

Testimony

of

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before

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Hearing on

Medical Liability:

New Ideas for Making the System Work Better for Patients

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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 have continued to conduct research on that subject and have published the following articles and reports since that book was published: Vidmar, N., Gross, F., & Rose, M. *Jury Awards for Medical Malpractice and Post-verdict Adjustment of Those Awards*. 48 DEPAUL LAW REVIEW 265 (1998); Vidmar N. and Brown, Leigh Ann, *Tort Reform and the Medical Liability Insurance Crisis in Mississippi: Diagnosing the Disease and Prescribing a Remedy* 22 MISSISSIPPI COLLEGE LAW REVIEW 9-46 (2002); Neil Vidmar, JURIES AND JURY VERDICTS IN MEDICAL MALPRACTICE CASES: IMPLICATIONS FOR TORT REFORM IN PENNSYLVANIA , January 28, 2002; Vidmar, (Book Review) *First, Do No Harm: The Cure for Medical Malpractice*, 352 THE NEW ENGLAND JOURNAL OF MEDICINE 521 (2/3/2005); Vidmar, Lee, MacKillop , McCarthy and McGwinn, *Uncovering the "Invisible" Profile of Medical Malpractice Litigation: Insights from Florida*, 54 DEPAUL LAW REVIEW 315 (2005); Vidmar, *Medical Malpractice Lawsuits: An Essay on Patient Interests, the Contingency Fee System, Juries and Social Policy*, 38 LOYOLA LOS ANGELES LAW REVIEW 1217 (2005); Vidmar, MEDICAL MALPRACTICE AND THE TORT SYSTEM IN ILLINOIS: A REPORT TO THE ILLINOIS BAR ASSOCIATION, May 2005; Vidmar, *Medical Malpractice and the Tort System in Illinois*, 93 ILLINOIS BAR JOURNAL 340 (2005); Vidmar, MacKillop and Lee, *Million Dollar Malpractice Cases in Florida: Post-verdict and Pre-suit Settlements*, VANDERBILT LAW REVIEW (in press, 2006); Vidmar and MacKillop, "*Judicial Hellholes:*" *Medical Malpractice Claims, Verdicts and The "Doctor Exodus" in Illinois*, VANDERBILT LAW REVIEW (in press, 2006); Vidmar. *Medical Malpractice Litigation and Tort Reform in Pennsylvania: A Report for the Pennsylvania Bar Association*, May 2006.

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.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.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.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), 109th 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 Health⁴ 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*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.⁶ 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.⁷ Subsequent research involving Utah and Colorado found rates of negligent adverse events that were similar to the New York findings.⁸

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.⁹ 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.¹⁰

In 2000, the Institute of Medicine produced a report that relied on these studies and other data.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 2002.¹² 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.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.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.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.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 conducted¹⁷ 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.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.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.²⁰ 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.²¹

Research by Herbert Kritzer examined the decisions of plaintiff lawyers to take or decline cases.²² 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 “*remittitur*.” 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.²³ 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 Carolina jurors who decided medical malpractice cases showed that jurors viewed the plaintiffs' claims with great skepticism.²⁴ 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.²⁵ 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.²⁶

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.²⁷ 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.²⁸

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.²⁹ 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.³⁰ 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.³¹ 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.³² 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.³³ 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.³⁴ 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 1992.³⁵ 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 2003.³⁶ 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."³⁷

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.³⁸ 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.

**Table1:
Sample of Claims and Awards in Philadelphia’s Million Dollar Cases
Occurring Between July 2003 – December 2004**

Case Number	Verdict Date	Injury Claim	Verdict
10400199	9/18/03	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.	\$1,000,000
10301115	9/30/03	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.	\$1,500,000
10201487	10/02/03	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.	\$8,178,350
10402583	10/28/03	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.	\$10,015,000
10600976	11/17/03	Male, age 37, with two children, earning \$60,000 per year; elective surgery for hearing loss and died almost immediately upon administration of anesthesia.	\$2,910,000
10601622	11/25/03	Female, age 61, examined for gastrointestinal bleeding, but doctors failed to diagnose cancerous tumor until two years later and woman dies.	\$1,000,000
10800103	12/03/03	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.	\$1,800,000
10500659	12/23/03	Female, age 48, dies after failure to diagnose and treat adrenal insufficiency over an eight year period despite more than 40 visits to doctor.	\$1,000,000
10702977	1/30/04	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.	\$15,000,000
10300103	2/06/04	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.	\$20,500,000
98060057	2/11/04	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.	\$9,000,000
10402642	3/10/04	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.	\$3,200,000

Case Number	Verdict Date	Injury Claim	Verdict
10601566	3/12/04	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.	\$2,800,000
10902569	3/25/04	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.	\$1,151,028
10600854	3/25/04	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.	\$2,05,000

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.³⁹ 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.⁴⁰ 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.⁴¹ A study that I conducted on medical malpractice awards in Pennsylvania⁴² and a study of Texas verdicts⁴³ 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.⁴⁴ 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.⁴⁵

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 ascertic 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.⁵⁰ 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.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.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.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.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.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 of empirical research bearing on caps with specific reference to the state of Wisconsin.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.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.

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.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?

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.⁶³

In recent research I and my colleagues have been studying closed medical malpractice claims in the state of Florida.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

Settle Year	Case	Sex	Age	Injury	Settlement	Structured
1991	BMH	M	0	Spastic quad; cerebral palsy/riplegia	\$1,887,044	\$1 million cash plus \$887,044 annuity yielding an expected total payment to child of \$13,855,826
1992	WCD	M	1	Severe brain damage, blind, deaf, immobile	\$1,000,000	\$640,000 cash plus \$540,000 annuity yielding \$2,557/month for child plaintiff.
1992	UMS	F	0	Severe mental, emotional impairment	\$3,000,000	No details except an estimate that the annuity would yield \$5,914,774
1993	CRH	F	2	Severe cerebral palsy secondary to hypoxia	\$6,000,000	\$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 the settlement = \$989,164)
1993	TGP	M	43	Renal cell carcinoma	\$2,000,000	\$1,389,542 cash plus \$610,459 for structured settlement for 3 surviving minor children
1993	AHP	F	0	paraplegia	\$3,750,000	\$2,300,000 plus \$1,450,000 present value for annuity
1994	AR	M	0	Profound brain damage	\$1,000,000	\$440,178 cash plus \$559,822 annuity yielding a total of \$2,912,000
1994	GBP	F	39	Vegetative state, non-reversible	\$3,000,000	\$1,500,000 cash plus \$1,500,000 annuity expected to yield an expected payment to the plaintiff of \$8,783,183 for plaintiff and four minor dependants.
1995	FHH	M	25	spinal cord injury	\$2,647,617	\$1,156,000 cash plus \$1,491,000 for structured annuity expected to yield \$5,291,937.
1995	CHM	M	0	Canavan's Disease (degenerative disorder of central nervous system)	\$2,383,900	\$1,092,209 cash + \$1,291,691 for annuity yielding lump sum payments at five and ten years totalling \$2,000,000
1995	HBM	F	32	Coma	\$7,250,000	Cash and annuity cost unknown but annuity estimated to yield \$16,129,528
1996	RLC	UK	UK	Death	\$1,500,000	\$1,429,808 cash plus \$70,192 for annuity yielding a total payment to plaintiff's family of \$1,422,239
1996	CPC	M	0	Required resuscitation ;neurological damage	\$2,500,000	\$1,187,940 cash plus \$1,312,060 for annuity, yielding \$3,307,824 for the child
1996	ORH	F	0	Brain damage	\$7,300,000	\$5,100,000 cash paid on behalf of four defendants plus \$2,200,000 for an annuity. Total yield of annuity unknown.
1996	GMI	F	0	Severe brain damage	\$6,379,322	\$5,529,332 cash plus \$850,000 annuity yielding 8,066/mo for life of the child.
1996	DCH	M	0	Cerebral palsy	\$3,000,000	\$2,600,000 cash plus \$800,000 annuity expected to yield \$13,783,483 over the child's life.
1996	CKR	F	30	Brain herniation	\$3,000,000	\$1,800,000 cash plus \$1,200,000 from three insurance carriers for an annuity expected to yield a total of \$7,816,824
1996	FHA	M	0	Cerebral vasculitis and bilateral thalamic infarcts	\$6,500,000	\$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 year to \$250,000.
1997	SVC	M	52	Brain damage	\$1,000,000	\$582,935 cash plus \$417,065 for annuity, yielding expected total of \$1,572,935.
1997	HCP	M	49	Death	\$5,000,000	\$4,000,000 cash plus \$1,000,000 annuity yielding projected \$3,976,503 for decedent's minor daughter.
1997	KCM	F	37	Paraplegia and cauda equina syndrome (spinal cord ends)	\$3,520,160	\$1,845,160 cash plus \$1,675,000 to two annuity companies yielding an expected total of \$8,157,597
1998	GJL	F	52	Paraplegia	\$1,000,000	\$500,000 cash plus \$500,000 annuity starting at \$2,500 per month and then adjusted for inflation .

Settle Year	Case	Sex	Age	Injury	Settlement	Structured
1998	COR	M	56	Death	1,000,000	Payout of approximately \$2,000 per month over 35 years.
1997	LMG	M	39	Death	\$1,250,000	\$53,359.60 cash plus annuities purchased at \$354,4560, \$111,048.20 and 111,048.20 yielding at total of \$1,129,9120
1998	UM	F	56	Right ankle, left below knee amputation.	\$1,625,000	\$700,000 cash and annuity providing \$4000 per month for 5 years and \$1000 per month for 7 years.
1998	GSHI	M	62	Quadriparesis, neurogenic bladder.	\$1,449,032	\$675,000 cash and annuity providing \$9750 per month for 5 years or life.
1998	UCH	M	2	Profound brain damage	\$5,000,000	\$2500 per month, increase 3% per year. 20 years guaranteed, plus life.
1997	CKMC	F	37	Paraplegia and cauda equina syndrome (spinal cord ends)	\$3,520,000	Cash payment of \$1,845,1600 and two annuities purchased with present value of \$1,675,000: total payments estimated at \$8,157,597
1999	SPGH	F	0	Severe cognitive delays, requires occupational therapy, physical therapy, speech therapy.	\$5,500,000	Total annuities yielding \$12,754.31 per month.
1999	PRMC	F	21	Death	\$2,250,000	Cash of \$1,809,709 plus annuity for surviving child purchased at \$440,291.
1999	PRMC	F	1	Hemorrhagic periventricular leukomalacia, hypoxic ischemic injury resulting in motor development delay, cognitive defects.	\$3,300,000	Cash of \$907,829 plus annuity purchased for \$2,392,171 for life care of child.

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 Peebles 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.⁶⁹ 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.⁷⁰ 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 2002.⁷¹

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.⁷² 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.⁷³ 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!”⁷⁴ 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*,⁷⁵ 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.⁸¹ 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 l defense costs per each large claim that was paid rose steadily from 1988 through 2002.⁸²The 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 remain[ed] small relative to payouts.”⁸³

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 area or certain states.⁸⁴ One of those areas involved Madison and St. Clare counties in Illinois.⁸⁵ 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.⁸⁶ 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.⁸⁷ 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.⁸⁸ 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.
- ³ See, e.g. Thomas Baker, *THE MEDICAL MALPRACTICE MYTH* (2005) for an outstanding review of the literature.
- ⁴ See, e.g., <http://cgood.org/healthcare.html>; <http://www.hsph.harvard.edu/press/releases/press001102005A.html.html>.
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- 62 *E.g.* <http://www.theorator.com/bills109/s1337.html>.
- 63 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/smarrtest.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.
- 64 Neil Vidmar et al., *Uncovering the “Invisible” Profile of Medical Malpractice Litigation: Insights from Florida*, 54 DEPAUL LAW REVIEW 315 (2005).
- 65 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.
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- 67 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.
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- 75 *Id.* Frank Sloan et al. *SUING FOR MEDICAL MALPRACTICE* (1993) at 164-185 reports systematic data that are consistent with my conclusions.
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- 78 *Id.* at 33-34.
- 79 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.*
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