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ARTICLES

LEARNING TO CRAWL: THE USE OF VOLUNTARY CAPS ON DAMAGES IN MEDICAL MALPRACTICE LITIGATION

Ralph Peebles⁺ and Catherine T. Harris⁺⁺

Medical malpractice insurance “crises” seem to recur with distressing frequency. Indeed, the escalating costs of malpractice insurance premiums have become the focal point for advocates of tort reform. While we know quite a bit about the medical malpractice system, we know very little about what might work to fix things. Many reforms have been tried; little has worked. The two most commonly attempted reforms—at least at present—are legislatively imposed caps on noneconomic damages (i.e., pain and suffering) and the use of screening panels. Neither of these alternatives offers a satisfactory resolution to the problem.

This Article proposes the use of voluntary caps, selected (if at all) by the plaintiff and the plaintiff’s attorney. By the use of three separate litigation “tracks,” incentives can be provided for plaintiffs to agree to caps on damages, while also providing separate inducements for the insurers who defend malpractice defendants and the physicians that they insure. The underlying benefit for all would be substantially reduced costs of litigation. The end result would be improved access to the courts for injured plaintiffs and a more rational claims resolution system.

Legislation implementing the proposal would not be necessary; tailored discovery scheduling orders would suffice. In a politically charged climate, broad scale, equitable reform is not likely. Instead, we should begin a steady movement toward such reform in stages. We need to learn to crawl, before we can walk.

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I. INTRODUCTION

Again we find ourselves in a medical malpractice crisis.¹ Observers who follow such things generally agree that the crisis of the early 2000s is the third such crisis in recent memory. The first appeared in the mid-1970s; the second appeared in the mid-1980s.² The crisis is, by and large, about the level of malpractice insurance premiums physicians pay. Rates have increased substantially in the last several years over most of the country, and the rates have increased for all medical and surgical specialties.³ Several surgical specialties, including OB-GYN and orthopedic surgery, have experienced particularly dramatic rate increases.⁴ Beyond the attention paid to rising insurance premiums is the fear that for at least some specialties in some states, malpractice insurance is, or will soon become, unavailable.⁵ From a concern over rising insurance rates and diminishing availability of insurance, the next worry—one of access to health care—comes naturally. Will escalating premiums lead a substantial number of physicians (OB-GYNs are almost always used in this sort of argument) to abandon the practice of

1. Some writers prefer to place "crisis" in quotes, suggesting that the problem is a bit overstated. Certainly there is no shortage of overblown rhetoric in the continuing debate over medical malpractice reform. It is the position of this Article that the quotation marks are irrelevant. What matters is that the situation is widely *perceived* as a crisis, certainly by physicians and politicians, as well as many others. See, e.g., Bob Herbert, Editorial, *Malpractice Myths*, N.Y. TIMES, June 21, 2004 at A19; John P. McDaniel, Editorial, *Triage for a Crisis in Care*, WASH. POST, Nov. 21, 2004, at B8; Jack Torrey, *Bush Slams Malpractice Lawsuits*, COLUMBUS DISPATCH, Oct. 23, 2004, at A1. A perception this widespread simply can't be ignored.

2. William M. Sage, *Understanding the First Malpractice Crisis of the 21st Century*, in HEALTH LAW HANDBOOK 1-4 (Alice G. Gosfield ed., 2003); David M. Studdert et al., *Medical Malpractice*, 350 NEW ENG. J. MED. 283, 284-85 (2004); see also AM. MED. ASS'N, MEDICAL LIABILITY REFORM - NOW! 2 (2004), available at <http://www.ama-assn.org/ama1/pub/upload/mm/450/mlrnowdec032004.pdf>; Kenneth E. Thorpe, *The Medical Malpractice 'Crisis': Recent Trends and the Impact of State Tort Reforms*, HEALTH AFF., Jan. 21, 2004, at W4-20.

3. AM. MED. ASS'N, *supra* note 2, at 5-6.

4. Thorpe, *supra* note 2, at 21; see also U.S. GEN. ACCOUNTING OFFICE, GAO-03-702, MEDICAL MALPRACTICE INSURANCE: MULTIPLE FACTORS HAVE CONTRIBUTED TO PREMIUM RATE INCREASES 9-10, 13 (2003), available at <http://www.gao.gov/new.items/d03702.pdf>; William P. Gunnar, *Is There an Acceptable Answer to Rising Medical Malpractice Premiums?*, 13 ANNALS HEALTH L. 465, 470-71 (2004).

5. See, e.g., AM. MED. ASS'N, *supra* note 2, at 4; Sheri Hall, *Malpractice Rates Drive Off Doctors*, DET. NEWS, Oct. 25, 2004, at 1A; John Wagner, *Malpractice Pinch Has Md. Doctors Mulling Whether To Wait—or Leave*, WASH. POST, Nov. 30, 2004, at B1; Rachel Zimmerman & Christopher Oster, *Assigning Liability: Insurers' Missteps Helped Provoke Malpractice 'Crisis'*, WALL ST. J., June 24, 2002, at A1; Tanya Albert, *Two Illinois Towns Take Tort Reform into Their Own Hands*, AMEDNEWS.COM, Aug. 9, 2004, <http://www.ama-assn.org/amednews/2004/08/09/gvl20809.htm>.

medicine?⁶ More precisely, will escalating premiums, or the difficulty in obtaining insurance, induce a substantial number of physicians practicing in, say, Pennsylvania or New York or North Carolina⁷ to move to states with lower malpractice premiums? Although it may have been an answer, twenty-five or thirty years ago, for physicians to simply pass along the increased cost of insurance premiums by increasing the fees they charge, that option is much less realistic today. In a health care system dominated by managed care, it has become increasingly difficult for physicians to simply pass along their higher costs.⁸ Nor is it an answer to say to a physician, much as one might to a twenty-three-year-old driver, that you must simply be more careful, and eventually your rates will come down. Unlike drivers, physicians within a particular specialty are usually not “experience-rated.”⁹

Politicians and editorial writers around the country have all weighed in with their views about what ought to be done.¹⁰ Inevitably, proposals for tort reform have appeared at both the federal and state levels.¹¹ None of

6. See, e.g., Kathleen Kerr, *Docs Don't See Future in Babies*, *NEWSDAY* (New York), Oct. 19, 2004, at A6; News Release, American College of Obstetricians and Gynecologists, Medical Liability Survey Reaffirms More Ob-Gyns Are Quitting Obstetrics (July 16, 2004), http://www.acog.org/from_home/publications/press_releases/nr07-16-04.cfm.

7. AM. MED. ASS'N, AMERICA'S MEDICAL LIABILITY CRISIS: A NATIONAL VIEW, <http://www.ama-assn.org/ama/noindex/category/11871.html> (last updated Mar. 15, 2005) (listing Pennsylvania, New York, and North Carolina as three of the twenty states in a medical liability “crisis”).

8. Michelle M. Mello et al., *Caring for Patients in a Malpractice Crisis: Physician Satisfaction and Quality of Care*, *HEALTH AFF.*, July/Aug. 2004, at 42, 47 (2004); Sage, *supra* note 2, at 20; Studdert et al., *supra* note 2, at 286-87.

9. Michelle M. Mello & Troyen A. Brennan, *Deterrence of Medical Errors: Theory and Evidence for Malpractice Reform*, 80 *TEX. L. REV.* 1595, 1616 (2002); cf. PAUL WEILER, *MEDICAL MALPRACTICE ON TRIAL* 76-77 (1991). There is some indication, however, that the long-standing practice of charging one premium for all physicians practicing in the same specialty, such as general surgeons, or OB-GYNs, is changing. See David A. Hyman, *Medical Malpractice and the Tort System: What Do We Know and What (if Anything) Should We Do About It?*, 80 *TEX. L. REV.* 1639, 1645 n.18 (2002).

10. See, e.g., Herbert, *supra* note 1; McDaniel, *supra* note 1; Torry, *supra* note 1.

11. Several states (Florida, Idaho, Mississippi, Ohio, Oklahoma, Texas, and West Virginia) enacted cap legislation in 2003 and 2004, limiting the amount of noneconomic damages a medical malpractice plaintiff may recover, along with various other changes. NAT'L ASS'N OF MUT. INS. COS., AN OVERVIEW OF STATE LEGISLATIVE EFFORTS TO IMPROVE THE LEGAL SYSTEM, <http://www.namic.org/reports/tortReform/overview.asp> (last updated July 2004). In contrast, in 2004, voters in Oregon and Wyoming defeated ballot initiatives to impose caps on noneconomic damages. Tanya Albert, *State Tort Reform Ballot Wins Set Stage for Further Battles*, *AMEDNEWS.COM*, Nov. 22/29, 2004, <http://www.ama-assn.org/amednews/2004/11/22/gvl11122.htm>. Meanwhile, Florida voters approved a constitutional amendment limiting attorney fees in medical malpractice cases. See *id.* At the federal level, the House of Representatives passed House Bill 4280, the Health Act, in May 2004. See Help Efficient, Accessible, Low-cost, Timely Healthcare

this is new, of course. It all happened in the mid-1970s, and, to an extent, the mid-1980s. The fact that a third crisis appeared in the early 2000s speaks volumes about the effectiveness of the various proposals and reforms adopted in the past.

To this picture must be added another factor, hardly surprising in itself, but one that should not be overlooked. Physicians have little use for the tort liability system as it operates in the United States. One need only skim the American Medical Association's (AMA) web site¹² for a quick sense of this. Physicians consistently overestimate their chances of being sued.¹³ In a recent randomized survey of Pennsylvania medical specialists, 80% of the respondents characterized their malpractice insurance premiums as either an "extreme burden" or a "major burden."¹⁴ But beyond the obvious fact that doctors distrust the tort system in this country, there is a more basic concern. Physicians as a group doubt the ability of any finder of fact (be it judge, jury, or lawyer) to determine whether their conduct (their diagnosis, their treatment, their care in general) was negligent.¹⁵ In fact, it goes deeper than this. Many physicians are offended by the very idea that a non-physician might pass judgment on their medical decisions.¹⁶ It is not enough to acknowledge that "physicians are upset" and then concentrate one's efforts solely on the economic aspects of the problem. There is more to it than that. For any "reform" to have any chance of long-term success, the concerns of physicians—as well as their patients—must be acknowledged and addressed.

II. WHAT WE KNOW

It is a paradox that while we actually know quite a bit about medical malpractice, we know very little about what might work to fix it. More so than most other types of personal injury torts, medical malpractice has

(HEALTH) Act of 2004, H.R. 4280, 108th Cong. (2004), WL 2003 CONG US HR 4280. One of the key features of the bill was the imposition of a cap on noneconomic damages. *Id.* § 4. The Senate, to date, has not approved the bill.

12. AM. MED. ASS'N, <http://www.ama-assn.org> (last visited Mar. 22, 2005).

13. See Ann G. Lawthers et al., *Physicians' Perceptions of the Risk of Being Sued*, 17 J. HEALTH POL. POL'Y & L. 463, 475 (1992).

14. Mello et al., *supra* note 8, at 47-48.

15. See CATHERINE T. STRUVE, THE PROJECT ON MED. LIAB. IN PA., EXPERTISE IN MEDICAL MALPRACTICE LITIGATION: SPECIAL COURTS, SCREENING PANELS, AND OTHER OPTIONS 7-8 (2003), available at <http://medliabilitypa.org/research/struve1003/StruveReport.pdf>; PAUL WEILER ET AL., A MEASURE OF MALPRACTICE 128-29 (1993); Ralph Peeples et al., *Settlement Has Many Faces: Physicians, Attorneys, and Medical Malpractice*, 41 J. HEALTH & SOC. BEHAV. 333, 341-43 (2000).

16. See STRUVE, *supra* note 15, at 16; Timothy Marjoribanks et al., *Physicians' Discourse on Malpractice and the Meaning of Medical Malpractice*, 37 J. HEALTH & SOC. BEHAV. 163, 167 (1996).

consistently attracted scholarly attention. Of equal importance, this scholarly attention has often taken the form of empirical study, as opposed to case and statutory analysis, or mere theoretical discourse. Thus we know that most incidents of medical negligence never form the basis for a claim against the physician, the hospital, or the insurer, much less a civil lawsuit.¹⁷ Every study on the subject leads to the same conclusion: much more medical negligence takes place than most people think.¹⁸ On the other hand, a large number of ill-founded claims of medical negligence are made every year, as well.¹⁹ Thus, the problem is one of both under-inclusion and over-inclusion.

When lawsuits are filed, the evidence strongly suggests that the tort liability system does a good job of identifying meritorious cases (i.e., those cases involving actual negligence on the part of the physician), although the identifying and the compensating are typically done in a very inefficient and costly manner.²⁰ Almost all empirical studies have found that compensation is related to a determination of negligence on the part of the defendant physician. Thus, Danzon examined malpractice claims closed by California insurers in 1974 and 1976, and concluded that in general, the malpractice liability system operated in a rational way.²¹ Meritorious claims were more likely to be paid than non-meritorious claims.²² Cheney and others reviewed closed insurance company claims relating to anesthesiologists and found a clear connection between negligence and compensation.²³ Looking at over 8000 closed insurance files from New Jersey, and examining the assessments of physician-reviewers in those cases, Taragin and others also found that claims were much more likely to be paid if the physician-reviewers felt the defendant

17. PATRICIA M. DANZON, *MEDICAL MALPRACTICE* 19-29 (1985) (reviewing California data); see WEILER ET AL., *supra* note 15, at 137-39 (reviewing New York State data, as part of the Harvard Medical Practice Study); David M. Studdert et al., *Beyond Dead Reckoning: Measures of Medical Injury Burden, Malpractice Litigation, and Alternative Compensation Models from Utah and Colorado*, 33 IND. L. REV. 1643, 1676, 1682 (2000). See generally the summary provided in 1B Patricia M. Danzon, *Liability for Medical Malpractice*, in HANDBOOK OF HEALTH ECONOMICS 1339, 1351-54 (Anthony J. Culyer & Joseph P. Newhouse eds., 2000).

18. This was one of the key points made by the Institute of Medicine report in 2000. COMM. ON QUALITY OF HEALTH CARE IN AM., INST. OF MED., *TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM* 42-43 (Linda T. Kohn et al. eds., 2000); see also Hyman, *supra* note 9, 1642-43; Mello & Brennan, *supra* note 9, at 1598-600.

19. WEILER ET AL., *supra* note 15, at 71.

20. Studdert et al., *supra* note 2, at 285-86.

21. DANZON, *supra* note 17, at 32, 49-50.

22. See *id.* at 50.

23. Frederick W. Cheney et al., *Standard of Care and Anesthesia Liability*, 261 JAMA 1599, 1599, 1601 (1989).

doctor's conduct had fallen short of the relevant standard of care.²⁴ Farber and White reported similar findings, after a review of medical hospital records relating to 242 malpractice lawsuits,²⁵ as did Sloan and others, following a study of obstetrics and emergency malpractice claims in Florida.²⁶ Indeed, only one study—although probably the one most often cited—did *not* find a connection between medical negligence and compensation. That study, which was based on a review of approximately fifty-seven hospital records, instead found only a connection between severity of injury and compensation.²⁷ The connection between negligence and compensation can be shown not only in insurance company practice (paying only claims deemed meritorious, on the opinion of expert physician reviews)²⁸ but also with the ultimate arbiter in this area—the lay jury.²⁹ It appears that lay juries do “get it right” most of the time—their lack of medical training notwithstanding.

Most medical malpractice lawsuits never reach trial, although the trial rate for medical malpractice cases is consistently higher than the trial rate for other civil lawsuits.³⁰ The most common disposition is settlement. Approximately half of all medical malpractice lawsuits are settled prior to verdict.³¹ Unilateral abandonment of the case by the plaintiff—i.e., a voluntary dismissal, not involving the payment of money—is also quite common.³² When a medical malpractice case does go to trial, the

24. Mark I. Taragin et al., *The Influence of Standard of Care and Severity of Injury on the Resolution of Medical Malpractice Claims*, 117 ANNALS INTERNAL MED. 780, 781 (1992).

25. Henry Farber & Michelle White, *A Comparison of Formal and Informal Dispute Resolution in Medical Malpractice*, 23 J. LEGAL STUD. 777, 786-87, 795 (1994).

26. FRANK A. SLOAN ET AL., *SUING FOR MEDICAL MALPRACTICE* 6, 8, 166-68 (1993); Frank A. Sloan & Chee Ruey Hsieh, *Variability in Medical Malpractice Payments: Is the Compensation Fair?*, 24 LAW & SOC'Y REV. 997, 1003, 1010, 1014, 1025-26 (1990); see Frank A. Sloan & Chee Ruey Hsieh, *Injury, Liability, and the Decision To File a Medical Malpractice Claim*, 29 LAW & SOC'Y REV. 413, 413, 417-20 (1995).

27. Troyen A. Brennan et al., *Relation Between Negligent Adverse Events and the Outcomes of Medical Malpractice Litigation*, 335 NEW ENG. J. MED. 1963, 1964-65 (1996). The authors subsequently acknowledged the singularity of their findings. See Studdert et al., *supra* note 17, at 1654.

28. Ralph Peeples et al., *The Process of Managing Medical Malpractice Cases: The Role of Standard of Care*, 37 WAKE FOREST L. REV. 877, 884-86 (2002).

29. Taragin et al., *supra* note 24, at 780-84; Neil Vidmar, *The Performance of the American Civil Jury: An Empirical Perspective*, 40 ARIZ. L. REV. 849, 859 (1998).

30. Vidmar, *supra* note 29, at 851; Samuel Gross & Kent Syverud, *Getting to No: A Study of Settlement Negotiations and the Selection of Cases for Trial*, 90 MICH. L. REV. 319, 364 (1991); see Thomas B. Metzloff, *Resolving Malpractice Disputes: Imaging the Jury's Shadow*, 54 LAW & CONTEMP. PROBS. 43, 50 (1991).

31. DANZON, *supra* note 17, at 32, 42; SLOAN ET AL., *supra* note 26, at 164, 166; Peeples et al., *supra* note 28, at 881 & n.12.

32. DANZON, *supra* note 17, at 32; SLOAN ET AL., *supra* note 26, at 164, 167.

defendant physician prevails most of the time—this finding recurs in the literature.³³ While a number of explanations for this pattern at trial are possible (e.g., general jury bias in favor of physicians, better expert witnesses, or greater defense resources), the most likely reason is more basic. Insurers settle cases they believe they will lose. They try only those cases they believe they can win.³⁴ The insurer's assessment is usually borne out at trial. Thus, in a real sense, a plaintiff who takes her medical malpractice case all the way to trial has already lost: if she has been unsuccessful in coaxing a settlement from the insurer, the chances are excellent that she will be unsuccessful with the jury as well. Her attorney has also lost, most likely. Medical malpractice cases are always taken on a contingency basis. The percentages may vary (between 20% and 50%, with 33 1/3% being the most common)³⁵ but the basic truth does not change: the plaintiff's lawyer is paid only if money is recovered from the defendant's insurer.

Medical malpractice is in effect a specialty practice, although more so on the defense side than on the plaintiff side. Defense lawyers are retained and paid by the malpractice insurer.³⁶ The insurer typically uses a relatively small number of lawyers to represent its insureds.³⁷ As a result, defense lawyers are usually highly experienced "repeat players."³⁸

33. Studdert et al., *supra* note 2, at 285. The reported rates vary according to the sample studied, but the results uniformly indicate a success rate in excess of 50% for defendant physicians, and usually significantly higher than that. For example, Jury Verdict Research reported that defendant physicians prevailed 58% of the time in 2002. News Release, Jury Verdict Research, Medical-Malpractice Jury-Award Median Up Slightly: Overall Median Compensatory Award Down 30% (Apr. 1, 2004), http://www.juryverdictresearch.com/Press_Room/Press_releases/Verdict_study/verdict_study8.html. Weiler has estimated a defense win rate of 67%. Paul Weiler, *The Case for No-Fault Medical Liability*, 52 MD. L. REV. 908, 914 (1993). Sloan and Hsieh reported a rate of about 75% (Florida). Sloan & Hsieh, *supra* note 26, at 1007. A recent study of California verdicts by the RAND Institute for Civil Justice reported a defense win rate of about 78%, as compared to a 47% defense win rate for all other trials during the same period. NICHOLAS PACE ET AL., RAND INST. FOR CIVIL JUSTICE, CAPPING NON-ECONOMIC AWARDS IN MEDICAL MALPRACTICE TRIALS 19 (2004), available at http://www.rand.org/pubs/monographs/2004/RAND_MG234.pdf. Metzloff reported a rate of 81% (North Carolina). Metzloff, *supra* note 30, at 50. For the years 1985-1998, the Physician Insurers Association of America (PIAA) reported a defense "win" rate at trial of 81%. PHYSICIAN INSURERS ASS'N OF AM., MEDICAL MALPRACTICE CLAIM EXPENSES 2 (executive summary) (1999); see also Gross & Syverud, *supra* note 30, at 362-63.

34. Peeples et al., *supra* note 28, at 891.

35. SLOAN ET AL., *supra* note 26, at 77; Herbert M. Kritzer, *The Wages of Risk: The Returns of Contingency Fee Legal Practice*, 47 DEPAUL L. REV. 267, 285-86 (1998).

36. Gunnar, *supra* note 4, at 479-80; Peeples et al., *supra* note 28, at 880.

37. Peeples et al., *supra* note 28, at 880.

38. Marc Galanter, *Why the "Haves" Come Out Ahead: Speculation on the Limits of Legal Change*, 9 LAW & SOC'Y REV. 95, 114 (1974); see also Samuel Gross & Kent

Defense lawyers are usually paid on an hourly basis, although various incentive agreements are occasionally used.³⁹ In exchange for the assurance of a certain volume of work, defense lawyers often agree to a discount from their standard hourly rate.⁴⁰

Any lawyer admitted to practice can be a malpractice plaintiffs lawyer. All that is needed is a willing client. Thus, the level of sophistication among plaintiffs lawyers varies from the inexperienced to the well-seasoned. The costs involved in bringing a medical malpractice lawsuit are substantial. Medical records must be read and reviewed. The initial reviewing must be done by someone with a medical background of some sort—either by in-house staff, or by a paid consultant. Physicians who treated the plaintiff, other than the defendant(s), often will need to be identified and interviewed. Expert witnesses⁴¹ must be identified and retained—and they too will need to review the medical records. Usually at least several depositions will be necessary: that of the defendant(s), and at least the key defense experts. Depositions of other witnesses, such as subsequent treating physicians or members of the defendant's office staff, are not uncommon. Furthermore, the defense will almost always depose the plaintiff as well as the plaintiff's experts. Most observers estimate the cost of preparing a medical malpractice case at a minimum of \$50,000.⁴² Depending on the complexity of the case, the pretrial costs can easily run much higher.⁴³ If the case actually goes to

Syverud, *Don't Try: Civil Jury Verdicts in a System Geared to Settlement*, 44 UCLA L. REV. 1, 53 (1996); Joel Grossman et al., *Do the "Haves" Still Come Out Ahead?*, 33 LAW & SOC'Y REV. 803, 803-05 (1999).

39. See Gross & Syverud, *supra* note 38, at 15-16.

40. See Galanter, *supra* note 38, at 114.

41. Expert testimony from other physicians is a fixture of most medical malpractice litigation. Expert witnesses are used to testify as to the relevant standard of care to which the defendant physician should be held, and, to a lesser extent, as to causation of the alleged injury. See generally William Meadow, *Operationalizing the Standard of Medical Care: Uses and Limitations of Epidemiology To Guide Expert Testimony in Medical Negligence Allegations*, 37 WAKE FOREST L. REV. 675 (2002); Philip G. Peters, Jr., *The Quiet Demise of Deference to Custom: Malpractice Law at the Millennium*, 57 WASH. & LEE L. REV. 163 (2001).

42. E.g., Richie Kemp, *When Attorneys Come Back for Seconds: Increased Attorney Fees for Extraordinary Work in Medical Malpractice Cases*, 25 J. LEGAL MED. 79, 89-90 (2004).

43. *Id.* ("[Attorneys] risk between \$50,000 and \$100,000 [to] prepar[e] and litigat[e] the average medical malpractice action."); Gary T. Schwartz, *Empiricism and Tort Law*, 2002 U. ILL. L. REV. 1067, 1071 ("[T]he cost of mounting a plausible malpractice claim is at least \$50,000."); see also Gail B. Agrawal & Mark A. Hall, *What If You Could Sue Your HMO? Managed Care Liability Beyond the ERISA Shield*, 47 ST. LOUIS U. L.J. 235, 247 (2003); Stephen Daniels & Joanne Martin, *It Was the Best of Times, It Was the Worst of Times: The Precarious Nature of Plaintiffs' Practice in Texas*, 80 TEX. L. REV. 1781, 1798 (2002).

trial, substantial additional expenses must be added to the total cost. The high entry cost of medical malpractice lawsuits thus means that in practice, damages of at least \$100,000 must be involved in order to make bringing the case "worthwhile."⁴⁴

It is an expensive business, with high risks for the plaintiffs lawyer. Not only is there the risk of never being paid for the time expended; it is often the case that the plaintiffs lawyer advances the costs of pretrial preparation, with little expectation of recovering those funds unless money is obtained from the defendant either in settlement or at trial.⁴⁵ It is not surprising, then, that there are lawyers who specialize in medical malpractice litigation. Because of the pervasiveness of the contingent fee, their success is largely a function of the cases they handle.⁴⁶ Their ability to attract good cases, due to their own reputation, as well as their ability to obtain referrals from other attorneys are of obvious importance.⁴⁷ Ultimately, however, the success of a plaintiffs medical malpractice lawyer is a function of his or her case-picking ability.⁴⁸ A case of likely liability, but involving only limited recovery (such as a case where appendicitis was diagnosed later than it should have been, but the patient suffered little or no permanent harm) may not be worth pursuing. The amount of time and money needed to prepare the case, compared to the amount that can be recovered, will make it unlikely that an experienced plaintiffs lawyer would want to take the case. A case of very uncertain liability, but involving potentially high damages, might offer some allure, but unless there is a reasonable chance of a large recovery, an experienced attorney will likely decline to take that case as well. After all, 1/3 of zero is still zero. In fact, specialist plaintiffs attorneys can be compared to portfolio managers.⁴⁹ Some cases will yield a recovery, and some will not; certainty of outcome is never a part of the plaintiffs lawyer's practice. The key is to pick cases that offer a range of

44. NEIL VIDMAR, *MEDICAL MALPRACTICE AND THE AMERICAN JURY* 61 (1995); Schwartz, *supra* note 43, at 1071; Gary T. Schwartz, *Medical Malpractice, Tort, Contract, and Managed Care*, 1998 U. ILL. L. REV 885, 895. Almost twenty years ago, a U.S. General Accounting Office report estimated the damages threshold at \$50,000. U.S. GEN. ACCOUNTING OFFICE, GAO/HRD-87-73, *MEDICAL MALPRACTICE: A FRAMEWORK FOR ACTION* 23 (1987), available at <http://161.203.16.4/d28t5/133122.pdf>.

45. Daniels & Martin, *supra* note 43, at 1812; Kemp, *supra* note 42, at 89-90; Kritzer, *supra* note 35, at 270.

46. Studdert et al., *supra* note 2, at 284; Daniels & Martin, *supra* note 43, at 1823.

47. SLOAN ET AL., *supra* note 26, at 75-76; Daniels & Martin, *supra* note 43, at 1793-94.

48. See, e.g., Herbert M. Kritzer, *Seven Dogged Myths Concerning Contingency Fees*, 80 WASH. U. L.Q. 739, 754, 772 (2002).

49. Kritzer, *supra* note 48, at 754; see also Neil Vidmar & Leigh Anne Brown, *Tort Reform and the Medical Liability Insurance Crisis in Mississippi: Diagnosing the Disease and Prescribing a Remedy*, 22 MISS. C. L. REV. 9, 32 (2002).

recoveries, both in terms of dollar value and likelihood of success. In short, the plaintiffs lawyers who succeed are the ones who are adept at picking good cases. However, there is also a catch: because of the possible effect of a plaintiffs lawyer's reputation, a case in the hands of a well-known and respected attorney may be worth much more than the same case in the hands of a novice attorney.

The claims resolution process, especially when a lawsuit is filed, is usually slow and expensive for all involved.⁵⁰ A very high percentage—in excess of 55%—of premium dollars are used to pay the “overhead” of attorney fees, expert reviews, and trial-preparation expenses, to say nothing of the amount of money spent by the insurer internally.⁵¹ As a means of compensating injured patients, the claims resolution process is grievously inefficient for all concerned.⁵²

For all that we do know about medical malpractice, some questions remain unanswered. Only limited reliable data is available, for example, on the typical allocation (if there is such a thing) in a jury award between economic and noneconomic damages.⁵³ In many states, jurors are simply not instructed to make such a determination: damages are just damages.⁵⁴ In states where jurors are instructed to make an allocation between economic and noneconomic damages (for purposes of complying with a statutory cap on damages, or otherwise) data has not been rigorously collected and analyzed until quite recently. For the most part, those efforts have been limited to a single state—California.⁵⁵ It follows, then, that even less information is available about economic and noneconomic damages when cases are settled. Compounding the problem is the fact that confidentiality is a condition of many negotiated settlements.⁵⁶

50. Daniels & Martin, *supra* note 43, at 1798; Sage, *supra* note 2, at 29; Weiler, *supra* note 33, at 916.

51. Studdert et al., *supra* note 2, at 285-86; Stephen D. Sugarman, *Doctor No*, 58 U. CHI. L. REV. 1499, 1502-03 (1991). The high level of overhead is not unique to medical malpractice claims. A study conducted by Tillinghast-Towers Perrin in 2003 concluded that less than 50% of premium dollars goes to compensate injured people. TILLINGHAST-TOWERS PERRIN, U.S. TORT COSTS: 2003 UPDATE 17 (2003), available at http://www.towersperrin.com/tillinghast/publications/reports/2003_Tort_Costs_Update/Tort_Costs_Trends_2003_Update.pdf.

52. Hyman, *supra* note 9, at 1644; Weiler, *supra* note 33, at 926.

53. Extrapolating from the data derived from the Harvard Medical Practice Study (and as reported by WEILER, *supra* note 9), Sugarman estimated that only between 10% and 15% of malpractice premium dollars actually goes to compensate for out-of-pocket economic losses. Sugarman, *supra* note 51, at 1503.

54. See PACE ET AL., *supra* note 33, at xvii-xviii.

55. See, e.g., *id.*

56. Nonetheless, confidentiality cannot always be assured. For example, New Jersey now requires the on-line public posting of payments made by insurers on behalf of physicians in medical malpractice cases. See N.J. STAT. ANN. § 45:9-22.23 (West 2004);

We also do not know much about experts. Is it true that two are better than one, and that four are better than two? Is it important to have more experts than the other side? Are in-state experts better than out-of-state experts? Many lawyers assume they know the answers to these questions—but few assumptions about the use of experts have ever been tested empirically. Credible studies are not easy to find.⁵⁷ There is reason to believe, however, that experts drawn from the same specialty will frequently disagree with one another, even when reviewing the same medical records.⁵⁸

III. THE PROBLEM

Knowing all this about the claims resolution process, why is it that crises seem to occur with such annoying frequency? One answer, advanced by critics of the insurance industry, is to blame the problem on the insurance companies.⁵⁹ When income from the investment of premium revenues is robust, insurers price their policies aggressively, in an effort to expand market share; when income from investment of premium revenue declines (and losses from claims begin to increase) the industry increases the rates it charges, and blames the increase on the spiraling level of indemnity payments made to claimants and their attorneys.⁶⁰ Another answer is to argue that, in fact, the amount of money paid out in claims and in the defense of those claims has been rising dramatically; and so, rate increases are inevitable.⁶¹ It is a debate that generates more heat than light. Simple answers are not to be expected. It seems unlikely that a single cause for the problem exists. Instead, a combination of factors, including a steady increase in claims severity⁶² and a drop in insurance industry investment income over the

Mary P. Gallagher, *Internet Posting of Med-Mal Payouts Is Seen To Be Chilling Settlements*, N.J. L.J., Nov. 15, 2004, at 1, 8.

57. See, however, VIDMAR, *supra* note 44, at 72-76, for a useful discussion of the role expert witnesses play in medical malpractice litigation. See also Neil Vidmar & Shari Diamond, *Juries and Expert Evidence*, 66 BROOKLYN L. REV. 1121, 1121-27 (2001).

58. Karen L. Posner et al., *Variation in Expert Opinion in Medical Malpractice Review*, 85 ANESTHESIOLOGY 1049, 1049-54 (1996).

59. See, e.g., ROBERT HUNTER & JOANNE DOROSHOW, CTR. FOR JUSTICE & DEMOCRACY, PREMIUM DECEIT 2 (1999), available at <http://www.centerjd.org/air/PremiumDeceit.pdf>; Zimmerman & Oster, *supra* note 5.

60. See AMS. FOR INS. REFORM, MEDICAL MALPRACTICE INSURANCE: STABLE LOSSES/UNSTABLE RATES 2004, at 1, 2, 3-4, available at <http://www.insurance-reform.org/StableLosses04.pdf>.

61. See, e.g., AM. MED. ASS'N, *supra* note 2, at 3-5.

62. "Claims severity" refers to the amount of compensation demanded and/or recovered by a claimant.

past several years seems to be at fault.⁶³ What seems true, regardless of the cause of the crisis, is that few people are well served by the existing system: certainly not patients or physicians, and perhaps not plaintiffs lawyers, defense lawyers, or insurers. Most victims of medical negligence never seek redress—either by filing a claim, or by filing a lawsuit.⁶⁴ Thus, most injuries go uncompensated. Physicians are caught in the middle. Either they are being manipulated by their insurers, or they are being manipulated by dissatisfied patients and plaintiffs attorneys. Plaintiffs lawyers typically find themselves vilified as rapacious opportunists, while defense counsel are seen as a necessary (but still regrettable) evil.

The point here is not that medical malpractice law as it is practiced today fails because the premiums doctors have to pay are too high, or because doctors do not trust the tort liability system. Those two observations are symptoms of a larger failing. Judged by either of the two fundamental goals of modern tort law—deterrence and compensation⁶⁵—the medical malpractice system is a failure, for most of the people, most of the time.

There are many reasons to believe that as a system of deterrence, medical malpractice law does not work. For deterrence to work, a wrongful behavior must be identified, and a punishment must be imposed. In order to alter his or her behavior, the wrongdoer must know what it was he or she did wrong—and must know what the consequences will be of behaving wrongfully in the future. While doctors who are sued for malpractice usually know what it is they are alleged to have done wrong, it is not often the case that they agree with the ultimate determination of liability, if such an adverse determination is made.⁶⁶ It does not matter if the adverse determination is made by a jury at trial or by the physician's own insurer who chooses to settle the case. At bottom is the conviction that no layman has the training or insight to judge a physician's medical decisions or behavior.⁶⁷ Even if the jury actually gets it "right," that fundamental conviction remains. There is some irony to this: one of the key ways that an insurer will make a determination about liability is to send the relevant complaint and medical records to other physicians practicing in the same specialty for review. Only when the consensus of the outside reviewers indicates a serious problem will an

63. U.S. GEN. ACCOUNTING OFFICE, *supra* note 4, at 43-45; Thorpe, *supra* note 2, at 21.

64. See *supra* text accompanying notes 17-18.

65. DAN B. DOBBS, *THE LAW OF TORTS* §§ 10-11, at 17-19 (2000); W. PAGE KEETON ET AL., *PROSSER AND KEETON ON THE LAW OF TORTS* § 4, at 20-26 (5th ed. 1984).

66. Peebles et al., *supra* note 15, at 341-42.

67. Vidmar, *supra* note 29, at 858; see also *supra* notes 15-16.

insurer seek a settlement.⁶⁸ Thus, peer review does routinely happen—except that it's usually anonymous and almost never involves direct communication between reviewer and reviewed. Beyond these behavioral observations, there is the fact that when compensation is paid, it is paid by the insurer. Rarely is any portion of an award or settlement actually paid by the physician.⁶⁹ It should come as no surprise, then, that efforts to identify a meaningful deterrence effect produced by the malpractice liability system have been unsuccessful.⁷⁰

Judged against the goal of compensation—where only meritorious claims would be paid, and where the amounts paid would bear a consistent, logical connection to the type of injury sustained—the medical malpractice system fails badly. There are problems of erroneous compensation (paying the wrong claimants), of erroneous noncompensation (not paying patients injured by medical negligence), of overpayment, and of underpayment.

A. Erroneous Compensation

Not all claimants who receive compensation deserve it. This concern can be heard anywhere personal injury claims are defended; it is not unique to medical malpractice. There is substantial empirical evidence that indicates erroneous compensation is not uncommon in medical malpractice cases.⁷¹ Nonetheless, the incidence of successful “false” claiming does not seem excessive. Strictly “nuisance” payments do not seem to happen very often. Most professional liability insurers insist on a showing of at least potential liability before payment will be discussed.⁷²

B. Erroneous Non-compensation

Several major studies within the past twenty years indicate that the incidence of medical negligence far exceeds the rate at which injured

68. See Peebles et al., *supra* note 28, at 886.

69. Although deductibles are not commonly used in medical malpractice insurance, it is possible that one or more adverse events might induce an insurer to either refuse to renew coverage, or require a higher premium in the future. This rarely happens in practice, however.

70. Hyman, *supra* note 9, at 1644-45; Mello & Brennan, *supra* note 9, at 1607-09.

71. See, e.g., Brennan et al., *supra* note 27, at 1965-66 (stating that compensation is predicted by severity of injury, not medical negligence); Cheney et al., *supra* note 23, at 1601 (stating that in 42% of cases studied, payment was made even though care provided was deemed within the standard of care); Taragin et al., *supra* note 24, at 781 (stating that compensation paid in 21% of cases was deemed defensible by the insurer).

72. Peebles et al., *supra* note 28, at 886. For example, as reported by the PIAA, in 2002 almost 70% of all claims filed against physicians were closed without any payment. See AM. MED. ASS'N, *supra* note 2, at 2-3.

patients claim compensation for such injuries.⁷³ Most victims of medical negligence never assert a claim, much less file a lawsuit. One obvious reason for this is the high entry costs of medical malpractice litigation.⁷⁴

Beyond these concerns of simply paying the right cases, there is also the problem of the close case. Not all cases are clear cut on the issue of negligence. Experts often disagree as to what the standard of care requires.⁷⁵ Given the fact that experts are hired either by the plaintiff or the defendant, this should not be surprising.

An additional problem is the simple fact that the claims resolution process is an adversarial system. Factors other than medical negligence can influence the outcome—such as the disparate skill levels of the attorneys, the polish of one party's experts, the relative attractiveness of the plaintiff and the defendant, as well as the makeup of the jury.⁷⁶

C. Under- and Overpayment

Compensation is not a simple “yes or no” proposition. A \$5000 payment in settlement of a claim for a permanent, debilitating injury is unlikely to represent adequate compensation, just as a payment of \$500,000 for a simple delay in the diagnosis of appendicitis is likely to represent over-compensation. Although “lottery” type awards are not unheard of (and are invariably widely publicized), most research suggests that, at least in medical malpractice, claimants are typically undercompensated.⁷⁷

The problems of erroneous compensation, non-compensation, and over- and underpayment can also be seen easily enough in other areas of personal injury litigation.⁷⁸ Claiming rates may vary by type of injury (e.g., automobile versus hospital), but the problems of erroneous compensation and erroneous non-compensation are not unique to medical malpractice litigation. The puzzle of damages—how they should be calculated, what factors should be included, and who should do the calculating—is a problem common throughout tort law.⁷⁹ Ultimately, a

73. See, e.g., Mello & Brennan, *supra* note 9, at 1599; Studdert et al., *supra* note 17, at 1682.

74. See authorities cited *supra* notes 17-18; see also *supra* text accompanying notes 43-44.

75. See Peebles et al., *supra* note 28, at 884; Posner et al., *supra* note 58, at 1051.

76. This phenomenon—that factors other than the existence of medical fault can influence outcomes—has been occasionally noted in the literature, but seldom studied. See, e.g., SLOAN ET AL., *supra* note 26, at 183-84; Brennan et al., *supra* note 27, at 1965-66.

77. SLOAN ET AL., *supra* note 26, at 206-07; Sage, *supra* note 2, at 29; Weiler, *supra* note 33, at 918.

78. See, for example, the discussion in SLOAN ET AL., *supra* note 26, at 187-88.

79. See, e.g., Studdert et al., *Are Damage Caps Regressive? A Study of Malpractice Jury Verdicts in California*, 23 HEALTH AFF. 54, 55 (2004).

claimant's damages are whatever amount, if any, the jury awards, or that he or she is willing to accept in settlement. It is a land populated by rules of thumb and multipliers but few if any guidelines. Even one of the more well-known "rules of thumb"—that total damages should equal some multiple (often either two or three) of "special" (i.e., economic) damages—does not seem to be borne out in practice.⁸⁰ Indeed, plaintiffs lawyers themselves often disagree on what a case is worth.⁸¹ In an off-the-rack world, damage awards defy uniformity. Medical malpractice awards are no exception.⁸²

Medical malpractice litigation points out another failure of the goal of compensation, however. Medical malpractice claims, once they become lawsuits, are almost always expensive for both sides.⁸³ Expressed in premium dollar terms, most researchers estimate that 40% of every premium dollar is spent on litigation-related expenses, primarily legal fees.⁸⁴ Of this percentage, about half can be attributed to plaintiffs lawyers and about half to defense counsel.⁸⁵ In addition to the predictable legal fees and the usual discovery costs that will be incurred,

80. Herbert M. Kritzer, *Contingent-Fee Lawyers and Their Clients: Settlement Expectations, Settlement Realities, and Issues of Control in the Lawyer-Client Relationship*, 23 LAW & SOC. INQUIRY 795, 817-18 (1998).

81. See *id.* at 817. Two of the more famous studies are by DOUGLAS ROSENTHAL, *LAWYER AND CLIENT: WHO'S IN CHARGE* (1974), and GERALD WILLIAMS, *LEGAL NEGOTIATION AND SETTLEMENT* (1983).

82. A number of researchers, reviewing jury verdicts, have noted serious "horizontal equity" problems: compensation for the same or similar injury can vary greatly, from claimant to claimant. See, e.g., Sloan & Hsieh, *supra* note 26, at 1026; Studdert et al., *supra* note 79, at 56; see also Kirk B. Johnson et al., *A Fault-Based Administrative Alternative for Resolving Medical Malpractice Claims*, 42 VAND. L. REV. 1365, 1369 (1989).

83. A 2003 report prepared by the U.S. Department of Health and Human Services (HHS) estimated the average cost of defending claims that settled in 2001 was \$39,819 (using data provided by the PIAA). OFFICE OF THE ASSISTANT SEC'Y FOR PLANNING & EVALUATION, U.S. DEPT' OF HEALTH & HUMAN SERVS., *ADDRESSING THE NEW HEALTH CRISIS: REFORMING THE MEDICAL LITIGATION SYSTEM TO IMPROVE THE QUALITY OF HEALTH CARE* 12 (2003), available at <http://aspe.hhs.gov/daltcp/reports/medliab.pdf>. A previous report prepared by HHS estimated the average cost of defense, for all claims, settled or not, increased by \$24,000 between 1987 and 1999. OFFICE OF THE ASSISTANT SEC'Y FOR PLANNING & EVALUATION, U.S. DEPT' OF HEALTH & HUMAN SERVS., *CONFRONTING THE NEW HEALTH CARE CRISIS: IMPROVING HEALTH CARE QUALITY AND LOWERING COSTS BY FIXING OUR MEDICAL LIABILITY SYSTEM* 10 (2002), available at <http://aspe.hhs.gov/daltcp/reports/litrefm.pdf>. The largest insurer of physicians in North Carolina, Medical Mutual Insurance Company of North Carolina, has reported an average defense cost per claim of \$22,544, for 1848 claims filed during 1976-2003. David Sousa, *NC Medical Malpractice Insurance Data v. Plaintiffs' Attorneys: Can Fact Prevail over Fiction?*, 64 N.C. MED. J. 182, 185 (2003).

84. Studdert et al., *supra* note 2, at 286.

85. Danzon, *supra* note 17, at 1369; see WEILER, *supra* note 9, at 53 & n.28. A study conducted by Tillinghast-Towers Perrin, examining tort costs in general, estimated defense costs at 14% of the total amount. TILLINGHAST-TOWERS PERRIN, *supra* note 51, at 17.

both plaintiff and defendant will have to spend money on experts. It is rare that a claim or a defense can be made without the use of expert testimony as to standard of care and causation. State law rarely imposes any limitations on the number of experts that may be identified for possible use at trial.⁸⁶ As a result, “more is better” often dominates each side’s case preparation. In this particular arms race, however, the defense has the advantage. It remains true that recruiting defense experts, particularly those who practice within the state, is much easier than recruiting plaintiffs experts.⁸⁷ Regardless of who retains them, the services of experts do not come cheap. Hourly rates of several hundred dollars for reviewing medical records or testifying at deposition are common.⁸⁸ Even higher rates for trial testimony are also quite common.⁸⁹

In short, the malpractice liability system does a poor job of compensating injured patients, and it requires a high level of overhead to operate. There is little reason to think that the goal of deterrence is any better served. It is a woefully inefficient system badly in need of repair.

IV. WHAT HAS BEEN TRIED

Certainly many kinds of fixes have been tried. Even more have been proposed, and not tried. The more frequently tried reforms have included the imposition of statutory limits on the amount of damages that may be awarded to a successful plaintiff (caps); the use of pre-suit or pretrial screening panels (mandatory and voluntary); abolition or modification of the “collateral source rule”;⁹⁰ a requirement that prior to

86. Virginia is a notable exception. See VA. CODE ANN. § 8-01.581.20(C) (Michie 2000) (stating that each party is limited to using no more than two experts per medical discipline on any issue presented).

87. In addition, there is the perceived threat of professional sanctions being invoked against physicians who testify in favor of plaintiffs. To date, the threat is more perceived than real. However, there are recent instances of professional discipline being imposed on physicians who testify for plaintiffs (on the grounds that their testimony is at odds with the prevailing standard of care). See, e.g., *Austin v. Am. Ass’n of Neurological Surgeons*, 253 F.3d 967, 968 (7th Cir. 2001) (Posner, J.); Fred L. Cohen, *The Expert Medical Witness in Legal Perspective*, 25 J. LEGAL MED. 185, 186 (2004); Theresa DiPaola et al., *Silence of the Experts*, TRIAL, Oct. 2004, at 20, 20 (2004).

88. See, e.g., James A. Mellowitz, *Whatever the Market Will Bear: Fighting Exorbitant Expert Fees with Rule 26(B)(4)(c)(i)*, RES GESTAE, Feb. 1995, at 15, 16-17.

89. Ten years ago, Vidmar estimated typical expert witness fees as ranging between \$300 and \$500 per hour. VIDMAR, *supra* note 44, at 60, 74. Vidmar’s estimates were based on his observations of North Carolina cases. *Id.* at 60. Following extensive conversations with both plaintiffs and defense lawyers in North Carolina in 2004, I believe the “going rate” for expert review and testimony has at least doubled since that time.

90. See, e.g., NAT’L CONFERENCE OF STATE LEGISLATURES, STATE MEDICAL LIABILITY LAWS TABLE 1, available at <http://www.ncsl.org/programs/insur/medliability.pdf> (last visited Mar. 23, 2005). The collateral source rule excludes from the jury’s consideration the existence of other sources of insurance or other compensation

filing suit, the plaintiff's attorney certify in some way that he or she has consulted with a medical expert who will support the allegations of the complaint; and various types of alternative dispute resolution, primarily arbitration and mediation.⁹¹ Heightened regulation of malpractice (and other) insurers has also been occasionally tried.

There are, of course, other proposals that have never been tried, at least not on a serious scale. The most prominent of these include various no-fault proposals,⁹² in which the emphasis would be on compensation in the presence of an undesirable outcome due to medical intervention, rather than in the presence of medical negligence. Various changes directed at the judicial system itself have also been proposed, including the creation of a specialty court which would hear and determine only cases alleging medical malpractice;⁹³ or a resort to special juries, in which the jury pool would be limited to those with medical degrees;⁹⁴ or an administrative, fault-based system that would replace the trial court.⁹⁵ Like no-fault, these ideas have attracted few adherents outside the academy.

Of the various reforms that have actually been tried, the two most sweeping in their potential effect are the imposition of damage caps and the use of screening panels. The history of both these reforms has been checkered. In a number of states, these reforms have been declared unconstitutional by the courts.⁹⁶ Furthermore, assessing the success of these reforms has proved difficult for at least two distinct reasons. First, no two states have done it exactly the same way. In states that have imposed caps, there is considerable variation as to the amount of the cap,

(such as medical insurance, or workers' compensation) available to the injured party. See, e.g., *Salitros v. Chrysler Corp.*, 306 F.3d 562, 573 (8th Cir. 2002).

91. See, e.g., NAT'L CONFERENCE OF STATE LEGISLATURES, *supra* note 90, at 3.

92. See, e.g., Mello & Brennan, *supra* note 9, at 1626-27; David Studdert & Troyen Brennan, *No-Fault Compensation for Medical Injuries: The Prospect for Error Prevention*, 286 JAMA 217, 219-20 (2001); Randall R. Bovbjerg & Frank A. Sloan, *No-Fault for Medical Injury: Theory and Evidence*, 67 U. CIN. L. REV. 53, 55-56 (1998); Jeffrey O'Connell, *Offers That Can't Be Refused: Foreclosure of Personal Injury Claims by Defendants' Prompt Tender of Claimants' Net Economic Losses*, 77 NW. U. L. REV. 589, 615-16 (1982); Weiler, *supra* note 33, at 19-20.

93. See STRUVE, *supra* note 15, at 68-70; Lindsay Fortado, *States Weigh 'Med-Mal' Courts*, NAT'L L.J., Dec. 13, 2004, at 5, 5; Philip K. Howard, *The Best Course of Treatment*, N.Y. TIMES, July 21, 2003, at A15.

94. Alan Feigenbaum, Note, *Special Juries: Detering Spurious Medical Malpractice Litigation in State Courts*, 24 CARDOZO L. REV. 1361, 1415-17 (2003).

95. Johnson et al., *supra* note 82, at 1367.

96. Courts in Alabama, Illinois, Kansas, New Hampshire, North Dakota, Ohio, Oregon, South Dakota, Texas, and Washington have at various times found damage caps unconstitutional. AM. MED. ASS'N, *supra* note 2, at 36-37; Gunnar, *supra* note 4, at 486. Courts in Florida, Illinois, Missouri, Pennsylvania, and Wyoming have at various times found screening panels unconstitutional. See STRUVE, *supra* note 15, at 56-57.

and as to what sort of damages are subject to the cap.⁹⁷ Similar problems await when one attempts to measure the success (or lack thereof) of screening panels. Some are mandatory; some are not. Some are physician dominated; some are not. Panel findings are admissible at trial in some states, but inadmissible in others.⁹⁸

The second reason why assessing what works and what doesn't work is the problem of compounding factors. If a state adopts more than one reform, and insurance rates stabilize, to which reform should the credit (if any) be given? If rates do not stabilize, to which reform should the blame be directed? Further, factors outside the control of the legislature have an influence on rates: the level of insurance losses sustained in the past year, the prime rate, and market performance are just a few possibilities.⁹⁹

A. Caps on Damages

Caps come in many different styles and flavors.¹⁰⁰ Approximately half the states impose caps of some sort in medical malpractice cases.¹⁰¹ Most of those states simply place a dollar limit on the amount of noneconomic damages (i.e., pain and suffering, emotional distress, mental anguish) that may be recovered.¹⁰² Several states, however, limit the overall amount that may be recovered.¹⁰³ In some states, caps on damages are accompanied by limits on the plaintiff's attorney fees.¹⁰⁴

97. See, e.g., NAT'L CONFERENCE OF STATE LEGISLATURES, *supra* note 90.

98. See Jean Macchiaroli, *Medical Malpractice Screening Panels: Proposed Model Legislation To Cure Judicial Ills*, 58 GEO. WASH. L. REV. 181, 193 (1990).

99. Thorpe, *supra* note 2, at 21; Stephen Zuckerman et al., *Effect of Tort Reforms and Other Factors on Medical Malpractice Insurance Premiums*, 27 INQUIRY 167, 168 (1990); see also U.S. GEN. ACCOUNTING OFFICE, GAO-03-836, MEDICAL MALPRACTICE: IMPLICATIONS OF RISING PREMIUMS ON ACCESS TO HEALTH CARE 37 (2003).

100. Limits on punitive damages can be thought of as a type of cap, as well. Many states restrict the amount of punitive damages that may be awarded, in one fashion or another. See PACE ET AL., *supra* note 33, at 60. Punitive damages, however, are rarely an issue in medical malpractice cases. See *id.* at 59-60 (noting that punitive damages were awarded in less than 1% of the medical malpractice trials in California ending in a plaintiff's verdict).

101. See Studdert et al., *supra* note 79, at 54; see also AM. MED. ASS'N, *supra* note 2, at 24.

102. See AM. MED. ASS'N, *supra* note 2, at 24.

103. *Id.* at 25. States with caps on total damages (economic and noneconomic) include Colorado, Indiana, Louisiana, Nebraska, New Mexico, and Virginia. See *id.*

104. California's statute, the Medical Injury Compensation Reform Act (MICRA), CAL. BUS. & PROF. § 6146 (West 2003), enacted in 1975, is the most prominent example. Plaintiff's attorney fees in medical malpractice cases are limited to 40% of the first \$50,000 recovered; 33 1/3% of the next \$50,000 awarded; 25% of the next \$500,000 awarded; and 15% of any amount awarded over \$600,000. *Id.* § 6146(a). In 2004 Florida voters

In their present incarnation, there are several significant problems with the use of caps. First, there is the fact that not all injuries are alike, and not all plaintiffs are alike. Caps have the effect of imposing a limit on the amount of damages a plaintiff may recover—regardless of how grievously he or she has been injured. This remains true even when attention is limited to noneconomic caps. The fact that the cap, if set high enough, may only occasionally come into play merely lessens the problem: a limit has been imposed, and in at least some cases, that limit will mean that an injured party is less than fully compensated. There is, in other words, an inherent arbitrariness to caps.¹⁰⁵ The impact of caps does not seem to be limited to a small number of plaintiffs. A recent study of California medical malpractice verdicts found that the \$250,000 cap on noneconomic damages was imposed to reduce the plaintiff's recovery 51% of the time.¹⁰⁶ A similar study by the RAND Corporation Institute for Civil Justice reported that the \$250,000 cap was imposed 45% of the time.¹⁰⁷

As the severity of the claimant's injury increases, the chances increase that the cap will limit his or her recovery. On this point the available empirical evidence is consistent. Noneconomic caps work to the special detriment of severely injured claimants who can show relatively little in the way of economic losses. Typical examples would include cases involving deafness, disfigurement, or chronic pain.¹⁰⁸ Many wrongful death cases, and cases involving infants less than one-year-old, also seem to be disproportionately affected by such caps.¹⁰⁹ Unless we are willing to say that no injury, no matter how grievous, is worth, say, more than \$250,000 for pain and suffering, a cap has the effect of penalizing those who are most seriously injured by another's negligence.

Imposition of a cap also has the effect of exacerbating a disparity widely known in personal injury litigation: some lives are worth more

approved a constitutional amendment restricting attorney fees in medical malpractice cases as well. See FL. CONST. art. I, § 26 (West, WESTLAW through Nov. 2, 2004).

105. See MAXWELL J. MEHLMAN, THE PROJECT ON MED. LIAB. ON PA., RESOLVING THE MEDICAL MALPRACTICE CRISIS: FAIRNESS CONSIDERATIONS 69-70 (2003), available at <http://medliabilitypa.org/research/mehlman0603/MehlmanReport.pdf>; Studdert et al., *supra* note 79, at 63.

106. Studdert et al., *supra* note 79, at 57. Studdert's team collected jury verdict data for the period between 1985 and 2002. *Id.*

107. PACE ET AL., *supra* note 33, at 21. The RAND study reviewed California verdicts from 1995 to 1999. *Id.* at xviii. Both the Studdert and others study and the RAND study relied on data supplied by California Jury Verdicts Weekly. *Id.* at xix; Studdert et al., *supra* note 79, at 64. Because it is likely that smaller verdicts were underreported, the actual percentage of "capped cases" may be somewhat less than 45%. See the discussion of this issue in PACE ET AL., *supra* note 33, at 63-64.

108. Studdert et al., *supra* note 79, at 62.

109. PACE ET AL., *supra* note 33, at 23-30.

than others. The same injury, sustained by two different people, can lead to very different recoveries. If noneconomic damages are limited, then economic damages matter more. Thus, a thirty-year-old highly compensated stockbroker, now permanently disabled, will have economic damages (calculated on the basis of lost future earnings) far in excess of the economic damages sustained by a thirty-year-old stay-at-home parent. In the absence of caps, noneconomic damages can nonetheless be awarded to acknowledge that the pain and suffering of both the stockbroker and the stay-at-home parent are substantial. The stockbroker, due to his or her documented lost earnings, may still recover more than the stay-at-home parent; but the stay-at-home parent's recovery, already limited by the absence of significant economic damages, will not be limited a second time—unless caps are imposed. By exacerbating this sort of disparity, the use of caps has the secondary effect of further limiting access to the courts. Given the same sort of injury to two different people, one profitably employed and the other a stay-at-home parent, the odds are good that the latter will have a much more difficult time than the former finding a lawyer to represent her. In most parts of the country, a case capped at \$250,000 (if liability is established), with little in the way of economic damages, will not be a very attractive case for experienced attorneys to take.¹¹⁰

The second problem with caps is less theoretical. Legislation imposing caps has met with an uneven fate around the country. Efforts to implement caps on a national basis have, to date, been unsuccessful.¹¹¹ At the state level, some courts have upheld the use of caps, and others have not.¹¹² In the states where caps have been found to be unconstitutional, there is of course an additional option. The cap can be

110. *Id.* at xxviii; Studdert et al., *supra* note 79, at 63. It also appears that the imposition of noneconomic caps has a greater impact on women, than on men. The RAND researchers found that the median reduction in total award for women, due to the MICRA cap, was 34%; in contrast, the median reduction for men was 25%. See PACE ET AL., *supra* note 33, at 32. This may be because a higher percentage of the total award for women is attributable to noneconomic damages. See *id.* at 32-33.

111. See AMS. FOR INS. REFORM, *supra* note 60.

112. See Tanya Albert, *Challenges in State Courts: New Tort Reforms Under Fire*, AMEDNEWS.COM, Nov. 1, 2004, <http://www.ama-assn.org/amednews/2004/11/01/pr111101.htm>. Courts in eight states have struck down mandatory caps, while courts in fifteen states have upheld them. *Id.*; see also NAT'L CONFERENCE OF STATE LEGISLATURES, *supra* note 90; Albert Yoon, *Damage Caps and Civil Litigation: An Empirical Study of Medical Malpractice Litigation in the South*, 3 AMER. LAW & ECON. REV. 199, 201 (2001); Elizabeth Poisson, Comment, *Addressing the Impropriety of Statutory Caps on Pain and Suffering Awards in the Medical Malpractice System*, 82 N.C. L. REV. 759, 772-74 (2004).

made a part of the state constitution.¹¹³ In the end, whether or not caps are constitutional seems beside the point. The amount of time it takes to resolve the question makes the value of the exercise doubtful, if what is needed is prompt change.

A third problem has to do with the law of unintended consequences. To what extent does the imposition of a cap on some types of injuries, and on some types of damages, distort personal injury litigation in general? If medical malpractice recoveries are capped, then an incentive arises to recast lawsuits originally styled as malpractice as something else—medical products liability claims, perhaps, or claims based on lack of informed consent—or to find new defendants to sue who are not protected under the terms of the cap legislation in question.¹¹⁴

Fourth, it is not at all clear that mandatory caps have worked. While there is solid evidence that caps do seem to reduce or at least restrain claim severity by limiting total jury awards,¹¹⁵ it is less clear that caps have a meaningful or lasting effect on malpractice insurance premiums. Thus, Zuckerman and others reported, in a 1990 study, that “hard” caps (i.e., dollar limitations on all damages, both economic and noneconomic) reduced premiums.¹¹⁶ In a more recent study, Thorpe found that premiums in states with caps on damages were, on average, 17.1% lower than in states without caps on damages.¹¹⁷ Nonetheless, the evidence is less than compelling.¹¹⁸ Many factors affect malpractice insurance premiums. Some of those factors have little relation to tort reforms in

113. For example, in 2003 Texas voters approved proposition 12, amending the Texas Constitution. See TEX. CONST. art. III, § 66; TEX. CIV. PRAC. & REM. CODE ANN. § 74.301-.303 (Vernon 2004) (imposing a cap on noneconomic damages of \$250,000 per health care provider).

114. See, e.g., Sage, *supra* note 2, at 16-17.

115. PACE ET AL., *supra* note 33, at 20-23; Studdert et al., *supra* note 2, at 288. See generally Studdert et al., *supra* note 79; Yoon, *supra* note 112.

116. Zuckerman et al., *supra* note 99, at 175.

117. Thorpe, *supra* note 2, at 26.

118. For example, in June 2003 Weiss Ratings Inc. issued a report challenging the view that damage caps had an appreciable effect on medical malpractice insurance premiums. MARTIN D. WEISS ET AL., WEISS RATINGS INC., MEDICAL MALPRACTICE CAPS: THE IMPACT OF NON-ECONOMIC DAMAGE CAPS ON PHYSICIAN PREMIUMS, CLAIMS PAYOUT LEVELS AND AVAILABILITY OF COVERAGE (2003), available at <http://www.weissratings.com/MedicalMalpractice.pdf>. In an October 2004 news release, the Foundation for Taxpayer and Consumer Rights made a similar claim, citing documents filed by GE Medical Protective, a large malpractice insurer, with the Texas Department of Insurance. See News Release, The Foundation for Taxpayer & Consumer Rights, Nation's Largest Medical Malpractice Insurer Declares Caps on Damages Don't Work, Raises Docs' Premiums; Smoking Gun Document Exposes Insurance Industry Lies (Oct. 27, 2004), <http://www.consumerwatchdog.org/insurance/pr/pr004698.php3>.

general, or caps on noneconomic damage awards in particular.¹¹⁹ There is also the fact that the existence of caps does not necessarily insure against the appearance (or reoccurrence) of a crisis. In 2004 the AMA identified twenty states as “medical liability crisis states.”¹²⁰ Eight of the crisis states (40%) had noneconomic damage caps in place at the time,¹²¹ although in six of those states, damage caps were less than two years old.¹²² Of the thirty states not listed as being in crisis, nineteen (63%) had adopted cap legislation of some sort; eleven states (and the District of Columbia) had not.¹²³ The point seems to be that the imposition of caps lessens the chances of a “crisis,” but does not guarantee against it.

There is one last aspect to the use of caps that, though perhaps obvious, needs to be acknowledged. Caps are popular with doctors, insurers, and with many defense lawyers. Caps are unpopular with plaintiffs and plaintiffs lawyers. Any proposal to implement caps in a given state is certain to draw both strong support and strong opposition. In the event that caps are adopted by a given state, it is reasonable to expect constitutional challenges shortly thereafter—leaving the efficacy of the “reform” in doubt until the challenges are resolved, one way or the other. The point is simply this: when caps are proposed, there will be clear winners and clear losers, depending on the ultimate fate of the cap proposal.

B. Screening Panels

The story with respect to screening panels is also less than clear. The principle is certainly appealing. Medical malpractice liability turns on whether the relevant standard of care was met or not.¹²⁴ To determine

119. See U.S. GEN. ACCOUNTING OFFICE, GAO-03-702, MEDICAL MALPRACTICE INSURANCE: MULTIPLE FACTORS HAVE CONTRIBUTED TO INCREASED PREMIUM RATES 4-5 (2003), available at <http://www.gao.gov/highlights/d03702high.pdf>; Thorpe, *supra* note 2, at 27; Studdert et al., *supra* note 2, at 288. It should also be noted that the 2004 RAND study of California’s medical malpractice reforms did not attempt to measure the effect, if any, that damage caps have had on insurance premiums. See PACE ET AL., *supra* note 33, at 4.

120. AM. MED. ASS’N, *supra* note 2, at 9.

121. The states were Florida, Massachusetts, Mississippi, Missouri, Nevada, Ohio, Texas, and West Virginia. FLA. STAT. ANN. § 766.118 (West 2004); MASS. GEN. LAWS ANN. ch. 231, § 60H (West 2000); MISS. CODE ANN. § 11-1-60 (2004); MO. ANN. STAT. § 538.210 (West 2004); NEV. REV. STAT. ANN. § 41A.031 (Michie 2003); OHIO REV. CODE ANN. § 2323.43 (Anderson 2004); TEX. CIV. PRAC. & REM. CODE AN. § 74.301 (Vernon 2004); W. VA. CODE ANN. § 55-7B-8 (Michie 2004).

122. In contrast, Massachusetts and Missouri both adopted caps in 1986. MASS. GEN. LAWS ANN. ch. 31, § 60H Historical and Statutory Notes (West 2000); MO. ANN. STAT. § 538.210 (West 2004).

123. AM. MED. ASS’N, *supra* note 2, at 9, 24-25.

124. DOBBS, *supra* note 65, at 631-34; WEILER, *supra* note 9, at 19.

this, the expert testimony of other physicians is almost always required.¹²⁵ Given this need for expert testimony, a pre-suit or pretrial determination by a neutral panel, consisting of physicians and others, might have the effect of filtering out cases in which liability is unlikely to be shown. If all goes well for the defense, a public trial is avoided, and the defendant doctor is vindicated. Meanwhile, the plaintiff and his or her attorney have at least been spared the greater expense and delay of a full-blown trial—or they have at least been warned about the weakness of the case. If all does not go well for the defense, the plaintiff will know that pursuit of the claim is worthwhile. The defense will be on notice that a settlement may be worth pursuing.¹²⁶ As originally conceived, screening panels were intended to make the claims resolution process work more efficiently, by encouraging the settlement of meritorious cases, and by identifying nonmeritorious cases at an early stage.¹²⁷ The track record of screening panels has not borne out this sort of promise, however. At one time, more than thirty states used some sort of screening panel.¹²⁸ Today, due to judicial challenges and legislative repeals, that number is down to twenty.¹²⁹ A principal shortcoming has been increased delay in the claims resolution process.¹³⁰

The empirical studies have also been less than kind. Danzon found that screening panels had virtually no effect on medical malpractice litigation.¹³¹ Zuckerman and others likewise found that panels had no effect on the severity of paid claims, and had little effect on malpractice insurance premiums.¹³² Goldman, examining the performance of peer assessments by physicians, found a surprisingly low level of consistency with respect to their medical conclusions.¹³³ Because physician participation is an essential part of all screening panels, this finding casts doubt on the reliability of the conclusions reached by panelists regarding

125. DOBBS, *supra* note 65, at 639; *see also* DANZON, *supra* note 17, at 16.

126. STRUVE, *supra* note 15, at 55-56.

127. Macchiaroli, *supra* note 98, at 186.

128. STRUVE, *supra* note 15, at 3.

129. *Id.* at 57.

130. *Id.* at 62; Douglas Eitel et al., *Medicine on Trial: Physician Attitudes About Expert Medical Witnesses*, 18 J. LEGAL MED. 345, 351 (1997); Jona Goldschmidt, *Where Have All the Panels Gone? A History of the Arizona Medical Liability Review Panel*, 23 ARIZ. ST. L.J. 1013, 1107 (1991).

131. DANZON, *supra* note 17, at 78, 198-202.

132. Zuckerman et al., *supra* note 99, at 175-76.

133. Ronald L. Goldman, *The Reliability of Peer Assessments of Quality of Care*, 267 JAMA 958, 959 (1992).

liability.¹³⁴ In sum, it is hard to escape the conclusion that screening panels offer little in the way of malpractice reform.

V. A SIMPLE PROPOSAL

Thirty years after the “first” malpractice insurance crisis, promising solutions remain elusive. It may be that the reforms of the past have been too ambitious. Perhaps we have tried to do too much, too quickly. We now find ourselves in a position where, it seems, any reform significant enough to make a difference will necessarily produce clear winners and losers. The likely result is political impasse; the inevitable result is resentment all around. It is precisely this zero-sum aspect of the debate that makes a resolution difficult. With so much seemingly at stake, there is little reason not to simply adopt an entrenched position, and stay there. Any significant proposal will face an uncertain fate.

There is no reason for plaintiffs, and their attorneys, to favor the imposition of caps. There is, likewise, no reason for physicians, and their insurers, not to favor them. Maybe imposing caps will work, after all. Even if caps fail to have the desired effect, there will still be other benefits. Caps on damages have the effect of limiting the potential size of the fee a plaintiffs attorney can earn from a given case. This is true whether the cap is applied to all damages, or only to noneconomic damages. Thus, even if malpractice rates continue to rise, at least the plaintiffs malpractice bar will have been chastened. At a minimum, the economic incentive for bringing a malpractice lawsuit will have been curtailed. When limits are also imposed on the percentage of the recovery the plaintiffs lawyer is entitled to (typically referred to as “sliding scale” fees), the effect is even more pronounced.¹³⁵

Why not change the incentives? Perhaps it is possible to give everyone a little something. It should be possible to give physicians and their insurers what they want—caps on noneconomic damages—but in a way that makes the concession palatable to plaintiffs and their attorneys. At

134. *Id.* at 959-60; see also Robert A. Caplan et al., *Effect of Outcome on Physician Judgments of Appropriateness of Care*, 265 JAMA 1957, 1959 (1991) (finding that the judgment of medical reviewers, regarding compliance with the standard of care, can be influenced by the reviewers' knowledge of the severity of the outcome); Posner et al., *supra* note 58, at 1051-52.

135. See, e.g., PACE ET AL., *supra* note 33, at 35-37 (discussing the effect of California's rules). Imposing limits on the size of the fee a medical malpractice plaintiffs lawyer may charge, expressed in terms of a percentage of any award recovered, has become more popular of late. For example, in November 2004 Florida voters approved an amendment to the state constitution capping attorney fees in medical malpractice actions at 30% of any award recovered. See FL. CONST. art. I, § 26 (West, WESTLAW through Nov. 2, 2004).

one level, this idea is nothing more elaborate than simple horse trading. It may be, though, that more is at stake.

Within bounds, the malpractice insurance system works well for many—but not all—of the key players. The insurer collects premiums from its insured physicians, invests the money, and uses the proceeds to defend (and occasionally indemnify) its insureds. In return, the insurer expects to make at least a modest profit. The insured physicians, in exchange for their premium payments, are assured that in the event of a lawsuit, a defense will be provided. If an indemnity has to be paid, the insurer will see to it. Defense lawyers are paid out of the premiums, or the income generated by the premiums. So too are plaintiffs lawyers and plaintiff patients, when successful. It is an organic system in miniature, where the premium payments function as the life-blood. When only one of the key players is being shortchanged, the system can still function. When more than one key player is being shortchanged, “crisis” results. As the size of indemnity payments rises, so does the overall cost of defense.¹³⁶ The premiums needed to fund the system must also increase—but only to a point. Where that point lies depends on one’s perspective, but it does exist. Beyond that point, more and more physicians stop buying insurance, or move to another jurisdiction, or stop practicing medicine. The result is less money generated from premiums to fund the system.

It is silly to think that increased costs of defense can be addressed simply by injecting more money into the system. Raising premiums and “passing the costs along” is no longer possible, if it ever was.¹³⁷ Instead, the distribution of the money that flows through the malpractice claims resolution system needs to be readjusted. By adjusting the distribution patterns, the overall level of money expended on the claims resolution system can be controlled. At the same time, the system as it now exists could be improved for all concerned. This could be done by setting up a system of separate “tracks” for medical malpractice cases. The plaintiff alone would choose the track to use, determined by the amount of damages he or she plans to seek. The management of the case would differ, depending on the “track” chosen.

For example, three tracks could be made available: track one, for cases designated by plaintiff’s counsel as involving \$200,000 or less in damages; track two, for cases designated by plaintiff’s counsel as involving \$1,000,000 or less in damages; and track three, for all other cases—where there would be no limit imposed on damages. Choosing either track one

136. See SLOAN ET AL., *supra* note 26, at 172-73 (demonstrating that litigation cost varies systematically with the size of the loss and defendant liability).

137. See *supra* text accompanying note 8.

or track two would thus set a limit on the maximum amount of damages potentially payable to the plaintiff. The key point would be that the limits would be agreed to, rather than imposed. The idea would be to provide plaintiff with strong incentives for choosing the appropriate track. To avoid needless costs associated with bargaining, participating insurers would commit themselves in advance to proceed under track one or track two, for any case, if the plaintiff so elects. In outline, such a system might look like this:¹³⁸

Track One. In cases designated by plaintiff's counsel as involving \$200,000 or less in damages, each side would be limited to designating just one expert to testify at trial. Depositions would not be permitted. Instead, each party would be required to submit a detailed statement of their expert's opinion. The expert's testimony at trial would be limited to the content of the statement submitted. Aggressive discovery scheduling orders would be used as a way of reaching trial or other resolution in less than nine months. Use of mediation would be voluntary, available only if both parties requested it.¹³⁹ Track one, in other words, would be a no-frills alternative, in which costs are kept to a minimum.

Track Two. In cases designated by plaintiff's counsel as involving \$1,000,000 or less in damages, each side would be limited to designating no more than two experts per specialty. Deposition of those experts would be permitted. Aggressive discovery scheduling orders would also be a key feature of this track. The goal would be to reach trial or other resolution in twelve months or less. Mediation prior to trial would be required. The mediator would be drawn from a panel of mediators with experience in medical malpractice litigation.

Track Three. For all other cases, the plaintiff's counsel would not be required to indicate any limitation on the amount of damages to be sought. Pretrial discovery and case preparation would proceed as they do at present. However, the benefits of the other two tracks would not be available either. There would be no limitation on the number or use of experts, and there would be no assurance of a prompt resolution of the case. Table 1 below compares the features of the three proposed tracks.

138. There is no magic to these particular dollar amounts. The amount of either or both thresholds could be altered, up or down. The reasons for proposing thresholds of \$200,000 and \$1,000,000 are discussed below. See *infra* text accompanying notes 147-54, 180-84.

139. A number of states require mediation prior to trial. Deborah R. Hensler, *Our Courts, Ourselves: How the Alternative Dispute Resolution Movement Is Re-Shaping Our Legal System*, 108 PENN. ST. L. REV. 165, 167 (2003). However, there is invariably a provision allowing the trial court to excuse mediation, for good cause shown, or something similar. E.g., WASH. SUPER. CT. CIV. R. 53.4(c), WL WA R SUPER CT CIV CR 53.4.

Table 1

Feature	Track One	Track Two	Track Three
Limits on the number of experts	One	Two per specialty	None
Deposition of experts allowed?	No—written statement only	Yes	Yes
Time to trial	Nine months or less	Twelve months or less	Whenever scheduled by the court
Mediation required?	No	Yes—mediator to have a background in medical malpractice	Yes, if required under existing law

A. Why Do It?

Not every medical malpractice case requires a full-blown entourage of experts proffered by the plaintiff and the defendant. Not every case is complex. Some cases that appear complex need not be. Yet the amounts expended on case prosecution and defense do not reflect this. Most malpractice cases are expensive to prosecute or defend, without regard to the particular issues involved, and without regard to the amount of money involved.¹⁴⁰ A key reason why almost all malpractice cases are so expensive has to do with the fixed costs of medical record review and the almost inevitable use of experts. In their study of civil trials in California, Gross and Syverud found that medical malpractice trials typically involve more expert testimony than all other types of tort litigation, with the exception of products liability cases.¹⁴¹ For trials conducted in 1990-1991, the authors reported an average of 5.5 experts per medical malpractice trial.¹⁴² This is often just the visible part of the iceberg. For every expert who testifies, it is likely that more than that number were consulted or retained. For at least every expert who testifies (and for some who never do) it is likely that they have been deposed, with the attendant expenses of deposition: travel expenses, expert preparation time, attorney time, and stenographic services.

The current claims resolution system provides little incentive to control costs. The threshold amounts of \$200,000 for track one and \$1,000,000 for track two are intended to sort cases by complexity—using the amount of money sought as a rough proxy for complexity. To a lesser extent, a three-track system would also sort cases by the level of severity of the alleged injury.

140. See Weiler, *supra* note 33, at 916; see also Vidmar & Brown, *supra* note 49, at 32.

141. Gross & Syverud, *supra* note 38, at 33.

142. *Id.*

The threshold amounts are meant to include all damages, economic and noneconomic, as well as attorney fees and costs. Plaintiffs ought to be able to decide which track to use, in light of their own assessment of damages. The sorts of classifications and distinctions required by a cap on just one sort of damage add needless complexity and argument. If the cap is expressed in terms of noneconomic damages, there will always be some unfairness in their application.¹⁴³ It is simpler and wiser to leave the estimation of damages, of whatever sort, to the plaintiff and her attorney.

Restrictions on the number of experts, elimination or limitation of expert depositions, and a shortened time to trial are the common features of tracks one and two. By limiting the number of experts to be identified and deposed (or, as in track one, eliminating depositions altogether), the amount required for preparing for trial can be reduced dramatically. The minimum amount required both to pursue a medical malpractice action and to defend a medical malpractice action will be reduced. It makes good sense to do so. The overhead associated with medical malpractice litigation—specifically, the amount paid lawyers, experts, economists and others—is famously high. The consensus view is that less than 50% of all the money spent by insurers on medical malpractice claims ends up in the pockets of injured patients.¹⁴⁴ Most observers estimate that between 55% and 60% of all insurer expenditures go for expenses of one kind or another: plaintiff attorney fees, defense attorney fees, expert fees, records review, and claims administration.¹⁴⁵ Much of that money would be better spent compensating more claimants, or reducing the insurers' costs of doing business, or some combination of both. Reducing the overhead required will also improve access to the courts. The high fixed costs involved in bringing a malpractice lawsuit have the effect of denying access to the courts for many claimants, whose claims, otherwise meritorious, are simply "not worth it" in the opinion of counsel.¹⁴⁶ Improving access in turn will promote the two fundamental goals of tort law—compensation and deterrence.

B. Why \$200,000?

Cases in which the plaintiff agrees to limit his or her overall recovery to \$200,000 or less would be eligible for track one. The logic for using

143. See *supra* text accompanying notes 105-10.

144. TILLINGHAST-TOWERS PERRIN, *supra* note 51, at 15.

145. Studdert et al., *supra* note 2, at 285-86; Danzon, *supra* note 17, at 1369; Weiler, *supra* note 33, at 915. A 2003 report by Tillinghast-Towers Perrin estimated a net return to plaintiffs in all personal injury torts (including medical malpractice) of 46%, out of all defense expenditures. TILLINGHAST-TOWERS PERRIN, *supra* note 51, at 17.

146. This is not a new phenomenon. See, e.g., Johnson et al., *supra* note 82, at 1367-68.

\$200,000 as the ceiling for track one is simple. The fixed costs of case preparation on the plaintiff's side for any malpractice claim are likely to be at least \$50,000.¹⁴⁷ Assuming a typical contingency agreement of 33 1/3%, in a \$200,000 recovery, the plaintiff would receive between \$80,000 and \$100,000, depending on whether the fee is taken against the gross recovery of \$200,000, or the net recovery of \$150,000 after costs are recouped. To the extent that costs can be controlled or reduced, the recovery to the plaintiff would increase, under either scenario.¹⁴⁸

The fact that a patient's actual injuries might be no more than \$100,000 is not a reason to deny the patient compensation from the party responsible for the injury. Only because we are accustomed to hearing about much larger medical malpractice verdicts do we think that a less-than-six figure injury is not substantial. If the context is changed—for example, from medical malpractice to a “slip and fall” in a local supermarket—a \$100,000 injury seems more impressive.

Much of the overall expense of defending medical malpractice lawsuits can be attributed to relatively low-dollar cases. A high percentage of medical malpractice payments are less than \$200,000. In 2004, for example, 14,411 payments on behalf of physicians were reported to the National Practitioner Data Bank.¹⁴⁹ Eight thousand three hundred and fifty-four of those payments (57.97%) were in an amount less than \$200,000.¹⁵⁰ The sum of payments of less than \$200,000 was approximately \$694,140,450, representing 16.34% of all payments reported to the Data Bank on behalf of physicians in 2004.¹⁵¹ However, the important number is not the percentage total of all payments reported to the Data Bank. Instead, the frequency of these relatively

147. See *supra* text accompanying notes 42-44.

148. If the attorney's fee is taken from the gross proceeds, the net recovery to the plaintiff would be computed as follows: \$200,000-(1/3 of \$200,000)-\$50,000 costs = \$83,400. If the attorney's fee is taken from the net proceeds, the recovery to the plaintiff would be computed as follows: \$200,000-\$50,000 costs-(1/3 of \$150,000) = \$100,000. If costs turn out to be \$40,000, rather than \$50,000, the net recovery to the plaintiff increases, to either \$93,400 or \$106,720, respectively.

149. PRACTITIONER DATA BANKS BRANCH, U.S. DEPT OF HEALTH & HUMAN SERVS., NATIONAL PRACTITIONER DATA BANK, at <http://www.npdb-hipdb.com/publicdata.html> (Dec. 31, 2004) (on file with the author). The National Practitioner Data Bank (NPDB) was established by Congress in title 4 of the Health Care Quality Improvement Act, Pub. L. No. 99-660, 100 Stat. 3743, 3784 (1986), and codified at 42 U.S.C. § 11131. The Act requires that any amount paid by an insurer on behalf of a physician must be reported to the NPDB. 42 U.S.C. § 11131 (2000). Whether liability was ever established is not relevant. There is some reason to suspect that not all such payments are, in fact, reported. See Joseph T. Hallinan, *Doctor Is Out: Attempt To Track Malpractice Cases Is Often Thwarted*, WALL ST. J., Aug. 27, 2004, at A1.

150. PRACTITIONER DATA BANKS BRANCH, *supra* note 149.

151. *Id.*

small payments is more significant. For virtually every one of these payments,¹⁵² a substantial amount of money was likely spent prosecuting and defending the claim. For any lawsuit alleging medical malpractice, regardless of the amount the plaintiff seeks, there will be substantial expenses that neither side will be able to avoid, such as the cost of obtaining and reviewing medical records, the cost of locating and recruiting potential experts, and the cost of deposing the experts designated by the other side. On average, costs will be in excess of \$25,000 per case for the defense, and in excess of \$50,000 for the plaintiff.¹⁵³ Numbers this large should not be ignored. Because of the inevitable fixed costs of record review, expert recruitment, and depositions, low dollar cases are not necessarily cheaper to defend (or pursue) than high dollar cases. Furthermore, given the ways of pretrial discovery, and the absence of limits on the number of experts in particular, a party often has the ability to impose additional costs on the opposing party. For example, more experts can be designated than will be needed, requiring additional discovery depositions.

Certainly many, if not most of the low dollar payments reported to the Data Bank originated as claims that contemplated significantly higher amounts. Still, the fact remains that in the end, the plaintiff and her attorney were willing to accept these relatively modest amounts—for better or worse. The point is, that to arrive at even these modest amounts in settlement, a large amount of money had to be spent on the costs of defending and prosecuting these cases. The money could be better spent elsewhere.¹⁵⁴

C. A Cap on All Damages?

The distinction between economic and noneconomic damages is difficult to rationalize. Some injuries, even though severe, do not usually lead to significant economic damages.¹⁵⁵ Some injuries, even though not

152. Most, but not all payments reported to the NPDB were the result of lawsuits. See PRACTITIONER DATA BANKS BRANCH, U.S. DEPT OF HEALTH & HUMAN SERVS., NPDB SUMMARY REPORT (2005), available at http://www.npdb-hipdb.com/pubs/stats/NPDB_Summary_Report.pdf (last visited Mar. 24, 2005).

153. In 1998 the average cost of defending a medical malpractice case (regardless of outcome) was \$24,669, according to the PIAA. PHYSICIAN INSURERS ASS'N OF AM., *supra* note 33, at 2 (introduction). Even nonpayment cases were expensive; the average cost of defending nonpayment cases was \$20,045. *Id.*; see also *supra* note 83.

154. The percentage of low dollar payments does appear to be decreasing over time, however. In 1999 payments of less than \$200,000 accounted for 69.2% of all payments reported to the NPDB. PRACTITIONER DATA BANKS BRANCH, *supra* note 149. This pattern is consistent with the view that claims severity has been increasing over the past several years.

155. See MEHLMAN, *supra* note 105, at 69-70; Paul Weiler, *Fixing the Tail: The Place of Malpractice in Health Care Reform*, 47 RUTGERS L. REV. 1157, 1180 (1995); Poisson,

severe, may often lead to significant economic damages. Unfair results, particularly when analyzed in terms of vertical equity, seem inevitable.¹⁵⁶ It would be simpler, and wiser, to allow plaintiffs to decide how they wish to proceed, in light of their own assessment of damages. If the damages do not seem enormous, and the need for a prompt resolution is present, then either track one or track two will offer an attractive alternative. Otherwise, the plaintiff should be free to seek whatever amount she believes she is entitled to. Injecting the distinction between economic and noneconomic damages into the process is simply not worth the effort.

D. What Kinds of Cases?

Payment data from the National Practitioner Data Bank (NPDB) offers a glimpse of the types of cases that are likely to fit the parameters of track one and track two. Beginning in early 2004, the NPDB began to provide data on severity of the injury alleged, using a nine-level scale ranging from "1," emotional injury only, to "9," death. Table 2 sets out the number, average, and median payments made by severity category. Table 2 also sets out the percentage of cases, within each severity category, in which less than \$200,000 and \$1,000,000, respectively, was paid.

Table 2
Payment by Severity Category¹⁵⁷

n=12,629

Severity of Injury	Number of Cases	Average Payment	Median Payment	Pct. of Cases < \$200,000	Pct. of Cases < \$1,000,000
Emotional injury only	169	\$83,124	\$37,500	90.5%	100%
Insignificant injury	209	\$58,594	\$17,500	93.8%	100%
Minor temporary injury	1252	\$80,745	\$37,500	90.8%	99.7%
Major temporary injury	1139	\$173,727	\$105,000	73.5%	99.5%
Minor permanent	1535	\$175,665	\$97,500	73.9%	99.3%

supra note 112, at 783. See generally Studdert et al., *supra* note 79. Studdert and others point out, for example, that injuries such as deafness or disfigurement, although severe, are not usually accompanied by significant economic loss. *Id.* at 62.

156. See Studdert et al., *supra* note 79, at 62-63; Weiler, *supra* note 155, at 1180.

157. PRACTITIONER DATA BANKS BRANCH, *supra* note 149.

injury					
Significant permanent injury	1987	\$331,133	\$225,000	48%	96.8%
Major permanent injury	1317	\$482,830	\$295,000	34.1%	93.5%
Quadriplegic, brain damage, lifetime care	653	\$793,484	\$495,000	23.6%	87.4%
Death	4158	\$279,862	\$195,000	55.5%	98.5%

Emotional injuries, insignificant injuries, and minor temporary injuries seem well-suited for track one. Over 90% of the reported awards for these three categories were less than \$200,000.¹⁵⁸ Track one might also prove attractive for many major temporary injury and minor permanent injury cases. Over 72% of the reported awards for those two categories were less than \$200,000.¹⁵⁹

Track two should be attractive to all categories of injury severity, with the exception of category 8 (quadriplegic, brain damage, lifetime care), and possibly category 7 (major permanent injury). Only for level 8 does the percentage of million-dollar cases exceed 10%.¹⁶⁰ Most death cases (category 9) should be suitable for either track one or track two. Death cases represent almost 1/3 (4158/12,629) of the payments reported for 2004.¹⁶¹ The average indemnity payment for death cases was \$279,862.¹⁶² Only 1.5% of such payments exceeded \$1,000,000.¹⁶³

The choice of what track to use will remain with the plaintiff, of course. Nonetheless, the data are suggestive. For most injuries, much time and expense could be saved by opting for track one or track two, with little risk of forgoing a larger award.

E. More Lawsuits?

Reducing the overhead associated with medical malpractice litigation cuts both ways, of course. If it will cost less to defend a case, it will cost less to prosecute a case. A three-track system might therefore increase the number of lawsuits filed, at least initially. The increase would be most likely for track one cases—i.e., cases in which the plaintiff seeks no

158. See *supra* table accompanying note 157.

159. See *supra* table accompanying note 157.

160. See *supra* table accompanying note 157.

161. See *supra* table accompanying note 157.

162. See *supra* table accompanying note 157.

163. See *supra* table accompanying note 157.

more than \$200,000 in damages. This might well prove to be a benefit to all concerned.

It is important to understand a potential \$200,000 recovery in context. Under current practice, even assuming that the full \$200,000 is recovered, the plaintiff's net recovery would likely be not much more than \$100,000. Assuming a minimum of \$50,000 in pretrial expenses that will have to be paid, and assuming a standard contingency fee of 33 1/3%, at most \$83,400 will be left for the plaintiff.¹⁶⁴ If the attorney fees are calculated on the basis of net recovery (gross recovery, less expenses), the plaintiff's recovery will be a bit higher—but still no more than half of the gross amount recovered. If only \$100,000 is obtained, the net recovery to the plaintiff may well be less than \$20,000.¹⁶⁵ Furthermore, these examples assume likely liability on the part of the physician. If there is a significant chance of no recovery, the dollar value of the recovery (if obtained) would need to be higher, to offset the increased risk of recovering nothing. It should not be surprising, therefore, that cases valued at \$200,000 or less are precisely the cases that rarely get filed. Given the high rate of under-claiming by victims of medical negligence,¹⁶⁶ perhaps a higher volume of low stakes litigation is exactly what's needed.

More lawsuits may be the way to redirect medical malpractice litigation toward one of the fundamental goals of tort law: compensation. More lawsuits *might* mean more payments to more injured people. If such proved to be the case, it would not necessarily mean greater payments overall to claimants, due to the effect of the caps agreed to for track one and track two. The result instead would be greater horizontal equity among claimants with similar injuries. More importantly, the *possibility* of more lawsuits would mean greater access to the courts for injured patients. At present, for malpractice injuries that cannot be valued in excess of \$200,000, access to the courts is virtually nonexistent. In order to secure the services of an experienced plaintiffs attorney, the minimum amount is actually much higher. It is important to understand that this problem of very limited access exists even in the absence of caps legislation. When legislatively imposed caps are introduced, access to the courts becomes even more constrained.¹⁶⁷

For claims valued at more than \$200,000 but less than \$1,000,000, the availability of track two might also increase the number of lawsuits filed. Reducing the number of experts, and assuring a resolution of the case within twelve months would lower the costs and the risks of bringing a

164. See the computations described *supra* note 148.

165. This again assumes \$50,000 of expenses and a fee of around \$33,000.

166. See *supra* text accompanying note 17-18.

167. See PACE ET AL., *supra* note 33, at 26.

lawsuit. As a result, more economically marginal cases might be filed. Examples would include cases in which liability is uncertain or doubtful, but damages, if proved, would exceed \$200,000; or cases in which damages probably exceed \$200,000, but realistically are worth no more than several hundred thousand dollars. Cases such as these would become more attractive to plaintiffs lawyers.

In addition to promoting the tort law goal of compensation, an increase in the number of lawsuits would promote the goal of deterrence as well, by improving the signaling process. When a mistake has been made, followed by an injury, the party allegedly responsible should know about it. The party responsible should also know the outcome of the claim. These things happen—eventually—under existing practice. But they do not happen in predictable fashion, and they do not happen quickly. Instead, most injuries, even injuries caused by error, do not lead to a claim, much less a lawsuit.¹⁶⁸ When a claim is made, or a lawsuit is filed, resolution of the matter is certainly months away, and likely more than two years away.¹⁶⁹ When the resolution occurs, it will most likely take the form of either a voluntary dismissal (meaning the plaintiff simply abandoned the case) or a monetary settlement. Either way, there has been no determination of fault made by a court. Rarely is either vindication or condemnation the result for the defendant physician. The goal of deterrence goes unserved if the message (either vindication or condemnation) is so seldom sent. Increasing the volume of cases would change this pattern. There would be more resolutions of all types, including judgments. Because of the streamlined process required for tracks one and two, the outcomes would be known sooner.

So where is the benefit to defendants? That benefit appears when another result of the tracking system is considered: the costs of defending a claim will be reduced, just as the plaintiff's costs of preparing a claim will be reduced. There will be less reason to settle to avoid the high costs of trial. In fact, reducing the costs of defense should have the effect of reducing, overall, the amount offered by the insurer to settle the case. Reductions in settlement amounts would then follow.¹⁷⁰

If the case proceeds under either track one or track two, the maximum amount recoverable will be within the limits of many, if not most medical

168. See *supra* text accompanying notes 17-18.

169. See Johnson et al., *supra* note 82 at 1371.

170. Twenty years ago, Danzon ran a number of simulations to determine the effect on medical malpractice litigation that a hypothetical 30% reduction in litigation costs for both sides would have. Danzon concluded that such a reduction would result in a reduction in average settlement amounts, an increase in the trial rate, and a decrease in the number of cases dropped without payment by the plaintiff. DANZON, *supra* note 17, at 48-49.

liability policies written today.¹⁷¹ With the threat of potential personal liability removed, there will be less incentive to settle for reasons unrelated to actual fault. In other words, a defendant who genuinely feels she has not been negligent will find it easier to resist the temptation to settle, and instead insist on her day in court. She will not be risking personal liability for any excess judgment.¹⁷²

F. More Trials?

Far more malpractice cases settle than ever go to trial.¹⁷³ Thus, the effect that a three-track system would have on trial and settlement rates needs to be considered. There is a possibility that more trials would result. The reason for this is that for track one and track two cases, insurers will know that their potential exposure is now limited. Freed of the risk of excessive awards, insurers might be inclined to offer less than before for the same sort of injury. The defense wins much more often than it loses at trial, and everyone knows that.¹⁷⁴ Even in the face of the historically long odds that going to trial represents, plaintiffs may still conclude that they are better off going to trial. The trial preparation will be less expensive than before, and the time to trial will be reduced. Put another way, when the transaction costs are reduced, pursuing a case to verdict makes more sense. Plaintiffs will discount their claims less, and defendants will make corresponding adjustments to the amount they are willing to pay in settlement.¹⁷⁵ Still, going to trial will make sense only if a careful analysis of the merits of the case has been done prior to filing the lawsuit.

Just as with an increase in filings, an increase in the trial rate would yield benefits to all. There is reason to believe that plaintiffs pay a substantial discount from the value of their claims when they agree to settlement.¹⁷⁶ The payments reported to the Data Bank support this view. In 2004, for example, the median award at trial (as reported to the NPDB) was \$265,000.¹⁷⁷ In contrast, the median settlement amount was

171. The most common liability limits written for medical malpractice are \$1,000,000 per event, and \$3,000,000 per year. U.S. GEN. ACCOUNTING OFFICE, *supra* note 4, at 6.

172. Most professional liability policies contain a clause requiring the insured's consent to settle a claim. See Peebles et al., *supra* note 28, at 880; Kent D. Syverud, *The Duty To Settle*, 76 VA. L. REV. 1113, 1172-77 (1990).

173. See *supra* text accompanying notes 30-32.

174. See *supra* note 33 and accompanying text.

175. See DANZON, *supra* note 17, at 48.

176. SLOAN ET AL., *supra* note 26, at 206-07; see also Stephen Spurr & Walter Simmons, *Medical Malpractice in Michigan: An Economic Analysis*, 21 J. HEALTH POL. POL'Y & L. 315, 340-41 (1996).

177. PRACTITIONER DATA BANKS BRANCH, *supra* note 149.

\$165,000.¹⁷⁸ Even allowing for the savings to be expected in not going to trial, the disparity is still striking.¹⁷⁹ A similar result can be found at the high end of the scale. In 2004, 10.5% of all jury awards were in excess of \$1,000,000.¹⁸⁰ Only 2.2% of all settlements exceeded \$1,000,000.¹⁸¹ For defendants, the prospect of more trials—conducted quickly and at less expense—might be the most efficient way, over time, to discourage frivolous lawsuits. The battle will be over the merits of the claim. The recurring temptation to settle rather than incur defense costs that would exceed the likely settlement will be lessened.

G. Fewer Large Awards

One of the most frequently cited problems with medical malpractice litigation is the steady increase in claim severity.¹⁸² The trend is especially evident in the past several years. The size of payments of all types—judgments and settlements—has increased noticeably.¹⁸³ The use of the three-track system should have the effect of reducing the number of awards in excess of \$1,000,000. The restrictions on the use of experts and the promise of a prompt resolution should be enough to lure some cases that might otherwise result in a “runaway” jury award into the confines of track two. For example, imagine a case with a likely settlement value of \$500,000. Under present practice, there is always the possibility that the plaintiff will come away with an award far in excess of \$500,000—perhaps \$1,000,000, perhaps much more. Both sets of lawyers will be aware of the possibility of a “jackpot” award. The potential for a very large award becomes an argument in favor of settlement, that plaintiff’s counsel is likely to invoke—sometimes successfully, sometimes not. When plaintiff’s counsel decides to take advantage of the benefits of lower pretrial overhead and shorter time to resolution, the possibility of a very large award disappears. In other words, a three-track system should have the effect of screening out cases that, objectively viewed, are not worth seven figures, but, in the hands of a skillful advocate and a sympathetic jury, just might be. At present, there is no reason not to go

178. *Id.*

179. It is certainly possible that cases with greater amounts at stake go to trial more often. One way to test this would be to control for severity of injury in comparing awards at trial to settlement amounts. In other words, a completely disabling injury might, or might not, net about the same amount, whether at trial, or in settlement. However, NPDB data on severity of injury is only available for 2004 forward.

180. PRACTITIONER DATA BANKS BRANCH, *supra* note 149.

181. *Id.*

182. See Studdert et al., *supra* note 2, at 286; Thorpe, *supra* note 2, at 21, 23.

183. In 1999 the median payment (judgments and settlements) reported to the NPDB was \$105,000. PRACTITIONER DATA BANKS BRANCH, *supra* note 149. In 2004 the median payment (judgments and settlements) reported to the NPDB was \$165,000. *Id.*

for the jackpot award, at least in the lawsuit's early stages. With a three-track system in place, there will be good reasons to refrain from going for the jackpot award. Since jury verdicts provide the key reference point for settlements,¹⁸⁴ restraining the amount of jury verdicts will have a moderating effect on settlement amounts as well.

H. Longer Term Effects

Use of a three-track system would have two beneficial effects with respect to the behavior of plaintiff's counsel. First, the availability of different tracks will encourage counsel to value their cases realistically, from the start of the representation. It will make little sense to "default" to track three for a case truly worth no more than \$200,000; the result will be needless delay and expense. Realistic case evaluation, early in the representation, should have the effect of correcting inflated expectations that the client may have—expectations that may make a settlement harder to obtain later in the development of the case, when the weaknesses of the case become apparent. Second, the availability of different tracks means that counsel will need to discuss the filing options with the client. That will mean explaining the benefits and the disadvantages of a less expensive, speedier resolution. It should also mean that plaintiffs will assume a greater say in the prosecution of their claims. They will need to decide whether a prompt resolution, with limited expense but bound by a voluntary cap on damages, is more desirable than an opportunity, however slight, to recover a larger sum, with the attendant higher expenses and greater time to resolution. At present, plaintiffs do not have to make this determination, even though in many cases an award of less than \$1,000,000, or even less than \$200,000, would adequately compensate them for their injury.

I. Large Dollar Cases: Track Three

Of course, there will be cases where the amount of potential damages is truly in excess of \$1,000,000. There will also be very complex cases that, in the opinion of plaintiff's counsel, require the use of multiple experts. Nonetheless, there should not be many such cases.

First of all, a review of reports to the NPDB since 1990 shows that payments of any type in excess of \$1,000,000 are quite uncommon; judgments in excess of \$1,000,000 are more uncommon still. In 2004, 97.4% (14,032/14,411) of all payments were for \$1,000,000 or less.¹⁸⁵ Such

184. Daniels & Martin, *supra* note 43, at 1804-07; Sloan & Hsieh 1990, *supra* note 26, at 1026-27.

185. PRACTITIONER DATA BANKS BRANCH, *supra* note 149. As with payments of \$200,000 or less, this percentage has declined over the past several years. In 1999, 98.5% of all payments were for \$1,000,000 or less. *Id.*

payments accounted for 82.4% of all the payments reported to the NPDB for 2004.¹⁸⁶ Of those payments, 456 represented jury verdicts; only forty-eight judgments in excess of \$1,000,000 were reported to the NPDB in 2004.¹⁸⁷ Even allowing for the recent increase in severity of indemnity payments, these numbers indicate that very large payments still remain very much the rare exception to a more moderate pattern. In any event, the fact that the median and mean awards are increasing in amount is all the more reason to provide incentives not to seek such large amounts, except when plainly warranted. Voluntary caps can provide such an incentive.

Second, it needs to be understood that true multi-million dollar claims will often, of necessity, involve defendants other than a physician or two. Hospitals will likely be co-defendants. The reason for this is pragmatic. The most common liability limits for a medical malpractice policy are \$1,000,000 per event, and \$3,000,000 per year.¹⁸⁸ Deeper pockets will be needed, in other words. Yet once hospitals become critical (if not primary) defendants, the policy issues change. No longer is the concern, necessarily, driving individual physicians out of practice. It is easy enough to rally political support for Dr. Marcus Welby; it is a more difficult task to rally political support for a faceless medical center. Even more importantly, it is at the institutional level that deterrence might actually work—not with individual physicians.¹⁸⁹ We should therefore aim the cannon in that direction.

J. Effects on Settlement

It is widely understood that in order to settle a lawsuit for, say, \$500,000 the plaintiff must begin by demanding a much higher number, perhaps even higher than \$1,000,000. This is a key feature of the process of positional negotiation that most lawyers use.¹⁹⁰ If the maximum award is now capped at \$1,000,000, how does the settlement dance change? Realistically, an experienced plaintiffs lawyer would agree to a \$1,000,000 cap only if the true “goal” is considerably less than \$1,000,000—and so the defense will assume. Room must be left for the plaintiff to make concessions. For similar reasons, an insurer wishing to initiate settlement talks will begin with an offer considerably less than the amount it is willing to pay—and so the plaintiff’s lawyer will assume.

186. *Id.*

187. *Id.*

188. See U.S. GEN. ACCOUNTING OFFICE, *supra* note 4, at 6.

189. Mello & Brennan, *supra* note 9, at 1623.

190. See, e.g., HOWARD RAIFFA, *THE ART AND SCIENCE OF NEGOTIATION* 47-49 (1982); CHARLES B. CRAVER, *EFFECTIVE LEGAL NEGOTIATION AND SETTLEMENT* 151-55 (4th ed. 2001).

Does this mean that, in practice, a \$1,000,000 voluntary cap will attract only claims valued by the plaintiff's lawyer as worth, say, no more than \$500,000? That would be an unfortunate result, because it would mean that fewer cases are being "captured" by this second track. In effect, it would mean a de facto cap of no more than \$500,000-\$600,000, where perhaps a net of \$350,000, at most, goes to the injured patient.¹⁹¹ It doesn't have to be this way.

A three-track system would change the traditional choreography of the settlement dance. The effect of choosing track one or track two will be to reduce the time to trial to twelve months or less. The parties will have to make a choice: either bargain realistically, or go to trial. In a system where trial is never more than twelve months away, the opportunity (and incentive) for posturing and intransigence will be lessened. Knowing that a bluff can be called in short order, there should be less temptation to do so in the first place. Use of a three-track system would place the emphasis in case resolution where it ought to be: on the merits.¹⁹²

A larger question regarding settlement must also be considered, however. Most medical malpractice lawsuits are disposed of in one of two ways. Either they are abandoned unilaterally, or they are settled. The settlement rate for medical malpractice cases is much higher than the trial rate. Various studies have estimated the settlement rate, for filed cases, at around 50%.¹⁹³ In contrast, the trial rate is estimated at between 5.8%¹⁹⁴ and 11%.¹⁹⁵ Would fewer cases settle under a three-track system?

Perhaps so. Twenty years ago, Danzon concluded that a 30% reduction in litigation costs for both sides would result in more trials and fewer cases dropped without payment.¹⁹⁶ The effect would be temporary, however. Over time, lawyers will learn what suits not to bring. A three-track system rewards plaintiffs lawyers who are adept at picking cases that have real value, by reducing both the overhead and the carrying costs associated with malpractice litigation. The system punishes insurers who refuse to settle cases that should be settled. Under tracks one and

191. I.e., \$600,000 gross recovery, less \$200,000 contingency fee, and less \$50,000 in expenses.

192. The alternative would be to build in the room needed to stage the settlement dance. For example, the limits of track one and track two could be doubled, to \$400,000 and \$2,000,000, respectively. The assumption would be that these two tracks are aimed at cases realistically valued at \$200,000 and \$1,000,000.

193. See *supra* text accompanying note 31.

194. See AM. MED. ASS'N, *supra* note 2, at 3 (using data supplied by PIAA).

195. See Weiler, *supra* note 155, at 1163. In any event, there is general agreement that the trial rate for medical malpractice cases is higher than for other tort claims. See *supra* note 30.

196. DANZON, *supra* note 17, at 48-49.

two, the incentive for delay is diminished since a prompt trial is assured. The opportunity to settle on terms more favorable than trial will still exist, but with a trial in the near future, the opportunity will be shorter. In the end, the result will be a more efficient and more rational system.

One other benefit to a three-track system should not go overlooked. This proposal can be implemented without enabling legislation. All it takes is a willingness to experiment on the part of one or more insurers, at least some plaintiffs attorneys, and the local trial courts. The details could be expressed in nothing more elaborate than a discovery scheduling order. Samples of such orders appear in the Appendices.

VI. CONCLUSION

A three-track system will not, of itself, cure the medical malpractice insurance crisis. A true cure will require changes much larger than what is proposed here. Nonetheless, it is a start. Precisely because the changes that will be required will be substantial, it is unrealistic to think that they can be adopted with one bold step. When it comes to malpractice reform, we need to learn how to crawl before we can learn how to walk.

APPENDIX: 1

PROPOSED EXPEDITED DISCOVERY SCHEDULING ORDER
(Track One Cases)

THIS MATTER having come on for hearing before the undersigned presiding Judge, on the date indicated below, and the Court hereby finding that this is an action alleging medical malpractice;

that the parties wish to bring this action to a prompt resolution, and in any event within nine months of the date indicated below;

and that the parties have agreed that in no event shall the amount of money awarded or paid to the plaintiff exceed \$200,000;

the Court therefore finds that it would be in the best interest of justice for an Expedited Scheduling and Pretrial Order to be entered.

THEREFORE, IT IS HEREBY ORDERED, ADJUDGED AND DECREED that the parties to this action shall comply with the following Order:

[ASSUME, for illustration purposes, that the date of the Order is January 1]

1. The parties shall each be limited to designating a single expert witness.
2. On or before March 1, the Plaintiff shall identify the expert witness s/he intends to call at the trial of this action.
3. On or before April 1, the Defendant shall identify the expert witness s/he intends to call at the trial of this action.
4. As used in this Order, the term "identify" when used in the context of expert witnesses shall mean the furnishing of the following information about each such expert:
 - (a) name and address;
 - (b) training and qualifications (or curriculum vitae);
 - (c) a detailed statement setting forth the subject matter upon which the expert is expected to testify, a detailed statement of the facts and opinions to which the expert is expected to testify, and the basis for each opinion, including medical records, deposition testimony, and any other materials the expert has reviewed.
5. All discovery of any nature and description whatsoever shall be concluded on or before August 1. This case shall be set for trial to begin on or before October 1.
6. Any expert witness not identified in conformity with this Order shall not be permitted to testify at the trial of this action. The testimony of all expert witnesses shall be limited to the information specified in paragraph 4(c) of this Order.

7. The parties agree that in no event shall an amount in excess of \$200,000, including both economic and noneconomic damages as well as attorney fees and prejudgment interest, be paid to the Plaintiff, whether in settlement or as a result of a jury verdict. In the event of an award in excess of \$200,000, the Plaintiff agrees to accept a reduction in the amount of the award to \$200,000. The parties further agree that in no event will punitive damages be sought or awarded.

8. Plaintiff agrees to authorize the release of any and all medical records of the Plaintiff within one week of the date of this Order.

9. The parties agree that the right of the parties to appeal an adverse judgment or other dispositive ruling shall be unaffected by this order.

10. This Order may be modified by written agreement of all parties.
So ordered, this the 1st day of January, 20__.

Judge

CONSENTED TO:

[Attorney for Plaintiff]

[Attorney for Defendant]

APPENDIX: 2

**PROPOSED EXPEDITED DISCOVERY SCHEDULING ORDER
(Track Two Cases)**

THIS MATTER having come on for hearing before the undersigned presiding Judge, on the date indicated below, and the Court hereby finding that this is an action alleging medical malpractice; that the parties wish to bring this action to a prompt resolution, and in any event within twelve months of the date indicated below;

and that the parties have agreed that in no event shall the amount of money awarded or paid to the plaintiff exceed \$1,000,000;

the Court therefore finds that it would be in the best interest of justice for an Expedited Scheduling and Pretrial Order to be entered.

THEREFORE, IT IS HEREBY ORDERED, ADJUDGED AND DECREED that the parties to this action shall comply with the following Order:

[Assume, for illustration purposes, that the date of the Order is January 1]

1. The parties shall each be limited to designating no more than two expert witnesses.

2. On or before March 1, the Plaintiff shall identify the expert witnesses s/he intends to call at the trial of this action. By March 15, the Plaintiff shall make such expert witnesses available for any discovery depositions the defendant may wish to conduct.

3. On or before May 1, the Defendant shall identify the expert witnesses s/he intends to call at the trial of this action. By June 15, the Defendant shall make such expert witnesses available for any discovery depositions the Plaintiff may wish to conduct.

4. As used in this Order, the term “identify” when used in the context of expert witnesses shall mean the furnishing of the following information about each such expert:

(a) name and address;

(b) training and qualifications (or curriculum vitae);

(c) a statement setting forth the subject matter upon which the expert is expected to testify, a summary of the facts and opinions to which the expert is expected to testify, and the basis for each opinion, including medical records, deposition testimony, and any other materials the expert has reviewed.

5. All discovery of any nature and description whatsoever shall be concluded on or before October 1. This case shall be set for trial to begin on or before December 1.

6. Any expert witness not identified in conformity with this Order shall not be permitted to testify at the trial of this action.
 7. The parties agree that in no event shall an amount in excess of \$1,000,000, including both economic and noneconomic damages as well as attorney fees and prejudgment interest, be paid to the Plaintiff, whether in settlement or as a result of a verdict. In the event of an award in excess of \$1,000,000, the Plaintiff agrees to accept a reduction in the amount of the award to \$1,000,000. The parties further agree that in no event will punitive damages be sought or awarded.
 8. Plaintiff agrees to authorize the release of any and all medical records of the Plaintiff within one week of the date of this Order.
 9. The parties agree that the right of the parties to appeal an adverse judgment or other dispositive ruling shall be unaffected by this Order.
 10. This Order may be modified by written agreement of all parties.
- So ordered, this the 1st day of January, 20__.

Judge

CONSENTED TO:

[Attorney for the Plaintiff]

[Attorney for the Defendant]