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# THE TRUTH ABOUT MEDICAL MALPRACTICE LITIGATION

"Tort liability for medical malpractice is designed to serve several functions: to compensate injured patients for their harm, to encourage doctors to take appropriate safety precautions and avoid undue risk in treating their patients, and to provide a forum in which negligent physicians can be held publicly accountable. The litigation process can also provide a means for patients and their families to gain more information about the causes and circumstances of medical injuries."[1]

## PREVENTABLE MEDICAL ERRORS ARE WIDESPREAD BUT FEW INJURED PATIENTS FILE LAWSUITS.

- Each year, hundreds of thousands of Americans are killed or injured by avoidable medical errors.
    - According to a November 2010 study by the Office of Inspector General of the U.S. Department of Health and Human Services, about 1 in 7 Medicare patients in hospitals experience a serious medical error, 44 percent of which are *preventable*.[2]
    - The Institute of Medicine's seminal 1999 study, "To Err is Human," found that between 44,000 and 98,000 patients are killed in hospitals each year due to *preventable* "adverse events" caused by treatment itself and not an underlying condition.[3] The IOM used stringent criteria in choosing which adverse events to consider. The report also notes, "Some maintain these extrapolations likely underestimate the occurrence of preventable adverse events because these studies: 1) considered only those patients whose injuries resulted in a specified level of harm; 2) imposed a high threshold to determine whether an adverse event was preventable or negligent (concurrence of two reviewers); and 3) included only errors that are documented in patient records." In other words, the authors of the IOM study made special care to ensure that only incidents that were preventable or negligent were examined.
- Despite the amount of preventable medical negligence nationwide, very few injured patients file suit. This was the finding of two recent National Center for State Courts (NCSC) analyses of medical malpractice litigation in state courts.[4] As NCSC researchers put it in their 2010 study, "rarely does a medical malpractice caseload exceed a few hundred cases in any one state in one year."[5]

## MEDICAL MALPRACTICE LAWSUITS ARE RARE AND DECLINING IN NUMBER.

- According to an April 2011 NCSC report, "despite the widespread prevalence of medical negligence,"[6] in 2008 medical malpractice case filings "represented well under 2 percent of all incoming civil cases, and less than 8 percent of incoming tort cases"[7] in the general jurisdiction courts of 12 states reporting.

- NCSC data also show that medical malpractice claims are becoming less frequent. In an October 2011 study, researchers found that from 2000 to 2009, med mal filings fell by 18 percent in the general jurisdiction courts of seven states reporting.[8] In five of those states, filings fell by between 18 and 42 percent.[9] These findings are consistent with NCSC's April 2011 med mal report which concluded that "[c]ontrary to the claims of some tort reform advocates, medical malpractice caseloads have been decreasing over time."[10]

**MEDICAL MALPRACTICE CASES ARE RARELY RESOLVED THROUGH TRIAL.**

- In 2005, the most recent year studied by the U.S. Department of Justice (DOJ), only 7.8 percent of medical malpractice cases were disposed of by bench or jury trial in 49 jurisdictions reporting.[11]

- Between 1996 and 2005, the number of medical malpractice trials concluded in state courts in the nation's 75 most populous counties remained low and fairly stable, increasing by only 1.5 percent over the ten-year period.[12]

- In 2005, medical malpractice cases accounted for only 9.1 percent of all *civil* cases disposed of by trial in state courts.[13]

- After examining long-term data, DOJ found that the number of med mal cases as a percentage of all *civil* trials in the nation's 75 most populous counties remained low and relatively steady over a 14-year period, with med mal cases constituting 9.7 percent of all civil trials in 2001 and 11.3 percent of all civil trials in 2005.[14]

- DOJ data show that in 2005 medical malpractice cases accounted for 14.9 percent of *tort* cases disposed of by trial in state courts nationwide.[15]

- Long-term data from the nation's 75 most populous counties show that the number of medical malpractice cases as a percentage of all *tort* trials remained low and fairly stable from 1996 through 2005, increasing by only 2.8 percent between 2001 and 2005.[16]

**THE VAST MAJORITY OF TRUE MEDICAL MALPRACTICE CASES SETTLE.**

- In a 2006 closed claims study, the Harvard School of Public Health found that only 15 percent of claims were decided by trial verdict.[17] Other research shows that 90 percent of cases are settled without jury trial, with some estimates indicating that the figure is as high as 97 percent.[18]

- As Duke Law Professor Neil Vidmar, who has extensively studied medical malpractice litigation, testified before the U.S. Senate, "Research on why insurers actually settle cases indicates that the driving force in most instances is whether the insurance company and their lawyers conclude, on the basis of their own internal review, that the medical provider was negligent.….An earlier study by Rosenblatt and Hurst examined 54 obstetric malpractice claims for negligence. For cases in which settlement payments were made there was general consensus among insurance company staff, medical experts and defense attorneys that some lapse in the standard of care had occurred. No payments were made in the cases in which these various reviewers decided there was no lapse in the standard of care."[19]

  Vidmar added, "In interviews with liability insurers that I undertook in North Carolina and other states, the most consistent theme from them was: 'We do not settle frivolous cases!' The insurers indicated that there are minor exceptions, but their policy on frivolous cases was based on the

belief that if they ever begin to settle cases just to make them go away, their credibility will be destroyed and this will encourage more litigation."[20]

Vidmar further testified, "Without question the threat of a jury trial is what forces parties to settle cases. The presence of the jury as an ultimate arbiter provides the incentive to settle but the effects are more subtle than just negotiating around a figure. The threat causes defense lawyers and the liability insurers to focus on the acts that led to the claims of negligence."[21]

**JURIES ARE ABLE TO HANDLE MEDICAL MALPRACTICE CASES.**

- Empirical studies consistently show juries to be capable, effective and fair decision-makers in medical malpractice cases.[22] For example, University of Missouri-Columbia Law Professor Philip G. Peters, Jr. analyzed three decades of empirical research on jury decision-making and reached the following four conclusions: "First, negligence matters. Weak cases rarely win, close cases do better, and cases with strong evidence of medical negligence fare best. Second, the agreement rate between juries and experts is very high in the class of cases that most worries critics of malpractice litigation, that is, cases with weak evidence of negligence. Juries agree with expert reviewers in eighty to ninety percent of these cases. That is a better agreement rate than physicians typically have with each other. Third, the agreement rate is much lower in cases with strong evidence of negligence. Doctors consistently win about fifty percent of the cases that experts believe the plaintiffs should win. Fourth, the consistently low success rate of malpractice plaintiffs in cases that expert reviewers feel they should win strongly suggests the presence of one or more factors that systematically favor medical defendants in the courtroom, such as better litigation teams or pronounced jury reluctance to find doctors liable. From the perspective of defendants at least, jury performance is remarkably good."[23]

**JURIES ARE NOT ANTI-PHYSICIAN; IN FACT, THE OPPOSITE IS TRUE.**

- Cornell University Law Professor Valerie P. Hans and Duke University Law Professor Neil Vidmar, leading experts in the field of jury research, "explored the claims of doctors …about unfair treatment by juries but the empirical evidence does not back them up. The notion of the pro-plaintiff jury is contradicted by many studies that show both actual and mock jurors subject plaintiffs' evidence to strict scrutiny."[24]

- Interviews with North Carolina jurors who decided medical malpractice cases led Professor Vidmar to conclude that "many jurors initially viewed the plaintiffs' claims with great skepticism. Their attitudes were expressed in two main themes. First, they said that too many people want to get something for nothing, a skeptical attitude about claiming… . Second, they expressed the belief that most doctors try to do a good job and should not be blamed for a simple human misjudgment."[25] Vidmar added, "Indeed, these attitudes were even expressed in some of the cases in which jurors decided for the plaintiff. One jury that gave a multimillion-dollar award for a baby with severe brain injuries was very concerned about the possible adverse effect on the doctor's medical practice. This does not mean that in every such case jurors held these views. Sometimes, evidence of the doctor's seemingly careless behavior caused jurors to be angry about what happened. However, even in these latter cases, the interviews indicated that the jurors had initially approached the case with open minds."[26]

**IT IS DIFFICULT FOR PATIENTS TO WIN MEDICAL MALPRACTICE CASES.**

- In 2005, the latest year studied by DOJ, the plaintiff win rate for medical malpractice was 23 percent.[27]

- Juries decided against medical malpractice plaintiffs more than three-quarters of the time in 2005.[28] Injured patients were more successful before judges, winning 50 percent of the time.[29]

- Long-term data from state trials in the nation's 75 most populous counties show statistically significant decreases in win rates among medical malpractice plaintiffs. More specifically, the percentage of successful plaintiffs fell by 17 percent from 1996 to 2005 and by 27.7 percent from 2001 to 2005.[30]

**MEDICAL MALPRACTICE VICTIMS WHO PREVAIL AT TRIAL HAVE SUFFERED SEVERE INJURIES.**

- According to NCSC, in 2005, death was by far the most frequent type of injury among successful medical malpractice plaintiffs, accounting for 22 percent of med mal victims who prevailed at trial.[31] "[I]n the paralysis/amputation category, 100 percent of medical malpractice cases in which the plaintiff received an award involved paralysis caused by injury to the spine or brain…In the brain/head injury category, all injuries alleged by successful medical malpractice claimants were permanent…For burns, lacerations, skin infections, and other skin injuries, all winning medical malpractice patients suffered permanent injuries…."[32]

**MEDICAL MALPRACTICE VERDICTS ARE FAR SMALLER THAN COMMONLY BELIEVED.**

- In 2005, the latest year studied by DOJ, the median award for successful medical malpractice plaintiffs in state court was $400,000.[33] The median med mal award in jury-decided cases was also $400,000.[34] In contrast, state judges handed down a significantly higher median damage award to medical malpractice victims, $631,000.[35] It is important to note that these median amounts do not account for post-trial activity (such as award modifications) and appeals.[36]

**PREVAILING MEDICAL MALPRACTICE PLAINTIFFS RARELY RECEIVE PUNITIVE DAMAGE VERDICTS.**

- In 2005, the most recent year studied by DOJ, punitive damages were awarded in only 1 percent of medical malpractice cases where victims established liability at trial.[37]

- Long-term data from the nation's 75 most populous counties show that the percentage of successful medical malpractice plaintiffs receiving punitive damages is consistently low — 1.1 percent in 1996, 4.9 percent in 2001 and 2.6 percent in 2005.[38]

**THERE ARE LEGITIMATE REASONS WHY SUCCESSFUL MEDICAL MALPRACTICE PLAINTIFFS RECEIVE LARGER AWARDS THAN OTHER PERSONAL INJURY PLAINTIFFS.**

- According to DOJ, in 2005, the median award for successful medical malpractice plaintiffs was $400,000, compared to $19,840 for other successful personal injury plaintiffs.[39] In analyzing the different medians, NCSC explained that "[t]he larger damage awards in medical malpractice cases do not necessarily imply that juries are acting irrationally or being overly generous to medical malpractice plaintiffs. First, damage awards in medical malpractice cases are generally proportionate to the severity of the injury. Second, the high cost of pursuing a medical malpractice claim means that only those cases in which the plaintiff's injury is severe and the potential damages very large are likely to make it to trial. Because other types of tort cases are

less costly to litigate, lower-value cases of these types are more likely to be filed and taken to trial than are low-value medical malpractice cases."[40]

**MEDICAL MALPRACTICE AWARDS AND PAYMENTS REFLECT THE SEVERITY OF THE INJURY.**

- After looking at the most recent DOJ data available, NCSC researchers found that "[t]he most serious injuries, such as paralysis and cancer, received the largest awards. Consistent with other research, in medical malpractice cases death tended to be compensated somewhat less highly than some other serious injuries such as paralysis, in part because these injuries often require costly lifelong care. Less serious injuries, such as fractures and dental injuries, received smaller awards."[41]

- As Professor Vidmar told Congress in June 2006, "[T]he magnitude of jury awards in medical malpractice tort cases positively correlated with the severity of the plaintiffs' injuries, except that injuries resulting in death tended to result in awards substantially lower than injuries resulting in severe permanent injury, such as quadriplegia. I and two colleagues conducted a study of malpractice verdicts in New York, Florida, and California. We also found that jury awards of prevailing plaintiffs in malpractice cases were correlated with the severity of the injury."[42]

- Public Citizen's most recent analysis of National Practitioner Data Bank (NPDB) data shows that the overwhelming majority of medical malpractice payments compensate for death, catastrophic harms or serious permanent injuries.[43] Of the 10,195 medical malpractice payments in 2010,[44] "nearly two-thirds (64.5 percent) compensated for negligence that resulted in a significant permanent injury, major permanent injury, quadriplegia, brain damage, the need for lifelong care, or death. More important, the dollar value of payments for these extremely serious outcomes accounted for an even higher proportion — more than four-fifths (82.1 percent) of the total value of malpractice payments last year. Nearly half the money paid (46.6 percent) compensated victims and victims' survivors for negligence resulting in death, quadriplegia, brain damage or injuries requiring lifelong care."[45]

**VICTIMS OF MEDICAL ERRORS ARE RARELY COMPENSATED.**

- According to Public Citizen's analysis of 2010 NPDB data, "The number of medical malpractice payments made on behalf of physicians fell for the seventh consecutive year in 2010, plummeting to the lowest total in the history of the NPDB, which has tracked medical malpractice payments since 1990."[46] In absolute terms, "[p]ayments in 2010 were 19.6 percent fewer than in 1991, the earliest full year for which the NPDB collected data. Compared to the U.S. population, the number of payments was 37.5 percent lower in 2010 than in 1991."[47]

- Public Citizen's NPDB report also found that there were 3,597 medical malpractice payments for deaths due to negligence in 2010.[48] This means that even if one uses the low end of the IOM estimate — 44,000 deaths per year — about 12 times as many people were likely killed in hospitals in 2010 because of avoidable errors as the number of malpractice payments to survivors.[49] Using a 2009 *Hearst Newspapers* estimate (*i.e.*, 200,000 deaths from medical mistakes per year), just one in 55 deaths was compensated.[50] In other words, between 91 and 98 percent of deaths from medical negligence did not result in any liability payment.

- In addition, Public Citizen's analysis of NPDB data revealed that a total of 10,195 malpractice payments were made on behalf of doctors in 2010.[51] Thus, even by IOM's low-end estimate of 44,000 deaths a year, about four times as many people were killed by avoidable errors as received a medical malpractice payment for any adverse outcome, including death.[52] And based on the

*Hearst* estimate of 200,000 deaths per year, about 19 people were killed for every payment compensating any type of injury.[53]

- According to DOJ's most recent report on medical malpractice insurance claims in seven states from 2000 through 2004, most claims were closed without any compensation provided to those claiming a medical injury.[54]

**MEDICAL MALPRACTICE VERDICT PAYMENTS ARE FAR SMALLER THAN COMMONLY BELIEVED.**

- In its 2011 NPDB study, Public Citizen found that "[t]he cumulative value of malpractice payments in 2010 was the lowest in the history of the NPDB if adjusted for inflation by the consumer price index (CPI) or medical services index. In actual dollars, payments in 2010 were the lowest since 1998."[55]

- As Cornell Law Professor Valerie P. Hans and Duke Law Professor Neil Vidmar explain in *American Juries: The Verdict*, "The fact that the jury verdict is not the end of litigation is often overlooked in discussions of the role of the jury. This is especially true of medical malpractice trials."[56] According to the authors, "Research consistently indicates that outlier verdicts seldom withstand postverdict proceedings. The judge may reduce the award by *remittitur* (the legal term for a reduction), or the case may be appealed to a higher court at which time the award may be reduced. Perhaps most common of all, the plaintiff and the defendant negotiate a posttrial settlement that is less than the jury verdict. Plaintiffs are willing to negotiate lesser amounts," the researchers added, "because they need the money immediately and cannot wait for the years it will take to get the money if the case is appealed. Also, there is a risk that an appeals court will reduce the award or even overturn the verdict."[57] In the end, the plaintiff "negotiates a settlement around the defendant's insurance coverage."[58]

  For example, "[s]ome of the largest medical malpractice awards in New York that made national headlines ultimately resulted in settlements between 5 and 10 percent of the original jury verdict actually being paid."[59] Similarly, "Vidmar's Illinois study found that settlements in his sample of large jury awards averaged only 43 percent of the original verdicts."[60]

- Research by University of Illinois Law Professor David A. Hyman and colleagues from the University of Texas, New York University Law School and Georgetown University Law Center shows that most med mal jury awards receive post-verdict "haircuts."[61] According to the Texas data:

  - "Seventy-five percent of plaintiffs received a payout less than the adjusted verdict (jury verdict plus pre-judgment and post-judgment interest), 20 percent received the adjusted verdict (within ± 2 percent), and 5 percent received more than the adjusted verdict."[62]

  - "Overall, plaintiffs received a mean (median) per-case haircut of 29 percent (19 percent), and an aggregate haircut of 56 percent, relative to the adjusted verdict."[63]

  - "The larger the verdict, the more likely and larger the haircut. For cases with a positive adjusted verdict under $100,000, 47 percent of plaintiffs received a haircut, with a mean (median) per-case haircut of 8 percent (2 percent). For cases with an adjusted verdict larger than $2.5 million, 98 percent of plaintiffs received a haircut with a mean (median) per-case haircut of 56 percent (61 percent)."[64]

  - "Insurance policy limits are the most important factor explaining haircuts."[65]

- "Most cases settle, presumably in the shadow of the outcome if the case were to be tried. That outcome is not the jury award, but the actual post-verdict payout. … The parties surely bargain in the shadow of the jury, but in most cases, the terms of the bargain are shaped by the shadow of coverage."[66]

- "Because defendants rarely pay what juries award, jury verdicts alone do not provide a sufficient basis for claims about the performance of the tort system."[67]

**FAR FROM BEING "BROKEN," EXPERTS SAY THAT THE CURRENT MEDICAL MALPRACTICE SYSTEM WORKS WELL.**

- In an October 2011 study, California State University, Northridge Economics Professor and Cato Institute Adjunct Scholar Shirley Svorny analyzed existing empirical data and found that the medical malpractice system works just as it should. As Svorny explained,

  - "The medical malpractice system generally awards damages to victims of negligence and fails to reward meritless claims. Plaintiffs' attorneys, paid on a contingency basis, filter out weak cases. Patients who file valid claims are likely to collect, generally through out-of-court settlements."[68]

  - "The fact that settlement is common suggests courts are providing good signals as to when plaintiffs will prevail. Under these conditions, insurance companies assess the validity of claims and settle valid claims rather than go to court."[69]

  - "Critics of the system point to the fact that many initial claims do not involve negligence. This can be explained by patients and their attorneys seeking to gather information about the level of negligence associated with an injury. Once discovery shows a small likelihood of success, many plaintiffs drop their claims."[70]

  - "Critics of the medical malpractice system point to its high administrative costs. …Yet, as economist Patricia Danzon observes, the bulk of administrative costs are limited to the small fraction of cases that go to court. Meanwhile, the deterrent effect influences all medical practice."[71]

- In its 2006 closed claims study, the Harvard School of Public Health reported that legitimate claims are being paid, non-legitimate claims are generally not being paid and "portraits of a malpractice system that is stricken with frivolous litigation are overblown."[72] Among the researchers' more significant findings:

  - Sixty-three percent of the injuries were judged to be the result of error and most of those claims received compensation; on the other hand, most individuals whose claims did not involve errors or injuries received nothing.[73]

  - Eighty percent of claims involved injuries that caused significant or major disability or death.[74]

  - "The profile of non-error claims we observed does not square with the notion of opportunistic trial lawyers pursuing questionable lawsuits in circumstances in which their chances of winning are reasonable and prospective returns in the event of a win are high. Rather, our findings underscore how difficult it may be for plaintiffs and their attorneys to discern what

has happened before the initiation of a claim and the acquisition of knowledge that comes from the investigations, consultation with experts, and sharing of information that litigation triggers."[75]

- "[D]isputing and paying for errors account for the lion's share of malpractice costs."[76]

- "Previous research has established that the great majority of patients who sustain a medical injury as a result of negligence do not sue. …[F]ailure to pay claims involving error adds to a larger phenomenon of underpayment generated by the vast number of negligent injuries that never surface as claims."[77]

**LITIGATION IMPROVES PATIENT SAFETY.**

- David A. Hyman, Professor of Law and Medicine at the University of Illinois College of Law, and Charles Silver of the University of Texas at Austin School of Law, have researched and written extensively about medical malpractice. [78] They confirm, "The field of surgical anesthesia, where anesthesiologists adopted practice guidelines to reduce deaths, injuries, claims and lawsuits, is a strong case in point. … [T]wo major factors forced their hand: malpractice claims and negative publicity.… Anesthesiologists worked hard to protect patients *because* of malpractice exposure, not in spite of it."[79] As Hyman and Silver explain, the reason why tort liability promotes patient safety is obvious: Providers are rational. When injuring patients becomes more expensive than not injuring them, providers will stop injuring patients.[80]

- In a breakthrough article by George J. Annas, J.D., M.P.H., the *New England Journal of Medicine* confirmed that litigation against hospitals improves the quality of care for patients. The author wrote, "In the absence of a comprehensive social insurance system, the patient's right to safety can be enforced only by a legal claim against the hospital. … [M]ore liability suits against hospitals may be necessary to motivate hospital boards to take patient safety more seriously.… Anesthesiologists were motivated by litigation to improve patient safety. As a result, this profession implemented 25-years-ago a program to make anesthesia safer for patients and as a result, the risk of death from anesthesia dropped from 1 in 5000 to about 1 in 250,000."[81]

- Numerous other medical practices have been made safer only after the families of sick and injured patients filed lawsuits against those responsible. In addition to anesthesia procedures, these include catheter placements, drug prescriptions, hospital staffing levels, infection control, nursing home care and trauma care.[82] As a result of such lawsuits, the lives of countless other patients have been saved.

- The Harvard Medical Practice Study also acknowledged, "[T]he litigation system seems to protect many patients from being injured in the first place. And since prevention before the fact is generally preferable to compensation after the fact, the apparent injury prevention effect must be an important factor in the debate about the future of the malpractice litigation system."[83]

**FEAR OF LITIGATION IS NOT THE MAIN REASON DOCTORS FAIL TO REPORT ERRORS.**

- A January 2012 report from the U.S. Department of Health and Human Services (HHS) found that massive error underreporting at hospitals is caused by widespread employee failure to recognize patient harm.[84] According to the HHS Inspector General, "[T]he problem is that hospital employees do not recognize 'what constitutes patient harm' or do not realize that particular events harmed patients and should be reported. In some cases, he said, employees

assumed someone else would report the episode, or they thought it was so common that it did not need to be reported, or 'suspected that the events were isolated incidents unlikely to recur.'"[85]

- According to a 2006 study by Dr. Thomas Gallagher, a University of Washington internal-medicine physician and co-author of two studies published in the *Archives of Internal Medicine*, "Comparisons of how Canadian and U.S. doctors disclose mistakes point to a 'culture of medicine,' not lawyers, for their behavior."[86] In Canada, there are no juries, non-economic awards are severely capped and "if patients lose their lawsuits, they have to pay the doctors' legal bills…yet doctors are just as reluctant to fess up to mistakes."[87] Moreover, "doctors' thoughts on how likely they were to be sued didn't affect their decisions to disclose errors."[88] The authors believed "the main culprit is a 'culture of medicine,' which starts in medical school and instills a 'culture of perfectionism' that doesn't train doctors to talk about mistakes."[89]

- Research by George J. Annas, J.D., M.P.H. "found that only one quarter of doctors disclosed errors to their patients,"[90] but "the result was not that much different in New Zealand, a country that has had no-fault malpractice insurance"[91] (*i.e.*, no litigation against doctors) for decades. In other words, "[t]here are many reasons why physicians do not report errors, including a general reluctance to communicate with patients and a fear of disciplinary action or a loss of position or privileges."[92]

**THE BEST WAY TO REDUCE MALPRACTICE LITIGATION IS TO REDUCE THE AMOUNT OF MALPRACTICE.**

- As the Rand Institute for Civil Justice found in its 2010 study of California malpractice:

  - "Our results showed a highly significant correlation between the frequency of adverse events and malpractice claims: On average, a county that shows a decrease of 10 adverse events in a given year would also see a decrease of 3.7 malpractice claims. Likewise, a county that shows an increase of 10 adverse events in a given year would also see, on average, an increase of 3.7 malpractice claims. According to the statistical analysis, nearly three-fourths of the within-county variation in annual malpractice claims could be accounted for by the changes in patient safety outcomes."[93]

  - "We also found that the correlation held true when we conducted similar analyses for medical specialties—specifically, surgeons, nonsurgical physicians, and obstetrician/gynecologists (OB-GYNs). Nearly two-thirds of the variation in malpractice claiming against surgeons and nonsurgeons can be explained by changes in safety. The association is weaker for OB-GYNs, but still significant."[94]

  - "These findings are consistent with the basic hypothesis that iatrogenic harms are a precursor to malpractice claims, such that modifying the frequency of medical injuries has an impact on the volume of litigation that spills out of them. Although this is an intuitive relationship, it is not one that has been well validated previously. It suggests that safety interventions that improve patient outcomes have the potential to reduce malpractice claiming, and in turn, malpractice pressure on providers."[95]

  - "[N]ew safety interventions potentially can have positive effects on the volume of malpractice litigation — a desirable result to seek out, even beyond the immediate impact of medical injuries avoided."[96]

  - "Presumably, the one thing that all parties to the debate can agree on is that reducing malpractice activity by reducing the number of iatrogenic injuries is a good idea. Arguments

about the merits of statutory tort intervention will surely continue in the future, but to the extent that improved safety performance can be shown to have a demonstrable impact on malpractice claims, that offers another focal point for policymakers in seeking to address the malpractice crisis. Based on the results of the current study, we would suggest that that focal point may be more immediately relevant than has previously been recognized."[97]

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**NOTES**

[1] Robert C. LaFountain and Cynthia G. Lee, "Medical Malpractice Litigation in State Courts" (April 2011) at 1, found at http://www.ncsconline.org/d_research/csp/Highlights/CH_Medical_Malpractice_April_2011.pdf.
[2] U.S. Department of Health and Human Services, Office of the Inspector General, *Adverse Events in Hospitals: National Incidence Among Medicare Beneficiaries* (November 2010), pp. i-ii, found at http://oig.hhs.gov/oei/reports/oei-06-09-00090.pdf.
[3] *To Err Is Human, Building a Safer Health System,* Institute of Medicine, 1999.
[4] Robert C. LaFountain and Cynthia G. Lee, "Medical Malpractice Litigation in State Courts" (April 2011) at 2, 7, found at http://www.ncsconline.org/d_research/csp/Highlights/CH_Medical_Malpractice_April_2011.pdf; Richard LaFountain et al., *Examining the Work of State Courts: An Analysis of 2008 State Court Caseloads* (National Center for State Courts 2010) at 26, found at http://www.ncsconline.org/d_research/csp/2008_files/Civil.pdf.
[5] Richard LaFountain et al., *Examining the Work of State Courts: An Analysis of 2008 State Court Caseloads* (National Center for State Courts 2010) at 26, found at http://www.ncsconline.org/d_research/csp/2008_files/Civil.pdf.
[6] *Id.* at 2.
[7] *Ibid.*
[8] National Center for State Courts, "Tort Reforms Can Shape Medical Malpractice Caseload Trends" (viewed December 15, 2011), found at http://www.courtstatistics.org/Civil/CivilMedicalMalpractice.aspx.
[9] *Ibid*.
[10] Robert C. LaFountain and Cynthia G. Lee, "Medical Malpractice Litigation in State Courts" (April 2011) at 3, found at http://www.ncsconline.org/d_research/csp/Highlights/CH_Medical_Malpractice_April_2011.pdf.
[11] U.S. Department of Justice, Bureau of Justice Statistics, "Tort Bench and Jury Trials in State Courts, 2005," NCJ 228129 (November 2009) at 14 (Table 13), found at http://bjs.ojp.usdoj.gov/content/pub/pdf/tbjtsc05.pdf.
[12] *Id.* at 12 (Table 12).
[13] U.S. Department of Justice, Bureau of Justice Statistics, "Civil Bench and Jury Trials in State Courts, 2005," NCJ 223851 (October 2008) (revised April 9, 2009) at 2 (Table 1), found at http://www.prisonpolicy.org/scans/bjs/cbjtsc05.pdf.
[14] *Id.* at 8, 9 (Table 10).
[15] U.S. Department of Justice, Bureau of Justice Statistics, "Tort Bench and Jury Trials in State Courts, 2005," NCJ 228129 (November 2009) at 2 (Table 1), found at http://bjs.ojp.usdoj.gov/content/pub/pdf/tbjtsc05.pdf.
[16] *Id.* at 12 (Table 12).
[17] David M. Studdert et al., "Claims, Errors, and Compensation Payments in Medical Malpractice Litigation," 354 *N Engl J Med* 2024, 2026 (2006), found at http://www.hsph.harvard.edu/faculty/michelle-mello/files/litigation.pdf.
[18] Testimony of Neil Vidmar, Russell M. Robinson II Professor of Law, Duke Law School, before the U.S. Senate Committee on Health, Education, Labor and Pensions, Hearing on "Medical Liability: New Ideas for Making the System Work Better for Patients," June 22, 2006 at 17 (citations omitted), found at help.senate.gov/imo/media/doc/vidmar.pdf.
[19] *Id.* at 17-18, 22.
[20] *Id.* at 23.
[21] *Ibid.*
[22] For an extensive list of studies demonstrating the competence of juries, *see*, *e.g.*, Testimony of Neil Vidmar, Russell M. Robinson II Professor of Law, Duke Law School, before the U.S. Senate Committee on Health, Education, Labor and Pensions, Hearing on "Medical Liability: New Ideas for Making the System Work Better for Patients," June 22, 2006 at 10, found at help.senate.gov/imo/media/doc/vidmar.pdf. *See also*, Valerie P. Hans and

Neil Vidmar, "The Verdict on Juries," 91 *Judicature* 226, 227 (March-April 2008), found at http://www.ajs.org/ajs/publications/Judicature_PDFs/915/Hans_915.pdf; Marc Galanter, "Real World Torts: An Antidote to Anecdote," *55 Md. L. Rev.* 1093, 1109, n. 45 (1996), citing Michael J. Saks, Small-Group Decision Making and Complex Information Tasks (1981); Robert MacCoun, "Inside the Black Box: What Empirical Research Tells Us About Decisionmaking by Civil Juries," in *Verdict*: *Assessing the Civil Jury System* 137 (Brookings Institution, Robert E. Litan ed., 1993); Christy A. Visher, "Juror Decision Making: The Importance of Evidence," 11 *Law & Hum. Behav.* 1 (1987); Richard O. Lempert, "Civil Juries and Complex Cases: Let's Not Rush to Judgment," 80 *Mich. L. Rev.* 68 (1981).

[23] Philip G. Peters, Jr., "Doctors & Juries," 105 *U. Mich. L. Rev.* 1453, 1454 (May 2007), found at http://www.michiganlawreview.org/assets/pdfs/105/7/peters.pdf.

[24] Valerie P. Hans and Neil Vidmar, "The Verdict on Juries," 91 *Judicature* 226, 227 (March-April 2008), found at http://www.ajs.org/ajs/publications/Judicature_PDFs/915/Hans_915.pdf.

[25] Valerie P. Hans and Neil Vidmar, *American Juries: The Verdict*. Amherst, NY: Prometheus Books (2007) at 331.

[26] *Ibid.*

[27] Robert C. LaFountain and Cynthia G. Lee, *Medical Malpractice Litigation in State Courts* (April 2011) at 4, found at http://www.ncsconline.org/d_research/csp/Highlights/CH_Medical_Malpractice_April_2011.pdf.

[28] *Ibid.*

[29] U.S. Department of Justice, Bureau of Justice Statistics, "Tort Bench and Jury Trials in State Courts, 2005," NCJ 228129 (November 2009) at 4 (Table 4), found at http://bjs.ojp.usdoj.gov/content/pub/pdf/tbjtsc05.pdf.

[30] *Id.* at 12 (Table 12).

[31] Robert C. LaFountain and Cynthia G. Lee, *Medical Malpractice Litigation in State Courts* (April 2011) at 6, found at http://www.ncsconline.org/d_research/csp/Highlights/CH_Medical_Malpractice_April_2011.pdf.

[32] *Id.* at 7.

[33] *Id.* at 6.

[34] *Ibid.*

[35] U.S. Department of Justice, Bureau of Justice Statistics, "Tort Bench and Jury Trials in State Courts, 2005," NCJ 228129 (November 2009) at 5 (Table 5), found at http://bjs.ojp.usdoj.gov/content/pub/pdf/tbjtsc05.pdf.

[36] *Ibid.*

[37] U.S. Department of Justice, Bureau of Justice Statistics, "Punitive Damage Awards in State Courts, 2005," NCJ 233094 (March 2011) at 4 (Table 5), found at http://bjs.ojp.usdoj.gov/content/pub/pdf/pdasc05.pdf.

[38] U.S. Department of Justice, Bureau of Justice Statistics, "Tort Bench and Jury Trials in State Courts, 2005," NCJ 228129 (November 2009) at 12 (Table 12), found at http://bjs.ojp.usdoj.gov/content/pub/pdf/tbjtsc05.pdf.

[39] Robert C. LaFountain and Cynthia G. Lee, *Medical Malpractice Litigation in State Courts* (April 2011) at 4, found at http://www.ncsconline.org/d_research/csp/Highlights/CH_Medical_Malpractice_April_2011.pdf.

[40] *Ibid.*

[41] *Id.* at 5.

[42] Testimony of Neil Vidmar, Russell M. Robinson II Professor of Law, Duke Law School, before the U.S. Senate Committee on Health, Education, Labor and Pensions, Hearing on "Medical Liability: New Ideas for Making the System Work Better for Patients," June 22, 2006 at 10, found at help.senate.gov/imo/media/doc/vidmar.pdf.

[43] Public Citizen's Congress Watch, *Medical Malpractice Payments Declined Again in 2010* (May 2011) at 2, found at http://www.citizen.org/documents/NPDB-2010.pdf. This report analyzes data in the National Practitioner Data Bank released May 2011.

[44] *Ibid.*

[45] *Id.* at 8.

[46] *Id.* at 1.

[47] *Id*. at 4.

[48] *Id*. at 8 (Figure 5).

[49] National Academy of Sciences, Institute of Medicine, *To Err is Human* (1999).

[50] Katherine Harmon, "Deaths from avoidable medical error more than double in past decade, investigation shows," *Scientific American Blog*, August 10, 2009, found at http://www.scientificamerican.com/blog/post.cfm?id=deaths-from-avoidable-medical-error-2009-08-10; Cathleen F. Crowley and Eric Nalder, "Dead By Mistake," *Hearst Newspapers*, August 9, 2009, found at http://www.timesunion.com/local/article/Dead-by-mistake-547875.php. *See also*, Cathleen F. Crowley and Eric Nalder, "Year after report, patients still face risks," *Hearst Newspapers*, September 20, 2010, found at

http://www.timesunion.com/local/article/Year-after-report-patients-still-face-risks-665059.php.
[51] Public Citizen's Congress Watch, *Medical Malpractice Payments Declined Again in 2010* (May 2011) at 4 (Figure 1), found at http://www.citizen.org/documents/NPDB-2010.pdf. This report analyzes data in the National Practitioner Data Bank released May 2011.
[52] National Academy of Sciences, Institute of Medicine, *To Err is Human* (1999).
[53] Cathleen F. Crowley and Eric Nalder, "Dead By Mistake," *Hearst Newspapers*, August 9, 2009, found at http://www.timesunion.com/local/article/Dead-by-mistake-547875.php. *See also*, Cathleen F. Crowley and Eric Nalder, "Year after report, patients still face risks," *Hearst Newspapers*, September 20, 2010, found at http://www.timesunion.com/local/article/Year-after-report-patients-still-face-risks-665059.php.
[54] U.S. Department of Justice, Bureau of Justice Statistics, "Medical Malpractice Insurance Claims in Seven States," 2000-2004," NCJ 216339 (March 2007) at 1, found at http://bjs.ojp.usdoj.gov/content/pub/pdf/mmicss04.pdf.
[55] Public Citizen's Congress Watch, *Medical Malpractice Payments Declined Again in 2010* (May 2011) at 1, found at http://www.citizen.org/documents/NPDB-2010.pdf. This report analyzes data in the National Practitioner Data Bank released May 2011.
[56] Valerie P. Hans and Neil Vidmar, *American Juries: The Verdict*. Amherst, NY: Prometheus Books (2007) at 333.
[57] *Id.* at 334-335.
[58] *Id*. at 335.
[59] *Ibid.*
[60] *Ibid.*
[61] David A. Hyman et al., "Do Defendants Pay What Juries Award? Post-Verdict Haircuts in Texas Medical Malpractice Cases, 1988–2003," 4 *Journal of Empirical Legal Studies* 3 (March 2007), found at http://papers.ssrn.com/sol3/papers.cfm?abstract_id=914415.
[62] *Id.* at 3, 4.
[63] *Ibid.*
[64] *Id.* at 4.
[65] *Ibid.*
[66] *Id*. at 4, 59.
[67] *Id*. at 4.
[68] Shirley Svorny, "Could Mandatory Caps on Medical Malpractice Damages Harm Consumers?" *Cato Institute*, October 20, 2011 at 3, found at http://www.cato.org/pubs/pas/pa685.pdf.
[69] *Ibid.*
[70] *Ibid.*
[71] *Ibid.*
[72] David M. Studdert et al., "Claims, Errors, and Compensation Payments in Medical Malpractice Litigation," 354 *N Engl J Med* 2024, 2025, 2031(2006), found at http://www.hsph.harvard.edu/faculty/michelle-mello/files/litigation.pdf.
[73] *Id.* at 2027-2028.
[74] *Id.* at 2026.
[75] *Id.* at 2030-2031 (2006).
[76] *Id.* at 2031.
[77] *Ibid.*
[78] David A Hyman and Charles Silver, "The Poor State of Health Care Quality in the U.S.: Is Malpractice Liability Part of the Problem or Part of the Solution?," *90 Cornell L. Rev.* 893, 917 (2005).
[79] *Ibid* at 920, 921.
[80] Maxwell J. Mehlman and Dale A. Nance, *Medical Injustice: The Case Against Health Courts* (2007) at 47, citing David A. Hyman & Charles Silver, *Medical Malpractice Litigation and Tort Reform: It's the Incentives, Stupid*, 59 Vand. L. Rev. 1085, 1131 (2006).
[81] George J. Annas, J.D., M.P.H., "The Patient's Right to Safety – Improving the Quality of Care through Litigation against Hospitals," *New England Journal of Medicine*, May 11, 2006.
[82] Meghan Mulligan & Emily Gottlieb, "Hospital and Medical Procedures," *Lifesavers: CJ&D's Guide to Lawsuits that Protect Us All,* Center for Justice & Democracy (2002) at A-36 *et seq*., B-12 *et seq*.
[83] Maxwell J. Mehlman and Dale A. Nance, *Medical Injustice: The Case Against Health Courts* (2007) at 47, citing Paul C. Weiler, Joseph P. Newhouse, & Howard H. Hiatt, *A Measure Of Malpractice: Medical Injury, Malpractice Litigation, And Patient Compensation* 133 (1993).

[84] Robert Pear, "Report Finds Most Errors at Hospitals Go Unreported," *New York Times*, January 6, 2012, found at http://www.nytimes.com/2012/01/06/health/study-of-medicare-patients-finds-most-hospital-errors-unreported.html (citing U.S. Department of Health and Human Services, Office of the Inspector General, *Hospital Incident Reporting Systems Do Not Capture Most Patient Harm* (January 2012), found at http://oig.hhs.gov/oei/reports/oei-06-09-00091.pdf).
[85] *Ibid.*
[86] Carol M. Ostrom, "Lawsuit fears aren't reason for docs' silence, studies say," *Seattle Times*, August 17, 2006, found at http://seattletimes.nwsource.com/html/health/2003204605_apologies17m.html (citing from Thomas Gallagher, M.D. et al, "Choosing your Words Carefully: How Physicians Would Disclose Harmful Medical Errors to Patients," *Archives of Internal Medicine*, August 14, 2006).
[87] *Ibid.*
[88] *Ibid.*
[89] *Ibid.*
[90] George J. Annas, J.D., M.P.H., "The Patient's Right to Safety – Improving the Quality of Care through Litigation against Hospitals," *New England Journal of Medicine*, May 11, 2006.
[91] *Ibid.*
[92] *Ibid.*
[93] Michael D. Greenberg et al., *Is Better Patient Safety Associated with Less Malpractice Activity? Evidence from California*, Rand Corporation (2010) at x, found at http://rand.org/pubs/technical_reports/2010/RAND_TR824.
[94] *Ibid.*
[95] *Id.* at 15.
[96] *Id.* at 15-16.
[97] *Id.* at 19.