

Medical Malpractice Litigation and Tort Reform: It's the Incentives, Stupid

David A. Hyman* and Charles Silver**

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* Professor of Law and Medicine and Galowich-Huizenga Faculty Scholar, University of Illinois.

** Co-Director, Center on Lawyers, Civil Justice, and the Media, and McDonald Endowed Chair in Civil Procedure, University of Texas School of Law. We received helpful comments when this paper was presented at Vanderbilt University School of Law, and helpful written comments from Bert Kritzer, Cathy Sharkey, and David Studdert.

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I. INTRODUCTION

Health care providers and tort reformers invariably claim that the medical malpractice litigation system is rife with behaviors that are irrational, unpredictable, and counter-productive. They attack civil juries, asserting that verdicts are skyrocketing without reason, are highly variable, and bear little or no relation to the merits of plaintiffs' claims. They complain about patients, arguing that the few with valid claims sue rarely, while the many who receive non-negligent treatment sue all the time. They attack greedy lawyers, alleging that they rake in obscene profits by routinely filing frivolous complaints. They complain that compensation flows almost randomly, winding up in the hands of patients who were treated non-negligently as often as (or even more often than) it reaches patients with valid complaints. They argue that the tort system does a poor job of distinguishing real victims from phony ones, claiming that it no more discourages malpractice than a police officer would discourage speeding by ticketing drivers randomly. Instead of motivating providers to do better, the system supposedly paralyzes them with fear and causes them to hide their mistakes.

Many of the preceding claims are facially implausible. The medical malpractice liability system is an enormous market whose principal trading partners—trial lawyers and liability insurers—are

sophisticated, economically-oriented repeat players. They run the system, and they have the knowledge and incentives to select efficient means to accomplish their respective ends. Given this backdrop, their behavior and the behavior of the system they administer should not be random, or even particularly hard to explain. Nor, given the absence of market power and barriers to entry, should attorneys earn more than market-driven returns on the services they provide.

Most of the preceding claims are also inconsistent with empirical studies of the medical malpractice liability system. These studies, which now constitute a substantial body of research, depict a system that is stable and predictable, that sorts valid from invalid claims reasonably well, and that responds mainly to changes in the frequency of errors and the cost of dealing with them. The system does have a number of pathologies, however, including its loading costs, the snail's pace at which it processes claims, and its failure to compensate patients injured by medical negligence as fully and as often as it should.

It is possible to reform the liability system to address these shortcomings, but tort reform proposals like caps on non-economic damages and attorneys fees will not do so. The goal of these proposals is to reduce insurance prices by making the system less remunerative for claimants. If implemented, these measures will predictably worsen the problem of under-compensation by limiting the remedies available to patients with serious injuries and by reducing the number of valid claims that are sufficiently profitable for attorneys to pursue. They will also weaken providers' incentives to protect patients from avoidable perils.

In this Article, we review the findings of empirical research into matters internal to the medical malpractice litigation process, including studies we have produced or are working on currently.¹ These studies demonstrate that the medical malpractice litigation system is both stable and predictable. We argue that economic incentives account for the tendencies and patterns the studies report. However, the empirical findings are what they are, whether or not our

1. See generally David A. Hyman & Charles Silver, *The Poor State of Health Care Quality in the U.S.: Is Malpractice Liability Part of the Problem or Part of the Solution?*, 90 CORNELL L. REV. 893 (2005) [hereinafter *Part of the Problem or Part of the Solution*]; David A. Hyman & Charles Silver, *Speak Not of Error*, REGULATION, Mar.-Apr. 2005, at 52; David A. Hyman & Charles Silver, *Medical Malpractice Reform Redux: Déjà vu All Over Again?*, 12 WIDENER L.J. 121 (2005); David A. Hyman & Charles Silver, *Believing Six Improbable Things: Medical Malpractice and "Legal Fear"*, 28 HARV. J.L. & PUB. POL'Y 107 (2004); David A. Hyman, *Medical Malpractice and the Tort System: What Do We Know and What (If Anything) Should We Do About It?*, 80 TEX. L. REV. 1639 (2002). In this Article, we do not discuss the effects of lawsuits on defensive medicine or access to care. We have written about these subjects elsewhere.

incentive-based explanations are correct. We therefore summarize the literature first and then offer our explanation for the patterns we observe.

Part II addresses the frequency with which patients bring malpractice suits. Part III considers the accuracy with which the malpractice system sorts claims. Part IV examines the frequency of frivolous complaints. Part V addresses the correlation between patients' injuries and the amount of compensation they receive. Part VI focuses on trends in payment frequencies and amounts over time. Part VII examines the rate at which plaintiffs win medical malpractice trials. Part VIII offers an incentive-based explanation of the behaviors and phenomena outlined in Parts II through VII. Part IX proposes various reforms, based on the evidence presented in the balance of the Article, and Part X concludes.

II. HOW OFTEN DO PATIENTS SUE?

It seems appropriate to begin a tour of the empirical literature on the malpractice system with studies of patient litigiousness. Those steeped in the rhetoric of tort reform may think it unnecessary to explore this topic, since they "know" that Americans will sue at the drop of a hat.² Americans' reputation for litigiousness is so firmly established that obstetricians joke about being sued when a child they delivered doesn't get into Harvard.³ Foreigners refer to personal injury lawsuits as "the American disease."⁴

2. See, e.g., TOM BAKER, THE MEDICAL MALPRACTICE MYTH 19–21 (2005) (cataloging seven myths of medical malpractice, including alleged litigiousness of Americans); John Engler & Dan Pero, *End Jackpot Justice*, WASH. TIMES, Jan. 28, 2005, at A17 ("Jackpot justice has saddled America with the most expensive tort system in the world Our lawsuit-happy culture is a growing disadvantage for U.S. businesses that must compete in a global marketplace."); American College of Surgeons, *The Medical Liability Crisis and the Litigation Explosion*, <http://www.facs.org/ahp/litexplosion.html> (last visited May 31, 2006) ("Across the nation, doctors are facing staggering increases in medical liability premiums The reason? The rising number of meritless lawsuits filed each year and the concentration of those cases in tort friendly states.").

3. Cf. Edward Martin, *Critical Condition*, BUS. N.C., June 2004, available at <http://www.businessnc.com/archives/2004/07/malpractice.html> ("If your kid doesn't get into Harvard or Duke, you can come back to us and claim something happened at birth.").

4. Charles Fleming, *Ireland Curbs 'American Disease'—Personal Injury Lawsuits*, WALL ST. J., Jan. 25, 2005, at B1. A comparative study not limited to personal injury suits found that the U.S. trailed Germany, Sweden, Israel, and Austria in lawsuits per capita and differed little from the United Kingdom and Denmark. See Herbert Kritzer, *Lawyer Fees and Lawyer Behavior in Litigation: What Does the Empirical Literature Really Say?*, 80 TEX. L. REV. 1943, 1982 (2002) (reproducing chart of litigation rates found in Christian Wollschlager, *Exploring Global Landscapes of Litigation Rates*, in SOCIOLOGIE DES RECHTS: FESTSCHRIFT FÜR ERHARD BLANKENBURG ZUM 60, 60 (Jurgen Brand & Dieter Stempel eds., 1998)).

Empirical studies, however, provide little evidence that injured Americans rush to the courts:

Research typically shows [that] Americans rarely take their disputes to court. Of every one hundred Americans injured in an accident, only ten make a liability claim, and only two file a lawsuit. Of every one hundred Americans who believe they have lost more than \$1,000 because of someone else's illegal conduct, only five file a suit. . . . Far from a nation of litigators, the United States seems to be filled with "lumpers," people inclined to lump their grievances rather than press them. . . . Some researchers even believe that Americans are no more innately lawsuit prone than the Japanese, the supposed saints of nonlitigiousness.⁵

Indeed, the frequency of tort filings per 1,000 Americans reached its apex in 1990 but declined by 5 percent between 1993 and 2002.⁶ By contrast, the rate of contract filings rose during the same period, reflecting either the growing number of American businesses (after controlling for population) or their growing litigiousness.

Are patients eager to sue? Or are they reluctant, like other tort victims? Popular perceptions notwithstanding, the evidence is quite clear that while many patients are injured, few ever sue. At the highest level, one can compare the estimated number of medical injuries—more than one million per year—to the number of malpractice lawsuits filed nationwide—approximately 85,000 annually.⁷ With about ten times as many injuries as malpractice claims, the only conclusion possible is that injured patients rarely file lawsuits.⁸

Three major studies also examined patient litigiousness, using data from four different states. The first evaluated the frequency of negligence among patients hospitalized in twenty-three representative California hospitals during 1974. One percent of the patients studied

5. THOMAS F. BURKE, LAWYERS, LAWSUITS, AND LEGAL RIGHTS: THE BATTLE OVER LITIGATION IN AMERICAN SOCIETY 3 (2002). To be sure, the frequency of claiming is affected by numerous factors, including knowledge, social norms, injury severity, ease of access to counsel, and the presence of insurance. On "lumping it," see generally Allen R. Meyers, *Lumping It: The Hidden Denominator of the Medical Malpractice Crisis*, 77 AM. J. PUB. HEALTH 1544 (1987).

6. BRIAN OSTROM, NEAL KAUDER & NEIL LAFOUNTAIN, EXAMINING THE WORK OF STATE COURTS 23 (2003). Interestingly, this source indicates that the number of malpractice claims went up by six percent from 1998 to 2002. However, the National Association of Insurance Commissioners (NAIC) reported a four percent decline, from 90,212 malpractice claims in 1995 to 86,480 in 2000. NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS, STATISTICAL COMPILATION OF ANNUAL STATEMENT INFORMATION FOR PROPERTY/CASUALTY INSURANCE COMPANIES (2001) (on file with author).

7. *Id.*

8. Insurers settle a modest number of claims without a lawsuit being filed, but not enough to materially affect the figure in the text. David A. Hyman et al., Tort Reform and the Pretrial Litigation Process: Evidence From Texas Medical Malpractice Cases, 1988-2003 (May 31, 2006) (unpublished draft, on file with authors).

were negligently injured. Extrapolating statewide, negligent injuries exceeded malpractice claims filed in California by a factor of ten.⁹

The second major study, the Harvard Medical Practice Study ("HMPS"), used a similar methodology, but focused on hospitalizations in fifty-one hospitals in New York during 1984.¹⁰ The HMPS concluded that 1 percent of hospitalized patients suffered a negligent injury and the total number of negligent injuries was 6.7 times the number of state-wide malpractice claims. More importantly, these researchers matched cases of negligent injury with actual claim filings, and determined that only 2 percent of those who were negligently injured filed a claim.¹¹

A related team of authors conducted the third major study, focusing on hospitalizations in Colorado and Utah in 1992.¹² This study found roughly comparable figures for negligent injury (0.8 percent (Colorado) and 0.9 percent (Utah) of hospitalized patients), ratios of negligent injuries to state-wide claim filings (5.1:1 (Colorado) and 6.7:1 (Utah)) and matched claim filings (2.5 percent).¹³

Other findings are consistent with these results. For example, from 1996 through 1999, Florida hospitals reported 19,885 incidents of medical negligence to a state agency, but patients filed only 3,177 new medical malpractice claims. Thus, the total number of *hospital-reported* negligent incidents was 6.3 times the number of state-wide malpractice claims.¹⁴ Because under-reporting of such incidents is

9. See Don Harper Mills, *Medical Insurance Feasibility Study*, 128 W.J. MED. 360, 363 (1978); see also CALIFORNIA MED. ASS'N & CALIFORNIA HOSP. ASS'N, REPORT ON THE MEDICAL INSURANCE FEASIBILITY STUDY (Don H. Mills ed., 1977); PATRICIA DANZON, MEDICAL MALPRACTICE: THEORY, EVIDENCE AND PUBLIC POLICY 4 (1985).

10. The HMPS resulted in two books and numerous articles in medical, legal, and health policy journals. See Hyman, *supra* note 1, at 1641-42 n.6.

11. See Troyen A. Brennan et al., *Incidence of Adverse Events and Negligence in Hospitalized Patients*, 324 NEW ENG. J. MED. 370, 371 (1991) (noting that the likelihood of a claim was substantially higher when the injury was more severe).

12. See David M. Studdert et al., *Negligent Care and Malpractice Claiming Behavior in Utah and Colorado*, 38 MED. CARE 250, 250-60 (2000); Eric J. Thomas et al., *Incidence and Types of Adverse Events and Negligent Care in Utah and Colorado*, 38 MED. CARE 261, 261-71 (2000); Eric J. Thomas et al., *Costs of Medical Injuries in Utah and Colorado*, 36 INQUIRY 255, 255-64 (1999).

13. Studdert, *supra* note 12, at 255; see also Michelle M. Mello & Troyen A. Brennan, *Deterrence of Medical Errors: Theory and Evidence for Malpractice Reform*, 80 TEX. L. REV. 1595, 1619 (2002).

14. FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION, DIVISION OF HEALTH QUALITY ASSURANCE, REPORTED MALPRACTICE CLAIMS BY DISTRICT COMPARED TO REPORTED ADVERSE INCIDENTS 1996, 1997, 1998, 1999 (on file with authors). In 2004, there were 6,456 incidents reported, but only 1,068 new malpractice claims - meaning that malpractice claims were only 16% of reported incidents. See FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION, DIVISION OF HEALTH QUALITY ASSURANCE, REPORTED MALPRACTICE CLAIMS BY DISTRICT COMPARED TO

common, and the study did not include negligent incidents in the outpatient setting, the actual ratio of negligence to malpractice claims is undoubtedly much higher. Additionally, an observational study of patients in a single hospital in Chicago found that only 1.2 percent of patients who experienced a medical error made a claim.¹⁵ Another study focused on birth injuries in Florida in 1987 that resulted in death or permanent injury.¹⁶ Of 220 women whose babies suffered serious injuries or died, only twenty-three sought legal advice and *none* sued.

There are also anecdotal reports of such forbearance. A recent mass market book on medical errors recounts the story of a man who was injured in an automobile crash.¹⁷ He was hospitalized and placed in a semi-private room alongside a patient with diabetes. The attending nurse forgot which patient was which and gave the injured man insulin. He fell into a coma and suffered a lasting brain injury, but he refused to sue because he liked the nurse.¹⁸

Although many negligently injured patients do not sue, some patients sue even though their injuries were not caused by provider negligence. The frequency of such filings and the frequency with which they lead to payments are discussed in Parts III and V.

Thus, whether one is looking at cross-national comparisons of litigiousness,¹⁹ or the rate of litigation relative to the incidence of

REPORTED ADVERSE INCIDENTS 2004, available at http://ahca.myflorida.com/MCHQ/Health_Facility_Regulation/Risk/documents/2004_MalpracticeByArea_Hospital.pdf.

15. Lori B. Andrews, *Studying Medical Error in Situ: Implications For Malpractice Law and Policy*, 54 DEPAUL L. REV. 357, 370 (2005); Lori B. Andrews et al., *An Alternative Strategy for Studying Adverse Events in Medical Care*, 349 LANCET 309, 309 (1997). One complication is that the definition of medical error in this study does not map as neatly onto the legal definition of negligent treatment as the other studies.

16. Frank A. Sloan & Chee Ruey Hsieh, *Injury, Liability, and the Decision to File a Medical Malpractice Claim*, 29 LAW. & SOC. REV. 413, 413–35 (1995).

17. ROSEMARY GIBSON & JANARDAN P. SINGH, WALL OF SILENCE: THE UNTOLD STORY OF THE MEDICAL MISTAKES THAT KILL AND INJURE MILLIONS OF AMERICANS 128–29 (2003).

18. Empirical studies find that patients are reluctant to sue providers they like, and that communication skills are an important factor in whether patients like their providers. See Gerald B. Hickson et al., *Obstetricians' Prior Malpractice Experience and Patients' Satisfaction with Care*, 272 JAMA 1583, 1583 (1994); Gerald B. Hickson et al., *Factors that Prompted Families to File Medical Malpractice Claims Following Perinatal Injuries*, 267 JAMA 1359, 1359 (1992) [hereinafter *Factors that Prompted Families*].

19. It is difficult to compare the litigiousness of malpractice victims in the U.S. and other countries, but other countries have experienced spectacular growth in claims in recent years. See MAKING AMENDS: A CONSULTATION PAPER SETTING OUT PROPOSALS FOR REFORMING THE APPROACH TO CLINICAL NEGLIGENCE IN THE NHS 58 (2003) (reporting “a nearly fifteen-fold increase in the number of claims” handled by the National Health Service Litigation Authority from 1996/97 to 2002/03). Some also believe that other countries have similar rates of malpractice litigation. Daniel Cappello, *Bad Medicine*, THE NEW YORKER, Nov. 11, 2005, available at http://www.newyorker.com/online/content/articles/051114on_onlineonly01 (“The

injury, Americans are not “suit-happy.” The medical malpractice system experiences both substantial under-claiming (by patients who deserve payment but do not sue) and substantial over-claiming (by patients who sue but do not deserve payment). Although both problems are significant, the former dwarfs the latter.²⁰ Indeed, if anything, “the medical setting has provided the strongest evidence that the real tort crisis may consist in *too few* claims.”²¹ The next Part discusses how effectively the legal system sorts through this mix of cases, and the following section addresses whether the observed degree of over-claiming is attributable to frivolous litigation.

III. DO THE MERITS MATTER?

Critics of the tort system argue that it is essentially random, using language like “jackpot justice” and “lawsuit lottery” to describe the manner in which the system allocates payments.²² The basic

major difference between malpractice here and in Great Britain and Canada turns out not to be in the number of lawsuits. At this point, the U.K. and Canada seem to be catching up with our rate of lawsuits.”) (quoting Atul Gawande).

20. Hyman, *supra* note 1, at 1643; *see also* ROBERT M. WACHTER & KAVEH G. SHOJANIA, INTERNAL BLEEDING 305 (2004).

21. PAUL C. WEILER ET AL., A MEASURE OF MALPRACTICE: MEDICAL INJURY, MALPRACTICE LITIGATION, AND PATIENT COMPENSATION 62 (1993) (emphasis in original).

22. *See, e.g.*, Randall R. Bovbjerg et al., *Juries and Justice: Are Malpractice and Other Personal Injuries Created Equal?*, 54 LAW & CONTEMP. PROBS. 5, 6 (1991) (“A major complaint of well-insured defendants, especially physicians, is that juries are biased against defendants, especially those with ‘deep pockets.’ This availability of funds allegedly encourages easier awards of higher damages for similar injuries and hence the bringing of less meritorious claims.”); Troyen A. Brennan & Philip K. Howard, Editorial, *Heal the Law, Then Health Care*, WASH. POST, Jan. 25, 2004, at B07 (“Justice today . . . is basically random. . . . Meritorious cases often lose or are settled on the cheap. . . . [D]octors who did nothing wrong are often hit with huge verdicts.”); AMERICAN ASSOCIATION OF HEALTH PLANS, “LAWSUIT LOTTERY” CAUSES MEDICAL MALPRACTICE CRISIS, available at <http://www.americanbenefitscouncil.org/documents/refutingstockmarketargument.pdf>; U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, OFFICE OF THE ASSISTANT SECRETARY FOR PLANNING AND EVALUATION, ADDRESSING THE NEW HEALTH CARE CRISIS: REFORMING THE MEDICAL LITIGATION SYSTEM TO IMPROVE QUALITY OF HEALTH CARE (Mar. 3, 2003), available at <http://aspe.hhs.gov/daltcp/reports/medliab.htm> (referring to “jackpot judgment[s]” and the “litigation lottery”); AMERICAN MEDICAL ASSOCIATION, MEDICAL LIABILITY REFORM—NOW! 35, 51 (on file with authors) (discussing the “lawsuit lottery” theory).

The President of Johns Hopkins University has been a particularly enthusiastic proponent of these claims:

This is the real problem with our system of malpractice litigation. I call it the medical lottery: it randomly awards outsized payments to a lucky few, and fails to help in any way the far greater number whose needs are every bit as great, but whose luck or timing or ability to manipulate the system are not as finely honed.

William Brody, President, The Johns Hopkins University, Manhattan Institute for Policy Research Luncheon: Is the Legal System Killing Healthcare? (Feb. 25, 2003), available at <http://web.jhu.edu/president/speeches/2003/legalsys.htm>; William R. Brody, Editorial, *Dispelling Malpractice Myths*, WASH. POST, Nov. 14, 2004, at B07 (“The medical justice system today is

claim is that payments bear little or no relation to the merits of claims. This argument is frequently bolstered with anecdotes (Heard about the woman who got a million bucks because a CT scan “erased” her psychic powers?), and complaints about the irrationality of non-economic damages. Critics routinely cite a finding in the HMPS that a substantial percentage of cases in which payment is made do not actually involve negligent treatment.²³

As Table 1 reflects, any system for making compensation determinations will generate four kinds of results: true positives (cell 1), false positives (cell 2), false negatives (cell 3), and true negatives (cell 4). True positives and true negatives occur, respectively, when people entitled to payments receive them and when people not entitled to payments do not. False positives and false negatives occur, again respectively, when persons not entitled to payments receive them and when persons entitled to payments are turned down. True positives and true negatives are correct results. False positives and false negatives are mistakes. The goal is to maximize the number of cases in cells 1 and 4, and minimize the number of cases in cells 2 and 3. Expressed in dollar terms, the goal is to concentrate payouts in cell 1 and to minimize the amounts paid out for cases in cell 2 and not paid out for cases in cell 3.

Table 1: A Typology of Correct and Erroneous Malpractice Liability Payments

| Injured by Substandard Care? | Compensated? | |
|---------------------------------|-------------------------|-------------------------|
| | Yes | No |
| Yes | True Positive (Cell 1) | False Negative (Cell 3) |
| No | False Positive (Cell 2) | True Negative (Cell 4) |

mostly random; it has become essentially a lottery. . . . Juries often deliver sizable awards against providers who commit no errors for what are unfavorable, but random, outcomes of nature.”)

23. As one of us noted in an earlier article,

Once cases are filed, the tort system does a fair job of sorting the wheat from the chaff, but in an appreciable percentage of cases, it reaches the ‘wrong’ decision—i.e., awarding damages when there was no negligence or adverse event, and not awarding damages when there was negligence. Indeed, the best predictor of the size of an award is the severity of disability, not whether there was negligence, or an adverse event.

Hyman, *supra* note 1, at 1642. As this Article notes, the last sentence in this description is based on the HMPS; other studies paint a more favorable picture of the performance of the tort system. *Id.* at 1642, n.13. To be sure, such complaints are not unique to medical malpractice litigation. See, e.g., Janet Cooper Alexander, *Do the Merits Matter? A Study of Settlements in Securities Class Actions*, 43 STAN. L. REV. 497 (1991).

This Part evaluates how well the medical malpractice system performs against these goals. We draw heavily on a recent article by Professor Tom Baker which both summarizes the literature and incisively criticizes the portion of the HMPS that has been cited in support of the “lawsuit lottery” claim.²⁴ This Part also discusses a successor study to the HMPS that strongly supports Professor Baker’s views but appeared after his article was written.²⁵ The bottom line is that a strong correlation exists between the likelihood of receiving payment and the merits of malpractice claims. The HMPS, the only study to find the contrary, is unreliable on this point, for reasons Professor Baker carefully explains.

The first important point is that when the tort is medical malpractice, one must sue to be paid, and one must find a lawyer in order to sue. In our database of medical malpractice claims in Texas, from 1988 to 2003, 98.5 percent of claimants who obtained payments exceeding \$10,000 (in nominal dollars) employed attorneys.²⁶ Only 1.5 percent of claimants represented themselves, and only a tiny fraction of these claimants (0.1 percent of the total) commenced litigation. In all, our dataset of 13,663 claims that closed with payment contains seventeen *pro se* lawsuits—about one per year.

In the rare instances where the provider pays without litigation, it is usually because the provider admits negligence, meaning the claims are true positives. Recent initiatives encouraging providers to apologize and pay compensation may cause the frequency of voluntary payments to grow, but such payments are very much the exception today.²⁷

The second important point is that when patients do sue, the malpractice system sorts their claims relatively well. Table 2 briefly summarizes the studies Professor Baker reviewed, excluding the HMPS.

24. Tom Baker, *Reconsidering the Harvard Medical Practice Study Conclusions about the Validity of Medical Malpractice Claims*, 33 J.L. MED. & ETHICS 501, 502–06 (2005).

25. David M. Studdert et al., *Claims, Errors and Compensation Payments in Medical Malpractice Litigation*, 354 NEW ENG. J. MED. 2024 (2006). We are grateful to David Studdert and Michelle Mello for sharing a preliminary version of their study.

26. For a description of the dataset, see Bernard Black et al., *Medical Malpractice Claim Outcomes in Texas, 1988-2002*, 2 J. EMPIRICAL LEGAL STUD. 207, 213–22 (2005). The figure reported in the text is for the NAR dataset, which includes all claims in which the business class was a doctor, hospital, or nursing home, the insurance type was medical professional liability, and the cause of injury was a medical or surgical procedure. Both of the authors of the present article were co-authors of that article.

27. See Hyman & Silver, *Part of the Problem or Part of the Solution*, *supra* note 1, at 943.

Table 2: Summary of Studies of the Accuracy of the Malpractice System

| Study | Database | Reviewers | Correlation between Negligence and Payments |
|---|---|---|---|
| Ogburn et al., St. Paul Insurance Company Obstetrics Claims Study | 153 closed claims involving serious permanent injury or death to a baby | Obstetricians | Patients received payments in 90% of the cases in which the physician was found to have been negligent. |
| Rosenblatt and Hurst, Physicians Mutual Obstetrics Claims Study | 33 lawsuits involving obstetrics claims | Rosenblatt | No indemnity payments in non-meritorious cases. In cases with payments, "there was general consensus among insurance company staff, medical experts, defense attorneys and the physician defendants that some lapse in standard of care contributed to the observed outcome." |
| Cheney et al., Anesthesiologist Closed Claim Review | 869 closed claims against anesthesiologists | Anesthesiologists | Payments made in 82% of the instances in which care was inappropriate, and in 42% of the instances in which care was appropriate. The amount paid was strongly correlated to negligence and injury type. |
| Farber and White, Single Hospital Study | 252 malpractice cases against a single hospital | Confidential experts retained by the hospital | Care quality and outcomes were strongly related. Claimants were paid in 89% of the "bad" care cases, 25% of the "good" care cases, and 69% of the "ambiguous" cases. The hospitals' expected liability was 25 times as high on average in a "bad" care case as in a "good" care case. |
| Sloan and Hsieh, Florida Closed Claims I | 1549 closed claims against ob-gyns, general surgeons, and orthopedic surgeons | Physicians | "[C]ases involving a higher appearance of fault were more likely to be paid," and payment amount correlated positively with injury severity. |

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| Sloan et al., Florida Closed Claims II | 127 birth injury cases and 60 emergency room cases | Four panels of physicians | “No negligence” claims were most likely to have been voluntarily dropped with no payment, “negligence” claims were most likely to have been settled with a payment, and claims with split or uncertain determinations were more mixed. |
| Taragin et al., New Jersey Closed Claim Study | 8231 claims closed a large malpractice insurer | Insurer interviewed defendant physician, had claim representative assess the claim, and obtained peer review for any case that the claims representative did not conclude was clearly defensible | Strong correlation between carriers’ evaluations and outcomes. Claimants received payments in 91% of the indefensible cases, 21% of the defensible cases, and 59% of the unclear cases. Injury severity did not affect the likelihood of payment, but did affect payment amounts in cases in which payments were made. |
| Spurr and Howze, Michigan Single Hospital Study | 165 closed claims against a hospital in Michigan | Internal assessment made by hospital’s risk managers | Fault was only statistically significant factor affecting likelihood that claim was dropped; fault and injury severity affected claim size, with fault being more important. |

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| Peeples et al., North Carolina Study | 87 closed claims involving a hospital or physician covered by a cooperating liability insurer | Insurer's initial and final liability assessments, including its assessment of whether the standard of care was breached, and whether defendant's conduct caused harm; consensus of outside experts engaged by the insurer | Insurer offered to settle in 96% of the cases in which it concluded that the standard of care was breached; plaintiffs received money in 93% of those cases. Plaintiffs received money in only 15% of the cases in which the insurer concluded that the standard of care was not breached and in 37% of the cases in which the insurer was uncertain. |
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Although these studies vary in quality and robustness, the consistency of the findings is impressive.²⁸ All find that the merits matter, and some find that the merits matter more than anything else. Plaintiffs who received substandard care generally obtained compensation (cell 1); plaintiffs who received proper care generally did not (cell 4); and plaintiffs whose care quality was uncertain wound up in between. The malpractice system does not sort cases perfectly, but perfection is an unrealistic standard. As Sloan and his co-authors observe, "To the extent that there is highly incomplete knowledge about the effect of particular interventions by health care providers on outcomes, it is unrealistic to expect courts to be omniscient in this regard."²⁹

28. Professor Baker omitted another closed claim study that yielded similar findings. See Patricia Munch Danzon & Lee A. Lillard, *Settlement Out of Court: The Disposition of Medical Malpractice Claims*, 12 J. LEGAL STUD. 345, 369 (1983) ("[T]he settlement process is not random with respect to which cases are paid: cases more likely to win in court are more likely to win out of court.").

29. See Frank A. Sloan, *Policy Implications*, in *SUING FOR MEDICAL MALPRACTICE* 219, 219 (Frank A. Sloan et al. eds., 1993). On variation in expert medical opinion regarding treatment quality and causation, see Ralph Peeples et al., *The Process of Managing Medical Malpractice Cases: The Role of Standard of Care*, 37 WAKE FOREST L. REV. 877, 884 (2002) (finding that independent reviewers hired to evaluate claims by insurers disagreed 34.3% of the time); K.L. Posner et al., *Variation in Expert Opinion in Medical Malpractice Review*, 85 ANESTHESIOLOGY 1049, 1051-52 (1996) (noting that anesthesiologists disagreed on whether care was negligent 38% of the time because they used implicit standards of review instead of explicit criteria).

What then should be made of the HMPS findings that payment and negligence are effectively uncorrelated, and disability is a better predictor of payment than negligence? As Professor Baker explains, this finding is problematic for a number of reasons, including:

- The finding was based on an examination of forty-seven malpractice claims, a sample smaller than any study in the table save one.
- The HMPS employed an extremely conservative scoring system that was designed to “provid[e] a solid, lower bound estimate of the rate of those [negligent] injuries . . . that would be trusted by medical providers.”³⁰
- The HMPS assigned all cases in which reviewers disagreed about care quality to the non-negligent category. Tests using multiple reviewers showed that reviewers often disagreed about care quality in particular cases where patients were identified as having sustained care-related injuries.³¹
- The HMPS examined only the hospital records in making the determination as to whether care was negligent or not. Many errors do not appear in hospital records. They may be left out intentionally or inadvertently, or they may involve shortcomings like failure to diagnose of which no record can be made. Evidence of negligent treatment provided on an outpatient basis is similarly unlikely to be in the hospital medical record.³²
- When one looks at the reviewers’ assessments, one finds that the HMPS actually provides evidence of a strong connection between care quality and the likelihood that patients will file malpractice claims.³³

30. Baker, *supra* note 24, at 503.

31. *Id.* at 504.

32. It is important not to overstate the significance of this observation. Hospital record review is the benchmark standard for these types of studies.

33. *Id.* Baker also notes that:

[A] patient whose hospital record provided the strongest evidence of medical malpractice was twenty[-]two times more likely to make a claim than the average patient, eight times more likely to make a claim than all other patients with sufficiently strong evidence of a medical management injury to reach the second stage of the HMPS review, and two and a half times more likely to make a claim than all other patients the HMPS physicians determined to have suffered a medical management injury.

Id. at 506. This is hardly a picture of malpractice claiming run amok. See also Michelle M. Mello & David Hemenway, *Medical Malpractice as an Epidemiological Problem*, 59 SOC. SCI. MED. 39, 42–43 (2004).

- Because its sample size was so small, outlier cases strongly affected the HMPS's reports of payment means for claims involving different levels of care quality. Reclassifying a few close cases causes the differences between the HMPS and the studies summarized in the table to disappear, and turns the HMPS into yet another study showing that the malpractice system sorts cases reasonably well.³⁴
- The HMPS's treatment of cases in which hospitals wrote off their bills prejudiced its logistic regression against a finding that negligence predicted the likelihood of payments.³⁵
- Although HMPS researchers noted many of these shortcomings in early publications, they did not emphasize them in later works and the study's weaknesses gradually dropped out of the policy debate.³⁶ Not surprisingly, tort reform advocates emphasize the over-claiming findings of the HMPS and ignore the under-claiming findings and the limitations of the study.³⁷

A more recent study completed by researchers at the Harvard School of Public Health, one of whom participated in the HMPS, confirms that the medical malpractice system does a surprisingly good job of differentiating between plaintiffs who should and should not receive compensation.³⁸ Instead of relying on hospital records, as the HMPS did, this study reviewed closed claim files randomly selected from five insurance companies operating in different parts of the

34. Baker, *supra* note 24, at 507.

35. *Id.* at 508.

36. *Id.*

37. Ted Frank provides a clear example of a tort reform advocate who relies on the HMPS without noting its limitations. In a posting dated May 2, 2005, he writes:

The Harvard Study found that . . . the litigation system was just as likely to award damages in a case where no medical malpractice has taken place as one where medical malpractice has taken place; indeed, the sued non-negligent doctors paid more on average to injured patients than the sued negligent doctors, and the majority of patients receiving compensation weren't injured by negligence.

Posting of Ted Frank to Point of Law Blog, <http://www.pointoflaw.com/archives/001122.php> (May 2, 2005, 23:08 EST). Mr. Frank mentions no limitations in the quote or elsewhere in his post. The omission is ironic given that Frank was responding to a post by Professor Michael Saks, who pointed out some of the HMPS's failings in an early book review. See Michael Saks, *Medical Malpractice: Facing Real Problems and Finding Real Solutions*, 35 WM. & MARY L. REV. 693, 710–13 (1994) (book review). For another example of tort reformers' use of the HMPS to support the charge of over-claiming, see AMERICAN MEDICAL ASSOCIATION, *supra* note 22 (asserting that "a substantial majority of malpractice claims filed are not based on actual provider carelessness," and citing the HMPS).

38. See Studdert et al., *supra* note 25.

country. The files contained the complete claim file, including medical records and litigation-related materials, with expert opinions from both sides.³⁹ The methodology they employed was similar to that in the HMPS and the studies of Colorado and Utah previously described. Their findings are consistent with those reported in the studies summarized in Table 2 and inconsistent with the HMPS.

In particular, they found that the “right” result (i.e., true positives and true negatives) was reached about 73% of the time, with “error claims” accounting for 64% of all claims and 84% of total indemnity payments. A false negative (no payment in an error claim) was 1.6 times more likely than a false positive (payment in a non-error claim). Payment in non-error claims averaged 60 percent of the amounts paid for error claims.⁴⁰ As the conclusion of the article reflects, “the vast majority of expenditures go toward litigation over errors and payment of them.”⁴¹

To summarize, the merits of a claim are the best predictor of the likelihood of payment and the amount received.

IV. HOW COMMON ARE FRIVOLOUS MALPRACTICE LAWSUITS?

When stumping for caps on malpractice liability, President George W. Bush routinely blames frivolous lawsuits for the medical malpractice crisis.⁴² He is far from alone in lodging this complaint. Health care providers have denounced frivolous malpractice lawsuits for years, and complaints about frivolous cases are common currency in tort reform circles. Consider one revealing example. On the eve of the 2002 election, Texas Republicans mailed out an advertisement (attached as Appendix A) claiming that “86% of lawsuits filed by personal injury trial lawyers against Texas doctors & nurses are frivolous,” with the word “frivolous” enlarged and highlighted. This willingness to quantify the percentage of lawsuits that are frivolous is unusual.⁴³ Until fairly recently, no academic study quantified the

39. *Id.*

40. *Id.* at 2029.

41. *Id.* at 2024.

42. Warren Vieth, *Bush Hammers Medical Malpractice Suits*, L.A. TIMES, Jan. 6, 2005, at A17 (“What’s happening all across this country is that lawyers are filing baseless suits against hospitals and doctors They know the medical liability system is tilted in their favor.” (quoting President George W. Bush)); see also Peter Baker, *Bush Campaigns to Curb Lawsuits; President Says ‘Junk’ Litigation is Driving Small-town Doctors Out of Business*, WASH. POST, Jan. 6, 2005, at A6 (“America’s health care professionals should be focused on fighting illnesses, not on fighting lawsuits. Junk lawsuits change the way docs do their job. Instead of trying to heal the patients, doctors try not to get sued.” (quoting President George W. Bush)).

43. But hardly unique. See, e.g., AMERICAN MEDICAL ASSOCIATION, *supra* note 22, at 53 (asserting that “[t]he vast majority of claims—almost 70 percent—have no merit”).

number of frivolous complaints in any area of civil litigation.⁴⁴ Academics who write about frivolous lawsuits generally concede that there is no evidence indicating they are a serious problem.⁴⁵ Furthermore, most judges believe that frivolous lawsuits are a minor problem, according to a recent survey by the Federal Judicial Center.⁴⁶

Texas Republicans relied on a Medical Liability Study conducted by the Texas Medical Association (“TMA”) to support their claim that 86 percent of medical malpractice lawsuits are frivolous. However, the TMA study states that “[t]he percentage of claims closed with no indemnity paid increased to 86%” in 2000—an entirely different assertion.⁴⁷ First, the assertion concerns claims, not lawsuits. Claims are insurance files, and insurance carriers sometimes open files in circumstances where victims fail to sue, such as when physicians report errors but patients decide to lump it or plaintiffs’ attorneys decline their cases. Thus, the 86 percent figure overstates the frequency of non-payment in lawsuits to an unknown degree.⁴⁸ Second, TMA’s study says *nothing* about the merits of claims that closed without payment. It observes that 86 percent of claim files closed without payments, not that 86 percent *rightly* closed without payments. To show the latter, one would have to review evidence bearing on the merits of the unpaid claims. TMA made no such review. It is therefore possible that payments *should* have been made on some or all of these unpaid claims. In terms of the typology of Table 1, these claims may have been false negatives (cell 3), a possibility supported by a nationwide study of closed insurance

44. Efforts to quantify the frequency of frivolous lawsuits have made the most headway in the securities field. See James Bohn & Stephen Choi, *Fraud in the New-Issues Market: Empirical Evidence on Securities Class Actions*, 144 U. PA. L. REV. 903, 935 (1996) (finding that many securities class actions meet a test of frivolousness). Even here, though, academics disagree. Charles Yablon argues that many securities class actions thought to be frivolous actually involve non-frivolous long-shot claims. Charles M. Yablon, *A Dangerous Supplement? Longshot Claims and Private Securities Litigation*, 94 NW. U. L. REV. 567, 586–93 (2000).

45. Chris Guthrie, *Framing Frivolous Litigation: A Psychological Theory*, 67 U. CHI. L. REV. 163, 163 n.2 (2000) (citing sources recognizing dearth of hard evidence showing that frivolous lawsuits are a serious problem).

46. DAVID RAUMA & THOMAS E. WILLGING, REPORT OF A SURVEY OF UNITED STATES DISTRICT JUDGES’ EXPERIENCES AND VIEWS CONCERNING RULE 11, FEDERAL RULES OF CIVIL PROCEDURE, FEDERAL JUDICIAL CENTER 3 (2005) (finding that 85 percent of judges view frivolous lawsuits as either “no problem,” a “very small problem,” or a “small problem”).

47. TEXAS MEDICAL ASSOCIATION, MEDICAL LIABILITY STUDY (on file with authors).

48. A study of closed medical malpractice claims in Minnesota found that 36 percent of incident files were closed without payment because the claim was not pursued. MINNESOTA DEPARTMENT OF COMMERCE, MEDICAL MALPRACTICE CLAIM STUDY 1982–1987 (1989). Insurers have some incentive not to open claim files unnecessarily. We do not know how often Texas liability insurers open files on unpursued claims.

claims.⁴⁹ The high non-payment rate reported in TMA's study may actually show that Texas's malpractice system is too frugal.

Although the misuse of the TMA study is blatant, health care does provide fertile ground for non-meritorious complaints. Patients often experience bad outcomes after receiving appropriate care. The nature of medicine is that many patients do not recover even when providers do their utmost to help them. Patients also find it hard to evaluate the quality of care they receive. When there is a bad outcome, patients may not be able to readily determine whether bad luck or bad medicine was the cause.

These considerations create the potential for invalid claims but do not necessarily require them to occur. Patients who experience bad outcomes may identify nature as the cause. Patients who believe that errors occurred may be reluctant to sue because they like their providers or are intimidated by courts. Patients who wrongly blame providers for their problems may not find plaintiffs' attorneys who are willing to represent them. Even when soil is fertile, nothing may grow. The frequency of frivolous complaints can only be determined empirically.

One indication of the likely frequency of frivolous lawsuits is provided by the sorting efforts of plaintiffs' lawyers, who have "a strong incentive to screen prospective plaintiffs and to accept only cases having sufficiently high expected value" because they work on contingency.⁵⁰ Many studies show that plaintiffs' attorneys reject weak cases. Professor Bert Kritzer surveyed plaintiffs' attorneys in Wisconsin to determine how often they accepted cases. Respondents reported a total of 53,584 contacts requesting representation, of which almost 70 percent were declined.⁵¹ The main reasons for declining cases were weak evidence of liability or small damages. Malpractice lawyers are even choosier. They reject 80 percent or more of the requests for representation they receive. Professor Kritzer personally observed three lawyers, who collectively received fourteen requests for

49. See DANZON, *supra* note 9, at 43 (studying 6,000 closed insurance claims and "estimat[ing] that between 39 and 53 percent of the claims dropped without payment—about one-quarter of all claims in the data base—would have produced an award for the plaintiff if taken to verdict").

50. Henry S. Farber & Michelle J. White, *Medical Malpractice: An Empirical Examination of the Litigation Process*, 22 RAND J. ECON. 199, 200 (1991).

51. HERBERT M. KRITZER, RISKS, REPUTATIONS, AND REWARDS: CONTINGENCY FEE LEGAL PRACTICE IN THE UNITED STATES 69–74 (2004); Herbert M. Kritzer, *Seven Dogged Myths Concerning Contingency Fees*, 80 WASH. U. L.Q. 739, 754–57 (2002); Herbert M. Kritzer, *Contingency Fee Lawyers As Gatekeepers in the Civil Justice System*, 81 JUDICATURE 22, 24 (1997); Herbert M. Kritzer, *Holding Back the Floodtide: The Role of Contingent Fee Lawyers*, WIS. LAW., Mar. 1997, at 10, 63.

representation over a three month period from clients with medical malpractice claims, and rejected all of them.

Another study evaluated how plaintiffs' attorneys handle the cases of individuals who called their office complaining about medical malpractice.⁵² The lawyers' offices received calls from 730 persons seeking representation over ten randomly selected days in 1991. Only one in thirty calls led to a lawsuit, meaning that the lawyers rejected 97 percent of the potential plaintiffs. Cases with modest expected damages (less than \$50,000) or an imminent or expired statute of limitations were declined routinely. Cases that met these screens were regularly reviewed by independent physician-experts.⁵³ Many requests for representation were rejected when the reviews came in.⁵⁴

Most patients with weak cases or low expected damages give up looking for lawyers after being rejected a few times. A few are more persistent. In one extreme case, a Texas woman reported that 92 lawyers refused her request for help in bringing a malpractice suit against the hospital that treated her 18-year-old son, who died of pneumonia.⁵⁵ She ultimately sued the hospital by herself because no lawyer would represent her.

The frequency with which plaintiffs' attorneys drop medical malpractice cases after taking them might be thought to indicate that these dropped cases were actually frivolous. Empirical studies do not support the inference that plaintiffs' attorneys file lawsuits they know are weak. The studies find that "drops" occur when cases thought to be strong initially turn out to be weak once discovery is performed.⁵⁶ The pattern of filing cases that look good and withdrawing them when doubts arise indicates that the malpractice system itself weeds out weak cases. This is, of course, the intended result of the pretrial process.

Finally, negligence determinations are often "close calls," even for expert physicians who have the benefit of a complete medical record and the claim file. Given this backdrop, it is unreasonable to

52. LaRae I. Huycke & Mark M. Huycke, *Characteristics of Potential Plaintiffs in Malpractice Litigation*, 120 ANNALS INTERNAL MED. 792, 796 (1994).

53. *Id.* ("Attorneys obtained medical records for 90 claims, and independent medical experts reviewed 85."). Some law firms employ nurses as full-time staff members to provide internal assessments.

54. *Id.* (noting that independent review of 85 claims resulted in outright rejection of 53 claims (62% of the total)). "Of those claims rejected after being evaluated by medical experts, most were felt to have had insufficient damages (42%) or lacked negligence on the part of the health care provider (26%)." *Id.*

55. Claire Osborn, *Many Lawyers Avoiding Malpractice Cases*, AUSTIN AM.-STATESMAN, June 14, 2004, at A1.

56. Farber & White, *supra* note 50, at 215-16.

expect plaintiffs' lawyers to perfectly distinguish strong medical malpractice cases from weak ones at the outset of a lawsuit.

V. DO INJURED PATIENTS GET WHAT THEY DESERVE?

Part III addressed the accuracy with which the malpractice system matches payment to negligent error. This Part focuses on the degree to which payment and severity of injury correspond. Tort reformers assert that the "lawsuit lottery" allows ignorant jurors to award staggering sums to sympathetic patients with minor injuries and persuasive contingent-fee lawyers.⁵⁷ This is a caricature of compensation patterns in the tort system, as empirical researchers have known for years.⁵⁸ Professor Michael Saks summarized the findings of these empirical studies as follows: under-compensation is the norm in the tort system, although victims with small claims are sometimes modestly overpaid.⁵⁹ Under-compensation also correlates positively with injury severity, so that victims suffering the worst injuries recover the smallest portions of their losses. As Saks notes, "[t]his pattern of overcompensation at the lower end of the range and under-compensation at the higher end is so well replicated that it qualifies as one of the major empirical phenomena of tort litigation ready for theoretical attention."⁶⁰

The hallmark of a lottery is that winners invest small and win big—and are accordingly happy to have played. In the tort system, however, the biggest "winners"—the claimants who receive the most money—are the biggest losers as well. They suffer serious injuries or death, and they do not even recover their losses, especially after legal fees and expenses are paid. They probably prefer winning in the tort

57. U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, *supra* note 22, at 3 ("The results [produced by the malpractice system] are as arbitrary for patients as they are for providers. When there are recoveries, they often are based on sympathy, attractiveness of the plaintiff, and the plaintiff's socio-economic status (educated, attractive patients recover more than others)." (citation omitted)).

58. See, e.g., JAMES S. KAKALIK ET AL., COSTS AND COMPENSATION PAID IN AVIATION ACCIDENT LITIGATION (1988); ELIZABETH M. KING & JAMES P. SMITH, COMPUTING ECONOMIC LOSS IN CASES OF WRONGFUL DEATH (1988); ELIZABETH M. KING & JAMES P. SMITH, ECONOMIC LOSS AND COMPENSATION IN AVIATION ACCIDENTS (1988).

59. Michael J. Saks, *Do We Really Know Anything About the Behavior of the Tort Litigation System—And Why Not?*, 140 U. PA. L. REV. 1147, 1218 (1992).

60. *Id.* More recently, Professor Saks reaffirmed these observations in an online post, indicating that "under-compensation, even of special damages, is the rule, and over-compensation (except for the smallest injuries) is the exception." Michael Saks, On Ted Frank's Series of Unfortunate Errors, Or, The Risks of Making it All up Out of Thin Air, *quoted in* Posting of Ted Frank to Point of Law Blog, <http://www.pointoflaw.com/archives/001122.php> (May 2, 2005, 23:08 EST).

system to losing in it, but they would have been much better off had they been able to avoid playing the tort “lottery” at all.

Evidence specific to the malpractice context shows that it too lacks the “invest small/win big” structure of a lottery. Looking at cases involving emergency room treatment or prenatal care, economist Frank Sloan and colleagues compared plaintiffs’ economic losses—mainly, their past and future medical costs and their lost wages or expected income—to the amounts they received.⁶¹ They found that “claimants tended to be under-compensated, and [that] the fraction of loss recovered tended to be less for the most severe injuries and for deaths, in particular for infants.”⁶² On average, the plaintiffs recovered about half their losses.

The “lawsuit lottery” charge (that sympathetic jurors award enormous sums to patients with minor injuries) actually raises two questions: how often do patients with minor injuries get to trial, and how do they fare when they do so? Trials involving patients with minor injuries appear to be few and far between. Studying a sample of medical malpractice trials drawn from large counties nationwide, the Bureau of Justice Statistics (“BJS”) found that “90% of medical malpractice trials involved plaintiffs who claimed malpractice had caused death or permanent injury.”⁶³

When cases involving less severe injuries are tried, they result in smaller verdicts. The BJS’s study of medical malpractice trials nationwide found an enormous impact of injury severity on damage awards: “[M]edian award amounts for medical malpractice trials arising from death claims (\$837,000) and permanent injuries (\$412,000) were higher than the median awards for medical malpractice trials that stemmed from temporary injuries (\$77,000).”⁶⁴ Given the lottery metaphor, another finding in the BJS report is even more interesting: *no* patient with a temporary injury received an award exceeding \$1 million from a jury.⁶⁵ According to the

61. Frank Sloan & Stephen van Wert, *Costs of Injuries*, in *SUING FOR MEDICAL MALPRACTICE* 139, 139 (Frank A. Sloan et al. eds., 1993).

62. *Id.* at 220.

63. THOMAS H. COHEN, U.S. DEPT OF JUSTICE, BUREAU OF JUSTICE STATISTICS, *MEDICAL MALPRACTICE TRIALS AND VERDICTS IN LARGE COUNTIES 2001*, at 1 (Apr. 2004), available at <http://www.ojp.usdoj.gov/bjs/pub/pdf/mmtv1c01.pdf>. The BJS data includes separate variables for permanence of injury and seriousness of injury. See Catherine M. Sharkey, *Unintended Consequences of Medical Malpractice Damages Caps*, 80 N.Y.U. L. REV. 391, 506 (2005) (constructing severity variables from three BJS variables, including permanence and seriousness of injury).

64. COHEN, *supra* note 63, at 2.

65. *Id.*

BJIS study, the set of true lottery winners—patients with small losses who win big jury awards—is empty.

Similarly, a recent study of California jury verdicts with large non-economic awards found that significant verdicts favoring plaintiffs with minor injuries are rare. As the study notes, “[I]n general, plaintiffs’ injuries were severe: Approximately half resulted in death, grave injury, or major injury. No claims involved emotional or insignificant injury exclusively, and only 3% involved temporary minor injury.”⁶⁶ Non-economic damages and the chance of a multi-million dollar verdict correlated strongly with injury severity.⁶⁷

It also takes a long time for patients to get compensation from the legal system. The General Accounting Office found that claims closed in the mid-1980s took sixteen months from injury to claim and twenty-five months from claim to disposition.⁶⁸ Claims involving more severe injuries and larger payments took longer than others to resolve, with claims involving more than \$1 million having the longest disposition times.⁶⁹ Medical malpractice cases also appear to take longer than tort cases of other kinds. Studying a nationwide sample of tried cases, Professor Michael Heise found a mean length for all civil cases that reached juries of 30.2 months, while the average tried malpractice case lasted more than half a year longer, 38.4 months.⁷⁰

To summarize, payment and injury are closely correlated—but injured patients often do not get what they deserve because the malpractice system is stingy. Adding insult to injury, it takes a long time for the under-compensation to arrive.

66. David M. Studdert et al., *Are Damages Caps Regressive? A Study Of Malpractice Jury Verdicts In California*, 23 HEALTH AFF. 54, 57 (2004).

67. *Id.* at 58, 60 (reporting “a statistically significant jump between the mean[] [noneconomic awards] for the bottom three [injury severity categories] and [the] top three severity categories”); see also Lucinda M. Finley, *The Hidden Victims of Tort Reform: Women, Children, and the Elderly*, 53 EMORY L.J. 1263, 1269 (2004) (emphasizing severity of injury in tried cases).

68. U.S. GEN. ACCOUNTING OFFICE, MEDICAL MALPRACTICE: CHARACTERISTICS OF CLAIMS CLOSED IN 1984, at 18 (1987).

69. *Id.*; see also *id.* at 34 (“[C]laims for which no payment was made had a median disposition time of 17.0 months, and the claims that received the smallest indemnity payments (\$1 to \$999) had the lowest median and average disposition times of 6.0 and 11.9 months,” respectively). The median and average time from claim to disposition of claim with an indemnity payment of \$1 million was 76 months and 64.9 months, respectively. *Id.*

These delays are not unique to the United States. Fenn and Rickman report similar disposition times in England. “In the UK, a National Audit Office report (NAO (2001)) estimates that medical malpractice cases take, on average, five and a half years to settle.” PAUL FENN & NEIL RICKMAN, LEGAL LIABILITY AND THE TIMING OF SETTLEMENT IN MEDICAL MALPRACTICE 2 (2005), available at <http://law.bepress.com/cgi/viewcontent.cgi?article=1543&context=alea>.

70. Michael Heise, *Justice Delayed? An Empirical Analysis of Civil Case Disposition Time*, 50 CASE W. RES. L. REV. 813, 834 (2000).

VI. HOW OFTEN DO PLAINTIFFS WIN AT TRIAL?

Provider-defendants win the vast majority of medical malpractice trials. According to the Insurance Information Institute, a study of almost 11,000 medical malpractice trials between 1985 and 1999 found that provider-defendants won approximately 81 percent of the time.⁷¹ The BJS study of medical malpractice cases tried in large counties across the United States in 2001 found that provider-defendants won approximately 73 percent of the time.⁷² The recent Harvard study of closed insurance claims found a comparable imbalance.⁷³

Plaintiffs win trials of other kinds of lawsuits far more often than they persuade juries in medical malpractice cases. For example, the BJS study reports that plaintiffs won 52 percent of all tort trials in its sample that took place in 2001. The remarkably high defense win rate in medical malpractice cases ranks as one of the most robust findings of empirical studies of the civil justice system.

When plaintiffs do win at trial, they receive a “trial premium” relative to the amounts they would have received had they settled. Studying Florida cases, Sloan et al. found that “those who won at trial received 22 percent more than economic loss.”⁷⁴ By comparison, patients who settled usually recovered much less than their economic costs.⁷⁵ The new study of payment/error matching by Studdert et al. also reports a trial premium.⁷⁶ In an ongoing study of Texas closed claims data, we find a trial premium as well.⁷⁷

To be sure, it is misleading to measure trial premiums in terms of trial verdicts. The actual premium is not the difference between the mean or median trial verdict and the mean or median settlement; it is the difference between the mean or median amount a plaintiff who wins at trial actually recovers and the mean or median settlement

71. Insurance Information Institute, Hot Topics and Insurance Issues: Medical Malpractice, <http://www.iii.org/media/hottopics/insurance/medicalmal/> (last visited May 31, 2006).

72. COHEN, *supra* note 63, at 1.

73. Studdert et al., *supra* note 25.

74. Sloan, *supra* note 29, at 195. Ted Frank used this finding to imply that patients who win at trial recover too much. See Posting of Ted Frank, *supra* note 37. However, Sloan et al. expressly denied that the trial premium implies over-compensation. “When one considers that patients have to pay their attorneys, defray expert fees and other litigation costs, and reimburse Medicare, Medicaid and other payers from these sums, even the trial recoveries seem ungenerous.” Sloan, *supra* note 29, at 195. Sloan et al. also emphasized that any overpayments won in tried cases fail by far to offset the overall problem of under-compensation caused by under-claiming. *Id.*

75. *Id.*

76. Studdert et al., *supra* note 25.

77. See Hyman et al., *supra* note 8.

payment. Because post-verdict payments are often substantially discounted by settlement or remittitur, the actual trial premium is much smaller than a focus on undiscounted verdicts would make it appear. Professor Neil Vidmar, who has conducted numerous studies of jury verdicts in medical malpractice cases, finds that large jury awards tend to be reduced drastically on appeal, in subsequent settlement negotiations, or by other means. The larger the award, the more likely it is to be substantially reduced.⁷⁸ For example, in a report on Pennsylvania medical malpractice cases that closed between 1999 and 2001, Vidmar found that “[o]f twenty-two cases involving jury verdicts of \$5 million or more, the final payment to the plaintiffs ranged between 6 percent and 46 percent of the jury verdict, with the average settlement being 22 percent of the jury award. As in previous research, the largest awards tended to be reduced the most.”⁷⁹ In a study we are currently completing of Texas closed claims, we find that post-verdict “haircuts” are more common and larger than has been previously observed.⁸⁰

VII. PAYMENT FREQUENCY AND AMOUNT

When premiums for liability insurance spike, health care providers and tort reformers point the finger at various aspects of the malpractice litigation system, including overly generous juries and frivolous lawsuits. In political circles, these explanations are the conventional wisdom. One can assess the validity of these charges by examining payment trends for all closed claims. If a significant increase in jury verdicts occurred, payments (both total and per claim) should have become larger, triggering a lagging increase in the number of claims. In the absence of these changes, it is hard to see how changes in jury verdicts can drive up insurance premiums. If a rising tide of frivolous lawsuits generated an increasing flow of extortionate settlements, claims and total payments should have

78. See Neil J. Vidmar, Felicia Gross & Mary Rose, *Jury Awards for Medical Malpractice and Post-verdict Adjustments of Those Awards*, 48 DEPAUL L. REV. 265, 280, 298 (1998); see also NEIL VIDMAR, MEDICAL MALPRACTICE AND THE AMERICAN JURY: CONFRONTING THE MYTHS ABOUT JURY INCOMPETENCE, DEEP POCKETS AND OUTRAGEOUS DAMAGE AWARDS 261 (1995); Neil J. Vidmar, *The American Civil Jury for Auslander (Foreigners)*, 13 DUKE J. COMP. & INT'L L. 95, 122 (2003).

79. Neil Vidmar, *Juries and Jury Verdicts in Medical Malpractice Cases: Implications for Tort Reform in Pennsylvania* (Jan. 28, 2002) (unpublished manuscript, on file with Neil Vidmar); see also Neil Vidmar & Leigh Ann Brown, *Tort Reform and the Medical Liability Insurance Crisis in Mississippi: Diagnosing the Disease and Prescribing a Remedy*, 22 MISS. C. L. REV. 9, 30 (2002).

80. See Hyman et al., *supra* note 8.

increased, although payments per claim may well have dropped. In the absence of these changes, it is hard to see how frivolity can be responsible for the premium increase. More broadly, tracking total payments, claims, and payments per claim allows one to test the global claim that the malpractice system caused liability insurance premiums to spike. If total payments held steady or changed slowly and predictably over time in response to known cost drivers, forces outside the malpractice system must be responsible for the premium spikes.

It is difficult to perform such longitudinal studies, because the necessary closed claims data are often not publicly available or do not cover enough years. However, three longitudinal studies were published in 2005—and all three come to broadly similar conclusions.

Black et al. studied malpractice payment trends in Texas during the period from 1988 to 2002 using a closed claim database created by the Texas Department of Insurance (“TDI”).⁸¹ The title of this study—“Stability, Not Crisis”—conveys its core finding: no sudden changes occurred in the number or size of payments that could account for the dramatic premium spikes in Texas beginning in late-1999. When adjusted for population growth, the number of closed claims, the number of claims with payouts of \$25,000 or more (in constant 1988 dollars), and the percentage of claims that produced large payouts were all stable. The number of claims and of large paid claims grew slower than the supply of Texas physicians, causing claims and paid claims per 100 physicians to fall. Claim and paid claim frequency showed no time trend when adjusted for health care expenditures. Payout per large paid claim rose by 0.1 to 0.5 percent per year, but the increase was either not statistically significant or barely significant, depending on the dataset employed. Median payouts on large paid claims were flat, controlling only for general inflation. With the same adjustment, the mean payout grew slightly, reflecting a gradual decline in the frequency of small paid claims. Total payouts to patients were also roughly constant over time when adjusted for inflation and health care consumption.

Using a similar dataset maintained by Florida insurance regulators, Vidmar et al. examined trends in claim frequency and

81. Black et al., *supra* note 26, at 209. Starting in 1988, TDI required all malpractice insurers to file detailed individual reports of claims with payments above \$10,000, and to make aggregate reports of smaller claims annually. Individually reported claims accounted for the bulk of the dollars paid. Because TDI audited the data for accuracy starting in 1990, the findings for 1990-2002 are likely the most robust.

payments in that state from 1990 to 2003.⁸² Their findings differ from those of Black et al. in some important respects, but they nonetheless describe a claiming environment that was generally stable. Total claim frequency held level over 1990 to 1997, averaging about 2,600 claims per year. Paid claims grew in number from 1990 to 2003, roughly in line with Florida's rising population, but more slowly than Florida's supply of physicians. Paid claims per 100 doctors fell from 3.98 in 1990 to 3.33 in 2002. Turning to payment amounts, Vidmar et al. found that mean (median) payments for paid claims increased substantially, from \$177,000 (\$49,000) in 1990 to \$300,000 (\$150,000) in 2003, in constant 2003 dollars. The number of \$1 million payments also increased, from twenty-nine in 1990 to ninety-seven in 2003, but the average size of payments over \$1 million did not change. In other words, more patients received \$1 million payments, but the average payment to a patient who received a \$1 million payment did not change.⁸³

Vidmar et al. attribute the observed increase in payment size to a significant increase in the severity of the injuries claimants sustained, and to larger awards within injury severity categories, possibly driven by the growing cost of health care.⁸⁴ Florida's experience with malpractice claims thus appears to have been more dynamic in the 1990s than Texas's system. But if Vidmar et al. are right, the changes in Florida reflect neither frivolous lawsuits, nor injuries run amok, nor any other defect in the malpractice system. Rather, Florida, like Texas, witnessed a gradual decline in small medical malpractice cases. Payments rose because plaintiffs' attorneys adjusted their portfolios, taking fewer cases with minor injuries and more cases with severe injuries or death. The problem was not a sudden rash of frivolous cases but instead, a host of serious ones.

Chandra et al. evaluated trends in claims and payments by drawing on reports of malpractice settlements filed with the National Practitioner Databank between 1991 and 2003.⁸⁵ Their sample contained 184,506 reports concerning physicians in all fifty states. In general, their findings mirrored those of Black et al. and Vidmar et al.

82. Neil Vidmar et al., *Uncovering the "Invisible" Profile of Medical Malpractice Litigation: Insights from Florida*, 54 DEPAUL L. REV. 315, 333-35 (2005). Owing to changes in Florida's reporting practices, many findings in this study are limited to 1990-1997.

83. Vidmar et al. did not provide information on total payments.

84. Unfortunately, Vidmar et al. did not perform a regression analysis to estimate the relative importance of these factors.

85. Amitabh Chandra, Shantanu Nundy & Seth A. Seabury, *The Growth of Physician Medical Malpractice Payments: Evidence from the National Practitioner Databank*, 26 HEALTH AFF. W5-240, 241-47 (2005).

They found that the frequency of paid claims was stable. The number of payments per 100,000 persons actually fell slightly, from 5.2 to 5.0. Like the Florida researchers, they found that payment size increased: a 52 percent rise in real dollars from 1991 to 2003, yielding an average increase in severity of 4 percent per year. Curiously, the rate of growth slowed to 1.6 percent during 2000 to 2003, the years during which liability premiums spiked nationwide.

Chandra et al. also followed the Florida team in finding relatively little growth in the size of the largest payments, although they employed a different methodology. Instead of focusing on payments above \$1 million, Chandra et al. isolated the top 10 percent of claims by size. The mean payment for this subgroup rose from about \$868,000 in 1991 to about \$1,155,000 in 2003. The average annual growth rate for the largest claims was 2.5 percent—much lower than the 4.0 percent rate of increase for all reported payments. Finally, Chandra et al. calculated physician malpractice liability per \$1,000 in health care expenditures (measured two ways), and showed that the ratio changed little over time. The stability of the ratio led them to conclude that “rising medical costs, which contribute to the size of compensatory awards, may explain a sizable portion of payment growth, consistent with other findings.”⁸⁶

These three studies indicate that factors outside the medical malpractice system were responsible for the premium spikes that commenced in 1999.⁸⁷

VIII. INCENTIVE-BASED EXPLANATIONS FOR THE FINDINGS OF EMPIRICAL RESEARCH

The studies summarized in Parts II through VII paint a clear and fairly comprehensive picture of the medical malpractice system at work. Patients rarely sue, and those who sit on their rights rarely receive compensation. Virtually all patients who do sue suffered adverse outcomes involving serious physical injuries, and most have plausible or valid claims. Truly frivolous complaints are rare. Far more common are claims that seem strong initially but that turn out to lack merit. The malpractice system weeds out these claims fairly well. Patients with meritorious complaints are more likely to receive payments and tend to receive larger amounts. Over the past fifteen

86. *Id.* (citing Seth A. Seabury et al., *Forty Years of Civil Jury Verdicts*, 1 J. EMPIRICAL LEGAL STUD. 1 (2004)).

87. The Bureau of Justice Statistics found that median awards and the percentage of plaintiffs receiving awards of more than one million dollars were stable in 1992 and 1996, but rose significantly in 2001. We addressed this point in an earlier article.

years, the system also appears to be stable in important respects. Claim frequency, payment frequency, payment amount, and jury verdicts have all fallen slightly, held roughly constant, or risen slightly. There are no dramatic changes in any of these measures, and the trends that have been noted appear to reflect rising health care costs or the progressive removal of smaller cases from the system.

To be sure, the medical malpractice liability system is far from perfect. It often withholds compensation from patients with valid complaints, it under-compensates victims systematically when it does pay them, and it generates high loading costs which appear to be rising. Despite the conventional wisdom to the contrary, the medical malpractice liability system does not seem to favor the interests of plaintiffs. This fact is demonstrated by the frequency of under-compensation and its magnitude, the exceptional win rates defendants enjoy at trial, the willingness of plaintiffs to discount jury verdicts when settling, and the dollar amounts these patients often give up.⁸⁸

What accounts for these patterns? In this Part, we offer our take on the incentives that account for the findings reported in Parts II through VII, separately examining the behavior of patients, plaintiffs' lawyers, providers/carriers, and overall system dynamics. We approach the malpractice system as a collection of iterated exchange relationships involving sophisticated repeat players seeking the highest possible returns.⁸⁹ This approach makes sense because the malpractice system operates mainly through voluntary transactions (settlements) effected by plaintiffs' attorneys and insurance carriers, both of whom are repeat players. These exchanges differ from trades that occur in free consumer markets for two important reasons. First, in the absence of agreement, participants can force exchanges at prices set by others (judges and juries), if they are willing to spend the money needed to go to trial. Second, participants are locked into sequential bilateral monopolies. These differences have important implications for participants' preferred strategies. In particular, they discourage liability carriers from throwing good dollars at bad claims, and they encourage plaintiffs' attorneys to specialize and to develop reputations for choosing good cases and winning at trial. Both of these strategies help maximize the probability that payments will be made in true positive cases, and not in false positive and true negative cases.

88. We are not suggesting that the malpractice system *should* favor the interests of negligently injured patients. Instead, the malpractice system should create optimal *ex ante* incentives to treat all patients non-negligently.

89. Cf. Danzon, *supra* note 9, at 49–50 (“[S]imple, self-serving rationalism largely explains average behavior and outcomes in the disposition of medical malpractice claims.”).

A. Patient Behavior

1. How Do Patients Learn They May Have A Claim?

Patients learn they may have claims in two ways: by monitoring care quality directly, and by receiving information from others. Even unsophisticated patients catch some errors, the canonical examples being wrong-site surgeries and post-operative infections caused by forgotten surgical tools. But patients may also pick up on blood type mismatches, misdelivered and undelivered test results, and certain obvious medication errors. Patients with chronic illnesses have numerous opportunities to observe their medical treatments and obtain better information about what is (and is not) an error.

Patients also receive information about medical mistakes from others, including the health care providers who commit them. Although one frequently hears that fear of litigation prevents providers from admitting mistakes, studies indicate that first-party disclosures are reasonably common, although far from universal.⁹⁰ Other potential informants include health care providers who observed the malpractice but did not participate in it, providers who treated the patient for the resulting injury, or family members and friends.⁹¹

2. Why Don't Most Patients With Claims Sue?

It is clear that most negligently injured patients do not sue.⁹² In most respects, the reasons for passivity are obvious. First, medical errors are often hard to spot. The popular literature on health care quality is replete with stories of patients who either never discovered their harms or never identified medical errors as the cause.⁹³ Even

90. The evidence on voluntary disclosure practices is summarized in Hyman & Silver, *Part of the Problem or Part of the Solution*, *supra* note 1.

91. Hickson et al., *Factors that Prompted Families*, *supra* note 18, at 1361 (finding that 33% of the respondents were "advised or influenced to sue by someone outside the immediate family," and that "[i]n 23 of these 41 cases [56%], the influential acquaintance was a member of the medical profession.").

92. Ironically, tort reformers seem not to regard this observation as a point in favor of the tort system. When injured patients sue, tort reformers decry their litigiousness. When they do not sue, tort reformers point out that the malpractice system fails to compensate them. "Heads, I win; tails, you lose," anyone?

93. For example, *Internal Bleeding*, *supra* note 20, at 83-87, describes the case of an elderly woman who died after being given insulin by mistake. The cause of death was a mystery until a nurse found a vial in the ICU. The vial, which had contained insulin, resembled one used for

physicians asked to review patients' charts often miss departures from the standard of care. Patients who do not "name" and "blame" do not "claim."⁹⁴ Since statutes of limitations for malpractice are exceedingly short (usually two years), patients who do not learn about errors expeditiously can lose their rights.⁹⁵

Second, and mercifully, most medical errors inflict harms that are small or temporary. For example, the study of Colorado and Utah hospitalizations calculated that 41 percent of negligent adverse events resulted in a minor temporary disability, and "insignificant" disability accounted for another 7 percent of negligent adverse events. The HMPS found that 46 percent of those negligently injured recovered completely within one month. Like other tort contexts, medical malpractice injuries are skewed toward the minor end of the scale—and patients know better than to "sweat the small stuff."

Third, health insurance generally covers most of the treatment costs associated with negligent injury.⁹⁶ This reduces the incentive to sue, especially in jurisdictions that have abrogated the collateral source rule.⁹⁷ The health insurer also has a subrogation claim against any recovery, further reducing (and complicating) the incentive to proceed with a lawsuit.⁹⁸

Fourth, the malpractice system is expensive, burdensome, and slow. To become a plaintiff, a patient may have to terminate an existing relationship with a health care provider and find a new source of treatment. A patient may fear being "blacklisted," that is, being refused treatment by other physicians or providers who steer clear of patients known to sue.⁹⁹ A patient must also be willing to be

heparin, a blood thinner used to keep intravenous lines open. The patient's ICU nurse, intending to flush the intravenous line with heparin, "had inadvertently injected a fatal dose of insulin," killing the patient. *Id.* at 87.

94. See generally William Felstiner, Richard L. Able & Austin Sarat, *The Emergence and Transformation of Disputes: Naming, Blaming, Claiming*. . . , 15 *LAW & SOC. REV.* 631 (1980-81).

95. Huycke & Huycke, *supra* note 52 (finding that 13 percent of persons who called law firms with malpractice complaints did so after the statute of limitations expired).

96. See William G. Johnson et al., *The Economic Consequences of Medical Injuries: Implications for a No-Fault Insurance Plan*, 267 *JAMA* 2487, 2489 (1992) ("Compensation from existing health insurance, for example, reduces the net cost of medical care from \$1805 million to \$240 million."); see also DEBORAH R. HENSLER ET AL., *COMPENSATION FOR ACCIDENTAL INJURIES IN THE UNITED STATES* (1991).

97. BAKER, *supra* note 2.

98. *Id.*

99. See, e.g., Christine Wiebe, *Business of Medicine Briefing*, MEDSCAPE MONEY & MED., Apr. 30, 2004, available at <http://www.medscape.com/viewarticle/474639> (reporting that Texas doctors began blacklisting malpractice claimants and that doctors are requiring patients to pledge not to assert claims). Doctors are also refusing to treat medical malpractice attorneys, their family members, and others whom they blame for high insurance rates. See Don Babwin, *Malpractice Wars: Doctors vs. Lawyers: Some Physicians Refuse Non-Emergency Care to Lawyers*

interrogated by several plaintiffs' attorneys (because most requests for representation in medical malpractice cases are refused), to submit to a deposition (because insurance companies routinely make plaintiffs prove their cases, even when their own consultants agree that malpractice occurred), to wait years for compensation, to go to trial if the case does not settle, and to pay a lawyer a sizable contingent fee (usually 33 to 50 percent of the recovery plus expenses).

Fifth, the malpractice system is stingy. Patients usually lose, and those who obtain payments usually recover less than their economic losses. Patients may not know these facts, but the plaintiffs' attorneys on whom they rely make it their business to know what claims are worth. A contingent fee lawyer who consistently takes bad cases will not remain in practice long. Thus, the expected value of the claim—the predicted recovery discounted by the probability of obtaining it—must be large enough to interest an attorney in the case.

Sixth, when it comes to dealing with defective care, there are alternatives to the legal system. Patients may change providers, complain to their providers, or report providers to regulators and disciplinary authorities.¹⁰⁰ These alternatives (exit and voice) are cheaper than suing, and some are also faster—and they siphon off some patients who might otherwise sue.¹⁰¹

Given this, the dearth of malpractice lawsuits (relative to the number of medical injuries) is easily explained. Most of the time, patients have an insufficient incentive to sue. The rational course for most patients is some combination of lumping it, switching providers, and complaining.¹⁰²

3. Why Do Some Patients With Claims Sue?

Patients file lawsuits when they have a sufficient incentive to do so. The incentive to sue depends on the severity of the injury, out-of-pocket expenses, and the extent of the patient's irritation with the

They Blame for Soaring Costs of Insurance Coverage, HARTFORD COURANT, June 16, 2004; Jeff Bell, *Provoked by Mounting Malpractice Suits, One Doctor Refuses Care for Trial Lawyers*, BUS. FIRST OF COLUMBUS, May 21, 2004. USA TODAY reported that Selina Leewright, a nurse, was fired from her post at a hospital because her husband worked as a lawyer at a firm that did medical malpractice work. Laura Parker, *Medical-Malpractice Battle Gets Personal: Some Doctors Refuse to Treat Attorneys*, USA TODAY, June 14, 2004, at 1A.

100. See Marlynn L. May & Daniel B. Stengel, *Who Sues Their Doctors? How Patients Handle Medical Grievances*, 24 LAW & SOC'Y. REV. 105, 108 (1990) (finding that patients with medical grievances who do not sue change providers (46%), complain (25%), consult a lawyer but do not sue (9%), or "lump it" (26%)).

101. However, some of those who sue take advantage of these options as well. *Id.* (finding that 85% of those who sued switched doctors, and 31% complained).

102. See *supra* note 5, and accompanying text.

provider. Injury severity significantly affects the likelihood that a patient will consult a lawyer, as well as the likelihood that a lawsuit will result.¹⁰³ Most of those who file a lawsuit are significantly injured,¹⁰⁴ and the severity skew appears to be increasing over time, as tort reform makes cases involving less severe injuries nonviable.¹⁰⁵ Health insurance reduces out-of-pocket expenses, but not everyone has health insurance, and it typically does not cover all medical expenses, let alone lost earnings. Studies indicate that substantial out-of-pocket expenses are an important factor in whether patients sue.¹⁰⁶ Finally, patient irritation (usually related to failures in communication after an injury has occurred) is an extremely important predictor of which patients will sue.¹⁰⁷ Stated differently, although lawyers seek to attract malpractice claimants through a variety of strategies, they are marketing their services to people who are already unhappy with the outcome of their medical care.¹⁰⁸

These studies indicate that patients respond to incentives and information when deciding whether to bring malpractice claims to the legal system for resolution. Injury severity, which determines the magnitude of patients' losses and their litigation recoveries, is the most important driver. Given the cost, delays, and cumbersomeness of the malpractice system, it is hardly surprising that it is appealing primarily to patients with severe injuries and large damages.

103. See May & Stengel, *supra* note 100, at 117.

104. Even injuries classified as minor or temporary on the NAIC's 9-level scale usually look serious when examined closely. The NAIC scale does not accurately track human assessments of injury severity. See Allen J. Hart, Roselle L. Wissler, & Michael J. Saks, *Multidimensional Perceptions of Illness and Injury*, CURRENT RES. SOC. PSYCHOL., 1997, available at <http://www.uiowa.edu/~grprproc/crisp/crisp.2.4.htm>.

105. See Vidmar et al., *supra* note 82; see also Black et al., *supra* note 26 (finding gradual disappearance of small cases over time).

106. Hickson et al., *supra* note 18, at 1361 (noting that 24 percent of claimants offered financial need as a reason for filing suit). See generally BARRY WERTH, DAMAGES (1998) (family which filed lawsuit did so because of overwhelming cost of health care services for their child).

107. Hickson et al., *supra* note 18, at 1361 (finding that 24 percent of malpractice plaintiffs complained "that [the] physicians had failed to be completely honest with them about what happened, allowed them to believe things that were not true, or intentionally misled them," and another 20 percent sued because they believed "the courtroom was the only forum in which they could find out what happened from the physicians who provided care").

108. See *id.* (finding "only a single case in which parents failed to suspect a problem until approached directly by a previously unknown lawyer").

B. Lawyer Behavior

1. Why Do Lawyers Screen Cases?

The process of finding a lawyer is the first formal step by which the malpractice system distinguishes between valid and invalid claims. Not having an attorney effectively means not having a malpractice lawsuit—but the attorney must be convinced that the claim is worth pursuing. Most potential plaintiffs are rejected out of hand because their claims are too small or too weak. In the words of the title of a well-known article on the subject, plaintiffs' lawyers help "hold back the floodtide" by turning down the overwhelming majority of cases that come to their attention.¹⁰⁹ Attorneys are strict gatekeepers because they are paid on contingency, and medical malpractice cases are risky and expensive to litigate.

Medical malpractice cases are risky because defendants are reluctant to settle and win a substantial majority of trials.¹¹⁰ They are expensive because experts are costly, and three of the four elements of the cause of action (breach, causation, and damages) are routinely contested.¹¹¹ The defense bar is replete with sophisticated repeat players, and everyone knows that plaintiffs' attorneys only get paid if they win.¹¹² Plaintiffs' attorneys can not charge supra-competitive

109. Kritzer, *Holding Back the Floodtide*, *supra* note 51.

110. See Samuel R. Gross & Kent D. Syverud, *Why Civil Cases Go to Trial: Strategic Bargaining and the Desire for Vindication*, DISP. RESOL. MAG., Winter 1997, at 21, 23 (finding that defendants engaged in strategic bargaining by making no settlement offers in approximately 60 percent of medical malpractice trials); see also Samuel R. Gross & Kent D. Syverud, *Getting to No: A Study of Settlement Negotiations and the Selection of Cases for Trial*, 90 MICH. L. REV. 319, 328–29, 369 (1991) [hereinafter *Getting to No*].

111. See, e.g., Osborn, *supra* note 55 (quoting Bill Whitehurst, a prominent practitioner in Austin, Texas, as stating that "the cost of taking a medical malpractice suit to court can be up to \$450,000").

112. See, e.g., Posting of John Day to Evan Schaeffer's Legal Underground, http://www.legalunderground.com/2005/08/guest_post_a_pl.html (Aug. 17, 2005):

Our office turns down hundreds of cases every year, almost every one of them is a sad story, and many of them are downright tragedies Every hour we spend working on cases that have a ten percent chance of recovery we are taking away hours from maximizing the value of the 'good' cases. . . . It is hard to learn the lesson that we cannot help everybody. Unfortunately, we have to give serious consideration to be more like a good oncologist: you can have concern and empathy for that person with Stage 4 pancreatic cancer, but there is little you can do to help them. Some things we just can't fix So, don't be afraid to take a tough case, but do enough homework before you accept the case that you know what you will be investing by way of time and money and can make a reasoned judgment that the juice is worth the squeeze.

rates because the market for legal services is a first-party payer market and is quite competitive.¹¹³

Consider the issue from a more concrete perspective. In a closed claims study published in 1987, the General Accounting Office (“GAO”) estimated that 11,073 malpractice claimants who received payments in 1984 paid \$307.4 million in fees, an average of \$27,761 per person who received a positive recovery.¹¹⁴ This works out to an average fee of \$52,209 in 2005 dollars, adjusting for general inflation. To generate fees of this size, plaintiffs’ lawyers must focus their efforts on cases in which the recoverable damages are large—greatly exceeding those involved in tort cases of other kinds. To put the point another way, many tort claims that would gain the attention of lawyers if they stemmed from automobile accidents are too small for medical malpractice lawyers to handle. These claims may be meritorious in the sense that they would qualify as true positives if paid, but they wind up as false negatives because the cost of pursuing them is too high. A liability carrier is likely to have to pay when a traffic accident causes \$10,000 in damage to a car, but a carrier rarely must pay when a medical error saddles a patient with an equivalent loss because a plaintiff’s attorney cannot credibly threaten to litigate so small a case. When it comes to losses that most people would regard as serious—losses ranging up to \$50,000—the malpractice system gives health care providers a free pass.¹¹⁵

Critics of medical malpractice litigation argue that attorneys have an incentive to pursue long-shot cases, because they only need to win a few to make the gamble worthwhile.¹¹⁶ But to maintain fees at the indicated levels, plaintiffs’ lawyers must also reject weak cases, because expected fees reflect both the damages incurred and the

113. See Danzon & Lillard, *supra* note 28, at 363 (finding that caps on contingent fees increased the rate at which claims were dropped, decreased settlement size, and reduced the frequency of trials; arguing that these findings “tend to refute the common argument that contingent fees yield above-competitive, windfall returns” by showing that fees cannot be reduced without also reducing attorney effort; and concluding that “the evidence is more consistent with contingent fees yielding only competitive returns at the margin”).

114. UNITED STATES GENERAL ACCOUNTING OFFICE REPORT, MEDICAL MALPRACTICE: CHARACTERISTICS OF CLAIMS CLOSED IN 1984, at 48 (1987).

115. See Huycke & Huycke, *supra* note 52 (finding that “[s]mall recoverable damages (generally less than \$50,000 [or \$67,000 in 2006 dollars])” was the reason most commonly cited by attorneys for rejecting requests for representation); see also DANZON, *supra* note 10, at 42 (studying 6,000 closed malpractice claims and concluding that “[t]he evidence confirms that low stakes or high costs increase the likelihood that a case will be dropped”).

116. U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, *supra* note 22 (“Lawyers, therefore, have an interest in finding the most attractive case. They develop a portfolio of cases and have an incentive to gamble on a big ‘win.’ If only one case results in a huge verdict, they have had a good payday.”).

likelihood of winning. An investment in screening makes a great deal of sense, because it is better to learn that a case is weak initially, rather than find out after investing substantial resources and time. Indeed, this strict screening process makes hash of the assertion that plaintiffs' attorneys routinely file and pursue frivolous cases.¹¹⁷ A plaintiff's attorney would have to hoodwink or co-opt all of the following for a frivolous lawsuit to be cost-effective: the lawyer's partners (who share the burden of a lawsuit's costs) an independent expert reviewer (in jurisdictions that require lawyers to obtain certificates of merit before filing complaints), additional experts brought in to testify at trial; a defendant's malpractice insurer (which will typically hire independent experts of its own before paying a claim),¹¹⁸ arbitrators, mediators, or the members of screening panels in the many states that use them, a judge, and a jury.

Nor can one plausibly contend that the threat of pushing a frivolous case to conclusion is sufficient to generate an early settlement offer. First, the threat is not credible, given the obstacles one must surmount. Second, in the medical malpractice context, early settlements are rare and occur mainly when plaintiffs have strong cases, as discussed previously. Third, malpractice policies usually entitle physicians to object to settlements, and physicians often refuse to settle weak claims. Fourth, malpractice insurers regularly put plaintiffs to their proof, even when their own internal reviews indicate that malpractice occurred.¹¹⁹ Fifth, insurers simply do not make offers when their experts think providers performed well.¹²⁰ Sixth, how

117. Even law professors who study frivolous lawsuits acknowledge that no academic researcher has ever turned up hard evidence that there are enough of them to worry about. *See, e.g.,* Robert G. Bone, *Modeling Frivolous Suits*, 145 U. PA. L. REV. 519, 596 (1997). For a clear and brief discussion of existing economic accounts of frivolous lawsuits, see Peter H. Huang, *Lawsuit Abandonment Options in Possibly Frivolous Litigation Games*, 23 REV. LITIG. 47, 59–62 (2004) (modeling “possibly frivolous” litigation in terms of option rights, and concluding that a plaintiff can credibly threaten to commence litigation and to continue it as long as the option value of a claim exceeds the expected cost of remaining litigation stages (the premium the plaintiff must pay for the right to hold onto the option)).

118. Peeples et al., *supra* note 29, at 884 (finding that “outside reviews obtained by the insurer play a critically important role in the claims resolution process,” and that “the insurer will solicit more reviewers in a case where standard of care is eventually determined to have been breached”).

119. *Id.* at 886 (“Even in cases where the insurer concluded the standard of care was breached, the insurer routinely required proof and corroboration. In cases in which the insurer made an offer, the plaintiff was always deposed . . . , and an expert for the plaintiff was almost always identified . . . and almost always deposed.”).

120. *Id.* at 887:

The insurer consistently made an offer when it concluded that the standard of care was breached, and only once made an offer when it had concluded that the standard of care had not been breached. When the insurer was uncertain regarding breach, an offer was made in only six of seventeen cases.

plausible is it that liability insurers, who review hundreds or thousands of claims each year, are unable to tell strong claims from weak claims? To get a settlement payment, a plaintiffs' attorney has to bring a meritorious case.

Given the high cost of medical malpractice litigation, plaintiffs' attorneys' preference for cases with clear liability and large damages is understandable.¹²¹ Only these cases are likely to generate fees sufficient to cover upfront costs and provide an adequate return on invested time and effort. Indeed, as long as there is a pool of strong cases not being brought, as the empirical literature shows is the case, these incentives are magnified. A lawyer would have to be woefully incompetent to "double-down" on what discovery reveals is a weak case, instead of dumping it and finding a strong case to pursue.

2. Why do Lawyers Drop Cases After Accepting Them?

Despite their best efforts, plaintiffs' attorneys still bring a large number of weak cases. These cases are routinely dropped as soon as it becomes clear that they are weak. This dynamic is a matter of experience and math. Several studies find that experienced trial lawyers choose cases more wisely than novice attorneys, as measured by drop rates, frequency of payout, and frequency of insurer agreement that malpractice occurred.¹²²

Math matters because attorneys see far more weak claims than strong claims. Even if they assess the merits of each claim with great accuracy, plaintiffs' attorneys will still initiate many weak cases. A simple mathematical calculation demonstrates the problem. As detailed previously, approximately 1 percent of hospitalized patients are negligently injured. Assume that 10 percent of these negligently injured patients consult an attorney, and that a case will be brought in every instance where the attorney believes there has been negligent treatment. An additional 3 percent will suffer an adverse event which is not the result of negligence, and some additional number (assume 7 percent) will be dissatisfied with their care for one reason or another. As before, assume that 10 percent of these non-negligently injured patients consult an attorney, and that a case will be brought in every

121. See Vidmar & Brown, *supra* note 79, at 32 ("In Vidmar's research on medical malpractice, most plaintiff lawyers that were interviewed indicated that they could not consider taking a medical malpractice case unless the potential damages exceeded \$100,000 and unless they estimate that the chances of proving negligence are substantial.").

122. Peeples et al., *supra* note 29, at 885; Catherine T. Harris et al., *Who Are These Guys? An Empirical Examination of Medical Malpractice Plaintiffs' Attorneys*, 58 S.M.U. L. REV. 225, 245-47 (2005). See also Stephen Daniels & Joanne Martin, *Plaintiff's Lawyers, Specialization, and Medical Malpractice*, 59 VAND. L. REV. 1051 (2006).

instance where the attorney believes there has been negligent treatment. Finally, assume the attorney is 90 percent accurate in identifying strong cases and weak cases. In a population of ten thousand hospitalized patients, one hundred will be negligently injured, ten will consult an attorney, and nine strong cases will be brought. In like fashion, there will be a thousand dissatisfied patients, of whom one hundred will consult a lawyer, resulting in ten weak cases. The combination of a large non-negligently injured population and a small error rate in distinguishing cases means that 53 percent (ten out of nineteen) of the lawsuits that are brought will lack merit. The percentage of weak cases will be even larger if the number of negligently injured patients is smaller or if the attorney's screening processes are more error-prone.

The foregoing example is artificial because it assumes the line between strong claims and weak claims is clear. In reality, the divide is murky. As explained previously, medical experts frequently disagree when making quality of care assessments. Plaintiffs' attorneys cannot succeed where experts fail. Their portfolios will always contain some cases that some people will regard as bad. The project of sorting the wheat from the chaff is inherently difficult, especially at the outset of litigation when many facts are unknown.

Finally, claims may be dropped, not because there is no negligence, but because damages turn out to be insufficient. As noted previously, the inability of injured patients with meritorious claims but small damages to obtain compensation is a signal feature of our malpractice system. These cases become "false negatives" because they are incapable of generating fees sufficient to warrant their costs. Simply stated, a rational plaintiffs' attorney will drop weak cases (whether the weakness lies in damages, liability, or both) as soon as their deficiencies become clear.

3. Why Do Lawyers Invest in Reputations?

Plaintiffs' lawyers invest in reputations because they use them to signal their value to clients, other lawyers, and insurers. As noted previously, in the world of malpractice litigation, clients seek out lawyers, not the other way around. The most successful plaintiffs' lawyers rely on their reputations, and marketing of the same, to attract clients, rather than hanging around hospital wards and emergency rooms.¹²³ A robust referral market helps channel cases to

123. Indeed, disciplinary proceedings have been brought against lawyers who troll for clients in hospitals—and that hardly seems like the pathway to career success. *See, e.g., Fla. Bar v. Barrett*, 897 So. 2d 1269 (Fla. 2005) (disbarring an attorney who paid an employee to solicit

lawyers who can maximize the value of the claims, while rewarding those who identify the claims as meritorious in the first instance. The better the lawyer's reputation, the stronger the signal to the insurer that the claim is valid.¹²⁴

C. Provider/Carrier Behavior

1. Why Don't Providers Just Pay Up?

Providers, insurers, and tort reformers often criticize the malpractice system for delivering compensation to only a minority of patients who deserve it, and for taking too long to process valid claims. This argument strikes us as an example of the "chutzpah defense," best exemplified by the individual who killed his parents, and then threw himself on the mercy of the court because he was an orphan.¹²⁵ Nothing prevents providers or liability carriers from offering payments before patients sue or from paying valid claims expeditiously. Yet, they rarely compensate patients until threatened with litigation. A few hospitals and insurers have implemented a proactive approach on which they reach out to patients as soon as possible, and its widespread use would surely enable the malpractice system to operate more accurately, more quickly, and with smaller transaction costs.¹²⁶ Yet, by and large, compensation flows only to patients who sue and only after litigation becomes protracted. On economic grounds, this is easy to explain. Given the high degree of under-claiming and the high drop rates for malpractice cases, the strategy of paying claims only after protracted litigation minimizes expected liability costs.¹²⁷

clients in hospitals and a chiropractor office); *In re Blaylock*, 978 P.2d 381 (1999) (dismissing a complaint against the defendant, who was both an attorney and emergency room physician, for soliciting clients during his hospital shifts).

124. See Harris et al., *supra* note 122, at 246 (finding that insurers take account of attorneys' reputations when responding to claims); Martin & Daniels, *supra* note 122, at ** (same).

125. See Alex Kozinski & Eugene Volokh, *Lawsuit Shmawsuit*, 103 YALE L.J. 463, 467 (1993). See also *Yates v. City of New York*, 2006 WL 2239430 (D. N.Y. 2006) ("The word chutzpah. . . is now vastly overused in the legal literature. Yet, in a case such as this—in which an individual, after being mauled by the 450-pound Siberian tiger he had been raising inside his fifth-floor apartment along with an alligator, sues the city and the police who entered the apartment in an effort to rescue the animals for doing so without a search warrant—it is a most appropriate term to use.")

126. See Hyman & Silver, *Part of the Problem or Part of the Solution*, *supra* note 1, at 945–46.

127. See BAKER, *supra* note 2:

Because so few people file claims under the present approach—about five percent of those eligible—a new approach that compensated only one quarter of the people who

A similar dynamic appears to operate with regard to medical malpractice cases that go to trial. A government report argues that lawyers paid on contingency “have incentives to pursue selected cases to the end in the hope of winning the lottery, even when their client would be satisfied by a settlement that would make them whole economically.”¹²⁸ The unstated assumption is that in the cases that are tried, insurance companies routinely offer malpractice victims settlements that fully cover their economic losses. This assumption is untrue. Professors Gross and Syverud found that in most medical malpractice cases where trials occurred, defendants (or their insurers) *made no settlement offers at all*.¹²⁹

Providers, tort reformers, and insurers claim to be concerned about under-compensation of injured patients and litigation delays. They could mitigate these problems tomorrow, by abandoning the chutzpah defense, paying claims without forcing patients to sue and immediately offering full economic damages to patient-litigants with strong cases. Their choices (forcing patients to sue and aggressively fighting even meritorious claims) reveals that their true preference, consistent with their economic self-interest, is to force injured patients to bear the largest possible fraction of the cost of negligent treatment.

were eligible would be more expensive than the present approach, even if the compensation paid per claim were reduced to one quarter of what it is now. And the insurance premiums required to support a new approach that compensated even half of those eligible would dwarf the premiums of the present one under almost any set of reasonable assumptions.

128. U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, *supra* note 22.

129. Gross & Syverud, *Getting to No*, *supra* note 110, at 342; *see also* Deborah Jones Merritt & Kathryn Ann Barry, *Is the Tort System in Crisis? New Empirical Evidence*, 60 OHIO ST. L.J. 315, 372 (1999) (“In twenty-three of the forty-three cases for which we had information about the defendant’s best offer . . . , the settlement offer was zero Even among cases that plaintiffs won, defendants offered no settlement in about half (47.4%) of the cases for which we knew defendant’s final offer.”).

One might have thought that a practice of making zero-offers would be risky in a world where claims for bad-faith refusal to settle can be brought in the event of an above-limits judgment. Yet, a study of closed Texas malpractice claims finds that payments above the primary limits are uncommon. *See* Charles Silver et al., *Physicians’ Insuring Practices and Payments on Medical Malpractice Claims* (Mar. 2006) (unpublished draft, on file with authors) (finding that only 1.5% of paid malpractice claims involved payments exceeding the primary policy limits). We find similar results in another paper focusing on jury verdicts. *See* Hyman et al., *supra* note 8. Evidently, the risk of having to pay more than the policy limits is too small to discourage insurers from using the zero-offer strategy.

D. System Behavior

1. Why Do Medical Malpractice Cases Take So Long?

Studies of the civil justice system consistently find that larger, more complex, and more important cases take longer to resolve and consume more resources.¹³⁰ The larger the amount at stake, the more complex the issues and the less clear the facts, the more each side is justified in investing in discovery and pretrial maneuvering. Discovery allows the parties to share existing information and to acquire new information bearing on claim value. By eliminating uncertainty, discovery helps the parties resolve claims where there was initially disagreement. Discovery is not free, however, and parties use it in proportion to its cost and likely economic value. This means investing greater resources in cases involving more serious injuries and larger potential damages. Cases with both severe injuries and difficult liability issues should therefore take longer and require more litigation investments than cases in which only one or neither of these features apply.

This simple model is confirmed by a study of medical malpractice cases involving a group of hospitals in the United Kingdom with claim disposition times similar to those observed in the United States.¹³¹ The study found that “for many claims there is considerable uncertainty initially due to lack of information, and this is gradually resolved over time as more information becomes available about the circumstances of the event and the standard of care adopted by the hospital.”¹³² The study modeled the impact of claim managers’ assessments of liability and damages on the duration and ultimate disposition of claims, and found that strong claims (those where claim managers thought plaintiffs were likely to prevail) settled sooner than others and, in the absence of settlement, were less likely to be abandoned. Changes in managers’ assessments of liability and

130. See Charles Silver, *Does Civil Justice Cost Too Much?*, 80 TEX. L. REV. 2073, 2096 (2002) (summarizing studies and concluding that “[p]arties investigate more thoroughly and otherwise spend more time when claims are large and complicated than when they are small and straightforward”).

131. Fenn & Rickman, *supra* note 69, at 14 (“The mean delay for all claims from incident to initiation was just under three years, with a further delay of around the same duration from the claim’s initiation to its closure.”). See also NATIONAL AUDIT OFFICE, *HANDLING CLINICAL NEGLIGENCE CLAIMS IN ENGLAND* (2001) (estimating that medical malpractice cases take an average of five and a half years to settle) (cited in Fenn & Rickman, *supra* note 69).

132. For example, of the 909 claims that were initially evaluated as involving unclear liability, only 386 retained that ranking in the managers’ final assessments. A good deal of shifting also occurred in initial assessments of other types, e.g., from “probably liable” to “liable.”

damages had a predictable impact, as “new information weakening the hospital’s case . . . sped[] up the settlement process” and reduced the likelihood of abandonment.¹³³

The authors noted that their results indicate “that both the settlement and abandonment hazards for a given malpractice claim can oscillate significantly over the course of the litigation process,” as new information about the case is discovered.¹³⁴ From this perspective, the time spent on discovery generates information clarifying the strength and value of the case, paving the way for settlement. Stated differently, at least some of the “delay” is productive.

2. Why Do Plaintiffs Receive Trial Premiums?

For plaintiffs, trials are riskier propositions than settlements. Accordingly, plaintiffs who win at trial should do better on average than plaintiffs with similar claims who settle their cases. Expressed in financial instrument terms, the plaintiff owns an option that entitles him to a trial, whose outcome is uncertain.¹³⁵ He can sell the option to the defendant (by settling) or exercise it. If he exercises the option, he bears the associated risk and must be compensated for doing so – otherwise he would just settle and avoid the risks. Thus, it is not surprising that plaintiffs who win at trial receive larger payments than plaintiffs with similar claims who settle. At the same time, as we noted previously, jury verdicts considerably overstate the size of the trial premium. A more accurate calculation of the actual premium requires one to standardize the results across cases and compare actual post-verdict payments with the amounts received in settlement.

3. Why Do Malpractice Defendants Win at Trial So Often?

In a famous article, Professors Priest and Klein predicted that at trial plaintiffs and defendants will each win half of the time.¹³⁶

133. Fenn & Rickman, *supra* note 69, at 23.

134. *Id.* at 26.

135. One can also use lottery terminology, although the analogy is inapt for reasons we explained previously. The plaintiff has a lottery ticket, whose value can be determined in the drawing (in which case it is either a big winner or a complete loser) or he can sell it in advance of the drawing to the lottery operator. If the ticket is not drawn, the litigating plaintiff does worse than the one who settles. If the ticket is drawn, the litigating plaintiff does better than the one who settles.

136. George L. Priest & Benjamin Klein, *The Selection of Disputes for Litigation*, 13 J. LEGAL STUD. 1, 6–30 (1984); *see also* George L. Priest, *Reexamining the Selection Hypothesis*, 14 J. LEGAL STUD. 215 (1985).

This prediction rests on the assumption that parties settle easy cases and try cases that fall close to the line. Easy cases settle because the parties are likely to agree how trials would turn out. Close cases are tried because the parties' estimates of trial outcomes are likely to diverge. The 50 percent hypothesis follows because, if plaintiffs and defendants predict outcomes equally well, they should turn out to be right equally often, just as two people attempting to guess the outcome of a large number of coin tosses should both win half the time if one always says "heads" and the other always says "tails."

The Priest/Klein hypothesis fares poorly in studies of medical malpractice trials, which consistently find that plaintiffs lose more than 70 percent of the time.¹³⁷ It holds up better in other tort contexts, where plaintiff and defendant win rates are more balanced. Academic researchers have tried to identify the features of medical malpractice lawsuits that might account for this discrepancy. This is harder than one might think. Most of the obvious explanations should change plaintiffs' and defendants' expectations symmetrically, changing claim values but not causing tried cases to deviate from those with 50-50 odds.¹³⁸ To explain low plaintiff win rates in medical malpractice trials, considerations that make medical malpractice tribunals more or less pro-defendant generally will not suffice, as long as both sides know about them.

What is needed is an explanation for why trials often occur in cases with low likelihoods of success, even though plaintiffs and defendants agree on the litigation odds. Professional malpractice insurance, which sometimes requires consent of the insured to settle a case, is one possible explanation.¹³⁹ Suppose a plaintiff has a 25 to 35 percent chance of winning a case with large damages. Normally, an insurer would attempt to settle a long-shot case like this one by

137. Studying a nationwide sample of trials in large counties, the Bureau of Justice Statistics found that plaintiffs won 27% of medical malpractice trials, while tort plaintiffs in general won 52% of trials. See COHEN, *supra* note 63. The AMA contends that medical malpractice plaintiffs win at trial only 17.6% of the time. See American Medical Association, *supra* note 22 (stating that "of the 7% of claims that went to jury verdict, the defendant won 82.4% of the time") (citing Exhibits 1 and 6A of PHYSICIAN INSURERS ASS'N OF AM., PIAA CLAIM TREND ANALYSIS: 2003 (2004)). Unfortunately, the data on which the AMA relies is not available to researchers.

138. Suppose that juries are biased in favor of patients with severe injuries, as providers and tort reformers contend, or that they instead favor health care providers, as studies comparing jurors' assessments to experts' suggest. If plaintiffs and defendants know that juries lean to one side, they should alter their settlement postures by assigning claims higher or lower values than they would if juries were neutral. Settlements should still occur in cases where opposing parties agree, and trials should still split 50-50 because tried cases would still be those falling close to the line.

139. Gross & Syverud, *Getting to No*, *supra* note 110, at 361.

offering a payment discounted in light of the litigation odds. A consent-to-settle clause prevents an insurer from doing so without a doctor's permission, and a doctor might object to avoid the reputational, reporting, and insurance consequences that accompany a malpractice settlement.¹⁴⁰ If no settlement offer is forthcoming, a plaintiff and his or her attorney will face a stark choice: drop a case with a non-trivial likelihood of success, or try the case knowing that the odds favor the defendant. Predictably, the decision to try will be made when the expected damage award exceeds the marginal cost of going to trial. Also predictably, plaintiffs will lose most long-shot cases, but will do well when they win. Thus, both high plaintiff loss rates and high verdicts in a few long-shot medical malpractice cases can be explained.

The account just offered also explains why juries sometimes find malpractice in cases where providers honestly believe patients received proper care and can offer convincing evidence for this assessment. Long-shot cases are ones in which the evidence weighs in favor of the defendant, but is not conclusive. If enough of these cases are tried, the malpractice system will eventually produce a body of verdicts favoring plaintiffs in cases defendants think they should have won. Some frequency of jury verdicts in favor of plaintiffs with long-shot claims is predictable in a world where providers play "settlement hardball."

4. Why are Claim Frequencies and Payments Stable?

The academic studies covered in Part VII show that variations in the frequency and size of payments on medical malpractice claims stem mainly from inflation, injury severity, and other factors operating outside of the liability system. Some non-academic studies, such as an analysis performed by the Missouri Department of Insurance, reach the same conclusion.¹⁴¹

140. Blocking settlements is relatively costless for providers without large deductibles or self-insured retentions because carriers pick up the cost of judgments within the policy limits. Ongoing research by the authors finds that in only a tiny fraction of the cases (less than one percent) do insured providers contribute personal assets to judgments or settlements. See Silver, *supra* note 129.

141. See MISSOURI DEPARTMENT OF INSURANCE, MEDICAL MALPRACTICE INSURANCE REPORT (Oct. 2005), available at http://www.insurance.mo.gov/reports/medmal/2004_Med_Mal_Rpt.pdf.

Previous MDI analysis has shown that average awards are highly sensitive to medical inflation, the growth in real wages, and average injury severity. . . . Together, medical care and lost wages are the primary economic components of malpractice awards. These two factors have exerted a significant upward pressure on average awards in recent years.

Id.

It remains to explain why medical malpractice claim frequencies and payments have changed slowly and in response to identifiable factors. Bovbjerg et al. signaled the answer in 1997, writing that “[i]n the long run, without significant legislative or administrative change, one expects a program to reach a steady state of filings per year that is related to the underlying phenomena that generate injuries.”¹⁴² Here, the “underlying phenomena” are medical interventions, each of which has an associated probability of harming a patient. Other things being equal, one expects the number of injuries and their severity to reflect the volume and nature of the health care services patients consume. When consumption or population rises, injury frequency should rise as well. When consumption shifts toward services like surgery or anesthesia that can inflict serious harms, average injury severity should increase. Changes in claim frequency and size may not bear a linear relationship to consumption because the quality of health care may change (for better or for worse) with the quantity delivered, but there should be an observable relationship between health care outputs and outputs flowing from the malpractice system.

Other things are not equal, of course. Inflation—especially health care cost inflation—steadily causes malpractice payments to grow in size. Malpractice victims tend to incur substantial past and future health care costs. Rising wages also matter, because a significant purpose of compensatory relief is to replace lost income. Technological change is a huge cost driver too. First, it raises expectations about the quality of care patients should receive by increasing the potential for valuable interventions.¹⁴³ Second, it

142. Randall R. Bovbjerg et al., *Administrative Performance of ‘No-Fault’ Compensation for Medical Injury*, 60 *LAW & CONTEMP. PROBS.* 71, 87 (1997).

143. See William M. Sage, *Medical Malpractice in Crisis: Health Care Policy Options*, COUNCIL ON HEALTH CARE ECON. AND POL., Mar. 3, 2003, available at http://www.kaisernetwork.org/health_cast/uploaded_files/030303_chcep_welcome.pdf.

In fact the easiest way to look at it is that malpractice shows medicine to be a victim of its own success. It’s what medicine can accomplish and how much that costs that drives liability costs. This goes back to the first malpractice crisis in America in the 1870’s. It was a crisis of suits involving failure of limb fractures to heal after they were set. Why these suits in 1870? Well because twenty years previously in 1850 long bone limb fractures were amputated. Amputation does not give route to malpractice claims. Medical progress does. Most of the increase in recent claims have to do with things like failure to diagnose, failure to diagnose a disease claim matters because we can actually do a thing now that we couldn’t do previously and you see a host of claims related to missed or delayed diagnosis of cancer that really captures this phenomenon. Moreover even though medical progress has allowed us to rescue patients at advanced stages of disease you’ll see claims now that alleged malpractice because the side effects of treating the disease at the advanced stage are greater than the side effects of treating the disease if it had been diagnosed in a timely fashion. . . . Now many of those patients survive and can be treated and that changes the damage calculation and the litigation.

enables providers to save and to extend the lives of injured patients who years ago would have died or lived only a short while. Third, it increases the range of goods and services patients can receive to offset or adapt to their injuries. Somewhat perversely, the cost of dealing with malpractice grows as the lives of patients post-malpractice are improved.

For present purposes, the important point is that the factors mentioned in this Part operate on the malpractice system *from the outside*. Even if nothing inside the system changes—that is, even if patients claim at the same rate, plaintiffs' attorneys accept requests for representation at the same rate, and juries evaluate claims consistently—the system's outputs will nonetheless vary in response to external forces. Unless these external causes of variation are controlled for, it will appear that the malpractice system's outputs are changing—even though they are actually stable.

The conclusion that the malpractice system is generally stable and predictable seems surprising only because health care providers and tort reform advocates complain so loudly and so often that it is “broken” and “spinning out of control.” The system is a sizable market in which thousands of participants make millions of decisions in light of known incentives that reflect established substantive and procedural rules. Given its structure and highly diversified nature, the system's overall performance should not vary much in response to isolated perturbations, such as outlier jury verdicts and occasional payments of meritless claims. Shocks like these come out in the wash, much as the unexpected failure or success of an individual company has little impact on the overall performance of a diversified portfolio of stocks.

IX. WHAT SHOULD BE DONE?

People usually avoid activities that cost them money and engage in activities that make them money. One can understand much about the successes and failures of the American legal system (and the U.S. health care system) by keeping this simple insight in mind. Medical malpractice lawsuits are clumsy, expensive, and hard for plaintiffs to win. Consequently, patients rarely sue and malpractice lawyers choose their clients with care. Jurors have high regard for doctors and hospitals, and are suspicious of patients who demand large sums of money. Consequently, plaintiff's lawyers prefer

strong cases that they think they can win—and when they mistakenly accept a weak case, they drop it as soon as its weakness becomes clear.

The main problem with the legal system is that it exerts too little pressure on health care providers to improve the quality of services they deliver. Given the incentives that patients, plaintiff's lawyers, and health care providers face, this too is predictable. Safe health care is expensive, and the tort system forces providers to pay only pennies on the dollar for the injuries they inflict. Rather than spend money improving their systems, providers find it cheaper to tolerate the status quo.

So what should we do about these problems? Our answer is found in the title to this Article: "it's the incentives, stupid." More concretely, using incentives to align the interests of patients and providers is much more likely to improve the status quo than anything currently on the policy agenda. In particular, we propose the following steps, most of which we outlined in a previous article.¹⁴⁴

A. Make the Health Care Market Work Better

When markets work well, civil justice systems can safely play a subordinate role in quality improvement. Their main purpose can be to ensure a degree of civility and respect in economic relationships by taking the roughest edges off disagreements that buyers and sellers cannot work out on their own. Put another way, civil justice systems can supplement consumer-generated pressures to improve but cannot readily replace those incentives.

In the health care sector, law has historically had to shoulder too great a burden because market forces have been too weak. Where else can the government boast of serving customers better than the private sector does? Yet in health care, VA hospitals lead the private sector in deploying electronic medical records and in assuring that patients receive recommended treatments. Because health care quality problems abound, courts are asked to exert greater pressure for quality than they normally do. Even in theory, courts cannot play so large a role. Markets cause quality to improve automatically, by encouraging producers to generate new knowledge and to change their processes as their knowledge grows. Courts decide malpractice cases on the basis of old knowledge (that may or may not be reliable) that has been incorporated into a standard of care (that may or may not be efficient). Courts are therefore inherently limited in what they can do.

144. Hyman & Silver, *Part of the Problem or Part of the Solution*, *supra* note 1, at 983–90.

The first prescription for improving health care quality must therefore be to increase the strength of market forces. The highest priority should be given to arrangements that enhance providers' incentives by tying their compensation to measurable improvements in outcomes and that enable patients to effectively distinguish between superior and inferior providers. To restore the *ex post* tort system to its proper and limited role, we should place more emphasis on *ex ante* contracts between payers, patients, and providers. A good dose of first-party payment arrangements couldn't hurt either.

B. Allow Premiums for Malpractice Insurance to Rise

Providers are rational. When injuring patients becomes more expensive than not injuring them, providers will stop injuring patients. Stated more delicately, when insurance rates go up, they create a highly salient incentive for providers to improve the quality of the services they are offering. Lowering malpractice premiums through tort reform eliminates this incentive without putting anything in its place. Litigation rates and premiums will fall on their own when providers improve the quality of care—thus decreasing the pool of potential plaintiffs.¹⁴⁵

C. Use Caps Strategically

To date, approximately thirty states have enacted caps on damages. These caps apply whether providers have made great effort or no effort to improve the quality of services they provide. How dumb is that?¹⁴⁶ A better strategy, if caps are politically inevitable, is to use them to encourage providers to improve the quality of care they provide. One obvious approach is to reward providers for error reporting and punish them for hiding mistakes. For example, when a provider reports an error within a specified time of its occurrence, she would receive the protection of a limit on non-economic damages.

145. Providers occasionally admit this. See, e.g., Joel B. Finkelstein, *Senate Passes Patient Safety Bill with New Error Reporting System*, AM. MED. NEWS, Aug. 9, 2004 (on file with authors) (attributing to Dr. Donald J. Palmisano, the immediate past president of the American Medical Association, the view that “fewer errors . . . will reduce the number of lawsuits against physicians”).

146. This is a separate issue than the wisdom or stupidity of caps as such. On economic grounds, one would expect liability caps to reduce both the number of large paid claims and the average payout per claim. In the long run, this should lead to lower insurance premiums. The effect of caps in the short run is less determinate, because anchoring effects may predominate. To be sure, matters other than the cost of insurance bear on the desirability of caps as well, including their distributional consequences.

When a provider fails to report an error in a timely manner, we propose that non-economic damages be enhanced. One could use a similar strategy to reward providers who improve their performance on certain defined quality benchmarks, by allowing them to take advantage of a second (and lower) cap on non-economic damages. Otherwise, there is an incentive to simply file away any error reports, instead of using them to improve quality. We note that the HEALTH Act, recently passed by Congress and signed by President Bush, provides neither an incentive to report errors nor an economic reason to use error reports to improve quality.

D. Fix Under-claiming and Over-claiming

It is difficult for the tort system to send the appropriate signals when it is beset with both under-claiming and over-claiming.¹⁴⁷ Under-claiming is hard to fix because most of us cannot easily tell whether we received proper care. Many negligent injuries are too small to justify the high cost of malpractice litigation—particularly when first-party health care payers bear some of the costs. The prospects for increasing the claim rate are dim, unless we rely on persons other than patients to activate the legal system and to generate economic pressure on providers to improve their performance. Health care workers are the obvious candidates. They are more likely than patients to know about errors and faulty delivery systems. They may also know when health care providers are ignoring shortcomings instead of correcting them. A *qui tam* approach, loosely based on that found in the False Claims Act, could create substantial incentives for employees to break the conspiracy of silence and come forward. The approach we envision would reward workers for reporting problems to administrative agencies or third party quality monitors by paying them liquidated bonuses. The reports would remain confidential to ameliorate employees' fear of reprisal.

The over-claiming problem is difficult to fix as well, but one promising avenue is to recognize evidence-based medicine as an absolute defense to liability. To the extent physicians render care that

147. See Randall R. Bovbjerg, *Medical Malpractice on Trial: Quality of Care is the Important Standard*, 49 LAW & CONTEMP. PROBS. 321, 322 (1986) ("Because today's system handles so few of the valid claims that could be brought, medical quality would probably be better served in the long run by increasing rather than reducing the number of liability claims."); William B. Schwartz & Neil K. Komisar, *Doctors, Damages and Deterrence: An Economic View of Medical Malpractice*, 298 NEW ENG. J. MED. 1282, 1284 (1978) ("The ideal negligence signal is achieved only when every noteworthy incident of malpractice leads to a claim and every valid claim to a full award.").

meets consensus standards of quality, there is no reason to subject them to liability or to devote legal resources to such cases. Although there are obvious difficulties associated with the development of consensus standards, physicians who adhere to those standards should be immune from suit.¹⁴⁸ Of course, physicians could also help with the over-claiming problem, by being more forthcoming with patients.

E. Require Repeat Defendants to Undergo Quality Audits and Publicize the Results

A relatively small fraction of all physicians appear to account for a disproportionate share of malpractice claims, settlements, and judgments. Targeting reform efforts against those who are most responsible for the problem is an efficient use of limited resources. State licensing boards and the hospitals at which repeat defendants have privileges should be required to conduct prospective quality audits, publicize the results of those audits, and report them to the National Practitioner Databank.¹⁴⁹ Even if the audits do not result in any disciplinary action or limitation of privileges, the act of publicizing the quality audits should alone create considerable incentives for repeat defendant physicians to correct their deficiencies or find another line of work.

148. This would eliminate such cases as the one recently highlighted in JAMA, where compliance with evidence-based medicine was put on trial. See generally Daniel Merenstein, *Winners and Losers*, 291 JAMA 15 (2004). This approach could also be used to deal more broadly with claims that are effectively unsupported by empirical evidence, such as cerebral palsy cases that are alleged to result from intrapartum or peripartum asphyxia. See AMERICAN COLLEGE OF OBSTETRICS & GYNECOLOGY AND AMERICAN ACADEMY OF PEDIATRICS, NEONATAL ENCEPHALOPATHY AND CEREBRAL PALSY: DEFINING THE PATHOGENESIS AND PATHOPHYSIOLOGY (2003), available at http://www.acog.org/from_home/Misc/neonatalEncephalopathy.cfm. This approach could also be used to insulate from liability standardized treatment protocols, such as not performing a CT scan in pediatric patients who suffer a minor closed head injury. See generally Charles J. Homer & Lawrence Kleinman, *The Management of Minor Closed Head Injury in Children*, 104 PEDIATRICS 1407 (1999) (discussing the treatment of head injuries in children).

149. We do not presume to know how different institutions should weigh judgments, settlements, claims, and complaints in deciding which providers and services require a quality audit. We would predict that judgments and settlements are better signals of low quality care than claims, and claims are a better signal of low quality than complaints. But, there is considerable evidence that complaints, claims, and settlements are correlated with one another, and their informational utility should not be ignored.

F. Roll Back Past Tort Reforms

The effect of past tort reforms is to make malpractice cheaper for potential defendants by reducing the frequency of lawsuits and the amounts that must be paid to resolve them, while doing little about the volatility of insurance premiums.¹⁵⁰ Considerable evidence indicates that health care is not as safe as it should be.¹⁵¹ Tort reform reduces the incentive for providers to invest in measures that protect patients from harm and exercise due care in their treatments.¹⁵² If we are going to have a tort system, we may as well use it to help address the problem of low quality care. Repeal of past tort reforms is an obvious place to start.

G. Basic Research v. Translational Research

It is a truism in academic circles that the first finding of any study is the need for more studies. Medical malpractice is already the best studied area of the tort system, and most of the newer studies reinforce existing findings. Yet, the findings of empirical research have had little effect on the tort-reform debate. As Professor Bill Sage observed:

At a recent conference on medical malpractice policy, a state legislator remarked with some astonishment that the malpractice reform debate indeed seemed highly polarized, but that most profound disagreement was not between health care providers and the plaintiffs bar. The principal conflict he observed was between the major political stakeholders on one side, and the academic community on the other. The former group understood the central question to be the desirability of enacting MICRA-style measures to discourage lawsuits and limit recoveries, with a \$250,000 cap on non-economic damages as its centerpiece. The latter group was essentially unanimous in its opinion that traditional "tort reform" offers incomplete solutions to only a subset of critical problems.¹⁵³

Given this gap, more attention needs to be paid to translational research, so that what we know about the performance of the medical

150. Troyen A. Brennan & Michelle M. Mello, *Patient Safety and Medical Malpractice: A Case Study*, 139 ANNALS INTERNAL MED. 267, 271 (2003) ("Tort reform aims to decrease the expected value of a case for plaintiff's attorneys, changing the calculus about when it is worthwhile to bring a claim.").

151. See Hyman & Silver, *Part of the Problem or Part of the Solution*, *supra* note 1, at 893 ("Health care error rates are higher than they should be."); see generally Brennan & Mello, *supra* note 150 (discussing the tensions between the tort system and patient safety initiatives).

152. *But cf.* Paul H. Rubin & Joanna Shepherd, *Tort Reform and Accidental Deaths*, Feb. 20, 2006, available at <http://ssrn.com/abstract=781424> (finding various tort reforms lead to fewer accidental deaths).

153. William M. Sage, *Understanding the First Malpractice Crisis of the 21st Century*, in HEALTH LAW HANDBOOK 1, 31-32 (Alice G. Gosfield ed., 2004).

malpractice system will inform and shape the debate over what should be done, instead of being ignored.

X. CONCLUSION

During the 1992 election, James Carville kept the Clinton campaign focused and “on message” with a simple slogan: “It’s the economy stupid.” Carville reportedly wrote these four words on a whiteboard and showed it to (then-Governor, but soon-to-be President) Clinton before every speech and event. Clinton hammered the Bush (41) administration throughout the fall on the economy and won the election. Carville’s slogan demonstrates the power of a simple insight in framing the terms of the debate.¹⁵⁴ We do not expect “it’s the incentives, stupid” to have the same effect, but our slogan does have significant potential to improve the performance of the liability system and the health care sector. To ignore the power of the basic insight that people avoid activities that cost them money and engage in activities that make them money would be not just stupid, but profoundly stupid.

154. It mattered not at all that the economy had come out of the recession in March, 1991. See NATIONAL BUREAU OF ECONOMIC RESEARCH, NBER BUSINESS CYCLE DATING COMMITTEE DETERMINES THAT RECESSION ENDED IN MARCH 1991, *available at* <http://www.nber.org/March91.html>. Like the debate over tort reform, perception was more important than reality.

APPENDIX

86% OF LAWSUITS FILED BY PERSONAL INJURY TRIAL LAWYERS AGAINST TEXAS DOCTORS & NURSES ARE FRIVOLOUS
Source: Texas Medical Association Medical Liability Study, 2001 Results



PHANTOM PLAINTIFFS
 Doctors in trial lawyer-friendly counties, sued by patients they never treated.
Source: "Texas is a medical catastrophe in the making" column, Houston Chronicle June 10, 2002



GHASTLY LEGAL FEES
 Tobacco lawyers pocket \$3.3 BILLION!
Source: "Hounded by tobacco settlement" Houston Chronicle July 2, 2002

CAUSING SCARY INSURANCE RATES & MAKING FAMILY DOCTORS DISAPPEAR



BURYING LEGITIMATE CLAIMS
 Real medical claims delayed 2 1/2 years as trial lawyers overload our court system!
Source: 2001 Texas Verdict Survey, Jury Verdict Research Series

DEMOCRATS OPPOSE LAWSUIT REFORM
More than \$7 MILLION in trial lawyer contributions in Texas.
Source: Texans for Lawsuit Reform #02

END LAWSUIT ABUSE VOTE STRAIGHT REPUBLICAN TICKET
EARLY VOTING ENDS NOV. 1ST ELECTION DAY, NOV. 5TH
For voting location info, go to www.texasvictory.org Polls open from 7 AM - 7 PM

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