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How Reliable is Medical Malpractice Law? A Review of "Medical Malpractice and the American Jury: Confronting the Myths about Jury Incompetence, Deep Pockets, and Outrageous Damage Awards" by Neil Vidmar

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HOW RELIABLE IS MEDICAL MALPRACTICE LAW? A
REVIEW OF "MEDICAL MALPRACTICE AND THE
AMERICAN JURY: CONFRONTING THE MYTHS ABOUT
JURY INCOMPETENCE, DEEP POCKETS, AND
OUTRAGEOUS DAMAGE AWARDS" BY NEIL VIDMAR
(University of Michigan Press, 1995; published in paperback, 1997)

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CHRISTOPHER POHL²

"It is a capital mistake to theorize before one has data."³

In his book reviewed here Neil Vidmar adduces data which he maintains validates jury judgments in medical malpractice litigation and, by extension, invalidates criticisms of such litigation. The first point is questionable; the second clearly wrong.

We begin by asking which of the following metaphors most aptly describes the chief characteristics of medical malpractice litigation?

Imagine a two-dimensional Cartesian plane; now draw a diagonal line in the plane; color the area to one side of the line red, the other blue; now smudge the line a little. Finally, imagine that any point in the plane can be located by reference to its coordinates along the X and Y axis. Assuming that a given point is not located in the smudgy boundary area, our intuition tells us that it is possible to determine the color of all the points surrounding our original choice.⁴

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³OXFORD DICTIONARY OF QUOTATIONS 192 (3d ed. 1979), quoting SIR ARTHUR CONAN DOYLE, *THE MEMOIRS OF SHERLOCK HOLMES* (1893).

⁴This metaphor, as well as the "snowflake" metaphor to follow, are taken from a provocative essay by William Meadow and John D. Lantos, *Expert Testimony, Legal Reasoning, and Justice: The Case for Adopting a Data-Based Standard of Care in Allegation of Medical Negligence in the NICU*, in 23.3 *CLINICS IN PERINATOLOGY* 583 (Sept. 1996). The authors propose that in cases of alleged medical negligence, experts should testify regarding the standard of care that is ordinarily used in similar circumstances; that standard, in turn, can be determined a priori by acquiring data concerning the care used in a particular specialty. The authors suggest that experts whose testimony is based on data determined prior to trial and not in anticipation of litigation should be afforded

In law and mathematics, there is an established notion that if the outcome of a particular case is known, then the outcomes of cases with closely related facts should be similarly decided: in other words, once one determines the color of one point, its neighboring points ought to be the same color. The process by which the law arrives at these conclusions is called analogic reasoning, or reasoning by example,⁵ and is the central organizing principle⁶ of any rational legal system.⁷

What if, instead of a neatly bisected Cartesian plane, medical negligence findings resembled nothing so much as a Madlebrot figure: a red snowflake inscribed on a blue Cartesian plane, with smaller red snowflakes extending off the main figure in every direction?⁸ For any point in such a figure, an infinite number of near neighbors would exist that are either blue or red. The implications for a judicial system that produces such results are obvious: if any chosen neighboring point may be a different color—if cases that are virtually indistinguishable on the facts may be differently decided—then that system violates the basic premise of analogic reasoning.⁹

Many advocates of reforming the manner in which medical malpractice claims are evaluated in the United States argue that the current system produces results whose chief characteristics are uncertainty and unpredictability.¹⁰ Needless to say, proponents of tort law do not believe the current system produces results that, when plotted, resemble Mandelbrot figures. But with imperfect (or often nonexistent) data on hand, each side is too often reduced to making blanket assertion after blanket assertion that juries are or are not competent to decide medical malpractice cases, that damage awards

greater weight than experts who provide "anecdotal" evidence regarding negligent medical care. *Id.*

⁵See generally EDWARD LEVI, AN INTRODUCTION TO LEGAL REASONING, 2 (1949).

⁶See generally EDWARD LEVI, AN INTRODUCTION TO LEGAL REASONING at 2 (1949), quoted in Meadow and Lantos, *supra* note 5, at 584.

⁷See Meadow and Lantos, *supra* note 5, at 584:

1. Similarity is seen between cases (points are determined to be neighbors).
2. The rule of law inherent in the first case is announced (the color of the original point is determined).
3. The rule of law is made applicable to the second case (the color of the neighboring point is constrained).

⁸*Id.* at 584. According to Meadow and Lantos, "[t]his vision is an accurate (although incomplete) description of one member of what is commonly referred to as a Mandelbrot set: a collection of geometric figures arising from the solutions of a class of nonlinear functions. . . ." *Id.*

⁹*Id.* at 585.

¹⁰See generally, PETER HUBER, LIABILITY: THE LEGAL REVOLUTION AND ITS CONSEQUENCES (1988); WALTER OLSEN, THE LITIGATION EXPLOSION (1991); PAUL WEILER, MEDICAL MALPRACTICE ON TRIAL (1991).

are or are not inflated. Randall Bovbjerg of The Urban Institute sums up the situation as follows: "Folklore, anecdote, and stereotypes predominate [the tort reform debate] partly because solid information has been scarce for many years."¹¹

Duke University Law Professor Neil Vidmar's, book, "Medical Malpractice and the American Jury," purports to provide the medical malpractice reform debate with the kind of hard data it has been lacking for years.¹² Vidmar's purpose is to examine empirically the claims that malpractice juries deviate extensively from medical standards, and that they are a primary culprit behind the spiraling costs and inefficiencies that plague the American health care system.¹³

Vidmar makes three arguments. One, juries do not often find in favor of plaintiffs who bring medical malpractice claims. Two, jury findings of negligence are not the result of sympathetic bias arising out of the severity of injury suffered by the plaintiff. Three, damage awards—particularly noneconomic damage awards such as "pain and suffering"—are not rising dramatically, and juries do not typically sock it to "deep pocket" defendants like insurance companies. To the contrary, Vidmar argues that in the cases he studied in North Carolina and elsewhere, damages are generally proportional to the seriousness of the injury and are not often far above independent estimates of a patient's economic loss.¹⁴ And for the occasional jury that goes astray with respect to its verdict on liability or on damages, Vidmar argues that a number of post-verdict legal mechanisms operate to correct and adjust trial errors.¹⁵

These findings lead Vidmar to suggest that further efforts at tort reform are unnecessary. Vidmar clearly believes his conclusions should go a long way toward deflating critics of the tort system: "They have identified the malpractice jury as a central villain in the tort system. . . . [I]f one of their major premises is wrong we need to look very critically at the rest of their arguments."¹⁶ Vidmar dismisses recommendations such as the American Medical Association's suggestion that juries be replaced by an administrative

¹¹Randall Bovbjerg, *Medical Malpractice: Research and Reform*, 79 VA. L. REV. 2155, 2185 (1993).

¹²Neil Vidmar, *Medical Malpractice and the American Jury: Confronting the Myths About Jury Incompetence, Deep Pockets, and Outrageous Damage Awards*, 28 SUFFOLK UNIV. L. REV. 205 (1995).

¹³*Id.* at 8. "This book's organizing theme is the extent to which malpractice juries deviate from legal norms and, if so, for what reasons." *Id.*

¹⁴*Id.* at 266.

¹⁵*Id.*

¹⁶*Vidmar, supra* note 12, at 273.

system of neutral doctors in determining medical malpractice claims,¹⁷ since juries on average do a good job of determining whether care was negligent.¹⁸

In reply to all this in the first place, the civil jury is not in danger of being replaced in medical malpractice cases, and it is not clear that it ever was. While some juries have undoubtedly returned some questionable verdicts (or worse), and have been criticized in the popular press for it,¹⁹ one can concede that juries perform their job reasonably well in medical malpractice cases—especially given the murky nature of alleged causation and misconduct as well as the often (wildly) conflicting testimony of dueling medical experts—without for a moment endorsing tort law's handling of medical malpractice cases.

Instead, it is the nature of the tort system itself in medical malpractice cases, which requires both a finding of fault and computing the monetary value of nonmonetary loss as a legal precondition to compensatory relief for injured patients, that justifies the criticism of current medical malpractice law.²⁰ Tort law has long been seen as perversely ineffective and inefficient in providing compensation, particularly in the context of medical malpractice. In the words of Harvard Law School Professor Paul Weiler:

¹⁷This approach has not garnered any support before Congress or state legislatures. *See id.* at 161-62.

¹⁸*Id.* at 265. For a more detailed discussion of these issues, *see infra* pp. 11-17.

¹⁹*Id.* at 11-12. Vidmar calls these anecdotes "tort tales"—cases such as the oft-told tale of the "burglar" who sued a school system after he fell through a skylight, winning damages of \$206,000 plus \$1,500 per month for life. As Vidmar points out, these tort tales are consistently invoked to insist on jury restraint and a return to "common sense," despite the fact that the tales are often either misleading or flat-out wrong on the facts of a particular case. Another oft-told case involving the psychic and her CAT scan likewise refuses to die. The facts of the actual case on which the story is based, *Haimes v. Hart*, show that, while the plaintiff did bring a \$1 million claim that a CAT scan made her lose her psychic abilities, she had also sustained permanent brain damage due to an allergic reaction to a contrast dye that she claimed was negligently administered prior to her CAT scan. The judge instructed the jury to disregard the claim concerning the loss of psychic abilities and consider only the evidence on brain damage. Despite the fact that the true story regarding the lawsuit was published in the *National Law Journal* in 1987, the inaccurate version appeared in a report by Vice President Quayle's Council on Competitiveness in 1991, in books published in 1991 by Peter Huber and Walter Olsen, and in a 1993 article by Newsweek. *Id.* at 12. *See generally* *President's Council on Competitiveness, A Report from the President's Council on Competitiveness: Agenda for Civil Justice Reform* (1991), at 5; PETER HUBER, GALILEO'S REVENGE: JUNK SCIENCE IN THE COURTROOM (1991); OLSEN, *supra* note 10.

²⁰"In medical malpractice cases the legal guideline is whether the physician's treatment of the patient comported with the standards of professional practice followed by other physicians in the same field of medical practice in that community at the time that the injury occurred." *Vidmar, supra* note 12, 123-24. In other words, what would a reasonable doctor under the particular circumstances have done? *See id.*, at 123-26 (providing the general reader with an excellent summary of the varying standards by which medical malpractice is judged).

Viewed as a form of insurance, the malpractice regime has major flaws. . . . [T]ort benefits are doled out in a rather arbitrary manner to some—but not most—deserving victims, and also to those. . . who are not even "deserving" within tort law's fault-based frame of reference. Even worse, to make payment to the relative handful. . . who do surmount the natural and legal barriers to demonstrating legal entitlement to damages, the medical malpractice system must spend an inordinate amount of both time. . . and money. . . litigating whether the doctor was at fault so that the victim can be compensated.²¹

While Vidmar does manage to present a number of quotes from popular legal authors who have lashed out at triers of fact, including juries,²² critics of medical malpractice law need not base their displeasure with the present system on "jury incompetence;" instead one can indict other manifest inefficiencies of the present system as explained above. In acquitting the medical malpractice jury of judicial negligence, Vidmar purports to exonerate a factor not by any means crucial to the failures of the medical liability system.²³ Lawyer and author Philip Howard notes, "If Vidmar's goal is to show that the jury system is not the main culprit in a flawed judicial system, then he has proven his point: Jurors do not generally check their common sense at the jury room door. As a practicing lawyer, I would go even further: It's amazing that, in the vague and standardless world of malpractice claims, juries seem to get things right."²⁴

In this review, we examine each of the findings made by Professor Vidmar, and then compare those findings with other empirical examinations of medical malpractice litigation in the United States, notably the most recent findings by the Harvard Medical Practice Study.²⁵ In addition, we will argue that the data

²¹Paul C. Weiler, *The Case for No-Fault Medical Liability*, 52 MD. L. REV. 908, 915 (1993).

²²In particular, Vidmar cites Huber and Olsen, *supra* note 10, as examples of legal scholars who argue that juries too often view cases as opportunities to display boundless generosity. ("But judges and juries were, for the most part, committed to running a generous sort of charity. If the new tort system cannot find a careless defendant after an accident, it will often settle for a merely wealthy one.") Huber, *supra* note 10, at 12.

²³Ironically, by bolstering confidence in juries, Vidmar's work could in the long run be helpful to the cause of medical malpractice reform by forcing advocates to spend less time targeting politically expedient but ultimately disingenuous targets like "incompetent" juries.

²⁴See Philip K. Howard, *Review: Medical Malpractice and the American Jury*, WASH. MONTHLY, March 1, 1996, at 55.

²⁵Troyan A. Brennan, ET AL., *Relation Between Negligent Adverse Events and the Outcomes of Medical Malpractice Litigation*, 335 NEW ENG. J. MED. 1963 (Dec. 26, 1996). The authors state: "In the multivariate analysis, disability (permanent vs. temporary or none) was the only significant predictor of payment. . . . Neither the presence of an adverse event due to negligence . . . nor the presence of an adverse event of any type . . . was associated with payment to the plaintiff." *Id.* at 1965. See notes 52 and 106 *infra* and accompanying text.

compiled so far continues to indicate that victims whose injuries arise from medical maloccurrences, far from being well served by the present system as Vidmar suggests, would be far better served by some variant of a no-fault compensation scheme.²⁶

I.

Vidmar's early chapters seek to disprove what he says is a prevailing myth in American legal culture: the idea that doctors who get sued are routinely found liable. While he sporadically attempts to include data gathered from other states, Vidmar's claims are primarily derived from information found in his own backyard: first, he surveyed every medical malpractice case filed in the state and federal courts in North Carolina between July 1, 1984, and June 30, 1987, which constituted a total of 895 lawsuits.²⁷ In addition, Vidmar employs a second sample involving cases filed in fourteen of North Carolina's 100 counties between July 1, 1987 and December thirty-one, 1990: a sample of 326 cases. Vidmar estimates that they constitute 52% of malpractice cases filed during that period in North Carolina Superior Court (the state's court of general jurisdiction).²⁸

Of the 895 cases surveyed in North Carolina, approximately 50% were settled with the plaintiff receiving money from the defendant.²⁹ According to Vidmar, approximately 40% were dropped, either because the plaintiff withdrew the claim, allowed it to lapse beyond procedural or statutory deadlines, or received a judicial ruling that terminated the case in favor of the defendant.³⁰ Only 118 reached trial stage; and out of those, three were tried by a judge and thirty-one otherwise did not make it to the jury: these cases either were settled after trial had begun, were disposed of by a directed verdict, or were withdrawn by the plaintiff.³¹ The remaining 84 trial cases eventually reaching the jury thus constituted 9.4% of all cases filed in North Carolina from 1984 to 1987. The

²⁶See Jeffrey O'Connell, *Two-tier Tort Law: Neo No-Fault and Quasi-Criminal Liability*, 27 WAKE FOREST L. REV. 871 (1992). See also American Law Institute, *Reporter's Study on Enterprise Responsibility for Personal Injury*, Chapter 15: Elective No Fault Medical Liability, Vol. II, 487-516 (1991) (drawing heavily on O'Connell's work), and notes 115-18 *infra* and accompanying text.

²⁷VIDMAR, *supra* note 12, at 23. Vidmar estimates that he captured approximately 95% of the cases filed during that period.

²⁸*Id.* Additional details on the survey are contained in Neil Vidmar ET AL., *An Empirical Examination of a Legislated Procedural Reform: Court-Based Management of Medical Malpractice Litigation* (The Private Adjudication Center, Duke University School of Law, 1992).

²⁹*Id.* at 24.

³⁰*Id.*

³¹*Id.*

second study produced closely similar figures,³² leading Vidmar to project that between 7-10% of malpractice cases arguably eligible for jury determination were decided that way.

In the first study, seventeen plaintiffs—or 20%—prevailed, and in the second study plaintiffs in four of the 25 trials—or 16%—prevailed.³³ In these 21 cases, there were three awards of over \$1 million,³⁴ as well as an award for \$750,000 and two for \$300,000.³⁵ However, the remainder of the trials produced much smaller jury verdicts, such that while the mean award for the 21 cases in which plaintiffs prevailed was \$367,737, the median was just \$36,500.³⁶ Put differently, whereas a plaintiff's expected value of going to trial (equal to the average award when plaintiffs prevail, multiplied by the probability of obtaining a verdict) yielded a figure of \$70,849,³⁷ most plaintiffs in the study came away with very modest awards: only nine out of 109 of the cases decided by juries were awarded more than the expected value of their claims.³⁸ Furthermore, plaintiffs see the size of that award shrink considerably after the lawsuit is over. Says Vidmar: "Assuming, very conservatively, that expenses and fees averaged \$10,000 and that the attorney's share was 35%, or roughly \$25,000, the plaintiff who went to trial would expect to recover \$35,849."³⁹ Vidmar argues that the infrequency of plaintiff wins, coupled with the modest size of the awards when they do win, contradicts the popular belief that juries routinely return large damage verdicts against doctors.⁴⁰

³²VIDMAR, *supra* note 12, at 24. In the second study conducted by Vidmar, which covered the 1987-1990 time period, 51% of the 326 cases settled, 40% were dropped or terminated without payment to plaintiff, and 9% went to trial. Of the thirty-two trial cases, three were still pending at the end of data collection, two settled during trial, one resulted in the judge directing the jury to return a verdict for the defendants, and one was decided by a judge. Not including the three cases still pending, twenty-five cases, or 7.7% of all malpractice suits, went before a jury. *Id.*

³³*Id.*

³⁴*Id.* The exact amounts were for \$1.28 million, \$1 million, and \$3.5 million.

³⁵*Id.*

³⁶*Id.*

³⁷VIDMAR, *supra* note 12, at 24. To calculate this figure, simply divide the total of all awards in the sample (\$7,722,488) by the total number of jury trials (109). *Id.*

³⁸*Id.* Expected value is defined as "equal to the average award when plaintiffs prevail multiplied by the probability of obtaining a verdict." *Id.* For his discussion, Vidmar relies on 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 (1991).

³⁹VIDMAR, *supra* note 12, at 28. Vidmar cites Frank M. McClellan, *MEDICAL MALPRACTICE: LAW, TACTICS, AND ETHICS* 102 (1994) at 102, who reported that assessing the merits of a case in 1991 costs at least \$2,000 and often \$5000 to \$10,000; if the case goes to trial, expenses may total \$50,000 to \$75,000.

⁴⁰VIDMAR, *supra* note 12, at 35: "The fact that plaintiffs win only one case in five seems to contradict the extreme claim that juries are prone to side with plaintiffs regardless of

Vidmar's figures clearly show that plaintiffs who took their cases to trial did not typically do well with juries, winning slightly less than one case in five. When plaintiffs did receive an award it was usually for a modest amount of money. Indeed, when examined in light of the time and effort expended by plaintiffs attorneys in preparing the lawsuit, as well as the delay suffered by the victim in obtaining compensation, it seems difficult to understand the motivation to take these cases to trial at all. Vidmar explains the decision this way: "Trial cases are the residue of a complicated winnowing process involving the interrelated decisions of many actors involved in the lawsuit. They are the result of negotiation and settlement attempts that have failed."⁴¹

How are the medical malpractice cases that go to trial different from the 90% of cases that are settled? Using data from the 1984-87 North Carolina study, Vidmar divided those cases that went to trial into five subgroups according to severity of injury: emotional or minor injury, temporary disability, permanent partial disability, permanent total disability, and death.⁴² Vidmar found that minor or emotional injuries accounted for only 5% of the cases, while temporary disability accounted for 27%, permanent partial disability 39%, permanent total disability 8%, and wrongful death cases 21%.⁴³

Vidmar then contrasted those findings with the percentage of cases that resulted in (a) trial, (b) settlement with the plaintiff, and (c) no payment to the plaintiff for each of the types of injury.⁴⁴ As one might expect, the results showed that jury trials occurred less frequently when the injured party suffered only minor or emotional injury (9%) or temporary disability (7%), but occurred more frequently when the injured suffered permanent total disability (13%) or death (13%).⁴⁵ Permanent partial disability cases fell in the middle, with trials occurring in 10% of the cases.⁴⁶ In minor or emotional and temporary disability cases, 52% and 47% of claims, respectively, resulted in no payment to the plaintiff.⁴⁷ In contrast, only 19% of permanent total injuries and 31% of death

the evidence on liability. The statistics on awards suggest that the claim of jury profligacy also may be overstated." *Id.*

⁴¹*Id.* at 82.

⁴²*Id.* at 50. Emotional or minor injury was defined as "fright; temporary pain and suffering; lacerations; contusions; minor scars; rashes; no delays in recovery." Temporary disability was defined as "infection; miss set fracture; fall in hospital; burns; surgical material left in body; drug side effect; delayed recovery." Permanent partial disability was defined as "loss of fingers; damage to organs; deafness; loss of one limb, eye, kidney, or lung." Permanent total disability was defined as "paraplegia; blindness; loss of two limbs; brain damage; quadriplegia; lifelong care or fatal prognosis." *Id.*

⁴³*Id.* Vidmar found a similar pattern in the 1987-90 data set as well.

⁴⁴*Id.*

⁴⁵VIDMAR, *supra* note 12, at 50.

⁴⁶*Id.*

⁴⁷*Id.*

injuries resulted in no payment.⁴⁸ According to Vidmar, "[s]ettlements occurred with greater frequency in cases involving the most serious injuries, but proportionately more jury trials of serious injuries occurred as well."⁴⁹

II.

If doctors who are sued are routinely found not liable, as Vidmar's studies show, then what accounts for the medical profession's hostility towards the legal system in general, and toward juries in particular? One theory, not advanced by Vidmar, is that doctors' fear of the tort system stems from the unpredictability of its imposition. The 1988 report of the American Medical Association's Specialty Society Medical Liability Project summarizes concerns about the competence of the jury:

Juries are not optimally suited to decide the complicated issues of causation and duty of care. Under the best of circumstances, the determination of professional liability is not easily made by laymen.

With respect to the major elements of liability—duty of care and causation—the parties almost always must present expert testimony, which the jurors cannot evaluate independently.

[J]uries can never be as effective at deciding these cases as specialized hearing officers because jurors are exposed to the medical issues only once and thus they cannot develop an institutional memory to aid them in deciding a specific dispute. This not only impairs their ability to decide each case, but it also leads to inconsistency in verdicts across cases.⁵⁰

Critics of the jury system argue that the system is too random to secure the twin goals of the tort system: corrective justice and deterrence.⁵¹ Doctors and other health care providers may be held responsible for plaintiffs' losses when they should not be—outcomes we refer to as "false positives." However, many defendants may be held not responsible for plaintiffs' losses when they should be—outcomes known as "false negatives." As all involved in the litigation process struggle to avoid false positives or false negatives, long delays and huge transaction costs result. These delays and transaction costs are felt acutely by both plaintiffs and doctors caught in the midst of this uncertain process.⁵² One commentator put it this way: "[D]octors aren't irrational. They're scared

⁴⁸*Id.*

⁴⁹*Id.*

⁵⁰American Medical Association (AMA) Specialty Society Medical Liability Project, *A Proposed Alternative to the Civil Justice System for Resolving Medical Liability Disputes: A Fault-Based Administrative System* 8 (1988), cited in VIDMAR, *supra* note 12, at 122.

⁵¹See generally Michael Saks, *Medical Malpractice: Facing Real Problems and Finding Real Solutions*, 35 WM. & MARY L. REV. 693, 722-25 (1994).

⁵²See O'Connell, *supra* note 26, at 871.

because they believe the system is random. Most people don't like to play Russian roulette, even if the odds of getting the bullet are only one in 200. Those are the odds of a test pilot, not a caregiver."⁵³

Is the present system successful in ferreting out actual cases of doctor malfeasance? Or are lawsuits merely an "expensive sideshow,"⁵⁴ a cumbersome method of income redistribution for severely disabled patients? Evidence is growing that there is a poor correlation between injuries caused by negligent medical treatment and malpractice litigation. At the beginning of his discussion of jury competence on liability questions, Vidmar describes a study conducted in the mid-1980's where a team of researchers at the University of Minnesota studied 220 obstetrics cases that resulted in malpractice claims. Each case was reviewed by five obstetricians.⁵⁵ The experts who reviewed cases concluded that common obstetrical risks were recognized and recorded in medical records only 54% of the time, and the attending physicians correctly managed the risk factors only 32% of the time.⁵⁶ The study also concluded, however, that lawsuits occurred in more than 30% of cases in which the risks were appropriately managed.⁵⁷

These findings are similar to those made by the famous Harvard Medical Practice Study, a sample of 31,000 patients treated in fifty-one New York State hospitals during 1984.⁵⁸ The hospitals were a representative sample of the state's acute-care, nonpsychiatric hospitals.⁵⁹ The study carefully oversampled high-risk patients and undersampled low-risk patients, and weighted them so that the sampled cases could be extrapolated to the state's 2.6 million hospital patients that year.⁶⁰

The study found that there was a poor correlation between a malpractice suit and the presence of actual malpractice. In their examination of the hospital records of the 31,000 patients, the authors found 280 negligent adverse events inflicted on the patient sample. The authors then report the "key finding" that of forty-seven patients filing malpractice claims as a result of their hospitaliza-

⁵³Howard, *supra* note 24.

⁵⁴See *infra* note 108 and accompanying text. See also Susan Okie, *Who Wins Medical Malpractice Cases? Study Suggests Deciding Factor Is Not Merit, but Whether Plaintiff Was Permanently Disabled*, WASH. POST, Jan. 14, 1997, at C, discussing the latest findings of the Harvard Medical Practice Study, *supra* note 25.

⁵⁵Thomas M. Julian, ET AL., *Investigation of Obstetric Malpractice Closed Claims: Profile of Event*, 2 AM. J. PERINATOLOGY 320-24 (1985), cited in VIDMAR, *supra* note 12, at 121.

⁵⁶*Id.*

⁵⁷*Id.*

⁵⁸Brennan, ET AL., *supra* note 25. The study was ultimately put into book form. See PAUL WEILER, ET AL., *A MEASURE OF MALPRACTICE* (1993).

⁵⁹WEILER, *supra* note 58, at x-xi.

⁶⁰*Id.* at 40.

tion,⁶¹ only eight were brought by the 280 patients who had been negligently injured.⁶² "Expressed in the form of ratios calculated from the sampling weights, the chances that a claim would be filed by a patient with an identifiable negligent injury was. . . only 1 in 50."⁶³ The authors then go on to say that a more accurate ratio of what we term "false negatives" falls between one in fifteen and one in thirty instances of malpractice⁶⁴—still a staggeringly high number of actionable malpractice suits that could be brought but are not. The Harvard data put the ratio of erroneous filings of malpractice claims to erroneous non-filings at roughly one to seven (thirty-nine to 272)⁶⁵—in other words, for every doctor or hospital against whom an invalid claim is filed, there are seven claims that could be filed but are not.⁶⁶ Not emphasized by the authors, but also important, was the data's flip side—that of the forty-seven claims filed, few demonstrated any actual negligence, and many demonstrated no discernable injury.⁶⁷

These studies remind us that medical negligence does indeed occur—with often disastrous results. But what are policy-makers to do with such data? The empirical assumption underlying the American Medical Association's criticisms of juries in malpractice cases is that neutral doctors would decide cases differently—i.e., less randomly—than do juries.⁶⁸ In 1992, the Physicians Payment Review Commission stated bluntly: "physicians probably apply the standard [of negligence] differently than do juries."⁶⁹

But Vidmar questions the baseline against which jury decisions are condemned. In the first place, while Vidmar recognizes that there is not a perfect match between lawsuits and negligence, he labors over the course of sixty pages to demonstrate that many, perhaps most, malpractice suits are not technically complex, and that jurors are just as capable as anyone else—doctors included—of determining liability: "[M]alpractice cases do not hinge *solely* on

⁶¹*Id.* at 71.

⁶²*Id.* at 73.

⁶³*Id.*

⁶⁴WEILER, *supra* note 58, at 74-75.

⁶⁵*Id.* at 73.

⁶⁶For a more thorough analysis on these points, see Saks, *supra* note 51, at 702-04.

⁶⁷WEILER ET AL., *supra* note 58, at 71: "[Of those 47,]

10 claims involved hospitalization that had produced injuries, though not due to provider negligence; and another three cases exhibited some evidence of medical causation, but not enough to pass our probability threshold. That left 26 malpractice claims, more than half the total of 47 in our sample, which provided no evidence of medical injury, let alone medical negligence." (emphasis added)

⁶⁸VIDMAR, *supra* note 12, at 161-62.

⁶⁹*Annual Report of the Physician Payment Review Commission: 1992*, at 186, cited in VIDMAR, *supra* note 12, at 162.

technical matters that are beyond the scope and comprehension of laypersons (emphasis added).⁷⁰ To prove his point, Vidmar relies heavily on "case studies" of five malpractice trials which took place in North Carolina between 1987 and 1990. Of these, Vidmar describes three as not complicated.⁷¹ A patient who suffered from urinary incontinence did not improve after her doctor performed a supposedly ameliorative procedure;⁷² a mother whose breech baby suffered from oxygen deprivation during delivery sued her doctor for incorrectly estimating the duration of her pregnancy;⁷³ the husband of a woman who died from a puncture wound caused by an enema tip sued for wrongful death.⁷⁴ Vidmar then discusses two "complicated" case studies—trials which involved highly technical medical issues or complications and resulted in substantial jury disagreement.⁷⁵ These included a suit by a woman who became permanently blind due to a late diagnosis of a blood clot in her brain,⁷⁶ and a suit by the estate of a man who died from a reaction to contrast dye administered to perform a CT scan.⁷⁷ Afterwards, Vidmar interviewed the jurors about their understanding of the evidence and their attitudes toward the trial and its participants.⁷⁸

In discussing this research, Vidmar points out that, as a rule, a plaintiff can succeed in a malpractice action only if expert testimony supports a finding that the defendant doctor failed to follow the customary or accepted practice then prevailing in the relevant specialty or discipline.⁷⁹ Vidmar uses his first three case studies to make the point that malpractice suits often revolve around conflicting testimony of witnesses between patients and doctors or between medical personnel, not complicated causation questions.⁸⁰ In cases such as

⁷⁰VIDMAR, *supra* note 12, at 157.

⁷¹*Id.* at 142: "I would argue that [the three cases] were not beyond the intellectual competence of the group ability of 12 jurors." *Id.*

⁷²*Id.* at 127-32.

⁷³*Id.* at 132-37.

⁷⁴ *Id.* at 137-42.

⁷⁵VIDMAR, *supra* note 12, at 145.

⁷⁶*Id.* at 145-49.

⁷⁷*Id.* at 151-55.

⁷⁸*Id.* at 149-51 (blood clot), *Id.* at 155-57 (CT scan).

⁷⁹*Id.* at 123-24: "In medical malpractice cases the legal guideline is whether the physician's treatment of the patient comported with the standards of professional practice followed by other physicians in the same field of medical practice in that community at the time that the injury occurred." See also WEILER, *supra* note 10, at 19.

⁸⁰Vidmar, *supra* note 12, at 141-44. ("My own conclusion from the research described in this chapter is that a prima facie argument can be made that there is nothing so extraordinary in many of the cases that most or all of a group of 12 laypersons could not understand them. In some the issue of negligence, or its absence, is pretty straightforward. In others, the primary issue revolves around the credibility of patients

these, jurors are well qualified to make determinations as to witness credibility—a juror, for instance, does not need to be able to decipher complex medical data to know that a doctor who dates a pregnancy primarily by the last menstrual period was violating a recognized duty of care and should be held liable.⁸¹

As for the two "complicated" trials, Vidmar suggests that contrary to the AMA's position, experts are no better than juries at deciding questions of liability.⁸² Vidmar argues that for medically complex cases, doctors themselves cannot often agree on whether the medical care given in a particular case is appropriate. In addition, jury findings of negligence are not the result of spontaneous eruptions of sympathy for the injured plaintiff; Vidmar finds "no support for the hypothesis that juries are prone to find doctors liable simply when the plaintiff's injuries are severe."⁸³ These "complicated" trials are disproportionately more likely to revolve around ambiguous evidence, so "there is often no clear or uncontestable criterion by which jury performance may be judged."⁸⁴ Therefore, there can be no definitive answer to the question of whether juries "get it right" since, "in the end, legal negligence is a matter of human judgment."⁸⁵

To test whether juror intuitions track those of neutral doctors regarding questions of negligence, Vidmar discusses at length a study based on data obtained from the New Jersey Medical Insurance Exchange, a

versus doctors about what occurred and when. In still others, good lawyers and experts appear capable of educating laypersons about complex matters"). Vidmar explains away the inconsistency and unpredictability in the tort trial process by suggesting that perhaps it is the quality and quantum of evidence that lawyers presented to juries, and not juror incompetence, that best explains variability in jury awards. *Id.* at 260 ("If evidence on damages differs from trial to trial, differences in awards should be ascribed to the fault of the trial process or the parties involved, not the jurors"). There is another, more damning, way to view Vidmar's alternative explanation for jury variability. See Neil Vidmar, *Pap and Circumstance: What Jury Verdicts Tell Us About Jury Behavior and the Tort System*, 28 SUFFOLK U.L. REV. 1205 (1994). In this article, Vidmar cites interviews with lawyers that indicate that they "try cases differently depending on whether the fact finder is a jury or a judge." *Id.* at 1221. In particular, "[a]ttorneys indicate that in bench trials they presented every relevant detail of the case, whereas in jury trials they culled the evidence, abbreviated it, and presented it in a different manner." *Id.* For Vidmar, this implies that judges and juries may "simply have been responding to different evidence." *Id.* But what accounts for the culling and abbreviation of relevant evidence may be a factor that itself correlates with jury incompetence. Perhaps lawyers (who presumably know what they are doing) are presenting a lesser quantum of evidence in response to what they justifiably perceive as juries' inability to understand complex medical issues. See also note 119, *infra*.

⁸¹VIDMAR, *supra* note 12, at 136-37.

⁸²*Id.* at 161.

⁸³*Id.* at 164.

⁸⁴*Id.* at 175.

⁸⁵*Id.*

physician-owned insurance company that provides liability insurance to approximately 60% of New Jersey's doctors.⁸⁶ In the New Jersey study, "each claim filed against a doctor was assessed internally by the insurance company according to whether the doctor's actions were consistent with prevailing standards of medical care."⁸⁷ The evaluation was designed to provide a neutral assessment of possible negligence, so that the insurance company could decide whether to contest liability.⁸⁸ "If the physician admitted error to the insurance company, the case was labeled "indefensible—insurer admits deviation [from standard of care]."⁸⁹ If the physician claimed no error, the insurance company asked a doctor from the same medical specialty to conduct a review of the case, and this physician-reviewer discussed the case with a claims representative from the insurance company, a defense attorney, and the defending physician. In this way, the authors purported to classify each of the cases as either "indefensible," "defensible," or "unclear."⁹⁰ The results: 62% of the cases were classified as "defensible," 25% "indefensible," and 13% "unclear."⁹¹

The authors then further classified each case into three categories according to severity of injury: low,⁹² medium,⁹³ and high.⁹⁴ Injury severity was low in 28% of the cases, medium in 47%, and high in 25%. Jury trials took place in 15% of the above cases classified as defensible, 5% of cases classified as indefensible, and 10% where defensibility was unclear. All told, jury trials accounted for 12%, or 988, of the 8,231 cases. Plaintiffs won 24% of the trials, with awards ranging from \$3,281 to \$2,576,377. The median award was \$114,170.⁹⁵

⁸⁶VIDMAR, *supra* note 12, at pp. 162-64, discussing Mark Taragin ET AL., *The Influence of Standard of Care and Severity of Injury on the Resolution of Medical Malpractice Claims*, 117 ANNALS OF INTERNAL MEDICINE 780 (1992). The database relied on by Taragin consisted of 8,231 closed medical malpractice cases occurring between 1977 and 1992. *Id.*

⁸⁷VIDMAR, *supra* note 12, at 163.

⁸⁸*Id.*

⁸⁹*Id.* For a more detailed discussion, see Taragin ET AL., *supra* note 86, at 780.

⁹⁰*Id.* Taragin, *supra* note 86, at 781, explains that the unclear category was used when the reviewing physician could not clearly state whether the standard of care was violated or when a panel of reviewers disagreed about whether it was violated. *Id.*

⁹¹VIDMAR, *supra* note 12, at 163. In neurosurgery and orthopedics cases, where experts historically have held divergent opinions about the appropriate approach to medical problems, a panel of physicians reviewed the case. See Taragin, *supra* note 86, at 781.

⁹²VIDMAR, *supra* note 12, at 163. "Low" injury was defined as no, minor, or temporary disability.

⁹³*Id.* "Medium" injury was defined as a major injury with temporary disability.

⁹⁴*Id.* "High" injury category involved grave injuries, brain injury with impaired life expectancy, and death.

⁹⁵*Id.*

The study compares these awards with the above-mentioned insurance company categorization of negligence and severity. Of greatest interest to Vidmar was the study's finding that jury verdicts on liability were positively and significantly related to the neutral physicians' assessments of negligence.⁹⁶ Moreover, according to Vidmar, "the study found no support for the hypothesis that juries are prone to find doctors liable simply when the plaintiff's injuries are severe."⁹⁷

What is one to make of this combination of anecdotal and empirical evidence? Even the harshest critic of the tort system might well concede the validity of Vidmar's assertion that malpractice cases do not hinge solely on technical matters that are beyond the scope and comprehension of laypersons. Though case studies may strike one as a less satisfactory method of examining the tort system than the empirical studies Vidmar used to discuss plaintiff-win rates, Vidmar believes that "the [case] studies do show the evidentiary and legal diversity of medical negligence trials, and they produce a profile of how the juries responded to specific issues."⁹⁸ If the point of including the case studies was to show that many malpractice cases are not technically complex, the point would have been made more powerfully if Vidmar had selected the cases randomly and not for illustrative purposes.⁹⁹ Indeed the case studies arguably do not "show" anything—at least not anything beyond themselves.¹⁰⁰

But Vidmar then commingles his case studies with his empirical data to form together the basis of his argument that jurors understand the "technical matters of medicine," and can impose findings of negligence consistently (or, at least, not randomly). It is sometimes difficult to square this conclusion with the evidence Vidmar himself presents. He discusses a study which finds that even in a context when doctors were asked to give neutral, unbiased judgments about 252 malpractice actions brought against a hospital, the doctors could provide no clear answer regarding negligence in 30.6% of the cases.¹⁰¹ Vidmar notes this study as proof that experts are no better at determining negligence than jurors, but it tends also to make a very different point—and one far more significant than one relating only to jury competence. As Philip Howard notes,

⁹⁶*Id.* at 164. See also Taragin, *supra* note 86, at 781.

⁹⁷VIDMAR, *supra* note 12, at 164. "The severity of the plaintiff's injury was not correlated with the probability that the plaintiff would win."

⁹⁸*Id.* at 160.

⁹⁹*Id.*

¹⁰⁰*Id.* at 157. These cases do not conclusively demonstrate that jurors were able to capably render appropriate verdicts on the "technical elements of medicine." *Id.* While it is clear that Vidmar tried to talk to all of the jurors involved in the case study trials, it is unclear how much weight these post-trial discussions should be afforded in light of Vidmar's inability to speak to many jurors. *Id.*

¹⁰¹Henry Farber and Michelle White, *Medical Malpractice: An Empirical Examination of the Litigation Process*, 22 RAND J. ECON. 199-217 (1991), cited in VIDMAR, *supra* note 12, at 167.

a possible one-third margin of error scarcely encourages confidence in the negligence criterion we use to judge those charged with taking care of us.¹⁰²

In addition, some of the conclusions Vidmar reaches may need to be revised in light of recent publications mentioned above. Vidmar cites the New Jersey study in concluding that jury findings of negligence are not the result of sympathetic bias arising out of injury suffered by the plaintiffs.¹⁰³ According to Vidmar, "There appears to be no relationship between the severity of the plaintiff's injury and verdicts for the plaintiff, refuting the claim that sympathy for injured persons causes jurors to ignore the legal issues bearing on negligence."¹⁰⁴ However, the New Jersey study itself recognized that prior studies had come up with different conclusions as to whether the degree of patient injury influences the probability of plaintiff payment.¹⁰⁵

In this connection, the Harvard Medical Practice Study has even more recently analyzed how accurately malpractice litigation lead to payment. As in the New Jersey study, the authors reviewed confidential medical records to determine the insurers' honest assessment of the patients' injuries. The study's

¹⁰²Howard, *supra* note 24.

¹⁰³See text at *supra* note 86, *et seq.* Vidmar mentions a second study by Farber and White that reaches the same conclusion regarding sympathetic bias, see Henry Farber and Michelle White, *A Comparison of Formal and Informal Dispute Resolution in Medical Malpractice*, 23 J. LEGAL STUDIES 777 (1994), cited in VIDMAR, *supra* note 12, at 167. In an expanded version of their earlier study, the authors find no relationship between winning and the severity of the plaintiff's injury. But Vidmar himself points out that Farber and White relied upon a very small sample of jury trials to reach their conclusion. *Id.* But see note 106 *infra* and accompanying text.

¹⁰⁴VIDMAR, *supra* note 12, at 173. See also text at note 97.

¹⁰⁵See Taragin, *supra* note 86, at 782. The authors cite the following studies to demonstrate that the findings on this question are inconsistent: General Accounting Office, *Medical Malpractice: No Agreement on the Problem or Solutions* (1986); F.W. Cheney ET AL., *Standard of Care and Anesthesia Liability*, 261 JAMA, 1599 (1989); R. Bovbjerg ET AL., *Obstetrics and Malpractice: Evidence on the Performance of a Selective No-fault System*, 265 JAMA, 2836 (1991); F.A. Sloan & C.R. Hsieh, *Variability in Medical Malpractice Payments: Is the Compensation Fair?* 24 L. & SOC'Y REV. 997 (1990).

Vidmar has been criticized for his failure to mention prominent studies elsewhere. See, Frank P. Grad, *Review: Medical Malpractice and the American Jury: Confronting the Myths About Jury Incompetence, Deep Pockets, and Outrageous Damage Awards* by Neil Vidmar, 335 NEW ENG. J. MED., July 11, 1996, at 139-40.

In 1973, the great study of medical malpractice by the Department of Health, Education, and Welfare was published (it is not cited by Vidmar). This report found that relatively few physicians are sued for malpractice and that of the lawsuits that do go to trial, most end in verdicts for the physician. But physicians fear such suits because they are a professional threat and a personal ordeal. The current system of private malpractice actions does not adequately control the professional behavior of physicians. But medical-malpractice boards nationwide have a poor record of enforcing professional discipline, and malpractice actions have become the only available disciplinary instrument.

Id.

findings indicate that in malpractice claims, *only* the severity of the patient's disability, not negligence or even the occurrence of an injury caused by medical care, was statistically significant in predicting whether a plaintiff would receive payment.¹⁰⁶

From its previous study, the Harvard authors identified 51 litigated claims and followed them over a ten-year period. Of the 51 malpractice cases, 46 had been closed as of December 31, 1995. Among those cases, 10 of 24 that were originally identified as involving no adverse event were settled, with a mean payment of \$28,760; six of 13 cases classified as involving adverse events but no negligence were settled, with a mean payment of \$98,192. By the same token, five of nine cases in which adverse events due to negligence were found were settled, with a mean payment of \$66,944, while almost every claim involving permanent disability—seven of eight—were settled for the plaintiffs, with a mean payment of \$201,250. The authors conclude, "Among the malpractice claims we studied, the severity of the patient's disability, not the occurrence of an adverse event or an adverse event due to negligence, was predictive of payment to the plaintiff."¹⁰⁷ As one writer on seeing these findings put it: "If the permanence of a disability, not the fact of negligence, is the reason for compensation, the determination of negligence may be an expensive sideshow."¹⁰⁸

The authors conclude that other random factors influence the decision to settle, apart from the severity of injury:

Our review uncovered examples of the 'art' of litigation. In some cases there were substantial settlements only because the physicians would have made poor witnesses; in others, there was a tenacious defense even though negligence was privately acknowledged; and in still others, the cases were prolonged as part of a legal strategy. Such maneuvers are accepted as part of the art of litigation. Nonetheless, they raise questions about whether tort law is the most effective system of compensating injured patients and creating rational mechanisms of preventing injuries.¹⁰⁹

In other words, the question is not whether there are some elements of the tort system which are defensible (the approach Vidmar appears to take), but whether, taken as a whole, the present system is a defensible means of compensating injured people. If the Harvard study is near the mark, the answer is a resounding no.

¹⁰⁶BRENNAN ET AL., *supra* note 25, at 1963-67.

¹⁰⁷*Id.* at 1963.

¹⁰⁸Peter Huber, *Easy Lawsuits Make Bad Medicine*, FORBES, Apr. 21, 1997, at 166.

¹⁰⁹BRENNAN ET AL., *supra* note 25, at 1967.

III.

Unlike the Harvard study, Vidmar blames a number of disparate forces, including the mass media, legal scholars, doctors, and the "tort reform" movement, for the public's dim view of the tort system.¹¹⁰ Admittedly, doctors' views on medical malpractice juries and the need for tort reform are influenced by the fact that they are the targets of medical malpractice lawsuits and are forced to pay the (sometimes extraordinarily high) cost of medical malpractice insurance. When Vidmar presents evidence to medical groups that juries in medical malpractice cases get it right most of the time, Vidmar describes the typical reaction from most doctors as one of incredulity, followed closely by an offer of contrary anecdotal evidence. But Vidmar argues there is more than self-interest at work: in advocating medical malpractice reform, doctors are "seeking social support for a symbolic reaffirmation of their role and importance in society."¹¹¹ As such, he argues, the medical profession is particularly likely to find anecdotal evidence regarding jury incompetence believable, with empirical data purporting to disprove jury incompetence perceived as a direct attack on their profession.¹¹²

Vidmar goes on to argue the "tort reform" movement—a loose confederation of the insurance industry, corporate and professional organizations (including the AMA), and conservative political groups—frequently attempts to create a negative image of juries in the minds of the public and legislators in order to advance its political agenda: "[t]he fact that the jury is composed of laypersons rather than professionals makes it vulnerable to appeals to "common sense" that it cannot be competent."¹¹³ To be fair, Vidmar notes that opponents of tort reform are themselves hardly paradigms of honesty: in a typical, "pox on both your houses" paragraph, Vidmar states: "'tort reform' is a political struggle in which both sides engage in lobbying and propaganda that contain some element of real problems, half-truths, and outright distortions."¹¹⁴

Our basic premise is that one does not need to be a partisan of defendants to believe the common law tort system as applied to malpractice injuries malfunctions on such a scale that any authority—state or federal—with colorable jurisdiction over it should be encouraged to reform it. But the changes should not be, as Vidmar rightly suggests, of the type already enacted or proposed at the behest of defense interests or by legislatures, state or federal.

¹¹⁰VIDMAR, *supra* note 12, at 266.

¹¹¹*Id.* at 268. For a conclusion that statistics support doctors' argument that liability insurance is unavailable or unaffordable, see F. Patrick Hubbard, *The Physician's Point of View Concerning Medical Malpractice: A Sociological Perspective on the Symbolic Importance of "Tort Reform"*, 23 GA. L. REV. 295, 296-97 (1989).

¹¹²VIDMAR, *supra* note 12, at 268. "When I have presented some of my findings to medical groups, a common response, at least initially, has been incredulity supported by the telling of anecdotes about doctors who have been sued." *Id.*

¹¹³*Id.* at 270.

¹¹⁴*Id.*

Those changes uniformly weigh in on the side of defendants by either making it harder for claimants to be paid (e.g., by restrictive changes in joint and several liability) or to pay them less when they are paid (e.g., by capping awards for pain and suffering and/or punitive damages). They also do not make all that much difference in changing the fortuity, delay and huge transaction costs of determining (1) whose conduct was faulty or (2) the monetary value of nonmonetary losses. Real, balanced tort reform should involve a fair trade, as under no-fault workers' compensation laws, making it easier for victims with arguably valid claims to be paid promptly but paying them less, thereby lowering fortuity, delay and transaction costs. No-fault reform raises, though, the possibly huge difficulties of *ex ante* definitions of medically adverse results which are to be paid on a no-fault basis.¹¹⁵

In response to these *ex ante* difficulties, the senior author of this article has proposed an *ex post* "early offers/choice" plan, whereby any defendant in a personal injury claim is given the option of offering to a claimant within 180 days after a claim is made periodic payment of the claimant's net economic loss—relatively prompt payment compared to the tort system.¹¹⁶ Such payment will cover any medical expenses, including rehabilitation and wage loss, beyond any collateral sources already payable to the claimant, plus a reasonable hourly fee for the claimant's lawyer. (A minimum amount of, say, \$100,000 would be available under the offer to anyone suffering very serious injury.) A defendant in a tort suit promptly offering to effect such an open-ended major medical/disability policy paying economic losses to the claimant forecloses further pursuit of a tort claim. In other words, the claimant is forced to accept such an offer. Indeed, one might term the proposal, "Offers that can't be refused." (Offers could be refused, however, and a tort claim for both economic and noneconomic damages pursued, when the defendant's misconduct was intentional or wanton, proved by clear and convincing evidence.) Under this proposal, no defendant is *forced* to offer such a settlement; this avoids imposing unmanageable new burdens on potential defendants which a complete no-fault scheme for medical or product injuries, defined *ex ante*, might well cause.

When would a defendant be inclined to make such an "early offer"? If after examining the claim the defendant, for example, determines that the claimant never was in its hospital, the defendant would obviously not offer to pay net economic loss. But apart from such clear cases, even if the defendant thinks it might be able to defeat a more arguable claim, it might also determine that it *is*, after all, a claim by its patient for an adverse condition that clearly resulted from a stay in defendant's hospital. Although the defendant may believe the

¹¹⁵See O'Connell, *supra* note 26, at 881-82; RICHARD EPSTEIN, SIMPLE RULES FOR COMPLEX WORLD, 104 (1995); Michael Trebilcock, *The Social Insurance-Deterrence Dilemma of Modern North American Tort Law: Canadian Perspective on the Liability Insurance Crisis*, 24 SAN DIEGO L. REV. 929, 986-90 (1987); DON DEWEES ET AL., EXPLORING THE DOMAIN OF ACCIDENT LAW: TAKING THE FACTS SERIOUSLY 136 (1996).

¹¹⁶O'Connell, *supra* note 26, at 883-85.

adverse result was not its fault, it would calculate what it would cost to pay the claimant periodically for his net medical expense and wage loss. If that sum turns out to be less than what the defendant would pay to defense lawyers plus its exposure to full-scale tort damages, including payment for non-economic damages like pain and suffering, the defendant would arguably have found a good trade.

Given the huge costs of defending tort cases and the gamble of having to pay large sums for noneconomic losses, defendants would arguably be prompted to offer economic losses not just in cases where they are sure to lose but even in many—perhaps most—cases it now faces in which the issue of liability is in doubt. One leading defense lawyer hypothesizes that of the 250 cases his large office was then defending, all in various stages of litigation, he would advise making an offer to pay claimants' net economic losses in 200 of them if such a law came into effect.

The essence of this "neo no-fault" proposal is the opportunity for many injured persons to obtain relatively fast payment for their economic losses, while being able to make use of the full tort apparatus in egregious cases. Incentives—but not requirements—are built to encourage early resolution of tort disputes. The bill thereby attacks, within the tort system itself, the grievously high burdens on all sides of resolving tort disputes. Nightmares of compensation that is uncertain, inaccurate, underserved, delayed or denied are dramatically reduced. Much of the tort system's deterrence is retained. In those instances in which the defendant's behavior is clearly and grossly unreasonable, the full threat of tort damages remains as a disincentive.¹¹⁷ Other defendants are not relieved of full scale tort liability unless they *earn* that relief through promptly reimbursing an injured victim's otherwise unmet economic losses.¹¹⁸ The plan thus permits some of the tort law's strengths to function—forcing those arguably at fault to bear substantial burdens for injuries inflicted.

IV.

Despite its author's suggestion, *Medical Malpractice and the American Jury* does not demonstrate that further efforts at fundamental medical malpractice reform are unnecessary. On the contrary, as the Harvard study shows, despite huge transaction costs and almost endless deliberations, there are huge numbers of patients each year who suffer negligent medical treatment without compensation, as well as huge numbers of patients who receive monetary

¹¹⁷See *id.* at 887-88, discussing the important need to retain the threat of non-economic damages in certain circumstances to deter egregious conduct.

¹¹⁸For the terms of a bill (not limited to medical malpractice) implementing the early offers proposal, see S. 1861, 104th Cong. (1996). For an earlier version (applicable only to federally funded health care recipients), see S. 1960, 99th Cong. (1985) reprinted in 131 Cong. Rec. S. 17765 (daily ed., Dec. 17, 1985).

rewards from doctors who did not injure them.¹¹⁹ This misdirection of resources costs all of us billions in higher insurance premiums and defensive medicine costs. Rather than preserve a grossly inefficient system which perpetuates these kinds of inequities, we should turn away from the present system—even if, as Neil Vidmar argues, we acquit the jury of malpractice.

¹¹⁹Note that Vidmar himself admits such defects in the tort system. See Vidmar, *supra* note 12, at 60: "Overall, the discovery process is expensive and time consuming." Likewise, he states: "The litigation process is also expensive." *Id.* As to earlier writing, see VIDMAR, *supra* note 80, at 1220. In that article, Vidmar points to "other factors" than jury bias to explain tort law's inconsistency and unpredictability, but we emphasize that these other factors are themselves indictments of tort law as a woefully inadequate system of compensation, deterrence, or corrective justice. For example, in an attempt to explain away that blacks and women do not fare well in their treatment from juries in Cook County and San Francisco, Vidmar points to "other factors" such as the fact that "blacks may retain less competent lawyers, blacks may not be able to afford the economic or other experts to demonstrate liability or the costs of their injury, and blacks may have lower incomes and therefore cannot demonstrate economic losses as large as those of whites." VIDMAR, *supra* note 12, at 1220. Even if we grant Vidmar's point, that "jurors may be responding to different evidence and the quality of the evidence and arguments rather than engaging in discrimination," *id.*, we ought not fail to notice that our very expensive tort system itself is guilty of discrimination. Surely, there is a correlation between one's inability to play very expensive legal games and one's need for prompt compensation for injury. As for tort law's more regressive nature in contrast to no-fault, see Jeffrey O'Connell ET AL., *The Comparative Costs of Allowing Consumer Choice For Auto Insurance In All Fifty States*, 55 MD. L. REV. 160, 175-77 (1996). In the same article, Vidmar suggests that "[a]s a result of black's [sic] lesser wealth, they may have greater needs for immediate money, and thus plaintiffs settle for less money rather than face trial." VIDMAR, *supra* note 12, at 1220 note 82. For Vidmar, this offers a "selection confound," ostensibly absolving juries of bias. *Id.* But that defendants can use the complexity and dilatory nature of the tort system to coerce those most desperately in need to accept especially inadequate compensation condemns the tort system itself, does it not? See also *supra* note 80.

