

What We Know About Malpractice Settlements

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INTRODUCTION

Critics of malpractice law contend that the civil justice system is an irrational lottery in which a plaintiff's chance of receiving a substantial settlement has nothing to do with the defendant's fault. President George W. Bush stated the charge this way:

Doctors and hospitals realize . . . it's expensive to fight a lawsuit, even if it doesn't have any merit. And because the system is so unpredictable, there is a constant risk of being hit by a massive jury award. So doctors end up paying tens of thousands, or even hundreds of thousands of dollars to settle claims out of court, even when they know they have done nothing wrong.¹

Is this claim correct? Its strongest empirical support comes from the 1996 findings of the Harvard Medical Practice Study ("Harvard Study").² This study concluded that the merits of a malpractice claim have no bearing on the likelihood of a settlement.³ The authors of the study even suggested that the entire adjudicative process is "an expensive sideshow."⁴

The widespread reliance of both tort critics and the media on this single study is unfortunate.⁵ Its findings are decidedly inconsistent with the growing body of empirical data that researchers have accumulated over the past two decades. Taken as a whole, these studies demonstrate that settlement outcomes are driven by the strength of the plaintiff's case.⁶ Weak claims fare worst, toss-ups do better, and strong claims fare best. Although the fit is not perfect, it is surprisingly good.⁷

1. TOM BAKER, THE MEDICAL MALPRACTICE MYTH 12–13 (2005) (quoting President George W. Bush, Speech in Collinsville, Ill. (Jan. 2005)).

2. Troyen A. Brennan et al., *Relation Between Negligent Adverse Events and the Outcomes of Medical-Malpractice Litigation*, 335 NEW ENG. J. MED. 1963, 1963 (1996). See generally HARVARD MED. PRACTICE STUDY, PATIENTS, DOCTORS, AND LAWYERS: MEDICAL INJURY, MALPRACTICE LITIGATION, AND PATIENT COMPENSATION IN NEW YORK (1990).

3. Brennan et al., *supra* note 2, at 1963, 1966–67.

4. *Id.* at 1967.

5. See, e.g., RICHARD A. EPSTEIN, MORTAL PERIL: OUR INALIENABLE RIGHT TO HEALTH CARE? 388 (1997) (stating, based on this study, that "[t]he system seems broken from both ends"); CAROLE R. GRESENZ ET AL., RAND CORPORATION, A FLOOD OF LITIGATION? PREDICTING THE CONSEQUENCES OF CHANGING LEGAL REMEDIES AVAILABLE TO ERISA BENEFICIARIES 5 (1999), available at http://www.rand.org/pubs/issue_papers/2006/IP184.PDF (citing the study for proof that "[s]everity of injury plays a strong role in determining the liability, however, and may even overshadow the effect of the presence or absence of negligence in a significant number of cases"); Common Good, Selected Malpractice Claim Data, <http://cgood.org/healthcare-reading-cgpubs-factsheets-14.html> (last visited Apr. 1, 2007) (citing the study for the proposition that outcomes correlate with injuries, not with quality of care).

6. See *infra* Part I.

7. See *infra* Part I.A, p. 114 tbl.1.

Remarkably, however, scholars and policymakers continue to understate the strength and consistency of the correlation between negligence and settlement outcome.⁸ Some of that misunderstanding probably stems from the unfavorable findings in the Harvard Study. Some is due to the absence of widespread knowledge about the favorable findings of the overall body of settlement research. Only Tom Baker, a prominent professor and scholar in this field, has attempted to collect those findings and to examine their implications.⁹ However, his important summary of the research did not attempt to quantify the cumulative findings of the studies or to identify the patterns revealed by them. Nor did he offer a theory to explain the research findings. This Article takes up those tasks.

When examined in detail, the research data support several important hypotheses, none of which support the suspicions that malpractice settlements are irrational. Weak claims are much less likely to result in a settlement payment than strong claims. Only 10% to 20% of the weak cases result in a payment, and it is typically only a token amount, such as forgiveness of any unpaid doctor bills. Strong cases settle at a much higher rate (85% to 90%) and for a much larger average payment. Borderline cases fall in the middle.

The evidence that defendants avoid payment in the great majority of weak cases and settle the rest for highly discounted amounts means that the settlement rate, standing alone, is a misleading indicator of the problem of "erroneous" payments. In addition, the data indicate that defendants are able to extract similar advantages in their settlement of borderline cases. They make settlement payments in approximately half of these cases and then pay a highly discounted amount in the cases they decide to settle. This amounts to a double discount and results in a payment below the expected value of the claim. Although the data do not permit a similarly confident statement about the resolution of strong malpractice claims, the data hint that they too are settled for less than expected value. The ability of malpractice defendants to settle cases below expected value suggests that defendants have a marked superiority in bargaining power. In turn, that superiority enables them to obtain settlements that are more favorable than are justified by the merits.¹⁰

The superior bargaining power possessed by malpractice defendants probably has several sources. These sources include superior risk tolerance, better access to information, more-experienced attorneys and insurance representatives, easier access to expert witnesses, and the incentive to fight

8. See *supra* note 5 (citing scholars' reactions to the Harvard study).

9. BAKER, *supra* note 1, at 1963; Tom Baker, *Reconsidering the Harvard Medical Practice Study Conclusions About the Validity of Medical Malpractice Claims*, 33 J. L. MED. & ETHICS 501, 502, 509–11 (2005).

10. See *infra* Part II.

low-odds claims vigorously.¹¹ Defendants probably gain additional bargaining power from the fact that malpractice claims are very hard to win at trial, even with strong evidence of negligence.¹² As a result, the data strongly contradict the popular assumption that the settlement process is unfair to defendants.

This Article proceeds as follows. Part I summarizes the findings of the principal studies regarding medical malpractice settlements. Part II synthesizes those findings and explores their implications, paying special attention to the likelihood of double discounting. Part III identifies the likely sources of the defendants' superior bargaining power. The Article concludes by suggesting that the Harvard Study was an outlier, that settlement outcomes are closely tied to the quality of claims, and that the departures from this pattern favor defendants more often than they favor plaintiffs.

I. THE STUDIES

Over the past three decades, more than a dozen studies have examined the relationship between the strength of a plaintiff's malpractice claim and the eventual settlement of her case. The resulting body of data amply justifies a search for patterns and policy implications. This Article undertakes that search.

The studies can be usefully subdivided according to the sensitivity with which they rated the quality of care given to the patient.¹³ Most of the studies divided the claims into three or more categories, e.g., negligent, not negligent, and uncertain. A few studies, however, used only two categories, e.g., negligent or not negligent. This difference proved material. The two-category studies showed a much weaker correlation between negligence and settlement outcome than the three-category studies. As this Article will explain, the weaker correlation is a predictable consequence of the two-

11. *See infra* Part III.

12. *See infra* Part III.C.

13. For this synthesis, the studies could have been organized in several different ways. First, the studies could have been classified according to the method used to determine whether or not the patient's malpractice claim had merit. Some studies have relied on the opinions provided to liability insurers by physicians retained specifically to evaluate the strength of the plaintiff's claim, while one study relied on the ratings provided by the hospital's risk managers. The best studies attempted to minimize bias by asking independent physicians to rate the quality of care given to the claimant. Second, the studies could be distinguished by the completeness of the information made available to the reviewers. Ratings that are given soon after the claim is made, especially those based entirely on the patient's medical records, are more likely to be inconsistent with the eventual resolution of the case than those rendered closer to the time of settlement. Although these different rating methods could be important in some circumstances, the studies using these methods have yielded surprisingly similar findings about the correlation between the medical negligence and settlement outcome. *See infra* p. 120 tbl.1, p. 121 tbl.2, p. 124 fig.4. As a result, I have not chosen to subdivide the studies on these bases.

category design.¹⁴ As a result, the number of categories used by the study is an attribute that must be taken into account when drawing conclusions from the cumulative data. To set the stage for that analysis, the literature review that follows discusses the two sets of studies separately.

A. THREE-CATEGORY STUDIES

In eight of the settlement studies, the researchers used three categories to rate the quality of care given to the patient by the defendant physician. All eight found a direct correlation between the quality of care rendered and the likelihood of a settlement payment. Only three of these eight studies tested the relationship between quality of care and settlement size, and they reached conflicting conclusions. The studies are discussed in the order of their sample size, except when multiple studies were done by the same authors.

1. Taragin et al.

In the largest of the malpractice-settlement studies, Mark Taragin and his colleagues examined 8,231 claims made against doctors insured by a physician-owned New Jersey company between 1977 and 1992.¹⁵ As a part of that company's claims procedure, whenever the claims representative had harbored any doubts about the defensibility of a claim, a review of the claim was performed by a physician chosen from a panel of volunteers from the same medical specialty.¹⁶ The insurance company's expert reviewer discussed the case with the "claims representative, the defense attorney, and the defending physician" before giving his evaluation.¹⁷ In orthopedic and neurosurgery cases, a panel of outside physicians was employed and a majority vote determined the rating of defensibility.¹⁸

After examining the disposition of these claims, the authors found a significant association between negligence and the probability of settlement.¹⁹ The plaintiff received a settlement payment in 91% of the cases

14. See *infra* Part I.B.

15. Mark I. Taragin et al., *The Influence of Standard of Care and Severity of Injury on the Resolution of Medical Malpractice Claims*, 117 ANNALS INTERNAL MED. 780, 780 (1992). About 80% of these claims ultimately resulted in a lawsuit. See *id.* at 783 tbl.2 (showing that a total of 1,654 cases were resolved before suit was filed). Physician care was considered defensible in 62% of the claims, indefensible in 25% of the claims, and unclear in 13% of the claims. *Id.* at 781, 781 tbl.1.

16. See *id.* at 780–81. At the outset, the defendant physician was contacted. *Id.* at 780. The claim was deemed "indefensible" if the physician admitted error. *Id.* If the physician did not admit error, then a claims representative reviewed the claim. *Id.* If the claims representative concluded that the claim was "clearly defensible," then no further review was performed. *Id.* If he concluded otherwise, then external review was performed. *Id.* at 780–81.

17. *Id.* at 781.

18. *Id.*

19. *Id.* (finding a significance level of $P < 0.001$).

where medical care was judged to be negligent, in 59% of the cases where liability was unclear, and in 21% of the cases in which the medical care was defensible.²⁰ The correlation between care quality and settlement size was also positive but was not statistically significant.²¹

The authors concluded, “The defensibility of the case and not the severity of patient injury predominantly influences whether any payment is made. . . . Our findings suggest that unjustified payments are probably uncommon.”²² They reached this conclusion despite the finding that payment had been made in 21% of the “defensible” cases.²³ The authors attributed this discrepancy to their rating process:

First, the determination about physician care was made very early after a claim was generated and may have been inaccurate as more information became available. Second, a physician-based review process may be biased toward assessing physician performance in the physician’s favor. Third, the insurance company may err toward an initial determination of physician care as defensible to avoid unnecessary settlement payments.²⁴

As a consequence, they concluded that unwarranted payments were uncommon.

2. Farber and White (2 Studies)

In their 1991 study, Henry Farber and Michelle White examined the files of 252 lawsuits filed between 1977 and 1989 against a single large hospital.²⁵ In each case, the hospital asked multiple experts to determine whether the professional standard of care had been met by the defendant.²⁶ The experts who provided these evaluations included the supervising physicians, other hospital physicians in the relevant specialty, and independent physicians.²⁷ Care was coded as “good” or “bad” only if all the

20. Taragin et al., *supra* note 15, at 781. In addition, severity of injury had a small, but statistically significant, association with the likelihood of payment. *Id.* (revealing frequency of payment at 39% for low severity, 43% for medium severity, and 47% for high severity).

21. *Id.* at 781 (finding a significance level of $P=0.16$).

22. *Id.* at 780.

23. *Id.* at 780–82.

24. *Id.* at 782. In addition, roughly half of the cases in which the medical care was deemed defensible were reviewed only by a claims representative, while all initial determinations of poor quality were reviewed by other doctors. *Id.* at 781 tbl.1 (showing that 29% of the cases were deemed defensible with “no peer review”). This asymmetry in the evaluation procedure could bias the ratings in favor of defendants.

25. Henry S. Farber & Michelle J. White, *Medical Malpractice: An Empirical Examination of the Litigation Process*, 22 RAND J. ECON. 199, 203 (1991).

26. *Id.* at 204.

27. *Id.*

experts agreed on this assessment.²⁸ Care was rated as “ambiguous” if the reports were ambiguous or divided.²⁹

When Farber and White compared the quality-of-care rating with outcomes of the cases, they found “a strong relationship between care quality and disposition.”³⁰ Settlements were least likely when the care received by the claimant was judged to be “good” (24.2%).³¹ Settlements were more likely when the quality of care provided to the patient was rated as uncertain (68.9%).³² Most likely to settle were the cases of “bad” care—over 89% of these cases ended with a settlement.³³

Care quality also significantly influenced settlement size, though much less than severity of injury.³⁴ The mean settlement was \$14,109 for a case with good care, \$146,160 for ambiguous care, and \$203,209 for bad care.³⁵ The hospital’s payments were between fifteen and twenty-five times higher when care quality was bad versus when it was good, depending on the predictive model used.³⁶ Because their data showed such a strong relationship between care quality and tort outcomes, the authors concluded that “the negligence system provides a substantial incentive for high-quality medical care.”³⁷

In a later study, Farber and White examined a larger sample of files from the same hospital over roughly the same time period and confirmed their earlier findings.³⁸ Fault was significantly associated with the probability of payment.³⁹ It was also significantly associated with settlement amount.⁴⁰

28. *Id.* at 204–05.

29. *Id.*

30. Farber & White, *supra* note 25, at 205 (finding a significance level of $P < 0.0001$). Of the 252 cases, ninety-two were dropped or dismissed (36.5%), 147 cases were settled out of court (58.3%), and thirteen went to a verdict (5.2%). *Id.*

31. *Id.* at 204 tbl.1, 205.

32. *Id.* at 204 tbl.1.

33. *Id.*

34. *Id.* at 206 (stating that 40% of the variance was explained by severity and 8% by fault).

35. Farber & White, *supra* note 25, at 215 tbl.7.

36. *Id.* at 214, 215 tbl.7. The mean log settlement, using good care as the base, was 0.93 (.466) for cases with ambiguous care and 1.54 (.448) in cases with bad care. *Id.* at 206, 207 tbl.3.

37. *Id.* at 214.

38. Henry S. Farber & Michelle J. White, *A Comparison of Formal and Informal Dispute Resolution in Medical Malpractice*, 23 J. LEGAL STUD. 777, 777–79 (1994). Farber and White looked at the files of 355 complaints made to a single large hospital between 1976 and 1989 concerning the hospital or its providers (half of which were resolved without a lawsuit) and the files of 242 additional disputes initiated by the filing of a lawsuit. *Id.* at 786. The researchers had available to them the files of the hospital’s patient-relations office and its legal-affairs office, including the opinions of the experts the hospital asked to assess the quality of medical care. *Id.* at 786–87. When informal complaints were received, the hospital got an evaluation from a supervisor or provider in the same specialty. *Id.* When lawsuits were filed, the hospital also retained outside experts. *Id.* at 787.

39. *Id.* at 798, 799 tbl.8. The coefficient, using good care as the constant, for ambiguous care was 1.69 (.245), and for bad care, the coefficient was 2.75 (.245). *Id.* at 799 tbl.8.

Using a predictive economic model developed by the authors to standardize their findings, the predicted settlement amounts were \$7112 for good-quality care, \$91,008 for ambiguous-quality care, and \$177,320 for bad-quality care.⁴¹

Farber and White found these strong correlations despite their use of a rating process that was probably biased in favor of malpractice defendants because it sometimes relied on co-workers to evaluate the quality of care rendered by the defendant.⁴²

3. Ogburn et al.

Paul Ogburn and his colleagues examined 220 claims of obstetrical negligence filed between 1980 and 1982 against physicians insured by the St. Paul Company.⁴³ However, they looked only at claims which had not been dropped or dismissed prior to incurring at least \$1,000 in defense legal fees.⁴⁴ A team of five obstetricians reviewed the company's closed claim files to determine whether the defendant had negligently inflicted injuries on a neonate (the so-called "bad baby" cases), rating the care as malpractice, not malpractice, or unsure.⁴⁵

Their data showed that the likelihood of receiving a settlement payment was significantly related to the quality of care rendered to the claimant.⁴⁶ Plaintiffs received a settlement payment in 90% of the cases involving negligent medical care and in 55% of the cases involving proper medical care.⁴⁷ The high settlement rate in low-odds cases may have been caused by the authors' decision to exclude from their calculations all claims which had

40. *Id.* at 799. The coefficient estimate of the log real settlement amount, using good care as the constant, was .579 (.273) for ambiguous care and 1.34 (.247) for bad care. *Id.* at 801 tbl.10.

41. Farber & White, *supra* note 25, at 215 tbl.7. In cases with similar severity, settlements with bad care were nearly four times larger than settlements in cases with good care. Farber & White, *supra* note 38, at 799. Likewise, settlements in cases with ambiguous care were nearly twice as large as settlements in cases with good care. *Id.* at 800 (showing that settlements in ambiguous-care cases were almost 80% larger than good-care cases). In a separate paper, White reexamined this data and found that, among settled cases, the average recovery in a case rated as negligent was five times higher than one in which the care was rated as good. Michelle J. White, *The Value of Liability in Medical Malpractice*, HEALTH AFF., Fall 1994, at 75, 80 exhibit 2 (finding the difference to be \$205,000 in ambiguous-care cases as compared to \$41,800 in good-care cases).

42. This could cause poor-care cases to be misclassified as having good care; then settlement of these cases would show up as the settlement of a case involving good care.

43. Paul L. Ogburn, Jr. et al., *Perinatal Medical Negligence Closed Claims from the St. Paul Company, 1980-1982*, 33 J. REPROD. MED. 608, 609-10 (1988). The medical care was rated as "malpractice," "not malpractice," "or unsure." *Id.* at 610 fig.1.

44. *Id.* at 608.

45. *Id.* at 609. The cases were reviewed a second time by a physician on the research team "to confirm prior judgments about medical negligence." *Id.*

46. *Id.* (finding a significance level of $P < 0.001$).

47. *Id.* at 609-10.

been dropped or dismissed without payment prior to expending \$1,000 in defense legal fees. The authors acknowledged this and warned that their results “cannot be extrapolated to all closed claims.”⁴⁸ For this reason, their findings are not included in the bar graphs set out in this Article.

4. Sloan and Hsieh

Frank Sloan and Chee Ruey Hsieh examined all of the 6,612 medical malpractice claims against Florida obstetrician-gynecologists, general surgeons, and orthopedic surgeons closed between October 1985 and March 1988.⁴⁹ The authors hired physicians to rate these cases for likely liability and found that the ratings were highly correlated with settlement outcomes.⁵⁰ Those cases in which liability was considered probable were most likely to result in payment, followed by cases in which liability was unclear, and then cases with unconvincing evidence of liability.⁵¹ Unfortunately, however, the reviewers based their ratings entirely on a summary of the claim submitted to the Department of Insurance by the liability insurer.⁵² The reliability of this study, thus, turns largely on the fairness and accuracy of these summaries.⁵³

5. Sloan et al.

Sloan and his colleagues then undertook a deeper examination of two different subsets of Florida malpractice claims.⁵⁴ The first were claims

48. Ogburn et al., *supra* note 43, at 609. The researchers also stated that “[t]he majority of cases judged to be medical negligence were not difficult to evaluate because they included gross physician neglect and/or mismanagement.” *Id.* at 610. This introduces the possibility that the physician reviewers were using an unduly demanding threshold for a determination of negligence. However, the reviewers had access to the insurance file that contained the most complete picture of case quality that is realistically available.

49. Frank A. Sloan & Chee R. Hsieh, *Variability in Medical Malpractice Payments: Is The Compensation Fair?*, 24 LAW & SOC’Y REV. 997, 1003–04 (1990). Florida requires insurance companies to report all closed claims to the Florida Department of Insurance, and the reports are publicly available. *Id.* at 1003.

50. *Id.* at 1010, 1014–17, 1018 tbl.3 (showing a regression coefficient of 0.69, with a significance level of $P=0.01$, in a two-tailed t-test).

51. *Id.* at 1014. These findings led the authors to conclude that “there is a relationship between the probability of payment and the degree of liability.” *Id.*

52. *Id.* at 1003.

53. In addition, Sloan & Hsieh aggregated all claims made against separate doctors arising out of a single incident into a single case and used the information from the defendant, if any, who paid the highest indemnity. *Id.* at 1003. This methodology is likely to understate the number of unfounded claims and to overstate the average settlement paid.

54. FRANK A. SLOAN ET AL., *SUING FOR MEDICAL MALPRACTICE 17–20* (1993). The study included some claims which never resulted in a lawsuit. *Id.* at 25 tbl.2.2. The authors rated a claim “liable” only if a majority of the four reviewers concluded that at least one of the defendants had caused the claimant’s injuries through negligent treatment. *Id.* at 99–100. They rated a claim as “not liable” if a majority felt that none of the defendants had negligently caused the injuries. *Id.* The authors deemed all other cases “uncertain.” *Id.* at 100, 107. The uncertain

alleging permanent injuries sustained at birth, and the second were claims alleging permanent injuries to adults occurring in hospital emergency departments.⁵⁵ Expert reviewers selected by the authors rated the 187 files as “liable,” “not liable,” and “uncertain.”⁵⁶ A team composed of a neonatologist, an obstetrician-gynecologist, a general pediatrician, and a family practitioner who performed obstetrical care rated the birth-injury claims.⁵⁷ A panel of four specialists in emergency medicine evaluated the emergency-department claims.⁵⁸ These ratings were significantly associated with the likelihood of a settlement,⁵⁹ a finding which led the authors to conclude that their results were inconsistent with the view that the tort system is a “lottery.”⁶⁰

6. Spurr and Howze

In this 2001 study, Stephen Spurr and Sandra Howze looked at 165 closed claims from a single hospital in Michigan.⁶¹ To measure the quality of care rendered in these cases, the researchers used the written evaluations of

cases involved either a disagreement among the reviewers or an inability to give a rating due to the limited availability or quality of the medical records. *Id.* at 107–08. Each reviewer read and scored the claims individually. *Id.* at 98. The physicians evaluated them in three rounds. *Id.* at 98–99. The first round used only the information submitted to the state on the Florida closed claim form. *Id.* The form included the date of occurrence, age and gender of the patient, description of alleged actions that caused the claim to be filed, the nature of the procedures performed, and the principal injury giving rise to the claim. *Id.* In round two, reviewers were also sent information from interviews with the claimants, along with selected medical information taken from the medical records. *Id.* at 99. They were then asked whether they wished to change their ratings. *Id.* In round three, when the hospital charts could be supplied by the hospital (roughly one-third of the cases), the reviewers received abstracts of the hospital charts prepared by the research team. *Id.*

55. *Id.* at 6–8 (indicating the second set was limited to adults between the ages of twenty-five and fifty-four).

56. *Id.* at 98.

57. *Id.*

58. *Id.*

59. SLOAN ET AL., *supra* note 54, at 200, 206. The plaintiffs eventually dropped most of the no-liability cases. *Id.* In the cases that received a settlement payment, regardless of rating, compensation was less than economic losses in nearly 80% of the cases. *Id.* at 196–97, 197 tbl.9.4. Only one factor suggests any bias in the findings. Surprisingly, in eight of the twenty-eight cases given a “no liability” rating, the family had been told by a physician or nurse that the patient’s injuries were caused by negligent medical care. *Id.* at 105. In one case, the defendant physician had encouraged the family to file a claim against him, stating that “in cases like this, we have insurance to cover it.” *Id.* at 105, 107, 107 box 6.7. The classification of these claims as defensible may suggest reviewer bias.

60. *Id.* at 206.

61. Stephen J. Spurr & Sandra Howze, *The Effect of Care Quality on Medical Malpractice Litigation*, 41 Q. REV. ECON. & FIN. 491, 495 (2001). These claims represented all of the medical negligence claims brought against the hospital, its staff, and affiliated physicians that were closed between 1987 and 1995. *Id.* at 495. Of the 165 closed claim files, 91 were settled, 65 were abandoned, and 9 were tried to a verdict. *Id.*

the hospital risk managers.⁶² The risk managers often had relied on the opinions of physicians whom they had asked to evaluate the quality of care in each case.⁶³ The researchers found that the hospital's internal assessment of care quality was correlated strongly with the likelihood of a settlement payment.⁶⁴ Care quality also correlated with the amount of the settlement.⁶⁵ As in the Farber and White studies, Spurr and Howze found a strong correlation between claim quality and disposition despite the use of a rating process that was probably biased in favor of the defendants. In this study, the hospital risk managers easily could have been biased in favor of the physicians with whom they worked.⁶⁶

7. Peeples, Harris, and Metzloff

In this 2002 study, Ralph Peeples and his colleagues examined eighty-one malpractice claims filed in North Carolina between 1991 and 1995,⁶⁷ intensively reviewing both the insurer's claims files and the associated court files.⁶⁸ To determine whether the plaintiff had been given negligent medical care, the researchers relied on written reports obtained by the insurance company from independent medical experts practicing in the same specialty as the defendant.⁶⁹ The researchers found that the medical experts'

62. This information was used to construct a continuous scale from zero (beyond reproach) to one (conclusive evidence of negligence). *Id.* at 496. The mean of the fault variable in the settled cases was 0.54, which was "significantly greater" than the "dropped cases," which had a mean at 0.11 ($P=1.72 \times 10^{-10}$). *Id.* at 505.

63. *Id.* at 496. The researchers' translations were based on the risk managers' assessments of the quality of care, not the claims' likelihoods of success at trial. *Id.*

64. *Id.* at 497-99, 499 tbl.2. The likelihood of settlement was not related to the severity of the patient's injuries. *Id.* at 499.

65. Settlements were more closely correlated with quality of care than were mediation awards. *Id.* at 505-06, 506 tbl.5 (showing a log settlement payment coefficient of 2.63 with a standard error of 0.57 and significance at the 5% level, and a log mediation award coefficient of 2.07 with a standard error of 0.79 and significance at the 5% level ($P=.05$)).

66. In addition, the risk managers presumably understood that their in-house evaluation of care quality could reach the ears of the affected doctors, thus potentially souring economically crucial hospital-physician relationships.

67. Ralph Peeples, Catherine T. Harris & Thomas Metzloff, *The Process of Managing Medical Malpractice Cases: The Role of Standard of Care*, 37 WAKE FOREST L. REV. 877, 877 (2002). The files were obtained from a major teaching hospital and a major North Carolina malpractice liability insurer. *Id.* at 881. The researchers looked only at lawsuits that had progressed to the entry of a court order directing mediation. *Id.* Thus, cases that were dropped, dismissed, or settled immediately after the answer were not included.

68. *Id.* at 881-82. The insurance files included expert- and physician-review summaries as well as witness-deposition summaries. *Id.* at 882. Because the contents of these files are so much richer than the bare medical record, insurer files are considered the "gold standard" for conducting medical malpractice research. *Id.*

69. *Id.* at 884. The reviewers were also usually from the same state. *Id.*

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opinions were directly correlated with the insurers' assessment of liability.⁷⁰ Among the cases that were closed prior to trial, payment was made in 86.2% of cases where liability was rated as probable, 36.8% of the cases where liability was deemed to be uncertain, and 11.1% of the cases rated as defensible.⁷¹

Here, too, the study found correlations despite the use of methods that could have skewed the ratings in favor of defendants. In the claims examined in this study, the liability insurer had taken extra precautions to guarantee that it did not erroneously rate the care of its customers as probably negligent; the insurer was more likely to seek additional reviewers if the initial review suggested breach of duty than if that first review exonerated the sued physician.⁷² Thus, the insurer designed its methodology to cure erroneous attributions of negligence but not to cure erroneous exonerations. This methodology created the risk that the study would misclassify meritorious cases as lacking merit, thereby overstating the frequency with which payment had been made in cases with good medical care.

70. *See id.* (showing that in 80% of the cases that the insurers assessed as "probably liable," the medical experts also found liability likely, and that in 65.4% of the cases that the insurers assessed as "unlikely liable," the medical experts also found liability unlikely).

71. *Id.* at 899 tbl.6. When cases that went to trial are added to the total, payment was made in 93.1% of the cases where liability was rated as probable, 36.8% of the cases where liability was deemed to be uncertain, and 14.8% of the cases rated as defensible. *Id.* at 886 n.35, 888–89.

72. Peeples et al., *supra* note 67, at 884 (finding an average of 3.07 reviews if the insurer found no breach, 3.27 reviews if the insurer was uncertain, and 4.43 reviews if the insurer found a breach). Peeples and his colleagues concluded that insurers "proceed more carefully in those cases in which liability appears likely." *Id.*

Table 1. Settlement Percentages in Three-Category Studies

<u>Study</u>	<u>Sample Size</u>	<u>Statistical Significance</u>	<u>Good Care</u>	<u>Uncertain Care</u>	<u>Poor Care</u>	<u>Methodological Limitations</u>
Taragin et al.	8231	0.001	21%	59%	91%	Used reviews done for insurer
Farber & White 1991	252	0.001	24%	69%	89%	Used reviews done for hospital
Ogburn et al.	220	0.001	55%	Not stated	90%	Excluded early abandonments
Peeples et al.	81	Not tested	11%	37%	86%	Used reviews done for insurers
Farber & White 1994	355	—	Constant	Coeff. 1.69 (std. error 0.245)	Coeff. 2.75 (std. error 0.245)	Used reviews done for hospital
Sloan & Hsieh	6612	—	Constant	0.11 (.26) (not sig)	0.69 (.25) (P=.01)	Reviewers relied on claims summaries
Spurr & Howze	165	—	Coefficient 2.29			Hospital's ratings
Sloan et al.	187	Yes				—

B. TWO-CATEGORY STUDIES

Three other empirical studies used a less-finely grained metric for measuring claims' quality. The authors of these studies rated the medical care provided by the defendant simply as negligent or not negligent. A fourth and very recent study used both a two-category and a multi-category format to report its data. Three of the four studies found a significant correlation between the quality of care given to the claimant and the likelihood of payment—only the Harvard Study did not. Three of the studies also looked at the size of settlement payments, and each one found that payment size went up with the strength of the plaintiff's evidence. Interestingly, the Harvard Study was one of those studies.

1. Cheney et al.

In this 1989 study, Frederick Cheney and his colleagues sought to determine the impact of the standard of care, as judged by claims filed against practicing anesthesiologists, on the likelihood and amount of tort

recovery.⁷³ They examined 1,004 closed claims files collected from seventeen insurance organizations throughout the United States.⁷⁴ Payment occurred in 82% of the cases involving care judged to be substandard⁷⁵ and in 42% of the cases involving care judged as appropriate.⁷⁶ In addition, settlement size was significantly related to fault.⁷⁷

Because this study was sponsored by the American Society of Anesthesiologists and administered by its Committee on Professional Liability, it is possible that the anesthesiologists chosen to do the case reviews were more sympathetic to defendants than the “independent” physicians employed in some of the other studies.⁷⁸ However, the design of this study was superior to most other studies in that the reviewers had access to the entire lawsuit file.

2. Rosenblatt and Hurst

In this small study, Roger Rosenblatt and Andy Hurst examined thirty-three obstetrical malpractice lawsuits closed by a single physician-sponsored insurer between 1982 and 1988.⁷⁹ They rated the quality of care given to each claimant after reviewing the entire claim file, including depositions taken of the medical experts for both sides.⁸⁰

They found that none of the claims against doctors who had provided appropriate care resulted in a settlement payment, while 95% of the plaintiffs whose claims arose out of negligent care did receive a payment.⁸¹ In every case in which the defendant had paid a settlement, “there was general consensus among insurance company staff, medical experts, . . . and the physician defendants that some lapse in the standard of care contributed

73. Frederick W. Cheney et al., *Standard of Care and Anesthesia Liability*, 261 JAMA: J. AM. MED. ASS'N, 1599, 1599 (1989). The goal of the study was to define the impact of the “standard of care” on the likelihood and amount of financial recovery. *Id.* The reviewer instructions defined appropriate care as “that which met the standard of care for a prudent anesthesiologist practicing anywhere in the US at the time of the event.” *Id.*

74. *Id.* at 1599–600. In each instance, a single volunteer anesthesiologist reviewed the lawsuit file and determined whether the care was appropriate or inappropriate. *Id.* For the 869 cases in which the appropriateness of care could be judged, the reviewer scored care as appropriate in 46% of cases and inappropriate or below standard in 54% of cases. *Id.* at 1601.

75. *Id.* Ten percent received no payment and payment data was missing for 8%. *Id.*

76. *Id.* at 1601 (finding a significance level of $P < 0.01$). Severity of injury did not influence the likelihood of payment. *Id.*

77. *Id.* (finding a significance level of $P < 0.05$).

78. Cheney et al., *supra* note 73, at 1599.

79. Roger A. Rosenblatt & Andy Hurst, *An Analysis of Closed Obstetric Malpractice Claims*, 74 OBSTETRICS & GYNECOLOGY 710, 710 (1989). The insurer covered the majority of the state’s physicians. *Id.* It is also worth noting that one of the researchers—Rosenblatt—is a physician. *Id.*

80. *Id.* at 711.

81. *See id.* at 712 tbl.3 (showing that the 95% figure was calculated from data indicating that nineteen of thirty-three cases involved negligence and eighteen payments were made).

to the observed outcome.”⁸² The authors wrote that their findings should “help to reassure physicians who are concerned that the tort process itself is unjust.”⁸³

Although these findings must be treated cautiously because the sample of cases was small and tests for statistical significance apparently were not done, the study’s credibility is enhanced by the access that its reviewers had to the full insurance file, including the depositions of the competing experts.

3. The Harvard Study (Brennan et al.)

Critics of the medical malpractice system commonly point to the findings of the Harvard Medical Practice Study in New York hospitals to support their complaints about settlement fairness.⁸⁴ This large study examined a sample of over 31,000 patient charts taken from fifty-one New York state hospitals during 1984.⁸⁵ The study’s principal objective was to learn about the nature and extent of patient injuries caused by medical care. A small offshoot of the study by Troyen Brennan and his colleagues looked at the fifty-one medical malpractice claims generated by these 31,000 hospitalizations, forty-six of which had been resolved by 1995.⁸⁶ They found that cases involving medical negligence were more likely to result in a settlement payment than those cases lacking evidence of negligence, but the difference was not statistically significant.⁸⁷ While five of the nine claims for injuries caused by negligence resulted in payment, so did ten of the twenty-four claims deemed to lack causation and six of the thirteen cases deemed to lack negligence.⁸⁸ They concluded that “the determination of negligence may be an expensive sideshow.”⁸⁹ Not surprisingly, their findings and phraseology have become a standard part of most stump speeches advocating malpractice reform.⁹⁰

In a major critique, Tom Baker has argued that this reliance on the Harvard Study is misplaced.⁹¹ His most telling criticism deserves mention here. He points out that the Harvard data show a strong association between

82. *Id.* at 712.

83. *Id.* at 713.

84. *See supra* note 5.

85. Brennan et al., *supra* note 2, at 1963–64; A. Russell Localio et al., *Relation Between Malpractice Claims and Adverse Events Due to Negligence*, 325 NEW ENG. J. MED. 245, 245 (1991).

86. Brennan et al., *supra* note 2, at 1964. The hospital charts for these patients had been reviewed as part of the larger study by nurses and then by physicians retained by the researchers. *Id.* at 1967

87. *Id.*

88. *Id.* The presence of a permanent disability was predictive of payment, however. *Id.*

89. *Id.* at 1967.

90. *See supra* notes 1, 5.

91. Baker, *supra* note 9, at 501–02.

the amount *paid* and the strength of the case on liability, even though they do not show a correlation between claim quality and settlement *rates*.⁹² Claims for injuries caused by negligence received a mean settlement of \$162,750, those with causation but not negligence received \$31,375, and those lacking causation received \$23,552.⁹³ As will be explained further in this Article,⁹⁴ discounting settlement size to reflect weaknesses in the plaintiff's case achieves just outcomes that are not revealed in the bare settlement rate.

The study also suffers from an important shortcoming in its design. Whenever the two expert reviewers assigned to each file were evenly split on the propriety of the physician's conduct, the case was classified as a no-liability case.⁹⁵ Because the divided-opinion cases constituted one-third of the sample, the decision to classify them as unfounded cases rather than to create a separate, intermediate category for these toss-up cases was highly significant. It guaranteed a finding that settlement payments are commonly made in ostensibly "unfounded" cases. As Michael Saks notes, this classification system profoundly biased the study toward a finding of systematic error in the civil justice system.⁹⁶

92. *Id.* at 507–08. Baker also points out that the association that the researchers found between payment and injury severity "means something other than it first seems." *Id.* at 508. This is because the study only assigned disability scores to those injuries that the reviewers felt had been caused by the patient's medical care. *Id.* Thus, the study's regression analysis showed not, as is commonly believed, that every badly disabled patient is likely to get a settlement, but that a patient who is seriously disabled by her medical care is more likely to receive a payment than a patient whose care causes only temporary injuries or none at all. In other words, patients who can prove causation are more likely to get a settlement if their injuries are serious than if they are minor. Thus construed, the finding accords with both common sense and the economic realities of malpractice litigation. Larger claims are more likely to be worth the costs of preparing for trial and will have higher expected values than smaller claims with similar evidence of negligence.

93. See Brennan et al., *supra* note 2, at 1966. These are the numbers obtained after the ratings were revised to reflect information that had surfaced subsequent to the rating process that occurred ten years earlier. *Id.* Almost half of the settled cases which had initially been deemed undeserving by the Harvard team's methodology (a methodology which was intentionally designed to understate the frequency of credible claims) received less than \$25,000. *Id.* at 1965. Most of these patients were simply given a write-off of the remaining fees due to the defendants for the contested medical care. *Id.*

94. See *infra* Part II.C.

95. Localio et al., *supra* note 85, at 249. The category of defensible cases were said to lack "positive" evidence of negligence. *Id.* at 250. Disagreements between the two physician reviewers on this issue were resolved by averaging the two scores and treating as negligent only those claims in which the average rating was at least "more likely than not." *Id.* at 246. Thus, any file in which the two reviewers were evenly split was classified as not caused by negligence. The authors conceded that their rating process was not like the resolution of a claim at trial. *Id.* at 249. ("In a lawsuit, a single expert opinion might be sufficient to support a finding of negligence; under our protocol it would not."). But they never explored how their calculations would have changed if the divided-opinion cases were treated as a separate category of claims.

96. See Michael J. Saks, *Medical Malpractice: Facing Real Problems and Finding Real Solutions*, 35 WM. & MARY L. REV. 693 (1994) (reviewing a 1993 book by the Harvard team). Of the twenty-

Finally, this study, like many of the others, was based on a small sample. As a result, its disparate findings may be due, at least in part, to its inadequate sample size. Furthermore, because it was only a small part of a larger study with different objectives, it was not fully designed or powered to test any hypotheses between claim merits and outcomes. The next study, however, was so designed, and it, too, was from the Harvard School of Public Health.

4. Studdert et al.

The most recent study to collect data on the fairness of malpractice settlements—and probably the best—was published by David Studdert and his colleagues in 2006.⁹⁷ This study could have been placed in either the two-category or multi-category groups, as it used both formats to present its data.

The study analyzed 1,452 claims files randomly selected from the archives of five major malpractice insurers.⁹⁸ The study focused on four types of clinical mishaps—obstetrical, surgical, misdiagnosis, and medication.⁹⁹ The researchers retained independent physicians to do the evaluations.¹⁰⁰ Physicians in the specialties of obstetrics, surgery, and internal medicine were hired and trained to review the claim files.¹⁰¹ A single reviewer read each file in its entirety and determined whether the claimant's injuries had been caused by medical error.¹⁰² Because the study used independent reviewers and gave them access to the entire closed claims file,¹⁰³ its findings are especially trustworthy. The researchers limited their analysis to the 1,404

one claims that were reviewed for the presence or absence of negligence, eight were considered by all reviewers to involve breach of duty and seven were considered by one reviewer to involve negligence. Localio, *supra* note 85, at 248 tbl.3. Only six claims were considered by both reviewers to lack evidence of breach of duty. *Id.* Thus, over two-thirds of the claims reviewed for breach of duty were determined by at least one of the two reviewers to involve negligent medical care.

97. David M. Studdert et al., *Claims, Errors, and Compensation Payments in Medical Malpractice Litigation*, 354 NEW ENG. J. MED. 2024, 2029 (2006) (finding that 40% of all malpractice claims are not meritorious and that most are resolved without any payment of money).

98. *Id.* Only 1,441 claims files were evaluated for merit. *Id.* at 2028.

99. *Id.* at 2025.

100. *Id.*

101. *Id.*

102. Studdert et al., *supra* note 97, at 2025. “Reviewers recorded their judgments using a 6-point confidence scale.” *Id.* at 2026. The study classified the medical care as erroneous if the claim had received a score of four or above. *Id.* Only a single reviewer rated each file (though a small number of files were distributed twice, without the reviewers’ knowledge); therefore, this study design cannot detect cases in which multiple reviewers would have reached divergent opinions. *Id.* at 2025. Cases that received a three or a four, both of which were described to reviewers as “[c]lose call” cases, were not sorted into a middle category of “unclear” cases. *Id.* at 2028. Errors were defined as “the failure of a planned action to be completed as intended (i.e., error of execution) or the use of a wrong plan to achieve an aim (i.e., error of planning).” *Id.* at 2026 (internal citations omitted).

103. *Id.* at 2025–26.

claims in which they could identify a physical or emotional injury¹⁰⁴ and reported their findings in both two-tier and multi-tier formats.

Using the two-category format, they calculated a settlement rate of 77% for the claims involving medical error and 34% for non-error claims.¹⁰⁵ When the claims were bifurcated in this way, the mean amount paid to non-error claimants was significantly lower than the amount paid to claimants with meritorious claims.¹⁰⁶

Researchers also divided the claims into six categories based on the strength of the plaintiff's case and calculated the odds of a settlement in each set of claims. To do this, they used a one-to-six scale to measure the reviewer's level of confidence in a determination of fault, ranging from "[l]ittle or no evidence" to "[v]irtually certain evidence."¹⁰⁷ The authors found that "[t]he probability of payment increased monotonically" following either a voluntary settlement or a plaintiff's verdict as the evidence of negligence became more persuasive.¹⁰⁸ Payments were made in 19% of the claims with "[l]ittle or no evidence" of error, 32% of the claims with "[s]light-to-modest evidence," 52% of the claims deemed "[c]lose calls but <50-50," 61% of the claims rated as a "[c]lose call, but >50-50," 72% of the claims with "[m]oderate-to-strong evidence," and 84% of the claims with "[v]irtually certain evidence."¹⁰⁹ Figure 1 depicts these findings graphically.

104. *Id.* at 2026, 2029 fig.2. For our purposes, it would have been ideal if the study had reported the settlement rate for all of the claims that did not go to a jury verdict. However, the authors excluded thirty-seven claims for which they could find no evidence of injury and nine with only dignitary injury, as well as two for which no rating of care quality was done. *Id.*

105. *Id.* at 2028 (P<0.001).

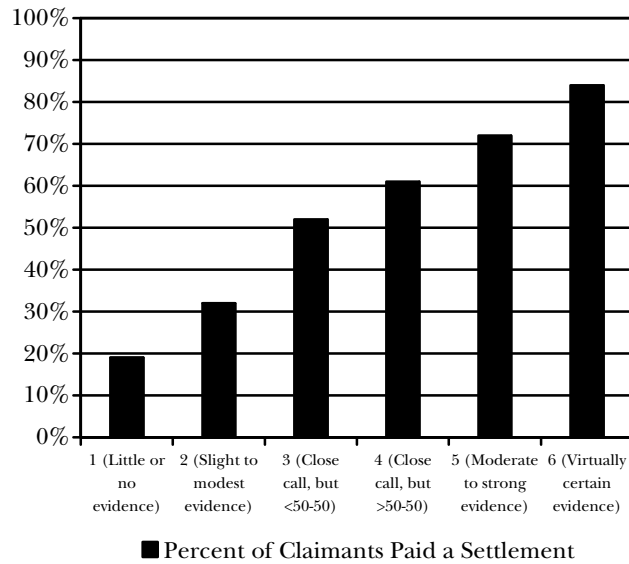
106. *Id.* (noting \$313,205 as the mean amount paid to non-error claimants versus \$521,560 as the mean amount awarded to meritorious claimants, P=0.004).

107. Studdert et al., *supra* note 97, at 2029 fig.2.

108. *Id.* at 2028. Only 6% of the cases in which payment was made involved plaintiff's verdicts. *Id.* at 2030 tbl.2.

109. *Id.* at 2029 fig.2 (noting that these numbers exclude claims with only dignitary injuries (nine), those with no injuries (thirty-seven), and those without judgments as to error (two)).

Figure 1. *Studdert et al.* Settlement Rate by Confidence in Determination of Error



As a result, the authors concluded that “the malpractice system performs reasonably well in its function of separating claims without merit from those with merit and compensating the latter.”¹¹⁰

110. *Id.* at 2031.

WHAT WE KNOW ABOUT MALPRACTICE SETTLEMENTS

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Table 2. Settlement Percentages in Two-Category Studies

Study	Sample Size	Statistical Significance	Good Care			Poor Care			Methodological Limitations
Cheney et al.	1004	0.01	42%			82%			None
Harvard Study	46	No	43%			56%			All close cases treated as good care
Rosenblatt & Hurst	33	Not tested	0%			95%			None
Studdert et al.	1354 ¹¹¹	0.001	34%			77%			None
Studdert et al. (6 fault levels)	1404 ¹¹²	Not stated	19%	32%	52%	61%	72%	84%	None

II. IMPLICATIONS OF THE DATA

With the notable exception of the 1991 Harvard Study,¹¹³ every study of malpractice settlements has found a relationship between settlement rate and case quality. The relationship is especially easy to see in the studies that have divided the cases into three categories¹¹⁴ rather than two,¹¹⁵ but both sets of studies confirm the relationship. The relationship is not perfectly consistent, however: some low-odds cases recover a settlement and some cases with strong evidence of negligence do not.

The studies also indicate that the plaintiffs who receive a settlement are unlikely to recover the full amount of their damages.¹¹⁶ Instead, the size of the payment they receive is discounted to reflect the strength or weakness of their claim.¹¹⁷ Because this discount supplements the discount in settlement rates, rather than substituting for it, the data strongly suggest that malpractice claims as a group are discounted in two separate ways—once in the insurer's decision whether to make any settlement offer at all and again in the size of the offer to make. The ability of defendants to extract this

111. This number excludes the thirty-seven claims that lacked evidence of causation.

112. This number includes fifty cases that went to a jury verdict, thirty-nine of which were won by defendants.

113. See *supra* Part I.B.3.

114. See *supra* Part I.A.

115. See *supra* Part I.B.

116. See *infra* p. 123 tbl.3, p. 131 fig.6.

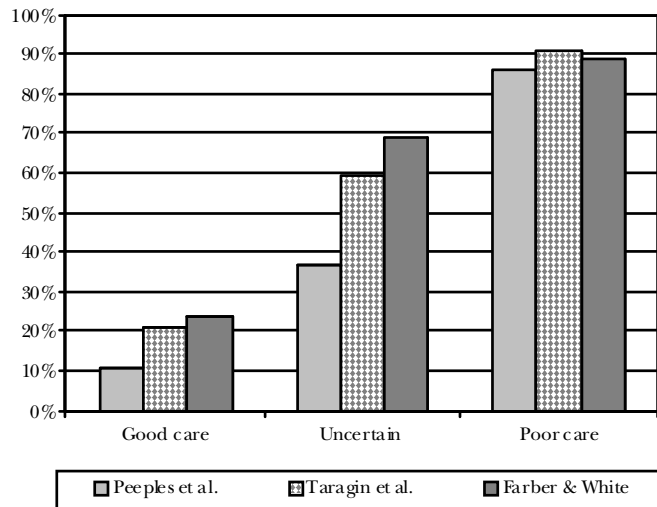
117. See *infra* p. 123 tbl.3, p. 131 fig.6.

double discount suggests that they have substantially stronger bargaining power than the average claimant.

A. SETTLEMENT RATES

The relationship between case quality and settlement rate is most evident when it is displayed graphically. Figure 2 displays the findings of the studies that used three categories to rate the quality of care provided to the plaintiff, e.g., liable, unclear, and not liable.¹¹⁸ Next, Figure 3 depicts the findings in the studies that used two categories of care quality.¹¹⁹

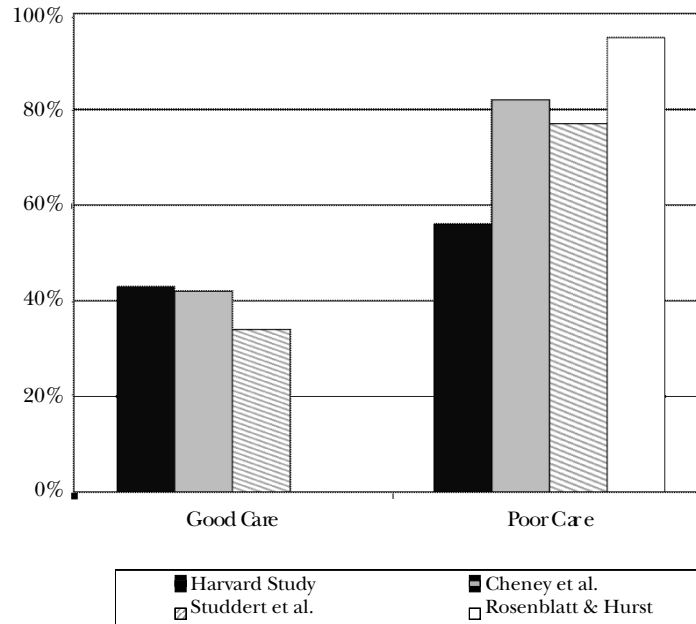
Figure 2. Settlement Rates in Three-Category Studies



118. Although all of the three-category studies found this association, only three reported their data in form suitable for depiction in this format.

119. In the Rosenblatt and Hurst study, none of the fourteen cases without medical negligence settled. Rosenblatt & Hurst, *supra* note 79, at 712 tbl.3. Thus, no bar appears under "Good Care" in Figure 3, *infra* p. 123 and Figure 4, *infra* p. 124.

Figure 3. Settlement Rates in Two-Category Studies



Both graphs show a direct correlation between case quality and settlement rate. The relationship is less dramatic, however, in the chart for the two-category studies because these studies lack a category in which to place the cases with merits that are unclear. This design forces the reviewers to place all of the cases in which liability is unclear into one of the two remaining categories. Consequently, the “good care” category in the two-tier studies contains a larger percentage of cases with a plausible argument for liability than the “good care” classification in three-category studies. In other words, the “good care” category includes more cases with legitimate settlement value in the two-tier studies than it does in the three-tier studies. Thus, more “good care” cases end up with settlements. The two-category design also forces the reviewers to place some of the “unclear” cases into the group of cases rated as “poor care” cases. This increases the odds that cases in that category will end up being dropped without a settlement payment. Because this design pushes the settlement rate in “good care” cases up and the rate in “poor care” cases down, these studies would not be expected to show as dramatic a correlation between care quality and settlement outcome as the three-category studies.

Figures 2 and 3 confirm these predictions. The two-category studies of malpractice settlements tend to find higher settlement rates in weak cases (about 40%) than are found in the three-category studies (about 20%). The two-category studies also have lower settlement rates in the strong cases than are found in the three-category studies, although the difference at this end

of the scale is less dramatic (56% to 95% for two-category studies versus 86% to 91% for three-category studies). The predicted relationship is further illustrated by Figure 4, which places the two sets of findings on a single graph.

Figure 4. Overall Association of Quality of Care with Probability of Payment

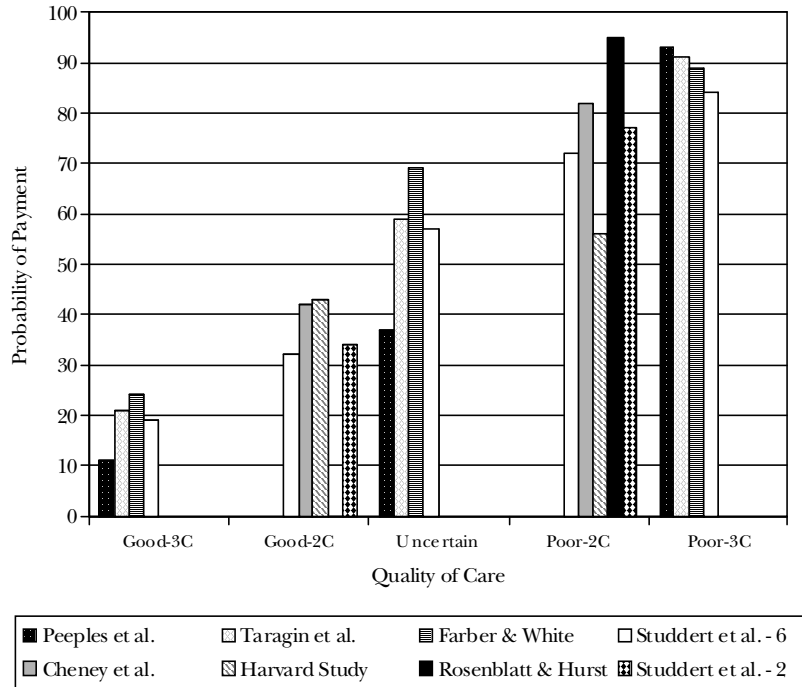
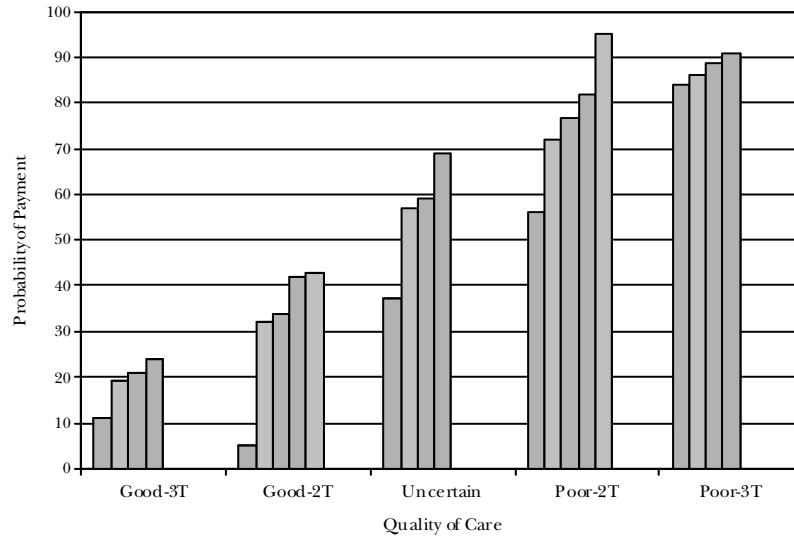


Figure 4A. Regrouped with Even Spacing and Ascending Order



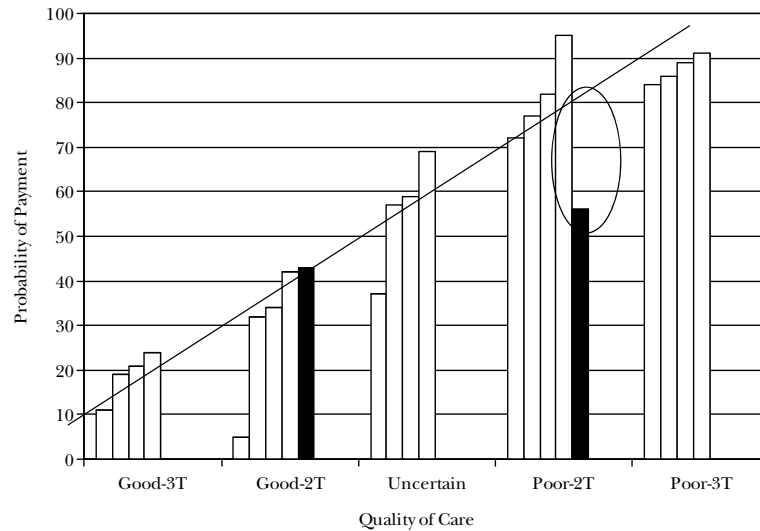
When the findings are consolidated in this manner, the correlation between settlement rate and negligence seems indisputable. It holds up with startling predictability across a variety of populations and study designs. Furthermore, the five-category analysis in Figure 4 reveals a strong association between claim strength and probability of settlement that is remarkably similar to the strong association that Studdert and his colleagues found using their six-category analysis as depicted in Figure 1. In each graph, the likelihood of a settlement payment rises steadily with the strength of the claimant's case.

Only the findings of the small Harvard Study call this conclusion into question. Two aspects of the Harvard Study explain its unique findings. The first explanation lies in the way that the study classified those cases in which the reviewers disagreed. Whenever the two reviewers were evenly split on the issue of negligence, the case was classified as a good-care case. That decision artificially inflated the settlement rate among the good-care cases by placing all of the toss-up cases in that category.

The second factor distinguishing the Harvard Study is more puzzling. In the Harvard sample, plaintiffs with strong claims of negligence had much less success obtaining a settlement than similarly situated claimants in other studies. As Figure 5 illustrates, it is not an unusually high rate of settlement

in good-care cases that distinguishes the Harvard Study, but its uniquely low rate of settlement in poor-care cases.

Figure 5. Revisiting the Harvard Findings on Settlement Rate



Either the small sample used in that study was very unrepresentative of litigation outcomes in New York or formidable obstacles stood in the path of negligently injured New Yorkers during the period of the Harvard Study. As a result, the troubling finding in the Harvard Study is not that too many low-odds cases settled, but that too few meritorious cases did.¹²⁰

When the findings of the Harvard Study are unpacked in this fashion, it becomes clear that the Harvard Study is an oddity. Its findings should not cast doubt on the overwhelming evidence that settlement rates are strongly correlated with the strength of the plaintiff's case.

Nevertheless, physicians will undoubtedly be dismayed by the fact that 10% to 20% of the cases rated as defensible result in a payment to the plaintiff. There are, however, three credible reasons why it would be wrong to assume that the payments rendered in cases rated by the expert reviewers as defensible were erroneously made. First, researchers have found that a certain amount of disagreement is inevitable whenever multiple individuals are asked to rate the quality of another person's past performance.

120. The simultaneous operation of forces driving the settlement rate up in good-care cases and down in poor-care cases explains why the authors found no statistical correlation between care quality and the settlement rate.

Reasonable professionals often reach different conclusions about the same evidence. In a definitive study of inter-reviewer agreement, Shari Diamond found that the disagreement rate for scientists engaged in peer review was 25%, the rate for employment interviewers was 30%, for psychiatrists diagnosing psychiatric illness it was 30%, and for physicians diagnosing physical illness it was between 23% and 34%.¹²¹ Diamond and Zeisel found a similar rate of disagreement among judges.¹²² Researchers who study physician agreement have found similar discrepancy rates.¹²³ A material rate of disagreement is inescapable because it is rarely possible to reconstruct past events with perfect confidence and because each reviewer will bring her own perceptions about minimum competence to the task. In medicine, the potential for disagreement is further compounded by frequent uncertainty among physicians over the appropriate standard of care and regional variations in the standard of care.¹²⁴

Measured against the expert discrepancy rate of roughly 30%, the 10% to 20% rate of discrepancy between malpractice settlements and a rating of good care by expert reviewers actually seems quite good.¹²⁵ The same can be said of the 85% to 90% settlement rate in cases that reviewers rated as

121. Shari S. Diamond, *Order in the Court: Consistency in Criminal-Court Decisions*, in 2 THE MASTER LECTURE SERIES: PSYCHOLOGY AND THE LAW 119, 125 (C. James Scheirer & Barbara L. Hammonds eds., 1983).

122. Shari S. Diamond & Hans Zeisel, *Sentencing Councils: A Study of Sentence Disparity and Its Reduction*, 43 U. CHI. L. REV. 109, 119 tbl.2 (1975) (finding a roughly 70% rate of agreement in two different cities among judges on whether an offender should be imprisoned).

123. See, e.g., Farber & White, *supra* note 25, at 204–05 (finding that in 30% of the cases, the experts disagreed or gave ambiguous evaluations); A. Russell Localio et al., *Identifying Adverse Events Caused by Medical Care: Degree of Physician Agreement in a Retrospective Chart Review*, 125 ANNALS INTERNAL MED. 457, 460–61 (1996) (finding a similar disagreement rate on both negligence and causation); Peebles et al., *supra* note 67, at 884 (finding that reviewers disagreed in 34.3% of the cases).

124. See David M. Eddy, *Variations in Physician Practice: The Role of Uncertainty*, HEALTH AFF., Summer 1984, at 74, 75 (outlining the sources of uncertainty); Philip G. Peters, Jr., *The Role of the Jury in Modern Malpractice Law*, 87 IOWA L. REV. 909, 956–58 (2002) (reviewing the evidence).

125. There are two other interesting theoretical explanations for the payment of a settlement in low-odds cases. One is that these are cases in which a desire for vindication motivates the plaintiff. These patients may, for example, believe that they were lied to or treated with disrespect. Studies show that plaintiffs seeking vindication are less likely to drop cases in which the evidence of negligent treatment is weak. See SLOAN ET AL., *supra* note 54, at 161. This persistence may lead to a settlement offer. In addition, prospect theory predicts that low-odds cases will be settled for a premium. See *infra* notes 206–14 and accompanying text. This prediction is based on research finding that individuals facing a low-probability gain (such as a frivolous lawsuit) tend to be risk-seeking while those facing a high-probability gain tend to be risk averse. The low settlement rate in low-odds malpractice cases suggests that the predicted difference in risk tolerances either is not routinely present in malpractice litigation or that it is usually trumped by other sources of negotiating power that favor defendants. In either event, the group of low-odds cases that settle may be the set of cases in which the predicted asymmetry in risk tolerance is most powerful.

having poor medical care. Here, too, the discrepancy rate is under 20%. It is probably unrealistic to expect a discrepancy rate much lower than that.¹²⁶

The second reason why the 10% to 20% settlement rate in cases rated as defensible cannot be treated as *prima facie* evidence of erroneous payments is that physicians are very reluctant to label the conduct of another physician as negligent. Doctors expressed a “pronounced reluctance” to label treatment decisions as negligent even when the care was “clearly erroneous.”¹²⁷ When faced with scenarios that a panel of senior physicians had previously judged to be clearly negligent, only 30% said that the patients should receive compensation.¹²⁸ Thus, the settlement of some cases rated as defensible may simply constitute the correction of a biased rating.

At the same time, there is troubling evidence that strategic factors unrelated to the quality of care received by the claimant strongly influenced some settlement outcomes. In one study, researchers found that defendants had settled several defensible cases because the insured physician was a bad witness, a fetal monitor tracing had been lost, or the providers had kept poor medical records.¹²⁹ Similarly, another study found that insurers had fought settlement in meritorious cases whenever the claimants were deemed “undesirable.”¹³⁰ In one case, defense counsel recommended against making a settlement offer because the plaintiff was “a worthless human being” who had abandoned his family and given himself an infection using dirty drug needles.¹³¹ In another, the insurer concluded that the jury would significantly discount damages for an “unemployed drifter” who prompted the need for medical care by attempting to commit suicide.¹³² In a third, the insurer refused to make a settlement offer at the level recommended by defense counsel because the patient was seriously overweight.¹³³

Only one study has attempted to quantify the impact of strategic factors. Its examination of the combined impact of the appeal of each party’s witnesses and the reputation of the plaintiff’s attorney found that these strategic factors had a large and statistically significant effect on the

126. Another factor working against a perfect agreement between settlements and the ratings given by external reviewers is the differences in the factual records on which their evaluations are based.

127. PAUL WEILER ET AL., *A MEASURE OF MALPRACTICE* 125 (1993) (“We found marked variation among physicians in their willingness to label certain kinds of medical outcomes as iatrogenic, and an even more pronounced reluctance to label as negligent those treatment decisions that, *ex post* at least, were clearly erroneous.”).

128. *Id.* at 172.

129. Ogburn et al., *supra* note 43, at 610.

130. See Thomas B. Metzloff, *Resolving Malpractice Disputes: Imaging the Jury’s Shadow*, 54 *LAW & CONTEMP. PROBS.* 43, 74–75, 83 n.126 (1991).

131. *Id.* at 74 n.104.

132. *Id.*

133. *Id.*

resolution of cases in which liability was uncertain.¹³⁴ In fact, settlement never occurred in an uncertain case when the defendant had an important strategic advantage.¹³⁵ The researchers also found some evidence that strategic factors affect the settlement of cases in which the evidence on liability is clearer, but those trends did not have statistical significance.¹³⁶

The role played by strategic factors is troubling. It gives credence to charges that the system is irrational and unfair. However, the current evidence suggests that its impact is largely confined to the uncertain cases.¹³⁷ Furthermore, the authors of this study found that the settlement process “primarily” was driven by evidence of negligence.¹³⁸ As in the other studies, cases with clear liability were most likely to settle, followed by unclear cases, and then weak cases. The authors also found that settlement in the two sets of cases in which the evidence of liability was relatively clear was not significantly affected by the presence of a one-sided strategic advantage.¹³⁹ Given the evidence currently available, it is reasonable to conclude that the bulk of the discrepancy rate found across the studies in the low-odds and high-odds cases is the product of normal inter-reviewer variability and, perhaps, rater bias—not strategic considerations.

The third reason for resisting the conclusion that the settlement of 10% to 20% of the low-odds cases is unjust is the evidence that most of these payments are insubstantial.¹⁴⁰ The fairness of a settlement cannot be

134. Catherine T. Harris, Ralph Peeples & Thomas B. Metzloff, *Placing “Standard of Care” in Context: The Impact of Witness Potential and Attorney Reputation in Medical Malpractice Litigation*, 3 J. EMPIRICAL LEGAL STUD. 467, 480–82 (2006).

135. *Id.* at 482.

136. *Id.* at 479–80 (describing cases with probable liability); *id.* at 482 (describing cases with unlikely liability).

137. With the significant exception of attorney experience (which strongly favors malpractice defendants), we do not yet know whether strategic factors tend to favor one side more often than the other. *See infra* notes 237–60 and accompanying text.

138. Harris, Peeples & Metzloff, *supra* note 134, at 489.

139. *Id.* at 479–80 (describing cases with probable liability); *id.* at 482 (describing cases with unlikely liability).

140. Doctors commonly characterize a settlement payment, no matter how small, as victory for the plaintiff. *See, e.g.*, Ralph Peeples, Catherine T. Harris & Thomas B. Metzloff, *Settlement Has Many Faces: Physicians, Attorneys, and Medical Malpractice*, 41 J. HEALTH & SOC. BEHAV. 333, 343–44 (2000) (noting the belief that “settlement means guilty” and concluding that “[s]ettlement means one thing to physicians and quite another to attorneys”). Thus, physicians are often dismayed when a weak claim is settled by their insurer, even for a very modest amount. In their eyes, these settlements belie the claim that liability is premised exclusively on proof of fault. *See id.* at 343. Physicians who feel this way implicitly believe that the truth is binary, i.e., a claim is either warranted or it is not. Just as a traffic light is red, green, or yellow, but never 40% red, a doctor’s treatment either meets the standard of care or it does not. However, this binary ideal simply does not apply to subjective judgments of fault. *See supra* notes 116–17 and accompanying text. Reasonable people disagree on judgments of this sort and there often is no objective benchmark to resolve their disagreement. *See id.* Even as to factual determinations, the binary view ignores the limitations in our ability to reconstruct past events. *Id.*

evaluated until the amount paid in settlement is ascertained. If the payment made to a low-odds claimant is substantially discounted, perhaps to a token or face-saving amount, then the mere existence of a settlement is a poor barometer of that settlement's fairness. In that event, the 10% to 20% settlement rate in low-odds cases will greatly overstate the magnitude of any unfairness. Yet, deep discounting of this sort is common in medical malpractice litigation.¹⁴¹

B. SETTLEMENT SIZE

Only a handful of studies have examined the correlation between claims quality and settlement size. Of these, all except the Taragin et al. study have found a positive correlation between the size of a settlement payment and the strength of the claimant's evidence of negligence.

Table 3. Average Settlement Payments for Differing Levels of Fault

		Good Care	Uncertain	Poor Care
<i>Three-Category Studies</i>				
Farber & White 1991		\$14,109	\$146,160 ¹⁴²	\$203,209 ¹⁴³
Farber & White 1994		\$7,112	\$91,008 ¹⁴⁴	\$177,320 ¹⁴⁵
Taragin et al.		Positive correlation, but not significant (P=.16)		
Spurr & Howze		Positive and significant correlation (P=.05) ¹⁴⁶		
<i>Two-Category Studies</i>				
Cheney et al. (median)	P<.05 P<.05	\$93,000 for high-severity \$10,000 for low-severity \$115,000 for death	\$463,000 for high-severity \$15,000 for low-severity \$200,000 for death	
Brennan et al. (Harvard Study)	Not stated	\$23,552 ¹⁴⁷	\$162,750	
Studdert et al.	.004	\$313,205	\$521,560	

141. See *infra* Part II.C.

142. Log coefficient of .931 (.466).

143. Log coefficient of 1.54 (.448).

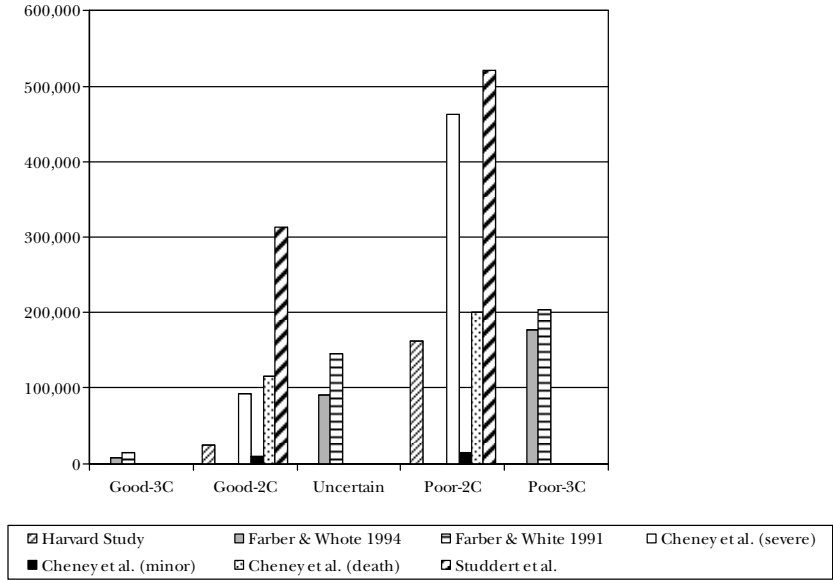
144. Log coefficient of .579 (.273).

145. Log coefficient of 1.34 (.247).

146. Log settlement payment coefficient of 2.63 with a standard error of 0.57.

147. The \$23,552 figure covers claims lacking both negligence and causation. The mean was \$31,375 for claims lacking only negligence.

Figure 6. Average Settlement Amount



On the relatively rare occasions when a claimant with a weak claim is able to elicit a settlement offer, Figure 6 shows that her case is likely to settle for a much smaller amount than a claimant with similar injuries and a stronger case on the merits. In the good-care cases, the defendant often simply forgives unpaid fees for medical care.¹⁴⁸ As would be expected, claimants with cases of uncertain merit receive more than claimants with low-odds cases, and plaintiffs with strong cases receive the largest settlements, though not necessarily the full amount of their injuries.

C. DOUBLE DISCOUNTING

The data show that the merits of the plaintiff's case affect her settlement in two distinct ways. First, the strength of the plaintiff's case affects the likelihood that she will receive a settlement. The weaker her case, the less likely that she will recover anything. Second, the strength of the plaintiff's case affects the size of the settlement offer that she will receive, assuming that she receives any settlement offer at all. The weaker her case, the smaller the size of the settlement offer she is likely to receive. Considered separately, each correlation seems fair. Weak claims should fare

148. Brennan et al., *supra* note 2, at 1964–65, 1965 tbl.1 (showing many settlements under \$25,000).

worse, and they do. Yet, the presence of both discounts means that malpractice claims as a group are doubly discounted. The evidence also indicates that the sum of these discounts is greater than fairness requires.

During settlement negotiations, lawyers routinely estimate the settlement value of a case by multiplying the odds of a plaintiff's verdict by the anticipated recovery in the event of a plaintiff's verdict. In the theory of negotiation and settlement, this product is called the "settlement value" or "expected value" of the claim and represents the value that a rational party would attribute to the claim.¹⁴⁹ A fifty-fifty case, therefore, has an expected value of roughly half of the plaintiff's damages.

The evidence of negligence in a case can range from very weak to very strong. In some cases, the evidence of negligence may be weak, such that seven reviewers out of ten would conclude that the defendant satisfied the standard of care. In much stronger cases, only two out of ten may reach this conclusion. In this concrete and realistic sense, the "merits" of a tort claim are based on probabilities. The calculation of a settlement value takes account of those probabilities.¹⁵⁰

As long as the probabilities used to calculate the settlement value fairly reflect the underlying merits of the case, the expected value of a claim will constitute both a rational settlement figure and a fair recovery for the plaintiff. Because the settlement value of a case is proportional to the persuasiveness of the evidence of negligence, claims with weak evidence of negligence should settle for a substantially smaller amount than should cases with strong evidence of negligence.

Nearly all claims with a nontrivial chance of success and serious injuries have some settlement value, although that value is often small.¹⁵¹ As long as settlement payments in those cases roughly correspond with expected value, a settlement rate approaching 100% for all but the weakest malpractice claims is fully consistent with a fair settlement process. Thus, it was a mistake for the Harvard researchers to claim that the civil justice system is an "expensive sideshow" when their data indicated that the size of the payments made to plaintiffs was tied directly to the strength of the plaintiffs' cases.¹⁵²

Because most serious claims have some settlement value, most should either settle or go to trial. In malpractice litigation, however, plaintiffs

149. See SLOAN ET AL., *supra* note 54, at 220 (noting that settlements, unlike trials, will discount the damages to reflect the probability of success); Spurr & Howze, *supra* note 61, at 502-04.

150. Spurr & Howze, *supra* note 61, at 499.

151. See Samuel R. Gross & Kent D. Syverud, *Getting to No: A Study of Settlement Negotiations and the Selection of Cases for Trial*, 90 MICH. L. REV. 319, 342 (1991) (stating that virtually every case has some probability, however low, that the plaintiff will prevail and every case has some settlement value). Gross and Syverud note that, under the basic economic model of settlement, zero-payment offers should be rare, even though they are not. *Id.* at 343 (reporting that no settlement offer was made in 25.2% of the personal injury cases in their sample).

152. Brennan et al., *supra* note 2, at 1963.

abandon a large fraction of their cases without any payment.¹⁵³ The combined abandonment and dismissal rate in low-odds cases is 80% to 90%, and in toss-up cases, it is around 40%.¹⁵⁴ It is possible that the high rate of zero-payment dispositions in low-odds cases occurs because virtually all of them are so frivolous that they have zero chance of success at trial. However, that assumption certainly has not been demonstrated. Unless it is true, the rarity of even nominal settlements strongly suggests that defendants have superior bargaining power and use it.

The likelihood of asymmetric bargaining power is more strongly suggested by the high rate of zero-payment dispositions in cases where the evidence of negligence is ambiguous. Negotiation theory predicts that essentially all such ambiguous cases will settle for roughly half of the plaintiffs' actual damages.¹⁵⁵ Yet, roughly 40% of the cases rated as toss-ups by medical experts are resolved without any payment being made by the defendant.¹⁵⁶ At the same time, the remaining toss-up cases are settled for far less than is paid in cases with stronger evidence of liability. Thus, borderline cases, as a category, are discounted twice—once in the amount paid to those claimants who do receive a settlement offer and again for the 40% who receive no payment at all. The ability of malpractice defendants to escape payment altogether in 40% of the toss-up cases suggests an *extra* discount beyond that justified by uncertainty of the merits. Defendants' ability to obtain a double discount in cases in which liability is uncertain suggests a significant advantage in bargaining power.

It is possible that malpractice defendants are able to extract an unwarranted discount in cases with strong evidence of medical negligence. However, this hypothesis cannot be tested directly using the existing studies. The published data do not reveal the fraction of full damages that is ultimately paid to most claimants with strong claims. If, however, defendants are able to extract double discounts in the low-odds and toss-up cases because of their superior bargaining power, as suggested in Part III, then that bargaining power is likely to bestow advantages in the settlement of many high-odds cases as well. The result would be settlements that are, on average, materially less than full compensation for the claimant's injuries.¹⁵⁷

The hypothesis that defendants can extract larger discounts than are warranted by the evidence of negligence also finds support in studies that

153. See *supra* p. 122 fig. 2.

154. See *supra* p. 114 tbl.1.

155. See *supra* Part II.B.

156. *Id.*

157. Just as the costs of litigation give defendants an incentive to make nominal payments to settle weak claims, the costs of litigation similarly provide plaintiffs who have strong evidence of negligence with an incentive to settle for an amount that is less than their actual damages. See RUSSELL KOROBKIN, *NEGOTIATION THEORY AND STRATEGY* 101 (2002) (noting that litigation costs lead plaintiffs to set lower settlement expectations).

have compared the amounts paid in malpractice settlements with the expected value of the claims. In one such study, Farber and White compared the amount recommended by state-mandated screening panels with the amount eventually paid in the actual settlement.¹⁵⁸ Based on the historical practice of the panels, Farber and White reasonably deduced that the panels were providing the parties with an estimate of the case's expected (or settlement) value.¹⁵⁹ When they compared those estimates to the actual settlements, they found that settlement amounts fell significantly below panel recommendations. In cases that did not settle at the amount suggested by the panel, the average settlement was almost \$200,000 below the panel's recommendation.¹⁶⁰

A study by Spurr and Simmons also found that disputes that failed to settle for the amount recommended by the screening panel were usually settled for a lesser amount.¹⁶¹ In this study, however, the difference was not large enough for the association to be statistically significant.¹⁶² In a separate study, Simmons found that the amount recommended by the screening panels was higher than the eventual settlement or judgment amount in 67.2% of the cases, while falling below the eventual settlement recovery in only 17.2%.¹⁶³ In addition, the average panel award was \$141,341, while the average recovery was \$95,612.¹⁶⁴ He found that defendants rejected the panel's recommendation 74.5% of the time, while plaintiffs rejected the recommendation only 49.3% of the time.¹⁶⁵ As a result, Simmons concluded that "bargaining favors the defendants."¹⁶⁶

Overall, the existing research on settlement outcomes strongly suggests that malpractice defendants usually settle claims against them for less than the expected value of those claims. This finding indicates that defendants

158. Farber & White, *supra* note 25, at 207–08.

159. *Id.* at 208.

160. *Id.* at 207 (noting that the average settlement was \$260,000 while the average recommendation was \$446,000, and stating that only seventeen of the sixty-eight settled cases in their sample were promptly settled for the figure recommended by the panel). It seems reasonable to assume that the fifty-one cases rejecting the panel's recommendations would have settled for even less had a screening panel not reviewed them and made recommendations.

161. Stephen J. Spurr & Walter O. Simmons, *Medical Malpractice in Michigan: An Economic Analysis*, 21 J. HEALTH POL. POL'Y & L. 315, 337 (1996) (noting that 68.6% of the cases settled for less than the panel recommended and that the average settlement was \$117,063 while the average recommendation was \$125,934).

162. *Id.* at 337. Only 2.1% had a mediation award of zero. *Id.* at 336.

163. Walter Orlando Simmons, *An Economic Analysis of Mandatory Mediation and the Disposition of Medical Malpractice Claims*, J. LEGAL ECON., Fall 1996, at 41, 51 (finding that 15.6% of the settlements equaled the panel award).

164. *Id.*

165. *Id.* at 51 tbl.7.

166. *Id.* at 52.

possess superior bargaining power and that they use it to extract favorable settlements.¹⁶⁷

D. SYNTHESIS

The evidence presented in the studies discussed above strongly indicates that the odds of a settlement and the likely size of any settlement are both closely related to the strength of the plaintiff's claim. Payment is most likely when the quality of care was poor, less likely when it was uncertain, and least likely when it was good. In addition, settlement amounts are lowest when the quality of care was good, higher when the quality of care was too close to call, and highest when the quality of care was poor.

Perhaps these findings should not be a surprise. Insurers, like claimants, have an economic incentive to evaluate their cases accurately and to shape their settlement strategies accordingly. Insurers accomplish their objective by undertaking a form of peer review in which they obtain multiple expert evaluations and rely on them heavily.¹⁶⁸ The findings reviewed in this Article confirm that insurers also have the bargaining power to insist that the eventual settlements be consistent with those expert assessments of settlement value.¹⁶⁹ As Peebles and his colleagues have noted, it is ironic that physicians see the absence of peer review as the major flaw in the current system of adjudicating malpractice cases.¹⁷⁰ Peer review is precisely what the settlement process currently provides.¹⁷¹

In addition, the data strongly indicate that malpractice defendants have superior bargaining leverage during the period between the filing of the claim and its disposition.¹⁷² As a result, they are able to extract two kinds of discounts: one in the settlement rate and another in the settlement amount.¹⁷³ In general, this combination of discounts appears to give defendants more discount than justice requires. The evidence that malpractice claims as a whole are settled for less than their expected value supports this hypothesis.

It seems likely that this combination of evidence-driven outcomes and asymmetric bargaining power yields a settlement pattern something like that

167. See, e.g., Farber & White, *supra* note 25, at 208; Spurr & Howze, *supra* note 61, at 495; Spurr & Simmons, *supra* note 161, at 340.

168. See Peebles et al., *supra* note 67, at 884–85, 891–93.

169. See *infra* Part III.

170. See Peebles et al., *supra* note 67, at 892 (noting that physicians see the lack of peer review as a major flaw even though physicians currently determine the standard of care).

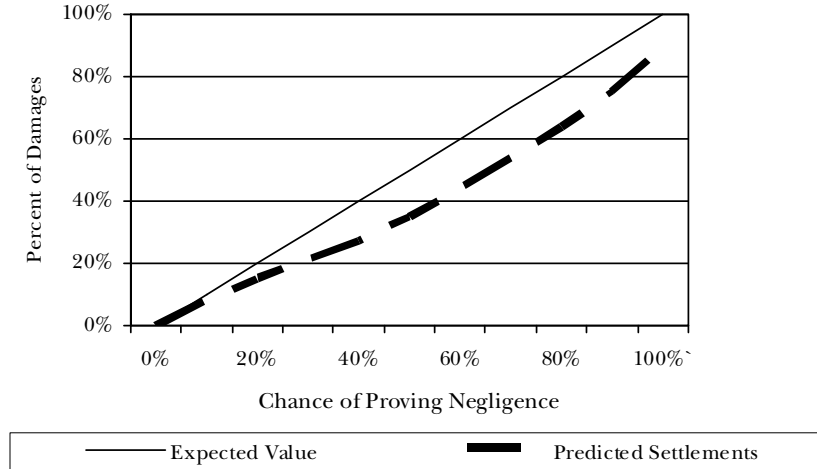
171. *Id.*

172. See *supra* Part II.C.

173. See *supra* Part II.C.

depicted in Figure 7.¹⁷⁴ In Figure 7, outcomes are directly related to the strength of the plaintiff's evidence, but average settlements fall short of expected value.

Figure 7: Theoretical Impact of Care Quality on Percent of Damages Recovered



The magnitude of this shortfall from expected value is still unclear. In addition, it is possible that the discount rate is not uniform across all levels of case strength. The important point for the purposes of this Article is that defendants are treated fairly by the settlement process. A secondary lesson is that the common reliance on settlement rates to measure the fairness of the existing current settlement is inappropriate; it omits the equally important aspect of settlement amount—another way in which defendants can insist that case strength be taken into account. Critiques that look only at settlement rates will inevitably and substantially overstate the frequency with which low-odds plaintiffs receive payments that are genuinely unfair. They will also overlook the extent to which patients who have been injured by medical negligence receive settlements that are materially smaller than those patients are due.

When the evidence regarding settlement rates is considered in conjunction with the evidence that settlements are significantly discounted, it appears that defendants not only obtain suitable discounts, but they also

174. One could make the same point with a graph showing that average recovery included not only the cases in which a settlement payment was made, but also all of the zero-payment cases.

extract, on average, more of a discount than the merits require. Their ability to do so suggests that defendants possess a material advantage in bargaining power.

III. SOURCES OF BARGAINING POWER IN MALPRACTICE LITIGATION

Lobbyists for malpractice insurers and physicians have successfully cultivated the popular belief that liability insurers are regularly forced to accede to the outlandish settlement demands of plaintiffs with dubious claims in order to avoid the “lottery” of a jury trial. The data suggest, instead, that malpractice insurers negotiate from a position of power and that they employ their power in a hard-nosed, business-like manner.

What explains this discrepancy in negotiating power? The most likely sources of the defendants’ advantage lie in asymmetric stakes that give defendants an incentive to fight low-odds claims fiercely, asymmetric risk tolerance that prompts plaintiffs to settle at a discount, shared knowledge that plaintiffs actually win very few jury trials, shared knowledge that cases resulting in plaintiff’s verdicts routinely are settled for significantly less than the jury award, and the defendant’s superior access to useful resources of several kinds. Together, these factors appear to push the amounts actually paid in settlement below the expected fair value of the claims based on their underlying merits.

A. ASYMMETRIC STAKES AND HARD BARGAINING

In malpractice litigation, doctors and the insurers who defend them are widely believed to have more at stake than the patients who sue them. While both parties stand to win or lose the monetary amount of a settlement or judgment, the doctor also risks her reputation, lost work time, emotional strain, and self-esteem. The insurer risks its reputation as a hard bargainer.

For doctors, the most obvious additional stake in malpractice litigation is their interest in preserving their reputations.¹⁷⁵ Equally important, but much less appreciated, is the impact that resolution of a malpractice claim has on a physician’s self-esteem.¹⁷⁶ Many physicians believe that a settlement payment constitutes an admission of fault.¹⁷⁷ Seeking public vindication,¹⁷⁸ they resist the settlement of claims in which the evidence of negligence is

175. See George L. Priest & Benjamin Klein, *The Selection of Disputes for Litigation*, 13 J. LEGAL STUD. 1, 26 (1984) (explaining that “the relative [settlement] calculus . . . changes” when one party has more to lose from an adverse verdict); Spurr & Simmons, *supra* note 161, at 338.

176. See Gross & Syverud, *supra* note 151, at 365–66 (suggesting that self-esteem is implicated more than reputation by the settlement decision).

177. See Peebles, Harris & Metzloff, *supra* note 140, at 343–44.

178. *Id.* at 342 (indicating that almost two-thirds of physicians who thought they were not liable expressed a desire for vindication).

weak, even if the case could be settled for a nominal amount.¹⁷⁹ Their obligation to report settlements in any amount to the National Practitioner Data Bank (“NPDB”) further reinforces their incentive to resist the settlement of low-odds cases.¹⁸⁰

Physician aversion to the settlement of low-odds cases is especially likely to affect settlement outcomes when the physician’s insurance policy has a contractual provision giving the insured physician the power of approval over all settlements.¹⁸¹ In one report, 17% of settlements recommended by the defense counsel were vetoed by physician-defendants possessing approval authority.¹⁸² In one set of cases in which no offer was ever communicated to the plaintiff, physicians had reportedly vetoed offers in 39.1% of the cases.¹⁸³ In addition, a California study estimated that there would be 14% fewer trials in the absence of a “physician consent” provision.¹⁸⁴ Although these clauses have become less common, these data nevertheless illustrate the importance that physicians place on fighting frivolous claims.

A liability insurer also has a powerful incentive to insist on favorable settlement terms. As a repeat player, the insurer values its reputation as a hard bargainer.¹⁸⁵ It will be especially reluctant to settle “nuisance” cases even when they can be settled at or below their expected value. Hard bargaining in low-odds cases will also appeal to their customers, as many physicians view settlement as an admission of guilt.

Although the insurer’s incentive to strike hard bargains is not confined to low-odds cases, it is easiest to document in this class of cases because defendants often make no settlement offer at all. For example, Thomas

179. See Gross & Syverud, *supra* note 151, at 366. For the same reason, plaintiffs who are strongly motivated by nonpecuniary objectives are less likely to drop their cases. See Frank A. Sloan & Thomas J. Hoerger, *Uncertainty, Information and Resolution of Medical Malpractice Disputes*, 4 J. RISK & UNCERTAINTY 402, 415 (1991).

180. See Teresa M. Waters et al., *Impact of the National Practitioner Data Bank on Resolution of Malpractice Claims*, 40 INQUIRY 283, 283 (2003) (finding that physicians have been less likely to settle claims since introduction of the NPDB in 1990, especially for payments less than \$50,000).

181. See, e.g., *Brion v. Vigilant Ins. Co.*, 651 S.W.2d 183, 184 (Mo. Ct. App. 1983) (calling this a “pride” provision); Kent D. Syverud, *The Duty to Settle*, 76 VA. L. REV. 1113, 1176 (1990) (stating that contracts with these clauses are 1% to 3% more expensive).

182. Gross & Syverud, *supra* note 151, at 361 n.103.

183. See *id.* (discussing “zero-offer cases in which a physician was the sole defendant at trial (9/23)”).

184. Syverud, *supra* note 181, at 1178–79.

185. “Hard bargaining” is predicted by negotiation theory when a repeat player, like the liability insurer, faces non-repeat litigants. See Priest & Klein, *supra* note 175, at 24–29 (discussing the “likelihood of litigation” when parties have “[a]symmetric [s]takes”); see also Robert Cooter et al., *Bargaining in the Shadow of the Law: A Testable Model of Strategic Behavior*, 11 J. LEGAL STUD. 225, 241–42 (1982) (“[O]ur model predicts that a repeat player whose opponents are not repeat players will adopt a hard bargaining strategy.”). For a discussion of the doctor’s stakes, see Spurr & Simmons, *supra* note 161, at 338 (noting “the costs of trial to a defendant physician in terms of lost time, emotional strain, and the damaging publicity”).

Metzloff found that no settlement offer of any kind had been made by the insurer in nearly 60% of the cases that went to trial.¹⁸⁶ Plaintiffs prevailed in only three of these trials.¹⁸⁷ He also found many comments in the claims files mentioning the insurance company's desire to cultivate a reputation for rejecting "nuisance value" settlements.¹⁸⁸ The insurer had declined to make a settlement offer in 80% of the cases rated as defensible and in 85% of the toss-up cases.¹⁸⁹ By contrast, it had only declined to make an offer in 9% of the cases it expected to lose.¹⁹⁰

The most dramatic evidence that defendants resist settlement in low-odds cases comes from the study done by Peeples, Harris, and Metzloff.¹⁹¹ In the cases they examined, defendants made offers in 96.3% of the claims in which the evidence of liability was strong (twenty-six of twenty-seven), only 35.3% of the toss-up claims (six of seventeen), and 4.5% of the cases believed to be defensible (one of twenty-two).¹⁹²

In their study of California trials, Gross and Syverud found that malpractice defendants were far less likely to have made a settlement offer prior to trial than defendants in other personal injury actions.¹⁹³ In their sample, the malpractice defendants had made no settlement offer to the plaintiff in 60% of the trials,¹⁹⁴ far exceeding the 25.2% rate for other personal injury trials.¹⁹⁵

Sloan and Hsieh concluded that malpractice defendants and their insurers tend to fight the defensible cases vigorously in order to preserve their reputations and to avoid setting a bad precedent.¹⁹⁶ Harris and her colleagues reached the same conclusion,¹⁹⁷ finding that insurers rarely made an offer before the plaintiff had identified a favorable expert witness.¹⁹⁸

186. Metzloff, *supra* note 130, at 77 n.111. No settlement offer was made in twenty-eight of forty-eight cases, or 58.3%. *Id.* Metzloff also found that settlement offers had been made prior to trial in over 90% of the likely successful claims (ten of eleven). *Id.*

187. *Id.* at 77 n.111.

188. *Id.* at 78.

189. *Id.* at 77 n.111. No offer was made in sixteen of twenty anticipated unsuccessful claims, eleven of thirteen toss-ups, and one of eleven successful claims. *Id.*

190. *Id.*

191. Peeples et al., *supra* note 67, at 887.

192. *Id.* at 899.

193. See Gross & Syverud, *supra* note 151, at 378.

194. *Id.* at 346 tbl.3.

195. *Id.* at 343.

196. See Sloan & Hsieh, *supra* note 49, at 1018. This hard bargaining, including the frequent failure to make any offer at all, may partially explain why malpractice trials are twice as likely to occur than trials of other personal injury claims. Plaintiffs are left with a choice between dropping the case and proceeding to trial. This posture may also explain the high fraction of zero-dollar dispositions in medical malpractice cases.

197. Peeples et al., *supra* note 67, at 887 (noting that insurers resist the settlement of cases in which the standard of care was not breached).

198. *Id.*

Finally, a 2003 study found that defendants became less willing to settle weak claims after the creation of the National Practitioner Data Bank.¹⁹⁹

However, the factors that give malpractice defendants incentive to drive a hard bargain in cases with weak evidence of negligence—such as protection of reputation and self-esteem—could make them eager to settle cases with strong evidence of negligence. According to negotiation theory, a party with more to lose from an adverse verdict has less bargaining power under those circumstances.²⁰⁰ If physicians have more to risk from an anticipated loss, they have strong incentive to settle the cases that they are most likely to lose,²⁰¹ even if they must pay a premium over expected value to do so.

The studies appear to confirm the hypothesis that malpractice defendants try more vigorously to settle the strong claims than to settle the weak ones. One study found that cases were consistently settled when the evidence of negligence was strong (86.2%) but rarely settled when the evidence was weak (11.1%).²⁰² Another found that when the plaintiff's claim appeared to be strong, the defendant was most likely to agree to the figure recommended by a screening panel.²⁰³

The studies do not reveal whether the defendant's incentive to settle results in the payment of a premium, however. The studies do not provide data with which to compare the expected value of these claims with their actual outcomes. If a premium is paid, then the pattern of predicted settlements would look more like Figure 8 than Figure 7.²⁰⁴

199. Waters et al., *supra* note 180, at 290 (finding that settlements in low-odds cases had dropped about 30% and also finding that the settlement rate in high-probability cases had declined, though the change was not statistically significant).

200. See Priest & Klein, *supra* note 175, at 40.

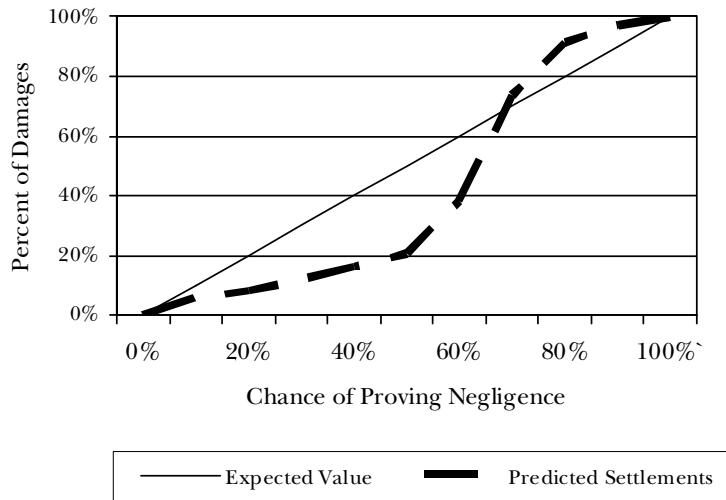
201. See *id.*

202. Peebles et al., *supra* note 67, at 886. Of the twenty-two low-odds cases in which the defendant made no settlement offer, half were dropped without payment and ten of the remaining cases resulted in defense verdicts. *Id.* at 888.

203. Simmons, *supra* note 163, at 42.

204. The amount paid to settle all malpractice claims falls short of their total expected value. Thus, Figure 8 shows heavier discounting in the low-odds and toss-up cases than Figure 7. See *supra* Part II.B. If the discount implicit in this finding is not present in the cases with strong evidence of liability, then it presumably is concentrated in the toss-up and low-odds claims. The extra discounting of low-odds claims is also consistent with the evidence showing that insurers resist settlement in these cases.

Figure 8. Theoretical (Revised) Impact of Care Quality on Percent of Damages Recovered



It is possible, however, that settling high-odds cases does not require a premium. This may be true because the advantage, if any, conferred on claimants by the inequality of stakes easily could be offset by other negotiating advantages that favor defendants, such as greater risk tolerance and superior resources. In addition, some scholars are unconvinced that the extra-judicial motivation of malpractice defendants is very powerful. Thomas Metzloff, for example, reviewed insurance-company litigation files and found no evidence that doctors were trying to influence the settlement decisions.²⁰⁵ If the extra-judicial costs that would be imposed on sued physicians by the trial process or by an adverse verdict do not play a large role in the settlement decision of malpractice insurers, then it is very unlikely that the insurers are paying a premium to settle cases. As will be discussed in the rest of this Part, too many other factors favor the insurers.

As a consequence, the role that asymmetric stakes play in the settlement of high-probability cases remains uncertain. However, the incentive that asymmetric stakes give malpractice defendants to resist the settlement of low-odds cases helps explain why 80% to 90% of the low-odds cases are resolved without even a nominal payment, contrary to the predictions of

205. Metzloff, *supra* note 130, at 78.

negotiation theory, and the remaining low-odds cases are settled at a deep discount.

B. ASYMMETRIC RISK TOLERANCE

In personal injury litigation, plaintiffs generally are believed to be more risk averse than the liability insurers with whom they are negotiating.²⁰⁶ Risk aversion is the tendency of people who face a choice between a certain gain and less-certain larger gain to prefer the certain gain.²⁰⁷ Insurers are believed to be less vulnerable to this tendency because they are “repeat players” who can average out their wins and losses over a series of cases unlike a one-shot plaintiff.²⁰⁸ On the other hand, personal injury plaintiffs who have only one chance at recovery and who receive a relatively low settlement offer are likely to find it difficult to refuse that offer (a certain gain) in the hopes of obtaining a larger verdict at trial.²⁰⁹ This tendency should allow defendants to settle cases at a discount.

Several researchers have concluded that the empirical data support this theoretical prediction. After analyzing several possible explanations for the low sums received by malpractice plaintiffs, Farber and White attributed these outcomes to greater risk aversion among plaintiffs.²¹⁰ Spurr and

206. See, e.g., *id.* at 62–63; Priest & Klein, *supra* note 175, at 27. A risk-neutral plaintiff would be indifferent to the choice between accepting a \$100,000 settlement offer and proceeding to trial in a case with a 50% chance of winning a verdict of \$200,000 because each choice has the same expected value. By contrast, a risk-averse plaintiff would prefer the settlement as it substitutes a sure gain for a risky one. She will do so even though the “expected values” are the same and a trial would offer the possibility of an even larger gain (something that would appeal to a risk-seeking individual). See Metzloff, *supra* note 130, at 62–63.

207. See Farber & White, *supra* note 25, at 208; Chris Guthrie, *Framing Frivolous Litigation: A Psychological Theory*, 67 U. CHI. L. REV. 163, 167 (2000); Sloan & Hsieh, *supra* note 49, at 998.

208. See Marc Galanter, *Why the “Haves” Come Out Ahead: Speculations on the Limits of Legal Change*, 9 L. & SOC’Y REV. 95, 99–100, 110 (1974) (noting that personal injury insurers typically are repeat players and that repeat players are more likely to be risk neutral, i.e., indifferent to uncertainty); KOROBKIN, *supra* note 157, at 46 (illustrating why repeat players are risk neutral).

209. In theory, this negotiating advantage should not extend to the weakest malpractice claims because social scientists have found that the tendencies to accept a settlement are reversed when the probability of gain is very small. See Guthrie, *supra* note 207, at 168–69. See generally Daniel Kahneman & Amos Tversky, *Prospect Theory: An Analysis of Decision Under Risk*, 47 ECONOMETRICA 263 (1979); Amos Tversky & Daniel Kahneman, *Advances in Prospect Theory: Cumulative Representation of Uncertainty*, 51 J. RISK & UNCERTAINTY 297 (1992). That may explain why 10–20% of the low-odds cases result in some settlement. See *supra* p. 124 fig.4, p. 125 fig.4A. In most low-odds cases, however, the plaintiff’s advantage apparently is outweighed by other factors that confer a negotiating advantage on defendants.

210. Farber & White, *supra* note 25, at 208. The authors ruled out lower trial costs and higher defendant optimism as explanations of this bargaining power. *Id.* at 208. For a description of how risk aversion affects litigants’ decisions, see W. Kip Viscusi, *Product Liability Litigation with Risk Aversion*, 17 J. LEGAL STUD. 101, 103 (1988) (concluding that claimants’ risk aversion is greater than defendants’ risk aversion). Patients who hold out until later in the negotiation process appear to get higher payments, thus rewarding their risk taking. Sloan & Hsieh, *supra* note 49, at 1026.

Simmons reached the same conclusion.²¹¹ The presence of asymmetric risk aversion is also consistent with the finding of Peeples and his colleagues that cases settle whenever the defendant makes an offer—any offer. They found that 94.4% of the cases in which the insurer made an offer were settled.²¹² Unequal risk tolerance is also suggested by the studies finding that defendants are more likely than plaintiffs to reject the recommendations of pretrial screening panels. Simmons found that defendants rejected the panel's recommendation in 74.5% of the cases, while plaintiffs rejected recommendations in 49% of the cases.²¹³ Farber and White also found that defendants were far more likely than plaintiffs to reject the amounts recommended by state screening panels.²¹⁴ Thus, it seems reasonable to conclude that plaintiff risk aversion explains some of the negotiating advantage possessed by malpractice defendants.

C. ANTICIPATED JURY SKEPTICISM

Trial lawyers have long known that malpractice claims are hard to win. The jury-verdict studies support them. Contrary to popular belief, juries tend to resolve close cases in favor of defendants.²¹⁵ The studies show that defendants win most of the cases that external reviewers classify as toss-up cases and half of the cases that the reviewers believe defendants should lose.²¹⁶ Thus, juries render verdicts for plaintiffs much less frequently than predicted by external reviewers. These findings show that juries are skeptical of patients who sue their doctors and, as a result, insist on more substantial proof than physician reviewers do. The teeth they give to the burden of proof essentially converts it into a “clear and convincing evidence” standard and gives defendants a substantial bargaining advantage during settlement negotiations.

Perhaps this should not be surprising. Many Americans are deeply concerned about excessive litigation and high liability-insurance premiums.²¹⁷ In one study, four of five potential jurors agreed that “[p]eople

211. See Spurr & Simmons, *supra* note 161, at 340 (attributing the difference between expected value and settlement amount to either plaintiffs' risk aversion or “their disadvantage in bargaining”).

212. Peeples et al., *supra* note 67, at 887.

213. Simmons, *supra* note 163, at 48. Simmons also found that 15.6% of the settlements equaled the panel award. *Id.* at 51.

214. Farber & White, *supra* note 25, at 208.

215. See generally, Philip G. Peters, Jr., *Doctors and Juries*, 106 MICH. L. REV. 1453 (2007) (comprehensively reviewing the empirical literature that tests the correlation between jury verdicts and evidence of negligence).

216. *Id.*

217. See David M. Engel, *The Oven Bird's Song: Insiders, Outsiders and Personal Injuries in an American Community*, 18 LAW & SOC'Y REV. 551, 553, 559–61 (1984) (finding that citizens in a rural Illinois county disapproved of “cashing in” via personal injury lawsuits and characterized those who did sue as “people looking for the easy buck”); Edith Greene et al., *Jurors' Attitudes*

are too quick to sue” and that “[t]here are far too many frivolous lawsuits today.”²¹⁸ Only one-third felt that “[m]ost people who sue others in court have legitimate grievances.”²¹⁹

This mood of public skepticism extends to lawsuits against physicians. In his study of potential jurors, Neil Vidmar found that members of the jury pool often made remarks during *voir dire* that revealed their skepticism about malpractice litigation.²²⁰ Many made comments like “too many people sue their doctors” and “[malpractice suits are] just going to raise the health insurance rates for the rest of us.”²²¹ In another study of potential jurors, one-third of the respondents believed that medical malpractice plaintiffs are looking for easy money.²²² Respondents were even more skeptical of plaintiffs’ lawyers. Two-thirds felt that these lawyers pressured clients into suing their doctors.²²³ Many felt that medical malpractice litigation is ruining the health-care system.²²⁴

These underling attitudes toward tort litigation were first explored in David Engel’s landmark summary of two years of fieldwork studying community attitudes toward personal injury litigation in a small, predominantly rural Illinois county he called “Sander County.”²²⁵ Although personal injury litigation rates were low, residents of Sander County strongly disapproved of personal injury lawsuits. Those surveyed characterized claimants as “greedy,” “quick to sue,” and “looking for the easy buck.”²²⁶ He observed that “[t]he negotiating process was, of course, strongly influenced

About Civil Litigation and the Size of Damage Awards, 40 AM. U. L. REV. 805, 814 (1991) (finding that 91% of jurors studied thought “there were too many lawsuits”); Valerie Q. Hans & William S. Lofquist, *Jurors’ Judgments of Business Liability in Tort Cases: Implications for the Litigation Explosion Debate*, 26 LAW & SOC’Y REV. 85, 94 (1992) (stating that “tort injuries approached their own cases with considerable suspicion about the plaintiff”).

218. Hans & Lofquist, *supra* note 217, at 93. This study asked potential jurors about tort cases against corporations. *Id.*

219. *Id.* Some of the skepticism about plaintiffs may be the product of cognitive dissonance—we do not want to think poorly of the people to whom we entrust our lives and well-being. Another possible explanation has been suggested by medical sociologists who believe that the poor success of malpractice plaintiffs in court is a predictable consequence of their lower social status relative to physicians. See Jeffrey Mullis, *Medical Malpractice, Social Structure, and Social Control*, 10 SOC. F. 135, 137, 145, 149 (1995) (arguing that wealth and social status help defendants in medical malpractice cases).

220. NEIL VIDMAR, *MEDICAL MALPRACTICE AND THE AMERICAN JURY: CONFRONTING THE MYTHS ABOUT JURY INCOMPETENCE, DEEP POCKETS, AND OUTRAGEOUS DAMAGE AWARDS* 169 (1995).

221. *Id.*

222. Ellen L. Leggett, *Identifying Juror Bias and Their Impact on Malpractice Cases* (Sept. 7, 1999) (unpublished article, on file with the Iowa Law Review).

223. *Id.*; see Greene et al., *supra* note 217, at 817 (finding that most jurors believe attorneys encourage people to file frivolous lawsuits).

224. See Leggett, *supra* note 222 (discussing her findings).

225. Engel, *supra* note 217, at 553, 559–61.

226. *Id.* at 553.

by the parties' shared knowledge of likely juror reaction if the case actually went to trial. Thus, plaintiffs found negotiated settlements relatively attractive even when the terms were not particularly favorable."²²⁷

Observers have also noted more recent signs that the public has lost patience with tort litigation. In Texas, lawyers report that the "going rate" for settlement of tort claims has gone down.²²⁸ In Wisconsin, defendants are now requesting jury trials in soft tissue cases.²²⁹ These signs indicate that the bargaining power of defendants has been strengthened by public concern over excessive tort litigation.

This bargaining advantage is further amplified by the success that losing malpractice defendants have had in negotiating post-trial settlements for substantially less than the damages awarded by the jury. Faced with the prospect of an appeal, an underinsured defendant, a damage cap, or possibly all three, winning plaintiffs typically settle their cases for somewhere between 44% and 71% of their jury award.²³⁰ The larger the verdict, the more likely a reduction in recovery will occur.²³¹ In cases with verdicts larger than \$22.5 million, a recent study determined that 98% of the plaintiffs settled for less than their jury award.²³² The average reduction was 56% and the median reduction was 61%.²³³ Insurance-policy limits were the most important explanation for these settlements.²³⁴ As a result, nearly every plaintiff with an extremely large award actually received less than half of that award in settlement.²³⁵

Of course, most cases settle prior to trial. But they do so in the shadow of their anticipated outcomes.²³⁶ It turns out that the ultimate payments are far lower than the sums awarded by juries as full compensation. This routine discounting of proven claims, which results from factors unrelated to liability, presumably has the effect of reducing the pretrial settlement value

227. *Id.* at 564–65.

228. 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, 1783, 1796 (2002); see also Stephen Daniels & Joanne Martin, *The Strange Success of Tort Reform*, 53 EMORY L.J. 1225 *passim* (2004) (arguing that the tort-reform debates have succeeded in changing the environment in which civil litigation occurs).

229. See HERBERT M. KRITZER, RISKS, REPUTATIONS, AND REWARDS: CONTINGENCY FEE LEGAL PRACTICE IN THE UNITED STATES 300 n.33 (2004) (reporting on anecdotal statements by counsel).

230. David A. Hyman et al., *Do Defendants Pay What Juries Award? Post-Verdict Haircuts in Texas Medical Malpractice Cases, 1988-2003*, J. EMPIRICAL LEGAL STUD. (forthcoming 2007) (manuscript at 2, on file with the Iowa Law Review), available at <http://ssrn.com/abstract=914415> (finding that plaintiffs receive a mean "haircut" of 29% and an average "haircut" of 56%).

231. *Id.*

232. *Id.*

233. *Id.*

234. *Id.*

235. Hyman et al., *supra* note 230, at 2.

236. *Id.*

of malpractice claims below the amount that would otherwise be justified by the merits of the claim. Therefore, it seems likely that this combination of skeptical juries and discounted verdicts explains a material portion of the bargaining advantage enjoyed by malpractice defendants.

D. SUPERIOR RESOURCES

Malpractice defendants have superior access to several resources that are important in litigation. Malpractice defendants have several advantages that can be translated into favorable settlements, such as their personal knowledge of the events that took place and their representation by more experienced attorneys.

1. Access to Information

The health-care providers who take care of the patient ordinarily know more than the patient about the circumstances of her treatment, which gives them a negotiating advantage.²³⁷ Malpractice defendants make use of this advantage, often resisting settlement despite knowledge that the patient's injuries were caused by medical negligence.²³⁸ One study observed that a hospital rarely made a settlement offer when patients used its voluntary, informal complaint process.²³⁹ Instead, it used the process "to learn about the litigiousness of specific patients," and it used "the filing of lawsuits as a hurdle that patients must overcome in order to convince the hospital that they are sufficiently litigious to justify a high settlement."²⁴⁰ In other words, peaceful patients were rarely compensated—not even when the hospital believed that medical negligence was the cause of the patient's injury.²⁴¹ Another study found that parties involved in cases with severe injuries generally did not settle prior to a patient's filing of a lawsuit.²⁴² Often the defendant would make no offer until the patient had not only filed suit, but had also retained an expert who would testify that the defendant breached the standard of care.²⁴³ This was true even when the defendant's expert consultants concluded that the defendant had violated the applicable

237. Lucian A. Bebchuk, *Litigation and Settlement Under Imperfect Information*, 15 RAND J. ECON. 404, 409 (1984).

238. *Id.*

239. Farber & White, *supra* note 38, at 788 (noting that thirty-seven of 355 claims were settled without a lawsuit when initiated by a complaint process).

240. *Id.* ("[T]hese empirical results are consistent with an information structure in which patients initially are poorly informed about the quality of medical care and the hospital initially is poorly informed about how litigious patients are.")

241. *Id.* at 795. At most, a hospital makes small settlement offers. *Id.* at 802. The goal is to avoid settling with the "peaceful" patients who will not file suit. *Id.* at 795.

242. Rosenblatt & Hurst, *supra* note 79, at 711 (noting that pre-suit settlement rarely occurred in cases of neonatal death).

243. See Peebles et al., *supra* note 67, at 886 (finding insurers almost always deposed experts for the plaintiff).

standard of care. Had these plaintiffs known what the hospital knew, their outcomes might have been very different.

2. Financial Resources

It seems reasonable to assume that liability-insurance companies will typically have superior financial resources, especially when a non-specialist attorney represents the claimant. These resources can be converted into superior bargaining power.²⁴⁴ Money can be used to buy the services of more talented and more experienced attorneys. It can be used to overwhelm the adversary with discovery requests or to hire more and better expert witnesses.²⁴⁵ Resources can also insulate a party from the costs and financial exigencies caused by delay, giving that party a bargaining advantage over parties for whom delayed resolution is more painful, such as an injured and unemployed plaintiff.²⁴⁶ A plaintiff who cannot pay her medical bills or her rent until she receives her settlement has much less bargaining power than an insured defendant. It is quite possible that the need for prompt compensation provides a more powerful explanation of the high settlement rate in cases with strong evidence of negligence than does the defendant's extra-judicial stakes.

3. Experts

Malpractice defendants are widely and quite reasonably believed to have less difficulty convincing well-respected practicing physicians to testify on their behalf.²⁴⁷ This advantage allows defense counsel to be more selective. In addition, defendants use their superior resources to call more expert witnesses at trial.²⁴⁸ Presumably, the mismatch is even more pronounced on the issues of liability and causation because the burden of proving damages prompts plaintiffs to call expert witnesses on that issue far more than defendants do.²⁴⁹

4. Lawyer Experience

Malpractice-defense attorneys as a group are substantially more experienced in medical malpractice litigation than plaintiffs' attorneys.²⁵⁰

244. KOROBKIN, *supra* note 157, at 153.

245. *See id.* at 156 (noting that it is not always cost-effective to hire more expert witnesses).

246. *Id.* at 171–72.

247. I have observed this belief throughout my many years serving as defense counsel in malpractice suits.

248. Neil Vidmar, *Are Juries Competent to Decide Liability in Tort Cases Involving Scientific/Medical Issues? Some Data from Medical Malpractice*, 43 EMORY L.J. 885, 902 (1994).

249. *See* SLOAN ET AL., *supra* note 54, at 92–93.

250. *See, e.g., id.* at 208, 216 (finding that specialists constitute a minority of plaintiffs' attorneys and recommending specialty certification); Galanter, *supra* note 208, at 110 (noting that, in general, personal injury insurers are typically repeat players, while personal injury

The studies strongly suggest that the difference in experience greatly affects outcomes. Most lawyers hired by malpractice insurers are experienced specialists who have represented them in the past.²⁵¹ By contrast, less than one quarter of the plaintiffs have lawyers with substantial malpractice experience.²⁵² One study found that a seasoned defense lawyer was four times as likely to be matched against an inexperienced plaintiff's attorney as an experienced plaintiff's attorney was to be matched against inexperienced defense counsel.²⁵³

Research shows that the extra experience matters. In one study, plaintiffs' attorneys who specialized in malpractice litigation negotiated settlements that were roughly twice as large as the amounts obtained by non-specialists in similar cases.²⁵⁴ The study found that non-specialists were more likely to accept a token settlement.²⁵⁵ Their cases were far more likely to settle for a fraction of the economic loss.²⁵⁶ The authors viewed this finding as a reason to favor the certification of malpractice specialists.²⁵⁷ Similarly, a North Carolina study concluded that "the skills of plaintiffs' attorneys in estimating the value of malpractice cases are in the aggregate less well refined than insurers' and defense counsels' skills."²⁵⁸ Defendants also have

plaintiffs are not); Catherine T. Harris, Ralph Peeples & Thomas B. Metzloff, *Who Are Those Guys? An Empirical Examination of Medical Malpractice Plaintiffs' Attorneys*, 58 SMU L. REV. 225, 241 (2005) (reporting that defense counsel in the study sample had handled an average of over twice as many malpractice cases as had their counterparts); Sloan & Hsieh, *supra* note 49, at 997-98 (reviewing the literature relating to variability in medical malpractice payments).

251. See Galanter, *supra* note 208, at 97-98 (noting that repeat players will have greater expertise and better access to specialists).

252. SLOAN ET AL., *supra* note 54, at 76. The definition of "specialist" was based on a combination of factors and included the attorneys in firms that handled four or more malpractice cases during the period of the study and those listed on several specialty lists. *Id.* at 170 (noting that specialists represented 23% of the claimants).

253. Harris et al., *supra* note 250, at 243. Unfortunately, however, this study did not measure case quality and, thus, could not rule out the chance that the superior outcomes of experienced counsel were the product of a better case mix.

254. SLOAN ET AL., *supra* note 54, at 216 (holding liability and severity constant). "Holding other factors constant," specialists got payments that were 92% higher. *Id.* at 201. Interestingly, this was not because specialists were able to obtain settlements in excess of the case's expected value or even in excess of the patient's economic losses. The settlements were too small on average to cover even economic loss. *Id.*

255. *Id.* at 208.

256. *Id.* at 216. The cases in which no payment or very low payment resulted constituted 51% of the cases handled by nonspecialists and 29% of the cases handled by specialists. *Id.* at 197 tbl.9.4.

257. *Id.* at 208.

258. Metzloff, *supra* note 130, at 80. He observed that plaintiffs' attorneys more often made outlandish demands. *Id.* at 75-76. Similarly, Russell Korobkin notes that an inexperienced attorney may be more likely to mistake his aspiration price for his reservation price, thereby leaving a decent settlement on the table. KOROBKIN, *supra* note 157, at 62-63. As to why this discrepancy in skill should be more powerful in medical malpractice cases than in other

acknowledged the relevance of experience; they spend considerably more money on trial preparations when they are defending against specialists than against non-specialists.²⁵⁹

Of course, plaintiffs will sometimes have a superior lawyer or an extraordinary expert. Perhaps this explains why some low-odds claims end up being settled rather than dropped.²⁶⁰ However, defendants seem to have the advantage of these mismatches more often than plaintiffs. This advantage could help explain how defendants are able to extract a double discount of the low-odds and toss-up claims.

E. SYNTHESIS

The most likely sources of a malpractice defendant's superior bargaining power are the incentives that repeat players have to fight low-odds claims vigorously; their superior risk tolerance; the mutual knowledge that plaintiffs usually lose at trial; and the defendant's superior access to a variety of trial resources, including information about the events in dispute, experienced representatives, and expert witnesses. However, defendants may lose some of their advantage in cases with strong evidence of negligence. Further study is needed to determine whether they pay a premium to settle this group of cases.

These are the systematic biases. The more recent studies of malpractice settlements have also suggested that settlement outcomes are materially influenced by strategic considerations that are not systematically distributed and thus cannot be detected from the aggregate data. The role played by these strategic factors is as troubling as the role played by the systematic biases already discussed. They, too, will lead critics to conclude that the system is irrational and unfair. At present, however, we know very little about the number of settlements that are materially changed by these strategic factors or whether they are distributed unevenly between the parties.

CONCLUSION

Contrary to the findings of the notorious Harvard Study, medical malpractice settlements are neither random nor irrational. Both the likelihood of a settlement payment and the amount paid in settlement are closely related to the merit of the underlying claim of medical negligence. Both are the products of an insurance-claims process that acts much like peer review. Payment is most likely when the quality of care was poor, less

personal injury cases, Metzloff suggests that malpractice cases accentuate the need to locate experts and to understand a unique body of substantive issues. Metzloff, *supra* note 130, at 80.

259. SLOAN ET AL., *supra* note 54, at 216. Specialists were no more or less likely to have a liable defendant but were slightly more likely to have an "uncertain" case. *Id.* at 185 app.8A. Their cases did, however, involve more severe injuries as measured by economic loss. *Id.* at 170.

260. See Peeples et al., *supra* note 67, at 895 (suggesting that strategic factors may explain why plaintiffs with "non-meritorious" claims pursue their claims).

likely when it was uncertain, and least likely when it was good. Settlement amounts are likely to be lowest when the quality of care was good, higher when care quality was too close to call, and highest when care quality was poor.

The studies also show, however, that 10% to 20% of the claimants with low-odds claims receive a settlement of some kind. Some readers may find that troubling. Fortunately, there are several reasons for believing that this finding does not justify serious concern. First, the discrepancy rate falls within the range of disagreement normally found when independent observers rate performance, even when the ratings are done entirely by experts. From this perspective, the agreement rate is actually remarkably good. Second, the studies generally use physicians to rate other physicians, thus introducing a high likelihood of rater bias. Together, inter-reviewer variability and reviewer bias could account for much, maybe all, of the 10% to 20% payment rate in low-odds cases and the nonpayment rate in meritorious cases. That conclusion contrasts starkly with popular perception.

Furthermore, the fact that some low-odds cases settle does not mean that the process is working unfairly. This conclusion would only be justified if the payments were not being discounted to reflect the weakness of the claims being settled. The studies show that settlement size is significantly smaller in low-odds cases than in cases with stronger evidence of negligence. Additionally, the evidence of discounting in both settlement rates and settlement size suggests that medical malpractice claims are discounted twice. This phenomenon is most clearly visible in the toss-up claims, but it may extend much more broadly.

The most likely explanation for this surplus discounting lies in the superior bargaining power of malpractice defendants. The sources of that bargaining power likely include superior risk tolerance, better access to information, more experienced attorneys and insurance representatives, easier access to expert witnesses, and the incentive to fight low-odds claims vigorously. Defendants gain additional bargaining power from trial lawyers' awareness that malpractice claims are very hard to win at trial, even with strong evidence of negligence.

At the same time, however, defendants may lose some of their bargaining superiority in cases with strong evidence of negligence. Theoretically, at least, defendants may be willing to pay a premium to settle their losses. That question deserves further study. On balance, however, the evidence indicates that malpractice defendants have sufficient bargaining power to settle the average malpractice case below its expected value.

The likely existence of a persistent asymmetry in bargaining power is a cause for concern. So, too, is the scattered evidence that many close cases, and perhaps some clear ones as well, are affected by strategic factors like client appeal. Each case resolved this way confirms the perception that malpractice litigation is an irrational lottery. Although the magnitude of

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these influences is still largely conjectural, it is no overstatement to say that follow-up research is warranted.

The outcomes revealed by the settlement data should, however, reassure those observers who are most concerned about its fairness to physicians. Quality of care drives settlement outcomes. To the extent that settlement outcomes depart from the merits, the discrepancies usually favor malpractice defendants. Defendants have superior resources, more experienced lawyers, and the benefit of other sources of bargaining power, such as a repeat-player's risk neutrality and incentive for hard bargaining. As a result, plaintiffs have more reason to complain about the system's imperfections than defendants do.