

Faulty Data and False Conclusions: The Myth of Skyrocketing Medical Malpractice Verdicts

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Introduction

A notion widely accepted by the public is that medical malpractice awards have been rising dramatically in the United States in recent years, driving up the cost of healthcare and forcing physicians out of practice. This impression has been fostered by physician organizations, the hospital and insurance industries, and other groups favoring “tort reform” as a rationale for imposing legislative caps on medical malpractice verdicts.

To a large degree those proposing “tort reform” have based their arguments on the misuse of data from Jury Verdict Research® (JVR). The premise that medical malpractice awards have been rising dramatically in the United States in recent years, driving up the cost of healthcare and forcing physicians out of practice, is not supported by relevant evidence. In fact, the preponderance of available relevant evidence clearly indicates that this notion is a myth.

As a result of the promulgation and acceptance of this myth, major changes in tort law are being advocated at the Federal level. These changes are based on the assumption that rising medical malpractice awards are a major cause, if not *the* major cause, of rising medical costs in this country. However, while it is true that healthcare costs have been rising and some physicians have curtailed their practices because of rising insurance premium costs, there are insufficient data to conclude that this is the result of rising medical malpractice awards.

The changes being advocated by the “tort reform” movement will not result in much, if any, decrease in the cost of medical care. The issues that are actually the driving factors in rising medical costs will not get appropriate attention and medical costs will most likely continue to rise.

At the same time, the proposed changes in tort law will be disadvantageous for individuals who are injured and will remove incentives for wrong-doers to change their ways. The threat of lawsuits, particularly punitive damages, is likely a major incentive for hospitals, HMOs, insurance companies, and pharmaceutical and medical device companies to behave responsibly. They know from experience how legal costs can adversely impact their bottom line.

This report examines the existing data about medical malpractice awards and the data sources. It discusses obstacles to understanding what is truly happening with regard to medical malpractice awards. It discusses why present data sources are inadequate for determining the veracity of this postulate, and reveals that there are numerous reasons to suspect it is false. The report also makes the case that improved data are needed as a basis for rational policy decisions, and proposes options for obtaining those data.

The Myth of Rising Medical Malpractice Awards

The Myth

A set of beliefs widely accepted in the United States is that “jury awards in medical malpractice cases in the United States have skyrocketed over the last ten years;” that overly-sympathetic jurors are “punishing” health care providers who somehow fall short of delivering “perfect” results; and that “runaway lawsuits” are a major factor driving up the cost of healthcare.

These postulates, and their alleged supporting documentation, are frequently repeated by physicians and even some lawyers.¹ They have become the central tenets in the drive for various changes to law, notably lobbying by physicians and their allies in the hospital industry to impose legislative caps on medical malpractice verdicts.² “Tort reform” is a major component of the Republican Party platform, and the public generally accepts these changes as being necessary.

From the standpoint of policy, it is critical to recognize that evidence to support this public perception, which might appropriately be termed a “myth,” is lacking, because of serious deficits in the supporting data.

What Is Keeping the Myth Alive?

Professional organizations such as the American Medical Association (AMA), and industry groups such as the American Insurance Association (AIA) and the U. S. Chamber of Commerce, which favor caps on professional liability awards, use the “skyrocketing malpractice awards” myth on a regular basis. In addition, the myth has been repeated through multiple channels and elaborated upon by groups such as the American Tort Reform Association (ATRA) and others that make up the so-called “tort reform” movement.

The “tort reform” movement is comprised of two main advocate groups:

1. Organizations (such as ATRA and AIA), which are backed by industries that are frequently named as defendants in civil actions, such as insurance, chemical, and tobacco companies; and
2. Right-wing multi-issue organizations (such as the Manhattan Institute) and individuals backed by ultra-conservative funders. They seek to limit legal awards as a means of

¹Robert H. Feinberg and Robert G. Vaught, “Runaway Malpractice Verdicts: Cause and Effect,” Health Lawyers News (November, 2003) p. 4. (“Jury awards in medical malpractice cases in the United States have skyrocketed over the last ten years.”)

²See, “The Malpractice of Tort Reform: Why “Reforms” of the Law Favoring Doctors and Hospitals Hurt Everybody and Don’t Make Health Care Safer.” (forthcoming)

defunding trial lawyers, who are major backers of their political opposition.

The dynamics and methods of the “tort reform” movement and its substantial communications infrastructure have been described in detail by David C. Johnson of the Commonweal Institute. He states:

“...[T]he tort reform movement is part of a two-pronged effort to influence public opinion and gain political power. Industry tort-reform groups utilize “independent voices” – PR agencies and phony “grass-roots” front groups that appear to be independent of the direct beneficiaries of “tort reform.” Meanwhile, the Right has in place a tremendous ideological messaging infrastructure, working for the past 30 years to influence the public’s underlying social and ideological attitudes on issues, including tort reform. They have been disciplined, strategic, and patient. They have focused substantial resources on changing the underlying political and social environment, rather than focusing only on single issues.”³

Perpetuation of the premise that the blame for rising insurance costs rests primarily or exclusively on the heads of trial lawyers is thus clearly in the interests of the “tort reform” movement. With their extensive mechanisms in place to promulgate the image of a failing legal system and “runaway lawsuits,” it is small wonder that many health professionals and the general public have continued to accept this notion.

Other Factors Perpetuating the Myth

The media, seeking for their own business reasons to appeal to the public, emphasize dramatic and “newsworthy” events. High-dollar malpractice awards related to egregious medical outcomes fall into this category. Nuanced follow-up stories about subsequent reductions in payments, negotiated settlements, and the numerous cases with outcomes that result in no cash settlement do not have this dramatic quality.

Organizations of physicians and other healthcare providers, aggrieved by periodic upward spikes in insurance rates and withdrawal of insurers from the market, look for a target on which to direct their anger. Occasional high malpractice awards and the plaintiff attorneys who attain them therefore attract disproportionate attention. Balanced alternative data are not readily available and busy medical professionals are not motivated to seek them out.

Insurance companies are also quite willing to place blame for rising premium rates on plaintiff attorneys and the legal system, rather than having it directed toward themselves.

³ “The Attack on Trial Lawyers and Tort Law”, David C. Johnson, Menlo Park, CA: Commonweal Institute, 2003. Also see online at www.commonwealinstitute.org/reports/TortReport.pdf.

Finally, many plaintiff attorneys highlight the high dollar awards they win for their clients, in the interests of attracting more business. They do not have the same incentive to discuss the details of the numerous cases that are rejected, those which result in no money for the plaintiff or are settled for small amounts, or often lost in the courtroom.

Alternative Explanations

The myth places full responsibility for rising medical insurance costs and changing patterns of medical malpractice litigation on the law and the legal system, referring to “a system that has turned courtrooms into casinos for jackpot justice,” without recognizing the significant responsibility shared by wrong-doers.⁴ This prevailing explanation denies the significant contributions of the medical profession, state medical boards, the economy, and the insurance and healthcare industries to the liability problem. It also ignores other factors, such as the insurance cycle,⁵ changes in both public perception of medicine and the influence of technology, and changes in legal technique and legal theory.

While there have been increases in jury verdicts in the last ten years, they are not nearly so large as physician groups suggest. However, as explained below, large initial rewards in the small fraction of cases that go to trial and are won by plaintiffs do not necessarily translate into large final settlements, due to post-trial reductions, appeals, etc. Occasional mega-verdicts are the result of identifiable changes in the legal environment, and are not the result of a system that is “out of control,”⁶ as many insist.

⁴The president of the American Medical Association best stated the old paradigm, “It’s a myth that bad doctors, a bad economy or bad insurance companies are behind the liability crisis. It is instead a system that has turned courtrooms into casinos for jackpot justice. You can find the facts – and the answers – on the AMA web site.” Yale B. Coble, Jr., M.D., “Today’s Fight for Tort Reform Will Ensure Care in Future,” *American Medical News* (May 19, 2003) p. 23, 24.

⁵The “insurance cycle” refers to a pattern whereby, when insurance companies are profitable, they compete to build market share by price-cutting (lowering insurance rates) (called a “soft market”). Profits are generally invested in other areas of the economy, such as the stock market. This pattern continues until one or more of the companies loses too much and quits the market. This usually is due to the fact that the stock market has deteriorated and the insurance company/companies are not making as much as they need on their investments. When they quit the market—stop selling malpractice insurance or go out of business altogether—other companies will start to raise their rates (called a “hard market”). The combination of fewer (or no) insurers plus rising rates creates a crisis for the physicians in that market.

⁶“We have a medical liability system that is completely out of control, absolutely out of control,” said Dr. Donald J. Palmisano, AMA president-elect (2003), who also has a law degree. “AMA President-Elect Says Now Is Time for Malpractice Reform,” *South Carolina Lawyers*

A significant factor in the larger initial awards is that plaintiff lawyers began to change their tactics and use of technology⁷ in about 1994 in response to the deterioration in medical malpractice recoveries, which had declined from 1987 through 1994, in terms of inflation-adjusted dollars.⁸ During this same period, medical board failures,⁹ coupled with doctors' and healthcare providers' failure to change their behavior, both in and out of the courtroom, shifted the medical malpractice balance to be more favorable to plaintiffs.

Weekly (May 5, 2003) p. 4.

⁷The new tactics have raised the competence level of all serious medical malpractice trial lawyers, increased the likelihood of a large verdict in any particular case, and fostered the emergence of a handful of super-litigators. Plaintiff lawyers now share information about common types of malpractice cases and, in particular, how to overcome new defenses that have been put forward in similar cases. They use the Internet to find quality experts, a major problem in pressing a patient's case. Plaintiff lawyers work together by sharing information, especially relating to "bad baby" cases; develop themes that build on jury members' anger toward physicians, not sympathy for the injured party; use technology, such as video taped depositions and pre-trial focus groups of simulated juries; and anticipate common defense ploys in order to deflect them early in the case. Doctors and their allies in the insurance and legal business for the most part have not made similar tactical shifts.

⁸"Med-Mal Jury Awards Return to '93 Levels," Legal Intelligencer (Dec. 28, 1995) p. 1. (Citing a 1994 Justice Department study).

⁹Because medical boards disdain jury verdicts, they use their own criteria for deciding whether to suspend a doctor's license. The classic example is the New Jersey doctor who literally killed a child cancer patient by giving him ten times the proper dose of chemotherapy and also gave antibiotics to which the child was allergic. He was fined \$5,000. Jim Edwards, "Bad Doctors Keep Practicing," New Jersey Law Journal (Dec. 15, 2003) pp. 1, 17.

Inappropriate Use of Large Loss Data

As indicated above, evidence supporting the prevailing explanation for the supposed medical malpractice “crisis” is lacking or, in many instances, false. Problems identified include inadequate data, inappropriate sources of data, incomplete data, data which is used for unintended purposes (misuse), and inappropriate application of statistical calculations. “Tort reform” proponents most commonly use large-loss data. This section describes the problems inherent in using such data for policy purposes.

Jury Verdict Research Data

Most of the data used to support the notion of “skyrocketing malpractice awards” come from one source – a proprietary publishing company called Jury Verdict Research, Inc. (JVR). JVR is a firm that maintains a database of verdicts and settlements resulting from personal injury claims. The database only includes jury awards. Of note, only four percent of malpractice cases are decided by juries.¹⁰ JVR does not include the 96 percent of cases that do not go to jury, nor does it track reductions in awards, nor appeals that often overturn the initial judgment. Jury Verdict Research (JVR) is proud that the media accredits its data and emphasizes that fact in its marketing.¹¹ But JVR has never asserted that its data should be used for *public policy* purposes. Rather, JVR sells its data to lawyers for case-specific purposes; it has never contended, for example, that insurance companies accredit its global data. Instead, the data are a device for lawyers’ use in understanding (and arguing) a specific case.

The value of jury verdict reporting data from sources such as JVR is that such data can give insights and practical tips regarding specific injuries, e.g. loss of any eye, death of a small child,¹² and results in certain types of medical misadventures. For example, a lawyer considering taking a case involving failure to diagnose breast cancer can gain a better understanding of

¹⁰Jackson Williams, *Medical Misdiagnosis: Challenging the Malpractice Claims of the Doctors’ Lobby*, Washington, DC: Public Citizen, 2003. p. 15.

¹¹Jury Verdict Research issues frequent press releases; for example, its March 20, 2003 news release was headlined, “No Change in Median Malpractice Jury Award, Plaintiff Recovery Rate Up a Fraction.” The news media pick up these releases as story leads. The JVR web site is www.juryverdictresearch.com.

¹²A court mentioned the median malpractice award of \$1 million in 1985, together with appellate opinions from other states, to lower a \$10 million verdict to \$3 million for the death of a two and one-half year old in a 1986 case. *Roberts v. Stevens Clinic Hospital*, 345 S.W. 2d 791, 810 (W. Va. Ct. App. 1986). (The doctor had performed an unauthorized colon biopsy following a sigmoidoscopy, perforating the child’s colon, which led to infection and death.)

verdict results (including defense verdicts), common liability and defense themes, and names of experts from a certain part of the country – or even a list of cases in which the same doctor has testified, by consulting a report prepared by a jury verdict reporting service.

Appellate courts have used JVR's data to illustrate whether a verdict is within the range of reasonableness in a specific type of injury such as loss of an eye,¹³ or to help determine whether an insurance company acted in bad faith in failing to settle a case. However, some courts have rejected the use of such data by juries as unsupported hearsay.¹⁴

However, physician organizations, and advocates of "tort reform" misuse JVR's data by focusing on two measures, namely, median verdicts¹⁵ and mean (average) verdicts. Most likely they do this in order to support their contention that medical malpractice is a "runaway" system of "jackpot justice." On occasion, the AMA and its "tort reform" allies even use misleading headlines to describe JVR data – "Plaintiffs Win Birth Lawsuits Most Often" was the false headline in a recent American Medical News article.¹⁶

The problem from the standpoint of the media is fundamentally one of a *dearth* of data – because JVR is the *only* source of aggregate data. The news media over-credit it and do not have a ready basis for questioning its use by "tort reform" advocates. The typical journalist simply takes what s/he finds, namely data from "Jury Verdict Research, a Pennsylvania-based company that gathers information on verdicts and awards nationwide."¹⁷ Government policy-makers are

¹³Schramm v. Long Island Railroad, 857 F. Supp. 255, 259 (E. D. N.Y. 1994).

¹⁴Miller v. Breidenbach, 520 N.W.2d 869, 874 (N. D. 1994). "The Jury Verdict Research publication is not legal authority and most certainly would be excluded from a trial as inadmissible hearsay." Anderson v. Werner Enterprises, Inc., 972 P.2d 806, 814 (Mt. 1998).

¹⁵The *median* is the mid-point, with half above and half below. The figure is often confused with an average, or *mean*, which is derived by aggregating all verdicts and dividing them by the total number of verdicts. See, generally, Stephen Daniels and Joanne Martin, *Civil Juries and the Politics of Reform*. (Chicago: American Bar Foundation and Northwestern Univ. Press, 1995).

¹⁶Tanya Albert, "Plaintiffs Win Birth Lawsuits Most Often," American Medical News (April 14, 2003) p. 9. The article reported on JVR's "Current Award Trends in Personal Injury" which found that the median jury verdict in a medical malpractice case was exactly the same in 2001 as 2000, namely \$1 million, but that the proportion of plaintiffs who win their cases increased to thirty-nine percent, up one percent from year 2000.

¹⁷See, "Runaway Verdicts," supra, note 1, at p. 5. The typical use of data comes from doctors who complain in terms of specific years. According to J. Edward Hill, M.D., chair of the AMA Board of Trustees, "Driving [the latest insurance crisis] are out-of-control liability awards." Dr. Hill continues, "Jury Verdict Research Inc., tells us that in just one-year period – between 1999 and 2000 – the median jury award nationally increased forty-three percent. That's seven times the rate of inflation." J. Edward Hill, "In the Liability Lottery, It's Our Patients Who Really Lose,"

similarly handicapped by the lack of data. The following are specific problems with statistics based on JVR data.

Inappropriate sources and incomplete data. The use of JVR data as a basis for national policy making is inappropriate and has been discredited since 1986, because JVR data, while technically accurate, are misleading. The data are incomplete and represent a biased sample. The company does not capture all malpractice verdicts nationwide.¹⁸ It relies on newspaper clippings, local jury verdict reporting newsletters¹⁹ and voluntary reports. As one would expect, JVR seldom receives voluntary reports of zero verdicts or small ones. Even industry-friendly voices such as the newsletter *Medical Liability Monitor*, which has been reporting on the so-called malpractice crisis for a quarter century, does not wholly embrace JVR data. “JVR qualifies its numbers, noting that it does not receive 100% of jury verdicts rendered nationwide and does not define its data base.”²⁰

The use of JVR data by the media and by advocates seeking caps on liability awards is inappropriate from the standpoint of statistical methodology. Neither median nor mean is an appropriate summary statistic for the wide-ranging distribution of verdicts.²¹ Moreover, JVR’s data analysis would not pass muster under the scientific *Daubert* standard if presented to a jury, since zero verdicts, remitted verdicts and verdicts overturned on appeal are *not* included in the so-called “median” or “average.” “You do not have to hold a Ph.D. in one of the social sciences

American Medical News (September 2, 2002) p. 33.

¹⁸According to one source, the company said that it captured about 60 percent of the total medical malpractice verdicts in the nation, or “about 1,000 medmal verdicts in each of the years from 1988 through 1994.” “See MD Medmal Payouts Falling But More and Higher Hospital Awards,” *Medical Liability Monitor* (March 24, 1995) pp. 5, 8.

¹⁹The fact that Jury Verdict Research captures the bulk of its data from local publications which themselves do not capture all local verdicts was demonstrated in litigation against the company. It was required to pay nominal damages in a contentious suit brought against it by the Chicago Law Bulletin (owner of the Cook County Jury Verdict Reporter). It had incorporated Chicago cases in its various reports without permission. See generally, *Law Bulletin Publishing Co. v. LRP Publications, Inc.*, 992 F. Supp. 1014 (N.D. Ill. 1998). (The case was removed to Florida for trial.)

²⁰“Spike in Claims Severity – How High? – How Widespread?” *Medical Liability Monitor* (May 18, 2001) p. 1.

²¹A. Russell Localio, “Variations on \$962,258: The Misuse of Data on Medical Malpractice,” *Law, Medicine & Health Care* (June, 1985) 126-127. The leading book on this topic is Neil Vidmar, *Medical Malpractice and the American Jury: Confronting the Myths About Jury Incompetence, Deep Pockets, and Outrageous Damage Awards*. (Ann Arbor: Univ. of Michigan Press, 1995).

to recognize the problems with these data,” wrote Professor Neil Vidmar in 1995. He said, “Newspapers are quick to report megaverdicts but tend to ignore cases in which plaintiffs lose or receive only a modest award. The latter are not newsworthy.”²² Newsworthiness aside, Jury Verdict Research itself does not include defense verdicts²³ in its calculation of median (half above, half below) “due to the fact that defense verdicts are more prevalent in certain liability situations, which would artificially skew the data.”²⁴

One case from Chicago will illustrate how the so-called “averages” provided by Jury Verdict Research are misleading. In 1991, a 12 year-old girl attempted to kill herself and was taken to a Chicago-area hospital where it was alleged she was prematurely discharged in acute respiratory distress. She was hospitalized again within four days. The suit alleged that her death was caused because she was not closely monitored in the hospital. The case was tried to a defense verdict in 1996. This zero verdict was not included in Jury Verdict Research’s tally of cases yielding a so-called “average” for that year because such zero verdicts are not included in their calculations. The case was appealed and sent back for a new trial. In May, 2001 – exactly ten years after the girl’s death – a Chicago jury awarded \$5.3 million.²⁵ This case was included in the so-called “average” for that year. However, two years later the Illinois Appellate Court overturned the verdict because a plaintiff’s expert gave an opinion at trial that differed from the opinion she gave in a pre-trial statement.²⁶ Thus, in the end, JVR’s so-called “average” for 2001 was simply wrong, just like the “average” for 1996.

Another Chicago case further illustrates the fact that so-called “average” verdicts are misleading, especially when they are overturned on appeal. Again in 2001, a jury awarded \$30 million for

²²Neil Vidmar. *Medical Malpractice and the American Jury: Confronting the Myths About Jury Incompetence, Deep Pockets, and Outrageous Damage Awards*. (Ann Arbor: University of Michigan Press, 1995) p. 14.

²³A defense verdict is one where the defendant does not have to pay any money other than the expenses of hiring paid expert witnesses and the defense lawyer(s).

²⁴“Current Award Trends in Personal Injury, 2002 Edition,” cited in “Blockbuster Cases Push Up 2001 Medmal Award Range,” *Medical Liability Monitor* (March 19, 2003) p. 1.

²⁵*Estate of Richlyn Cork v. Cook County Hospital, Cook County (IL) Circuit No. 99L-14351*; “Hospital Residents Fail to Maintain Airway in Twelve Year-Old Recovering From Windpipe Injury – Death – \$5.3 Million Verdict in Illinois,” *Medical Malpractice Verdicts, Settlements & Experts* (November, 2001) p. 29.

²⁶*Darleen Clayton v. County of Cook, No. 1-02-1009*. Illinois Appellate Court, 1st Division, 4th District, December 11, 2003, in *Chicago Lawyer* (February, 2004) p. 49; Kelly Quinn, “Undisclosed Opinions Should Not Have Been Allowed: Panel,” *Chicago Daily Law Bulletin* (Dec. 12, 2003) p. 3.

the birth injuries sustained by girl at LaGrange Memorial Hospital during delivery in 1995. The jury found the physician entirely at fault, but he was not present at trial, having settled earlier for one million dollars.²⁷ Here, a so-called “average” from JVR would show a \$30 million verdict. The plaintiff appealed, but the appellate court overturned the award because there was no expert evidence to support the contention that the hospital itself was negligent in failing to complete steps to perform a C-section within thirty minutes or that any institutional conduct on the part of the hospital delayed the C-section.²⁸ So in the end, the plaintiff received only \$1 million from the doctor and nothing from the hospital.

In recent years, several legal newspapers have begun to report malpractice settlements volunteered by victorious plaintiffs’ counsel. These provide fodder for JVR and similar services, but the standard report form reveals its data bias – the North Carolina Lawyers Weekly form is clearly headed, “Large Verdict & Settlement Report.”²⁹ Defense lawyers rarely submit such forms, even to legal newspapers, because they are not paid to do so, see no benefit to themselves or their clients, and are loath to reveal the names of court-accredited defense experts who might later testify in a plaintiff’s case.

The fact that plaintiffs’ lawyers are eager to tout their victories in legal newspapers (with the story migrating to general newspapers) has created a false impression of increased claim severity (to use insurance terminology). But the persons closest to the actual data suggest a different conclusion, “Severity has not gone up, and in fact, it has gone down a little,” said Donald J. Fager in 2001, an executive with Medical Mutual Liability Insurance Company (MLMIC), a large New York company.³⁰

Failure to correct for inflation. Another problem with so-called “averages” produced by JVR, or anyone else, is that they typically are used without considering the influence of inflation. For example, an award of \$360,000 in 1970 would have had to climb to the magic \$1 million mark by 1985 just to keep pace with inflation. Since 1985, the cost of health care, the largest element

²⁷Kylie Bryant v. Yong Kim, et al., Cook County Circuit (IL) No. [unspecified]; “Infant Suffers Cerebral Palsy Injury During Birth – Delay in Performance of Cesarean Blamed – \$30 Million Verdict in Illinois, But Jury Finds Only Obstetrician, Who Had Settled, at Fault,” Medical Malpractice Verdicts, Settlements & Experts (October, 2001) p. 34.

²⁸Yvette and Amos Bryant v. LaGrange Memorial Hospital, Illinois Appellate Court No. 1-02-0518; Kellye Quinn, “Appeals Panel Absolves Hospital From \$30 Million Jury Verdict,” Chicago Daily Law Bulletin (Dec. 17, 2003) p. 1, 24.

²⁹See, “Large Verdict & Settlement Report Form,” North Carolina Lawyers Weekly (Jan. 5, 2004) p. 5.

³⁰“Is Sudden Spurt in Costs of Malpractice Claims Due to Increase in Blockbuster Awards?” Medical Liability Monitor (June 20, 2001) p. 2.

in the cost of long-term care of a brain damaged baby, has risen 195 percent, more than doubling the consumer product index for this period.³¹

Actual case outcomes not reported. There are several other problems with JVR data that are not apparent to a casual reader of a newspaper article in a general circulation newspaper discussing JVR's latest report. First, the tally for verdict amounts only considers the gross verdict and does not describe what really happened in the case. For example, many high-severity cases are tried under "high-low" agreements. In such cases, the parties have agreed to both a floor and a ceiling, regardless of what the jury decides. Thus, a \$7.2 million Chicago verdict in 2003 for failure to treat a woman's pneumonia causing her death was actually resolved for \$4.3 million because of a high-low agreement.³² The year before, a Chicago jury had awarded \$6.5 million for the death of an injured construction worker who was mistakenly given the blood thinner heparin in the emergency room, medication that was intended for another patient. A high-low agreement in place meant the family received only \$800,000.³³ During the trial of a Pennsylvania case, the judge called the lawyers into his chambers and urged the defense lawyer to call the famous CAT Fund (the excess insurer for most Pennsylvania doctors) to urge it to agree to a \$3 million settlement. The Fund refused, relying on its decision to stick with a \$1.5-\$3.5 million high-low agreement already in place – the jury awarded \$5 million.³⁴ The CAT Fund has had good luck with high-low agreements. In another case in 2003, involving failure to diagnose melanoma, a "high" of \$3.75 million protected the doctor (and the Fund) from a \$5.176 million verdict in Philadelphia.³⁵

³¹See, data from the Bureau of Labor Statistics, <http://www.bls.gov/home.htm>.

³²Estate of Claretta Roth v. Edward Hospital, DuPage County (IL) Circuit No. ____; "Illinois Woman Dies of Pneumonia in Defendant Hospital – Family Claims Defendants Failed to Diagnose, Treat or Monitor Her Condition – \$4.3 Million Recovery Under High-Low Agreement After \$7.2 Million Verdict," Medical Malpractice Verdicts, Settlements & Experts (April, 2003) p. 16.

³³Estate of Waliczek v. Dr. Gutta, Cook County (IL) Circuit No. 97L-8110; "Heparin Mistakenly Administered to Man With Abdominal Bleeding – Brain Hemorrhage and Death – \$800,000 Recovery Under High-Low Agreement After \$6.5 Million Verdict in Illinois," Medical Malpractice Verdicts, Settlements & Experts (February, 2002) p. 21.

³⁴Wright v. DaAntonio, Philadelphia Common Pleas (PA) No. ____; "Young Man Suffered Pseudomotor Cerebri – Failure to Treat With Surgery – Irreversible Blindness – Pennsylvania Jury Awards \$5 Million," Medical Malpractice Verdicts, Settlements & Experts (July, 1999) p. 34.

³⁵Hunt v. Pelczar, Philadelphia Common Pleas (PA) No. ____; "Lab Fails to Detect Melanoma After Mole Biopsy – \$3.75 Million Pennsylvania Verdict," Medical Malpractice Verdicts, Settlements & Experts (June, 2003) p. 50.

Conflation of different types of data. But a much more confusing aspect of JVR's annual report on average verdicts is that it presents aggregate data combining *both* physician and hospital verdicts. Until 1998, JVR had reported separate numbers for physicians and for hospitals.³⁶ Since that time, it has not been possible to use JVR data to clearly separate trends in physician liability from those in hospital liability. Most journalists who use JVR data to write stories about so-called skyrocketing verdicts simply fail to understand the data -- and few who read JVR data seem to notice. A notable exception may be the readers of an industry-boosting newsletter (which has advocated so-called "tort reform" for a quarter century), *Medical Liability Monitor*, which remarked in 1998, "JVR Report Combines Doctor/Hospital Data."³⁷

Here is an example of how a large verdict that fails to distinguish between physician and hospital culpability confuses the picture of so-called "average" verdicts. In 1995, a jury awarded a \$24 million gross verdict against a doctor and an outpatient surgery center for the injury to a twenty-nine year-old woman left blind, speechless and paralyzed from a negligent D & C procedure.³⁸ The medical press was outraged at such an award.³⁹ However, the actual award was \$9.4 million because, under California law, it was reduced to present value,⁴⁰ payable over the woman's

³⁶"Jury Awards in Malpractice Cases Continue to Rise in 1997," *Medical Liability Monitor* (March 15, 1999) p. 3, citing, "1998 Current Award Trends in Personal Injury," and asserting that median jury verdicts in medical malpractice cases had risen ten percent from \$500,000 in 1996 to \$551,750 in 1997. According to JVR, the "probability range" for a malpractice verdict was \$225,000 to \$2,053,561 in 1997, with the average award, according to its methodology, of \$2,189,089.

³⁷"JVR Report Combines Doctor/Hospital Data," *Medical Liability Monitor* (May 18, 1999) p. 8. Compare, "See MD Medmal Payouts Falling But More and Higher Hospital Awards," *Medical Liability Monitor* (March 24, 1995) p. 5. (According to JVR's report for 1994, the so-called average physician award was \$958,771 and the so-called average hospital award was \$1,062,685.)

³⁸*Hamel v. Outpatient Surgery Center, Orange County (CA) Superior No. 71-99-47*; "California Doctor Attempts a High Tech Cauterization When He Discovers a Fibroid During a D & C – No Consultation With Patient or Specialist – How Own Expert Calls Method He Used Evidence of Incompetence – Defendant Abandons Patient After She Goes Into Cardiac Arrest – Brain Damage, Paralysis, and Blindness for Twenty-Nine Year-old Woman – Over \$24 Million Verdict," *Medical Malpractice Verdicts, Settlements & Experts* (April, 1996) p. 20; *Hamel v. Keel*, 2001 Cal. App. Unpub. LEXIS 2630 (October 16, 2001).

³⁹"D & C Patient Winds Up Paralyzed, Blind, Mute: Award is \$24 Million," *Medical Liability Monitor* (October 17, 1995) p. 9.

⁴⁰Many states require that awards be "reduced to present value", namely the amount of money now, given a certain interest rate, that will give the injured plaintiff the amount of the gross verdict over the rest of her projected lifetime.

projected lifetime. The doctor then settled the case for \$4 million. The amount the surgery center paid, if any, was not reported.

Data are unevenly distributed. The final problem with interpreting JVR's so-called "averages" for policy-making is the problem of outliers, namely a few very high verdicts. Doctors like to call them "lottery" verdicts, but to win this so-called lottery the "winner" has to suffer brain injury, usually at birth.

An example illustrates the problem with outliers. In February, 2003, eleven cases went to trial in Philadelphia.⁴¹ The defense won eight (73%). The other three were plaintiff's verdicts of (1) \$50,000; (2) \$23,500,000; (3) \$100,000. Using Jury Verdict Research's "average" of \$23,650,000 divided by three, the so-called "average" was \$7,883,333, yet the "average" plaintiff got nowhere near this figure. Setting aside the outlier, the "average" when plaintiffs won was only \$75,000. Considering all 11 cases, including the eight zero verdicts as well as the three plaintiff wins, the average was \$2,150,000. Again, dropping the outlier, the average of the other ten verdicts was \$150,000 divided by 11, or \$13,636. So what was the "average" verdict in Philadelphia? Was it \$7.88 million, \$2.15 million, \$75,000, or \$13,636? Since most plaintiffs received nothing, use of the JVR average is both misleading and mean-spirited. See Appendix A for other examples of the outlier effect.

If one were to consider the fees that plaintiff lawyers received from taking these cases on a contingency basis, the valid average to use would be the one that includes the outcomes of all ten cases. The attorneys in each case put up their time and out-of-pocket expenses for all ten cases. In four cases, the attorneys received payment from the award moneys, but in the other six, the plaintiffs and their attorneys received nothing; in fact, the attorneys actually lost money. Contingency fee legal practice, which is common in the tort system, is always very risky.

To its credit, Jury Verdict Research itself does not endorse the use of the so-called "average" verdict data that it provides. The company says flatly, "Use of the mean [average] in most instances gives a distorted view of the data. Due to the nature of jury verdict data, the mean award can often be skewed by a small number of high awards."⁴²

JVR data do not support the idea of an unending rise in malpractice trial awards. For example, in 1994 the median award dropped substantially, from \$500,000 in 1993 to only \$350,000. Indeed, the so-called "average" in 1994 was \$977,000, down from the supposed \$2 million in 1993.⁴³ According to a JVR report, verdicts also fell 16 percent from 1999 to 2000.⁴⁴ Likewise,

⁴¹"February Verdicts & Findings," The Legal Intelligencer, May 13, 2003, p. 6.

⁴²"Current Award Trends in Personal Injury, 2002 Edition," cited in "Blockbuster Cases Push Up 2001 Medmal Award Range," Medical Liability Monitor (March 19, 2003) p. 1.

⁴³"Malpractice Settlements and Awards Dropped Last Year," American Medical News, Feb.

malpractice verdicts dropped in Massachusetts from 1998 to 2000, but increased again through 2003.⁴⁵ In 2002, two senior judges in Philadelphia published the results of their own study of malpractice verdicts – finding that verdicts in excess of a million dollars had actually *fallen* from thirty cases in 2000 to twenty cases in 2001.⁴⁶ In California, the number of known million-dollar verdicts and settlements fell in the year 2001. There were only 24 such cases, according to an insurance official who has been monitoring big cases for 20 years. There had been 33 such cases in 1998, 38 in 1999, and 39 in 2000. California’s famous MICRA rule, which limits pain and suffering to \$250,000, was a specific factor in seven of the 24 cases.⁴⁷

The owner of Jury Verdict Research himself told a Congressional committee in 1986 that his company’s data should not be used for public policy purposes and, in particular, that there was no evidence of “skyrocketing” awards.⁴⁸

Insurance Company Data

Not surprisingly, medical malpractice insurance companies do not accredit JVR data. However, they are reluctant to make their own data public, except on a selective basis. For twenty-eight years an official at a California malpractice insurance company, Ron Neupauer, has prepared an annual “Large Loss Study” by capturing information from legal newsletters (much like the JVR

13, 1995, p. 9.

⁴⁴Natalie White, “Med-Mal Verdicts on the Rise,” Lawyers Weekly USA (May 13, 2002) p. 13.

⁴⁵Jeanne Greely, “Are Torts on the Upswing?” The Massachusetts Lawyer, February 17, 2003, p. B1, B12.

⁴⁶“Seeking Amendments, Pennsylvania Doctors Block Quick Passage of Legislative Reforms,” Medical Liability Monitor (Feb. 26, 2002) p. 6. The judges were John W. Herron and Albert W. Sheppard, Jr.

⁴⁷“California Experiences “Sharp Decline” in Claims Closed With \$1 Million or More Payouts,” Medical Liability Monitor (May 14, 2002) p. 8.

⁴⁸Testimony of Phillip Hermann, House Subcommittee Hearing on Liability Insurance Crisis, Aug. 6, 1986. See, Report to the Subcommittee on Economic Stabilization on the Committee on Banking, Finance and Urban Affairs: Testimony on the Liability Crisis Focusing on the Facts of the Insurance Crisis, in HR 241.15.4, Part I Liability Insurance Crisis (Solon, Ohio: Jury Verdict Research, August 6, 1986). Discussed in Robert E. Litan, ed., Verdict: Assessing the Civil Jury System. (Washington, D.C., Brookings Institution, 1993) p. 85-86.

methodology), but Neupauer makes clear this is “not a scientific process.”⁴⁹ Of note, Neupauer’s reports do not include data taken directly from his or other insurance company files.

Data from a recent Neupauer report, the 2003 California Large Loss Trend Study,⁵⁰ which looked only at cases with awards and settlements of \$1 million or greater, illustrate the substantial variability in averages from year to year. The annual averages ranged between \$2.6 million and \$3.6 million during the entire decade, with the exception of two outlier years: 1998, when the average was only \$1.2 million, and 1999, when it was over \$4 million. The report may also be misleading, as it compares 5-year periods—1994-1998 versus 1999-2003—to conclude that there had been a dramatic rise in the size of awards, where indeed much of the drama was due to how the data from the two outlier years were included in the 5-year groupings.

The only insurance company that reveals data from its own files does not reach conclusions that match JVR’s, nor does it follow the JVR method of showing “average” recoveries. ProMutual Group (Boston) annually produces its own “Large Loss Review.” In 2000 it closed 695 cases, 402 (58%) without payment and 293 (42%) with payment. In twenty-seven cases (4% of those closed) the indemnity exceeded a million dollars. Even using JVR’s methodology, namely, aggregating the total amount of the “winnings” by the plaintiffs and dividing it by the number of plaintiff-winning cases, the figures are nowhere near what JVR reports for an “average” recovery. Applying JVR methodology to the Massachusetts data yields a so-called “average” recovery of \$396,535, namely \$116.19 million divided by 293 “winning” cases. When defense wins are added to the picture (402 closed with no payment) the average drops to \$167,179 – this in a year in which claims with large loss payouts had supposedly ballooned from a mere 183 in

⁴⁹“No Sudden Spike in California Large Losses,” *Medical Liability Monitor* (May 18, 2001) p. 2. “Our study does not purport to catalog every one million dollar plus verdict or settlement,” Neupauer said. His “Large Loss Study” for the current year is generally available from the Medical Insurance Exchange of California (MIEC) website. It is www.miec.com. Neupauer’s reports are read with interest in the industry. For example, he suggested that a reason for an increase in non-hospital based claims was the effect of managed care “forcing” doctors to take care of more patients in their offices, coupled with an increase in post-surgical cases as hospitals themselves cut back on staffing. See “Latest Study of California Large Losses Sees Return to More Hospital-Based Cases,” *Medical Liability Monitor* (Nov. 22, 1999) p. 5. See also “California Company Sees Big Losses Fall Slightly; Massachusetts Claims Go Through Roof,” *Medical Liability Monitor* (Nov. 23, 1998) p. 4. See also “Failure to Diagnose Claims Outstrip Those for Surgical Problems, Birth Injuries,” *Medical Liability Monitor* (July 12, 1996) p. 5. (“For the second straight year, the number of California cases for \$100,000 dropped – down from 149 in 1994 to 133 in 1995.”) See also “California Large Losses Hit All-Time High; See More Out-Patient Claims,” *Medical Liability Monitor* (September 15, 1995) p. 4.

⁵⁰Ron Neupauer, *2003 California Large Loss Trend Study*.
<http://www.miec.com/largeloss/losstrend2003.htm>

1999 to 293 in year 2000. “We won over 96 percent of cases tried to conclusion, but still there sometimes were huge verdicts on the remaining ones,” explained Mark Steffan, the company’s chief operating officer.⁵¹

⁵¹“Mass. Reports Far More Claims Activity in 2000,” Medical Liability Monitor (May 18, 2001) p. 2. The company generally makes its study available on its website. Promutualgroup.com/html/n-claims.htm

What Other Data Sources Indicate about Medical Malpractice

Unfortunately, there is no single source of reliable data about national “averages” on closed claims or any of the other parameters needed to inform public policy decision-makers. Those data that do exist are scattered, and may apply only to short time periods or a single state. However, data from the federal government’s National Practitioner Data Bank (NPDB),⁵² individual state reports, and the Consumer Federation of America, do provide some insight.

Data on closed claims - the average settlements when the denominator includes all medical malpractice cases initially filed, those that receive any payment and those that receive nothing - would give the best picture of what has really been happening with regard to the size of medical malpractice awards. Unfortunately, the lack of data (always captured at the state level, if at all) has plagued the federal government’s efforts in researching the issue of verdicts and how they influence both patient care and physician distribution. Ever since its first study of the issue of medical malpractice in 1973, the federal government has complained about the lack of data from which to make recommendations.⁵³

Reliable data on malpractice claims are unavailable because state insurance departments do not require insurance companies to provide the data, despite the National Association of Insurance Commissioners’ longstanding approval of a form designed to report closed claims.

The National Association of Insurance Commissioners (NAIC) is an organization that makes recommendations to the states about how to set rates and gather data on malpractice claims. For over twenty years the NAIC has had a special form, “Medical Professional Liability Claim Report,” which lists sixteen questions that should be answered about each closed claim. However, not all states require insurance companies to fill out and transmit these forms. The NAIC itself does not collect this information from the states, and cannot provide information on which states gather data and what is done with what data is collected.

⁵²The National Practitioner Data Bank is primarily an alert or flagging system intended to facilitate a comprehensive review of individual health care practitioners' professional credentials, including specific areas of a practitioner's licensure, professional society memberships, medical malpractice payment history, and record of clinical privileges. <http://www.npdb-hipdb.com/npdb.html>, accessed 07Aug04.

⁵³See, U. S. Department of Health, Education and Welfare. Report of the Secretary’s Commission on Medical Malpractice. (Washington, DC, Pub. No. OS 73-89, 1973); U.S. General Accounting Office. Medical Malpractice: Characteristics of Claims Closed in 1984. (Washington, DC, Pub. No. GAO/JRd-87-55, 1987).

Even when closed claim data are reported by states, there are “holes.” For example, Texas requires regulated insurance companies to report closed claims, but many self-insurers operate as insurance trusts, which are not required to report.⁵⁴

Average settlements in all closed claims. In 1999, the Consumer Federation of America stated that only three people out of 10,000 have a malpractice claim closed in a typical year. Less than one in 10,000 (that is, less than 30% of those whose claims close) receives any payment at all. Per year, the number of people in a typical state who got paid for a malpractice injury was 418. The payout average in 1999 was \$25,923 for all filed claims, which includes the 74 percent who get nothing.⁵⁵

This closed claims figure is similar to that observed in a single state, Indiana, where insurers paid nothing in 77% of all cases. The true average for all closed claims (those with and without payment) was only \$28,524, and remained steady for the decade ending 2001. Where plaintiffs did receive any money, the average payout for those closed claims was \$107,587.⁵⁶

Average payments to plaintiffs. Cries of a malpractice “crisis” by “tort reform” proponents do not appear to correlate with the actual payments received by the average plaintiff. As shown below, a sampling of various single-state reports show that average payments to those plaintiffs who receive anything range between \$107,000 and \$409,427.

In Mississippi, a so-called crisis state according to the American Medical Association, the average indemnity payment was \$156,234 in 2000 according to an insurance company official.⁵⁷

One of the few states that produces regular reports on medical malpractice is Missouri, which has required the NAIC data and prepared an annual report for the past 17 years. Insurance companies in Missouri paid an average indemnity of \$132,000 for all claims in 1994.⁵⁸ A special

⁵⁴“Caught in Crisis: The Blame, Solutions and Statistics Behind the Insurance Debate,” Special Advertising Roundtable, Texas Lawyer (Dec. 9, 2002) p. 3A, 4A.

⁵⁵“Medical Malpractice Insurance Premiums Minuscule, Declining Part of Health Care Cost,” (press release, March 31, 1999), Consumer Federation of America, Washington, DC.

⁵⁶“New Study: Average Medical Malpractice Payout \$28,525,” Indiana Lawyer, Feb. 26-Mar. 11, 2003, p. 19.

⁵⁷“Normally Untouched States Begin to Feel the Brunt of Large Awards,” Medical Liability Monitor (June 20, 2001) p. 9. Quoting Charles Dunn, chief operating officer of Medical Assurance Company of Mississippi. The problem of outliers is well illustrated in a state like Mississippi. Because of an \$8 million verdict in 1998, the average indemnity that year rose to \$268,318. But the average for 1997 was only \$113,224; 1999 was only \$161,124.

⁵⁸“Medical Malpractice Insurance Companies Continue Long Trend of Improving Results,” Missouri Lawyers Weekly (March 25, 1996) p. 2; see, Missouri Department of Insurance, 1994

report for the governor in February, 2003, revealed that amounts paid had increased, but also showed that something unusual appeared to have happened in Missouri healthcare in the preceding year – paid claims involving deaths shot up 49 percent in one year, to a total of 205. Still, the average payments were not out of line with those that have been reported in other states. Average payments in death cases were \$254,944. Patients who survived but had permanent injuries amounted to another 170 cases, which had an average payment of \$291,079.⁵⁹

Average versus median payments to plaintiffs. As would be expected, the occasional high award case results in the average payment being higher than the median. In New Jersey, a state in which the doctors descended on the state capitol to demand “reforms,” a recent average payment to plaintiffs in malpractice suits was \$349,111 but the median was only \$180,991.⁶⁰ This median figure is not greatly different from the median malpractice payment calculated from the NPDB data:

According to the [NPDB], the median medical malpractice payment by a physician to a patient rose 35 percent from 1997 to 2001, from \$100,000 to \$135,000. By contrast, data from Jury Verdict Research...shows that awards rose 100 percent from 1997 to 2000, from \$503,000 to \$1 million. The reasons for the huge difference: JVR only collects jury *verdict* information that is reported to it by attorneys, court clerks and stringers. The NPDB is the most comprehensive source of information that exists because it includes both verdicts and settlements. Ninety-six percent of all medical malpractice cases are settled, as opposed to decided by a jury, and settlements result in much lower awards than jury verdicts.⁶¹

One scholar, Michael J. Saks, professor at the University of Arizona Law School, reports in a 2004 publication⁶² that, of all filed claims, slightly more than forty percent result in any payment at all to plaintiffs. These negotiated settlements produced median payments of less than

Missouri Medical Malpractice Report,” (The Department, Jefferson City, 1996). For a discussion of medical malpractice in Missouri, see “Medical Malpractice: The Plaintiff’s and Defendants’ Perspective,” 94 Missouri Medicine (1997) 323-331.

⁵⁹Scott B. Lakin, Medical Malpractice Insurance in Missouri: The Current Difficulties in Perspective. Missouri Department of Insurance, February, 2003. This report is available on the Insurance Department web site, <http://insurance.mo.gov>.

⁶⁰Jim Edwards, “The Malpractice Statistics,” New Jersey Law Journal, Dec. 15, 2003, p. 16.

⁶¹Jackson Williams, *Medical Misdiagnosis: Challenging the Malpractice Claims of the Doctors’ Lobby*, Washington, DC: Public Citizen, 2003. p. 15.

⁶²Michael J. Saks, “The Psychology of Medical Malpractice Litigation,” 15 Practical Litigator (January, 2004) pp. 47, 49. (Saks has been writing about jury issues since 1976, but does not cite a source for this average.)

\$50,000, in 1995 dollars. He also reports that the average jury award in a malpractice case is approximately \$329,000, but does not cite a source for this estimate.

Average awards in cases that go to trial. There is no mechanism for reliable state-to-state comparisons. In a single state example, 65 malpractice cases went to verdict in Kentucky in 2001. Plaintiffs won 18 (28 percent). Their total recovery was \$7,229,475, for an average of \$405,526. But if the defense verdicts are included, the average drops to \$111,222.⁶³

Payment on verdicts compared to settlements. Payments on claims that were settled out of court were roughly half (49-62 percent) of those cases that were settled in court during the period 1991-1999, according to Bhat.⁶⁴ During that time period, average settlement amounts increased steadily from \$153,068 to \$221,266, while average verdicts ranged in a more variable fashion between \$291,484 and \$409,427.

Punitive Damages. Punitive damages are awarded in only 1.1 percent of cases involving medical malpractice payments.⁶⁵

Loss ratios. The ratio of losses incurred to premiums earned is of special interest to insurance companies. In 2003, California's Dept of Insurance released NAIC data that indicated that the loss ratio for licensed medical malpractice insurers had averaged 37.2 percent over the 10-year period from 1991-2000. In 2001, the loss ratio rose sharply to 57.2 percent; it averaged 51.9 percent for the 2001-2003 period.⁶⁶ Data were not reported on the number or size of awards. Not surprisingly, SCPIE Indemnity Company, a mono-line California insurance company that offered professional liability coverage principally in Southern California, in 2003 requested approval of a rate increase of 15.6 percent for its physicians and surgeons medical malpractice program. That request was rejected, but a 9.9 percent rate increase was approved.⁶⁷

⁶³“The Medical Insurance Crisis: The President’s Solution in Kentucky,” 6 Kentucky Trial Court Reporter (September 2002) p. 17 (data from actual trials, not from NPDB).

⁶⁴Bhat VN. *Medical Malpractice: A Comprehensive Analysis*. Westport, CT: Auburn House, 2001. pp. 73-74. (These appear to be national data, source not reported.)

⁶⁵Bhat VN. *Medical Malpractice: A Comprehensive Analysis*. Westport, CT: Auburn House, 2001. p. 240. (Data, source not reported.)

⁶⁶Calculated average loss ratios based on data from 2003 California P&C Premium and Loss Summary, on Dept of Insurance website:
<http://www.insurance.ca.gov/RRD/RSU/MktShr2003/MktShrSummary2003.pdf>, accessed 19Sep04.

⁶⁷<http://www.insurance.ca.gov/ADM/DandR/SCPIEDecisionforInternet.pdf>, accessed 19Sep04.

It is worth noting, however, that this California loss ratio was not unique. Insurance companies in Missouri received \$118 million in premiums and paid out \$65 million in claims in 1994 (a loss ratio of 55%).⁶⁸

Relationship of medical malpractice payments to other economic measures. A study of medical malpractice recoveries in North Carolina from 1992 to 2002 showed recoveries increased 6.8 percent, compared to 6.7 percent medical cost inflation between 1990 and 2001, the latter data are from the Journal of Health Affairs, although most observers claim that medical inflation was closer to ten percent per year in the last three years.⁶⁹

Missouri (unlike Illinois, which receives the data but does not compile or publish it) places the NAIC data on its Insurance Department website. The Missouri Insurance Department found no evidence the legal system was out of control. In 2002, it reported flatly, “In the past decade, awards for malpractice damages actually lagged behind general inflation.” It concluded, “All increases in award sizes are accounted for by medical inflation, wage inflation (for lost earnings) and the increase in severity of the injury to the patient.”⁷⁰

In 1999, the Institute of Medicine (IOM) estimated that 98,000 preventable deaths occur each year in the United States due to medical errors.⁷¹ However, a more recent study released by HealthGrades indicated that over 575,000 preventable deaths—191,000 per year—occurred as a direct result of the 2.5 million patient safety incidents that occurred in U.S. hospitals from 2000 through 2002, excluding those in obstetric patients. The calculated medical cost of these excess deaths was \$19 billion.⁷² If one contrasts that figure with the Consumer Federation of America’s estimate that the number of people in a typical state who got paid in 1999 for a malpractice injury was 418 [which makes the calculated total 20,900 paid in the United States as a whole],⁷³

⁶⁸“Medical Malpractice Insurance Companies Continue Long Trend of Improving Results,” Missouri Lawyers Weekly (March 25, 1996) p. 2; see, Missouri Department of Insurance, 1994 Missouri Medical Malpractice Report,” (The Department, Jefferson City, 1996).

⁶⁹Ertel Berry, “Rise in Med Mal Recoveries Tracks Health Care Costs,” North Carolina Lawyers Weekly (April 14, 2003) pp. 1, 4.

⁷⁰Id., p. 1. For a discussion of the increase in severity of claims in Missouri, see the department’s “2002 Medical Malpractice Report,” available on the department’s web site.

⁷¹Kohn LT, Corrigan JM, Donaldson MS, eds. *To Err Is Human: Building a Safer Health System*. Washington: National Academy Press, 1999.

⁷²Health Grades, Inc. *Patient Safety in American Hospitals: Study Released by HealthGrades, July 2004*. Accessed 14Sep04 at <http://www.healthgrades.com/media/english/pdf/HGPatientSafetyStudyFinal.pdf>.

⁷³Medical Malpractice Insurance Premiums Minuscule, Declining Part of Health Care Cost,” (press release, March 31, 1999), Consumer Federation of America, Washington, DC.

it is clear that many cases of suffering and even death as the result of medical misadventure are never compensated.

Summarizing data from a number of sources, Public Citizen, a nonpartisan, nonprofit watchdog organization, reached the following conclusions:

- Rather than facing “runaway litigation,” doctors benefit from a claims gap; only a small percentage of medical errors result in lawsuits.
- Malpractice insurance costs amount to only 3.2 percent of the average physician’s revenues.
- The costs of malpractice to society are three to five times greater than the total amount spent on medical malpractice insurance.
- Increases in medical malpractice premiums and payments track—and do not exceed—increased costs of injuries.
- Malpractice insurance costs have risen at half the rate of medical inflation.
- The recent spike in medical liability premiums was caused by the insurance cycle, not by new claims or “skyrocketing” jury verdicts.
- “Repeat offender” physicians are responsible for the bulk of medical malpractice costs, with five percent of doctors responsible for 54 percent of malpractice payouts.
- Plaintiffs drop 10 times more claims than they pursue, and the small number of claims pursued to a defense verdict are not “frivolous.”
- Non-economic damage awards compensate real injuries.
- Jury verdicts bear a reasonable relationship to the severity of the harm suffered.⁷⁴

⁷⁴Williams J, with Denk G, Roomor R, Boughton B, Benore A, Clemete F. *Medical Misdiagnosis: Challenging the Malpractice Claims of the Doctors’ Lobby*. Washington: Public Citizen, March 2003.

Further Facts and Fallacies about Medical Malpractice Lawsuits

Number of lawsuits

Crisis rhetoric insists that malpractice lawsuits are increasing. However, the number of medical malpractice cases is not skyrocketing. Even some of the most ardent supporters of so-called tort reform agree: “Liability insurers from Maine to Florida, in the Midwest, in the Southwest, in California and the Pacific Northwest, said that claims frequency is flat, stable or has declined slightly.”⁷⁵

In most states, the numbers are actually falling. For example, in Connecticut, the number of malpractice cases fell steadily from 384 in 1995 to 369 in 2000.⁷⁶ In the summer of 2003, several hundred New Jersey doctors demonstrated at the state capital demanding more so-called tort reform legislation. However, only 1,656 medical malpractice cases were filed in 2002, down from 1,971 in 1997. (There are 8.5 million people in New Jersey.) Only 200 medical liability cases went before New Jersey juries in 2002, twenty-seven fewer than 2001. Overall, the number of plaintiff verdicts has dropped four percent since 1998 in New Jersey.⁷⁷ In Washington, D.C. the number of malpractice suits has dropped twenty-four percent from 1992 to 2002.⁷⁸ The same number of malpractice cases were filed in Cleveland in 2001 as in 1995 and the money awarded in verdicts was actually twenty-five percent less than in 1995, according to an analysis of 6,726 cases filed in the city from 1992 through 2002.⁷⁹ In Missouri, malpractice case filings dropped five percent from 1997 to 2001.⁸⁰ They dropped a whopping 35 percent

⁷⁵“Don’t Blame It on More Claims, Say Many Insurers,” *Medical Liability Monitor* (June 20, 2001) p. 1.

⁷⁶Amy Goodusky, “Malpractice Trends: Fewer Suits; More Dollars,” *The Connecticut Law Tribune* (March 12, 2001) p. 7.

⁷⁷Stephanie Fox Pierson, “No Litigation Explosion or Jackpot Awards Here,” *New Jersey Law Journal* (March 10, 2003) p. 23.

⁷⁸Jack H. Olender, “Tort Reform or Deform for D.C.?” *Legal Times* (May 26, 2003) p. 32.

⁷⁹“Malpractice Awards Haven’t Gone Up,” *Ohio Lawyers Weekly* (October 28, 2002) p. 2.

⁸⁰Emily Umbright, “Latest Study Renews Debate Over Medical Malpractice,” *St. Louis Daily Record* (Sept. 4, 2003) p. 1; “Medical Malpractice Filings Decline,” *Missouri Lawyers Weekly* (Sept. 8, 2003) p. 2; Emily Gottlieb and Joanne Doroshov, “Has America Been Duped by the AMA?” *Indiana Lawyer* (Sept. 10-23, 2003) p. 22.

from 1994 to 1995 in the St. Louis metropolitan area.⁸¹ A compilation of NAIC data showed that nationally there was a four percent reduction in lawsuits (claims) between 1995 and 2000.⁸²,⁸³

Who Gets Sued, Who Sues

Another myth is that a disproportionate percentage of malpractice lawsuits are caused by foreign medical school graduates. It is not true.⁸⁴

Neither is it true that poor patients are more likely to sue than those who are well-off. For years, doctors insisted they should be wary of caring for poor patients based on the notion that they were more likely to sue than wealthy (and insured) patients. That, too, is a fallacy.⁸⁵

Reasons for Malpractice Suits

Based on 1991-1996 data from the NPDB, the highest mean payments were made in obstetrics-related cases, followed in descending order by anesthesia-, diagnosis-, monitoring-, blood products-, surgery-, medication-, and treatment-related cases. However, the highest numbers of

⁸¹Lisa A. Buffa, "Fewer Malpractice Suits Being Filed," St. Louis Daily Record (Aug. 17, 1996) pp. 1, 8.

⁸²Joan Claybrooks, "Medical Errors, Not Lawsuits, Are Real Cause of Rising Malpractice Insurance Premiums," 19 Health Letter (Feb. 2003) p. 1. Accessed at <http://www.citizen.org/pressroom/release.cfm?ID=1297>. Also See: National Center for State Courts, Examining the Work of State Courts, 2002: A National Perspective From the State Court Statistics Project. National Association of Insurance Commissioners. Statistical Compilation of Annual Statement Information for Property/Casualty Insurance Companies in 2000 (2001).

⁸³National Association of Insurance Commissioners. Statistical Compilation of Annual Statement Information for Property/Casualty Insurance Companies in 2000 (2001).

⁸⁴Stephen S. Mick and Maureen E. Comfort, "The Quality of Care of International Medical Graduates: How Does it Compare to That of U.S. Medical Graduates," Medical Care Research and Review (Dec. 1997) 54(4):379-413.

⁸⁵General Accounting Office, Medicare/Medicaid Beneficiaries Account for Relatively Small Percentage of Malpractice Losses. (GAO, Washington, DC, August, 1993) p. 2. See also, Helen R. Burstn, et al., "Do the Poor Sue More? A Case-Controlled Study of Malpractice Claims and Socioeconomic Status," 270 Journal of the American Medical Association (October 13, 1993) pp. 1697-1701.

payments were made in treatment-, diagnosis-, and surgery-related cases, which together accounted for 79 percent [calculated] of reported payments in that time period.⁸⁶

The Fate of So-Called “Jackpot” Jury Verdicts

Most “lottery” or “jackpot” jury verdicts in medical liability cases are uncollectible because they are subsequently lowered (remitted) by the trial court, lowered by an appellate court, or settled because of limits in insurance coverage.⁸⁷

The most famous alleged “jackpot” jury verdict in recent history was not a result of medical liability—it was the famous “McDonald’s Coffee” case from Arizona. Laymen remember the case and insist the verdict was much higher than it was. Virtually none know what happened to the “jackpot” after the verdict was rendered. McDonald’s act of intentionally selling coffee at a temperature much higher than normally served in restaurants, despite numerous warnings and complaints, was the reason the jury got angry. It awarded \$2.7 million in punitive damages (the amount of money the company earns in one day on coffee). The jury also awarded the severely burned plaintiff compensation of \$200,000, but she was found to have been 20 percent at fault, so she only recovered \$160,000. The trial judge lowered the punitive damages to \$480,000, but the matter was settled for less than this while the case was on appeal.

Reduction of awards is a common result in so-called “lottery” medical malpractice cases.⁸⁸ Says powerhouse plaintiffs’ lawyer Andrew Mayer of Boston, “These [malpractice] verdicts you read about are generally uncollectible,” who in 2003 won \$7 million in verdicts but only collected \$1 million.⁸⁹ The reason in most instances is that the defendants lack full insurance coverage.⁹⁰

⁸⁶Bhat VN. *Medical Malpractice: A Comprehensive Analysis*. Westport, CT: Auburn House, 2001. p. 74. (Data source cited as Division of Quality Assurance, *National Practitioner Data Bank, 1996 Annual Report*, Rockville, MD: USDHHS, Health Resources and Services Administration, Bureau of Health Professions, 1997, Table 10.)

⁸⁷Bhat VN. *Medical Malpractice: A Comprehensive Analysis*. Westport, CT: Auburn House, 2001. p. 240. (Data, source not reported.)

⁸⁸See, Neil Vidmar, Felicia Gross & Mary Rose, “Jury Awards for Medical Malpractice and Post-Verdict Adjustment of Those Awards,” 48 *DePaul Law Review* (1998), p. 265.

⁸⁹Jeanne Greely, “Are Torts on the Upswing?” *The Massachusetts Lawyer*, February 17, 2002, p. B1, B13.

⁹⁰Henry Gottlieb, “Aftermath of Large Jury Verdicts Shows Much-Diminished Victories,” *New Jersey Law Journal* (February 2, 2004), p. 1. (\$20 million jury verdict against Camden County physician who had only one million in coverage. The company refused a policy limits demand.) See, “Federal Jury Awards \$20 Million for Disfiguring Infection After Facelift,” *New*

And caps on pain and suffering do not make much difference in what juries actually award, noting that Massachusetts has had a \$500,000 cap on pain and suffering since 1986. “In Massachusetts, people tend to forget that we already have a cap,” he explains.⁹¹

Some of the largest awards are won in “bad-baby” (birth injury) cases and those in which physicians are the plaintiffs. Examples of these large award cases are given in Appendices B and C, respectively. Appendix D shows examples of the ultimate outcome of several other large award cases.

Even if a jury awards substantial damages, doctors can avoid the award and still protect their assets with careful planning. A classic case involved Dr. Neil Solomon who faced claims of \$160 million dollars, much of it punitive damages, for a pattern of sexual misconduct with patients. When he filed bankruptcy listing \$2.1 million in assets, the former patients tried to get \$1.4 million that was in his individual retirement account (IRA). The 62-year-old doctor had surrendered his medical license, and his income had dropped from \$14,800 a month to \$2,650 a month. Because claims for punitive damages could not be discharged in a normal bankruptcy (called a Chapter 7), the doctor chose a so-called “Wage Earner’s Plan” (Chapter 13) which allows the discharge of such claims, provided the debtor comes forward with a plan to make a good faith effort to pay his creditors in a three-year period. Here, Dr. Solomon’s plan was to pay his former patients a total of \$45,000, namely \$750 a month for the next five years. The former patients cried foul and demanded he pay more out of his IRA. Too bad, ruled the court. Under Maryland law, IRAs are immune from the claims of creditors, and the bankruptcy court could not order Dr. Solomon dip into this amount.⁹²

It is true that a few doctors have been forced into bankruptcy because of malpractice judgments. But that is because they don’t have *any* insurance, not because they don’t have enough. The classic case is Dr. Patrick J. Barry, a Miami orthopedic surgeon who advertised himself as “knee doctor extraordinaire.” When a jury hit the uninsured Dr. Barry with a \$1.34 million verdict in 1994, he promptly filed Chapter 7 bankruptcy. Florida (since 1988) does not require doctors to carry insurance provided they show proof of so-called “self insurance” of \$250,000. Dr. Barry lost, among other things, his 1952 MG sports car, his 1978 Rolls-Royce, a vacation home and his Miami Heat season tickets worth \$2,480. His creditors collected twenty-five cents on the dollar, actually high for a personal bankruptcy. Unhappy with his plight, Dr. Barry promptly sued the

Jersey Law Journal (Dec. 15, 2003) p. 8.

⁹¹Id.

⁹²Gerald S. Susman, “Doctor’s IRA Millions Shielded From Claim,” *Legal Intelligencer* (Nov. 28, 1995) p. 9; *In re Neil Solomon, M.D.*, 67 F.3d 1128 (4th Cir. 1995). (Dr. Solomon’s net monthly income of \$2,650 included \$2,146 a month in his state pension payment from Maryland.) He told the bankruptcy court that he had no intention of withdrawing any of the \$1,413,888 held in his individual retirement accounts until required to at age seventy.

lawyer who defended him, claiming that an expert witness who testified against him should have been more vigorously cross-examined. The lawyer carried \$2 million in legal malpractice insurance.⁹³

⁹³Noreen Marcus, "Surgeon Avoids Pain of Million-Dollar Judgment," *The Daily Business Review* (May 5, 1995) pp. A6, A7.

Conclusions Regarding Malpractice Verdicts

No one knows how many medical malpractice verdicts are rendered each year in the United States.⁹⁴ What is known is this – verdicts and their shadow, settlements – are not skyrocketing. The headline in a legal newspaper summarized the facts: “Top Jury Verdicts Plummet in 2003.”⁹⁵

A study in 2002 revealed that the amount of money that malpractice insurance companies paid out from the 1970's to 2001, including all jury awards and settlements, directly tracked the rate of medical inflation.⁹⁶ One of the reasons no one knows how many malpractice verdicts are rendered in the nation is because no one keeps a record of how many malpractice suits are filed, and little use is made of the skimpy data that is available. For example, whenever a malpractice case is closed in Massachusetts, the court clerk is supposed to send a copy of the complaint and the malpractice tribunal decision to the Medical Board. There is no evidence that the Board does anything with the data.⁹⁷ A similar law requiring insurance companies to notify the Tennessee Medical Board has simply been ignored. In Pennsylvania, a state supposedly wracked by another insurance crisis, the lack of data on filings and verdicts prompted the state's Supreme Court chief justice in 2004 to tell local court officials to report the number of medical

⁹⁴Even insurance companies don't know with certainty. But the number is very small. For example, in 1995 the PIAA Data Sharing Project contained 11,100 closed claims, but only 666 (six percent) had been decided by a jury – and plaintiffs won only 19 percent of those verdicts. “Medical Malpractice Verdict, Settlement Median Are Highest Since 1996,” *Medical Liability Monitor* (September 9, 1997) p. 11. (Describing JVR's 1997 Current Awards Trends in Personal Injury.)

⁹⁵Denise G. Callahan, “Top Jury Verdicts Plummet in 2003,” *Ohio Lawyers Weekly* (January 19, 2004) p. 1. See also, Denise G. Callahan, “Breach of Contract, Fraud Verdicts Top List in 2003,” *Michigan Lawyers Weekly* (January 19, 2004) p. 1; Jason M. Scally, “Top Verdicts Reveal Strikingly Small Numbers in 2003,” *Massachusetts Lawyers Weekly* (January 19, 2004) p. 1. Jeanne Greeley, “Record Low Jury Awards Tallied Last Year,” *Rhode Island Lawyers Weekly* (February 2, 2004) pp. 1, 16. (Rhode Island's largest medical malpractice verdict of 2003 was \$200,000 for failure to diagnose a bowel obstruction necessitating emergency surgery.)

⁹⁶Americans for Insurance Reform. *Stable Losses/Unstable Rates*. (New York: AIR, 2002).

⁹⁷“Re-Thinking Med-Mal Tribunals,” *Massachusetts Lawyers Weekly* (July 21, 2003) p. 10.

malpractice lawsuits filed in the last four years. In response, a spokesman for the insurance industry expressed concern that the information would be misused.⁹⁸

There is no credible evidence of any jury bias against doctors or that juries look for “deep pockets” in order to assign liability in marginal cases or that juries are “out of control.” Researchers actually conclude that persons who suffer very serious injury, suffer the larger *uncompensated* loss.⁹⁹ Not only are juries not overly-generous – one study showed that plaintiffs in malpractice cases did better with bench trials (non-jury cases) than in front of juries – winning fifty percent in front of judges alone, but only twenty-nine percent from juries.¹⁰⁰

Recently, physicians have pushed for the federalization of medical malpractice law, in particular, federal legislation that places caps on non-economic damages and similar so-called reforms that are already in place at the state level. But the need for such caps, based on the notion of runaway verdicts in malpractice cases, has not been shown. The oft-cited source for so-called “average” verdicts is Jury Verdict Research. As this report has already discussed, JVR’s data are incomplete, unrefined, and unfairly presented (especially by the news media). JVR’s data may have some utility in specific cases, but it should not be used for public policy purposes.

In conclusion, the evidence does not support allegations of widespread “frivolous lawsuits” or claims that jury verdicts are random “jackpots.” As illustrated above, numerous factors act to substantially reduce the ultimate compensation in apparent “jackpot” cases. The insurance industry’s own numbers demonstrate that awards are proportionate to injuries.¹⁰¹

⁹⁸“Counties to Assemble Malpractice Lawsuit Data,” Pennsylvania Law Weekly (January 19, 2004) p. 9.

⁹⁹Michael J. Saks, “Malpractice Misconceptions and Other Lessons About the Litigation System,” Vol. 16 The Justice Journal (1993), pp. 289 - 290.

¹⁰⁰Brian McCormick, “Judges More Likely to Side With Malpractice Plaintiffs,” American Medical News (September 7, 1992) p. 5.

¹⁰¹Jackson Williams, *Medical Misdiagnosis: Challenging the Malpractice Claims of the Doctors’ Lobby*, Washington, DC: Public Citizen, 2003. pp. 23-26.

Recommendations

Before so-called tort reforms are enacted at the federal level, sufficient data about medical malpractice filings, verdicts and settlements should be compiled and presented to the public and other interested parties. These parties include, but are not limited to, public officials, regardless of political party affiliation; medical accreditation boards; insurance companies; organizations of medical professionals; healthcare providers; and the media.

Some of the types of data that would be helpful for understanding the medical malpractice situation would be:

- The percent of medical malpractice verdicts that are decided for the defense versus those for the plaintiffs (the figures mentioned in various sources in this report appear to indicate that plaintiffs win some award in a range between 26-42% of cases).
- The percent of medical malpractice verdicts that are appealed by either plaintiff or defendant; the outcomes, including percent reduced on appeal; and the percent reduction (mean, median, range).
- The percent of malpractice cases that are dropped (no money to plaintiff), are settled out of court, and go to verdict.
- Closed claim data -- how much money plaintiffs finally receive when the cases are closed, after award reductions by judges, high-low limits, defendant declarations of bankruptcy, and all appeals are exhausted.
- The average payments that plaintiffs receive from physicians, from hospitals or other healthcare institutions, and from insurance companies as a result of malpractice claims, and how these have changed over time.
- Aggregate data on the yield of medical malpractice cases for plaintiff attorneys, keeping in mind that, under the contingency fee system, plaintiff lawyers are only paid out of actual settlement monies received by plaintiff; therefore, the yield for a plaintiff lawyer is based on all of his/her closed cases, not just those in which the plaintiffs won at trial.

As detailed in this report, media reports of average and median verdicts in medical malpractice cases taken from Jury Verdicts Research, Inc., are unreliable and unscientific, and hence should not be used for public policy purposes. The same is true of other data of this type, obtained by similar means by other organizations. The media, as well as public officials, should be aware of the limitations of JVR data and not report them as having unique validity for establishing “averages” or trends in malpractice outcomes.

The National Association of Insurance Commissioners (NAIC) makes recommendations to the states about how to set rates and gather data on malpractice claims. State officials should take advantage of NAIC’s uniform data collection forms to collect data on their own state’s medical malpractice experience and publish it annually on the Internet for public information. Such data would inform state-level decisions makers regarding insurance rates and oversight of medical professionals and healthcare providers.

Insurance companies could capture information about catastrophic claims – the ones said to deserve caps on non-economic damages -- by requiring health care organizations (hospitals, HMO's and doctor's groups) to send a photocopy of the report the entity sends to its "excess" liability carrier. Most large health care systems (multi-hospital chains) are actually self-insured up to an "attachment point," which varies based on the demands of the excess insurer. The information given to the excess carrier already identifies the type of injuries sustained, when the injury occurred, and possible areas of negligence.¹⁰² Reportable events are described as unexpected deaths, unexpected cardiac/respiratory arrests, unanticipated neurological impairments, birth-related injuries, and unanticipated surgical/anesthesia-related injuries.¹⁰³

Insurance companies have access to reliable data on malpractice verdicts but generally will not share it for public policy purposes. It would be desirable for Congress to pass a law requiring insurance companies, especially the physician-owned insurance companies, to make public a detailed description of each and every payment made in a malpractice verdict and settlement. Technically, the companies and hospitals are supposed to transmit this data to the National Practitioner's Data Bank already, but before laws are made based on the unscientific data from Jury Verdicts Research, the real data should be analyzed. Funded research of jury outcomes indicates that malpractice outcomes are modest, but this type of data should be available on a routine basis for tracking.

Another desirable federal action would be for Congress to enact a "Medical Malpractice Data Information" law. Such a law would require that, as a condition to keeping a federal drug dispensing license, or as a condition for receiving Medicare reimbursement, a physician must send a copy of every malpractice lawsuit filed against him/her to an appropriate office of the federal government (e.g. Health Care Finance Administration) within thirty days of suit. Data from newly filed lawsuits could serve as an early warning system of problems with new techniques (e.g. laparoscopic cholecystectomy), and above all, persistent malpractitioners. Likewise, when a lawsuit is closed, the physician or his/her insurer would be required to send a NAIC closed malpractice claim form to the same office. These data could be used by health policy planners, epidemiologists, insurance companies and lawyers to study the nature, causes and prevention of medical errors. The data should be available to all – lawyers, medical researchers, insurance companies. Everyone has a stake in the medical liability system and everyone should benefit from access to the information.

It should not be left to isolated juries to inform a doctor he or she should not be practicing medicine (or practicing in an improper manner) in the context of a gravely injured person. But when a jury does find liability, the consequences should be made known to everyone. Optimally, the federal government or a designee should publish the final results—the closed case

¹⁰²"Reporting to Excess Liability Insurers," ASHRM Forum (January-February, 1994) p. 2-3.

¹⁰³Id.

results, after all appeals, reductions, and caps--of every medical malpractice jury verdict in the United States.

Settlements in most cases are not made public. If this practice remains legal, then the data collection mechanism should provide for mandatory reporting of closed case results with all personal identifying data removed.

Medical errors should be treated like a social problem, not a random act of misfortune that happens to doctors. The victims of medical malpractice are patients, not health care workers, and lawyers do not “cause” either injury or large damage awards. Lawyers take the facts as they find them and, within constraints established by the law, seek financial recoveries for their clients. If the federal government is going to consider modifying the system whereby injured patients would get less, then the federal government should also step in and assert greater regulation over health care providers and insurers to ensure that good practices are in place throughout the country.

In the longer term, it would be useful to have public dialogue about the pluses and minuses to society of having malpractice lawsuits, conducted as they presently are. An analysis of the malpractice system should examine what the costs would be of *not* having malpractice suits; they may or may not result in saving money for society. The contingency system allows people without resources to bring suits. However, the contingency system also encourages lawyers to pursue only cases that are likely to be “winners” and reject those which would have small settlements. As a result, many people cannot get justice in the system. Lawsuits may encourage health care practitioners and organizations to be more careful, more attentive to patient’s rights, yet there are also allegations that lawsuits encourage the practice of financially wasteful “defensive medicine.”

With medical malpractice a hot political issue, there is a clear need for adequate data upon which to base public policy decisions. All parties concerned with the issue, if they are to be responsible in their actions, should welcome data that are accurate and appropriate for addressing the real questions that exist about medical malpractice and its effects on society.

Appendix A: Outliers Affect “Average” Verdicts from JVR

Here are examples of the effect of outliers on interpreting “average” data:

In May, 2003, only ten cases were decided by Philadelphia juries.¹⁰⁴ The defense won six. The four plaintiffs’ wins were: (1) \$450,000; (2) \$2,000,000; (3) \$4,105,008; (4) \$250,000. Using Jury Verdict Research’s “average” of \$6,805,008 divided by four, the so-called average is \$1,701,252. But considering the zero verdicts, the average drops to \$680,500.

The plain silliness of JVR’s “average” verdicts can be illustrated in what happened in July and August, 2003, in Philadelphia.¹⁰⁵ Once again, there was one so-called “lottery” verdict of \$18,499,000. The others were (1) \$110,198; (2) \$12,350; (3) \$125,000; (4) \$14,039; (5) \$250,000; (6) \$720,000. Averaging all seven of the plaintiff verdicts, the JVR so-called “average” plunges to \$2,818,655. But leaving out the “lottery” win, the average plaintiff verdict drops to \$205,264. If all 20 cases (the 13 defense wins plus the 7 plaintiff wins) are included in the calculation, the average is \$986,529. But is this more realistic? Hardly. The only verdict of the 20 in that time period to come close to this average was \$720,000.

In September 2003, Philadelphia saw no so-called “lottery” verdicts, although some might consider \$5,561,278 to be one. The plaintiffs’ win percentage was 42 percent (five out of twelve verdicts). The other verdicts were (1) \$1.5 million; (2) \$1 million; (3) \$31,875; (4) \$350,000. Again, the so-called “average” of the five plaintiff wins fell to \$1,688,631; leaving out the highest award, the average of the other four was \$720,469. With all the plaintiff wins and the defense wins included, the average amount was \$703,596, a drop from previous highs.¹⁰⁶

¹⁰⁴“May Verdicts & Findings,” Legal Intelligencer, July 24, 2003, p. 6.

¹⁰⁵“July & August Verdicts & Findings,” Legal Intelligencer, September 25, 2003, p. 8.

¹⁰⁶“September Verdicts & Findings,” Legal Intelligencer, November 26, 2003, p. 8-9.

Appendix B: “Bad Baby” Cases

Reliable data on “bad baby” cases, the most egregious of all malpractice outcomes and the cases with the greatest likelihood for large verdicts, is nearly impossible to obtain.

There is no place in the United States a researcher can go to find information about actual outcomes in “bad baby” cases except for jury verdict newsletters like Medical Malpractice Verdicts, Settlements & Experts, and data is woefully incomplete because of nondisclosable settlements. These cases should be the best-studied, but little statistical data is available. In 1994, it was reported by American Medical News, the AMA’s weekly newspaper, that of every 100 “bad baby” lawsuits filed, 47 were dropped by the plaintiffs or dismissed by the court before trial. Of the remaining 53 cases, 40 (three-quarters) were settled by the payment of money. That leaves 13 cases. Of these, 78 percent were won by the doctor. In other words, plaintiffs won only three of the 13 that got to trial. This means that only three percent of bad baby cases result in a plaintiff’s verdict. “We win 78 percent of bad baby cases that go to trial!” trumpet doctors, using that figure to blast trial lawyers for forcing too many good doctors into “unfair” trials. But the fact remains that at least 40 percent of all “bad baby” cases result in money being paid for doctor wrongdoing.¹⁰⁷

The Physician Insurers Association of America (PIAA) issues a report on “bad baby” cases from time to time (1987) and 1998. Known as the Data Sharing Project, the information collected by this organization of insurance companies, goes back to 1985.¹⁰⁸ A report issued in 1998 said that forty-seven percent of infant neurologic deficit claims resulted in some sort of payment, but that

¹⁰⁷Bill Clements, “Don’t Get Sued, The Most Common Causes of Lawsuits and How You Can Protect Yourself: This Week – Dangerous Deliveries,” American Medical News, Aug. 1, 1994, p. 15, 16. Data such as this typically come from surveys of physicians and contain an obvious sampling bias. But absent hard data from insurance companies and the like, this type of information provides insights into claims behavior. Another survey (1996) of ob-gyns, asked to report on all types of claims, not just bad baby cases, found that for every 100 closed cases, the lawsuit had been dropped or dismissed in forty-eight, money had been paid by settlement in thirty-seven, and nine had gone to trial. The doctors won seven of these cases. Another three cases had gone to mediation, with the doctors winning two. Why these figures do not account for all 100 cases cannot be explained. “Medmal Pressures Continue to Hit Ob-Gyns, Failure to Diagnose Claims Are Rising,” Medical Liability Monitor (February 26, 1998) citing an untitled study by Larry Griffin, M.D., Kenneth V. Heland, Linda Esser and Susannah Jones published by the American College of Obstetrics and Gynecology (ACOG).

¹⁰⁸“Claims Over \$100,000 Now Comprise More Than One-Third of Total, PIAA Finds,” Medical Liability Monitor (February 23, 1995) p. 4. (In 1993 claims with a severity code of 8, which indicates a grave or fatal prognosis, amounted to 6.35 percent of claims paid, but amounted to 18.44 percent of total indemnity paid.)

the money did not come from jury awards. Instead, where indemnity was paid it was a result of a settlement of a lawsuit fully ninety percent of the time. The average indemnity payment was \$1.13 million.¹⁰⁹

Anecdotal evidence suggests that a rise in “bad baby” cases has occurred since doctors decided that it was safe for women who had once had a C-section to deliver a second baby vaginally. These are called VBAC (Vaginal Birth After Caesarean) cases. But catastrophic injuries to both mother and baby occur when the doctors ignore birthing problems in their mind-set that VBAC is safe. A classic example is the 1998 delivery of a baby girl at Lankenau Hospital in Philadelphia. The mother had been admitted on the basis of a telephone call by the most senior member of the medical group, but her care was handled by the most junior member, who was a year out of residency. The baby was shown to be in fetal distress at 5:50 p.m., and a prominent expert witness for the plaintiffs said the baby should have been delivered by C-section within twenty or thirty minutes. Instead both the doctor and the chief nurse ignored the mother’s pleas and the monitoring. The baby was vaginally delivered at 7:14 p.m. and the mother’s uterus had ruptured sometime before that. The hospital had a written protocol for determining the need for C-sections in VBAC situations. But neither the doctor nor the nurse had read them, and admitted such. At least seven of the fifteen written criteria for a C-section were found in the medical chart, and others were confirmed in deposition. The jury awarded \$24 million to the mother and child, who is profoundly brain damaged and afflicted with cerebral palsy and will never walk, talk, or eat on its own. During post-trial motions the defendants settled the case – but insisted on a confidential settlement.¹¹⁰

It is certainly not true that recoveries in bad baby cases are consistently shooting up everywhere. Because the data are lacking, the picture is simply anecdotal. For example, the average indemnity in birth-related cases in Massachusetts dropped thirty-seven percent in one year (1998) according to one insurance company’s own report.¹¹¹ A final reason reliable data about

¹⁰⁹“Find Few Expected Links with Maternal, Infant Risk and Medmal Claims in Study,” *Medical Liability Monitor* (July 24, 1998), citing, “PIAA Neurologic Impairment in Newborns: A Malpractice Claim Study,” *Physician Insurers Association of America* (Rockville, MD, 1998). “Ten Year Paid Claims Tab Raises to \$5.23 Billion,” *Medical Liability Monitor* (March 22, 1996) p. 1. (Discusses the PIAA Data Sharing Project.) According to a report in 1996, payments to defense attorneys for all closed files equal approximately twenty percent of all paid indemnity dollars and are sixty-nine percent of the total allocated expense payments. Payments to expert witnesses are approximately 8.8 percent of total expense payments on closed files.

¹¹⁰*Smith v. Women for Women, et al.*, Philadelphia County (PA) Common Pleas, No. 2000-01336. Arthur Hankin and James Smith for plaintiffs.

¹¹¹“Massachusetts Sees Increase in Birth-Related Cases But No Rise in Million Dollar Closed Claims,” *Medical Liability Monitor* (Nov. 22, 1999) p. 5, citing “1998 Large Loss Review,” *ProMutual* (Boston).

recoveries in birth-injury cases is unavailable is the existence of caps on recoveries. The Virginia cap is the nation's most severe – an absolute cap (not just on economic damages). In October, 2003 a Portsmouth, Virginia jury awarded \$7.2 million for the Erb's palsy (paralyzed arm) birth injury a girl suffered in 1994. The applicable cap is one million dollars.¹¹²

¹¹²Matthew Phillips, "Portsmouth Jury Awards Record Med-Mal Verdict," Virginia Lawyers Weekly (January 19, 2004) p. B-4, B-5; "Baby Diagnosed with Erb's Palsy After Vacuum Extraction," Legal Times, December 29, 2003, p. 20.

Appendix C: When Physicians Are Victims of Medical Malpractice

A survey by the Harvard School of Public Health reported that 35 percent of physicians said that a member of their families had experienced a medical error which had created a serious medical complication. Thirty percent of these doctors had witnessed a medical error that led to serious harm to patients other than their family during the past year.¹¹³ It is interesting to note that large medical liability-related recoveries may result when doctors themselves become victims of medical malpractice.

* The death of Dr. Marc Ebel, 53, following a lymph node biopsy at a Media, Pennsylvania hospital in July, 2000 brought a \$2.9 million verdict (upped to \$3.2 million with interest) despite the fact that Ebel technically had recurrent Hodgkin's disease. Dr. Ebel was chief of the hospital's gastroenterology division and was a good friend of one of the doctors found liable in his care. His nurse wife was at his side and heard her husband say, "I know I'm still bleeding," and watched as his stomach became distended. "It looked like he was more than nine months pregnant," she told the jury. Her lawyer, Thomas R. Kline, of Philadelphia, has represented more than a dozen families of physicians who have been victims of substandard medical care.¹¹⁴

* A Chicago jury gave a 61 year-old retired orthopedic surgeon \$12.5 million for leg paralysis he suffered in a 1998 knee surgery he underwent at Rush-Presbyterian-St. Luke's Medical Center. Dr. James York had traveled from New Jersey to have the surgery performed by a specialist. He was injured when a hospital anesthesiologist injected anesthesia into the wrong part of his spine. Dr. York had taken early retirement in 1991 but still traveled on church-sponsored medical tours to give free care in Africa. The jury awarded \$6 million for disability; \$2 million for disfigurement and \$3 million for future pain and suffering, and \$500,000 for medical bills.. His wife also received \$1 million for loss of consortium.¹¹⁵

* One of the largest medical-related verdicts in Tennessee history came in 1981, when Dr. Katherine Wolfe, a rural doctor, was awarded \$2.7 million in an action against the government under the Swine Flu Vaccine compensation program. The verdict included \$500,000 for pain

¹¹³Dr. Frank Boehm, "Ignoring Medical Errors Would be a Big Mistake," *The Tennessean* [Nashville] (January 14, 2003) p. 7A.

¹¹⁴Marelene DiGiacomo, "Doctor vs. Doctor, Delco Jury Awards \$2.9 Million to Doctor's Widow," *Daily Times* [Primos, Pa], March 13, 2003; Jennifer Batchelor, "Delco Jury Awards \$2.9 Million for Death of Physician," *Legal Intelligencer* (March 13, 2003) pp. 1, 28; Natalie White, "Doctor's Widow Sues Colleagues for Malpractice," *Lawyers Weekly USA* (April 14, 2003) p. 21.

¹¹⁵Abdon M. Pallasch, "Jury Awards \$12.5 Million to Paralyzed Surgeon," *Chicago Sun-Times* (June 14, 2002) p. 18.

and suffering.¹¹⁶

* The largest medical liability verdict in Connecticut history came in 1998 in favor of “Jane Doe, M.D.,” who had been a first-year resident at Yale-New Haven Hospital for only seven weeks in 1988 when she stuck herself with an AIDS-infected needle while attempting to insert a catheter into an AIDS patient’s artery. The doctor-plaintiff had performed the procedure successfully only once before, two days before, under supervision. The technique she used had not been corrected by the supervising resident. This time the doctor-plaintiff kept the needle in her hand after it was withdrawn, in case it had to be reinserted to reposition the catheter in the artery. No supervisor was present for this second procedure and when the doctor-plaintiff reacted to a gush of blood that spurting from the patient, she covered the catheter with her right thumb to stem the bloodflow. The thumb, however, also landed on the needle she held in her left hand, alongside the catheter opening. The doctor-plaintiff became HIV-positive from the injury. Her suit claimed neither the supervising resident nor she had been instructed in regard to prevention of needle sticks, nor had she been properly assessed to determine whether she was competent to perform the procedure. The jury found the doctor-plaintiff 22.5 percent liable and reduced her award by that amount – her net recovery was \$12,242,675.¹¹⁷

* The death of Dr. David Williams, an oral surgery resident at St. Joseph’s Hospital in New Jersey, has been taken as a “poster case” for the need for so-called tort reform. The doctor apparently killed himself with an overdose of Fentanyl. There was dispute over whether his death resulted from suicide, recreational use or illegal self-treatment by Williams for anginal pain, but there was no dispute that he, alone was responsible for taking the medication which caused his death. The suit alleged that both the hospital and Dr. Hillel Ephros were negligent in making the drug too available to Dr. Williams. The jury awarded \$5 million but this was reduced by 45 percent, for Dr. Williams’ own lack of self-care.¹¹⁸

Doctors (or their family members) who have been injured by malpractice reject so-called “reforms” such as caps. Dr. Keith Bennett, a member of the teaching staff at the University of

¹¹⁶Carol Clurman, “Vaccine Suit Nets Monterey Woman Doctor \$2.7 Million,” *Tennessean*, June 1, 1981, p. 1.

¹¹⁷*Dr. Doe v. Yale University School of Medicine*, New Haven (CT) Superior Court, number unknown; “New Resident Becomes HIV Positive From Needle Stick While Inserting Catheter Into AIDS Patient – Connecticut Jury Awards \$12.2 Million Against School of Medicine for Lack of Training and Supervision,” *Medical Malpractice Verdicts, Settlements & Experts* (April, 1998) p. 3. “Needle Stick Award Sounds Warning to Teaching Hospitals, Medical Schools,” *Medical Liability Monitor* (February 26, 1998) p. 5.

¹¹⁸Steven I. Kern, “Appellate Court Offers Best Reason for Tort Reform,” *New Jersey Law Journal* (June 30, 2003) p.23. The case is *Estate of David Williams v. St. Joseph’s Hospital and Medical Center*, A-2683-01T5 (New Jersey Appellate Division, June 2, 2003).

Arkansas Medical School, told a press conference held by the Oklahoma Trial Lawyers Association, “I don’t think [tort reform] is good for patients. It’s especially unfair for children, for elderly individuals and for women.” The reason Dr. Bennett appeared “on the other side,” was because a surgeon who misrepresented his experience with a specific operation he performed to relieve Dr. Bennett’s carpal tunnel syndrome severed a nerve in his dominant hand. “As a right- hand dominant surgeon, that effectively put an end to my surgical career.”¹¹⁹

Dr. John Faulkner of Raleigh, does not favor caps. His wife Joan, forty-four, a stay at home mom, suffered a medical disaster during surgery in June, 2002. A cauterizing tool ignited oxygen that was being pumped into her nose during a routine lymph node biopsy in her neck. Her husband called the disaster, “completely preventable.”¹²⁰ Her top lip melted off, her face, neck and chest suffered second and third degree burns that will require reconstructive surgery. After a three-week hospitalization, she was released in constant pain, numbed by powerful medications that sap energy and drive. Says doctor Faulkner, “If you cap my wife’s pain and suffering, we’d be delighted. But until you can cap my wife’s pain and suffering, you shouldn’t cap what it’s worth. That’s for a jury to decide.”¹²¹ Dr. Faulkner appeared on a panel discussion with Dr. Richard Anderson, chairman of the board of governors of The Doctors Company, the first national physician-owned medical malpractice insurer. Dr. Faulkner, referring to Anderson’s company, said, “I agree that a responsible insurer would have helped us. I’m sorry to say, Dr. Anderson, this hospital’s insurance company is The Doctor’s Company. Dr. Anderson replied, “No it’s not The Doctor’s Company, I can’t believe it’s The Doctor’s Company. We don’t insure hospitals in South Carolina.” Dr. Faulkner replied, “It’s North Carolina.”¹²² (Dr. Anderson reportedly earns \$2 million dollars a year as head of The Doctors Company.)¹²³

¹¹⁹Robin Maxey, “Victims Go to Capitol to Protest Tort Reform,” News & Eagle (Enid, Oklahoma) Feb. 19, 2003, p. 1.

¹²⁰“Whose Malpractice Crisis?” National Law Journal (June 9, 2003) pp. 10, 11, 12. He further explained that the hospital said it would hire an outside agency to conduct a complete investigation of the fire which was done. But the hospital has refused to release the results to the family – “They never have, despite repeated requests.”

¹²¹Sarah Avery, “For One Doctor, Cap Is an Insult,” News & Observer [Raleigh, NC] April 9, 2003, pp. 1B, 7B.

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¹²³Sasha Polakow-Suransk “Whose Malpractice Crisis?” National Law Journal (June 9, 2003) pp. 10, 12. y, “Bad Medicine: Why Bush’s Malpractice Policy Will Only Help Insurers,” American Prospect (July 3, 2003), reprinted in Vol. 19 Health Letter (August 2003) pp. 3-5.

Appendix D: The Fate of “Mega-Verdicts”

The first study of million dollar claims¹²⁴ prepared by someone associated with the healthcare industry (not a trial lawyer) to appear in the medical literature was published in 1995. The author said the data had severe limitations because it was based on voluntary reports. The study concerned claims from 227 Ohio hospitals for the period 1982-1992 and found 73 claims with a total payout of \$147 million dollars. The study said that the “number of million-dollar claims is likely to continue to increase.” (The calculated average award in these high-award cases was \$2,013,700.) It found that thirteen percent of the million dollar so-called “lottery winners” were under the age of ten and their catastrophic injuries captured 47 percent of all million dollar claims. Twenty-nine percent of the million dollar claims were for death, with the remaining seventy-one percent involving permanent, not minor injuries.¹²⁵ Persons over the age of sixty “won” just seven percent of the million dollar claims.

Stunning verdicts are occasionally brought in by lawyers who are convincing beyond most people’s skills – but even these lawyers don’t keep their so-called “lottery” verdicts. The classic example is New York superlawyer Thomas A. Moore’s headline-grabbing “bad baby” verdict against Harlem Hospital Center, a remarkable \$76 million dollars. The baby was essentially born unattended in the hospital. Under New York law at the time the jury was required to state in writing its award for future damages, with the figure not reduced to present value – a rule the doctors had demanded as part of a so-called tort reform package. Hence, the jury was forced to estimate this amount, namely \$76 million. The defendants had refused to settle the case for a mere \$3.5 million.¹²⁶ (The present value of the case was \$14 million.) While on appeal, the case was settled for \$9 million.¹²⁷

The fact that megaverdicts come at the hands of a few lawyers – and even these few seldom keep

¹²⁴Studies by insurance-affiliated researchers typically speak in terms of claims, not verdicts, because of the belief that the bulk of high recoveries come in settlements, and insurance-related researchers are loathe to provide disaggregated data.

¹²⁵Richard L. Sites, “11 Years of Million-Dollar Medical Malpractice Claims in Ohio,” *Journal of Healthcare Risk Management* (Summer, 1994) pp. 17, 18, 19.

¹²⁶“Jury Awards \$76.4 Million in Birth Case,” *Medical Liability Monitor* (July 16, 1999) p. 7. The case is *Yverose and Sensois Prindilus v. NYCHHC*, New York County (NY) Supreme Court Case No. 104830/94. Thomas A. Moore for plaintiff. See, “Claim of Failure to Attend Delivery – Severe Brain Damage – \$76 Million New York Verdict,” *Medical Malpractice Verdicts, Settlements & Experts* (February, 2000) p. 35.

¹²⁷*Prindilus v. New York City Health and Hospitals Corporation*, 294 A.D.2d 965, 743 N.Y.S.2d 770, 2002 WL 1034118 (N.Y.A.D. 1 Dept., March 23, 2002).

their so-called “lottery” verdicts - is best illustrated by three New York cases. The nation’s top ten jury verdicts of the year 2002 included three medical malpractice verdicts, all in New York. A \$94.8 million Brooklyn verdict was cut down to \$9 million by the trial court. Another was an \$80 million Long Island verdict that settled for \$5 million. The same two doctor-defendants had two years’ earlier lost a multi-million dollar verdict in a case handled by the *same* plaintiffs’ lawyer, super-advocate James R. Duffy, Uniondale.¹²⁸ New Jersey, a so-called “crisis” state according to the AMA, saw its largest verdicts shrink as well. The state’s largest verdict of 2002, \$9 million, was remitted by the court to \$1.4 million. Another \$400,000 verdict was cut to \$120,141.¹²⁹

Some states, like Tennessee have a “13th juror” rule. This means that if the judge isn’t happy with the award, s/he can reduce it. Tennessee’s biggest malpractice award of 2002 was \$5.8 million for the anesthesia death of a 49-year-old auto manufacturing executive. The trial judge cut this to \$3.9 million. Then the appellate court threw the case out entirely on a technicality; the trial judge had allowed the plaintiff too many peremptory challenges, namely, eight, the same number as the two defendants.¹³⁰ In Bangor, Maine, a federal judge ruled that \$1 million for the death of a newborn was excessive and lowered the verdict to \$400,000, giving the grieving parents the option of either a new trial or taking the lower amount.¹³¹

¹²⁸Jaclyn Jaeger, “Where Are They Now? A Look at 2002’s Top Ten Verdicts,” *Lawyers Weekly USA* (January 5, 2004) pp. B-25, B-27, citing, *Brenner v. Spector, et al.*, Suffolk County (NY) Supreme Court, No. 1581/95; “Failure to Properly Test Preterm Labor and Premature Rupture of Membranes – Infant Brain Damage – \$2.9 Million Settlement With University Hospital – Defense Verdict for One Physician – \$80 Million Verdict Against Two Obstetricians in New York,” *Medical Malpractice Verdicts, Settlements & Experts* (April, 2003) p. 38.

¹²⁹Stephanie Fox Pierson, “No Litigation Explosion or Jackpot Awards Here,” *New Jersey Law Journal* (March 10, 2003) p. 23.

¹³⁰*Hunter v. Ura*, 28 TAM 48-5 (Court of Appeals, Nashville, October 28, 2003).

¹³¹“Damages for Baby’s Death Excessive,” *Medical Liability Monitor* (June 20, 1995) p. 8. The case is *Julia Barrett v. Kennebec Valley Medical Center*, U. S. District Court, Bangor, Maine, No. 1-94-CV-30-MAB (unpublished Memorandum of Decision, March 21, 1995) (Suit had alleged the baby’s death was because of patient “dumping,” by the hospital. The parents accepted the remittitur.)