# Uncovering the Silent Victims of the American Medical Liability System

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*A frequently overlooked problem with the current medical liability system is the vast number of medical errors that go uncompensated. Although studies indicate that 1% of hospital patients are victims of medical negligence, fewer than 2% of these injured patients file claims. In this Article, I explain that many victims of medical malpractice do not file claims because they are unable to find attorneys willing to take their cases.*

*I conducted the first national survey of attorneys to explore medical malpractice victims' access to the civil justice system. The results from the survey indicate that the economic reality of litigation forces many contingent fee attorneys to reject legitimate cases. In fact, over 75% of the attorneys in my survey indicate that they reject more than 90% of the cases that they screen. The attorneys explain that insufficient damages and high litigation expenses are their primary reasons for rejecting cases and that several tort reforms have reduced their willingness to accept cases. Moreover, the majority of the attorneys report that they have threshold damage values below which they will not even consider accepting a case. Indeed, over half of the attorneys responded that they will not accept a case unless expected damages are at least $250,000—even for a case they are almost certain to win on the merits. For a case in which winning is less certain, most attorneys require minimum expected damages of $500,000 to accept the case. Because of the high cost of medical malpractice litigation, contingent fee attorneys simply cannot economically justify taking cases with damages below these thresholds.*

*To understand the extent of this access-to-justice problem, I use private-industry claims data to show that 95% of medical malpractice victims will find it extremely difficult to find legal representation unless their damages are significantly larger than the typical damages for their types of*

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*injuries. Thus, the medical liability system silences many legitimate victims of medical malpractice.*


I. INTRODUCTION .................................................................. 153
II. THE AMERICAN MEDICAL LIABILITY SYSTEM: THEORY AND PRACTICE ......................................................................... 156
  *A. Functions of the Medical Liability System* ............. 156
  *B. Empirical Evidence on the Functioning of the Medical Liability System* ...................................... 158
    1. How Well Does the Medical Liability System Compensate Victims?...................... 158
    2. How Well Does the Medical Liability System Deter Adverse Events?.................... 160
III. ACCESS TO JUSTICE IN THE MEDICAL LIABILITY SYSTEM.... 162
  *A. The Historical Context of Access to Justice in Tort Law* ....................................................................... 162
  *B. Causes of the Current Access-to-Justice Problem* .... 165
    1. Litigation Costs........................................... 165
    2. Tort Reform................................................ 167
      *a. Background of Medical Malpractice Tort Reform* ...................................... 167
      *b. The Impact of Tort Reform on Patients' Access to Justice* ................. 171
  *C. Consequences of the Access-to-Justice Problem* ....... 173
IV. SURVEY .......................................................................... 176
  *A. Methods* ................................................................ 177
  *B. Basic Demographic Characteristics of Respondent Plaintiffs' Attorneys* ............................................... 179
  *C. Case-Disposition Experience*.................................. 182
  *D. Case Screening and Access to Justice* ..................... 185
V. IMPLICATIONS OF THE ACCESS-TO-JUSTICE PROBLEM ........ 189
  *A. Identifying the Silent Victims* ............................... 189
  *B. The Worsening Access-to-Justice Problem* .............. 193
VI. CONCLUSION .................................................................... 194

## I. INTRODUCTION

The public narrative of the American medical liability system suggests a system in crisis: frivolous lawsuits deter doctors from performing valuable procedures, the threat of liability deters doctors from practicing in certain regions, and pervasive defensive medicine amplifies the overall cost of the healthcare system.[1] However, a routinely ignored detail is the large number of silent victims in the system—victims of medical negligence who never receive compensation for their injuries. According to the National Academy of Science's Institute of Medicine, medical errors are the leading cause of accidental death in the United States, taking the lives of "[a]t least 44,000 people, and perhaps as many as 98,000 people" each year.[2] Studies on the number of injuries from medical negligence indicate that 1% of all hospital patients suffer adverse events due to medical error.[3] Yet despite this high rate of medical negligence, fewer than 2% of the injured patients file claims.[4]

In this Article, I explain that many legitimate victims of medical malpractice do not file claims because they are unable to find attorneys willing to take their cases. Exorbitant litigation expenses and recovery-limiting reforms have made contingent fee lawyers increasingly unwilling, and unable, to accept many legitimate medical malpractice claims.[5] These attorneys simply cannot economically justify taking the cases because their expected recoveries will not offset the likely costs of litigating the claims. As a result, many legitimate victims of medical malpractice—victims who suffer real harm as a result of true medical negligence—are left with no legal representation and no way to seek redress in the civil justice system.

I conducted the first national survey of medical malpractice attorneys that explores the problem of silent victims in the medical liability system. The results from the survey indicate that the

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1. For a discussion of the empirical evidence on the effect of liability on physician behavior, see Joanna Shepherd, *Tort Reforms' Winners and Losers: The Competing Effects of Care and Activity Levels*, 55 UCLA L. REV. 905, 924–29 (2008).

2. INST. OF MED., TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM 1 (1999), *available at* http://www.iom.edu/Reports/1999/to-err-is-human-building-a-safer-health-system.aspx.

3. A. Russell Localio et al., *Relation Between Malpractice Claims and Adverse Events Due to Negligence: Results of the Harvard Medical Practice Study III*, 325 NEW ENG. J. MED. 245, 246 (1991).

4. *Id.* at 247.

5. This Article explores one negative consequence of tort reform: the inability of many legitimate victims to find legal representation. There are numerous other arguments both in favor of and against tort reform that are beyond the scope of this Article. For a review of these arguments, see Shepherd, *supra* note 1, at 905–21, 960–71.

economic reality of litigation forces many attorneys to reject legitimate cases. In fact, over 75% of the attorneys in my survey indicate that they reject more than 90% of the cases that they screen. The attorneys explain that insufficient damages and high litigation expenses are their primary reasons for rejecting cases and that several tort reforms have reduced their willingness to accept cases. Moreover, the majority of the attorneys report that they have threshold damage values below which they will not consider accepting a case. In fact, over half of the attorneys responded that they will not accept a case unless expected damages are at least $250,000, even for a case they are almost certain to win on the merits. For a case in which winning is less certain, most attorneys require minimum expected damages of $500,000 to accept a case. Because of the high cost of medical malpractice litigation, plaintiffs' attorneys simply cannot economically justify taking cases with damages below these thresholds.

Thus, my survey provides evidence confirming that many legitimate victims of medical malpractice have no meaningful access to the civil justice system. Moreover, using a private-industry claims dataset, I show that 95% of medical malpractice victims have extreme difficulty finding legal representation unless their damages are significantly larger than the typical damages for their types of injuries. Data also suggest that the problem of access to justice is worsening; half as many victims with low damage awards recovered in 2010 as they did twenty-five years earlier. The economic realities of the medical liability system are silencing a growing number of victims.

The Article proceeds as follows. Part II explains the principal objectives of the medical liability system: to compensate patients that are injured by the negligence of medical providers and to deter those medical providers from practicing negligently. I discuss numerous empirical studies suggesting that the medical liability system performs poorly on both of these dimensions. The majority of victims never file a claim at all, and the victims that do file claims often receive inadequate compensation that does not reimburse all of the malpractice-related costs. Moreover, delays in litigation and increasing litigation expenses further reduce the compensation to malpractice victims. Empirical evidence suggests that the lack of victim compensation has, in turn, reduced the liability system's deterrent effect by blunting incentives for the medical community to improve care; most studies find that malpractice liability does not influence physician behavior.

Part III discusses the history of tort victims' access to the civil justice system. Early American tort victims had limited access to legal representation because they were forced to pay attorneys' fees

regardless of whether they won or lost a case, and few had the financial resources to do so. Contingent fee arrangements evolved to ensure that all tort victims, regardless of their financial position, had access to legal representation in the civil justice system.

Yet, in the modern medical liability system, two factors have made contingent fee lawyers increasingly unwilling and unable to accept many legitimate claims. High litigation costs and damage-restricting tort reforms have made it economically infeasible for attorneys to take many medical malpractice cases. Plaintiffs' attorneys simply cannot justify taking cases that lack sufficient damages to warrant the litigation expense. As a result, most unrepresented victims receive no compensation for their harms. Moreover, the economic calculus required by the contingent fee system causes attorneys to gravitate towards some types of medical malpractice cases and victims while ignoring others. Evidence shows that contingent fee attorneys disproportionately reject cases from lower-income groups such as females, the elderly, children, and racial minorities because their expected damage awards are lower.

In Part IV, I discuss my national survey of medical malpractice plaintiffs' attorneys. The survey first asks a variety of questions to establish that the attorneys and their firms are representative of the larger population of medical malpractice attorneys. The survey inquires about the attorneys' experiences screening and rejecting cases and their primary reasons for rejecting the cases that they do. It asks various questions about the minimum amount of expected damages the attorneys require to accept cases with different likelihoods of winning on the merits. It inquires about the impact of various tort reforms on attorneys' willingness to accept cases. It also explores their typical legal expenses, clients' recoveries, and attorneys' fees in cases that close in settlements, trials, and dismissals.

The results from my survey indicate that many attorneys are unwilling to represent legitimate victims of medical malpractice if the attorneys do not expect a sufficiently large recovery. The attorneys reject the vast majority of cases and list economic factors as their main reason for rejecting cases. They indicate that tort reforms capping plaintiff recoveries have increased their rejections of potential clients. Accordingly, the majority of the attorneys indicate that they will not accept any case, even a near-certain victory, if expected damages are less than $250,000.

Part V explores which medical malpractice victims are most likely to be silent and how the access-to-justice problem has changed over time. Using a private-industry dataset of claims and payments in the medical liability system from 1985 to 2010, I show that only the

most severely injured victims will be able to easily find legal representation. In fact, my survey results imply that 95% of medical malpractice victims find it extremely difficult to find legal representation unless their damages are significantly higher than the typical damages for their types of injuries. The data also reveal a worsening access-to-justice problem. Over the past twenty-five years, the number of victims recovering low damage awards has declined by half. Without legal representation, the medical liability system compensates fewer and fewer of these victims for their harms.

Thus, this Article establishes that the medical liability system has many silent victims—the many legitimate victims of medical malpractice who are unable to obtain legal representation and thereby have no meaningful access to the civil justice system. Without legal representation, most of these victims are not compensated for the injuries they suffer as a result of medical negligence. In turn, the medical liability system fails to provide adequate precautionary incentives for healthcare providers. Without dramatic change, the access-to-justice problem will continue to hinder the system's ability to achieve its compensatory and deterrent functions.

## II. THE AMERICAN MEDICAL LIABILITY SYSTEM: THEORY AND PRACTICE

In this Part, I first briefly describe the primary functions of the medical liability system: deterrence and compensation. I then review existing empirical research on whether the current system achieves these functions.

### *A. Functions of the Medical Liability System*

Tort scholars have long focused on two main functions of the tort system: compensation and deterrence.[6] The compensatory function aims to reimburse victims for their losses from tortious acts and to restore them to their preinjury condition.[7] As a subset of tort

6. John C.P. Goldberg, *Twentieth-Century Tort Theory*, 91 GEO. L.J. 513, 521 (2003). For a discussion of other proposed functions of tort law, such as enterprise liability and social justice, see Joseph H. King, Jr., *Pain and Suffering, Noneconomic Damages, and the Goals of Tort Law*, 57 SMU L. REV. 163, 180–201 (2004).

7. *See, e.g.*, DAN B. DOBBS, THE LAW OF TORTS § 10 (2000):

> Compensation of injured persons is one of the generally accepted aims of tort law. Payment of compensation to injured persons is desirable. If a person has been wronged by a defendant, it is just that the defendant make compensation. Compensation is also socially desirable, for otherwise the uncompensated injured persons will represent further costs and problems for society.

Daniel W. Shuman, *The Psychology of Compensation in Tort Law,* 43 U. KAN. L. REV. 39, 45 (1994) ("The commonly understood goal of tort compensation is to restore the injured to their

law, a primary goal of the medical liability system is to compensate victims of medical negligence for any harm they suffer as a result of that negligence. For example, the system aims to compel the surgeon who botches an operation to reimburse the victim for any additional medical bills, lost income resulting from time away from work, and pain and suffering that resulted from the surgeon's mistakes.

Tort law seeks to achieve its second main function, deterrence, by incentivizing individuals to take precautions and avoid risky behavior.[8] Similarly, the medical liability system aims to incentivize medical providers to take precautions to reduce unnecessary risks associated with medical care.

If changes in the liability system increase potential liability, and subsequently the costs of engaging in dangerous activities, some potential tortfeasors may cease completely engaging in the activities, or they may reduce the number of high-risk procedures they perform.[9] For example, in response to increased liability, some OB-GYNs may reduce their number of high-risk deliveries, switch to a straight gynecology practice, or even leave the state.

Even if the increase in potential liability does not cause the potential tortfeasor to reduce or even cease the activity, she may respond by taking more precautions to reduce risks.[10] For example, she may more conscientiously keep current with the latest treatments or order more diagnostic tests.

Compensatory damages, as distinct from punitive damages, provide the crucial link between the compensatory and deterrent functions of tort law.[11] Although these damages are called "compensatory," they work to achieve both goals. First, as the name implies, compensatory damages compensate the victim for his injuries

preaccident condition, to make them whole."); Steven D. Smith, *The Critics and the "Crisis": A Reassessment of Current Conceptions of Tort Law*, 72 CORNELL L. REV. 765, 769 (1987) ("[I]njured plaintiffs should receive an amount necessary to make them 'whole,' that is, to restore them to the position they would have occupied but for the defendant's tortious conduct.").

8. *See, e.g.*, KENNETH S. ABRAHAM, THE FORMS AND FUNCTIONS OF TORT LAW 206 (2d ed. 2002); PETER CANE, ATIYAH'S ACCIDENTS, COMPENSATION AND THE LAW 361 (Cambridge University Press 6th ed. 2004) (arguing that deterrence is "[o]ne of the most important of the suggested functions of personal injuries compensation law"); Richard L. Abel, *A Critique of Torts*, 37 UCLA L. REV. 785, 808 (1990) ("At least since Learned Hand offered his famous formula . . . judges, lawyers, and legal scholars have argued that fear of liability will compel potential tortfeasors to engage in a cost-benefit analysis, taking just those safety precautions that cost less than the accidents they prevent."); Shuman, *supra* note 7, at 41–42 (discussing awarding compensation to the plaintiff when the defendant's conduct needs to be deterred).

9. Economists call such responses to increased liability "activity-level" responses. *See, e.g.*, ROBERT COOTER & THOMAS ULEN, LAW & ECONOMICS 323–28 (2004).

10. Economists' term for this is a "care-level" response. *Id.* at 368.

11. *See id.* at 320–23.

in an attempt to return him to his preinjury condition. Second, requiring the tortfeasor to compensate the victim forces her to internalize the costs of her risky behavior and deters her from engaging in inappropriately risky activities. The higher the expected compensatory damages he expects to pay, the greater the cost of engaging in the risky activity, and the more he will be deterred from engaging in the activity without proper precautions.[12] Similarly, the possibility of compensatory damages in medical malpractice cases gives medical providers a financial incentive to internalize the harm they impose on patients and to reduce the risks associated with medical care.

### *B. Empirical Evidence on the Functioning of the Medical Liability System*

In theory, medical malpractice law should both provide compensation to injured patients and induce doctors and hospitals to take appropriate precautions against adverse medical events. In practice, however, the medical liability system performs poorly on both of these objectives. In this Section, I first present the existing evidence regarding how effectively the system compensates the victims of medical malpractice. Then, I discuss empirical studies that examine the medical liability system's ability to deter adverse medical events.

#### 1. How Well Does the Medical Liability System Compensate Victims?

Many medical malpractice victims never receive compensation for their harm. The majority of victims never file a claim at all, and the victims that do file claims often receive inadequate compensation that does not fully reimburse their malpractice-related harms. Moreover, delays in litigation and increasing litigation expenses further reduce the compensation to malpractice victims.

Empirical evidence confirms that the vast majority of patients injured by medical error do not seek redress in the civil justice system. In 1991, the landmark Harvard Medical Practice Study analyzed the medical records and legal claims (when filed) of a random sample of

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12. For evidence of the tort system's deterrent effect, see Gary T. Schwartz, *Reality in the Economic Analysis of Tort Law: Does Tort Law Really Deter?*, 42 UCLA L. REV. 377, 390–422 (1994); *see also* FRANK A. SLOAN ET AL., DRINKERS, DRIVERS, AND BARTENDERS: BALANCING PRIVATE CHOICES AND PUBLIC ACCOUNTABILITY 18–20 (2000) (studying bartender liability for serving excessive liquor to patrons). Many other scholars doubt the effectiveness of the deterrent effect of tort liability. For a discussion, see King, *supra* note 6, at 188–92.

31,429 hospital patients in New York State.[13] The researchers determined that 1% of all hospital patients suffer adverse events due to medical negligence.[14] Yet despite this high rate of medical negligence, the researchers found that fewer than 2% of the injured patients file claims.[15] More recent research largely mirrors these findings. A review of 14,700 medical records in Colorado and Utah also shows that 1% of hospital patients suffer adverse events that are the result of negligent acts or omissions in the care rendered.[16] Of these victims, the data show that only 2.5% file a legal claim.[17] In Part III, I explain how victims' inability to find legal representation contributes to the low claim rate among legitimate victims of medical malpractice.

Moreover, the small proportion of malpractice victims that do file claims often go undercompensated. Empirical studies of malpractice lawsuits find that even for plaintiffs whom outside experts have determined to be legitimate victims of medical negligence—that is, in cases in which liability should be clear—the compensation rate only ranges from 32% to 89%.[18] Thus, even for the few malpractice victims who file claims, most claims go undercompensated.

Additionally, increasing litigation delays and legal fees undermine the malpractice system's compensatory function. Medical malpractice awards are subject to lengthy delays, which effectively reduce compensation as inflationary pressures reduce the value of damage awards. Research shows that, on average, resolving a malpractice claim takes approximately four years.[19] Moreover, because of rising legal fees, tort victims generally retain only a portion of compensatory damage awards. Empirical studies show that for every dollar defendants and insurers pay to compensate medical malpractice victims, between forty and sixty cents covers litigation

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13. Localio et al., *supra* note 3, at 245.

14. *Id.* at 246.

15. *Id.* at 247.

16. David M. Studdert et al., *Negligent Care and Malpractice Claiming Behavior in Utah and Colorado*, 38 MED. CARE 250, 251, 253 (2000).

17. *Id.* at 255.

18. Theodore Eisenberg, *The Empirical Effects of Tort Reform*, *in* RESEARCH HANDBOOK ON THE ECONOMICS OF TORTS (Jennifer Arlen ed., forthcoming 2014) (manuscript at 12), *available at* http://ssrn.com/abstract=2032740.

19. THOMAS H. COHEN & KRISTEN A. HUGHES, BUREAU OF JUSTICE STATISTICS, MEDICAL MALPRACTICE INSURANCE CLAIMS IN SEVEN STATES, 2000–2004, at 9 (2007), *available at* http://www.bjs.gov/content/pub/pdf/mmicss04.pdf.

expenses and other transaction costs.[20] As a result, victims keep only 40% to 60% of their damage awards.

Thus, the existing empirical literature confirms that underclaiming, undercompensation, delay, and rising litigation costs all plague the current medical liability system. In Part III, I explore how the access-to-justice problem contributes to the malpractice system's failure to achieve its compensatory goals.

2. How Well Does the Medical Liability System Deter Adverse Events?

Although the evidence indicates that only a small portion of malpractice victims seek redress in the civil justice system, and although an even smaller portion are adequately compensated for their harms, tort liability remains a principal vehicle for holding healthcare providers accountable for medical errors. However, empirical evidence suggests that the lack of victim compensation has, in turn, blunted incentives for the medical community to improve care.[21] Indeed, a significant body of empirical research examining the relationship between malpractice risk and health outcomes has generated only mixed results, with most studies finding that liability risk has no influence on physician behavior.

Because OB-GYNs are defendants in medical malpractice lawsuits at a higher rate than any other specialty,[22] the majority of empirical work has examined how they respond to litigation risk. Several studies have explored the relationship between an OB-GYN's cesarean rate and his claims history or malpractice risk to determine whether physicians prefer less-risky procedures (cesareans over natural labor) when malpractice pressure is greater. The results are

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20. PATRICIA M. DANZON, MEDICAL MALPRACTICE: THEORY, EVIDENCE, AND PUBLIC POLICY 187 (1985) (finding that for each dollar received by plaintiff, approximately sixty-six cents is spent by the parties on litigation, implying that plaintiffs' share of total expenditures is $1.00/$1.66 = 0.60); PETER W. HUBER, LIABILITY: THE LEGAL REVOLUTION AND ITS CONSEQUENCES 151 (1990) (claiming that sixty cents of every dollar spent on malpractice liability insurance are absorbed by administrative and legal costs, implying that only forty cents would be left for victims); David M. Studdert et al., *Claims, Errors, and Compensation Payments in Medical Malpractice Litigation*, 354 NEW ENG. J. MED. 2024, 2024 (2006) (claiming that for every dollar spent on compensation, fifty-four cents went to litigation expenses and other transaction costs).

21. Another explanation for the weak deterrent effect of the liability system is the distortion created by medical malpractice insurance. Medical providers with insurance typically do not pay the victims' damages. Moreover, the malpractice insurance is typically not strongly experience rated, so the premiums do not adjust to reflect the liability risk of a particular provider. Instead, the premiums typically reflect more general factors such as location and medical specialty. Frank A. Sloan, *Experience Rating: Does It Make Sense for Medical Malpractice Insurance?*, 80 AM. ECON. REV. 128, 128–29 (1990).

22. Studdert et al., *supra* note 20, at 2026.

mixed. Some studies have found a positive correlation between cesarean rates and litigation risk,[23] but several others have failed to find a relationship.[24] Another study found a small, short-lived increase in cesarean-section rates following litigation, but rates eventually returned to the baseline level.[25] Thus, despite some evidence of a positive relationship, the studies do not generally support a consistent association between liability pressure and cesarean-section rates. As a result, it is not clear that malpractice pressure has any influence on the behavior of OB-GYNs.

Other studies have examined the relationship between an OB-GYN's malpractice risk and actual health outcomes. Again, the results are mixed. One study found no relationship between malpractice risk and adverse birth outcomes.[26] However, other studies have found that higher malpractice risk is associated with fewer preventable complications in labor and delivery[27] and a reduction in fetal deaths.[28]

A few empirical studies have explored the influence of malpractice risk on health outcomes beyond obstetrics patients. Two widely cited studies find that tort reforms to reduce malpractice risk are not associated with any change in the health outcomes of elderly heart patients.[29] Thus, in contrast to what theory would predict,

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23. *See* Lisa Dubay et al., *The Impact of Malpractice Fears on Cesarean Section Rates*, 18 J. HEALTH ECON. 491, 509 (1999); Darren Grant & Melayne Morgan McInnes, *Malpractice Experience and the Incidence of Cesarean Delivery: A Physician-Level Longitudinal Analysis*, 41 INQUIRY 170, 170–88 (2004); A. Russell Localio et al., *Relationship Between Malpractice Claims and Cesarean Delivery*, 269 JAMA 366, 366 (1993); Stephen M. Rock, *Malpractice Premiums and Primary Cesarean Section Rates in New York and Illinois*, 103 PUB. HEALTH REP. 459, 459–60 (1988); A. Dale Tussing & Martha A. Wojtowycz, *Malpractice, Defensive Medicine, and Obstetric Behavior*, 35 MED. CARE 172, 185 (1997).

24. *See* Laura-Mae Baldwin et al., *Defensive Medicine and Obstetrics*, 274 JAMA 1606, 1606–10 (1995); Gilbert W. Gimm, *The Impact of Malpractice Liability Claims on Obstetrical Practice Patterns*, 45 HEALTH SERVS. RES. 195, 195–211 (2010); Beomsoo Kim, *The Impact of Malpractice Risk on the Use of Obstetrics Procedures*, 36 J. LEGAL STUD. S79, S79–S119 (2007).

25. David Dranove & Yasutora Watanabe, *Influence and Deterrence: How Obstetricians Respond to Litigation Against Themselves and Their Colleagues*, 12 AM. L. & ECON. REV. 69, 69–94 (2010).

26. Y. Tony Yang et al., *Does Tort Law Improve the Health of Newborns, or Miscarry? A Longitudinal Analysis of the Effect of Liability Pressure on Birth Outcomes*, 9 J. EMPIRICAL LEGAL STUD. 217, 217–45 (2012).

27. Janet Currie & W. Bentley MacLeod, *First Do No Harm? Tort Reform and Birth Outcomes*, 123 Q.J. ECON. 795, 795–830 (2008).

28. Jonathan Klick & Thomas Stratmann, *Medical Malpractice Reform and Physicians in High-Risk Specialties*, 36 J. LEGAL STUD. S121, S133–39 (2007); Frank A. Sloan et al., *Effects of the Threat of Medical Malpractice Litigation and Other Factors on Birth Outcomes*, 33 MED. CARE 700, 700–14 (1995).

29. Daniel Kessler & Mark McClellan, *Do Doctors Practice Defensive Medicine?*, 111 Q.J. ECON. 353, 353–90 (1996); Daniel Kessler & Mark McClellan, *Malpractice Law and Health Care Reform: Optimal Liability Policy in an Era of Managed Care*, 84 J. PUB. ECON. 175, 189 (2002).

higher malpractice risk does not improve health outcomes, and lower risk does not worsen outcomes. However, another study of elderly heart patients did find that increased malpractice risk is associated with reduced risk of death for these patients.[30]

Thus, the empirical evidence does not consistently show that the medical liability system provides incentives for appropriate care. The undercompensation of malpractice victims is at least partly to blame for the weakness of the system's deterrent signal. When doctors do not expect to bear the full cost of harms caused by their negligence, they do not have sufficient incentives to take precautions that reduce the risk of harm.[31] In the next Part, I explore how limited access to legal representation exacerbates both the problems of undercompensation and underdeterrence inherent in the medical liability system.

## III. ACCESS TO JUSTICE IN THE MEDICAL LIABILITY SYSTEM

In order for the malpractice system to provide both compensation to victims and precautionary incentives for physicians, victims of medical negligence must be able to find legal representation. Contingent fee arrangements evolved in the second half of the nineteenth century to enable tort victims to obtain legal representation that they could not otherwise afford. Today, lawyers working on a contingent fee basis bring most medical malpractice claims. However, victims of medical negligence are finding it increasingly difficult to locate contingent fee lawyers willing to take their cases. In this Part, I discuss the historical background of tort victims' access to legal counsel and the development of contingent fee arrangements. I then explain the causes and consequences of the current access-to-justice problem.

### *A. The Historical Context of Access to Justice in Tort Law*

Early American tort victims, including victims of medical malpractice, had limited effective access to legal representation in the civil justice system. Until the mid-nineteenth century, statutory or judicial schemes regulated lawyer compensation. These schemes dictated how plaintiffs were to compensate their attorneys, regardless

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30. Praveen Dhankhar et al., *Effect of Medical Malpractice on Resource Use and Mortality of AMI Patients*, 4 J. EMPIRICAL LEGAL STUD. 163, 163–83 (2007).

31. Eisenberg, *supra* note 18 (manuscript at 10); Daniel P. Kessler, *Evaluating the Medical Malpractice System and Options for Reform*, 25 J. ECON. PERSP. 93, 95 (2011).

of whether they won or lost in court.[32] Thus, although any citizen could in theory retain legal counsel, few had the financial resources to risk having to pay the attorney after losing the case.[33] As a result, a large portion of Americans had effectively no access to the civil justice system.[34]

However, beginning with New York's enactment of the Field Code in 1848, statutes regulating lawyers' fees were repealed across the nation. Soon after, the Field Code was revised to allow attorney compensation to be governed by contract and "not restrained by law."[35]

The precursors of a contingent fee arrangement first developed in the mid-1800s when attorneys involved in debt collection matters agreed to receive as payment a percentage of the amount collected.[36] However, contingent fee contracts did not expand to other areas of the law until the Industrial Revolution produced victims of industrial accidents with legitimate claims but insufficient resources to pursue them.[37] In the states that had not previously authorized contingent fee arrangements by statute, state supreme courts voiced support for such arrangements. By the end of the nineteenth century, most states sanctioned contingent fees, either judicially or legislatively.

The judicial supporters of contingent fees recognized that these arrangements were necessary to ensure that all tort victims, regardless of their financial position, had access to legal representation. For example, in 1840, Justice Samuel Harrington of Delaware's high court sanctioned a contingent fee arrangement, proclaiming that "[t]he poor suitor may not have the present means of payment, and this policy [of voiding contingent fee contracts] may deprive him of counsel . . . . His rights are nothing unless he can have the means of enforcing them."[38]

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32. Lester Brickman, *Contingent Fees Without Contingencies:* Hamlet *Without the Prince of Denmark?*, 37 UCLA L. REV. 29, 35 (1989).

33. Peter Karsten, *Enabling the Poor to Have Their Day in Court: The Sanctioning of Contingency Fee Contracts, a History to 1940*, 47 DEPAUL L. REV. 231, 243 (1998).

34. *Id.*

35. N.Y. Code of Remedial Justice, ch. 1, tit. II, art. 2, § 66, 1876 N.Y. Laws (current version at N.Y. JUD. CT. ACTS § 474 (McKinney 2013)); *see also* Lester Brickman & Lawrence A. Cunningham, *Nonrefundable Retainers: Impermissible Under Fiduciary, Statutory and Contract Law*, 57 FORDHAM L. REV. 149, 171–76 (1988) (detailing the evolution of New York attorney compensation law in the nineteenth century).

36. *See* MAXWELL BLOOMFIELD, AMERICAN LAWYERS IN A CHANGING SOCIETY 1776–1876, at 277 (1976) (describing the development of William Pitt Ballinger's mid-nineteenth-century legal practice).

37. Brickman, *supra* note 32, at 37.

38. Bayard v. McLane, 3 Del. (3 Harr.) 139, 207, 219–20 (1840).

Similarly, New Hampshire's Chief Justice Samuel Bell offered the same rationale for endorsing contingent fees in 1862:

> It is not uncommon that attorneys commence actions for poor people, and make advances of money necessary to the prosecution of the suit upon the credit of the cause. Thus a man in indigent circumstances is enabled to obtain justice in cases where, without such aid, he would be unable to enforce a just claim.[39]

Missouri's Judge Robert Bakewell agreed in 1876:

> Many a poor man with a just claim would find himself unable to prosecute his rights, could he make no arrangement to pay his advocate out of the proceeds of his suit . . . If [such agreements] are immoral or illegal, there are perhaps few attorneys in active practice amongst us who have not been habitual violators of the laws.[40]

Thus, most states approved contingent fees because they were viewed as a financing device that enabled a client to assert and prosecute an otherwise unaffordable claim.[41] Although most countries in the world still prohibit contingent fees,[42] all fifty U.S. states allow attorneys to enter into contingent fee contracts.[43]

Plaintiffs' attorneys in medical malpractice cases work almost exclusively on a contingent fee basis.[44] As in other torts cases, contingent fees enable medical malpractice victims to obtain legal counsel that they otherwise could not afford. Because of the substantial cost of litigating medical malpractice cases, the only way that most victims can afford legal representation is to hire a lawyer on contingency. Attorneys interviewed in previous studies of contingent fee practice have explained the necessity of contingent fee arrangements in medical malpractice cases:

> Ninety percent of the people out there make their living, they pay for the kids to go to school, they pay to take care of their kids, they pay for their mortgage, they pay for their one or two cars, and at the end of the month, they may have $100 left over if they're the lucky ones. . . . And so, for someone to have the ability to go hire a lawyer on anything other than a contingency fee, you know, I think it's a fiction.[45]

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39. Christie v. Sawyer, 44 N.H. 298, 303 (1862) (paraphrasing Shapley v. Bellows, 4 N.H. 347, 355 (1808)).

40. Duke v. Harper, 2 Mo. App. 1, 10–11 (1876).

41. Brickman, *supra* note 32, at 43.

42. *Id.* at 39.

43. Michael A. Dover, *Contingent Percentage Fees: An Economic Analysis*, 51 J. AIR L. & COM. 531, 535 (1986). Maine was the last state to eliminate barriers to contingent fees. 1965 Me. Laws 333 (amending ME. REV. STAT. ANN. tit. 17, § 801 (repealed 1975)).

44. Stephen Daniels & Joanne Martin, *The Texas Two-Step: Evidence on the Link Between Damage Caps and Access to the Civil Justice System*, 55 DEPAUL L. REV. 635, 648 (2006).

45. *Id.* at 646.

Another attorney explained, "The simple truth is at least 95 percent of our clients could not afford to pay the lawyer and could not finance the lawsuit. They just couldn't—at least 95 percent."[46]

Contingent fee arrangements developed to improve access to justice for this 95%. However, although contingent fees have reduced the disparity in access to legal representation between wealthy and poor plaintiffs, they have not eliminated the access-to-justice problem in the medical liability system.

### *B. Causes of the Current Access-to-Justice Problem*

In the modern medical liability system, high litigation costs and damage-limiting tort reforms have made it economically infeasible for attorneys to take many medical malpractice cases. As a result, many legitimate victims of medical malpractice have no way to seek redress. In this Section, I discuss how high litigation costs and tort reforms have created silent victims in the medical liability system.

#### 1. Litigation Costs

Medical malpractice suits are very expensive to litigate. The American Bar Association reports that the cost of prosecuting a single case of medical malpractice ranges from a low of $50,000 to a high of $500,000: "Every case require[s] hundreds of hours of work and a huge outlay of money to pay for the investigation, evaluation by experts, deposition testimony, travel, etc."[47]

Attorneys often assume, as a rule of thumb, that medical malpractice cases will cost at least $100,000 to litigate: "[Y]ou're talking about $100,000 that you're gonna spend on technical expertise to write reports, to give depositions, you know, to explain the standard of care and how it's been breached."[48] Another attorney echoed that in medical malpractice litigation, "[e]asily you can spend $100,000

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46. Stephen Daniels & Joanne Martin*, Plaintiffs Lawyers: Dealing with the Possible but Not Certain*, 60 DEPAUL L. REV. 337, 347 (2011).

47. James K. Carroll et al., *Report on Contingent Fees in Medical Malpractice Litigation*, 2004 A.B.A. TORT TRIAL & INS. PRAC. SEC. 30 (quoting affidavit of Thomas A. Schaffer); s*ee also* Claire Osborn, *Many Lawyers Avoiding Malpractice Cases*, AUSTIN AM.-STATESMAN, June 14, 2004, at A1 (quoting Bill Whitehurst, a prominent practitioner in Austin, Texas, who states that "the cost of taking a medical malpractice suit to court can be up to $450,000").

48. *See* Stephen Daniels & Joanne Martin, *'The Juice Simply Isn't Worth the Squeeze in Those Cases Anymore:' Damage Caps, 'Hidden Victims,' and the Declining Interest in Medical Malpractice Cases* 28 (Am. Bar Found. Research Paper Series 09-01, 2009), *available at* http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1357092 (interviewing several attorneys regarding the costs of medical malpractice litigation).

without blinking."[49] In my own survey of medical malpractice plaintiffs' attorneys described in the next Part, attorneys responded that the average cost of taking a medical malpractice claim to trial was just under $100,000.

Because of the high cost of investigating and litigating medical malpractice claims, contingent fee attorneys cannot economically justify taking cases that lack sufficient damages to recoup their expenses. Under most contingent fee arrangements, the attorney agrees to pay the litigation costs if he loses the case. If he wins the case, the plaintiff pays out of his damage award both the litigation costs and the attorney's contingent fee. The contingent fee is typically 33% to 40% of the award.[50] Because attorneys bear the risk of paying the litigation costs if a case loses, contingent fee arrangements require attorneys to evaluate cases in terms of the risks and potential returns of the case.[51] As a result, attorneys rationally reject cases that do not satisfy a sufficient risk-return tradeoff. As one attorney interviewed for my study noted, "[M]ed-mal litigation is the 'sport of kings' from an expense standpoint. . . . [T]he liability/damages mix must present sufficient strength in both measures to make economic sense." Another attorney that participated in my survey explained, "The cake has to be worth the candle. . . . I know if expenses will be high, I won't take the case without the likelihood of a large recovery."

Consider, for example, a medical malpractice case that is "cheap" to litigate, costing only $50,000. An attorney with a standard 33% contingent fee rate would likely reject many cases with potential damages below $150,000. Even with potential damages of $150,000, the attorney is risking the same amount he stands to earn; he pays $50,000 in litigation costs if he loses the case, and he earns a $50,000 contingent fee if he wins the case. As a result, the attorney has no choice but to reject many legitimate victims of medical malpractice that do not have sufficient damages to offset the litigation expenses.

Access to legal representation becomes even more difficult as litigation costs increase. A complex case with expected costs of $500,000 would likely be rejected unless the 33% contingent fee attorney expected potential damages in excess of $1.5 million. However, $1.5 million in damages merely allows the attorney to break

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49. 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).

50. Herbert M. Kritzer, *Contingency Fee Lawyers as Gatekeepers in the Civil Justice System*, 81 JUDICATURE 22, 25 tbl.3 (1997).

51. David A. Hyman & Charles Silver, *Medical Malpractice Litigation and Tort Reform: It's the Incentives, Stupid*, 59 VAND. L. REV. 1085, 1117 (2006).

even in expectation, so potential damages likely need to be even higher.

Although not all lawyers charge a 33% contingent fee, and although some lawyers employ variable fees that depend on their workload,[52] the basic point does not change—the expense of medical malpractice litigation eliminates many legitimate victims from the claims pool. Indeed, research shows that medical malpractice attorneys accept far fewer cases than they reject. One study of attorneys' acceptance rates found that attorneys reject 80% or more of the medical malpractice cases they screen.[53] Another report of medical malpractice attorneys' practice patterns found that 77.1% of attorneys reject more than 90% of the cases they screen.[54] One of the primary reasons the attorneys give for rejecting cases was an insufficient expected return on those cases that are expensive to litigate. [55]

### 2. Tort Reform

As a result of the high costs of medical malpractice investigation and litigation, many malpractice victims are left without legal remedy. Damage caps and other tort reforms that artificially reduce plaintiffs' damages exacerbate these problems. Below, I discuss the background of the tort reform movement, which reduced medical malpractice awards to plaintiffs. I then explain how these reforms reduce contingent fee lawyers' willingness to accept cases.

#### *a. Background of Medical Malpractice Tort Reform*

The tort reform movement can be traced back to the 1970s and 1980s, when doctors and insurers sought to avert a perceived crisis in medical malpractice insurance.[56] During this period, the number of

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52. Herbert M. Kritzer, *Seven Dogged Myths Concerning Contingency Fees*, 80 WASH. U. L.Q. 739, 759 (2002).

53. *Id.* at 755 tbl.3.

54. Michael D. Greenberg & Steven Garber, *Patterns of Specialization in Medical Malpractice Among Contingency Fee Attorneys* 23 tbl.9 (RAND ICJ Working Paper Series No. WR-700-ICJ, 2009), *available at* http://www.rand.org/content/dam/rand/pubs/working_papers/2009/RAND_WR700.pdf.

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

56. *See, e.g.*, ACADEMIC TASK FORCE FOR REVIEW OF THE INS. & TORT SYS., PRELIMINARY FACT-FINDING REPORT ON MEDICAL MALPRACTICE 43 (1987); AM. MED. ASS'N SPECIAL TASK FORCE ON PROF'L LIAB. & INS., PROFESSIONAL LIABILITY IN THE '80S: REPORT I, at 4–5 (1984) (detailing the increases in medical malpractice liability during the 1970s and early 1980s); F. Patrick Hubbard, *The Physicians' Point of View Concerning Medical Malpractice: A Sociological Perspective on the Symbolic Importance of "Tort Reform,"* 23 GA. L. REV. 295, 295–98 (1989) ("The

medical malpractice claims filed and the size of awards in malpractice cases grew rapidly.[57] Medical malpractice premiums increased sharply, largely as a result of insurers' rising costs of defending against medical malpractice claims.[58]

In response to the perceived crisis, physicians and malpractice-insurance carriers began to lobby heavily for changes that would reduce medical malpractice tort liability.[59] Proponents of such reform argued that legislation reducing both litigation and plaintiffs' awards would solve the liability-and-insurance crisis and fix an imbalanced system. Although several attempts to enact federal legislation failed, the lobbying efforts persuaded many state legislatures that medical malpractice reforms were necessary.[60] By the mid-1980s, medical malpractice tort reforms had been widely adopted across the nation.

State-level tort reforms have been aimed at addressing what critics view as the biggest problems with the medical liability system: excessive litigation, frivolous cases, and unjustifiably large damage awards. Although significant variation exists among the chosen reforms of individual states, most states have elected to reduce damage awards in some way. Below, I discuss the most common tort reforms that reduce the damages medical malpractice plaintiffs can receive.

Perhaps the loudest criticism of the current tort system centers on the imposition of damages for noneconomic losses. Noneconomic damages are for nonpecuniary losses, such as pain and suffering, loss of consortium, emotional distress, and other intangible losses. Critics assert that noneconomic damage awards should be restricted because the awards serve no compensatory purpose, since money cannot eliminate pain,[61] the awards are arbitrary and unpredictable,[62] and

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causes of the increased cost and decreased availability of medical malpractice insurance were believed to be . . . an unjustified increase in tort liability for physicians . . ."); Shirley Qual, *A Survey of Medical Malpractice Tort Reform*, 12 WM. MITCHELL L. REV. 417, 419–21 (1986) (describing how the medical malpractice insurance "crisis of availability" in the 1970s resurfaced as a "crisis of affordability" in the 1980s).

57. ACADEMIC TASK FORCE FOR REVIEW OF THE INS. & TORT SYS., *supra* note 56, at 44.

58. Hubbard, *supra* note 56, at 297. The increase in premiums was also likely linked to insurance companies' investment outcomes. *See, e.g.*, Tom Baker, *Medical Malpractice and the Insurance Underwriting Cycle*, 54 DEPAUL L. REV. 393, 394 (2005) (explaining how changed market conditions and cost projections encouraged increased malpractice insurance premiums).

59. F. Patrick Hubbard, *The Nature and Impact of the "Tort Reform" Movement*, 35 HOFSTRA L. REV. 437, 469–79 (2006).

60. *Id.* at 483–84.

61. *See, e.g.*, CANE, *supra* note 8, at 354 (noting that "when all has been done to minimize the pain and suffering by medical means, any residual pain and suffering cannot be shifted: it remains with the victim, no matter what compensation is paid to that person by others"); Abel, *supra* note 8, at 802 (arguing that the primary argument for torts damages "is hopelessly

the awards increase the cost of medical services because doctors and hospitals pass on their liability costs in the form of higher prices.[63] Thirty states have enacted reforms that cap noneconomic damage awards in medical malpractice cases.[64] The majority of these caps limit such awards to between $250,000 and $450,000.

Proponents of tort reform raise many of these same objections to punitive damages. Punitive damages are awarded not to compensate victims but to punish defendants for reckless or intentional conduct and to deter future conduct.[65] Critics of punitive damage awards point to recent U.S. Supreme Court decisions to highlight how punitive damages are often excessive in comparison to compensatory damages, violating the Due Process Clause of the Fourteenth Amendment.[66] Critics also argue that the arbitrary and unpredictable imposition of the awards has distorted the settlement process.[67] Forty-two states have adopted either caps on punitive damages or more stringent evidence requirements for awarding them

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incoherent—money cannot restore victims to their status quo before the accident" and that "money is a poor equivalent for non-pecuniary loss").

62. *See, e.g.*, Mark Geistfeld, *Placing a Price on Pain and Suffering: A Method for Helping Juries Determine Tort Damages for Nonmonetary Injuries,* 83 CALIF. L. REV. 773, 777 (1995) (asserting that there is substantial variability in jury awards for pain and suffering for injuries of equal severity); David W. Leebron, *Final Moments: Damages for Pain and Suffering Prior to Death*, 64 N.Y.U. L. REV. 256, 324–25 (1989) (analyzing pain-and-suffering awards in 256 wrongful death cases and concluding that there is a lack of horizontal equity in awards).

63. John E. Calfee & Paul H. Rubin, *Some Implications of Damage Payments for Nonpecuniary Losses*, 21 J. LEGAL STUD. 371, 371–74 (1992); Robert Cooter, *Towards a Market in Unmatured Tort Claims*, 75 VA. L. REV. 383, 392 (1989) ("[A] rational person would insure only against that pain and suffering that curtailed earnings . . . ."); George L. Priest, *A Theory of the Consumer Product Warranty*, 90 YALE L.J. 1297, 1346–47, 1352 (1981); Alan Schwartz, *Proposals for Product Liability Reform: A Theoretical Synthesis*, 97 YALE L.J. 353, 362–67 (1988).

64. Ronen Avraham, *Database of State Tort Law Reforms* (Tex. Law Econ. Research Paper No. 184, 2011), *available at* http://ssrn.com/abstract=902711.

65. BMW of N. Am., Inc. v. Gore, 517 U.S. 559, 568 (1996) ("Punitive damages may properly be imposed to further a State's legitimate interests in punishing unlawful conduct and deterring its repetition.").

66. State Farm Mut. Auto Ins. Co. v. Campbell, 538 U.S. 408, 429 (2003) ("The punitive award of $145 million, therefore, was neither reasonable nor proportionate to the wrong committed, and it was an irrational and arbitrary deprivation of the property of the defendant."); Pac. Mut. Life Ins. Co. v. Haslip, 499 U.S. 1, 42 (1991) (O'Connor, J., dissenting) ("Punitive damages are a powerful weapon. Imposed wisely and with restraint, they have the potential to advance legitimate state interests. Imposed indiscriminately, however, they have a devastating potential for harm. Regrettably, common-law procedures for awarding punitive damages fall into the latter category.").

67. *See, e.g.*, *Punitive Damage Reform*, ATRA, http://www.atra.org/issues/punitive-damages-reform (last visited Oct. 6, 2013) ("The difficulty of predicting whether punitive damages will be awarded by a jury in any particular case, and the marked trend toward astronomically large amounts when they are awarded, have seriously distorted settlement and litigation processes and have led to wildly inconsistent outcomes in similar cases.").

in medical malpractice cases.[68] The caps typically limit punitive damage awards to the greater of either a fixed dollar amount (i.e., $250,000) or three times the compensatory damage award. The stronger evidence requirements generally force plaintiffs to establish that the defendants' conduct was reckless, willful, or intentional by a clear-and-convincing-evidence standard, instead of the preponderance-of-the-evidence standard generally required in civil trials.[69]

Critics argue that in some states, not only are noneconomic damages and punitive damages excessive but so too are compensatory damages. According to this view, overly generous juries ignore facts and law to award excessive compensatory judgments.[70] The result is excessive deterrence and an unfair redistribution of wealth to plaintiffs. In response, ten states have capped total damage awards in medical malpractice cases.[71] In these states, a plaintiff's total recovery, including both economic and noneconomic damages, is capped at a fixed amount, often $500,000 or $1,000,000.

Numerous states have also enacted reforms to collateral source rules that reduce plaintiffs' damage awards. The traditional collateral source rule prevents the admission of evidence at trial showing that other sources, such as health insurance, have already compensated a plaintiff's losses. The rationale for the traditional rule is that a defendant should not benefit merely because the plaintiff had the foresight to purchase insurance. Although the rule promotes efficient deterrence by requiring a tortfeasor to pay damages even when another source previously paid the victim, critics argue that a plaintiff's award may exceed the value of the harm he suffered.[72] Reforms to collateral source rules include allowing evidence of collateral source payments or completely offsetting awards by the amount of those payments.[73] That is, these reforms allow plaintiffs' damage awards to be reduced by the amount of reimbursement they have already received from a collateral source such as health

68. Avraham, *supra* note 64.

69. Hubbard, *supra* note 59, at 501.

70. *See, e.g.*, *About ATRA,* ATRA, http://www.atra.org/about/ (last visited Oct. 6, 2013) (arguing that large verdicts or settlements in meritless cases are ruining the legal system and economy).

71. Avraham, *supra* note 64.

72. *See, e.g.*, *Collateral Source Rule Reform*, ATRA, http://www.atra.org/issues/collateral-source-rule-reform (last visited Oct. 6, 2013) ("The collateral source rule keeps important information relevant to the determination of damages from reaching the jury. It allows plaintiffs to be compensated twice for the same injury.").

73. Avraham, *supra* note 64.

insurance or workers' compensation. Thirty-eight states have enacted such collateral source reforms.[74]

Reforms to joint and several liability aim to reduce plaintiffs' recovery in cases involving multiple defendants. Under the traditional doctrine of joint and several liability, a plaintiff can recover the full cost of her injury from any party who is even found partially liable for the injury. This doctrine allows plaintiffs to collect all of their damages from a defendant with deep pockets, even if that defendant contributed only modestly to the plaintiff's injury. The deep pocket defendant can sue the other tortfeasors for contribution to force them to pay their share of the damages, but such crossclaims are often fruitless because the other tortfeasors often lack resources. Although these rules help to ensure that victims receive full compensation, critics argue that the rules fail to distribute liability equitably among defendants. In addition, proponents of reform assert that joint and several liability precludes optimal deterrence. The deep pocket is deterred excessively; the large damages may cause her to pay for excessive precautions or to cease offering the goods or services completely. The other tortfeasors are deterred inadequately; because the deep pocket pays for the harm that the others cause, the others do not pay for the full costs that their conduct imposes.[75] Forty-one states have enacted reforms to joint and several liability in the medical malpractice context.[76] Most reforms to the standard rule of joint and several liability impose proportionate liability limits for defendants who contributed only modestly to causing the injury.

Thus, many states have enacted tort reforms that reduce the damage awards that plaintiffs can recover in medical malpractice cases. Next, I discuss how these reductions in damages also restrict plaintiffs' access to legal representation in medical malpractice cases.

#### *b. The Impact of Tort Reform on Patients' Access to Justice*

Because the aforementioned tort reforms lower the damage awards that plaintiffs expect to receive in medical malpractice cases, contingent fee lawyers are less willing to accept such cases. And because the cost of trying cases remains the same as before tort reform but the damages—and, in turn, the contingent lawyer's expected

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74. *Id.*

75. For a general discussion, see *Joint and Several Liability Rule Reform*, ATRA, http://www.atra.org/issues/joint-and-several-liability-rule-reform (last visited Oct. 6, 2013) ("In a state that follows the rule of joint and several liability, . . . the plaintiff may recover 100 percent of her damages from the solvent defendant that is 5 percent responsible for her injuries.").

76. Avraham, *supra* note 64.

recovery—decline, fewer cases will make economic sense for the lawyer to accept.

Consider, for example, a medical malpractice case with expected economic damages of $50,000 and expected noneconomic damages of $500,000. An attorney with a 33% contingent fee rate would likely reject this case if he expects his litigation costs to be higher than his expected fee of $181,500 (33% of $550,000). However, if the state enacts a $250,000 cap on noneconomic damages, the attorney would reject an identical case if the expected litigation costs exceed $99,000; after the damages cap, the attorneys' expected fee is only $99,000 (33% of $300,000). Thus, tort reforms that lower plaintiffs' expected awards reduce access to the civil justice system by making cases financially unattractive to plaintiffs' lawyers working on a contingent fee basis.

One medical malpractice attorney interviewed for a study of the standard practices of plaintiffs' attorneys practices explained that he could not economically justify accepting many cases after his state capped noneconomic damages: "Because if it's a case that's gonna hafta be tried, and the up-end is $200,000 to $250,000, which is a $100,000 fee, we're not gonna risk $100,000 to get a $100,000 fee. You can't do that in this business if you expect to be around very long."[77]

Indeed, attorneys often lament that they have no choice but to turn down legitimate cases after their states enact tort reform:

> In this state there's an epidemic at this time in terms of people who have legitimate claims going unrepresented. I have looked at cases before [the cap] that had been seen by four or five other lawyers before they got to me. And I've looked at legitimate cases. . . . Now I'm afraid what's happening is they're not really getting looked at. . . . [T]hey're [lawyers] making a decision, and I don't know that's an unreasonable one. I think they're just saying, "We are not gonna do any case that doesn't have the potential upside to justify the risk that we're gonna take." . . . I would hate to be a plaintiff out there looking for a lawyer right now.[78]

Only two empirical studies have explored the degree to which tort reform has limited victims' access to the legal system. The first study directly examined the influence of noneconomic damage caps on the willingness of plaintiffs' attorneys to accept medical malpractice clients.[79] The researchers conducted surveys of Texas plaintiffs' attorneys in 2000 and 2006, before and after Texas instituted a $250,000 cap on noneconomic damages in medical malpractice cases. For the sixty attorneys who participated in both surveys, the

77. Daniels & Martin, *supra* note 48, at 29.

78. *Id.* at 33.

79. Steven Garber et al., *Do Noneconomic Damages Caps and Attorney Fee Limits Reduce Access to Justice for Victims of Medical Negligence?*, 6 J. EMPIRICAL LEGAL STUD. 637, 637 (2009).

researchers compared their stated willingness to accept cases of three hypothetical medical malpractice victims. Although the clients had different levels of economic damages, they all suffered facial disfigurement—indicating large noneconomic losses that could, absent a cap, result in a significant award. The empirical results revealed that the attorneys' willingness to accept all of the clients' cases declined after the cap was enacted, but it declined significantly more for the clients with low economic damages.

The second study analyzed the effects of noneconomic damage caps and attorney-fee limits on attorneys' willingness to accept medical malpractice cases.[80] The researchers surveyed 965 plaintiffs' attorneys from across the nation, asking how likely each was to accept a case in three different scenarios. The results confirmed that both noneconomic damage caps and attorney fee limits substantially discouraged attorneys from representing clients.[81]

Hence, the limited empirical work on the subject confirms that tort reforms and high litigation costs have restricted access to the legal system for many legitimate victims of medical malpractice. These factors have made taking cases with damages insufficient to warrant the litigation expense impossible for many plaintiffs' attorneys.

### *C. Consequences of the Access-to-Justice Problem*

As litigation costs and tort reforms make accepting many medical malpractice cases economically infeasible for attorneys, legitimate victims of medical malpractice are left without legal representation. In this Section, I discuss various consequences of this access-to-justice problem. Not only will unrepresented victims likely receive no compensation for their harms, but victims with low economic damages will be disproportionately excluded from the legal system.

Because of the complexity and expense of medical malpractice lawsuits, employing a lawyer is critical to a successful claim. Indeed, empirical evidence confirms that an inability to obtain legal representation effectively eliminates a victim's ability to obtain redress in the civil justice system. According to one study of medical malpractice claims, only 0.1% of claims that result in payment are brought by pro se victims.[82] Another study of closed claims found that

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80. Daniels & Martin, *supra* note 48, at 27–30.

81. *See id.* at 36–37.

82. Hyman & Silver, *supra* note 51, at 1094.

the success rate of pro se and unrepresented plaintiffs was only 5.5%, whereas the success rate for plaintiffs represented by counsel was 34%.[83]

Moreover, the economic calculus required by the contingent fee system causes attorneys to gravitate towards some types of medical malpractice cases and ignore others. High litigation costs give medical malpractice attorneys little choice but to ignore smaller cases and concentrate on cases with larger expected damages, as the lawyers' fees from a small case will rarely offset the expense of litigating the case. One medical malpractice attorney explained that a good case is "anything that has to do with neurological brain damage, something that's permanent—[a] young person that has a long . . . life expectancy; a brain-damaged baby where there's a long life expectancy that required 24 hour care. . . . [and] where the cost of the damages are exceedingly high."[84] Another echoed, "[T]here's no such thing, as far as I'm concerned, as a good small medical malpractice case."[85]

Because the majority of adverse events resulting from medical negligence do not impose serious harm,[86] many medical malpractice victims are unable to find legal representation, and their injuries go uncompensated. Although compensating victims who suffer serious harm is typically considered more important, even less serious harms are often still significant for many victims, and compensation of these harms is necessary to achieve deterrence. In fact, because many contingent fee attorneys assume that litigation expenses average $100,000, they could not economically justify accepting claims that most people would regard as serious; even a $300,000 damage award would only allow an attorney with a 33% contingent fee to risk the same amount he stands to earn if his litigation expenses are $100,000. As a result, many attorneys develop minimum damages thresholds below which they will not consider a case. For example, one attorney interviewed for my survey replied that he would generally not consider "anything below a $300,000.00 potential recovery."

Although the survey I conducted for this Article is the first to explore attorneys' minimum damages thresholds in a range of cases, along with the causes and consequences of those thresholds, one previous study of specialization among medical malpractice attorneys asked whether the respondents had a general threshold value for

83. Stephen Daniels et al., *Why Kill All the Lawyers? Repeat Players and Strategic Advantage in Medical Malpractice Claims* (Am. Bar Found. Working Paper No. 9210, 1992).

84. Daniels & Martin, *supra* note 48, at 32.

85. *Id.* at 33.

86. Studdert et al., *supra* note 16, at 254–55.

rejecting medical malpractice cases. Over half of the respondents in that previous survey replied that they would not accept a case if the expected damages were below $250,000.

Moreover, by limiting certain types of damages relative to other damages, tort reform disproportionately reduces both compensation and access to justice for specific segments of the population. For example, studies show that caps on noneconomic damages disproportionately reduce compensation to females, children, the elderly, and the poor, because a much greater proportion of their damage awards are in the form of noneconomic damages.[87] These demographic groups often have lower incomes than other groups, and, as a result, they have correspondingly less economic loss and relatively more noneconomic loss.[88] Thus, noneconomic damage caps act as a regressive tax by reducing the recoveries of lower-income plaintiffs by a higher fraction than the recoveries of higher-income plaintiffs.

The tort reforms that disproportionately reduce the expected recoveries for lower-income groups also disproportionately reduce the expected contingent fee that lawyers recover from these clients. Thus, these reforms disproportionately reduce contingent fee lawyers' willingness to represent lower-income groups. Empirical evidence confirms that after tort reforms that restrict noneconomic damages, attorneys disproportionately refuse to represent females, children, the elderly, and the poor on a contingent fee basis because of the low potential recovery.[89] Interviews with medical malpractice attorneys

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87. NICHOLAS M. PACE ET AL., CAPPING NON-ECONOMIC AWARDS IN MEDICAL MALPRACTICE TRIALS: CALIFORNIA JURY VERDICTS UNDER MICRA 30–33 (2004), *available at* http://www.rand.org/content/dam/rand/pubs/monographs/2004/RAND_MG234.pdf; Lucinda M. Finley, *The Hidden Victims Of Tort Reform: Women, Children, and the Elderly*, 53 EMORY L.J. 1263, 1265–66 (2004); Eleanor D. Kinney et al., *Indiana's Medical Malpractice Act: Results of a Three-Year Study*, 24 IND. L. REV. 1275, 1288–89 (1991).

88. Michael L. Rustad, *Nationalizing Tort Law: The Republican Attack on Women, Blue Collar Workers, and Consumers*, 48 RUTGERS L. REV. 673, 749–50 (1996); Christian E. Schlegel, Note, *Is a Federal Cap on Punitive Damages in Our Best Interest?: A Consideration of H.R. 956 in Light of Tennessee's Experience*, 69 TENN. L. REV. 677, 697–98 (2002); Mark Donald, *Access Denied: Does Tort Reform Close Courthouse Doors to Those Who Can Least Afford It?*, TEX. LAW. (Jan. 10, 2005), http://www.law.com/jsp/tx/PubArticleTX.jsp?id=900005421359&Access_Denied_Does_Tort_Reform_Close_Courthouse_Doors_to_Those_Who_Can_Least_Afford_It&slreturn=20130114021026.

89. Catherine M. Sharkey, *Unintended Consequences of Medical Malpractice Damage Caps*, 80 N.Y.U. L. REV. 391, 490 (2005) (showing that awards for overall damages have stayed the same while economic damages have increased, possibly because plaintiffs' lawyers have screened out women, minorities, and children, who are less likely to receive high economic damages); Troy L. Cady, Note, *Disadvantaging the Disadvantaged: The Discriminatory Effects of Punitive Damage Caps*, 25 HOFSTRA L. REV. 1005, 1033 (1997) ("Lawyers will become increasingly unwilling to represent plaintiffs in lawsuits that have little or no prospect of yielding adequate

also indicate that certain tort reforms limit access to the legal system for certain demographic groups. As an attorney interviewed for my study explained, "[N]on-wage-earners, seniors, nonworking women . . . are the first ones to lose access to the courts when things like caps on pain and suffering awards are enacted." Similarly, an attorney interviewed in another study explained, "The biggest problem is the cap on damages; the $250,000 cap does nothing more than hurt the children and the housewives and the elderly the most, because they don't have any economic damages, they don't have any earning capacity and they don't have any lost wages . . . ."[90]

In Part IV, I discuss the findings from my own survey of medical malpractice attorneys. My results confirm that many of the attorneys quoted in this Section are representative of the general sentiment among medical malpractice attorneys. Attorneys generally agree that the costs of litigating medical malpractice cases are high, that economic realities force them to reject many legitimate cases that do not have high expected damage awards, and that tort reforms further restrict the number of legitimate cases that attorneys are able to accept.

## IV. SURVEY

To better understand the problem of silent victims in the medical liability system, I conducted a survey of attorneys who currently represent medical malpractice plaintiffs. The survey asked various questions about the respondents and both their firms (such as demographic characteristics, firm characteristics, and experience in medical malpractice work) and their practice patterns (including the respondents' experiences with medical malpractice case dispositions, recoveries, and expenses). It also posed questions pertaining to case-screening procedures and access-to-justice issues (such as case-rejection rate, reasons for rejecting cases, and minimum damages among accepted cases). In this Part, I discuss my survey methods and present data on the survey responses to various questions.

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compensation for the large amount of time and money invested . . . ."); Rachel Zimmerman & Joseph T. Hallinan, *As Malpractice Caps Spread, Lawyers Turn Away Some Cases*, WALL ST. J., Oct. 8, 2004, at A1, *available at* http://online.wsj.com/article/0,,SB109717758841639476,00.html ("[C]aps on damages for pain and suffering . . . [are] turning out to have the unpublicized effect of creating two tiers of malpractice victims. . . . [L]awyers are turning away cases involving victims that don't represent big economic losses—most notably retired people, children and housewives . . . .").

90. Daniels & Martin, *supra* note 44, at 668 (quoting an interview with a personal injury lawyer in Texas).

### *A. Methods*

I drew contact information from a list of attorneys published by Consumer Base and RSA List Services in the spring of 2012.[91] These companies obtain their contact lists from various sources, including business directories, conference attendance lists, firm websites, and other sources.

I developed a thirty-five-item online survey addressing various aspects of attorneys' practices, case-screening procedures, and case-disposition experience. In May 2012, I sent an e-mail with a request to participate in an online survey to all 23,026 e-mail addresses on my contact list. The e-mail described the following purpose of the survey:

> We are developing a knowledge base of general practice patterns of medical malpractice attorneys that we can share with all trial attorneys. Although there has been much speculation about the way that factors such as case characteristics, state laws, and the nature of an attorney's practice influence litigation and case outcomes, there has been no systematic study of these influences. This study will explore how these factors influence attorney decisions to accept or reject cases at screening, and how they relate to cases that are dismissed, settled, or proceed to trial.

The e-mail also confirmed that the survey responses were anonymous and provided contact information for follow-up questions or comments. I received hundreds of comments, several of which are quoted in Part III of this Article.

The online survey was open for approximately one month. Four hundred sixty-four attorneys completed the survey during this time. Ideally, I would be able to estimate a response rate based on the 464 responses. However, to estimate this accurately, I would need to know the number of medical malpractice attorneys that received my e-mail request and had the opportunity to take the survey. For various reasons, this is impossible to know.

First, although my initial contact list contained 23,026 e-mail addresses, a significant number of the contacts contained incorrect or out-of-date addresses. Second, not all of the attorneys on the list were medical malpractice attorneys; many attorneys replied that they had never litigated medical malpractice cases or had not litigated such cases in many years. In fact, many had not practiced law in years and were either retired or working in a different career. Finally, some e-mail requests were caught in an unknown number of spam folders.[92]

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91. EXACT DATA CONSUMER BASE, http://www.consumerbase.com/index.html (last visited Aug. 23, 2012); RSA LIST SERVS. EXECUTIVE EMAIL LISTS, http://www.rsalistservices.com/ (last visited Aug. 23, 2012).

92. Although I filled out hundreds of requests from e-mail providers to skip the spam folder, many attorneys responded that they had found my e-mail in their spam folder.

As a result, the list of 23,026 contacts significantly overestimates the number of medical malpractice attorneys that actually received the survey and had an opportunity to respond.

Moreover, to determine the percentage of the total population of U.S. medical malpractice attorneys that my respondents represent, I would need to know how many attorneys are actively litigating medical malpractice cases. However, this number is impossible to estimate. There is no database that identifies all attorneys in the United States by the type of work they do. Martindale.com, the largest online index of attorneys, which includes contact information for over one million practicing attorneys, is likely the source closest to a comprehensive list of American attorneys.[93] Martindale.com reports that there are 10,894 attorneys across the United States that self-identify as practicing in the area of medical malpractice. Only 3,493 of these attorneys are active members of the American Bar Association. Even these numbers may overestimate the true number of medical malpractice lawyers. And because attorneys self-report their practice area, the Martindale.com index reports the type of work that attorneys would be willing to do, not the type of work in which they have experience. As a result, many of the 10,894 attorneys that checked the "medical malpractice" box may have little or no experience litigating medical malpractice cases.

As with any voluntary survey, there is a potential for selection bias, even if the underlying pool of attorneys to whom I sent the survey is unbiased. Because my e-mail describing the survey suggested that the purpose of the research is to understand medical malpractice attorneys' practice patterns and how various factors affect these patterns, attorneys that are more concerned with the state of their current practice may be more likely to respond. As a result, the responses may disproportionately reflect the concerns and practices of only this group of attorneys. Nevertheless, as I show in the next Section, the responses to the basic demographic questions all indicate that my sample of respondents is very representative of the larger population of medical malpractice attorneys. Moreover, the survey responses are consistent with other research findings, suggesting that selection bias may not be a serious problem.

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93. MARTINDALE.COM, http://www.martindale.com (last visited Aug. 23, 2012).

### *B. Basic Demographic Characteristics of Respondent Plaintiffs' Attorneys*

The survey elicited information regarding a series of demographic characteristics about the respondents and their practices. The first question asked whether the respondents had primarily represented medical malpractice plaintiffs or defendants in the past year. Of the 464 respondents, 259 reported that they had primarily represented medical malpractice plaintiffs; the other 205 respondents reported that they had primarily engaged in medical malpractice defense. The respondents' answer to this first question directed them to either a set of questions relevant to plaintiffs' attorneys or a set of questions relevant to defense attorneys. As this Article is concerned with the access-to-justice issue among medical malpractice plaintiffs, the remainder of my discussion of the survey results will only pertain to the responses of the 259 plaintiffs' attorneys. Future work on other topics will discuss the survey questions and responses for the defendants' attorneys.

The survey's demographic questions were designed to determine whether respondents were representative of the larger population of U.S. medical malpractice attorneys. Attorneys from at least thirty-nine states answered the online survey,[94] suggesting a great deal of geographic diversity among the survey respondents.[95]

The first two questions were designed to determine whether the respondent's firm characteristics are representative of the larger population of medical malpractice attorneys. Answers to the question, "Which of the following best describes the location of the office in which you work?" revealed that the great majority of the survey respondents practice in urban areas. Table 1 reports the distribution of attorney respondents among different office locations. This distribution of locations is consistent with other studies finding that medical malpractice plaintiffs' attorneys overwhelmingly practice in urban areas.[96]

94. A number of respondents chose not to provide their state.

95. The number of respondents practicing in each state were: No Answer: 94; Alabama: 4; Arizona: 14; Arkansas: 1; California: 6; Colorado: 2; Connecticut: 4; Florida: 18; Georgia: 11; Hawaii: 1; Illinois: 7; Indiana: 3; Kansas: 4; Kentucky: 3; Louisiana: 1; Maine: 1; Maryland: 10; Massachusetts: 2; Minnesota: 2; Mississippi: 2; Missouri: 2; Nebraska: 1; Nevada: 1; New Hampshire: 1; New Jersey: 3; New Mexico: 1; New York: 7; North Carolina: 3; Ohio: 14; Oklahoma: 2; Pennsylvania: 13; Rhode Island: 1; Tennessee: 3; Texas: 5; Utah: 2; Virginia: 4; Washington: 3; Washington, D.C.: 1; Wisconsin: 1; Wyoming: 1.

96. Greenberg & Garber, *supra* note 54, at 13 (finding that 64.7% and 28.9% of respondents worked in urban and rural settings, respectively).

**Table 1: Office Location of Respondents**

| Office Location | Percentage of Respondents |
|---|---|
| Rural | 4.27% |
| Suburban | 24.39% |
| Urban | 71.34% |

To the second question—"Approximately how many attorneys work in your law office?"—the majority of respondents reported that they worked in offices with fewer than five attorneys. Table 2 shows the distribution of the survey respondents among different firm sizes. This distribution is consistent with other reports on medical malpractice attorneys, which find that the average firm specializing in medical malpractice has only two attorneys.[97]

**Table 2: Firm Size of Respondents**

| Firm Size | Percent of Respondents |
|---|---|
| Solo practice | 12.80% |
| 2 to 5 attorneys | 43.29% |
| 6 to 10 attorneys | 25.00% |
| 11 to 50 attorneys | 16.46% |
| More than 50 attorneys | 2.44% |

I designed the next set of survey questions to determine whether the litigation experience of my respondents is representative of the larger population of medical malpractice attorneys in the United States. Answers to the question, "How many years have you been litigating medical malpractice cases?" revealed a substantial amount of experience among my respondents. As reported in Table 3, the majority of the respondents had over twenty years of experience. This level of experience is consistent with other reports that have found an average of twenty-four years of practice experience among medical malpractice attorneys.[98]

97. Stephen Daniels & Joanne Martin, *Texas Plaintiffs' Practice in the Age of Tort Reform: Survival of the Fittest — It's Even More True Now*, 51 N.Y.L. SCH. L. REV. 285, 305–06 (2006).

98. Greenberg & Garber, *supra* note 54, at 11.

**Table 3: Experience Litigating Medical Malpractice Cases**

| Years | Percent of Respondents |
|---|---|
| Fewer than 10 years | 4.85% |
| 10 to 19 years | 23.64% |
| 20 to 29 years | 35.15% |
| More than 30 years | 36.36% |

The survey also asked the respondents, "Approximately how many medical malpractice cases are you working on now?" As shown in Table 4, most of the respondents were handling fewer than fifteen such cases at the time of the survey. In general, the respondents that were involved in more cases tended to practice in larger firms.

**Table 4: Number of Current Medical Malpractice Cases**

| Number of Current Cases | Percent of Respondents |
|---|---|
| Fewer than 5 cases | 31.90% |
| 5 to 15 cases | 41.10% |
| 16 to 50 cases | 22.09% |
| More than 50 cases | 4.91% |

Finally, to understand the amount of specialization in medical malpractice cases among the respondents, the survey asked, "Which of the following best describes how much time you spend working on medical malpractice cases?" Table 5 shows that substantial diversity exists in the degree of specialization among the survey respondents. The majority of the survey respondents devoted either less than 25% of their time or more than 75% of their time to medical malpractice cases. Again, this distribution of specialization is consistent with other reports on the practice patterns of medical malpractice attorneys.[99]

99. *Id.* at 12 (finding that 41.6% of respondents spent less than 25% of their time on medical malpractice cases and that 79.94% of respondents spent more than 75% of their time on medical malpractice cases).

**Table 5: Specialization on Medical Malpractice Cases**

| Percentage of Time | Percent of Respondents |
|---|---|
| Less than 25% of my time | 32.72% |
| Between 25% and 50% of my time | 19.14% |
| Between 51% and 75% of my time | 14.81% |
| More than 75% of my time | 33.33% |

Thus, the survey respondents practice in at least thirty-nine states and work in firms that are representative of the larger population of U.S. medical malpractice attorneys. Moreover, the respondents' practice experience and specialization in medical malpractice work is similar to that found in other reports of the practice patterns of medical malpractice attorneys.

*C. Case-Disposition Experience*

To better understand the practice patterns of medical malpractice attorneys, the survey asked a series of questions about the attorneys' recent experience in case dispositions. Responses to the question, "Approximately how many [medical malpractice] cases did you close last year?" revealed that the average respondent closed fourteen cases last year. Table 6 reports the distribution of closed cases among the survey respondents.

**Table 6: Medical Malpractice Cases Closed Last Year**

| Cases Closed | Percent of Respondents |
|---|---|
| Fewer than 5 cases | 37.36% |
| 5 to 10 cases | 33.33% |
| 11 to 50 cases | 25.86% |
| More than 50 cases | 3.45% |

To explore how these cases were closed, the survey asked, "Approximately what percentage of the cases that you closed last year were: dismissed without payment, settled with payment prior to trial proceedings, settled with payment during trial, and went to jury verdict?" Table 7 reports that the majority of cases were settled.[100] The percentage of cases that went to trial (9%) is consistent with data from

100. The percentages in Table 7 do not add up to 100%, but they exclude certain case-disposition outcomes such as bench trials.

the largest independent medical-professional-liability research database, which reports that 8.5% of medical malpractice claims went to trial in 2010, the most recent year for which data was available.[101]

**Table 7: Case Dispositions Among Survey Respondents**

| Percent of Medical Malpractice Cases | Average Percent Among Respondents |
|---|---|
| Dismissed without payment | 11% |
| Settled with payment prior to trial proceedings | 54% |
| Settled with payment during trial | 2% |
| Went to jury verdict | 7% |

To explore plaintiffs' success at trial, the survey asked questions pertaining to plaintiff win rates and plaintiff recovery. Responses to the question, "What percentage of your cases that went to a jury verdict last year were in the plaintiff's favor?" indicate that the average plaintiff win rate by jury was 27%. This plaintiff win rate is low compared to plaintiff win rates in general civil trials, which a recent study been found to be 56%.[102] However, the survey's low percentage of plaintiff wins is consistent with other data on medical malpractice trial outcomes, which find that plaintiffs win in 23% of medical malpractice trials.[103]

To further explore plaintiff outcomes, the survey also asked the question, "What would you estimate was the average amount awarded to the plaintiff in your cases that settled for payment last year and resulted in a jury verdict for the plaintiff?" The respondents reported an average settlement award of $652,060 and an average damage award from jury verdict of $1,519,727. Table 8 reports the distribution of respondents indicating average award amounts for settlements and jury verdicts. Not surprisingly, awards from jury verdicts tend to be much higher than settlement amounts. In fact, the majority of jury awards reported were over $1 million. Although the proportion of jury awards over $1 million among my responses is slightly higher than a recent report on civil trial awards, the concentration of jury awards over $500,000 is consistent with recent research.[104]

101. PHYSICIAN INSURERS ASS'N OF AM., CLAIM TREND ANALYSIS: A COMPREHENSIVE ANALYSIS OF MEDICAL LIABILITY DATA REPORTED TO THE PIAA DATA SHARING PROJECT, Exhibit 6c (2011).

102. LYNN LANGTON & THOMAS H. COHEN, BUREAU OF JUSTICE STATISTICS, CIVIL BENCH AND JURY TRIALS IN STATE COURTS, 2005, at 4 (2008), *available at* http://bjs.ojp.usdoj.gov/content/pub/pdf/cbitsc05.pdf.

103. *Id.* (reporting that plaintiffs win in 23% of medical malpractice trials).

104. *Id.* at 5.

**Table 8: Average Plaintiff Awards in Settlements and Jury Verdicts**

| Average Award Amount | Percent of Respondents Indicating Average Award in Settlements | Percent of Respondents Indicating Average Award from Jury Verdict |
|---|---|---|
| Less than $50,000 | 3.38% | 0.00% |
| $50,000 to $150,000 | 12.16% | 12.73% |
| $150,000 to $500,000 | 48.65% | 27.27% |
| $500,000 to $999,999 | 14.86% | 9.09% |
| $1 million or greater | 20.95% | 50.91% |

To explore attorneys' recovery and costs in medical malpractice cases, the survey asked questions relating to contingent fees and litigation expenses. The survey asked the question, "What is your average fee as a percentage of the award in cases that settle with payment made to the plaintiff and result in a jury award to the client?" Among the respondents, the average contingent fee in cases that ended in a settlement was 35%, and the average contingent fee in cases that ended in a jury award to the plaintiff was 36%. Table 9 reports the distribution of average contingent fees among cases ending in settlement and jury awards.

**Table 9: Average Contingent Fee in Settlements and Jury Verdicts**

| Average Contingent Fee | Percent of Respondents Indicating Average Fee in Settlements | Percent of Respondents Indicating Average Fee from Jury Verdict |
|---|---|---|
| Less than 20% | 6.38% | 4.85% |
| 20% to 29% | 12.06% | 7.77% |
| 30% to 40% | 73.05% | 80.58% |
| Greater than 40% | 8.51% | 6.80% |

Finally, to understand the attorneys' litigation expenses, the survey asked, "What would you estimate are the average litigation costs of your medical malpractice cases that: were dismissed without payment, settled with payment made to the plaintiff, and resulted in a jury verdict for the plaintiff?" Table 10 reports the averages of the respondents' answers. Not surprisingly, the litigation costs are highest when cases go to trial. Moreover, the $97,369.79 average litigation

cost among cases ending with a jury verdict for the plaintiff is very similar to the expected $100,000 cost that many attorneys use as a rule of thumb when screening cases.

**Table 10: Average Litigation Expenses Among Different Cases**

| Case Disposition | Average Litigation Costs |
|---|---|
| Dismissed without payment | $18,062.76 |
| Settled with payment made to the plaintiff | $58,275.89 |
| Resulted in jury verdict for plaintiff | $97,369.79 |

*D. Case Screening and Access to Justice*

The final set of survey questions relate to the attorneys' experiences screening cases and the problem of victims' access to justice. The responses reveal that the majority of screened cases, even strong cases, are rejected if the expected damage award is not large enough to offset litigation costs. Thus, the survey confirms that access to justice is a significant problem in today's medical liability system.

To understand attorney screening procedures, the survey asked questions about the number of cases screened and the percent of those cases rejected. Responses to the question, "Within the last year, approximately how many medical malpractice suits did you screen?" indicate that the majority of respondents screened fewer than fifty cases. Table 11 reports the number of cases screened among the survey respondents.

**Table 11: Medical Malpractice Cases Screened in Last Year**

| Cases Screened in Last Year | Percent of Respondents |
|---|---|
| Fewer than 10 cases | 12.17% |
| 10 to 50 cases | 42.61% |
| 51 to 100 cases | 20.00% |
| 101 to 500 cases | 20.00% |
| More than 500 cases | 5.22% |

Next, the survey asked, "Approximately what percentage of the cases that you screened did you reject?" The responses, shown in Table 12, indicate that the majority of attorneys reject between 95% and 99% of the cases they screen. In fact, 76.8% of the attorney

respondents indicate that they reject more than 90% of the cases they screen. This percentage is remarkably consistent with results from another report of medical malpractice attorneys' practice patterns, which found that 77.1% of attorneys accept fewer than 10% of the cases they screen.[105]

**Table 12: Percent of Screened Cases That Are Rejected**

| Percent of Screened Cases that Are Rejected | Percent of Respondents |
|---|---|
| Less than 75% | 5.21% |
| 75% to 89% | 18.01% |
| 90% to 94% | 25.59% |
| 95% to 99% | 42.18% |
| More than 99% | 9.00% |

To understand the reasons why attorneys reject so many cases, the survey asked, "Which of the following was your primary reason for rejecting the cases that you did last year?" As reported in Table 13, the most common reason for rejecting cases was insufficient damages. Moreover, over half of the respondents indicated that cost factors—either insufficient damages or the expense of bringing the claim—were the primary reasons for rejecting cases.

**Table 13: Primary Reasons for Rejecting Case**

| Reason for Rejecting Case | Percent of Respondents |
|---|---|
| Unclear causation | 19.25% |
| Unclear evidence of malpractice | 29.11% |
| Case is unlikely to settle | 0.94% |
| Insufficient damages expected from trial or settlement | 38.73% |
| Complexity and expense of bringing the claim | 11.74% |
| Hospital not involved in malpractice | 0.23% |

To further explore the degree to which the expected damages affect attorneys' likelihood of accepting cases, the survey asked, "Do you have a minimum threshold for the potential damages award, below which you will not accept a case?" If the attorneys answered in the affirmative, they were asked the amount of the damages threshold. This question was asked with different percentage likelihoods of succeeding on the legal merits—95%, 51%, and 25%.

105. Greenberg & Garber, *supra* note 54, at 14.

Table 14 reports the damage threshold chosen for each likelihood of winning. As expected, the minimum damages threshold below which attorneys will not accept a case increases as the likelihood of winning the case decreases; as case risk increases, so does the required return. This risk-return tradeoff is economically rational and is seen in all areas of investment behavior.

**Table 14: Damage Thresholds for Accepting Cases**

| Damages Threshold To Accept Case | Percent of Respondents with 95% Success on the Merits | Percent of Respondents with 51% Success on the Merits[106] | Percent of Respondents with 25% Success on the Merits[107] |
|---|---|---|---|
| Less than $50,000 | 1.18% | 0.78% | 0% |
| $50,000 to $149,000 | 20.71% | 3.10% | 4.17% |
| $150,000 to $249,000 | 22.49% | 7.75% | 4.17% |
| $250,000 to $499,000 | 27.81% | 17.83% | 8.33% |
| $500,000 and over | 27.81% | 70.54% | 83.33% |
| Median Damages Threshold | $250,000 | $500,000 | $1,000,000 |

The results confirm that access to justice is a significant problem in today's medical liability system. First, virtually no attorney will accept any medical malpractice case if the expected damages are less than $50,000, even if the likelihood of winning is 95%. As the majority of medical malpractice victims do not suffer harm that equates to an exorbitant damage award,[108] this result indicates that many victims will not be able to obtain legal representation.

Second, well over half of the attorneys indicated that they would not accept a case, regardless of the likelihood of winning, if the expected damages are less than $250,000. This is consistent with a

106. Thirteen percent of respondents indicated that regardless of the expected damages, they would never accept a case with this likelihood of winning on the merits.

107. Nineteen percent of respondents indicated that regardless of the expected damages, they would never accept a case with this likelihood of winning on the merits.

108. PHYSICIAN INSURERS ASS'N OF AM., *supra* note 101, at Exhibit 8.

RAND survey (*Patterns of Specialization in Medical Malpractice Among Contingency Fee Attorneys*) that has examined whether attorneys have a damage threshold below which they will not accept a case.[109] Although the RAND survey did not allow respondents to enter their own damage-threshold categories and did not differentiate between different likelihoods of winning, it similarly found that 53% of attorneys would automatically reject a case if the expected damages were less than $250,000.

Finally, the median thresholds in the survey responses indicate the damages below which at least half of medical malpractice attorneys will not even consider taking a case. The reported medians reveal that most attorneys will not accept a slam dunk case (95% likelihood of winning) unless the expected damages are over $250,000. Most attorneys, moreover, will not accept a case that is more likely than not to be decided in the plaintiff's favor (51% likelihood of winning) unless the expected damages are over $500,000. And finally, most attorneys will not accept a case that is tough to win on the merits (25% likelihood of winning) unless expected damages are at least $1 million.

Lastly, to determine whether tort reform has exacerbated the medical liability system's access-to-justice problem, the survey asked, "Which of the following reforms have reduced your willingness to accept cases?" Table 15 reports the percentage of respondents who selected each choice. Over 80% of the respondents indicated that some tort reform had reduced their willingness to accept cases. As predicted by the theoretical literature and the two previous studies of tort reform's impact on case acceptances,[110] the reform that was most commonly named as affecting attorneys' willingness to accept cases was noneconomic damage caps.

**Table 15: Tort Reforms' Impact on Willingness to Accept Cases**

| Tort Reform | Percent of Respondents |
|---|---|
| Noneconomic damage caps | 31.25% |
| Punitive damage caps | 3.87% |
| Reforms eliminating joint and several liability | 12.50% |
| Reforms to the collateral source rule | 15.77% |
| None | 19.35% |
| Other | 17.26% |

109. Greenberg & Garber, *supra* note 54, at 14.

110. Daniels & Martin, *supra* note 48, at 32–33; Garber et al., *supra* note 79, at 638.

## V. IMPLICATIONS OF THE ACCESS-TO-JUSTICE PROBLEM

In this Part, I further explore the implications of this access-to-justice problem. First, using data on median plaintiff recoveries in medical malpractice actions from 1985 to 2010, I show that only the most severely injured victims will be able to easily find legal representation. Then, I present data that reveal a worsening access-to-justice problem. These data show that plaintiffs with expected damage awards lower than $250,000 are finding it increasingly difficult to obtain legal representation. Without legal representation, fewer and fewer of these plaintiffs are recovering any payment for their harms.

The data I employ are from the Physician Insurers Association of America ("PIAA"), the insurance-industry trade association representing domestic and international companies providing medical-professional liability insurance.[111] PIAA maintains the world's largest independent research database on medical-professional liability. It collects data from its members, which provide insurance protection to more than 60% of America's private practice physicians and write approximately 46%, or $5.2 billion, of the total industry premium. The PIAA medical malpractice data provide information on more than 274,000 medical and dental claims and lawsuits. As the PIAA data cover such a large proportion of the litigation in the U.S. medical liability system, it is frequently used to develop national overviews of claims and litigation.

### *A. Identifying the Silent Victims*

Drawing from the PIAA data, Table 16 reports the median payment made to plaintiffs between 1985 and 2010 by severity of plaintiff injury and primary allegation against the medical provider.[112] For example, the table reports that for allegations of improper performance—when either an operative or diagnostic procedure is done incorrectly—the median payment to plaintiffs suffering only

111. *See generally* PHYSICIAN INSURERS ASS'N OF AM, *supra* note 101.

112. *Id.* at Exhibit 8. The severity of the patient injuries is defined as follows: *emotional injury only*: "fright, no physical damage"; *insignificant injury*: "lacerations, contusions, minor scars, and rash. No delay in recovery"; *minor temporary injury*: "infections, misset fractures, fall in hospital, Recovery delayed"; *major temporary injury*: "burns, surgical material left, drug side effects, brain damage. Recovery delayed"; *minor permanent injury*: "loss of fingers, loss or damage to organs. Includes non-disabling injuries"; *significant permanent injury*: "deafness, loss of limb, loss of eye, loss of one kidney or lung"; *major permanent injury*: "paraplegia, blindness, loss of two limbs, brain damage"; *grave*: "quadraplegia, severe brain damage, lifelong care or fatal prognosis." COHEN & HUGHES, *supra* note 19, at 6.

emotional injury was $20,000. In contrast, the median payment to settle similar allegations made by plaintiffs suffering grave injuries—injuries requiring lifelong care—was $457,341. The payment data are from a significant number of claims; for example, the data on median payments made for improper performance claims is collected from 65,603 closed claims.

**Table 16: Median Payment Made to Plaintiffs Between 1985 and 2010 by Severity of Plaintiff Injury and Primary Allegation Against the Medical Provider**

| Severity of Patient's Injury | Median Indemnity for Improper Performance | Median Indemnity for Errors in Diagnosis | Median Indemnity for Failure to Supervise or Monitor | Median Indemnity for Medication Error |
|---|---|---|---|---|
| Emotional injury only | $20,000 | $16,625 | $36,625 | $20,000 |
| Insignificant injury | $17,500 | $16,278 | $12,500 | $10,000 |
| Minor temporary injury | $30,000 | $25,000 | $25,000 | $12,500 |
| Major temporary injury | $75,000 | $60,000 | $70,000 | $25,000 |
| Minor permanent injury | $85,000 | $100,000 | $100,000 | $60,311 |
| Significant permanent injury | $152,659 | $142,341 | $175,000 | $115,000 |
| Major permanent injury | $300,000 | $225,000 | $250,000 | $220,079 |
| Grave | $457,341 | $200,000 | $464,031 | $292,500 |
| Death | $150,000 | $150,000 | $110,000 | $100,000 |
| Total Number of Closed Claims from 1985 to 2010 | 65,603 | 52,159 | 18,115 | 10,473 |

The data on median payments are for actual claims and thus situations when victims of medical malpractice were able to obtain legal representation. These claims likely had higher expected damage awards, therefore, than the majority of cases that the attorneys were unwilling to take. Nevertheless, the data reveal that recoveries for less serious injuries are often small enough that if the attorneys expected the final recovery to equal the median recovery,[113] they

113. The definition of "median" implies that half of the cases in each category result in payments less than or equal to that median recovery.

would often refuse to take the case. Although the specific decision to take a case will depend on both the expected recovery and the expected costs—so that attorneys will take low recovery cases if they expect litigation costs to be low as well—many of the median payments in Table 16 are lower than the median minimum damage thresholds indicated in my survey results.

For example, Table 14 reported that even for a case that had a 95% likelihood of winning on the merits, over 98% of attorneys would refuse to take the case if expected damages were below $50,000. Table 17 shows that if these attorneys expected the final recovery in such a case to be equal to the median recovery reported in the PIAA data, they would refuse to take all of the cases represented by the shaded regions. Thus, attorneys would *never* accept a case with median expected recovery—even with slam dunk odds—if the only injuries were emotional, insignificant, or minor and temporary, regardless of the allegations against the doctor.

**Table 17: Attorney Rejection of Cases if Minimum Damages Threshold Is $50,000**

| Severity of Patient's Injury | Median Indemnity for Improper Performance | Median Indemnity for Errors in Diagnosis | Median Indemnity for Failure to Supervise or Monitor a Case | Median Indemnity for Medication Error |
|---|---|---|---|---|
| Emotional injury only | $20,000 | $16,625 | $36,625 | $20,000 |
| Insignificant injury | $17,500 | $16,278 | $12,500 | $10,000 |
| Minor temporary injury | $30,000 | $25,000 | $25,000 | $12,500 |
| Major temporary injury | $75,000 | $60,000 | $70,000 | $25,000 |
| Minor permanent injury | $85,000 | $100,000 | $100,000 | $60,311 |
| Significant permanent injury | $152,659 | $142,341 | $175,000 | $115,000 |
| Major permanent injury | $300,000 | $225,000 | $250,000 | $220,079 |
| Grave | $457,341 | $200,000 | $464,031 | $292,500 |
| Death | $150,000 | $150,000 | $110,000 | $100,000 |

Moreover, the PIAA data indicate that the injuries depicted in the shaded region of Table 17 make up over 24% of claims for medical negligence. This implies that 98% of attorneys would refuse to accept

almost a quarter of medical malpractice victims' claims unless the expected damages were significantly greater than the typical damages for those injuries.

The situation becomes even more dire when considering the cases that will be rejected by 50% of attorneys, even given a 95% likelihood of success. As reported in Table 14, most attorneys would not accept a slam dunk case (95% likelihood of winning) unless the expected damages are over $250,000. As a result, Table 18 shows that for at least half of the attorneys in my survey,[114] if the final recovery in a case is expected to equal the median recovery, they would refuse to take any case falling within the shaded regions. Thus, even for cases that they are almost certain to win, at least half of the attorneys would never accept a case that resulted in any injury not grave or major and permanent unless they expected damages that were considerably above the median. At least half of the attorneys would refuse to accept a case that resulted in death if they only expected a median recovery.

**Table 18: Attorney Rejection of Cases if Minimum Damages Threshold Is $250,000**

| Severity of Patient's Injury | Median Indemnity for Improper Performance | Median Indemnity for Errors in Diagnosis | Median Indemnity for Failure to Supervise or Monitor | Median Indemnity for Medication Error |
|---|---|---|---|---|
| Emotional injury only | $20,000 | $16,625 | $36,625 | $20,000 |
| Insignificant injury | $17,500 | $16,278 | $12,500 | $10,000 |
| Minor temporary injury | $30,000 | $25,000 | $25,000 | $12,500 |
| Major temporary injury | $75,000 | $60,000 | $70,000 | $25,000 |
| Minor permanent injury | $85,000 | $100,000 | $100,000 | $60,311 |
| Significant permanent injury | $152,659 | $142,341 | $175,000 | $115,000 |
| Major permanent injury | $300,000 | $225,000 | $250,000 | $220,079 |
| Grave | $457,341 | $200,000 | $464,031 | $292,500 |
| Death | $150,000 | $150,000 | $110,000 | $100,000 |

114. At least half of the attorneys indicated that their minimum damages threshold for a case with a 95% likelihood of success was $250,000.

Moreover, the PIAA data indicates that the shaded region in Table 18 represents over 95% of injury claims. Thus, 95% of medical malpractice victims will find it extremely difficult to find legal representation unless their damages are substantially more than the typical damages for their types of injuries.

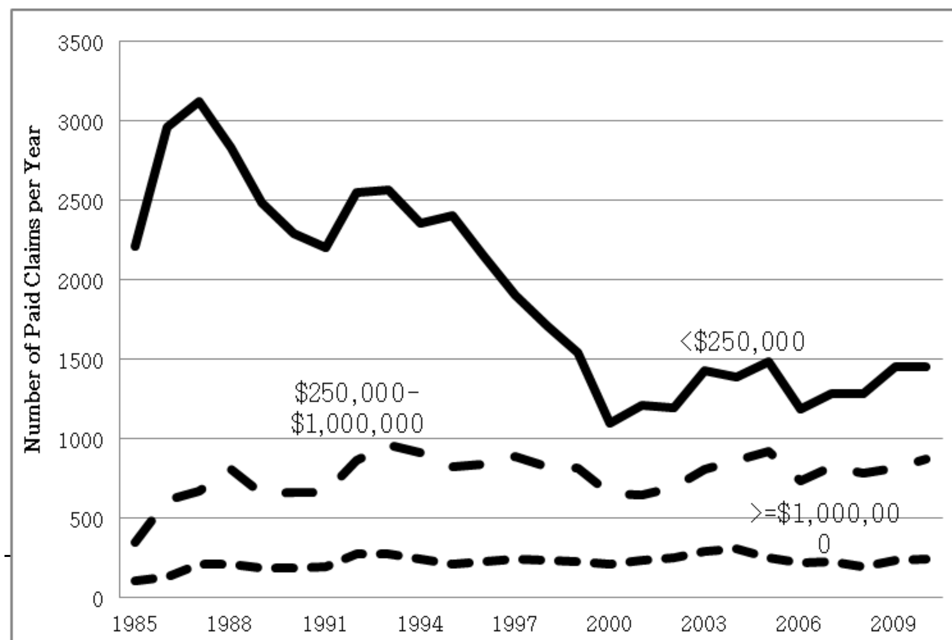
The data on median payments indicate that unless attorneys expect a recovery that is far greater than the median, they will not accept cases for anything but the most serious injuries. This finding is consistent with attorneys' claims that "there's no such thing . . . as a good small medical malpractice case."[115]

*B. The Worsening Access-to-Justice Problem*

Next, I analyze data on closed claims resulting in payments of different dollar amounts from 1985 to 2010. The data suggest that the problem of access to justice is worsening.

Figure 1 reports PIAA data on the dollar values of payments to medical malpractice plaintiffs from 1985 to 2010, in 2010 dollars. The data reveal that, although the number of payments above $250,000 has remained relatively constant over this period, the number of payments below $250,000 has dropped dramatically. In fact, there were fewer than half the number of payments below $250,000 in 2010 as there were at the peak in the late 1980s.

**Figure 1: Trends in Dollar Value of Paid Medical Malpractice Claims from 1985 to 2010 (2010 Dollars)**



These data confirm that plaintiffs with expected damage awards lower than $250,000 are finding it increasingly difficult to obtain legal representation. Indeed, other explanations for the dramatic drop in payments under $250,000 seem improbable. For example, it is unlikely that the number of medical errors causing small injuries with harm under $250,000 decreased over two decades while the number of medical errors causing larger harms remained constant. Similarly, it is improbable that plaintiffs' attorneys have become less successful at winning small cases while remaining consistently successful at winning large cases. Instead, the time-trend data suggest that without legal representation, fewer and fewer victims with small harms are receiving compensation for their harms.

## VI. CONCLUSION

This Article presents survey results that confirm that there are many silent victims in the American medical liability system. High litigation costs make accepting many legitimate cases economically infeasible for contingent fee attorneys. Unless expected damages are large, the attorneys simply cannot justify accepting many cases because the expected fees will not offset the high costs of medical malpractice litigation. Moreover, the economic calculus required by the contingent fee system causes attorneys to gravitate toward some types of medical malpractice cases and victims while ignoring others. Evidence shows that contingent fee attorneys disproportionately reject cases from lower-income groups such as females, the elderly, children, and racial minorities because their expected damage awards are often relatively low.

Victims who cannot attain legal representation are effectively excluded from the civil justice system. Because of the complexity and expense of medical malpractice lawsuits, employing a lawyer is critical to a successful claim. Thus, without legal representation, most of these victims will not be compensated for the harm they suffer as a result of medical negligence. In turn, the medical liability system will fail to provide adequate precautionary incentives for healthcare providers.

Without dramatic change, then, victims' limited access to justice will continue to hinder the medical liability system's ability to achieve its compensatory and deterrent functions. Unfortunately, most legislative reforms over the past several decades have only exacerbated the access-to-justice problem. Damage caps and other tort reforms that artificially reduce plaintiffs' damage awards also reduce

contingent fee attorneys' expected recoveries. As a result, even fewer cases make economic sense for the attorneys to accept.

In order to increase victims' access to the medical liability system, future reforms should aim to either increase attorneys' willingness to accept cases or provide compensation to victims without an attorney. For example, reforms that increase legal-services funding would ensure that attorneys are minimally compensated for their time. Similarly, reforms imposing attorneys' fees awards on negligent defendants would encourage some attorneys to accept cases even if the expected damages and, in turn, the expected contingent fees, are low.[116]

Alternatively, reforms could create a system under which legitimate victims receive compensation even if they do not have legal representation. For example, several scholars have proposed an administrative compensation system under which claims for medical injuries are handled through an administrative body rather than the judicial system.[117] Proposals for such a model indicate that the process would be simple enough that claimants would not need legal representation, as their claims would be resolved by neutral adjudicators and neutral medical experts. America's experience with such a system is limited to the federal Vaccine Injury Compensation Program, which covers certain vaccine-related injuries, and Florida and Virginia's administrative systems, which cover certain birth-related neurological injuries. However, broader administrative systems have successfully operated in other countries—Sweden, Denmark, Finland, Norway, and New Zealand—for decades. Although replacing America's current medical liability system with an administrative system would be a dramatic change, only a significant overhaul of the current system will resolve the access-to-justice crisis.

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116. The Brennan Center has proposed similar reforms to increase access to justice for low-income citizens. *Closing the Justice Gap*, BRENNAN CTR. FOR JUSTICE, http://www.brennancenter.org/content/section/category/civil_justice/ (last visited Sept. 2, 2012).

117. *See, e.g.*, Michelle M. Mello et al., *Administrative Compensation for Medical Injuries: Lessons from Three Foreign Systems*, 14 ISSUES INT'L HEALTH POL'Y 1, 2 (2011) (explaining that in the administrative reform model, medical injury claims are referred through an administrative body or "health court," rather than other courts, which allows claimants to avoid obtaining legal counsel).