, at 2030 tbl.2 (showing 91 claims involving an error in treatment and 117 not involving medical error).
  \item \textsuperscript{48} \textit{See, e.g.}, Metzloff, \textit{supra} note 6, at 62–63; Priest & Klein, \textit{supra} note 18, at 27.
  \item \textsuperscript{49} \textit{See, e.g.}, Metzloff, \textit{supra} note 6, at 63; Priest & Klein, \textit{supra} note 18, at 7.
  \item \textsuperscript{50} \textit{See Priest & Klein, supra} note 18, at 13, 19; \textit{see also} Robert D. Cooter & Daniel L. Rubinfeld, \textit{Economic Analysis of Legal Disputes and Their Resolution}, 27 \textit{J. Econ. Literature} 1067, 1074 (1989). If the parties share an incorrect perception of what juries are likely to do, that too will lead to verdicts that depart from a fifty-fifty split. See Clermont & Eisenberg, \textit{supra} note 15, at 590; Kevin M. Clermont & Theodore Eisenberg, \textit{Trial by Jury or Judge: Transcending Empiricism}, 77 \textit{Cornell L. Rev.} 1124, 1131, 1156, 1170–72 (1992).
  \item \textsuperscript{51} On unequal risk tolerance, see Farber & White, \textit{supra} note 44, at 208 (concluding that the bargaining process favors defendants because plaintiffs are more risk averse), and Stephen J. Spurr & Walter O. Simmons, \textit{Medical Malpractice in Michigan: An Economic Analysis}, 21 \textit{J. Health Pol. Pol’y & L.} 315, 340 (1996) (attributing the difference between expected value and
shared, but mistaken, assumption that juries will be pro-plaintiff, the incentives created by the different ways in which plaintiffs’ and defendants’ lawyers are compensated, and the unusually severe damages common in malpractice cases.\textsuperscript{52} Although we currently lack the data needed to evaluate the role played by each of these plausible contributing factors, the evidence does suggest that defendants are reluctant to make settlement offers of any size in “frivolous” cases and are anxious to settle claims backed by strong evidence of negligence, especially if they can extract a discount from a risk-averse or less well-represented plaintiff.\textsuperscript{53} These proclivities probably explain much of the imbalance in the malpractice trial mix.

Because weak cases dominate the malpractice trial mix, the poor trial success of malpractice plaintiffs tells us nothing about the fairness of the jury verdicts. In this setting at least, the intuitive assumption that a fair process will produce a roughly even split in verdicts is simply wrong.

\textbf{III. Jury-Expert Agreement}

Fortunately, social scientists have attempted to measure the fairness of jury verdicts more directly. Over the past three decades, seven studies have compared the verdicts rendered in individual malpractice cases with independent evaluations of each claim by medical or legal experts. Although the methodologies have varied, the studies have consistently found that the odds of a plaintiff’s verdict increase as the evidence of negligence improves. At the same time, the studies show that the correlation between jury verdict and expert opinion is imperfect, especially in cases in which expert reviewers believe that the patient was injured by medical negligence.

The most common strategy used in these studies has been to compare the jury’s verdict in an individual case with the evaluation of that case made by one or more physicians at the request of defendant’s liability insurer. While this approach poses the risk that the ratings given to the case will be biased in favor of the defendant and, thus, will overstate the frequency of

\textsuperscript{52} See Priest & Klein, supra note 18, at 39 n.77.

\textsuperscript{53} See Peters, supra note 27, at 42–47.
jury error, this strategy is much less expensive than paying for a truly independent review of the cases. A few important studies have avoided this weakness by asking independent physicians to rate the quality of care given to each plaintiff. The remainder of the studies has relied on ratings given by insurance claims adjusters, lawyers, and presiding judges.

Although these methodological differences could potentially have affected the findings, the studies actually yielded surprisingly similar results. Plaintiffs win about 10% to 20% of the cases with weak evidence and 50% of the cases with strong evidence of negligence.

A. Taragin et al.

![Figure 1](image_url)

In the largest study of malpractice verdicts, Mark I. Taragin and his colleagues reviewed 976 malpractice cases that had resulted in a jury verdict between 1978 and 1992. The cases came from the files of a single large New Jersey insurance company that insured roughly 60% of the physicians in New Jersey.

As part of its normal litigation procedure, the insurance company had asked one or more physicians to evaluate each of these claims shortly after its receipt. The reviewers gave each claim a rating of “defensible,” “indefensible,” or “unclear.” When the Taragin team compared each evaluation with

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54. Taragin et al., supra note 39.
55. See id. at 780–81. These ratings were produced using a multi-step process. First, the defendant-physician was contacted, and if the physician admitted error, the claim was labeled “indefensible.” Otherwise, the claims representative reviewed the claim. If she deemed the claim “clearly medically defensible,” then no further review was performed. If not, a physician from the same
the jury verdict rendered in the case, it found that the jury verdict conformed to the insurance company’s rating in 79% of the cases rated as “defensible.” Plaintiffs, thus, won 21% of those cases. They also won 30% of the cases rated as “unclear,” and 42% of the cases thought by the reviewers to be “indefensible.”

The researchers felt that the 21% discrepancy rate in cases rated as defensible could be explained by several features of the study’s design:

First, the determination about physician care was made very early after a claim was generated and may have been inaccurate as more information became available. Second, a physician-based review process may be biased toward assessing physician performance in the physician’s favor. Third, the insurance company may err toward an initial determination of physician care as defensible to avoid unnecessary [settlement] payments.

The study, therefore, probably produced an overestimate of the number of defensible claims. As a consequence, the researchers concluded that “our data suggest that inappropriate payments are probably uncommon.”

specialty was chosen to give an opinion. This external reviewer discussed the case with the claims representative, the defense attorney, and the defending physician before classifying the claim. In orthopedic and neurosurgery cases, the process was different: a panel of outside physicians was employed and a majority vote determined the classification. The researchers obtained the ratings information from a standardized computer database created by the insurer. Id.

56. Id. at 781.

57. Id.

58. Id. at 782. They could have added two other potential sources of bias. First, the insurer may want to maintain a favorable relationship with its customers until it becomes absolutely necessary to disagree. Second, roughly half of the cases in which the medical care was deemed defensible were reviewed only by a claims representative, rather than by an outside physician. Id. at 781 tbl.1. By contrast, all initial determinations of poor quality were reviewed by consulting physicians. This asymmetry in the evaluation procedure may have biased the ratings in favor of defendants.

59. Id. at 782.
In a very recent study, David Studdert and his colleagues at the Harvard School of Public Health examined the outcomes of 208 malpractice trials.\textsuperscript{60} They located these trials in a sample of malpractice claims that had been randomly drawn from the closed claims files of five major malpractice insurers. To reduce the risk of biased reviews, they retained their own physicians to do the evaluations. Physicians in the relevant specialties were hired and trained to review each file in its entirety and to determine whether the claimant’s injuries had been caused by medical error.\textsuperscript{61} No separate category for unclear cases was used.

The study found that plaintiffs won nine percent of the trials in which the medical care had been deemed proper and forty-three percent of the cases in which the reviewer felt that the physician had made an error (P<0.001).\textsuperscript{62} Evidence of negligence may also have played a role in the jury’s award of damages as plaintiffs were awarded an average of $326,009 in no-error cases and $765,486 in the cases thought to involve medical error, even though injury severity was roughly the same (P=0.24).\textsuperscript{63}

\begin{figure}
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\caption{Studdert et al. (Plaintiff Win Rate)}
\end{figure}

\textsuperscript{60} Studdert et al., supra note 29.

\textsuperscript{61} Id. at 2025. Because their sampling criteria focused on four types of clinical mishaps—obstetrical, surgical, misdiagnosis, and medication—they used specialists in obstetrics, surgery, and internal medicine. Reviewers recorded their judgments using a six-point confidence scale. The study classified the medical care as erroneous if the claim had received a score of four or above. Id. at 2025–26. A single reviewer rated each file.

\textsuperscript{62} Id. at 2028, 2030 tbl.2.

\textsuperscript{63} Id. at 2030 tbl.2.
In this study, Thomas Metzloff analyzed all the cases filed against physicians who had been insured by the three largest malpractice insurers in North Carolina between 1984 and 1987. Among the cases that had gone to a jury verdict, he found forty-eight where the insurer’s file contained an estimate of the odds of a defense verdict. Using these probabilities, he divided the cases into three categories: (1) cases that the insurer felt the plaintiff would win (odds better than 60%), (2) cases the plaintiff was likely to lose (odds worse than 40%), and (3) “toss up” cases (where the probability estimate fell between 40% and 60%).

When Metzloff compared the eventual jury verdicts to the insurer’s predictions, he found that the plaintiffs had won one of the nineteen cases that they were expected to lose (5%) and six of the eleven cases that they were expected to win (55%). They also won verdicts in four of the seventeen

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64. Metzloff, supra note 6, at 45, 48. Metzloff identified all of the medical malpractice cases filed in North Carolina’s state and federal courts over a three-year period (July 1, 1984 to June 30, 1987). Id. at 47.

65. Id. at 68.

66. Id. at 68. The principal shortcoming of the study is its apparent reliance on ratings that were intended to predict the odds of a favorable jury verdict, rather than to assess the quality of care given. These two metrics will not always be identical because strategic factors, like attributes of the parties, attorneys, and witnesses, may have a bearing on the probability of success even though they do not have a bearing on the objective merits of the case.

67. Id. at 83 tbl.9.
“toss up” cases (24%), but effectively lost two of those four because they were awarded only nominal damages.  

D. Farber and White

Figure 4

Farber & White (Plaintiff Win Rate)

Henry Farber and Michelle White examined the files of 252 lawsuits against a single large hospital filed between 1977 and 1989, thirteen of which were tried to a verdict.  In each case, the hospital asked multiple experts to determine whether the defendant had met the professional standard of care. The experts who provided these evaluations included supervising physicians, other hospital physicians in the relevant specialty, and independent physicians. Care was coded as “good” or “bad” if all the experts agreed and as “ambiguous” if the reports were unclear or divided. The study does not state when the expert reports were written. The researchers found “a strong relationship between care quality and disposition (p-value < .0001).” Payments, whether due to trial verdict or settlement, were least likely to be made in cases with good medical care, more likely to be made in cases with ambiguous care, and most likely in cases with bad medical care. Looking exclusively at trials, however, they found no relationship between outcome and care quality because defendants

68. Id. at 83 & tbl.9.
69. Farber & White, supra note 44, at 203.
70. Id. at 204.
71. Id. at 204–05.
72. Id. at 205.
won all thirteen of the jury trials, even though one involved care that had been rated as poor and three were ambiguous. In a later study, Farber and White examined a larger sample of files from the same hospital over roughly the same time period. This sample had 26 jury trials, and plaintiffs won 4 of them. Plaintiffs won none of the 13 trials involving care that had been rated as “good” by the hospital’s reviewers. However, plaintiffs won 2 of the 4 trials involving medical care rated as ambiguous (50%) and 2 of the 4 cases in which the defendant’s care had been rated as “bad” (50%). The correlation between quality of care and trial outcome was statistically significant (p=0.035).

73. Id. at 203. Twenty cases went to trial, but six were settled and one was dropped. Id. at 203 n.10.
74. Id. at 204 tbl.1.
75. Farber & White, supra note 43. They looked at the files of 355 complaints which had been made to a single large hospital between 1976 and 1989 concerning the hospital or its providers (half of which were resolved without a lawsuit) and also the files of 242 additional disputes which were initiated by the filing of a lawsuit. Id. at 786. The researchers had available to them the files of the hospital’s patient relations office and its legal affairs office, including the opinions of the experts asked by the hospital to assess the quality of medical care. Id. at 786–87. When informal complaints were received, the hospital would get an evaluation from a supervisor or provider in the same specialty. When lawsuits were filed, the hospital also retained outside experts. Id. at 787.
76. Id. at 802.
77. Id.
78. Id. at 802, 795 tbl.6. The text indicates that plaintiffs won four cases, but then only identifies three of them. Table 6, however, indicates that two involved ambiguous care and two arose out of bad care.
79. Id. at 802.
In this study, Stephen Daniels and Lori Andrews reviewed the trials of twenty-three labor and delivery cases alleging the misuse of oxytocin, a drug used to induce labor. Because the drug had been used since 1910, the circumstances for safe use were well understood by the medical profession. Daniels and Andrews analyzed the trial transcripts to determine whether the drug had been used on patients when contraindicated. They found that plaintiffs won fourteen of the sixteen trials in which evidence of contraindications had been presented at trial (88%), and only one of the seven cases in which evidence of contraindication was absent (14%). While their finding of a low win rate in cases with weak evidence of negligence is consistent with the other studies, their finding that plaintiffs won 88% of the cases with poor medical care is quite unusual.

80. Daniels & Andrews, supra note 34, at 189.
81. All cases involving contraindications had resulted in permanent injury or death. Id. at 191. Both losses involved grave permanent injury. Id.
82. Id. at 190.
This study examined eighteen jury verdicts from North Carolina state courts involving claims filed between 1991 and 1995. In each case, the insurer obtained expert evaluations from one or more physicians in the same specialty, usually from the same state. The authors used these expert reviews to divide the cases into three categories: (1) probable liability, (2) uncertain liability (when experts disagreed), and (3) unlikely liability.

They found that plaintiffs won 10% of the trials in which the defendant’s care had been rated as good, 16.7% of the trials involving care rated as uncertain, and 50% of the trials involving care rated as poor.

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83. Peeples et al., supra note 45. The trials were culled from eighty-one closed claims files obtained from a North Carolina teaching hospital and one of the state’s principal liability insurers. They reviewed both the entire insurance file and the court records. Id. at 881–82. The insurance files included expert and physician review summaries as well as witness deposition summaries.

84. Id. at 884.

85. See id. at 888.
In this unusual study, Bryan Liang asked 11 anesthesiologists who practiced in an academic medical center to review 12 summaries of actual jury trials. Liang’s results show that plaintiffs won 1 of the 4 cases in which the reviewers concluded that no negligence had occurred (25%), and 4 of the 8 cases rated as having negligent care (50%).

This study is often cited for its finding that the overall correlation between jury verdicts and physician ratings is barely better than random. Liang reached this conclusion because the reviewers agreed with the jury verdict in only seven of the twelve cases. Yet, this interpretation oversimplifies the insights that can be gleaned from Liang’s data. On closer examination, it is apparent that the high rate of overall disagreement in this study was not produced by jury willingness to compensate undeserving

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86. Bryan A. Liang, Assessing Medical Malpractice Jury Verdicts: A Case Study of an Anesthesiology Department, 7 CORNELL J.L. & PUB. POL’Y 121, 129 (1997). In five of the twelve cases, the anesthesiologists significantly disagree with the jury’s verdict. Id. The validity of the ratings provided by the anesthesiologists turns on the even-handedness and accuracy of the case summaries provided to them by the researchers. In addition, academic anesthesiologists may be harsher on their peers than clinicians from other settings. The physician ratings gain strength, however, from the fact that eleven physicians rated each case. Of course, the sample of cases is tiny.

87. See id. at 157–160 tbls.2A, 2B, 2C, 2D, 2E & 2F.

88. Id. at 129 (finding fifty-eight percent and fifty-six percent agreement in two surveys).
claimants, but by the reluctance of juries to render verdicts for the plaintiffs when the evidence of negligence was strong. Liang’s results show that plaintiffs lost half of the eight cases that the consulting physicians felt they should win, while they won only one of the four cases that the reviewers felt they should lose. When the data are disaggregated in this way, they reveal the same pattern that was observed in the larger and more reliable studies. Juries are more skeptical than medical reviewers of medical malpractice lawsuits.

H. Judge-Jury Agreement

No studies have compared the verdicts reached by juries in medical malpractice cases with the verdicts that the presiding judges would have recommended. However, a number of important studies have examined the judge-jury agreement rate in personal injury lawsuits more generally. The most famous and largest of these studies was undertaken in the 1960s by Harry Kalven and Hans Zeisel. They reviewed approximately 4000 civil trials and found that the judge and jury agreed in 78% of them. When they looked only at personal injury cases, they found a similar rate of agreement. A more recent, but much smaller, study by Larry Heuer and Steven Penrod examined 67 civil trials from 33 states and found agreement in 71.4% percent of the cases.

Kalven and Zeisel also analyzed the cases in which judge and jury had disagreed to ascertain whether these disagreements reflected systematic favoritism toward one side or another. The judge and jury had disagreed in 22% of the cases and those disagreements were about evenly split between cases in which the jury rendered a verdict for the plaintiff (12%) and those in which the jury found for the defendant (10%). Heuer and Penrod did a similar analysis with similar results. In the cases on which judge and jury had disagreed (37% of the total set of cases), judges disagreed with jury

89. Id. at 129, 157–160 tbls.2A, 2B, 2C, 2D, 2E & 2F; cf. id. at 135 (finding that respondents were “extremely critical of the defendant” physicians).
90. See supra note 88.
92. Id. at 63.
93. Id. at 64 n.12.
94. Larry Heuer & Steven Penrod, Trial Complexity: A Field Investigation of Its Meaning and Effects, 18 Law & Hum. Behav. 29, 48 tbl.13 (1994). In addition, researchers have found similar rates of judge-jury agreement in criminal trials. See, e.g., Kalven & Zeisel, supra note 91, at 58 tbl.12 (78%); Heuer & Penrod, supra, at 48 tbl.12 (73%). Two other surveys of judicial opinion have found similar or higher estimates of the rate of judge-jury agreement. See John B. Attanasio, Forward: Juries Rule, 54 SMU L. Rev. 1681, 1684 (2001); R. Perry Sentell, Jr., The Georgia Jury and Negligence: The View from the Bench, 26 GA. L. Rev. 85, 97–98 (1991); R. Perry Sentell, Jr., The Georgia Jury and Negligence: The View from the (Federal) Bench, 27 GA. L. Rev. 59, 70–71 (1992) [hereinafter Sentell, Federal Bench].
defense verdicts (19%) as frequently as they disagreed with jury verdicts for plaintiffs (18%).

Thus, the judge-jury agreement rate in tort cases is even stronger than the jury-reviewer agreement rate observed in the medical malpractice studies previously discussed, especially in the cases that jurors feel have strong evidence of negligence. These reassuring findings are also consistent with the many surveys that have found that judges generally hold a positive view of the jury.

It would be even more informative, of course, if these studies had separately reported the judge-jury agreement rate for medical malpractice cases. Because they did not, the only studies that shed light on the judge-jury agreement in medical malpractice cases are the few that have compared how judges and juries decide the malpractice cases that are actually assigned to them. When Kevin Clermont and Theodore Eisenberg looked at the win rates for all federal civil trials between 1979 and 1989, they found that malpractice claimants had significantly less success in front of juries than they had before judges. While malpractice plaintiffs won 50% of their bench trials, they won only 29% of their jury trials. The findings of the Bureau of Justice Statistics, using 2001 data from the country’s 75 largest counties, were very similar. The Bureau found that medical malpractice plaintiffs won 50% of their bench trials but only 26% of their jury trials.

Overall, malpractice plaintiffs appear to win half as often in front of juries as they do in front of judges. This sizeable discrepancy rate is atypical of most personal injury litigation. In most civil litigation, other than malpractice and product liability litigation, Clermont and Eisenberg found that bench and jury success rates were roughly the same. The Bureau findings also suggest that malpractice litigation is unusual. The judge-jury discrepancy rate was much larger in medical malpractice cases than it was in civil litigation generally (24% compared to 14%). These findings raise the possibility that juries are more deferential to physicians and more skeptical of patients who sue them than judges are.


97. In the Kalven and Zeisel study, for example, the judges typically believed that a jury that decided the case differently had reached a reasonable decision. See Vidmar, American Civil Jury, supra note 10, at 853. A Georgia survey of state and federal judges found 94% of the judges felt the jury understood the case, and 87% believed that juries are not pro-plaintiff. Sentell, Federal Bench, supra note 94, at 116 tbls.16 & 17. All of the federal judges and 98% of the state judges felt that jury performance was satisfactory or would be if some procedural reforms were adopted. Id. at 117 tbl.18. Over 97% of both groups said that they agreed with jury verdicts more often than was reported in the Kalven and Zeisel study. Id. at 115 tbl.14.

98. Clermont & Eisenberg, supra note 50, at 1137, 1174.

99. Id. at 1137.


101. Clermont & Eisenberg, supra note 50, at 1137.

102. COHEN, supra note 100, at 4 tbl. 3. (finding 65 versus 51% in civil litigation generally).
Still, it would be a mistake to give significant weight to the studies comparing bench trials with jury trials because we do not know whether malpractice attorneys systematically direct a different mix of malpractice cases to judges than to juries. Because the difference in win rates could simply reflect a different mix of cases, the studies comparing bench trial outcomes with jury trial outcomes provide a less appropriate basis for evaluating jury performance than the studies that compare jury verdicts with the verdicts that judges or experts would have reached in the same cases.

1. Synthesis of the Findings

![Figure 8: Care Quality and Trial Outcome](image)

The studies that compare jury verdicts with the conclusions reached by experts are startlingly consistent. Each indicates that the probability of a plaintiff’s verdict grows as the evidence of negligence improves. Patients with claims that the reviewers believe to be weak are highly unlikely to win a jury verdict. Patients with “close” cases are roughly twice as likely to win their cases as those with weak cases. Finally, patients with strong evidence of negligence are the most likely to prevail before a jury. These findings are collected in Figure 8.

The studies also consistently find that juries are deferential to physicians. While they are very likely to find for the defendant when the

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103. *See* Clermont & Eisenberg, *supra* note 50, at 1174.
reviewers believe that the plaintiff’s evidence is weak, they are just as likely to find for the defendant as for the plaintiff when the evidence of negligence is strong. Thus, juries are several times more likely to depart from the judgment of the reviewers when doing so will exonerate the defendant than they are to disagree when doing so will lead to liability. The jury verdicts in cases rated as toss-ups also show this deference. Despite expert ratings consistent with a fifty-fifty split in the verdicts, juries rendered defense verdicts in about seventy percent of the cases. The repeated finding that juries rule in favor of defendant physicians more often than physician reviewers do is remarkable given the documented reluctance of physicians to label another physician’s care as negligent.

To the extent that jury bias in favor of plaintiffs is the perceived danger, these findings should be reassuring. The studies show that juries favor doctors even more than physician reviewers do. The empirical literature, therefore, does not support the view that juries are biased in favor of injured plaintiffs and are easily manipulated by plaintiffs’ lawyers.

Furthermore, the consistency of these findings across multiple studies offsets the otherwise legitimate concern that most of these studies are small. Moreover, researchers reached similar results despite differences in the population of cases being examined and in the choice of reviewers. Some studies were state-specific and others national. Some targeted selected clinical specialties, and some did not. Some had multiple reviewers, while others relied on a single reader. Most used the ratings of physician reviewers, but some relied on the opinions of lawyers, judges, or insurance company claims evaluators. Some used two categories (negligent or not) to classify the quality of care rendered, and others added a third category for toss-up cases. Yet the consistency of their findings is extraordinary. Juries favor defendants.

Although these findings should be welcomed by physicians, the fit between external ratings and jury verdicts is not perfect. Plaintiffs win some of the cases that raters think they should lose. In the largest study, this rate reached twenty-one percent. To be sure, that study took place before the media campaign of the past decade. A 2006 study with the second largest sample found only a nine percent plaintiff win rate in the cases experts rated as lacking merit, despite the fact that this study used a two-category design which allocated half of the close cases to the no-merit category. Still, doctors facing the risk of an adverse judgment that could materially change their lives may see a ten to twenty percent “error” rate as catastrophic. Plaintiffs have an even stronger basis for complaining about the current rate of disagreement. They lose fully half of the trials that expert reviewers feel

104. See infra text accompanying note 110.

105. See Liang, supra note 86. Although the discrepancy rate in the Liang study was twenty-five percent, that entire rate was attributable to a single discrepant verdict. The study examined only twelve cases.
they should win, along with most of the close cases. What accounts for these disagreements is the subject of Part IV.

IV. DISAGREEMENT

This Part examines the factors most likely to explain the observed discrepancies between jury verdicts and the ratings given by external reviewers. The most plausible explanations include inter-rater variability, reviewer bias, asymmetric information, scientific complexity, procedural restrictions on the ascertainment of truth, jury bias, unequal litigation resources, and the burden of proof. The discussion which follows examines each of these potential influences and offers a working hypothesis that most of the discrepancies between jury verdicts and external reviews are produced by a combination of inter-rater variability, jury respect for the burden of proof, jury reluctance to hold physicians liable, and superior defense resources.

A. Inter-Rater Variability

Whenever individuals are asked to evaluate the quality of someone else’s performance, a certain amount of disagreement is inevitable. Even when researchers ask physicians to rate the quality of care provided by other physicians, the participants disagree among themselves. The frequency of these disagreements is surprisingly high. Several studies, including the Harvard Study of New York Hospitals and a more recent study by Peeples, Harris, and Metzloff, have found that physicians who evaluate the quality of care provided by other physicians disagree in about 30% of the cases.\(^{106}\) Reasonable professionals often reach different conclusions about the same evidence.

In a fascinating review of the literature, Shari Diamond collected data on the agreement rates of people who make complex decisions in a variety of other settings. She found that a disagreement rate of 25%–30% was persistent across all fields. The disagreement rate for scientists engaged in peer review was 25%, the rate for employment interviewers was 30%, for psychiatrists diagnosing psychiatric illness it was also 30%, and for physicians diagnosing physical illness it was 23%–34%.\(^{107}\) Diamond and Hans Zeisel found a similar rate of disagreement among judges. In their study of the recommendations of judges participating in sentencing councils, they found a

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\(^{106}\) See, e.g., Farber & White, supra note 44, at 204–05 (finding 30% disagreement or ambiguous findings); Peeples et al., supra note 45, at 884 (finding that reviewers disagreed in 34.3% of the cases).

30% or greater rate of disagreement on whether the offender should be sentenced to prison.\textsuperscript{108}

It is now well established that a modest, but significant, level of disagreement is inherent in the nature of performance assessment. That is hardly surprising, given the frequent presence of disputed facts and the subjective nature of quality assessment. In medicine, the potential for disagreement is further compounded by frequent uncertainty among physicians and regional variation over the appropriate standard of care.\textsuperscript{109}

Consequently, a significant fraction of the jury-reviewer disagreements may be inherent in the nature of these decisions. The studies suggest that normal inter-rater variability causes discrepancy rates of roughly 25% to 30%. Yet, the discrepancy rate in the malpractice cases with relatively weak evidence of negligence is only 10% to 20%. Because a certain level of interobserver disagreement is inevitable, and because the discrepancy rate observed in malpractice cases is much lower than the rate found in other settings, virtually all the disagreement between juries and reviewers occurring in cases with relatively weak evidence of negligence is probably the product of routine inter-observer variability. In this set of cases, jury performance is exceptional.

At the same time, further improvement is both possible and desirable. Courts should continue to experiment with innovative efforts to make scientific proof more comprehensible to lay jurors, such as early jury instruction, jury note-taking, ongoing jury deliberations, and jury submission of questions. They should also continue their search for better ways to distinguish legitimate experts from professional actors. However, the relatively high agreement rate that already exists between juries and physician-reviewers in low-odds cases probably means that only a modest improvement is possible.

By contrast, inter-rater variability provides a much less complete explanation for the disagreement rate in cases with strong evidence of negligence. The fifty percent discrepancy rate found in these cases means that additional factors are at work.

B. Reviewer Bias

Another possible explanation for jury-reviewer disagreement is that the physicians whose ratings were used by the studies were biased in favor of the defendant physicians. Research has shown that physicians are very reluctant to label the conduct of another physician as negligent. One study found a “pronounced reluctance to label as negligent those treatment deci-


When faced with scenarios that had been previously judged by a panel of senior physicians to be clearly negligent, only thirty percent of the participants in the study said that the patients should receive compensation. In the Farber and White study, the risk of bias was even more acute because some of the raters were co-workers and supervisors of the defendants.

In addition, the processes used by insurance companies to rate the quality of claims against their insureds are often skewed in favor of the insured. For example, some insurance companies take more precautions to avoid an erroneous attribution of negligence to their insured than they do to prevent an erroneous exoneration. In addition, the fact that many major insurers are physician-sponsored corporations increases the risk that the claims adjustment process will favor physicians.

However, the jury verdict data simply do not substantiate the fear that pro-physician bias is a significant cause of jury-reviewer disagreement. If the reviewers’ ratings reflected a substantial pro-physician bias, we would expect to see a high jury disagreement rate in cases rated by the reviewers as lacking merit. That is because less biased juries would be expected to rule for the plaintiffs in a significant fraction of these cases. Pro-defendant reviewer bias should also produce a low rate of disagreement in the cases rated as having merit because reviewers would give that rating only when negligence was indisputable. Yet, the studies show a dramatically different pattern of disagreement. They reveal that disagreement is most common in the cases rated as having merit and least common in cases rated as lacking merit. This pattern is inconsistent with the presence of systematic pro-defendant bias in the external reviews. That, in turn, makes it unlikely that we can explain a significant fraction of the plaintiffs’ verdicts in low-odds cases as the jury’s correction of a biased rating.

C. Asymmetric and Incomplete Information

Both juries and expert reviewers rely on incomplete information. The evidence available to the external reviewers, in particular, will often be less complete than the evidence produced at trial. It may also be more one-sided.

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10. Paul C. Weiler et al., A Measure of Malpractice 125 (1993) (“We found marked variation among physicians in their willingness to label certain kinds of medical outcomes as iatrogenic, and an even more pronounced reluctance to label as negligent those treatment decisions that, ex post at least, were clearly erroneous.”).

11. See Peeples et al., supra note 45, at 884 (finding that the liability insurer was more likely to seek additional reviewers if the initial review suggested breach of duty than if that review exonerated the sued physician). The insurer’s average number of reviews grew from 3.07 to 3.27 and then to 4.43 as the evidence of breach got stronger. See id. The authors concluded “that the insurer proceeds more carefully in those cases in which liability appears likely.” Id. Similarly, in the Taragin study, only about half of the cases in which the medical care was initially deemed defensible by a claims representative were reviewed by an outside physician, while all initial determinations of poor quality were reviewed by consulting physicians. See Taragin et al., supra note 39, at 781 tbl.1 (deeming twenty-nine percent defensible with “[n]o peer review”).
The hospital chart, for example, is controlled by prospective defendants and may paint a very different picture than the story that emerges when all of the witnesses have testified. If so, juries can be expected to disagree occasionally with the ratings given by insurance reviewers.

At present, however, we do not know whether a significant fraction of the jury-reviewer disagreements arises out of access to different information about the patient’s treatment. Given the strong agreement rate in low-odds cases, however, it is unlikely that pro-defendant ratings errors caused by incomplete information are as large a problem as many observers would have expected. Instead, the more interesting question is whether, contrary to expectation, the jury’s access to more complete information helps to explain why the jury finds for the plaintiff in only fifty percent of the cases that the reviewers rated as indefensible. We currently lack the data needed to answer that question.

D. Scientific Complexity

Many critics of jury decision-making charge that juries are unable to understand complex medical evidence. Doctors fear that the ensuing confusion works to the plaintiffs’ advantage, making the jurors vulnerable to manipulation by plaintiffs’ attorneys, sympathetic plaintiffs, and dishonest expert witnesses. Although several studies have attempted to determine the jury’s capacity to digest complex evidence and to decide difficult cases fairly, the results have been inconclusive.

Some of the findings are reassuring. For example, researchers have found that greater case complexity does not produce more disagreement between juries and presiding judges. In the largest and most famous of the studies, Kalven and Zeisel concluded that their findings of strong judge-jury agreement were “a stunning refutation of the hypothesis that the jury does not understand.”

At the same time, other studies have documented the limitations of a lay jury in complex cases. The most clearly established weakness lies in the

112. See Vidmar, supra note 4, at 59–67 (containing case studies that reveal how estimates of case strength change as information is uncovered).

113. See, e.g., Vidmar, Are Juries Competent, supra note 10 (reviewing the literature and concluding that juries are competent to decide scientific tort cases).


115. Kalven & Zeisel, supra note 91, at 157 (“While, as we can see, jury disagreement is greater in close cases than in clear ones, there is virtually no difference between the frequency of disagreement when the case is easy and when the case is difficult.”).

comprehension and application of probabilistic evidence. For example, people tend to overestimate the significance of some low probability risks. This could cause them to overestimate, in hindsight, the riskiness of a physician’s clinical decisions.

Although the literature on jury comprehension is voluminous and far more nuanced than this brief summary can reflect, it provides neither a basis for concluding that juries commonly err in medical malpractice cases nor a basis for concluding that they do not. Perhaps the most revealing data comes from the studies on jury-reviewer agreement. The exceptionally high rate of agreement between juries and physician reviewers in the low-odds cases is inconsistent with the theory that the case complexity produces unfair plaintiffs’ verdicts.

In fact, the studies on jury-reviewer agreement raise the surprising possibility that case complexity favors defendants. As will be discussed further below, the complexity and ambiguity of the scientific evidence in conjunction with the burden of proof could explain why juries find for defendants in half of the cases rated by experts as indefensible and in seventy percent of the borderline cases. Juries may be reluctant to hold a defendant liable when jurors are uncertain or confused about the evidence.

E. Procedural Barriers to the Ascertainment of Truth

Our adversary system relies on the parties to produce all of the relevant evidence for the jury. Yet, the parties actually have a very different objective. They are trying to prevail in a zero-sum game. Neither is interested in presenting the “whole” truth. Instead, each presents a partial picture that it hopes will be taken as the truth. This objective aligns awkwardly with the jury’s twin goals of ascertaining the truth and reaching a just verdict.

The obstacles placed in the search for truth are not limited to the system’s reliance on the parties to adduce the evidence. The civil justice system impedes the search for truth in other ways as well. Consider, for example, the protection of attorney work-product and the many restrictions placed on access to information about experts consulted by an opposing party, some of whom may have opinions inconsistent with that party’s theory of the case.


In situations like these, where courts have placed the protection of other important values above an unfettered search for the truth, the process itself may place an upper limit on the accuracy of its outcomes. As a result, the incentives and rules of the adversary process may produce some of the cases in which juries and extra-judicial reviewers disagree.\textsuperscript{121}

However, the relatively low discrepancy rate in the low-odds cases suggests that any reforms enacted to improve the process, such as refinements in the rules governing expert witnesses, will have at most a very modest effect on that set of cases. Yet those are the cases that most concern the critics of tort law.

F. Jury Bias

Jury bias, like reviewer bias, could explain some of the cases in which juries and reviewers disagree. Jury bias in favor of injured claimants could be responsible for some of the low-odds cases that plaintiffs win. At the same time, other juries may be biased in favor of medical defendants, potentially explaining much of the success that defendants have in cases rated as toss-ups or indefensible.

Unfortunately, the role played by jury bias in malpractice cases has not been measured directly. Nevertheless, the studies of jury-reviewer agreement provide some promising clues about the role that jury bias plays in malpractice litigation. First, the low level of jury-reviewer disagreement in low-odds cases suggests that pro-plaintiff jury bias produces very few indefensible plaintiffs’ verdicts. Second, the surprising level of defense success in cases deemed indefensible by expert reviewers cannot be explained by inter-rater variability alone. As a result, jury verdicts in these cases must be driven by one or more factors that systematically favor defendants at trial. Pro-defendant jury bias is one of the likely factors, along with the defense’s superior resources, and jury respect for the burden of proof.

The possibility that juries are biased in favor of physicians runs counter to conventional wisdom. Juries, we are told, sympathize with injured patients and penalize wealthy physician defendants. However, jury reticence to hold physicians liable is consistent with public opinion research indicating that the public is deeply concerned about excessive litigation and high liability insurance premiums.\textsuperscript{122} In one study, four of five potential jurors agreed

\textsuperscript{121} However, studies comparing adversarial and inquisitorial styles of adjudication suggest that no major gains would be achieved by moving toward a more European model. See Diamond & Rose, supra note 16 (reviewing the literature). Each system has its own shortcomings.

that “[p]eople are too quick to sue” and that “[t]here are far too many frivolous lawsuits today.” Only one-third felt that “[m]ost people who sue others in court have legitimate grievances.” In Texas, lawyers report that the “going rate” for settlement of tort claims has gone down. In Wisconsin, defendants are now requesting jury trials in soft tissue cases.

This mood of public skepticism extends to lawsuits against physicians. In his study of potential jurors, Neil Vidmar found that members of the jury pool often made remarks during voir dire revealing their skepticism about malpractice litigation. Many made comments like “too many people sue their doctors” and “it is just going to raise the health insurance rates for the rest of us.” In another study of potential jurors, one-third of the respondents believed that medical malpractice plaintiffs were looking for easy money. Respondents were even more skeptical of plaintiffs’ lawyers. Two-thirds felt that these lawyers pressured clients into suing their doctors.

Many felt that medical malpractice litigation was ruining the health care system.

This widespread skepticism toward claimants and protective ness toward physicians could have several causes, including (1) the media

ity in Tort Cases: Implications for the Litigation Explosion Debate, 26 LAW & SOC’Y REV. 85 (1992); ELLEN L. LEGGETT, JURY RESEARCH INSTITUTE, IDENTIFYING JUROR BIAS AND THEIR IMPACT ON CASES (1999) (finding that one-third of the respondents believed that medical malpractice plaintiffs are looking for easy money). Medical sociologists also point out that a low win rate is to be expected when lower status individuals make demands on persons with higher social status. See Jeffery Mullis, Medical Malpractice, Social Structure, and Social Control, 10 SOC. F. 135, 142, 145, 149 (1995).

123. Hans & Lofquist, supra note 122, at 93. This study asked about tort cases against corporations.

124. Id. Some of the skepticism about plaintiffs may be the product of cognitive dissonance—we do not want to think poorly of the people to whom we entrust our lives and well-being. Another possible explanation has been suggested by medical sociologists who believe that the poor success of malpractice plaintiffs in court is a predictable consequence of their lower social status relative to physicians. See Mullis, supra note 122, at 142, 145, 149.


127. Vidmar, supra note 4, at 169.

128. Leggett, supra note 122.

129. Id.; see also Greene et al., supra note 122, at 817 (finding that most jurors believe attorneys encourage people to file frivolous lawsuits).

130. See Leggett, supra note 122 (discussing the findings).

131. Further complicating this analysis is the realistic possibility that jury bias may vary materially from one locale to another. We know already that plaintiffs’ win rates vary substantially across the country and even across states. See, e.g., Mary R. Rose & Neil Vidmar, The Bronx “Bronx Jury”: A Profile of Civil Jury Awards in New York Counties, 80 Tex. L. Rev. 1889, 1896 (2002) (studying the so-called “Bronx effect” and finding that Bronx County ties with Brooklyn for the highest plaintiff win rate in the metropolitan New York area—at or above 50%); Daniels & Martin, supra note 3, at 139 tbl.4.6 (finding that the win rate in Dallas was roughly 20% from 1970 to 1990, while the win rate in Cook County, Illinois, went from 42% down to 26% and then back up to 41% over the same time period). However, no study has attempted to separate the role
campaigns undertaken to create a political climate favorable to tort and malpractice reform legislation, (2) “Main Street” social norms against playing the tort lottery, and (3) the credibility, authority, and trustworthiness that are commonly attributed to high-status positions, like physicians.

1. Media

Most obviously, the media coverage of three medical malpractice crises in the mid-1970s, mid-1980s, and early 2000s has made the public very sensitive to the costs of malpractice litigation. On the heels of those crises, the political and public-relations campaigns in support of reform legislation further shaped public perceptions. In Texas, for example, the settlement value of tort cases has declined because the tort reform movement has changed the courtroom environment.  

In their important study of the public tort reform debate, Stephen Daniels and Joanne Martin point out that rhetoric is often more important than reality. Critics of tort law have mastered that rhetoric far better than its defenders. Cumulatively, they have created a widely shared picture of juries who are biased in favor of injured claimants and who pick the pockets of insured defendants in order to provide the claimants with generous recoveries.

2. Social Norms Against Claiming

A question not yet asked in the malpractice literature is why the public has been so receptive to this message. The answer may lie in norms about claiming. Many Americans have decidedly mixed feelings about tort claimants. While they are sympathetic to people who have been badly injured, many are also uncomfortable with attempts to “profit” from that injury.

These underling attitudes toward tort litigation were first revealed by the pioneering work of David Engel. His 1984 article *The Oven Bird's Song* summarized two years of fieldwork studying community attitudes toward personal injury litigation in a small, predominantly rural Illinois county he called “Sander County.” Although personal injury litigation rates were low played by local norms from the role played by regional differences in the kinds of cases that are selected for trial. Thus, plaintiffs may win more verdicts than they should in some communities and less in others. If so, the unexpected plaintiffs’ verdicts found in the jury verdict studies may be concentrated in different venues than those that produce the unexpected defendants’ verdicts.

132. See generally Daniels & Martin, *supra* note 125 (reporting on interviews with many plaintiffs’ lawyers).


134. *Id.* at 11.


136. *Id.* at 552. Although more than half of the population lived in the county seat, agriculture continued to play a central role in county life. *Id.* at 554.
there, residents of Sander County strongly disapproved of personal injury lawsuits. Claimants were characterized as “very greedy,” “quick to sue,” and “looking for the easy buck.”

Engel found the explanation for these beliefs in the culture of Sander County. Residents shared a brand of individualism that emphasized self-sufficiency and personal responsibility. In this farming community, the risk of injury was ever-present. People were expected to “provide their own protection against injuries” and “absorb the consequences of harms they fail[ed] to ward off.” Money was earned through hard work, not the courts. Against this norm of stoicism, “cashing in” on misfortune was considered highly inappropriate. Most local residents were hesitant to file lawsuits. When they took a case to court, awards were low and suspicion of plaintiffs high. Jurors felt that they had been “out there slaving away for every penny they’ve got and they [weren’t] about to just give it away to make that free gift to anybody.”

Social attitudes like these could provide at least a partial explanation for the difficulty that malpractice plaintiffs frequently experience in jury trials. It would be easy to dismiss the “Sander County” views as those of an isolated and small rural community many years ago, but that would be unwise. The last quarter century has seen a resurgence of voter support for politicians seeking to reinvigorate “traditional” social values like those held in Sander County. This broader political zeitgeist may spill over into jury deliberations. For community members who share these values, tort reform may closely resemble welfare reform, each ending an era of unearned

137. Id. at 553.
138. Id. at 558–59.
139. Id. at 558.
140. Id. at 558–59. For the traditionalists, transforming an injury into a lawsuit was “an attempt to escape responsibility.” Id. at 559.
141. Id. at 559. The community treated contract lawsuits far more approvingly. Contract actions, usually involving collections for sales, services, or loans, were nearly ten times as common in Sander County as personal injury lawsuits. Id. at 574–75. Yet community members voiced no complaints about this litigation as it enforced the sanctity of a promise. As one person observed, “a farmer’s word is good.” Id. at 576. Contract actions insured that promises were kept, debts honored, and payment received for work performed. Id. (noting that even violent self-help by creditors was tolerated). As a consequence, contract actions reinforced the existing social order, while tort claims challenged it.
142. Id. at 561. When they wanted to file a claim, it was hard to find a local lawyer willing to take the case. Although members of the local bar filed 72.5% of all non-tort lawsuits in the county, they filed only 12.5% of the personal injury claims. Id. at 565.
143. Id. at 560.
144. Id. (quoting an insurance adjuster).
145. In addition, now, as then, contract litigation is growing more rapidly than tort litigation. Malpractice lawsuits are actually declining on a per capita basis.
giveaways. Where these views are prevalent, plaintiffs will face a demanding burden of proof.

3. Challenging Privileged Members of Society

Malpractice claimants also face another potential barrier to success that differentiates malpractice lawsuits from most other categories of tort litigation. Patients who file malpractice claims directly challenge the competency and authority of an upstanding member of the community with high social standing. A theory in legal sociology called “status expectations theory” contends “that the influence attempts of high-status individuals succeed, and those of lower-status people fail, due to socially shared cognitions and expectations that link social status to attributions about personal ability and worth.”

Higher-status individuals have more cultural capital than individuals with lower status because of cultural beliefs about their character and reputation.

This theory was first formally articulated in 1976 by Donald Black, who argued that the relative social standing of the defendant and his victim significantly influence the outcome of both criminal and civil cases. Marshaling the studies then available, he claimed that low-status individuals who injure high-status victims are treated more harshly by the law than high-status individuals who injure low-status victims. He also believed that

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147. This particularly American brand of individualism probably helps explain why the pleas of tort reformers have resonated so strongly with the public. Advocates of tort reform have chosen their terms wisely. Complaints about “frivolous claims,” “lottery mentality,” and “windfall recovery” are likely to have considerable salience for Americans who share the creed of individualism and self-sufficiency.

148. Further complicating this analysis is the realistic possibility that the direction of jury bias varies with locality. Usually, defendants favor rural juries and plaintiffs favor urban. Because local norms and attitudes vary, plaintiffs may win more verdicts than they should in some communities and less than they should in others. Thus far, however, there is no useful data on this topic because the few studies comparing local win rates have not controlled for case quality. See, e.g., Daniels & Martin, supra note 3, at 127; Theodore Eisenberg & Martin T. Wells, Trial Outcomes and Demographics: Is There a Bronx Effect?, 80 Tex. L. Rev. 1839 (2002); Mary R. Rose & Neil Vidmar, The Bronx “Bronx Jury”: A Profile of Civil Jury Awards in New York Counties, 80 Tex. L. Rev. 1889, 1896 (2002). If the folklore is correct, however, the data on jury-reviewer disagreement suggests that the rural counties favored by defendants may be just as unfair to plaintiffs as urban juries reputedly are to defendants.


150. Id.

the more intimate the personal relationship between the defendant and the victim, the less harshly the defendant would be treated.  

The reception of Black’s theory has been mixed. Some studies confirm his predictions, but others do not. In addition, the applicability of this research to malpractice trials remains uncertain because nearly all of it involves criminal justice and race, rather than civil liability and occupational privilege. The impact of social status on malpractice outcomes is further complicated by the possibility that malpractice plaintiffs can materially raise their effective social standing by retaining attorneys and experts with better social pedigree than their own. As a result, we lack the data needed to know whether the social standing of physicians explains any of the surprising success that physicians have when the evidence against them is strong, but the social status of the patient is not.

Despite these uncertainties, however, there are good reasons for leaving open the possibility that social status affects malpractice outcomes. Most importantly, the gulf in social power and prestige between physicians and ordinary patients is massive. This chasm provides ample raw material for the operation of subtle differences in the attribution of credibility and authority to doctors and patients. The tendency to favor the doctor may be further deepened by the social relationship out of which the lawsuits arise. Every malpractice case is a lawsuit by an ill patient against the healer who tried to make her well.

Black’s theory is also supported by a recent study of tax audits which found that auditors accept the oral testimony of high-status taxpayers more

152. Black, Behavior, supra note 151, at 11. For example, intrafamily abuse is less likely to be prosecuted than violence against strangers. Their degree of interdependence also matters. Id. at 13, 73.

153. Compare David F. Greenberg, Donald Black’s Sociology Of Law: A Critique, 17 Law & Soc’y Rev. 337, 347, 357–59 (1983) (conceding that individual attributes and relationship “unquestionably influence outcomes” but arguing that subsequent studies refute Black’s specific predictions), with Allan V. Horwitz, Resistance To Innovation In The Sociology of Law: A Response To Greenberg, 17 Law & Soc’y Rev. 369, 379–81 (1983) (questioning Greenberg’s critique). For example, scholars debate whether studies showing that blacks and whites receive similar sentences have any bearing on this claim that crimes committed by blacks against whites will be treated differently than crimes committed by whites against blacks. See id. at 380.


often than that of low-status taxpayers. The authors concluded “that taxpayers of a low occupational prestige face a higher burden of proof than either middle- or high-prestige taxpayers.” Auditors use clues about social status to make inferences about the competence and credibility of the taxpayers.

Experiments have also shown “that the credibility of people in court increases if they testify in a style characteristic of high-status people.” High-status people seem more competent and trustworthy. According to one review, “witnesses such as professionals and executives generally have more credibility than manual laborers or clerks, whites more than blacks, men more than women, and so on.” Information about social status is communicated not only by occupation, speech patterns, race, and gender, but also by other signals such as hairstyle, jewelry, and grooming.

These clues make it unwise to rule out the possibility that the occupation, education, income, and social standing of physicians matter in the courtroom, even though we cannot currently estimate the size and practical significance of this advantage. At the very least, our respect for, and reliance upon, physicians may make us more receptive to the media campaigns waged on their behalf.

G. Unequal Litigation Resources

Some of the success that defendants have in cases with strong evidence of negligence is likely to be the product of superior resources. Money can be used to buy the services of more talented and more experienced attorneys. It can be used to hire more and better expert witnesses. In these ways and others, superior resources can yield verdicts that were not warranted by the evidence.

156. Kinsey & Stalans, supra note 149, at 153 (reporting that auditors accepted oral testimony from twenty-two percent of low-status taxpayers, forty-three percent of middle-prestige taxpayers, and fifty-nine percent of high-prestige taxpayers).

157. Id. The significance of this finding is weakened, however, by the failure to find an association between oral testimony and favorable audits. Id.

158. Id. at 154.

159. BLACK, SOCIOLOGICAL JUSTICE, supra note 151, at 18 & n.98 (noting, for example, that high-status individuals make less use of “um” and “uh” and “sort of”). The evidence also “suggests that status-based expectancies especially influence decisions or judgments about people under conditions of ambiguity or lack of information.” Kinsey & Stalans, supra note 149, at 140. Ambiguity apparently provides an area of discretion within which sociological “tie breakers” can operate.

160. BLACK, SOCIOLOGICAL JUSTICE, supra note 151, at 18 & n.100.

161. Id. at 18–19.

162. Id. at 69.

163. See RUSSELL KOROBKIN, NEGOTIATION THEORY AND STRATEGY 154–56 (2002) (noting that resources can be deployed to improve the odds of success at trial).

164. Id. at 156 (noting that it is not always cost-effective to do so).
The theory that superior resources contribute to the jury-reviewer discrepancy rate is consistent with what we know about the relative resources of malpractice plaintiffs and defendants. Most importantly, defendants usually have more experienced attorneys. Neil Vidmar found that virtually all medical defendants were represented by attorneys with significant malpractice experience, while sixty-two percent of the patients were represented by attorneys with relatively little experience.165

The extra experience matters. Catherine Harris and her colleagues found that plaintiffs won fifty percent of their trials when a seasoned plaintiff’s attorney was matched against a less seasoned defense counsel, but only ten percent when the mismatch favored the defendant.166 They also found that defendants benefited from mismatches four times as often as plaintiffs.167 However, the findings should be viewed only as suggestive because the study did not control for the quality of cases in each attorney’s portfolio.168 Of course, the plaintiff sometimes has the more experienced lawyer. Perhaps, these mismatches account for some of the plaintiffs’ verdicts in low-odds cases.169 However, defendants benefit from mismatches far more often than plaintiffs do.

In addition, physicians probably have access to more and better expert witnesses. Physicians are widely believed to have less difficulty convincing well-respected practicing physicians to testify on their behalf. If true, this advantage would allow defense attorneys to be more selective, choosing the best witnesses for their side.

Defendants also hire more expert witnesses. Despite the fact that plaintiffs, unlike defendants, must offer expert testimony on the issue of damages and, thus, offer this testimony far more often than defendants,170 defendants still offer more total experts than plaintiffs do at trial.171 Malpractice defendants also benefit from the experience that their liability insurers bring to the litigation team. Experienced insurance representatives can assist their attorneys in identifying and exploiting strategic advantages.

165. Vidmar, supra note 4, at 54–55 (finding that sixty-two percent had handled fewer than four such cases during a four year study).
166. Harris et al., supra note 51, at 243.
167. Id.
168. However, a different study found that experienced attorneys had larger, but not more defensible, cases. See Sloan et al., supra note 20, at 185–86. It also found that defense counsel spend considerably more money on trial preparations when they are defending against another specialist. Id. at 216.
170. See Sloan et al., supra note 20.
171. See Vidmar, Are Juries Competent, supra note 10, at 902.
Finally, defendants typically possess better access to information about the circumstances surrounding the plaintiff’s treatment than plaintiffs do. Some of this advantage probably survives discovery. If so, defendants can exploit this information asymmetry to win cases they should lose.

Thus, it seems reasonable to accept the working assumption that defendants benefit from superior resources more often than plaintiffs. In addition, the findings of the Harris study make it reasonable to posit that superior resources affect trial outcomes, though the magnitude of this advantage is unclear. Thus, it seems likely that some of the indefensible cases that end in defense verdicts reflect the influence of superior resources.

H. Medical Uncertainty and the Burden of Proof

Scholars have overlooked the possibility that much of the difficulty that malpractice plaintiffs experience in the trial of their strongest cases may stem from jury reluctance to hold a physician liable when the evidence is unclear or conflicting. The individuals who sit in the jury box will hear and rely on experts hired by the respective parties to advance their view of the case. If the defendant’s expert is credible, jurors may find it difficult to determine whether the defendant has been negligent and, thus, may decline to hold the defendant legally responsible. This deference in the face of doubt could explain why juries rule for defendants in many cases that experts feel the plaintiff should win and in most of the cases thought by the expert reviewer to be toss-ups.

In legal terms, this deference can be understood as strict insistence that the plaintiff meet her burden of proof. As a result, plaintiffs only win if they have convinced the jury that the defendant violated the standard of care. If the jury has genuine doubts after hearing the defendant’s experts, then that burden has not been met.

In addition to the burden of proof, the “two schools of thought” rule may also help to explain the deference that juries pay to medical defendants. In most states, the jury will be instructed to rule in favor of the defendant if it finds that respectable medical opinion is divided and the defendant’s care falls within one of the reputable schools of thought. This rule is premised on the judicial belief that juries are not competent to choose the “better” school of thought when physicians themselves are unable to do so. If the jury finds the defendant’s experts credible, then it may feel obliged to conclude that the defendant’s conduct falls within a reputable school of thought. By contrast, expert reviewers may feel fewer obligations to refrain from


judgment because they are medical experts themselves and are making their judgments in a very different setting.

Jury respect for the burden of proof and the two schools of thought rule would explain the observed pattern of jury verdicts. When the jury is in doubt, the benefit of that doubt goes to the defendant. This caution gives shelter to physicians who, in the eyes of their peers, have violated the standard of care.\textsuperscript{174}

If this hypothesis is correct, then juries understand the limits of their expertise, and this awareness favors the defendant. That is precisely the opposite of the effect that the jury’s lack of expertise is commonly thought to have on jury verdicts. Critics assume that the “battle of the experts” frees juries to award unjustified recoveries. The data suggest that it is more likely to shelter negligent physicians. Thus, the common presence of clinical uncertainty and professional disagreement may actually help defendants in the courtroom, rather than create confusion that the plaintiff’s attorney can exploit.

Although this hypothesis has not yet been tested, it is consistent with both the poor success of plaintiffs in cases rated by experts as indefensible and also their unexpectedly poor success in cases rated as toss-ups, only twenty to thirty percent of which are won by plaintiffs. It may help explain why malpractice plaintiffs fare better in front of judges than before juries. Judges may be more confident than jurors in their ability to determine when an expert’s foundation is thin and, thus, more willing to conclude that a defendant’s experts are unconvincing. If this explanation for the low plaintiff win rate in cases with strong evidence of negligence is true, then it is not necessary to develop more detailed ex ante standards of care, as some scholars have recommended, in order to protect physicians from unfair verdicts.\textsuperscript{175}

I. Synthesis

Inter-rater variability is almost certainly the least appreciated and least escapable source of jury-reviewer disagreement. It probably explains most of the discrepancy rate of ten to twenty percent in low-odds cases, suggesting that further improvements will be very difficult. Its presence is neither a cause for alarm nor a basis for celebration. Instead, the presence of a modest level of inter-observer disagreement simply reflects our limited capacity to reconstruct the past and agree on its propriety.

Two of the factors that can produce jury-reviewer disagreement actually improve the fairness of trial outcomes. Thus, we should welcome

\textsuperscript{174.} Jury deference in the face of apparent medical disagreement may also help to explain why plaintiffs fare better in front of judges. Perhaps judges are more confident in their ability to determine when the defendant has manufactured a superficial medical disagreement.

\textsuperscript{175.} See Michelle M. Mello, Of Swords and Shields: The Role of Clinical Practice Guidelines in Medical Malpractice Litigation, 149 U. Pa. L. Rev. 645, 668–77 (2001) (reviewing the literature and separating the proposals into three categories: the ex ante contract model, the judicial notice model, and the affirmative defense model).
those jury-reviewer disagreements that arise when a rating given by the insurance company’s experts is biased against the plaintiff. Similarly, disagreements that stem from the jury’s access to more complete information simply mean that the system is working as it should. However, the existing data do not provide a basis for estimating the frequency with which these corrections occur or the portion of the jury-reviewer disagreements that they explain.

Other likely causes of jury-reviewer disagreement are decidedly unwelcome. They include jury inability to understand complex evidence, one party’s access to superior litigation resources, barriers to truth posed by some of the rules of trial and pretrial practice, pro-plaintiff jury bias, and pro-defendant jury bias. Although none of these factors appears to play a substantial role in the resolution of low-odds cases, several appear to infect jury decision-making in cases with strong evidence of negligence.

**CONCLUSION**

Over the past thirty years, three medical malpractice “crises” have come and gone. In reaction to these crises, three generations of malpractice reform legislation have been enacted across the country. Yet, the subject of jury competence remains a front-page issue. Today, it serves as a prime justification for proposals to make fundamental changes in malpractice litigation, such as the legislative authorization of binding early offers and the creation of administrative health courts.

It is time to stop relying on intuitions and anecdotes when debating jury performance. Three decades of research provide an ample evidentiary basis for evaluating jury decision-making. The findings revealed by that data are mixed and, in some ways, paradoxical. On the one hand, negligence matters, weak cases are decided correctly, and juries appear to take the burden of proof seriously. On the other hand, juries are so reluctant to hold physicians liable that they render defense verdicts in half of the cases that medical experts think plaintiffs should win. Given the well-established reluctance of physicians to label other physicians as negligent, this is a remarkable finding that deserves further research.

On one criterion, juries perform well. The stronger the plaintiff’s evidence of negligence, the greater the likelihood of a plaintiff’s verdict. Plaintiffs win 10% to 20% of the cases that reviewers feel they should lose, 20% to 30% of the cases rated as toss-ups, and roughly 50% of the cases with strong evidence of negligence.

Of most importance to critics is the finding that meritless cases rarely win. In fact, doctors win a larger percentage of these cases (80% to 90%) than would be predicted from the data on inter-rater variability. As a result,
the disagreements observed in the low-odds medical malpractice cases can be fully explained by normal inter-observer disagreement. In addition, some of these disagreements can probably be attributed to reviewer bias in favor of physicians and jury access to more complete and stronger evidence of medical negligence. It is, therefore, unlikely that a significant fraction of the plaintiffs’ verdicts in these cases constitute genuinely erroneous verdicts caused by factors such as pro-plaintiff jury bias, superior plaintiff’s counsel, and the jury’s inability to understand the evidence. In fact, it is possible that the unexpectedly high agreement rate indicates a pro-defendant bias.

Of course, many physicians will be alarmed by a 10% to 20% chance that they will be found liable in a case that lacks merit in the eyes of the liability insurer and the defendant. Yet that agreement rate already reveals more deference by juries to medical defendants than is usually given by other physicians. If an 80% to 90% agreement is still not good enough, then the cure is unlikely to lie in piecemeal reforms of a fault-based tort system or even in more fundamental changes, such as the creation of specialized medical courts. A nontrivial discrepancy rate is inevitable unless the issue of fault is removed entirely from the case, as would happen in a no-fault compensation regime. Even then, causation is likely to be a frequently contested issue.

By contrast, the high rate of disagreement in cases thought by reviewers to be indefensible (50%) is too large to be explained entirely by inter-rater variability. Jury access to better information may explain some of that discrepancy rate, but it probably accounts for a small portion of those disagreements because defendants ordinarily have better access to information about the plaintiff’s treatment than plaintiffs do. The rest is probably produced by factors that systematically favor defendants. The finding that defendants win roughly 70% of the cases rated as toss-ups also suggests the operation of pro-defendant factors.

Although the data are not sufficiently detailed to permit a definitive assessment, several explanations are especially promising. First, juries may be skeptical of patients who sue their doctors. Second, the preliminary evidence, though scanty, suggests that defendants are much more likely than plaintiffs to have more experienced attorneys and superior experts. Third, juries may take the burden of proof very seriously in medical malpractice cases, giving physicians the “benefit of the doubt” when the experts for both sides are credible. Of the three influences, only the last produces fair outcomes. Unfortunately, the data on jury-reviewer disagreement do not provide a basis for estimating the relative importance of each of these three pro-defendant forces. However, they do establish that the cumulative impact of these factors provides doctors with a significant advantage in front of the juries.

Collectively, these forces make it quite difficult for malpractice plaintiffs to win even their strongest cases. Because this finding is contrary to our usual assumptions about the allocation of risk in the courtroom, little scholarly thought has been given to reforms that might level the playing field. One important exception is the intriguing suggestion made by Frank Sloan
and his colleagues that we make it easier for plaintiffs to locate experienced plaintiffs’ attorneys by creating a certified specialty in malpractice litigation.\footnote{Sloan et al., supra note 20, at 215–17.}

Health courts are another reform that could potentially produce fairer outcomes for claimants. Because juries are more deferential to the defendant physicians than expert reviewers are, it is conceivable that medical courts will rule in favor of claimants in a larger percentage of the cases that independent reviewers think plaintiffs should win. Other attributes of health courts could also aid plaintiffs. For example, the use of trained judges might reduce the advantage associated with defendants’ superior resources. Similarly, the elimination of hired-gun experts has potential to help plaintiffs more than defendants because the data show that defendants and their hired guns are more successful than plaintiffs and their hired guns at persuading juries to render verdicts at odds with the opinions of medical experts.\footnote{Innovative Solutions to Medical Liability: Hearings Before the Subcomm. on Health of the H. Comm. on Energy and Commerce, 109th Cong. 6 (2006) (statement of Paul Barringer, General Counsel of Common Good).}

If health courts actually operate in this fashion, then patients, not physicians, should be lobbying for them.

Of course, none of these hypotheses has been tested. Furthermore, there are good reasons to fear that health courts will treat patients unfairly. Current proposals for health courts suggest that discovery will be greatly truncated, fees of plaintiffs’ attorneys will be capped, pain and suffering will be capped, and expert testimony will be restricted to “neutral” experts who risk regulatory punishment if their testimony is not “objective.”\footnote{However, health courts would lack the democratic legitimacy associated with jury verdicts. See Peters, supra note 109, at 958–59.}

Moreover, the public setting in which these experts will render their opinions could place considerable pressure on them to demonstrate their loyalty to the profession. As a consequence, these “neutral” experts may show the same reluctance to label another physician’s care as negligent that physicians have exhibited in other settings. As noted above, researchers have found that physicians are so unwilling to label another physician’s care as negligent that they refuse to do so even when the treatment given to the patient was “clearly erroneous.”\footnote{See supra note 110.}

There is an obvious tension between the finding that physicians are loath to indict one another and the evidence that physician reviewers who work for insurers and researchers are more willing to condemn the tort defendants than juries are. Setting seems to matter. The relevance of role and context is most clearly demonstrated by the principal study measuring physician willingness to criticize peers. In this study, the subjects were asked, among other things, whether the injured patient deserved compensation. Yet the same scenarios had been deemed “clearly erroneous” by consultants to the re-
search team. In that study, the role played by the physicians mattered. Context may also explain why physicians who perform case reviews for malpractice insurers and social science researchers are relatively willing to make negative judgments about other physicians. If they were asked to do that in the more public setting of health courts, they might be much less willing to criticize their peers. As a result, our initial experiments with health courts should be small pilot projects during which researchers collect the data needed to evaluate the fairness of their outcomes.

In recap, the data demonstrate that juries treat physicians very fairly, perhaps with too much deference. Given the limits of human capacity to reconstruct past events and the inevitable subjectivity of judgments about the quality of past performance, it is probably not possible to design a fault-based adjudication system that will have a substantially higher agreement rate in the cases with weak evidence of negligence. At most, modest improvements may be possible through careful refinements of trial procedure and the supervision of expert witnesses. As a consequence, both piecemeal reforms and more fundamental alternatives to malpractice litigation should not be driven by the mistaken assumption that juries treat physicians unfairly. Although the current system of resolving malpractice claims has many shortcomings, neither randomness nor favoritism toward injured patients is among them.
Testimony

of

Neil Vidmar,
Russell M. Robinson, II Professor of Law
Duke Law School

before

The Senate Committee on Health, Education, Labor and Pensions

Hearing on

Medical Liability:
New Ideas for Making the System Work Better for Patients

Thursday, June 22, 2006
My Background

I am Neil Vidmar, I hold the Russell M. Robinson II Professor of Law chair at Duke Law School. I received my Ph.D. in Psychology from The University of Illinois (1967). At Duke I also have a joint appointment in the Department of Psychology. I have published over 100 articles in scholarly journals and several books. A new book, *American Juries*, will hopefully be completed this summer.

I have been conducting empirical research on medical malpractice litigation since I came to Duke Law School in 1987. Under support from the Robert Wood Johnson Foundation, The State Justice Institute and other sources I published a number of articles on medical malpractice in the 1990s. This research and other studies were combined into my book, *Medical Malpractice and the American Jury: Confronting the Myths about Jury Incompetence, Deep Pockets, and Outrageous Damage Awards*. (University of Michigan Press, 1995).


I am appearing here today to provide this committee with my professional knowledge of medical malpractice litigation. I am receiving no remuneration for my testimony. My travel expenses are being reimbursed from my Duke Law School faculty account. The opinions that I offer are, however, my own and are not necessarily those of Duke Law School or Duke University.
Testimony

In May of this year the New England Journal of Medicine published an article authored by researchers associated with the Harvard School of Public Health that closely examined 1452 closed medical malpractice claims in four areas of the United States.\textsuperscript{1} Their main conclusions merit direct quotation:

Our findings point toward two general conclusions. One is that portraits of a malpractice system that is stricken with frivolous litigation are overblown. Although one third of the claims we examined did not involve errors, most of these went unpaid. The costs of defending against them were not trivial. Nevertheless, eliminating the claims that did not involve errors would have decreased direct system costs by 13 percent...to 16 percent. In other words, disputing and paying for errors account for the lion’s share of malpractice costs.

A second conclusion is that the malpractice system performs reasonably well in its function of separating claims without merit and compensating the latter. In a sense our findings lend support to this view: three quarters of the litigation outcomes were concordant with the merits of the claim.\textsuperscript{2}

These conclusions are a good starting point to address issues about medical malpractice litigation they are consistent with my own research findings and that of other researchers.\textsuperscript{3}

Some Proposals for Alternatives or Changes to the Tort System Would Abolish or Severely Curtail the Constitutional Right to Trial by Jury

Some of the proposed experimental programs in the proposed Fair and Reliable Medical Justice Act (S.1337), 109\textsuperscript{th} Cong. (2005) would force patients to enter into an administrative scheme without the right to trial by jury: e.g. The Administrative Determination of Compensation Model and the Special Health Care Court Model.

The proposal for Health Courts developed by Common Good and the Harvard School of Public Health\textsuperscript{4} also raise issues about constitutional rights.

Voluntary resolution procedures, such as those discussed by Senators Clinton and Obama in the New England Journal of Medicine\textsuperscript{5} do not raise these constitutional issues.

I will not address the constitutional issues in my testimony, though I do want to call attention to the fact that the Seventh Amendment to the U.S. Constitution and the constitutions of the fifty states provide that all citizens the right to jury trial for all common law civil claims.
Rather I want to address the commonly held myths that have been raised about the tort system and in particular the jury system. Empirical research evidence strongly goes against these myths.

Myths about the Tort System in Medical malpractice Cases

The commonly perpetrated myths about the tort system, in no particular order, are as follows:

- Jury verdicts constitute the major source of costs for medical liability payments and defense expenses.
- Jury verdicts drive the settlement process.
- Jury verdicts are biased against doctors on the issue of liability, either due to prejudice against doctors or because juries are confused and misled by plaintiff medical testimony.
- Juries are driven by sympathy for plaintiffs rather than the evidence.
- Jury damage awards are excessive and not rational.
- The major portion of jury damage awards are for “general damages” (also, inappropriately labeled “non-economic damages” or simply “pain and suffering.”)
- Caps on pain and suffering will reduce health providers’ liability insurance premiums.
- Jury awards and their fallout are driving doctors from states without caps on “pain and suffering.”
- Many lawsuits are frivolous and driven by the expectation that a jury will award mega damages.
- The cost of defending frivolous cases has increased.

I want to address these myths by describing what research findings demonstrate.

Medical Injuries from Negligence Are a Serious Problem

The Harvard study of medical negligence examined hospital records of 31,000 patients and concluded that one out of every 100 patients admitted to hospital had an actionable legal claim based on medical negligence. Some of these patients’ injuries were minor or transient, but 14% of the time the adverse event resulted in death and 10% of the time the incident resulted in hospitalization for more than six months. Significantly, seven of those ten persons suffered a permanent disability. Generally, the more serious the injury the more likely it was caused by negligence. Subsequent research involving Utah and Colorado found rates of negligent adverse events that were similar to the New York findings.

There are reasons to believe that the Harvard study may have underestimated the incidence of medical negligence because the data were based solely on hospital records. Andrews conducted a study in a large Chicago-area hospital and studied actual incidence of negligent events in hospital wards. Andrews discovered that many injuries were not recorded on the records as required, especially when the
main person responsible for the error was a senior physician. Other research is consistent with the Andrews’s findings.\textsuperscript{10}

In 2000, the Institute of Medicine produced a report that relied on these studies and other data.\textsuperscript{11} The report concluded that each year 98,000 persons die due to medical error and that many other patients sustain serious injuries.

In 2004, HealthGrades, Inc., a company that rates hospitals on health care for insurance companies and health plans, studied Medicare records in all fifty states for the years 2000 to 2002.\textsuperscript{12} HealthGrades concluded that the Institute of Medicine’s figure of 98,000 deaths was too low and that a better estimate was 195,000 annual deaths. In addition the HealthGrades report estimated that there were 1.14 million “patient safety incidents” among thirty-seven million hospitalizations. HealthGrades further concluded that “[o]f the total 323,993 deaths among Medicare patients in those years who developed one or more patient-safety incidents, 263,864, or 81 percent, of these deaths were directly attributable to the incidents” and that “[o]ne in every four Medicare patients who were hospitalized from 2000 to 2002 and experienced a patient-safety incident died.”

In 2005 HealthGrades released another annual report that found 1.24 million total safety incidents.\textsuperscript{13} The report concluded that “for the second year in a row, patient safety incidents have increased—up from 1.14 and 1.18 million reported in HealthGrades’ First and Second Annual Patient [reports].” The report further concluded that “Of the 304,702 deaths that occurred among patients who developed one or more patient safety incidents, 250,246 were potentially preventable.”

It is important to note that the patient error rates reported in the IOM and the Healthgrades reports do not always mean that negligence was involved. Additionally, some critics have charged that the various estimates in these studies are too high.\textsuperscript{14} However, there is no serious question that medical negligence not only occurs, but that it occurs at a substantial rate.

**Injuries Due to Medical Negligence Have High Costs**

More than a dozen years ago, Frank Sloan and Stephen van Wert, two economists, conducted systematic assessments of economic losses (medical costs, income losses, and other expenses) in Florida cases involving claims of medical negligence that occurred as a result of birth-related incidents.\textsuperscript{15} Even though those researchers offered the caution that their assessment procedures probably underestimated losses, severely injured children’s economic losses were, on average, between $1.4 and $1.6 million in 1989 dollars. If adjusted for inflation using the consumer price index, these figures in 2005 dollars
translate roughly to $2.3 million per case. In the same study, the losses of persons who survived an emergency room incident were estimated at $1.3 million per case, or $2.1 million in 2005 dollars. For persons who died in an emergency room incident, the loss to their survivors was estimated at $0.5 million, which translates to $0.8 million in today’s dollars. It is important to note that there was considerable variability in these estimated averages: some patients had much higher economic losses and, conversely, others had lesser economic losses.

Sloan and van Wert’s estimates, moreover, did not consider “non-economic” losses, such as pain and suffering, disfigurement or loss of enjoyment of life’s amenities. So called “non-economic” losses in fact often have economic consequences as state courts have recognized.\textsuperscript{16} Disfigurement or “loss of a normal life,” for example, may affect employment or marriage opportunities.

A more recent study of Florida closed claim data that I and my colleagues conducted\textsuperscript{17} indicated that the average payout for a permanent significant injury such as deafness, loss of a limb, loss of an eye or one kidney or lung in 2003 dollars was $601,828. For a permanent major injury such as paraplegia, blindness, loss of two limbs or brain damage, the payout was $601,828. For a grave injury such as quadriplegia, severe brain damage, lifelong care or a fatal prognosis, the average payment was $694,427. The range of payments within these categories was considerable; sometimes the payments were many times the average payment. This should not be surprising. A young person requiring lifelong care will cost more than an aged person requiring lifelong care. A professional or a business executive will have greater lost income than an unskilled worker.

**Only One Out of Seven Injured Patients Sues**

There is a widespread belief that injured patients sue at the drop of a hat or because they are persuaded to do so by rapacious plaintiff lawyers. In fact, the opposite appears to be true. One of the most striking findings from the Harvard medical malpractice project is that seven times as many patients suffered from a medical negligence injury as filed a claim.\textsuperscript{18} Put in different words, for every seven patients who suffered a negligent injury, just one claim was filed. Claims were also filed in cases in which the research team of health care providers concluded that there was no negligence. However, the bottom line is that for every doctor or hospital charged with a claim where no negligence was found, there were as many as seven valid claims that were not filed.\textsuperscript{19}

There are a number of explanations as to why the rate of claiming for negligent medical injuries is about one in eight. The plaintiff may never suspect that negligence has occurred or may never be told that the outcome was due to negligence. The patient may be told that an error occurred, but that the
medical provider corrected the injury. Even if the error cannot be corrected, the patient, or his or her heirs in the case of a wrongful death, may be reluctant to sue because the medical provider is well-liked or offers an apology.

Another important reason is that a patient may not be able to find a lawyer to represent him. Sloan and Hsieh studied 220 childbirths in Florida in 1987 that involved death or permanent injury to the child. The researchers had physicians independently review the files and determine if negligence had taken place. The families of the children were interviewed. Of the 220 cases, 23 parents sought legal advice. These tended to be cases in which the child suffered very serious injuries and independent reviewing physicians had concluded that negligence was probably involved. However, not a single suit was filed in any of the 220 cases. Sloan and Hsieh concluded that:

The lack of claimants among the 220 women whose babies had serious birth-related injuries and the failure of 23 women to obtain [legal] representation runs counter to the “conventional wisdom” that patients sue when they obtain less than a “perfect result.” In fact, lawyers filter out many potential claims that injury victims might lose. Research by Herbert Kritzer examined the decisions of plaintiff lawyers to take or decline cases. Kritzer found that because lawyers working on a contingency fee basis have their own time and money at stake, they tend to very carefully screen cases and weed out those that have minor injuries, low damages potential, or that have a low potential of winning at trial. In ordinary cases, lawyers may decline as many as nine cases in ten; in medical malpractice cases, the proportion of declined cases may be even higher. Economic reality drives lawyers’ decisions to accept or reject cases. Kritzer’s research findings are consistent with those of Sloan and van Wert.

Combined with the factors of patients not discovering that they are victims of negligence or patients’ reluctance to sue even if negligence is discovered, plaintiff lawyers’ screening of cases helps explain the low claiming rates found in the Harvard study and subsequent studies. Patients who find a lawyer and file lawsuits are more likely to have suffered a serious injury and have a reasonable likelihood of prevailing on liability and demonstrating serious economic damages.

Myths That Are Perpetuated about Juries

Are juries as irresponsible and incompetent as tort reform critics say they are? Are jury decisions responsible for medical malpractice insurance premium hikes? The results of more than three decades of systematic research by many scholars are not consistent with these claims. Critics of juries usually make their charges through anecdotes that are nothing more than urban legends. They ignore many research findings that doctors win between six or seven out of ten cases that go to trial, that damage awards are
related to the severity of the patient's injury and that only a small percentage of malpractice payments result from jury trial.

Trial by Judge and Jury

"Trial by jury" is misleading. It is "trial by judge and jury." The trial judge presides over the trial, determines which evidence is allowed and which is not. The judge hears and sees the same evidence as the jury. Before the jury's verdict can be recorded as a legal judgment, the trial judge must agree that the evidence was sufficient to support the verdict. If the judge disagrees on the issue of negligence, he or she can set aside all, or parts, of the verdict. If the judge believes that the amount of damages is too high, the amount can be reduced through the legal device called "remititur." If the plaintiff is unwilling to accept the judgment, the judge can order a new trial.

Plaintiffs Lose Most Jury Trials

Many studies have examined win rates in medical malpractice trials. The findings contradict widespread beliefs about jury verdicts. For example, the Bureau of Justice Statistics systematically sampled jury verdicts in 1992, 1996, and 2001 in courts representing the seventy-five most populous counties in the United States. There were 1,156 medical malpractice cases in the sample, and 96% of these were tried before juries. In 1992, plaintiffs won 30.5% of jury trials, but in 2001, the win rate had dropped to 26.3%, roughly one case in four. Win rates vary slightly by state and by counties within states. The fact that doctors win two-thirds of the case filed is not evidence that these suits are frivolous cases. These are cases where a judge concluded that a legitimate triable issue, a factual dispute, existed between the parties.

Jurors View Plaintiff Claims With Skepticism

The assertion that jurors decide cases out of sympathy for injured plaintiffs rather than the legal merits of the case is one of the most persistent claims of opponents of civil jury trial. Research finds little support for these claims.

Interviews with North Carolinajurors who decided medical malpractice cases showed that jurors viewed the plaintiffs' claims with great skepticism. Jurors expressed their attitudes in two main themes: first, too many people want to get something for nothing, and second, most doctors try to do a good job and should not be blamed for a simple human misjudgment. This does not mean that in every case jurors held these views. Sometimes, evidence of the doctor's behavior caused jurors to be angry about the negligence. However, even in these latter cases the interviews indicated that the jurors had approached the case with open minds. Hans
interviewed jurors who decided tort cases, including medical malpractice, and obtained similar findings. Hans concluded that jurors often penalized plaintiffs who did not meet high standards of credibility and behavior, including those who did not act or appear as injured as they claimed, those who did not appear deserving due to their already high standard of living, those with pre-existing medical conditions, and those who did not do enough to help themselves recover from their injuries.

No Evidence for the “Deep Pockets” Claim

Closely related to the claim of “jury sympathy” verdicts is the claim that juries are more likely to render verdicts against doctors, hospitals, and corporations, not because they are seen as negligent, but only because the jurors perceive them as having the ability to pay large awards - a so-called “deep pockets” effect. A number of research studies have assessed this hypothesis and find no support for it.

Jury Verdicts Agree with Judgments of Neutral Medical Experts

An important study of medical malpractice litigation by Taragin et al. compared jury verdicts with the opinions of doctors hired by an insurance company to review the medical records to provide a neutral assessment of whether they believed medical personnel had acted negligently. The review decisions were confidential and could not be obtained by the plaintiff or used at trial. The research team compared the doctors’ ratings with jury verdicts. The verdicts tended to be consistent with these assessments. Moreover, the study also found that juries’ decisions on liability or negligence of doctors were not correlated with the severity of the plaintiff’s injury. The results, therefore, contradict the claim that juries decide for the plaintiff out of sympathy rather than apply the legal standard of negligence.

The New England Journal of Medicine study that I referenced at the beginning of my testimony is consistent with the Taragin et al. research. Juries tended to reject claims that had no merit.

Judges Agree With Jury Verdicts

Some studies asked trial judges to make independent assessments of who should have prevailed in civil cases over which they presided. The judgments were made while the jury was still deliberating and, therefore, were not contaminated by knowledge of the outcome. The judge’s decision was then compared to the jury verdict in that case. Although the research did not specifically focus on malpractice juries, the findings indicate that there was high agreement between the judge and the jury. Moreover, in instances when the judge would have decided differently than the jury, the judge usually indicated that, nevertheless, the jury could reasonably have come to a different conclusion from the trial evidence. Other studies asked large national samples of judges to draw on their professional experience with juries and
give their opinions about jury decisions. The surveys uncovered a general consensus that jurors accept and take very seriously their civic responsibility. The overwhelming number of the judges gave the civil jury high marks for competence, diligence, and seriousness, even in complex cases.

**Juries Are Not “Overwhelmed” By Plaintiff’s Experts**

An often-repeated charge is that the plaintiff’s experts in medical malpractice cases overwhelm jurors. This confusion and deference to experts, it is alleged, plays to the advantage of plaintiffs because the jury simply defers to the plaintiff’s experts and allows juror sympathies for the plaintiff to be the basis of their verdict. There is fuzzy logic in this claim, however, because it ignores the fact that defendants also cross-examine plaintiff’s experts and call their own experts who offer opinions contrary to the plaintiff’s experts. Moreover, the defendants often call more experts than the plaintiff.

Systematic studies of jury responses to experts lead to the conclusion that jurors do not automatically defer to experts and that jurors have a basic understanding of the evidence in malpractice and other cases. Jurors understand that the adversary system produces experts espousing opinions consistent with the side that called them to testify. Moreover, jurors carefully scrutinize and compare the testimony of opposing experts. They make their decisions through collective discussions about the evidence.

**Damage Awards Correlate with Severity of Injury**

Bovbjerg et al. found that the magnitude of jury awards in medical malpractice tort cases positively correlated with the severity of the plaintiffs’ injuries, except that injuries resulting in death tended to result in awards substantially lower than injuries resulting in severe permanent injury, such as quadriplegia. I and two colleagues conducted a study of malpractice verdicts in New York, Florida, and California. We also found that jury awards of prevailing plaintiffs in malpractice cases were correlated with the severity of the injury. In these studies, there was variability of awards within levels of injury. However, economic losses vary by patient. The economic loss for a quadriplegic who is 40 years old with a yearly income of $200,000 and a family of three young children would ordinarily be much greater than an identical quadriplegic who is retired, widowed, 75 years old, has no dependents, and whose annual income never exceeded $35,000. Moreover, losses can vary by a given location because the costs of living, including the costs associated with medical care and treatment, are higher in urban areas compared to rural areas.
Jury Damage Awards Have Increased, but There Are Plausible, Rational Reasons

The Bureau of Justice Statistics study found that in 2001 the median verdict in medical malpractice trials when plaintiffs prevailed was $431,000, compared to $253,000 in 1992. Punitive damages were awarded in 4% of cases, and those tended to involve cases of gross malfeasance, such as sexual assaults on patients. Most state laws proscribe punitive damages in malpractice cases except for cases involving fraud, or wanton and willful behavior. My own research in Florida, involving a study of closed claims compiled by the Florida Department of Insurance also showed that awards increased between 1990 and 2003. Claims have been made that this increase is due to increased jury profligacy, but there are very plausible alternative explanations.

A study of the Texas closed claim data base over a 15-year period by Charles Black and his co-authors found the medical malpractice system was largely stable and generated few significant changes in claim frequencies, payments, or jury verdicts. The authors concluded that "Average payments on medical malpractice claims rose because small claims were squeezed out of the system over time, not because payments on larger claims increased." Patients may have sustained more serious injuries. Due to medical advancements, patients can survive negligent injuries for longer periods of time than in the past, and thus their medical bills have increased. For example, only a few years ago many brain injured babies died. Today, thanks to medical advancements those babies now live, but at enormous medical expense. Our society must and should support those children, but the costs can sometimes be astronomical.

Another explanation may lie in the possibility that plaintiff lawyers have become more adept at “proving” damages by using experts who document economic losses better than in the past. An additional possible cause is that the cost of negligent medical injuries and lost income may have increased. During the 1990’s, medical costs, and consequently cost for needed medical care, increased 51.7% and general inflation, which is reflected in lost wages, increased 26.2%.

Another explanation for the increase in costs is that cases with claims of more serious injuries may be tried to juries in 2001, compared to 1992. This last possible explanation needs elaboration. The study of medical malpractice litigation in Florida that I and my colleagues conducted found that, compared to the first three years of the 1990s, during the first three years of the 2000-decade, there were more settled cases involving claims of negligent deaths and fewer cases involving less serious injuries. The change in types of cases is unlikely to explain all of the increase in awards, but it does appear to be a possible partial explanation.
In short, like many other parts of the medical malpractice controversy, the questions about damages are complex, and at present there are not satisfactory answers to all of these questions.

Some Examples of Injuries from Medical Negligence

Statistics do not tell stories of injuries as well as case examples. I offer some recent examples of jury verdicts from Philadelphia, although I can equally provide other examples from Florida and Illinois. The examples provide graphic illustrations of the sometimes catastrophic injuries suffered by patients as a result of medical negligence.

### Table 1:

**Sample of Claims and Awards in Philadelphia’s Million Dollar Cases**

**Occurring Between July 2003 – December 2004**

<table>
<thead>
<tr>
<th>Case Number</th>
<th>Verdict Date</th>
<th>Injury Claim</th>
<th>Verdict</th>
</tr>
</thead>
<tbody>
<tr>
<td>10400199</td>
<td>9/18/03</td>
<td>In 1984, at 3 weeks old this female had surgery for hip dysplasia and suffered damage to her femoral nerve. At age 19, she suffers permanent physical pain, disability, disfigurement and has had to spend money for hospitalization, medication, treatment and rehabilitation.</td>
<td>$1,000,000</td>
</tr>
<tr>
<td>10301115</td>
<td>9/30/03</td>
<td>Doctor failed to diagnose an intra-cranial tumor in female, resulting in loss of hearing in one ear, resulting in additional surgery, diminution of earning potential, pain and emotional distress; $37,500 to husband for loss of services, companionship.</td>
<td>$1,500,000</td>
</tr>
<tr>
<td>10201487</td>
<td>10/02/03</td>
<td>Female lupus patient with dialysis in severe pain, but doctors failed to conduct tests and gave improper medication and discharged patient who became a quadriplegic plus multiple hospitalizations and future medical costs.</td>
<td>$8,178,350</td>
</tr>
<tr>
<td>10402583</td>
<td>10/28/03</td>
<td>Male, age 19, was in hospital after suicide attempt. Intensive care nurses failed to respond in timely manner to bedside monitor alarm, resulting in severe brain damage. $600,000 in past medical expenses and life care estimated at $6 to $12 million. Punitive damages of $15,000 for nurse altering records.</td>
<td>$10,015,000</td>
</tr>
<tr>
<td>10600976</td>
<td>11/17/03</td>
<td>Male, age 37, with two children, earning $60,000 per year; elective surgery for hearing loss and died almost immediately upon administration of anesthesia.</td>
<td>$2,910,000</td>
</tr>
<tr>
<td>10601622</td>
<td>11/25/03</td>
<td>Female, age 61, examined for gastrointestinal bleeding, but doctors failed to diagnose cancerous tumor until two years later and woman dies.</td>
<td>$1,000,000</td>
</tr>
<tr>
<td>10800103</td>
<td>12/03/03</td>
<td>Female, age 55, claimed failure to diagnose and treat liver disease that resulted in liver cancer. Plaintiff underwent four hospitalizations, had end-stage liver disease at time of trial, and was seeking a liver transplant.</td>
<td>$1,800,000</td>
</tr>
<tr>
<td>10500659</td>
<td>12/23/03</td>
<td>Female, age 48, dies after failure to diagnose and treat adrenal insufficiency over an eight year period despite more than 40 visits to doctor.</td>
<td>$1,000,000</td>
</tr>
<tr>
<td>10702977</td>
<td>1/30/04</td>
<td>Pregnant female, age 34, in auto accident causing injured ankle; surgery performed after birth with bone graft and screws. Claim of lack of informed consent and result of severe, permanent injuries to bones, muscles nerves and blood vessels in right leg with permanent pain, depression, and inability to care for her child plus additional surgeries and nursing care.</td>
<td>$15,000,000</td>
</tr>
<tr>
<td>10300103</td>
<td>2/06/04</td>
<td>Female, age 39, suffering gastrointestinal problems had bowel surgery and surgeon severed her bile duct that could not be repaired, resulting in permanent pain and spasms, gastroparesis, motility and risk of progressive liver disease, possibly needing a liver transplant.</td>
<td>$20,500,000</td>
</tr>
<tr>
<td>98060057</td>
<td>2/11/04</td>
<td>Female, age 30, had corrective surgery to ureter which was accidentally severed and repaired improperly ureter placed on top of bladder instead of side resulting in reflux disorder, chronic kidney infection and will probably require kidney removal.</td>
<td>$9,000,000</td>
</tr>
<tr>
<td>10402642</td>
<td>3/10/04</td>
<td>Female, age 49, claimed that a neurosurgeon inappropriately recommended implantation of a device to treat multiple sclerosis and failed to obtain informed consent. Patient now a paraplegic with loss of bowel and bladder control.</td>
<td>$3,200,000</td>
</tr>
<tr>
<td>Case Number</td>
<td>Verdict Date</td>
<td>Injury Claim</td>
<td>Verdict</td>
</tr>
<tr>
<td>-------------</td>
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<td>------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-----------</td>
</tr>
<tr>
<td>10601566</td>
<td>3/12/04</td>
<td>Male, age 39, with six children had abdominal complaints, but doctor did not order diagnostic tests, which would have shown gastric cancer. Cancer went from stage 1 to stage 2 requiring radiation and chemotherapy. Two-thirds of stomach removed and increased risk of recurring cancer.</td>
<td>$2,800,000</td>
</tr>
<tr>
<td>10902569</td>
<td>3/25/04</td>
<td>Male, age 61, died after a misdiagnosis with regard to a drug interaction between Lopid and Lipitor. Doctors improperly prescribed the medications together and failed to discontinue them when he showed signs of a debilitating muscle condition.</td>
<td>$1,151,028</td>
</tr>
<tr>
<td>10600854</td>
<td>3/25/04</td>
<td>Female had mammogram and doctors failed to detect cancer allowing carcinoma to advance resulting in mastectomy, reconstructive surgeries, chemotherapy, severe pain, and prospect of future medical expenses.</td>
<td>$2,05,000</td>
</tr>
</tbody>
</table>

Cases go to trial because patients and doctors disagree about whether negligence occurred or because they disagree about the values of the damages resulting from the negligent injury. The above sample of cases were ones in which the juries ruled in favor of the plaintiff. Certainly on their face the damage awards seem reasonable, given the degree of injury.

**Outlier Awards Tend Not To Withstand Post-Verdict Adjustments**

Despite the substantial evidence indicating that juries are ordinarily conservative in deciding damages in malpractice cases, there are exceptions resulting in what are commonly labeled “outlier awards.” There are a number of reasons for outlier awards that I have discussed elsewhere and I need not detail here.\(^3^9\) The important point is that research evidence indicates that outlier verdicts seldom withstand post verdict proceedings.

Post-trial reductions have been documented in a number of studies.\(^4^0\) I and two colleagues found that some of the largest malpractice awards in New York ultimately resulted in settlements between five and ten percent of the original jury verdict.\(^4^1\) A study that I conducted on medical malpractice awards in Pennsylvania\(^4^2\) and a study of Texas verdicts\(^4^3\) found similar reductions.

My recent research on medical malpractice verdicts in Illinois found that, on average, final payments to plaintiffs were substantially lower than the jury verdicts.\(^4^4\) This does not mean that the original verdict was too high. Rather, needing money immediately and wanting to avoid a possibly lengthy appeal process the plaintiffs settled for the health providers’ insurance policy limit. Generally speaking, the larger the award, the greater the reduction in the settlement following trial.

**Caps on Pain and Suffering**

Advocates of change in the tort system claim that the jury system is broken. In addition to seeking an alternative court some have advocated for a cap of $250,000 for non-economic damages that presumably includes not only pain and suffering, but also disfigurement and loss of society.\(^4^5\)
The basic assumption for caps is that juries are too generous with their pain and suffering awards. Consequently, it is assumed that in many instances jury awards need to be reduced to some “reasonable” figure.

No one disputes the fact that caps reduce the awards to injured persons. For example, a study of California jury trials occurring between 1995 and 1999 by RAND’s Institute for Civil Justice showed that California’s MICRA cap of $250,000 on non-economic damages reduced awards about 25% in cases involving an injury and over 51% in cases involving death.46

But questions abound regarding the fairness of caps and about their effectiveness in reducing insurance premiums.

The Fairness of Caps

David Studdert et al. examined the effects on injured patients of California’s $250,000 cap on non-economic damages.47 Their findings indicate that reductions under the cap affected the patients with the most severe injuries. Those researchers concluded:

Imposition of greater reductions on more severe injuries may be justified if compensation for this particular group of injuries were especially prone to excess. In fact available evidence suggests the reverse is true: Plaintiffs with the most severe injuries appear to be at the highest risk for inadequate compensation. Hence, the worst-off may suffer a kind of “double jeopardy” under caps.48 (Italics added)

In another study, Lucinda Finley systematically examined jury verdicts in California, Florida and Maryland to determine if caps had a disparate effect on the monetary recoveries of women, and elderly persons.49 She found that to be the case. Finley’s research pointed out that cap laws tend to “place an effective ceiling on recovery for certain types of injuries disproportionately experienced by women, including sexual assault and gynecological injuries that impair child bearing or sexual functioning.” In wrongful death cases women were shown to be disadvantaged in awards they would receive compared to men.

Finley separately analyzed gynecological malpractice cases involving misdiagnosed breast cancer, negligence in prenatal care that caused pregnancy loss, negligent injuries during hysterectomies, and malpractice resulting in infertility. Finley showed that over 70% of women’s awards were for non-economic losses. When men suffered sexual injuries during medical treatment (e.g. partial removal of a bowel and scrotum, leaving a man, age 28, impotent and infertile; a 54 year old male treated for genital warts with undiluted ascetic acid on the scrotum and penis causing severe burns, scarring and severe pain if sexual intercourse was attempted) the pain and suffering awards were similar to those of women with
roughly comparable sexual injuries. However, women are statistically far more likely to suffer such sexual injuries than men. She also pointed out that elderly people, both men and women, tend to be disadvantaged by caps. Finley also observed that because of the reduced likelihood of recovery, plaintiff lawyers are less able to take such cases because the amount that can be recovered under the caps often does not justify litigation expenses.

In 2005, the Wisconsin Supreme Court overturned that state’s $350,000 cap on pain and suffering in medical malpractice cases. The court reasoned that plaintiffs “with the most severe injuries appear to be at the highest risk for inadequate compensation” (italics added). For example, a patient suffering a severe infection for a period of months, but who eventually recovered, could receive $350,000 for pain and suffering in a jury award. In contrast, a patient who was so badly injured that she will suffer excruciating pain the rest of her life would be limited to the same amount. In the Wisconsin Supreme Court’s words, “[t]he cap’s greatest impact falls on the most severely injured persons.”

The plaintiff in the Wisconsin case was a boy who was severely deformed at birth due to medical negligence; he can be expected to live for another 69 years. He was awarded $10,000 per year for pain and suffering. Under the cap, the Supreme Court concluded that amount would be almost halved. The Court further concluded that many cases that would be affected by caps involve children.

In summary, two systematic studies by respected researchers and the Wisconsin Supreme Court arrived at the same conclusion. Caps on pain and suffering have a disproportionate negative impact on the fairness of compensation for persons injured through medical negligence.

Considering California’s MICRA Cap and Fairness

An issue of fairness also arises about California’s MICRA cap of $250,000. The MICRA bill was passed in 1975. In 2005 dollars, that cap was worth $899,281. In short, the MICRA cap at the time it was passed was almost nine-tenths of a million dollars. However, during the past three decades the cap has never been adjusted for inflation. Thus, patients with pain and suffering awards in California have progressively lost ground due to inflation. What the California legislature decided was fair compensation in 1975 has, in real terms, been reduced by 72%. This insight adds to the issue of whether the cap is fair.

The Ineffectiveness of Caps

Research on the effectiveness of caps in reducing medical malpractice premiums lends, at best, equivocal support to the argument that they are effective.
In 2003 a United States Government Accounting Office (GAO) report concluded that there are no data to establish the proposition that damage caps have an effect on the number of malpractice claims, losses by medical insurers, litigation expenses, or the rates charged doctors for insurance.\textsuperscript{51}

In the same year, Weiss Ratings, Inc., a highly respected insurance rating company, also concluded that caps do not have an effect on physicians’ the insurance premiums.\textsuperscript{52} Indeed, Weiss found that in comparison to states without caps, states with caps had greater increases in median annual insurance premiums for practices involving internal medicine, general surgery and obstetrics-gynecology.

An analysis of statistical information for 2003 by the Kaiser Family Foundation, another highly respected organization dedicated to health care, showed that the number of paid claims per 1000 active physicians was unrelated to whether a state had caps on pain and suffering.\textsuperscript{53}

Catherine Sharkey analyzed medical malpractice jury verdicts from 22 states for the years 1992, 1996 and 2001 that were collected by the National Center for State Courts.\textsuperscript{54} Sharkey found no statistically significant relationship between the presence or absence of caps and compensatory damages in jury verdicts and trial court judgments.

I analyzed a sample of Illinois jury verdicts that provided breakdowns of the verdicts into their specific components, including pain and suffering.\textsuperscript{55} My analysis showed that a proposed $500,000 cap on pain and suffering would functionally affect very few cases.

The Wisconsin Supreme Court decision analyzed a substantial body or empirical research bearing on caps with specific reference to the state of Wisconsin.\textsuperscript{56} The Court drew a number of conclusions that included:

“Based on the available evidence from nearly 10 years of experience with caps on non-economic damages in medical malpractice cases in Wisconsin and other states, it is not reasonable to conclude that the $350,000 cap has its intended effect of reducing medical malpractice insurance premiums.”

“The available evidence indicates that health care providers do not decide to practice in a particular state based on the state’s cap on non-economic damages.”

“We agree with those courts that have determined that the correlation between caps on non-economic damages and the reduction of medical malpractice premiums or overall healthcare costs is at best indirect, weak and remote.”

In 2003, GE Medical Protective Company, the nation’s largest medical malpractice insurer, reported to the Texas Department of Insurance as follows:
Non-economic damages are a small percentage of total losses paid. Capping non-economic damages will show loss savings of 1.0%.” 57

The company also said that a provision in Texas law allowing for periodic payments of awards would provide a savings of only 1.1%. Medical Protective eventually raised the rates on its physician policyholders. 58

In California in 2003, despite the cap of $250,000, GE Medical Mutual sought an increase of 29.2% in liability insurance premiums. Thus, the cap did not prevent insurers seeking a major increase in liability insurance rates. 59

Explanations for the Ineffectiveness of Caps

The rationale for caps is predicated on the following two assumptions: (1) juries are irresponsible and excessive in awarding pain and suffering; and (2) the fear of large jury awards for pain and suffering cause doctors and hospitals to settle cases for more than they are actually worth.

The first problem with the caps rationale is that it ignores the fact that most cases with large jury awards are settled for much less than the verdict, often for amounts close to the plaintiff’s economic losses. Functionally, the plaintiff does not typically receive the large award for pain and suffering.

The second problem with the rationale is that it assumes that jury awards directly drive settlements. More than 90% of cases are settled without jury trial, with some estimates indicating that the figure is as high as 97%. In my study of 831 Florida malpractice cases between 1990 and 2003, more than 92% of claims with million-dollar payments were settled without a jury trial. Thirty-seven cases resulted in payments over $5 million. Only two of these cases were decided by a jury. Five of the 831 cases exceeded $10 million dollars, but only one was the result of a jury trial. Of the remaining four cases, one settled in pre-litigation negotiations.

A study of closed claims in Texas from 1966 through 2002 showed that plaintiff verdicts averaged only 3% of paid claims over $10,000. 60 In any year, jury verdicts never accounted for more than 5% of paid claims.

To be sure, the prospect of a jury award is possible if the case is not settled before trial, but if the case does go before a jury, data from many studies show that at trial doctors win between six and eight times out of ten. Defense lawyers and their insurers are aware of these odds because they are repeat players in the litigation process. They also know that when there is a jury award, the case frequently settles for less than the verdict amount. Research on why insurers actually settle cases indicates that the
driving force in most instances is whether the insurance company and their lawyers conclude, on the basis of their own internal review, that the medical provider was negligent.\textsuperscript{61} If they conclude negligence occurred, an attempt is made to settle; the case proceeds to trial only if the plaintiff monetary demand is unreasonable or if there is a strong disagreement over whether liability exists. Payments are typically not made in cases in which the defense concludes there is no liability.

Finally, the rationale for caps ignores problems associated with the insurance business cycle that may be responsible in whole or in part for the costs of liability insurance premiums.

\textbf{Caps and “Defined Payment Schedules”}

The fairness problems of caps as detailed above are endemic in any system that proposes “defined payment schedules” for so-called non-economic damages.\textsuperscript{62} My study of actual medical malpractice cases shows there is a great deal of variation among injured persons. For example, one person with a leg amputation may experience mild or no pain whereas another may experience constant excruciating “phantom pain” for the rest of his or her life.

Even when some leeway is built into compensation schedules, they cannot take into account the number of factors and extreme variability of pain and suffering, physical impairment, mental anguish, loss of society and companionship, and other elements of damages that fall under the rubric of non-economic damages. That is why these matters have been entrusted to juries. They provide justice on an individualized basis.

Moreover, there is another form of fairness problem that involves types of claims. A person injured in an automobile accident will have a full right to have his or her damages decided by a jury. A person with exactly equal injuries resulting from medical negligence will not have this right. What possible rationale can be given for treating medical patients differently?

\textbf{Too much emphasis on Juries! Most Cases Settle before Trial}

In testimony before the Illinois General Assembly in 2005, Lawrence Smarr, President of The Physician Insurers Association of America presented data indication that jury verdicts for plaintiffs constituted only about 3 percent of medical malpractice payments.\textsuperscript{63}

In recent research I and my colleagues have been studying closed medical malpractice claims in the state of Florida.\textsuperscript{64} Florida has required medical liability insurers to file detailed reports of closed medical malpractice claims with the Department of Health since 1975. In this research we centered on
cases closed between 1990 and 2003. A total of 21,809 claims were closed with a payment to the claimant during those fourteen years. We found that 20.2 percent of paid claims were settled without the claimant even resorting to a lawsuit, 6.3 percent of claims were settled in arbitration and 70.8 percent settled before a jury verdict, leaving just 2.7 percent of paid claims that resulted from a jury verdict.65

To pursue this insight further we singled out cases involving a million dollars or more.66 We found that 10.5 percent were settled without a lawsuit and 4.6 percent were settled in arbitration, 77.4 percent were settled before or during trial and only 7.6 percent resulted from a jury verdict. Put in the obverse, more than 92 percent of claims with million dollar payments were settled without a jury. Going further, we found that 37 of the 831 million dollar cases resulted in payments over $5 million. Only two of these cases were settled following a jury trial. Five of the 831 cases exceeded $10 million dollars but only one was the result of a jury trial; of the remaining four cases one was settled in pre-litigation negotiations, and three settled before a trial had commenced.

Perhaps Florida is different than other states. It is hazardous to generalize because each state has its own unique set of laws and legal culture. Nevertheless, it is interesting to observe that data from North Carolina seems roughly consistent with the Florida findings. I compared Carolina data on verdicts and settlements.67 The data tended to show some interesting patterns. As early as the first part of the 1990s decade there were verdicts and settlements exceeding $1 million. Over the period from 1990 through 2002, the number of million-dollar-plus settlements exceeded the number of million-dollar-plus jury verdicts by a factor of over three to one. The average amounts of $1 million plus settlements were comparable to the jury awards. A statistical test on the data indicated that the distributions and the magnitudes of payments for jury verdicts and non-jury settlements were not statistically different from one another. In short, the North Carolina findings also indicated that most of the payments exceeding a million dollars involved settlements rather than jury trial.

These findings have a major implication. Whether we are talking all cases or just million dollar cases the process by which claims are paid in Florida (and, it appears, also in North Carolina) involves the negotiation table, not the jury room. In Florida settlements exceed jury trials by a factor of more than nine to one for million dollar cases.

A Look at Florida Million Dollar Settlements without Lawsuits

Our Florida research on million dollar cases allow further insights into the losses incurred in medical negligence cases. Recall again that in these cases the health providers did not contest liability, and settled to avoid the expenses of a lawsuit they were almost sure to lose. Through 1998 the Florida
closed claim files contained information on “structured settlements.” The details of these cases provide insights about the nature of the injury, the long term costs and about the collateral losses such as children left without the services of a parent.68

Table 2
Year, Case Name, Injury and Details of Settlement

<table>
<thead>
<tr>
<th>Settle Year</th>
<th>Case</th>
<th>Sex</th>
<th>Age</th>
<th>Injury</th>
<th>Settlement Description</th>
<th>Structured Settlement Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1991</td>
<td>BMH</td>
<td>M</td>
<td>0</td>
<td>Spastic quad; cerebral palsy</td>
<td>$1,887,044</td>
<td>$1 million cash plus $887,044 annuity yielding an expected total payment to child of $13,855,826</td>
</tr>
<tr>
<td>1992</td>
<td>WCD</td>
<td>M</td>
<td>1</td>
<td>Severe brain damage, blind, deaf, immobile</td>
<td>$1,000,000</td>
<td>$640,000 cash plus $540,000 annuity yielding $2,557/month for child plaintiff.</td>
</tr>
<tr>
<td>1992</td>
<td>UMS</td>
<td>F</td>
<td>0</td>
<td>Severe mental, emotional impairment</td>
<td>$3,000,000</td>
<td>No details except an estimate that the annuity would yield $5,914,774</td>
</tr>
<tr>
<td>1993</td>
<td>CRH</td>
<td>F</td>
<td>2</td>
<td>Severe cerebral palsy secondary to hypoxia</td>
<td>$6,000,000</td>
<td>$4,922,115 cash; plus $1,077,885 present value for structured trust expected to yield $3,179,273 (Note medical expenses incurred to date of settlement = $989,164)</td>
</tr>
<tr>
<td>1993</td>
<td>TOP</td>
<td>M</td>
<td>43</td>
<td>Renal cell carcinoma</td>
<td>$2,000,000</td>
<td>$1,389,542 cash plus $610,459 for structured settlement for 3 surviving minor children</td>
</tr>
<tr>
<td>1993</td>
<td>AHP</td>
<td>F</td>
<td>0</td>
<td>Paraplegia</td>
<td>$3,750,000</td>
<td>$2,300,000 plus $1,450,000 present value for annuity</td>
</tr>
<tr>
<td>1994</td>
<td>AR</td>
<td>M</td>
<td>0</td>
<td>Profound brain damage</td>
<td>$1,000,000</td>
<td>$440,178 cash plus $559,822 annuity yielding a total of $2,912,000</td>
</tr>
<tr>
<td>1994</td>
<td>GBP</td>
<td>F</td>
<td>39</td>
<td>Vegetative state, non-reversible</td>
<td>$3,000,000</td>
<td>$1,500,000 cash plus $1,500,000 annuity expected to yield an expected payment to the plaintiff of $7,883,183 for plaintiff and four minor dependents.</td>
</tr>
<tr>
<td>1995</td>
<td>FHH</td>
<td>M</td>
<td>25</td>
<td>Spinal cord injury</td>
<td>$2,647,612</td>
<td>$1,156,000 cash plus $1,491,000 for structured annuity expected to yield $5,291,937.</td>
</tr>
<tr>
<td>1995</td>
<td>CHM</td>
<td>M</td>
<td>0</td>
<td>Canavan's Disease (degenerative disorder of central nervous system)</td>
<td>$2,383,900</td>
<td>$1,092,209 cash plus $1,291,691 for annuity yielding lump sum payments at five and ten years totaling $2,000,000</td>
</tr>
<tr>
<td>1995</td>
<td>HBM</td>
<td>F</td>
<td>32</td>
<td>Coma</td>
<td>$7,250,000</td>
<td>Cash and annuity cost unknown but annuity estimated to yield $16,129,528</td>
</tr>
<tr>
<td>1996</td>
<td>RGC</td>
<td>UK</td>
<td>UK</td>
<td>Death</td>
<td>$1,500,000</td>
<td>$1,429,808 cash plus $70,192 for annuity yielding total payment to plaintiff's family of $1,422,239</td>
</tr>
<tr>
<td>1996</td>
<td>CPC</td>
<td>M</td>
<td>0</td>
<td>Required resuscitation; neurological damage</td>
<td>$2,500,000</td>
<td>$1,187,940 cash plus $1,312,060 for annuity, yielding $3,307,824 for the child</td>
</tr>
<tr>
<td>1996</td>
<td>ORH</td>
<td>F</td>
<td>0</td>
<td>Brain damage</td>
<td>$7,300,000</td>
<td>$5,100,000 cash paid on behalf of four defendants plus $2,200,000 for an annuity. Total yield of annuity unknown.</td>
</tr>
<tr>
<td>1996</td>
<td>GMI</td>
<td>F</td>
<td>0</td>
<td>Severe brain damage</td>
<td>$6,379,322</td>
<td>$5,529,332 cash plus $850,000 annuity yielding $8,066/mo for life of the child.</td>
</tr>
<tr>
<td>1996</td>
<td>DCN</td>
<td>M</td>
<td>0</td>
<td>Cerebral palsy</td>
<td>$3,000,000</td>
<td>$2,600,000 cash plus $800,000 annuity expected to yield $13,783,483 over the child's life.</td>
</tr>
<tr>
<td>1996</td>
<td>CKR</td>
<td>F</td>
<td>30</td>
<td>Brain herniation</td>
<td>$3,000,000</td>
<td>$1,800,000 cash plus $1,200,000 from three insurance carriers for an annuity expected to yield total of $7,816,824</td>
</tr>
<tr>
<td>1996</td>
<td>FHA</td>
<td>M</td>
<td>0</td>
<td>Cerebral vasculitis and bilateral thalamic infarcts</td>
<td>$6,500,000</td>
<td>$4,500,359 cash plus $1,999,641 for an annuity yielding $7,855/mo for life plus periodic cash payments graduating from $50,000/yr to balloon at $25,000 per annum &gt; $250,000.</td>
</tr>
<tr>
<td>1997</td>
<td>SVC</td>
<td>M</td>
<td>52</td>
<td>Brain damage</td>
<td>$1,000,000</td>
<td>$582,935 cash plus $417,065 for annuity, yielding expected total of $1,572,935.</td>
</tr>
<tr>
<td>1997</td>
<td>HCP</td>
<td>M</td>
<td>49</td>
<td>Death</td>
<td>$5,000,000</td>
<td>$4,000,000 cash plus $1,000,000 annuity yielding projected $3,976,503 for decedent's minor daughter.</td>
</tr>
<tr>
<td>1997</td>
<td>KCM</td>
<td>F</td>
<td>37</td>
<td>Paraplegia and cauda equina syndrome (spinal cord ends)</td>
<td>$3,520,160</td>
<td>$1,845,160 cash plus $1,675,000 to two annuity companies yielding an expected total of $8,157,597.</td>
</tr>
<tr>
<td>1998</td>
<td>GIL</td>
<td>F</td>
<td>52</td>
<td>Paraplegia</td>
<td>$1,000,000</td>
<td>$500,000 cash plus $500,000 annuity starting at $2,500 per month and then adjusted for inflation.</td>
</tr>
<tr>
<td>Settle Year</td>
<td>Case</td>
<td>Sex</td>
<td>Age</td>
<td>Injury</td>
<td>Settlement</td>
<td>Structured</td>
</tr>
<tr>
<td>-------------</td>
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<td>-----</td>
<td>----------------------------------------------------------------------</td>
<td>----------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>1998</td>
<td>COR</td>
<td>M</td>
<td>56</td>
<td>Death</td>
<td>1,000,000</td>
<td>Payout of approximately $2,000 per month over 35 years.</td>
</tr>
<tr>
<td>1997</td>
<td>LMG</td>
<td>M</td>
<td>39</td>
<td>Death</td>
<td>$1,250,000</td>
<td>$553,359.60 cash plus annuities purchased at $354,4560, $111,048.20 and 111,048.20 yielding at total of $1,129,9120</td>
</tr>
<tr>
<td>1998</td>
<td>UM</td>
<td>F</td>
<td>56</td>
<td>Right ankle, left below knee amputation.</td>
<td>$1,625,000</td>
<td>$700,000 cash and annuity providing $4000 per month for 5 years and $1000 per month for 7 years.</td>
</tr>
<tr>
<td>1998</td>
<td>GSHI</td>
<td>M</td>
<td>62</td>
<td>Quadriplegiasis, neurogenic bladder.</td>
<td>$1,449,032</td>
<td>$675,000 cash and annuity providing $9750 per month for 5 years or life.</td>
</tr>
<tr>
<td>1998</td>
<td>UCH</td>
<td>M</td>
<td>2</td>
<td>Profound brain damage</td>
<td>$5,000,000</td>
<td>$2500 per month, increase 3% per year. 20 years guaranteed, plus life.</td>
</tr>
<tr>
<td>1997</td>
<td>CKMC</td>
<td>F</td>
<td>37</td>
<td>Paraplegia and cauda equina syndrome (spinal cord ends)</td>
<td>$3,520,000</td>
<td>Cash payment of $1,845,160 and two annuities purchased with present value of $1,675,000; total payments estimated at $8,157,597</td>
</tr>
<tr>
<td>1999</td>
<td>SPGH</td>
<td>F</td>
<td>0</td>
<td>Severe cognitive delays, requires occupational therapy, physical therapy, speech therapy.</td>
<td>$5,500,000</td>
<td>Total annuities yielding $12,754.31 per month.</td>
</tr>
<tr>
<td>1999</td>
<td>PRMC</td>
<td>F</td>
<td>21</td>
<td>Death</td>
<td>$2,250,000</td>
<td>Cash of $1,809,709 plus annuity for surviving child purchased at $440,291.</td>
</tr>
<tr>
<td>1999</td>
<td>PRMC</td>
<td>F</td>
<td>1</td>
<td>Hemorrhagic periventricular leukomalacia, hypoxic ischemic injury resulting in motor development delay, cognitive defects.</td>
<td>$3,300,000</td>
<td>Cash of $907,829 plus annuity purchased for $2,392,171 for life care of child.</td>
</tr>
</tbody>
</table>

In some instances the estimated payments were staggering, reflecting medical costs to the patient, income losses, and/or financial support for surviving minor children. Case BMH (1991) was estimated at over $13 million; Case GBP (1994) was estimated at almost $9 million; case DCH (1996) was estimated at almost $14 million. In case CKR (1996), which the insurer rated only a 7 in level of injury seriousness, the estimated cost was almost $8 million, suggesting that the medical injury was more serious than reported, that the claimant had a large income loss or a combination of both of these factors. Case HBM (1995) was estimated at over $16 million; and Case KCM (1997) was estimated at over $8 million.

There is one additional matter to consider about these data. We compared these non-lawsuit settlements with the final settlements of cases that were settled following a jury verdict. The verdict settlements were comparable to the cases in which negligence was conceded. These data provide further confirmation that the ultimate outcome of jury verdicts tends to reflect actual losses incurred by severely injured patients.

**The Shadow Effect of Jury Trials is Misleading**

Was it a fear of large jury awards—the “shadow effect”- that caused defendants to settle? Alternatively, was the negligence and severity of loss so clear in most of the cases that it made no sense to go to trial because defendants’ liability insurers would incur heavy litigation costs in the face of a likely win for the patient? Without question the threat of a jury trial is what forces parties to settle cases. The
presence of the jury as an ultimate arbiter provides the incentive to settle but the effects are more subtle than just negotiating around a figure. The threat causes defense lawyers and the liability insurers to focus on the acts that led to the claims of negligence.

Research by Peeples et al. on a sample of insurers’ medical malpractice files indicated that insurers tend to settle cases primarily based on whether their own internal reviews by medical experts indicate the provider violated the standard of care. If they decide the standard has been violated they attempt to settle. Those authors concluded that claims proceed to trial only when the plaintiff cannot be convinced that there was no violation of the standard and cannot extract a reasonable offer from the insurer. An earlier study by Rosenblatt and Hurst examined 54 obstetric malpractice claims for negligence. For cases in which settlement payments were made there was general consensus among insurance company staff, medical experts and defense attorneys that some lapse in the standard of care had occurred. No payments were made in the cases in which these various reviewers decided there was no lapse in the standard of care.

I used some of the same closed claim files from medical insurers in my book, Medical Malpractice and the American Jury. I reached a similar conclusion.

At the very least the findings strongly suggest that all of the emphasis on jury verdicts appears misplaced.

Rising Claims and Rising Costs: A Complicated Issue

The Florida data also allow us address the question of whether the frequency of malpractice claims have been rising and whether simultaneously so have the costs of payouts. We found that the number of claims involving payments to the claimant had increased between 1990 and 2003. However, Florida’s population also increased at the same time as did the number of licensed physicians. When we adjusted for population growth, the number of paid claims per 100,000 residents in 2003 was no higher than in 1990. Similarly, we found the paid claims per 100 licensed physicians also were no higher. This would seem to support consumer groups who say there has been no increase.

Doctors and insurers say that the number of claims began to rise steeply around the year 2000 and continued through 2003. Claims with no payment also incur transaction costs to defend. It is noteworthy, that data collected by the National Center for State Courts on a national sample of cases showed that while there was an overall decline in medical malpractice case filings between 1992 and 2001, filings did rise in 2002.
Our Florida closed claims data also revealed that between 1990 and 2003 the inflation adjusted cost of the average paid claim showed a modest upward increase over the fourteen-year period. Part of the explanation might be that medical costs, which have increased at rates greater than the Consumer Price Index, are the cause. But there are other explanations. Our data also showed that on average the paid claims, beginning in 2002, included a greater proportion of serious injuries, including death.

Frivolous Litigation

Claims about frivolous litigation are based, in part, on findings that in medical malpractice cases doctors prevail in approximately 70 percent of cases that go to trial and that as many as 50 percent of cases filed against health care providers ultimately result in no payment to the plaintiff. Additionally, opponents of medical malpractice litigation argue that jury verdicts, especially those involving larger awards, encourage lawyers to file lawsuits in cases that are not meritorious because doctors and liability insurers will settle claims, not out of merit, but rather out of fear of a large and unjustified award if the case goes before a jury. These claims are not supported by research evidence.

Liability Insurers Tend to Not Settle Frivolous Cases

In interviews with liability insurers that I undertook in North Carolina and other states, the most consistent theme from them was: “We do not settle frivolous cases!” The insurers indicated that there are minor exceptions, but their policy on frivolous cases was based on the belief that if they ever begin to settle cases just to make them go away, their credibility will be destroyed and this will encourage more litigation.

Cases Dropped by Claimants before Trial Are Not Necessarily Frivolous

In Medical Malpractice and the American Jury, I reported that despite up-front screening by plaintiff lawyers, there is still a lot of uncertainty about whether negligence has occurred. This can usually only be determined after a lawsuit is filed, depositions are taken and expert opinions are obtained. As documented in that book, research into the files of liability insurers showed that this is as true of the defense side as it is of the plaintiff side: lawyers for the defendants and their insurers get conflicting opinions as to whether negligence has occurred. Sometimes, after an extensive process of consulting with experts and the taking of depositions, it becomes reasonably apparent that no legal negligence has occurred, or that, in any event, the case is “not winnable” because of the costs that would be entailed in pursuing it. At this juncture plaintiff lawyers tend to drop the case. In North Carolina nearly 40 percent of filed cases were dropped on these grounds. Again, the point to be made is that it makes little economic sense for a plaintiff lawyer to continue to invest time and money in a case that he or she is unlikely to
win. It is true that occasionally lawyers misjudge the merits of cases and continue to pursue them, but far more often they are dropped.

Thus, given the fact that both plaintiff and defendant are faced with uncertainty, it is inappropriate to call the vast majority of dropped cases “frivolous.” Rather, they should be labeled “non-meritorious” cases in recognition of the fact that both sides took them very seriously at the beginning of the lawsuit.

**Doctor’s High “Win Rates” at Trial Do Not Mean the Lawsuit Was Frivolous**

As I discussed earlier, statistics indicate that, nationwide, doctors prevail in about 70 percent of cases that go to trial.

Nevertheless, a plaintiff loss at trial is not grounds for concluding that the litigation was “frivolous.”76 Cases that go to trial are ones where negligence is uncertain. As discussed above, when pretrial investigation shows that the case is clearly not winnable, lawsuits tend to be dropped before trial. On the other hand cases with clear negligence tend to be settled, particularly if the parties can negotiate the amount of damages. Thus, only “close cases” tend to go to trial.

There are a number of possible explanations, other than non-merit, as to why doctor win rates at trial are so high.77 One reason is that jurors generally tend to be skeptical of plaintiff claims and essentially place a burden on the plaintiff that is greater than the legally appropriate “balance of probabilities” standard. Another is that plaintiffs often have a more difficult time obtaining and hiring the experts, relative to the defense. It is also important to observe that my research showed that in many instances, plaintiffs who lost at trial against one doctor nevertheless obtained settlements from other doctors who had been named in the lawsuit.78 This might suggest that medical negligence had occurred in the case, albeit at trial the jury did not think that the evidence against the remaining defendant or defendants was sufficient to find liability. On the other hand it is certainly possible that despite insurers’ insistence that they do not make settlements for non-meritorious claims, in some instances they may decide that a modest and confidential settlement payment avoids bad publicity for the doctor and saves expensive litigation costs. Such decision could explain why some doctors settle.79

**Claims about Increasing Litigation Costs**

Insurers have made claims about increasing litigation costs and blamed them on frivolous litigation.80 However, there are two studies that have provided data on these transaction costs.
The Florida closed claim files that we examined in our research also contained insurers’ reports on their litigation expenses. The data on no-payment claims were reliable only for the years 1990 through 1997. The mean, or average, litigation expense, adjusted to 2003 dollars, was $22,205 per claim. It is again important to reemphasize my findings that non-paid claims should not necessarily be characterized as frivolous. Many unfounded claims begin as credible claims in both the eyes of the plaintiff and the defendant. It is only after sometimes lengthy periods of depositions of experts and other investigation that the evidence indicates that it is unlikely that negligence occurred. To be sure these are unfortunate transaction costs to insurers—as well as plaintiff lawyers.

Our research also examined insurers’ litigation costs for pain claims over a 14-year period covering 1990 through 2003. The litigation costs for these claims in the years 2000 through 2003, when adjusted for inflation were not statistically greater than a comparable period a decade earlier (1990-1993).

Research by Bernard Black and his co-authors on closed claim files from Texas showed that defense costs per each large claim that was paid rose steadily from 1988 through 2002. The ratio of defense costs relative to payout increased from about 8 percent to about 15 percent. However, the data showed that defense costs rose gradually, and the absolute size of these costs remained small relative to payouts.

Litigation costs may vary from state to state depending on a number of factors. Nevertheless two independent studies using data supplied by insurers to the states of Florida and Texas do not support extreme claims of rising litigation costs.

“Judicial Hellholes:” The Doctor Exodus Claim

The American Medical Association has identified a number of “crisis states” in which it is alleged that because of the “abusive litigation” climate doctors were leaving certain areas or certain states. One of those areas involved Madison and St. Clare counties in Illinois. Indeed President Bush traveled to those counties in January 2005 after being informed that these were two counties in deep trouble because of medical malpractice litigation. Reports of the number of doctors leaving those counties as reported in the Wall Street Journal and other sources ranged as high as 180 doctors. That figure would amount to more than twenty-six percent of the total doctors in those counties. I checked those claims by using official American Medical Association statistics reported in its annual publications of Physician Statistics and Distribution in the U.S.
I considered only doctors described as “treating non-federal physicians,” thus centering only on the doctors whose liability insurance rates would be affected by the alleged crisis. Contrary to the wild assertions, these statistics showed a steady increase in the number of doctors in the combined from 1994 through 2003. In comparison to 2000 the number of physicians increased by four percent in 2003.

Similar claims were made for the whole state of Illinois particularly with respect to Cook and Du Page counties. When I checked the AMA statistics I again found steady increases in the number of doctors, both in absolute numbers and in relation to Illinois’ population growth. Because obstetrician-gynecologists and neurosurgeons are alleged to be two groups most affected in the alleged exodus, I found that their numbers, relative to Illinois’ population had remained relatively steady since 1994.

Pennsylvania is another state alleged to be experiencing a doctor exodus. A media release by the Pennsylvania Medical Society claimed that a survey: “...discovered one in four Pennsylvanians lost their doctors due to the rising costs of liability insurance. According to the poll, 26 percent said they saw their doctors move, give up certain procedures, or stop practicing medicine as liability insurance costs skyrocketed.”

Once again I went to the official American Medical Association statistics. Similar to Illinois I found that the number of patient care physicians increased at an average annual rate of about 1 percent per year in proportion to the population. The number of obstetricians declined slightly, but so had Pennsylvania’s birth rates, strongly suggesting that the drop may have been a result of fewer needs for this medical specialty. There was a slight decline in the number of neurosurgeons but Pennsylvania still had more neurosurgeons per capita than the rest of the nation.

In short the doctor exodus claims received no support in studies of the American Medical Associations own statistics.

Health Care Courts: Be Careful for What You Wish For!

Finally, I wish to offer a brief commentary on proposed the Special Health Care Courts. Consumer Interest groups, such as the Center for Justice and Democracy, have raised serious criticism about such health courts. They argue that the proposed courts deprive citizens of the constitutional right to jury trial because they provide no right to appeal the court’s decision. They also argue that the probable schedule of payments to injured persons is likely to ignore the unique circumstances of losses of claimants. They further argue that the courts, the experts likely to be appointed by the courts and they amounts of payments under the schedules are likely not consider the factual circumstances. Additionally, they identify the danger that those courts, as
proposed, are very likely to be subject to many political pressures that could affect the rights of persons injured through medical negligence. I agree with those criticisms!

However, I wish to add an additional problem. The Health Court proposal assumes that cases can be handled more efficiently than the current tort system. To be sure there are inefficiencies in the tort system. However, those inefficiencies have to be weighed against inefficiencies that will be endemic to health courts as well. As I have pointed out in my discussion of so-called frivolous litigation in my testimony today and in my book, *Medical Malpractice and the American Jury*, medical malpractice cases involve complex issues that can only be sorted out after considerable investigation and discovery. When patients make claims of negligence the process of discovering whether negligence occurred requires investigating medical records, interviewing the involved parties (through sworn depositions), finding experts, sorting out conflicts between the opinions of experts, reinvestigating the records and testimony as new insights are uncovered and then reaching some kind of consensus, if possible, about what actually occurred and whether those facts meet the definition of legal negligence. This process takes considerable time as well as money. For complex cases the process of finding competent experts and getting them to review cases under their busy, over-booked schedules means that cases cannot be resolved in weeks, indeed even in months. Sometimes it takes years. Any competent defense or plaintiff lawyer who works in this area will confirm my assertions. To be fair to both sides, health courts will have to do the same thing. Health courts will also have to bear these transaction costs.

As I have pointed out in my testimony today, under the current tort system many of these investigative costs are borne now by plaintiff lawyers. They screen cases and eliminate many cases before legal claims are made. Under a Health Court System, if those claims are to be fairly adjudicated, most of the costs will be borne by the health courts and the American taxpayers who underwrite the costs of those courts.

**Conclusion**

I will not reiterate the many points I have made in my testimony. The bottom line is that most of the claims made about juries and the tort system do not stand up to empirical scrutiny.

Finally, I want to close with a statement that I am strongly in favor of measures that improve the quality of health care. I am strongly in favor of voluntary measures such as the Medical Error Disclosure Program at the University of Michigan. Such programs should be voluntary on the part of patients and they should retain the right to trial by jury.
Endnotes

1 David M. Studdert et al., Claims Errors, and Compensation Payments in Medical Malpractice Litigation, 354 NEW ENGLAND JOURNAL OF MEDICINE 2024 (May 11, 2006).
2 Id. at 2031.
5 Hillary Clinton and Barak Obama, Making Patient Safety the Centerpiece of Medical Liability Reform, 354 NEW ENGLAND JOURNAL OF MEDICINE 2205 (2006).
7 Id. at 44, Table 3.2.
8 Eric J. Thomas et al., Incidence and Types of Adverse Events and Negligent Care in Utah and Colorado, 38 MEDICAL CARE 261, 261 (2000).
14 For criticism of the Harvard study or controversy over some of the findings, see Rodney A. Hayward and Timothy P. Hofer, Estimating Hospital Deaths Due to Medical Errors, 286 JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION 415 (2001); Clement J. McDonald et al., Deaths Due to Medical Error Are Exaggerated, in Institute of Medicine Report, 284 JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION 93 (2000).
15 Frank A. Sloan and Stephen S. VanWert, Cost of Injuries, in Frank A. Sloan et al., SUING FOR MEDICAL MALPRACTICE 123, 139-40 (1993).

19 Michael Saks, Medical Malpractice: Facing Real Problems and Finding Real Solutions, 35 William & Mary Law Review 693, 702, 703 (1994), presents one of the clearest expositions of these findings. In further calculations, Saks points out that the probability of a health care provider being sued for a negligent injury is 0.029 whereas the probability of being sued for a non-negligent injury is 0.0013.  


21 Id. at 430.  


26 For a review of this research, see Hans, BUSINESS ON TRIAL; Neil Vidmar, Empirical Evidence on the Deep Pockets Hypothesis: Jury Awards for Pain and Suffering in Medical Malpractice Cases, 43 Duke L.J. 217 (1993).  


29

See Catherine Sharkey, _Unintended Consequences of Medical Malpractice Damages Caps_, 80 NEW YORK UNIVERSITY LAW REVIEW 391 (2005).

See Neil Vidmar, _Medical Malpractice Lawsuits: An Essay on Patient Interests, The Contingency Fee System, Juries and Social Policy_, 38 LOYOLA OF LOS ANGELES LAW REVIEW 1217 (2005). There are four processes by which awards are reduced. The judge reduces the award verdict through remittitur. An appeals court reduces the award. Sometimes the sides agree that there was negligence, but disagree about the amount of damages and set a high-low agreement prior to trial or during trial: they agree that if the jury verdict is above a certain limit, the plaintiff will only get the high limit and if it is below the bottom limit or even if the defendant prevails at trial, the plaintiff will receive the minimum payment. Most common of all, the plaintiff and the defendant negotiate a post-trial settlement that is less than the jury verdict, often for the amount of the doctor’s liability coverage.


_Id._ at 61.


The Kaiser data for individual states can be found at http://www.statehealthfacts.org/rm/medicalpractice.cfm.

Catherine Sharkey, Unintended Consequences of Medical Malpractice Damages Caps, 80 NEW YORK UNIVERSITY LAW REVIEW 391 (2005).


Ferdon v. Wisconsin Patient Compensation Fund et al., Case 2003 AP 988 (2005 WI 125), at paragraphs 129, 166 and 175.


Id.


Lawrence E. Smarr, Testimony before the Illinois General Assembly, House Judiciary—Civil Law Committee Hearing, April 7, 2005 at http://www.ihatoday.org/issues/liability/talk/smarttest.pdf. This interpretation of Smarr's data is taken from Exhibit B of his testimony. The exhibit shows that paid claims constituted 25.2% of all claims and that plaintiff verdicts constituted .8% of this total.


Trial rates for medical malpractice cases usually range between 7 and 10 percent of lawsuits. These include cases in which defendants prevail, approximately seven or eight trials in ten, see Vidmar, supra note 2 at 39. The data reported here do not include plaintiff verdicts at trial but they do include cases that never became lawsuits. In short our data are using a different numerator and different denominator than previous studies.

The payments were adjusted for inflation so that we could compare earlier cases with later cases.

Testimony of Neil Vidmar before the North Carolina House Blue Ribbon Task Force on Medical Malpractice, Raleigh, NC, January 7, 2004. The same data have been used by the North Carolina Trial Lawyers Association and by Medical Mutual of North Carolina, a doctor-owned liability insurer.


Peeples et al., The Process of Managing Medical Malpractice Cases: The Role of Standard of Care, 37 WAKE FOREST LAW REVIEW 877 (2002),


Id. Frank Sloan et al., Suing for Medical Malpractice (1993) at 164-185 reports systematic data that are consistent with my conclusions.


Id.

Id. at 33-34.

Many doctors want to avoid the publicity, the emotional pressures and the time from her practice that a trial would entail. However, in other cases the doctor may insist on going to trial to clear her reputation, Id.


Id. at 252.


Id.


Center for Justice and Democracy, Why Health Courts are Unconstitutional, Pace Law Review (in press).