

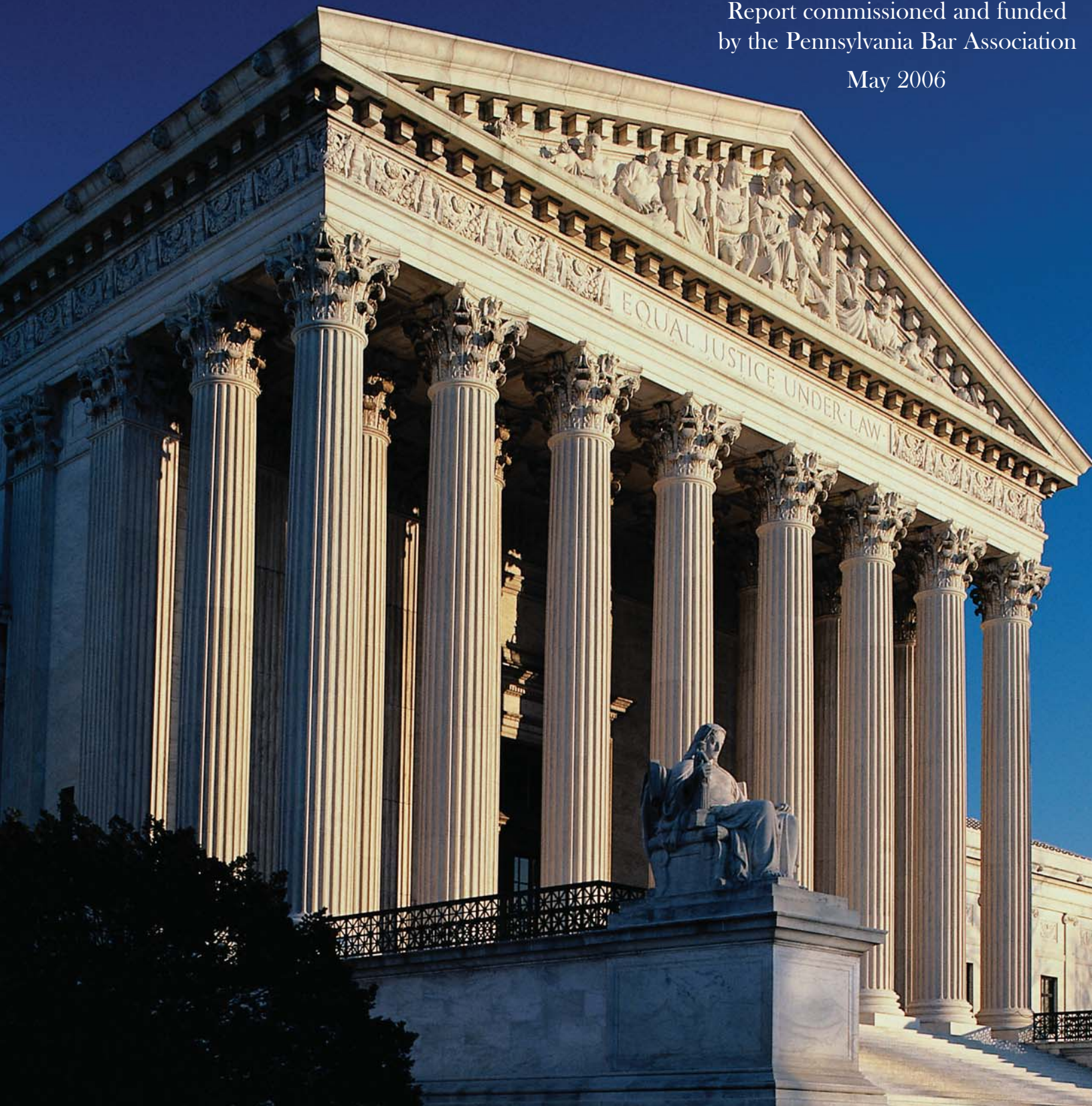
# Medical Malpractice Litigation in Pennsylvania



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by the Pennsylvania Bar Association

May 2006



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**A Report for the Pennsylvania Bar Association**

*by Neil Vidmar, Ph.D.*

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May 2006

Neil Vidmar is Russell M. Robinson II Professor of Law at Duke Law School and  
Professor of Psychology, Duke University.

This commissioned report was conducted independently of Duke University. The opinions and conclusions in the report are solely those of the author and do not necessarily represent the opinions of Duke Law School or Duke University. Kara MacKillop and Jordan Namerow provided assistance with the research for this project.

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# Executive Summary

- Medical malpractice lawsuits are a controversial topic. Despite a series of changes to the legal system in 2002 some groups have called for additional measures, including the creation of an alternative court system for medical malpractice cases and a cap the “pain and suffering” component of jury awards.
- This report draws upon existing data and research to assess whether the changes to the legal system in 2002 in Pennsylvania have corrected the perceived problems with its tort system. It also discusses the issue of whether further changes would be fair to negligently injured patients and whether they would have any effect on liability insurance premiums and availability of doctors.
- The report draws attention to an often-ignored subject: the plight of patients who have been injured through medical negligence. It also addresses claims that Pennsylvania has been losing doctors to other states as a result of the malpractice litigation climate.
- In 2002 The Supreme Court of Pennsylvania made four major rule changes and the Pennsylvania General Assembly passed eight other changes intended to correct deficiencies in the medical malpractice tort system. (Chapter 1).
- Pennsylvania Supreme Court Statistics show that, following the rule changes malpractice claims dropped 37% from immediately preceding years. In 2004 the number of MCARE (Pennsylvania’s liability compensation fund) payments was down 12.6% and the annual payout was down 17.5%. (Chapter 2). In the debate over the need for further changes in the legal system, patients are often implicitly portrayed as undeserving, greedy and manipulated by trial lawyers, but the evidence shows that there is a high incidence of medical negligence and the economic costs to injured patients can be devastating. Injured patients need lawyers to pursue their right to compensation. (Chapter 3).
- Juries are often characterized as biased against doctors, incompetent and irresponsible, but research shows that doctors win in more than two out of three cases tried to juries and that the amounts of jury awards are positively related to the seriousness of the injury. Trial judges and neutral medical experts tend to agree with jury verdicts. Very large awards are usually settled for a small fraction of the actual verdict. In any event jury awards constitute only a small fraction (between 5% and 7%) of all medical malpractice payouts; most cases are settled prior to trial. (Chapter 4).
- Plaintiff win rates in Philadelphia are somewhat higher than in the rest of the state, but this is likely due to case selection factors. However, even in Philadelphia doctors and hospital prevail over plaintiffs in most jury trials. An examination of the jury awards over \$1 million shows that the patients in these cases suffered very severe injuries or death. Research shows that large awards are often settled for much less than the original jury verdict. (Chapter 5).
- Research shows that caps on pain and suffering are unfair to patients with the most severe injuries, to women, to elderly persons and to children. While caps reduce the amounts of payments to negligently injured patients, research does not support the proposition that caps reduce the liability insurance premiums of doctors. (Chapter 6).
- Despite claims that Pennsylvania is losing doctors to other states as a result of high liability insurance premiums, official statistics from the American Medical Association and from the Federation of State Licensing Boards show an actual per capita increase in treating physicians. (Chapter 7).

There is no question that over the past several years doctors in Pennsylvania, and indeed in many states, experienced a substantial increase in their professional liability insurance premiums. Medical groups and liability insurance companies have blamed the problem on the tort system.<sup>1</sup> Consumer groups and other organizations have ascribed the problem to the actual incidence of medical malpractice and to problems associated with the business cycle for professional liability insurers.<sup>2</sup>

Although the Pennsylvania General Assembly and the Pennsylvania Supreme Court have each undertaken major actions to address perceived deficiencies with the tort system, medical groups and insurers have argued that additional actions are required. Specifically, they argue that there is a pressing need for an alternative court system and various additional reforms, including a cap on the pain and suffering component of jury awards in medical malpractice cases.

The calls for additional reforms, particularly an alternative court system, need to be evaluated in the light of two main considerations. Article IX. of the 1776 *Declaration of the Rights of Inhabitants of the Commonwealth of Pennsylvania* asserts, “That in controversies respecting property, and in suits between man and man, the parties have a right to trial by jury, which ought to be held sacred.”<sup>3</sup> Second, any attempt to change that right based upon the claim of a medical malpractice tort system in crisis needs to be evaluated in the light of empirical evidence bearing on that claim.

The purpose of this report is to address the second consideration. It draws upon existing data and research to assess whether perceived shortcomings with the Pennsylvania tort system have been addressed with changes already undertaken. It also discusses the issue of whether a cap on pain and suffering would be fair to negligently injured patients and whether it would have any effect on liability insurance premiums and availability of doctors. The report also addresses claims that Pennsylvania has been losing doctors to other states as a result of the malpractice litigation climate.

## Claims About the Failure of the Tort System

The cost of medical liability insurance is a complex problem, involving patient safety, the legal system, and insurance reform.<sup>4</sup> However, a major focus has been on the claimed need for further changes to the legal system.<sup>5</sup>

Exploring alternative dispute systems, placing a limit on “non-economic” damage awards, and placing a cap on the amount of money that plaintiff lawyers charge for their services are all advocated changes to the legal system. Contingency fees of 30 to 40 percent plus expenses have been described as exorbitant, and a more structured system for legal fees has been suggested. The “jackpot payday” claim appears to be based on the beliefs that Pennsylvania juries are easily misled, anti-doctor, incompetent or irresponsible in rendering verdicts and that lawyers file frivolous lawsuits that nevertheless cost medical liability insurers many dollars to defend.

A 2005 report published by the Pennsylvania Medical Society entitled *The State of Medicine in Pennsylvania* included a discussion of physician liability issues. While acknowledging that MCARE payouts reached a new low level in 2005, the report went on to state that “it is still uncertain whether policy interventions have succeeded in changing... [previous] trends”<sup>6</sup> and asserted a need to permanently address the “medical liability dilemma.” The particular solution or solutions were unstated.

## The Goals of This Report

This report assesses the empirical viability of the claims about the tort system by drawing upon statistical data from the Supreme Court of Pennsylvania, the Philadelphia County Court of Common Pleas, the Medical Care Availability and Reduction of Error Act (MCARE) fund, the American Medical Association

(AMA) and the Federation of Medical Licensing Boards. In addition, the report involves original research in the Pennsylvania Court of Common Pleas and draws upon bodies of research bearing on jury performance and the processes of settling malpractice claims.

A second set of goals is to draw attention to the needs of patients who have been injured through medical malpractice. Most of the public debate tends to ignore the fact that substantial numbers of patients are injured through medical negligence and sometimes suffer catastrophic economic and emotional losses. The report explains the needs of injured persons and the role of the legal system in attempting to meet those needs.

## **Recent Changes to the Tort System in Pennsylvania**

In some respects, until 2002, Pennsylvania was behind other states in instituting certain changes to the tort system. But in that year, both the Pennsylvania Supreme Court and the Pennsylvania General Assembly undertook actions that bring Pennsylvania up-to-date. As this report will show, there is evidence indicating that some of the effects of these changes are already evident, and it is likely the changes will impact the medical malpractice climate even more in the immediate future.

Recognition of these changes in the legal system is important in understanding some of the statistics presented in this report, as well as understanding the present and longer-term effects on the tort system.

### **Supreme Court Rule Changes In 2002**

In 2002, the Supreme Court of Pennsylvania recognized shortcomings with the existing processes of litigation that could be addressed by significant changes in the Pennsylvania Rules of Civil Procedure.<sup>7</sup> These are summarized below with brief commentary on their intended effects.

**1. Certificate of Merit** — Rule 1042.3 now requires that any legal action claiming that a licensed professional deviated from the standard of care, the plaintiff or the plaintiff’s attorney must file with the court a written statement that a licensed professional has reviewed the case facts and concluded that there is a reasonable probability that the person against whom the claim is being made deviated from the accepted standard of care. Prior to this Rule, a plaintiff could file a claim on mere speculation. The Rule is intended to curb frivolous lawsuits.

**2. Change of Venue** — Rule 1006 requires that a lawsuit must be filed in the county in which the alleged injury — the “cause of action” — occurred. Prior to the enactment of Rule 1006, many lawsuits were filed in Philadelphia (and perhaps other cities, like Pittsburgh), even though the alleged injury may have taken place elsewhere because it was convenient for the lawyers or because the lawyer believed a more favorable jury result could be obtained in that city. As will be seen in a following chapter, evidence strongly suggests that the Rule has successfully achieved this aim.

**3. Dismissal Upon Affidavit of Noninvolvement** — Rule 1036 allows a healthcare provider named in a lawsuit to submit an affidavit stating that he or she had no involvement in the alleged injury. Plaintiffs and their lawyers are often uncertain of which healthcare providers might actually bear some or all of the responsibility for the negligence. As a consequence, they name all providers, causing grief and costs to the noninvolved provider. The new Rule not only allows the provider to opt out early from the suit, but may also assist plaintiffs and the court by eliminating defendants at an early stage in the lawsuit.

**4. Jury Instructions on Non-Economic Losses** — Rule 222.3 directs the trial judge to provide the jury with guidance on how to determine damage awards by enunciating the components of non-economic losses including past and future “pain and suffering,” “embarrassment and humiliation,” loss of ability to enjoy the pleasures of life,” and “disfigurement.” The new jury instructions provide the specific definitions of each relevant component and the standards of juries are to apply, i.e., “the plaintiff is entitled to be fairly and adequately

compensated.” The jury is told that it should consider eight criteria that include the plaintiff’s age, severity of injuries and whether they are temporary or permanent, the extent to which the injuries affect the basic activities of daily living, etc. In the past, judicial instructions were more general and the jury had to rely on submissions by the plaintiff and defense lawyers during closing arguments.

These rules were expected to have an effect on litigation and jury awards for cases filed in 2003 and after. They were not expected to affect cases filed before that date. As will be discussed in Chapter 2, evidence of substantially reduced new court filings is consistent with the expected effects of these rule changes.

## **Legislative Changes**

The Pennsylvania General Assembly passed the Medical Care Availability and Reduction of Error Act (MCARE) Act in 2002.<sup>8</sup> MCARE replaced the Catastrophic Injury Fund (CAT Fund). MCARE assists in Pennsylvania’s health care system in a number of ways. It provides excess liability coverage to reduce the liability insurance premiums of doctors and hospitals. It created the Patient Safety Authority intended to collect data on medical errors and thereby assist in designing systems-level improvements in the delivery of medical care. However, it also contains important provisions that change the trial of medical malpractice cases.

**1. Expert Testimony** — Section 1303.5049(c) requires that, with a few exceptions, expert testimony is necessary to prove the standard of care was violated. Section 1303.512 specifies criteria for experts, namely a person with the education and experience to offer a competent opinion to the jury or other trier of fact in the area relevant to the issues in dispute. This section also clearly defines the criteria for determining the “standard of care” so that the trial judge may make an informed ruling on whether the expert is competent to testify.

**2. Punitive Damages** — Section 1303.505 limits punitive damages in medical malpractice cases to those relatively rare instances in which the provider engaged in “wanton conduct or reckless indifference to the rights of others,” or “gross negligence.” The section also limits “vicarious liability” for punitive damages for acts of a health care provider’s agents to very exceptional circumstances. This Section also “caps” punitive damage awards at 200% of the compensatory damages awarded.

**3. Affidavit of Non-Involvement** — Section 1303.506 mirrors the Supreme Court Rules of Civil Procedure by allowing a health care provider to ask for dismissal as a defendant by providing an affidavit of non-involvement in the actions that led to the alleged injury.

**4. Statute of Repose** — Section 1303.513 sets a time limit of seven years from the date of the alleged medical negligence for the plaintiff to file a lawsuit. A wrongful death claim must be filed within two years. There are exceptions to these limits for persons who were minors at the time of the incident and for injuries caused by a foreign object left in the body following surgery. The intent of this provision is to prevent a plaintiff from making claims many years after the alleged incident when evidence to support a defense may have disappeared (e.g. records lost or witnesses becoming unavailable.)

**5. Collateral Source Rule and Damages** — Section 1303.508 proscribes a plaintiff from claiming past medical and past lost earnings resulting from the injury that are paid by a health or wage insurer prior to trial. In the past, a plaintiff could claim those losses even if they had been paid by another source. There are some exceptions to this rule, but it is expected to reduce the amount of damages a plaintiff can recover.

**6. Determination of Damage Award and Payments** — Section 1303.509 makes a number of changes to the way that the jury or other trier of fact determines damages and how the payments are to be made. In the past, juries typically returned “general” verdicts, i.e. a lump sum amount that did not tell the valuation of each of the components of the damage award. This section of the legislation requires a “special verdict” in which the jury or other trier of fact must specify a dollar amount for each component of the award: that is what is

awarded for past and future medical, income and other losses. This section also allows the future damages to be awarded in periodic payments rather than in a lump sum.

**7. Reduction To Present Value** — Section 1303.510 provides that future damages for loss of earnings or earning capacity shall be redeemed to present value. While the jury or other trier may consider the effects of inflation and medical care improvements in calculating the future damages award, the award must be “reduced to present value,” that is what the award is worth in today’s dollars.

**8. Remittitur Review of Damages** — Section 1303.515 (a) requires the judge in malpractice cases to review the damage award and “consider evidence of its impact, if any, upon the availability or access to health-care in the community.” As will be discussed below, the jury’s verdict is not the final word until the trial judge approves the verdict and enters judgment. While judges have always had *remittitur* power, the new statute directs their attention in a more focused way to verdict review and presumably allows a lower standard for adjusting a jury verdict.

## Summary

Claims have been made that the tort system for medical malpractice cases in Pennsylvania is flawed. The claims suggest that a major problem lies with juries giving “jackpot” or “lottery” awards and encourages lawyers to file “frivolous” lawsuits in the hope of getting an undeserved payday. In turn, jackpot awards and frivolous cases allegedly cause defendants and their insurers to settle cases for more than they are worth out of fear that they will suffer a devastating jury verdict. As a direct consequence of these claimed flaws, it is suggested that professional liability insurance rates have increased so much that doctors are leaving Pennsylvania for states with more hospitable climates. A major claim is that a needed remedy is a cap on the “pain and suffering” and other “non-economic components of awards” (such as damages for “disfigurement”).

The claims have ignored the fact that both the Pennsylvania General Assembly and the Pennsylvania Supreme Court have already taken substantial actions to reduce frivolous lawsuits, to provide juries with guidance in determining damage awards, to reduce the economic damages that can be claimed in lawsuits, and to provide for periodic payments spread over years. The data in this report strongly suggest that court-initiated changes have had an immediate effect on the legal system, most dramatically on the number of and location of new filings. The legislative changes, on the other hand, were expected to be effective over the longer term. Overall, thirteen changes were made in 2002 that were intended to curb any abuses of the litigation system.

## Overview of the Rest of This Report

In the chapters that follow the report examines data bearing on the performance of the tort system in Pennsylvania and elsewhere, recent trends in malpractice claims, and the perspective of patients who have been injured through medical negligence. The perspective of injured patients has been largely ignored in the tort reform debate. Chapter 3 fills an important gap in the current public policy debate in Pennsylvania by discussing the problems of negligently-injured patients. Two chapters examine the role of the jury in deciding malpractice cases and especially the amount cases are settled for following jury verdicts. One chapter is devoted to an examination of what research has shown about the effect of caps on pain and suffering on the amounts plaintiffs recover, on professional liability insurance premiums, and the supply of doctors. A final chapter examines the claim that Pennsylvania has suffered a loss of doctors.

## Chapter 2      The Frequency of Claims and Payouts in Pennsylvania: Effects of Recent Reforms

**H**ave medical malpractice claims and payouts increased over the past half-decade? The Supreme Court of Pennsylvania has provided comprehensive and reliable statistics for the years 2000 through 2005.<sup>9</sup> The MCARE fund has statistics on payouts that extend even farther back.

### Context for Understanding Claims and Payouts: Caveats

Claims that appear in court do not necessarily reflect all of the claims that may be made for medical negligence. Some medical negligence claims are settled without a lawsuit being filed. Although data are not available for Pennsylvania, a recent study of closed claims in Florida that covered the years 1990 through 2003 showed that 20.2% of negligent claims were paid without a lawsuit being filed and another 6.3% were settled for payment during arbitration.<sup>10</sup> These payments were not just claims involving small amounts of money. Of claims involving \$1 million or more, almost 15% were settled without a formal lawsuit.

Similarly, many lawsuits filed in court never reach jury trial. The Florida research showed that fewer than 3% of all paid claims were a result of a jury trial; even among cases involving payments of a million dollars or more, only 7.5% were made after a jury trial.<sup>11</sup> A Texas study showed that from 1998 through 2002, jury verdicts for plaintiffs never amounted to more than 5% of paid claims in any year and averaged at about 3% per year.<sup>12</sup>

Research in North Carolina showed that roughly 45% of lawsuits resulted in no payment being made to the plaintiff.<sup>13</sup> The data from Florida showed a similar figure, around 44%.<sup>14</sup> It is important to point out, however, that claims resulting in no payment often incur legal fees, sometimes substantial legal fees, especially in trial cases.

Claim frequency as reflected in court statistics, therefore, is only a rough measure of claiming behavior.

### Claim Frequency in Pennsylvania: 2000-2005

Table 2.1 reports the frequency of court filings in medical malpractice cases in Pennsylvania. It shows that the mean number of medical malpractice filings dropped dramatically — 37% — in the three years of 2003 through 2005 compared to the mean of the previous three years. Specifically there was an average of 1741 cases per year for the 2003 -2005 period, versus 2751 cases per year for the 2000-2002 period.

**Table 2.1: The Frequency of Medical Malpractice Filings Pennsylvania: 2000-2005**

<i>Year</i>	<i>Pennsylvania Filings</i>
2005	1698
2004	1815
2003	1712
2002	2917
2001	2678
2000	2660

This drop of 37% coincides with the changes enacted by the Legislature and rules passed by the Supreme Court.

## Filings in Selected Counties

Table 2.2 presents data on the five Pennsylvania counties with the largest numbers of filings. Philadelphia is the largest county and has the largest number of filings. The data show that in 2003 and 2005 the number of filings in Philadelphia dropped 48.8% compared to the previous three years. In contrast, the number of filings in nearby Montgomery County jumped to 102 cases from around an average of 22 cases in the 2000-2003 period. Allegheny County showed a substantial drop in 2002, although a 9.1% increase in 2005 over 2004.

**Table 2.2: Filings in Selected Counties: 2000-2005**

<i>Year/County</i>	<i>Philadelphia</i>	<i>Montgomery</i>	<i>Allegheny</i>	<i>Dauphin</i>	<i>Lackawanna</i>
2005	540	104	324	44	35
2004	599	102	297	41	31
2003	577	14	272	43	34
2002	1365	21	426	82	69
2001	1162	26	372	83	88
2000	1085	18	399	71	99

The shifts in case filings from Philadelphia County is most likely a result of the Supreme Court's rule change requiring that cases be filed and litigated in the county where the alleged malpractice occurred. It seems likely that Montgomery County's increase was from the transfer of cases from Philadelphia. The 9% increase in Allegheny County in 2005 may be only a statistical fluctuation and needs to be viewed in the context of the state-wide drop of 37% in filings.

## Changes in Frequency and Amount of Payments by the MCARE Fund

The MCARE fund keeps statistics on both the annual frequency and annual amounts of payouts. Table 2.3 reports the frequency of cases involving payouts, the total amount of payouts, and the average payout per case from 2001 through 2004 with a comparison year of 1995. As a comparison guide, Table 2.3 also provides rounded data on the number of licensed treating physicians practicing in Pennsylvania.

**Table 2.3: MCARE Payout Frequency Total Annual Payout and Number of Licensed Physicians: 1995, 2001-2004\***

Year	Number of Cases	*Total Annual Payout	Number of Licensed Physicians**
2004	476	\$320,669,132	33,000
2003	543	\$388,830,361	31,247
2002	534	\$365,596,355	29,221
2001	547	\$342,930,844	30,292
2000	544	\$374,280,951	29,043
1995	550	\$346,409,178	29,337

\* Payouts adjusted to 2004 dollars by consumer price index

\*\* Source: Federation of State Medical Boards at <http://www.fsmb.org>.

The table shows that in comparison to 2003, there were 67 fewer paid cases in 2004, a 12.6% decrease. Compared to 2000, there was a 12.5% decrease. It is important to draw attention to the fact that a decrease in filings does not affect cases already in the court system. However, as filings decrease the defense costs for liability insurers would also be expected to decrease, particularly with respect to cases that result in no payment to the claimant.

Going back 10 years to 1995, the number of cases in 2004 was 13.5% less than a decade before. The 1995 comparison is particularly striking when it is considered that there were 12.5% more licensed treating physicians in 2004 than there were in 1995. In short, the number of Pennsylvania doctors was up 12.5% and the number of paid claims was down 13.5%.

Table 2.3 also shows that in 2004 the total annual payout from MCARE was over \$68 million less than in 2003 — a 17.5% drop. In fact, after adjusting for inflation, the payout in 2004 was actually 7.4% less than in 1995.

A recent report by *Issues Pennsylvania*<sup>15</sup> stated these figures with minor differences, also citing the Pennsylvania Department of Insurance. That report said the total MCARE payout in 2004 was \$318.9 million compared to \$376.8 million in 2003 and \$348.1 million in 2002. It stated that the total number of MCARE paid claims decreased 13% from 2003 to 2004 and that the total number of cases in which MCARE made a payment in 2004 decreased 14% from 2003. That report further stated in 2004 the average per-claim payout was \$515,250 compared to \$539,045 in 2003. The average per-case payout in 2004 compared to 2003 decreased to \$671,452 from \$695,189.

The *Issues Pennsylvania* report concluded that most of the drop in payouts is probably due to a decreased number of claims. Nevertheless, it cautioned that while total MCARE payouts decreased 18% the average per-claim payout decreased only 4% and the average per-case payout decreased only 5%. It further cautioned that changes in MCARE requirements, such as the threshold for a claim to reach the MCARE excess limits, would also affect the amount paid out by MCARE. The *Issues Pennsylvania* report did not elaborate

further, but there are plausible alternative explanations for the relatively smaller drop in the average per-case payouts. One is that the dollar amounts for medical and lost income for injured patients increased. Another is that more serious injuries were represented in the claims being made by injured patients. There are no available data to support or refute these alternative explanations at this time.

The 2005 Pennsylvania Medical Society report discussed above adds additional information. It stated that in comparison to MCARE payouts of \$379 million in 2003 and \$320 million in 2004, the projected payout for 2005 was \$232 million.<sup>16</sup>

Although the data collected for this report, the *Issues Pennsylvania* data and the Pennsylvania Medical Society data differ in minor ways, they all point in the same direction: a big downward shift in MCARE payments.

## **Conclusion**

Even with some shifting internally within various counties, the data in this chapter reveal a dramatic drop in overall Pennsylvania new filings beginning in 2003. This astounding drop roughly coincides with the actions of the Supreme Court and the Pennsylvania General Assembly that took effect in 2003. Possibly some other factors could have contributed to the drop, as discussed immediately above, but it is hard to escape a conclusion that the changes in the Pennsylvania tort system have been effective in eliminating frivolous filings.<sup>17</sup> The other important finding is that the total annual MCARE payments decreased substantially in 2004 and 2005.

In most of the public discussion about medical malpractice reform, little or no attention has been given to the plight of patients who are injured through medical negligence. Certainly the plight of doctors with respect to medical liability insurance is an important issue and needs to be addressed, but consideration must be given to the plight of patients injured through medical negligence. The Pennsylvania Constitution provides that for every wrong, the doors of the court are open to provide a remedy.

In fact, when public discussion about changes to the legal system for medical malpractice cases takes place, patients are by innuendo characterized as greedy, undeserving and manipulated by trial lawyers. It is appropriate, therefore, that the plight of injured patients is discussed before we turn to other data bearing on the tort system itself.

### Injuries from Medical Negligence Occur

The Harvard study of medical negligence examined hospital records of 31,000 patients and concluded that one out of every 100 patients admitted to hospital had an actionable legal claim based on medical negligence.<sup>18</sup> Some of these patients' injuries were minor or transient, but 14% of the time the adverse event resulted in death and 10% of the time the incident resulted in hospitalization for more than six months. Significantly, seven of those ten persons suffered a permanent disability. Generally, the more serious the injury the more likely it was caused by negligence.<sup>19</sup> Subsequent research involving Utah and Colorado found rates of negligent adverse events that were similar to the New York findings.<sup>20</sup>

There are reasons to believe that the Harvard study may have underestimated the incidence of medical negligence because the data were based solely on hospital records. Andrews conducted a study in a large Chicago-area hospital and studied actual incidence of negligent events in hospital wards.<sup>21</sup> Andrews discovered that many injuries were not recorded on the records as required, especially when the main person responsible for the error was a senior physician. Other research is consistent with the Andrews's findings.<sup>22</sup> For example, in one study, Dr. Thomas Julian had a panel of obstetricians review obstetric malpractice claims.<sup>23</sup> He concluded, "...common obstetrical risks were often not recognized or not recorded in medical records."

In 2000, the Institute of Medicine produced a report that relied on these studies and other data.<sup>24</sup> The report concluded that each year 98,000 persons die due to medical error and that many other patients sustain serious injuries.

In 2004, HealthGrades, Inc., a company that rates hospitals on health care for insurance companies and health plans, studied Medicare records in all fifty states for the years 2000 to 2002.<sup>25</sup> HealthGrades concluded that the Institute of Medicine's figure of 98,000 deaths was too low and that a better estimate was 195,000 annual deaths. In addition the HealthGrades report estimated that there were 1.14 million "patient safety incidents" among thirty-seven million hospitalizations. HealthGrades further concluded that "[o]f the total 323,993 deaths among Medicare patients in those years who developed one or more patient-safety incidents, 263,864, or 81 percent, of these deaths were directly attributable to the incidents" and that "[o]ne in every four Medicare patients who were hospitalized from 2000 to 2002 and experienced a patient-safety incident died."

In 2005 HealthGrades released another annual report that found 1.24 million total safety incidents.<sup>26</sup> The report concluded that "for the second year in a row, patient safety incidents have increased — up from 1.14 and 1.18 million reported in HealthGrades' First and Second Annual Patient [reports]." The report further concluded that "Of the 304,702 deaths that occurred among patients who developed one or more patient safety incidents, 250,246 were potentially preventable."

It is important to note that the patient error rates reported in the IOM and the Healthgrades reports *do not always mean that negligence was involved*. Additionally, some critics have charged that the various estimates in these studies are too high.<sup>27</sup> However, there is no serious question that medical negligence not only

occurs, but that it occurs at a substantial rate. Indeed, recent calls by medical groups to have malpractice claims settled through special courts without juries is an implicit acknowledgement that medical negligence occurs at a rate that may require a special court to process all of the potential claims.<sup>28</sup>

## **Medical Negligence in Pennsylvania**

There are no available data that allow an accurate calculation of the incidence of medical malpractice in Pennsylvania. However, the Pennsylvania Patient Safety Reporting System, established by the Pennsylvania Patient Safety Authority, produced a report on medical errors in Pennsylvania occurring between June 7 and December 31, 2004.<sup>29</sup> The report is very clear in cautioning the reader that medical errors do not necessarily mean that medical negligence was involved! The report contains information on “serious errors” defined as “an event, occurrence or situation involving the clinical care of a patient in a medical facility that results in death or compromises patient safety and results in an unanticipated injury requiring the delivery of additional health care services to the patient.” Some of the reported events involve “slip and fall” injuries that should not be considered medical error. In other instances, an unanticipated event may not be due to negligence, i.e. an allergic reaction to a medicine in which neither the patient nor the physician was aware of any allergies.<sup>30</sup>

Nevertheless, the report provides insight into some of the potential negligent medical errors that occurred in Pennsylvania. Between June 7 and December 31, 2004, a total of 3,747 serious events were reported.<sup>31</sup> Extrapolating from those seven months, we can estimate that in 2004 approximately 6423 serious events resulting in death or compromised patient safety occurred. Extrapolating to the full year yields an estimate that 354 deaths resulted.<sup>32</sup>

*It is not possible to estimate how many of the total recorded serious events were due to negligence, but data from two areas raise important issues. In the seven-month period there were 198 medication errors that included wrong drugs (32 cases), overdose (55 cases), extra dose (15 cases), wrong patient (12 cases), and wrong IV rate (9 cases).<sup>33</sup> During the seven months, there were 48 serious events resulting from patient identification problems that included wrong patient medication (12 cases), wrong surgery procedure (2 cases), wrong surgical site (9 cases), wrong side for surgery (10 cases), wrong laboratory result or wrong patient (12 cases). Extrapolating from the seven months to all of 2004, we can estimate that 339 patients suffered serious injuries just from medication errors and 82 patients suffered serious injuries from identification errors. These two areas do not cover all of the possible ground in which negligent medical injuries may have occurred.*

While not all serious errors are the result of medical malpractice, the above findings are generally consistent with the Harvard study and subsequent research. They provide a perspective on Pennsylvania that helps understanding of the context out of which medical malpractice suits arise.

## **Injuries Due to Medical Negligence Have High Costs**

More than a dozen years ago, Frank Sloan and Stephen van Wert, two economists, conducted systematic assessments of economic losses (medical costs, income losses, and other expenses) in Florida cases involving claims of medical negligence that occurred as a result of birth-related incidents.<sup>34</sup> Even though those researchers offered the caution that their assessment procedures probably underestimated losses, severely injured children’s economic losses were, on average, between \$1.4 and \$1.6 million in 1989 dollars. If adjusted for inflation using the consumer price index, these figures in 2005 dollars translate roughly to \$2.3 million per case. In the same study, the losses of persons who survived an emergency room incident were estimated at \$1.3 million per case, or \$ 2.1 million in 2005 dollars. For persons who died in an emergency room incident, the loss to their survivors was estimated at \$0.5 million, which translates to \$0.8 million in today’s dollars. It is

important to note that there was considerable variability in these estimated averages: some patients had much higher economic losses and, conversely, others had lesser economic losses.

Sloan and van Wert cautioned that a major share of past losses was covered by collateral sources, such as private health insurance or taxpayer-supported sources such as Medicare. However, even if future medical expenses were covered by these other sources, loss of income and other expenses, such as care given by family members resulting in diminished income from those family members would not be covered. Sloan and van Wert's estimates, moreover, did not consider "non-economic" losses, such as pain and suffering, disfigurement or loss of enjoyment of life's amenities. As noted in Chapter 1, Pennsylvania's legislative enactment, MCARE, has eliminated potential double recovery through changes to the collateral source rule.

A more recent study of Florida closed claim data<sup>35</sup> indicated that the average payout for a permanent significant injury such as deafness, loss of a limb, loss of an eye or one kidney or lung in 2003 dollars was \$601,828. For a permanent major injury such as paraplegia, blindness, loss of two limbs or brain damage, the payout was \$601,828. For a grave injury such as quadriplegia, severe brain damage, lifelong care or a fatal prognosis, the average payment was \$694,427. The range of payments within these categories was considerable; sometimes the payments were many times the average payment. This should not be surprising. A young person requiring lifelong care will cost more than an aged person requiring lifelong care. A professional or a business executive will have greater lost income than an unskilled worker.

Using data obtained from the National Practitioner Data Bank, the Kaiser Family Foundation reported that Pennsylvania's average payout per paid malpractice claim was \$305,704 ranking it 25th among the fifty states.<sup>36</sup> The analysis did not provide breakdowns with regard to seriousness of injuries.

There are many problems with the National Practitioner Data Bank including missing data.<sup>37</sup> For example, each report is theoretically required to contain a rating of the seriousness of injury. A search of the data for Pennsylvania shows that only about half of the reports contain these ratings. With due caution because of these shortcomings, it is useful to report that in 2004 about 36% of malpractice payments involved wrongful deaths, 4% involved grave injuries such as quadriplegia or severe brain damage, almost 9% involved permanent major injuries such as paraplegia or blindness, and 17% of patients had suffered permanent significant injuries such as deafness, loss of a limb, or loss of one eye, kidney or lung. In short, approximately 66% of payments involved death or very serious, often catastrophic, injuries.

Insight into why costs can be so high following medical negligence injuries can be gleaned from a hypothetical example.<sup>38</sup>

- Assume a male patient, age 35, makes \$40,000 per year in his construction job. He has a wife and two young children. His total assets include \$10,000 in savings and \$15,000 equity in his home, but like many Americans, he did not carry health insurance. During medical treatment for a benign tumor, the patient incurred a serious injury that required six months of hospitalization. Despite his eventual recovery, the injury will prevent him from working the rest of his life. In addition, he has partial paralysis on right side of his body and chronic pain severe enough to frequently require strong painkillers. Furthermore, assume the following:
- Negligence has occurred, or, more properly, it appears that negligence has occurred, because "negligence" is a legal concept that has to be admitted by the defendant or proved in court.

The uncontested economic losses to the patient are:

- Past medical bills (intensive care and rehabilitation): \$300,000;

- Future medical bills resulting from injury, at \$15,000 per year, for his life expectancy of 39 years to age 74: \$585,000;
- Past income lost during year of recovery: \$40,000; and
- Future income loss to age 65 at \$40,000 per year for 29 years, plus expected inflation/promotion adjustments reduced by personal maintenance expenses: \$1,200,000.

The patient's total economic losses over his lifetime will amount to \$2,125,000.

A severely brain-damaged child may incur even greater costs. That child may need special medicines to prevent seizures, be susceptible to serious infections, and require around-the-clock nursing care. No one can say how long the child may live, but the future medical costs may reach astronomical proportions if the child lives 50 or even 70 more years.

As noted above, the Pennsylvania General Assembly eliminated the potential for a windfall jury award of future medical expenses by providing for periodic payments which terminate on the death of the claimant.<sup>39</sup>

### **Only One Out of Seven Injured Patients Sues**

There is a widespread public belief that injured patients sue at the drop of a hat. In fact, the opposite appears to be true. One of the most striking findings from the Harvard medical malpractice project<sup>40</sup> is that seven times as many patients suffered from a medical negligence injury as filed a claim. Put in different words, for every seven patients who suffered a negligent injury, just one claim was filed. Claims were also filed in cases in which the research team of health care providers concluded that there was no negligence. However, the bottom line is that for every doctor or hospital charged with a claim where no negligence was found, there were as many as seven valid claims that were not filed.<sup>41</sup>

### **Why Plaintiffs Need Lawyers**

The plight of plaintiffs can be further understood by returning to the hypothetical case of the injured patient. Assume the defendant physician contests the claim of negligent injury. To prove negligence and obtain compensation the patient must:

- Request, receive, and review his medical records;
- Determine the appropriate law and the appropriate court venue for a lawsuit;
- Find and retain a medical expert or experts to review the medical records and who is willing to testify that negligence was the cause of the injury. The patient will probably also need an expert to testify about the degree of his disability and an economic expert to testify about his future medical and financial losses;
- File a lawsuit and pay the required filing fees;
- Pay those experts (fees of \$500 per hour or more are common for the medical experts);
- Take the depositions (examination under oath prior to trial to learn the basis of the opinions) of the defendant's experts. This includes paying the experts' hourly fees for deposition time and travel costs to wherever they are located;
- Perhaps have to retain additional experts in light of what is learned from the defendant's experts during discovery;

- Prepare all of this information for trial;
- Pay experts who testify at trial for their time and travel costs; and
- Incur additional costs, e.g. court fees.

In complicated trials, it is not unusual for the plaintiff to incur costs of \$100,000 to \$300,000 for experts and associated expenses. The typical patient doesn't understand the law or know how to file his case, find experts, or conduct depositions (even if he were physically able). And he doesn't have money to pay the experts (let's say \$150,000 in his case). The patient will, therefore, have to find and retain a lawyer.

Continuing further with the hypothetical example, assume that the patient finds a lawyer who investigates his case. He most likely will need a specialist in medical malpractice litigation because proving medical negligence is often very complex and difficult. The investigation will entail a thorough review of the case that includes an initial screening, hiring of one or more medical experts to review the files and assist the lawyer in understanding the specific medical issues in the case, a necessary requirement in order to negotiate with the defense lawyers or examine and cross-examine expert witnesses at trial.

The investigation will possibly take the lawyer weeks of research (with salaried paralegals and secretaries). Many hours may be spent in these endeavors before the lawyer even decides medical negligence has occurred and files a lawsuit. After filing, the lawyer will face hours or days of depositions (pre-trial examinations of plaintiff and defense experts and other witnesses, including the patient). There is also likely to be travel to distant locations to depose these witnesses. The lawyer will spend hours drafting motions on the law in response to motions from defense lawyers. In this hypothetical case, trial time is estimated at two weeks. During trial, the lawyer may possibly spend 18-hour days in actual trial time and preparation. In complex cases, the lawyer may often need to retain co-counsel (also paid, of course) to handle the workload. Since the patient has no money, the lawyer will also pay for the \$150,000 needed for expert fees and related expenses, money that will be lost if the case results in no payment.

The lawyer will most likely charge the patient on a contingency fee basis, usually one-third of what is recovered from the defendant; perhaps less if the case is settled before trial. The patient likely will eagerly accept this arrangement because without a lawyer he will recover nothing.

Even when a lawyer is willing to take a case, success is far from assured. Sometimes further investigation of the facts of the case shows that negligence did not occur, or in any event, it cannot be legally proved. As many as one of every two lawsuits is dropped without payment because the evidence proves to be insufficient to support the plaintiff's claim. This does not necessarily mean that the lawsuit was frivolous, only that a thorough examination of the evidence during discovery shows that the initial assumptions of the lawyer and the patient proved to be legally liable.<sup>42</sup>

## **Explanations for the Low Rates of Claiming for Negligent Injuries**

It is now possible to offer some explanations as to why the rate of claiming for negligent medical injuries is about one in eight. The plaintiff may never suspect that negligence has occurred or may never be told that the outcome was due to negligence. The patient may be told that an error occurred, but that the medical provider corrected the injury. Even if the error cannot be corrected, the patient, or his or her heirs in the case of a wrongful death, may be reluctant to sue because the medical provider is well-liked or offers an apology.

Another important reason is that a patient may not be able to find a lawyer to represent him. Sloan and Hsieh studied 220 childbirths in Florida in 1987 that involved death or permanent injury to the child.<sup>43</sup> The

researchers had physicians independently review the files and determine if negligence had taken place. The families of the children were interviewed.

Of the 220 cases, 23 parents sought legal advice. These tended to be cases in which the child suffered very serious injuries and independent reviewing physicians had concluded that negligence was probably involved. However, not a single suit was filed in any of the 220 cases. Sloan and Hsieh concluded that:

The lack of claimants among the 220 women whose babies had serious birth-related injuries and the failure of 23 women to obtain [legal] representation runs counter to the “conventional wisdom” that patients sue when they obtain less than a “perfect result.” In fact, lawyers filter out many potential claims that injury victims might lose.<sup>44</sup>

Research by Herbert Kritzer examined the decisions of plaintiff lawyers to take or decline cases.<sup>45</sup> Kritzer found that because lawyers working on a contingency fee basis have their own time and money at stake, they tend to very carefully screen cases and weed out those that have minor injuries, low damages potential, or that have a low potential of winning at trial. In ordinary cases, lawyers may decline as many as nine cases in ten; in medical malpractice cases, the proportion of declined cases may be even higher. Economic reality drives lawyers’ decisions to accept or reject cases.

Combined with the factors of patients not discovering that they are victims of negligence or patients’ reluctance to sue even if negligence is discovered, plaintiff lawyers’ screening of cases helps explain the low claiming rates found in the Harvard study and subsequent studies. Patients who find a lawyer and file lawsuits are more likely to have suffered a serious injury and have a reasonable likelihood of prevailing on liability and demonstrating serious economic damages.

### **The New England Journal of Medicine Study**

In 2006 the *New England Journal of Medicine* published an article authored by researchers associated with the Harvard School of Public Health that closely examined 1452 closed medical malpractice claims in four areas of the United States.<sup>46</sup> The authors’ main conclusions merit direct quotation:

Our findings point toward two general conclusions. One is that portraits of a malpractice system that is stricken with frivolous litigation are overblown...  
“...[D]isputing and paying for errors account for the lion’s share of malpractice costs.”

A second conclusion is that the malpractice system performs reasonably well in its function of separating claims without merit and compensating the latter. In a sense our findings lend support to this view: three quarters of the litigation outcomes were concordant with the merits of the claim.<sup>47</sup>

Fair reporting of the article also requires noting that the authors added three caveats to these conclusions that they considered “troubling.” Many potentially deserving victims of negligent medical error did not receive compensation. The malpractice system is inefficient in resolving claims. The tort systems overhead costs, in the authors’ opinion, are “exorbitant.”

The study does not have data to show that alternative resolution systems would be either more efficient or less costly. In addition the methodology of the study examined *closed* claims. Thus, the researchers had the advantage of hindsight because the claims were reviewed only at the end of a settlement or a jury verdict. As described earlier in this chapter, at the beginning of a lawsuit neither the plaintiff nor the defendant lawyers

can know if negligence has occurred. It is only after medical records have been obtained and experts consulted and examined in depositions, that some of the uncertainty is resolved. Many lawsuits are dropped when the new evidence and opinion shows the claim to be without merit. These problems would exist to some degree in any alternative system for resolving disputes and thus the inefficiency and cost of the tort system must be weighed relative to alternative systems, not in absolute terms.

The caveats of the Harvard study's authors and methodological concerns about whether the study actually underestimated efficiency cannot be resolved in the present report, but the main conclusions to be drawn from the data are consistent with the other findings reviewed in this chapter. Claims about the unfairness and caprice of the tort system are undermined by empirical evidence.

### **Summary and Comment**

Empirical evidence shows that medical negligence that results in substantial harm or death to patients is not infrequent. The financial losses for subsequent medical care and lost income can be staggering.

Nevertheless, for every seven patients injured through medical negligence only one patient makes a claim. Sometimes patients do not file lawsuits because they are unaware they have been victims. In other cases they are reluctant to sue. An additional important reason is that patients need lawyers to pursue their claims, but because of the risks and costs of medical malpractice litigation, plaintiff lawyers only choose cases with a reasonable possibility of success; but even then the uncertainties in the initial stages of a claim result in many cases being dropped without payment.

It is true that claims that prove to be non-meritorious also cost liability insurers money in defending them. This is an unfortunate defense cost of the tort system, but it is likely true of any alternative system. Alternative systems, with all medical errors being evaluated for compensation by a separate tribunal or system, would result in many thousands of additional claims to be resolved.<sup>48</sup> The costs and efficiencies of proposed alternative systems are, however, beyond the scope of this report.

By addressing the problem of the incidence and costs of medical negligence, this chapter attempts to address an imbalance in public discussion about efforts to change the tort system. The interests of patients who have been injured through medical negligence are often ignored when the subject of medical malpractice litigation is brought before legislatures and the general public.

### What Are the Facts?

Are juries as irresponsible and incompetent as tort system critics say they are? Are jury decisions responsible for medical malpractice insurance premium hikes? The results of more than three decades of systematic research by many scholars are not consistent with these claims. Critics of juries usually make their charges through anecdotes that are nothing more than urban legends. They ignore many research findings that doctors win between six or seven out of ten cases that go to trial, that damage awards are related to the severity of the patient's injury and that only a small percentage of malpractice payments (between 3 and 8 percent) result from jury trial. This chapter reviews the research findings in order to put jury verdicts in a realistic context and to provide background for the next chapter on Pennsylvania jury verdicts.<sup>49</sup>

### Trial by Judge and Jury

"Trial by jury" is misleading. It is "trial by *judge* and jury." The trial judge presides over the trial, determines which evidence is allowed and which is not. The judge hears and sees the same evidence as the jury. Before the jury's verdict can be recorded as a legal judgment, the trial judge must agree that the evidence was sufficient to support the verdict. If the judge disagrees on the issue of negligence, he or she can set aside all, or parts, of the verdict. If the judge believes that the amount of damages is too high, the amount can be reduced through the legal device called "*remittitur*." If the plaintiff is unwilling to accept the judgment, the judge can order a new trial.

### Plaintiffs Lose Most Jury Trials

Many studies have examined win rates in medical malpractice trials. The findings contradict widespread beliefs about jury verdicts. For example, the Bureau of Justice Statistics systematically sampled jury verdicts in 1992, 1996, and 2001 in courts representing the seventy-five most populous counties in the United States.<sup>50</sup> There were 1,156 medical malpractice cases in the sample, and 96% of these were tried before juries. In 1992, plaintiffs won 30.5% of jury trials, but in 2001, the win rate had dropped to 26.3%, roughly one case in four. Win rates vary slightly by state and by counties within states. The fact that doctors win two-thirds of the case filed is not evidence that these suits are frivolous cases. These are cases where a judge concluded that a legitimate triable issue, a factual dispute, existed between the parties.

### Jurors View Plaintiff Claims With Skepticism

The assertion that jurors decide cases out of sympathy for injured plaintiffs rather than the legal merits of the case is one of the most persistent claims of opponents of civil jury trial. Research finds little support for these claims.

Interviews with North Carolina jurors who decided medical malpractice cases showed that jurors viewed the plaintiffs' claims with great skepticism.<sup>51</sup> Jurors expressed their attitudes in two main themes: first, too many people want to get something for nothing, and second, most doctors try to do a good job and should not be blamed for a simple human misjudgment. This does not mean that in every case jurors held these views. Sometimes, evidence of the doctor's behavior caused jurors to be angry about the negligence. However, even in these latter cases the interviews indicated that the jurors had approached the case with open minds.

Hans interviewed jurors who decided tort cases, including medical malpractice, and obtained similar findings.<sup>52</sup> Hans concluded that jurors often penalized plaintiffs who did not meet high standards of credibility and behavior, including those who did not act or appear as injured as they claimed, those who did not appear deserving due to their already high standard of living, those with pre-existing medical conditions, and those who did not do enough to help themselves recover from their injuries.

## **No Evidence for the “Deep Pockets” Claim**

Closely related to the claim of “jury sympathy” verdicts is the claim that juries are more likely to render verdicts against doctors, hospitals, and corporations, not because they are seen as negligent, but only because the jurors perceive them as having the ability to pay large awards — a so-called “deep pockets” effect. A number of research studies have assessed this hypothesis and find no support for it.<sup>53</sup> This general finding includes experiments that specifically tested for a deep pockets effect in medical malpractice cases.<sup>54</sup>

## **Jury Verdicts Agree with Judgments of Neutral Medical Experts**

An important study of medical malpractice litigation by Taragin et al. compared jury verdicts with the opinions of doctors hired by an insurance company to review the medical records to provide a neutral assessment of whether they believed medical personnel had acted negligently.<sup>55</sup> The review decisions were confidential and could not be obtained by the plaintiff or used at trial. The research team compared the doctors’ ratings with jury verdicts. The verdicts tended to be consistent with these assessments. Moreover, the study also found that verdicts for the plaintiff were not correlated with the severity of the plaintiff’s injury. The results, therefore, contradict the claim that juries decide for the plaintiff out of sympathy rather than apply the legal standard of negligence.

## **Judges Agree With Jury Verdicts**

Some studies asked trial judges to make independent assessments of who should have prevailed in civil cases over which they presided.<sup>56</sup> The judgments were made while the jury was still deliberating and, therefore, were not contaminated by knowledge of the outcome. The judge’s decision was then compared to the jury verdict in that case. Although the research did not specifically focus on malpractice juries, the findings indicate that there was high agreement between the judge and the jury. Moreover, in instances when the judge would have decided differently than the jury, the judge usually indicated that, nevertheless, the jury could reasonably have come to a different conclusion from the trial evidence. Other studies asked large national samples of judges to draw on their professional experience with juries and give a general opinion about jury decisions.<sup>57</sup> The surveys uncovered a general consensus that jurors accept and take very seriously their civic responsibility. The overwhelming number of the judges gave the civil jury high marks for competence, diligence, and seriousness, even in complex cases.

## **Juries Are Not “Overwhelmed” By Plaintiff’s Experts**

An often-repeated charge is that the plaintiff’s experts in medical malpractice cases overwhelm jurors.<sup>58</sup> This confusion and deference to experts, it is alleged, plays to the advantage of plaintiffs because the jury simply defers to the plaintiff’s experts and allows juror sympathies for the plaintiff to be the basis of their verdict. There is fuzzy logic in this claim, however, because it ignores the fact that defendants also cross-examine plaintiff’s experts and call their own experts who offer opinions contrary to the plaintiff’s experts. Moreover, the defendants often call more experts than the plaintiff.

Systematic studies of jury responses to experts lead to the conclusion that jurors do not automatically defer to experts and that jurors have a basic understanding of the evidence in malpractice and other cases.<sup>59</sup> Jurors understand that the adversary system produces experts espousing opinions consistent with the side that called them to testify. Moreover, jurors carefully scrutinize and compare the testimony of opposing experts. They make their decisions through collective discussions about the evidence.

## **Damage Awards Correlate with Severity of Injury**

Bovbjerg et al. found that the magnitude of jury awards in medical malpractice tort cases positively correlated with the severity of the plaintiffs' injuries, except that injuries resulting in death tended to result in awards substantially lower than injuries resulting in severe permanent injury, such as quadriplegia.<sup>60</sup> Another study of malpractice verdicts in New York, Florida, and California also found that jury awards of prevailing plaintiffs in malpractice cases were correlated with the severity of the injury.<sup>61</sup> In these studies, there was variability of awards within levels of injury. However, economic losses vary by patient. The economic loss for a quadriplegic who is 40 years old with a yearly income of \$200,000 and a family of three young children would ordinarily be much greater than an identical quadriplegic who is retired, widowed, 75 years old, has no dependents, and whose annual income never exceeded \$35,000. Moreover, losses can vary by a given location as the costs of living, including the costs associated with medical care and treatment, are higher in urban areas.

## **Jury Damage Awards Have Increased, But There Are Multiple Reasons**

The Bureau of Justice Statistics study found that in 2001 the median verdict in medical malpractice trials when plaintiffs prevailed was \$431,000, compared to \$253,000 in 1992.<sup>62</sup> Punitive damages were awarded in 4% of cases, and those tended to involve cases of gross malfeasance, such as sexual assaults on patients.

Multiple reasons may be offered for the increase in awards. Juries may have become more generous. Patients may have sustained more serious injuries. Due to medical advancements, patients can survive injuries for longer periods of time than in the past, and thus their medical bills have increased. Plaintiff lawyers may have become more adept at "proving" damages by using experts who document economic losses better than in the past. An additional possible cause is that the cost of negligent medical injuries and lost income may have increased. During the 1990's, medical costs, and consequently cost for needed medical care, increased 51.7% and general inflation, which is reflected in lost wages, increased 26.2%.

Another explanation for the increase in costs is that cases with claims of more serious injuries may be tried to juries in 2001, compared to 1992. This last possible explanation needs elaboration. The study of medical malpractice litigation in Florida found that, compared to the first three years of the 1990s, during the first three years of the 2000-decade, there were more settled cases involving claims of negligent deaths and fewer cases involving less serious injuries. The change in types of cases is unlikely to explain all of the increase in awards, but it does appear to be a possible partial explanation.

In short, like many other parts of the medical malpractice controversy, the questions about damages are complex, and at present there are not satisfactory answers to all of these questions.

## **Outlier Awards Tend Not To Withstand Post-Verdict Adjustments**

Despite the substantial evidence indicating that juries are ordinarily conservative in deciding damages in malpractice cases, there are exceptions resulting in what are commonly labeled "outlier awards."

There are a number of reasons for outlier awards. One is that doctors might contest the case solely on liability and not contest damages at all. The plaintiff, on the other hand, presents the losses through experts who give a high-end version of the plaintiff's losses. The judge instructs the jury to decide damages solely on the evidence, but the jurors have only the plaintiff's figures to work with. Despite reservations, the jurors follow the judge's instructions and accept the plaintiff's suggested award because that is the only evidence that they have. In other instances, the defense may call an economist who offers an alternative to the plaintiff's damage estimate; the level of damages may be quite high due to the seriousness of the injury. The jury uses this as floor from which damages are estimated. Additionally, in some jurisdictions juries are presented with the gross amount of a loss or of a life care plan that is not reduced to present value. As noted above, beginning

in 2003, Pennsylvania’s legislative enactment, MCARE, changed the law for cases that are filed. Thus, cases that are in the system that were filed in 2003 are now just reaching trial.

One final potential explanation reflects the human nature of the jury. Specifically, evidence brought out at trial may cause the jurors to become so outraged at the negligence of the defendant that they appear to add a punitive component into their compensatory award, contrary to the judge’s instructions. Outlier awards, due to the “anger factor,” are not frequent as they are portrayed in the mass media, but they unquestionably do occur.

Nevertheless, research evidence indicates that outlier verdicts seldom withstand post-verdict proceedings. There are four processes by which awards are reduced.

- The judge reduces the award verdict through *remittitur*;
- An appeals court reduces the award;
- Sometimes the sides agree that there was negligence, but disagree about the amount of damages and set a high-low agreement prior to trial or during trial: they agree that if the jury verdict is above a certain limit, the plaintiff will only get the high limit and if it is below the bottom limit or even if the defendant prevails at trial, the plaintiff will receive the minimum payment; and
- Most common of all, the plaintiff and the defendant negotiate a post-trial settlement that is less than the jury verdict, often for the amount of the doctor’s liability coverage.

Post-trial reductions have been documented in a number of studies. One study found that some of the largest malpractice awards in New York ultimately resulted in settlements between five and ten percent of the original jury verdict.<sup>63</sup> A study of medical malpractice awards in Pennsylvania found similar reductions.<sup>64</sup> A recent study of medical malpractice verdicts in Illinois found that, on average, final payments to plaintiffs were 42% lower than the jury verdict.<sup>65</sup> These findings are consistent with earlier research.<sup>66</sup>

## Summary Perspective

Research evidence does not support the general claims of irresponsible and incompetent juries. While occasional jury verdicts may be excessive, judges or post-verdict settlements moderate the effects of outlier verdicts. The overview of jury trials in this chapter sets the stage for an examination of medical malpractice verdicts in Pennsylvania, which is the subject of the next chapter.

This chapter explores jury trials in Pennsylvania with particular attention to Philadelphia's Court of Common Pleas. Philadelphia County has the most malpractice cases in Pennsylvania. It is also the most controversial court, with claims that it has one of the highest plaintiff win rates in the country, and with claims that more than half of the verdicts equal or exceed \$1 million.<sup>67</sup>

Pennsylvania has been a difficult state in which to collect adequate data on jury verdicts because there are no reliable state-wide verdict reporters and because, until the 2002 legislation, juries rendered only general verdicts that do not allow a breakdown of the verdict into the economic and non-economic components. In addition information on post-verdict settlements, which are often substantially less than the actual verdicts, is sparse and difficult to obtain. However, this chapter reports data compiled from several sources plus a systematic review of case files in the Philadelphia Court of Common Pleas. It provides a perspective on Philadelphia juries that is at variance with anecdotal negative stereotypes of Philadelphia juries.

### Sources of Data for this Chapter

The U. S. Bureau of Justice Statistics in conjunction with the National Center for State Courts conducted a systematic survey of civil jury verdicts in large urban courts nationwide in 1996 and 2001.<sup>68</sup> Philadelphia and Allegheny counties are included in the survey. The raw data are archived with the Interuniversity Consortium for Political and Social Research at the University of Michigan. For this chapter, medical malpractice verdicts for Philadelphia and Pittsburgh were drawn from that data base and analyzed.

In 1999, Judge John Herron gathered data on medical malpractice jury verdicts in Philadelphia for 1998.<sup>69</sup>

In 2003, the author of this report obtained official statistics from the Pennsylvania CAT fund for the years 1999, 2000, and 2001.<sup>70</sup>

The Supreme Court of Pennsylvania has reported aggregated statistics on plaintiff and defense verdicts covering the period of July 1, 2003 through December 31, 2004 and January 1 through December 31, 2005.<sup>71</sup>

The Philadelphia Court of Common Pleas compiled statistics on medical malpractice verdicts from July 1, 2003 through December 31, 2004. The data contained the case docket number. The data involved 58 plaintiff verdicts and 123 defense verdicts. Details for each of the plaintiff verdicts were obtained from either a physical examination of the court files or from summaries of cases contained in jury verdict reports compiled in the Westlaw database. In a number of cases data from both sources was available, allowing for a check on consistency and reliability. The data had reliability over 95% between the two sources.

### Plaintiff Win Rates in Pennsylvania and Philadelphia

The Supreme Court statistics show that for all of Pennsylvania from June 2003 through 2004 the annualized plaintiff win rate in jury trials was 21.6%. In 2005 there were 223 jury trials of medical malpractice cases and plaintiffs prevailed in 44, thus yielding a plaintiff win rate in Pennsylvania as a whole of 19.7%.

Table 7.1 reports the number of plaintiff verdicts in malpractice cases in Philadelphia and the plaintiff win rates for the years 1996, 1998,<sup>72</sup> 2000 through 2001 and 2003,<sup>73</sup> 2004 and 2005. The data were compiled from the sources described immediately above.<sup>74</sup>

**Table 7.1: Philadelphia Jury Trials and Plaintiff Win Rates: 1996, 1998, 2000, 2001, 2003-2005**

<i>Year</i>	<i>No. of Trials</i>	<i>Plaintiff Wins</i>	<i>Plaintiff Win Rate</i>
2005	56	21	37.5%
2004	124	39	31.5%
2003	114	38	33.3%
2001	—	36	—
2000	—	42	—
1998		50	33.0%
1996	115	33	28.6%

Table 7.1 shows that in 2005 Philadelphia had 56 jury trials, thus accounting for 25.1% of the state-wide total of 223 jury trials. The trial total represented a substantial decline in the number of cases decided by juries in Philadelphia County.

Win rates were consistently higher in Philadelphia (37.5%) than in the rest of the state (19.7%). This does not necessarily mean that juries are more pro-plaintiff in Philadelphia. If cases are selected differently for trial in Philadelphia compared to other counties, the nature of the case and the type of evidence could explain the difference. Put simply, Philadelphia juries may be deciding cases from a different mix of cases rather than deciding cases differently. Philadelphia’s court may have been more aggressive in getting cases settled, leaving only the more difficult and higher stakes cases for jury trial. Philadelphia has many more teaching hospitals than other parts of the state and probably has proportionately more plaintiff lawyers who specialize in medical malpractice. If those lawyers more carefully screen their cases than lawyers in other parts of the state, it would mean that juries in Philadelphia were hearing different types of cases. Some support for this hypothesis may be seen by comparison with Pennsylvania’s second highly urbanized county. In 2005 there were 23 medical malpractice jury trials in Allegheny County and plaintiffs prevailed in 7, a win rate of 30%.

The other important statistic in Table 7.1 is the finding that in 2005 there were only 56 jury trials in Philadelphia, 45% fewer than in 2004 and 49 % fewer trials than in 1996. This is a truly striking finding. Some of the explanation may be ascribed to the reforms on place of venue, but some other causes may be associated with the change, though at present no one can say what they might be.

Case selection for trial and its implications for drawing inferences from verdict statistics is a complicated matter<sup>75</sup> and will not be explored further in this report.

### **Jury Awards in Pennsylvania**

Judge Herron’s research indicated that in the 1998 trials, the awards broke down as follows:

Under \$100,000	7 cases	14%
Under \$200,000	6 cases	12%
\$200,000-\$1 million	18 cases	36%
Over \$1 million	<u>19 cases</u>	<u>38%</u>
<b>Total</b>	<b>50 cases</b>	<b>100%</b>

These awards might be different if adjusted for inflation to today's dollars, but without those adjustments Judge Herron's research revealed that 38% of 1998 jury verdicts equaled or exceeded \$1 million.

The Supreme Court of Pennsylvania compiled statistics on verdicts occurring between July 1, 2003 and December 31 2004. These figures were divided by 1.5 to provide an annualized estimate of jury verdict awards over the 2003-2004 period. Table 7.2 reports the verdict awards disaggregated by the categories reported by the Supreme Court. Data are presented for the whole state the state minus Philadelphia and for Philadelphia alone.

**Table 7.2 Annualized Number of Plaintiff Jury Verdict Awards for Pennsylvania and Philadelphia: 2003 and 2004**

<i>Amount</i>	<i>Annualized Pennsylvania Verdict Awards</i>	<i>Percent of All Pennsylvania Cases</i>	<i>Annualized Pennsylvania Verdict Awards Minus Philadelphia</i>	<i>Percent of Cases: Pennsylvania Minus Philadelphia</i>	<i>Annualized Philadelphia Verdict Awards</i>	<i>Percent of Cases: Philadelphia</i>
\$500K or less	29	45%	12	44%	17	45%
\$500K-\$1 million	10	15%	5	19%	5	13%
\$1-\$5 million	19	29%	7	26%	12	32%
\$5-10 million	5	8%	3	11%	2	5%
\$10 million plus	2	3%	0	0%	2	5%
Total	65	100%	27	100%	38	100%

Table 7.2 shows that in both Pennsylvania (minus Philadelphia) and Philadelphia 44% of jury awards were below \$500,000. In Pennsylvania 37% of awards exceeded \$1 million; in Philadelphia 42% exceeded \$1 million.

Similar Supreme Court data have now been provided for 2005. They are reported in Table 7.3.

**Table 7.3 Number of Plaintiff Jury Verdict Awards for Pennsylvania and Philadelphia: 2005**

<i>Amount</i>	<i>Pennsylvania Verdict Awards</i>	<i>Percent of All Pennsylvania Cases</i>	<i>Pennsylvania Verdict Awards Minus Philadelphia</i>	<i>Percent of Cases: Pennsylvania Minus Philadelphia</i>	<i>Philadelphia Verdict Awards</i>	<i>Percent of Cases: Philadelphia</i>
\$500K or less	19	43%	13	57%	6	29%
\$500K-\$1 million	12	27%	5	22%	7	33%
\$1-\$5 million	10	23%	4	17%	6	28.5%
\$5-10 million	3	7%	1	4%	2	9.5%

<i>Amount</i>	<i>Pennsylvania Verdict Awards</i>	<i>Percent of All Pennsylvania Cases</i>	<i>Pennsylvania Verdict Awards Minus Philadelphia</i>	<i>Percent of Cases: Pennsylvania Minus Philadelphia</i>	<i>Philadelphia Verdict Awards</i>	<i>Percent of Cases: Philadelphia</i>
\$10 million plus	0	0%	0	0%	0	0%
Total	44	100%	23	100%	21	100%

Table 7.3 shows that 39% of jury trials won by plaintiffs equaled or exceed \$1 million, roughly the same percentage as 2004.

The Philadelphia million dollar verdicts in 2003-2004 and 2005 cannot be accurately compared with Judge Herron's 1998 findings because of subsequent inflation. The 1998 dollar was worth only 86.3 cents in comparison to 2004 dollars and thus some of the 1998 awards may have exceeded \$1 million.

### **Million Dollar Awards in Philadelphia**

What kinds of claims are involved in million dollar awards? The names and docket numbers of Philadelphia plaintiff verdicts were available for the July 2003 through December 2004 period. As reported above, the court files supplemented by verdict reporters available in Westlaw were searched using that information. Table 7.4 summarizes the claims in the cases and the amounts awarded by the juries. Lesser awards can be of concern, but the million dollar cases are the ones that gather attention and comment in public discussion of medical malpractice litigation. Readers should closely examine the injury claims described in Table 7.4 and compare them to the jury verdicts. There is no "correct" standard against which the jury verdict can be compared so each reader can make a judgment about the reasonableness of the verdict in the light of the claimed injury.

**Table 7.4: Claims and Awards in Philadelphia's Million Dollar Cases: July 2003 – December 2004**

<i>Case Number</i>	<i>Verdict Date</i>	<i>Injury Claim</i>	<i>Verdict</i>
10400199	9/18/03	In 1984, at 3 weeks old this female had surgery for hip dysplasia and suffered damage to her femoral nerve. At age 19, she suffers permanent physical pain, disability, disfigurement and has had to spend money for hospitalization, medication, treatment and rehabilitation.	\$1,000,000
10301115	9/30/03	Doctor failed to diagnose an intra-cranial tumor in female, resulting in loss of hearing in one ear, resulting in additional surgery, diminution of earning potential, pain and emotional distress; \$37,500 to husband for loss of services, companionship.	\$1,500,000
10201487	10/02/03	Female lupus patient with dialysis in severe pain, but doctors failed to conduct tests and gave improper medication and discharged patient who became a quadriplegic plus multiple hospitalizations and future medical costs.	\$8,178,350

<i>Case Number</i>	<i>Verdict Date</i>	<i>Injury Claim</i>	<i>Verdict</i>
10402583	10/28/03	Male, age 19, was in hospital after suicide attempt. Intensive care nurses failed to respond in timely manner to bedside monitor alarm, resulting in severe brain damage. \$600,000 in past medical expenses and life care estimated at \$6 to \$12 million. Punitive damages of \$15,000 for nurse altering records.	\$10,015,000
10600976	11/17/03	Male, age 37, with two children, earning \$60,000 per year; elective surgery for hearing loss and died almost immediately upon administration of anesthesia.	\$2,910,000
10601622	11/25/03	Female, age 61, examined for gastrointestinal bleeding, but doctors failed to diagnose cancerous tumor until two years later and woman dies.	\$1,000,000
10800103	12/03/03	Female, age 55, claimed failure to diagnose and treat liver disease that resulted in liver cancer. Plaintiff underwent four hospitalizations, had end-stage liver disease at time of trial, and was seeking a liver transplant.	\$1,800,000
10500659	12/23/03	Female, age 48, dies after failure to diagnose and treat adrenal insufficiency over an eight year period despite more than 40 visits to doctor.	\$1,000,000
10702977	1/30/04	Pregnant female, age 34, in auto accident causing injured ankle; surgery performed after birth with bone graft and screws. Claim of lack of informed consent and result of severe, permanent injuries to bones, muscles nerves and blood vessels in right leg with permanent pain, depression, and inability to care for her child plus additional surgeries and nursing care.	\$15,000,000
10300103	2/06/04	Female, age 39, suffering gastrointestinal problems had bowel surgery and surgeon severed her bile duct that could not be repaired, resulting in permanent pain and spasms, gastroparesis, motility and risk of progressive liver disease, possibly needing a liver transplant.	\$20,500,000
98060057	2/11/04	Female, age 30, had corrective surgery to ureter which was accidentally severed and repaired improperly ureter placed on top of bladder instead of side resulting in reflux disorder, chronic kidney infection and will probably require kidney removal.	\$9,000,000
10402642	3/10/04	Female, age 49, claimed that a neurosurgeon inappropriately recommended implantation of a device to treat multiple sclerosis and failed to obtain informed consent. Patient now a paraplegic with loss of bowel and bladder control.	\$3,200,000

<i>Case Number</i>	<i>Verdict Date</i>	<i>Injury Claim</i>	<i>Verdict</i>
10601566	3/12/04	Male, age 39, with six children had abdominal complaints, but doctor did not order diagnostic tests, which would have shown gastric cancer. Cancer went from stage 1 to stage 2 requiring radiation and chemotherapy. Two-thirds of stomach removed and increased risk of recurring cancer.	\$2,800,000
10902569	3/25/04	Male, age 61, died after a misdiagnosis with regard to a drug interaction between Lopid and Lipitor. Doctors improperly prescribed the medications together and failed to discontinue them when he showed signs of a debilitating muscle condition.	\$1,151,028
10600854	3/25/04	Female had mammogram and doctors failed to detect cancer allowing carcinoma to advance resulting in mastectomy, reconstructive surgeries, chemotherapy, severe pain, and prospect of future medical expenses.	\$2,500,000
10404294	4/05/04	Female, age 57, suffered a permanent leg injury after her doctor advised her to discontinue taking an anti-coagulant prior to surgery and then postponed the surgery. Woman developed a blood clot and underwent two embolectomy surgeries plus bilateral fasciotomies to remove the clots.	\$1,350,000
20201608	4/07/04	Male, age unknown, underwent treatment for a blood disorder for 8 years only to discover he did not have the alleged disease when a new doctor treated him. Plaintiff suffered damages to nerves, pain, traumatic neurosis, and personality change.	\$1,000,000
20103187	4/21/04	Male, age 38, mortgage broker with child sought back pain treatment, became a heroin addict after doctor treated with medication without performing x-rays and died. Doctor prescribed methadone without testing for continued use of heroin. Jury found patient 25% comparative negligence, but awarded punitive damages against two doctors. Before comparative negligence reduction verdict was \$1,432,000.	\$1,216,000
10104056	5/12/04	Male, age 20, had x-ray for fractured knee that showed possible cancer, but cancer ruled out. Two years later cancer was detected and treated with chemotherapy, but plaintiff claimed a high risk for recurrence of the cancer. Verdict included \$1 million for loss of consortium.	\$3,500,000
20201606	5/27/04	Female, age 36, mother of 3 children died from blood clot following treatment for fractured knee. Claim was doctor ignored signs of a blood clot.	\$4,000,000

<i>Case Number</i>	<i>Verdict Date</i>	<i>Injury Claim</i>	<i>Verdict</i>
20204136	7/15/04	Pregnant woman presented to emergency room of hospital with painful contractions and in distress. Despite plea for assistance, treatment was delayed and a caesarean section was needed, but the baby female was born with an APGAR score of 0 and died.	\$3,500,000
10900742	8/12/04	Female, age unknown, with dislocated right shoulder; reconstructive surgery performed. In subsequent office visits, patient complained of pain with neurogenic signs and infection. MRI showed osteonecrosis. More surgery. Significant permanent injury to right shoulder affecting pain and suffering, and past and future loss of income.	\$2,500,000
951101760	9/02/04	During childbirth, male son suffered fractured skull and brain trauma. Medical bills of \$100,000. Child, now 10, has slowed intellectual development, learning disabilities, physical weakness, and seizures. Lost earning capacity and medical care estimated at \$1.7 million.	\$1,040,000
20301996	09/02/04	Male underwent spinal surgery without doctor warning of risks. Subsequently, the patient became quadriplegic with secondary morbidities.	\$2,000,000
20201557	10/14/04	Female, age 76. Radiologist failed to properly read MRI films, delay in treatment of carotid artery — massive stroke requiring permanent nursing home care.	\$5,200,000
20304275	10/25/04	Male, age 49, not closely monitored by hospital staff had epileptic seizure while in hospital and fell injuring head and back. Fractured vertebrae requiring implantation of rods and screws in spine with subsequent loss of range of motion and ability for employment with estimates of loss income between \$380,00-\$720,000.	\$3,000,000
20201524	11/09/04	Female, age unknown. Doctor discovered cysts in abdomen with advice to drain and remove them. Infection set in with high temperature for 2 days in hospital without doctors being called. Subsequent examination revealed bowel had been punctured in two places. Issues of informed consent and whether doctor created a record of a visit that never occurred.	\$2,611,000
20403435	11/10/04	Male, age 23, complaining of right chest pain given medication, but no x-rays ordered plus other tests, but tests not undertaken. Pneumonia set in with necrosis and upper half of lung had to be removed resulting in 25% loss of vital lung capacity, nerve damage with chronic pain syndrome and cannot engage in physical exertion and will be on narcotics for life.	\$2,650,000

Doctors and hospitals contested the cases summarized in Table 7.4. It is not possible to ascertain what the jury heard, how they reached their verdict or whether the verdict on liability or damages was correct by some standard other than the judgment of twelve jurors. The summaries of the alleged injuries, however, establish that these million dollar cases involved substantial, permanent and disabling injuries or death.

### Post-trial Adjustments to Jury Verdicts

Many large jury verdicts are ultimately settled for substantially less than the jury verdict. These adjustments are made through judicial *remittitur*, high-low agreements between the parties and post-verdict settlements between the parties in order to avoid further litigation costs by both parties.

An earlier research study by the author of this report compared jury verdicts and final settlements in Pennsylvania for the years 1999, 2000, and 2001.<sup>76</sup> The data were obtained from the Pennsylvania Catastrophic Injury Fund (CAT Fund). During these three years, data were available for 22 cases involving jury verdicts of \$5 million or more. The final payment to the plaintiffs in these cases ranged from 46% of the jury verdict to as low as 6% of the verdict, with the average settlement being 22% of the verdict. Fourteen cases involved jury awards of more than \$10 million. The final settlement in this subset of cases ranged from 36% down to 6% with an average settlement being 17% of the verdict. As a general rule, the larger the verdict the larger the downward adjustment.

Table 7.5 reports a sample of these cases that help to illustrate the above statistics.<sup>77</sup>

**Table 7.5: Jury Verdict versus Post-Trial Settlements and Basis of Settlement**

<i>Verdict</i>	<i>Settlement</i>	<i>Reduction Difference</i>	<i>Basis of Settlement</i>
\$8,500,000	\$1,200,000	-\$7,300,000	Parties Post-Verdict
15,000,000	\$6,000,000	-\$9,000,000	Parties Post-Verdict
11,700,000	\$3,200,000	-\$8,500,000	Parties Post-Verdict
3,500,000	\$1,800,000	-\$1,700,000	Hi-Low Agreement
\$14,000,000	\$1,250,000	-\$12,750,000	Hi-Low Agreement
\$6,800,000	\$1,200,000	-\$5,600,000	Hi-Low Agreement
\$9,300,000	\$4,200,000	-\$5,100,000	Hi-Low Agreement
\$1,900,000	\$800,000	-\$1,100,000	Hi-Low Agreement
\$45,000,000	\$7,500,000	-\$37,500,000	Parties Post-Verdict
\$16,000,000	\$3,200,000	-\$12,800,000	Parties Post-Verdict

It is possible that some of the payments to plaintiffs in Table 7.5 were higher than appear in the table. Awards higher than the CAT Fund limit may have been covered by insurance policies for excess liability above the CAT fund coverage. Many hospitals carry excess liability insurance. In some instances, the CAT fund may not have recorded these figures, although in some instances, excess insurance coverage was mentioned. Table 7.5 also does not deal with defense verdicts at trial in which other defendants named in the lawsuit may have settled in advance of trial.

Questions may arise as to why the verdicts are so high in the first place. The answers are complex. Previous research<sup>78</sup> has indicated that in some instances the dispute is about liability and at trial the defense puts on no evidence about damages, leaving the jury to rely solely on the evidence put forth by the plaintiff. In other instances, the jury may be upset by the behavior of the defendant such as callousness, attempts to alter medical records, or apparent fabrication of testimony during trial; they consequently inflate the damage award to send a message. This latter instance is an example of the jury not following the law. However, the important point is that either formal processes, such as *remittitur* and reductions by appeal courts, or informal pre- or mid-trial high-low arrangements or post-verdict negotiations between the parties, reduce the outlier awards. Research has shown that in most instances prevailing plaintiffs in high-award cases settle for the amount of liability insurance coverage of the defendant or defendants.<sup>79</sup>

In this report it was not possible to systematically follow up on the cases decided in 2003, 2004 and 2005 to ascertain the extent to which they underwent similar post-trial reductions. Nevertheless, research did uncover the fact that one of the awards over \$10 million in 2004 had settled for just \$1.5 million.

## Summary

The plaintiff win rate in Philadelphia has not substantially changed since 1998, although it is slightly higher than in 1996. Philadelphia's win rate is higher than the average across the rest of Pennsylvania; so is the rate in Allegheny county, although it lags behind Philadelphia. However, interpretation of win rates must take into consideration that rather than differences in jury behavior, there is a very real possibility that the win rates are due to differences in the types of cases that proceed to trial.

A summary of the injuries in cases in 2003 and 2004 involving awards of \$1 million or more shows that the injuries of the plaintiffs were very serious.

A sample of earlier cases from the Pennsylvania CAT Fund showed that settlements in outlier verdicts were often much less than the original jury award. Although data on post-trial settlements are not available for 2003 through 2005, the Cat Fund statistics and research from other states indicates that post-trial settlements for amounts less, sometimes less by magnitudes, are common. One important lesson is that very large jury verdicts do not accurately reflect the amount actually paid by the defendant.

Advocates of change in the tort system claim that the jury system is broken. In addition to seeking an alternative court some have advocated for a cap of \$250,000 for non-economic damages that presumably includes not only pain and suffering, but also disfigurement and loss of society.<sup>80</sup> Because the data reported in other chapters of this report strongly suggest that changes to the tort system already enacted by the Pennsylvania General Assembly and by the Pennsylvania Supreme Court appear to provide corrections perceived to have been needed in medical malpractice cases, the potential effects of caps deserve close scrutiny both with regard to the fairness of caps for negligently injured patients and with regard to the potential impact of caps on liability insurance rates and the supply of doctors.

The basic assumption for caps is that juries are too generous with their pain and suffering awards. Consequently, it is assumed that in many instances jury awards need to be reduced to some “reasonable” figure.

No one disputes the fact that caps reduce the awards to injured persons. For example, a study of California jury trials occurring between 1995 and 1999 by RAND’s Institute for Civil Justice showed that California’s MICRA cap of \$250,000 on non-economic damages reduced awards about 25% in cases involving an injury and over 51% in cases involving death.<sup>81</sup>

But questions abound regarding the fairness of caps and about their effectiveness in reducing insurance premiums.

### The Fairness of Caps

David Studdert et al. examined the effects on injured patients of California’s \$250,000 cap on non-economic damages.<sup>82</sup> Their findings indicate that reductions under the cap affected the patients with the most severe injuries. Those researchers concluded:

Imposition of greater reductions on more severe injuries may be justified if compensation for this particular group of injuries were especially prone to excess. In fact available evidence suggests the reverse is true: *Plaintiffs with the most severe injuries appear to be at the highest risk for inadequate compensation.* Hence, the worst-off may suffer a kind of “double jeopardy” under caps.<sup>83</sup> (Italics added)

In another study, Lucinda Finley systematically examined jury verdicts in California, Florida and Maryland to determine if caps had a disparate effect on the monetary recoveries of women, and elderly persons.<sup>84</sup> She found that to be the case. Finley’s research pointed out that cap laws tend to “place an effective ceiling on recovery for certain types of injuries disproportionately experienced by women, including sexual assault and gynecological injuries that impair child bearing or sexual functioning.” In wrongful death cases women were shown to be disadvantaged in awards they would receive compared to men.

Finley separately analyzed gynecological malpractice cases involving misdiagnosed breast cancer, negligence in prenatal care that caused pregnancy loss, negligent injuries during hysterectomies, and malpractice resulting in infertility. Finley showed that over 70% of women’s awards were for non-economic losses. When men suffered sexual injuries during medical treatment (e.g. partial removal of a bowel and scrotum, leaving a man, age 28, impotent and infertile; a 54 year old male treated for genital warts with undiluted asetic acid on the scrotum and penis causing severe burns, scarring and severe pain if sexual intercourse was attempted) the pain and suffering awards were similar to those of women with roughly comparable sexual injuries. However, women are statistically far more likely to suffer such sexual injuries than men. She also pointed out that elderly people, both men and women, tend to be disadvantaged by caps. Finley also observed that because of the reduced likelihood of recovery, plaintiff lawyers are less likely to take such cases because the amount that can be recovered under the caps often does not justify litigation expenses.

In 2005, the Wisconsin Supreme Court overturned that state's \$350,000 cap on pain and suffering in medical malpractice cases.<sup>85</sup> The court reasoned that plaintiffs "*with the most severe injuries appear to be at the highest risk for inadequate compensation*" (italics added). For example, a patient suffering a severe infection for a period of months, but who eventually recovered, could receive \$350,000 for pain and suffering in a jury award. In contrast, a patient who was so badly injured that she will suffer excruciating pain the rest of her life would be limited to the same amount. In the Wisconsin Supreme Court's words, "[t]he cap's greatest impact falls on the most severely injured persons."

The plaintiff in the Wisconsin case was a boy who was severely deformed at birth due to medical negligence; he can be expected to live for another 69 years. He was awarded \$10,000 per year for pain and suffering. Under the cap, the Supreme Court concluded that amount would be almost halved. The Court further concluded that many cases that would be affected by caps involve children.

In summary, two systematic studies by respected researchers and the Wisconsin Supreme Court arrived at the same conclusion. Caps on pain and suffering have a disproportionate negative impact on the fairness of compensation for persons injured through medical negligence.

### **Considering California's MICRA Cap and Fairness**

An issue of fairness also arises about California's MICRA cap of \$250,000. The MICRA bill was passed in 1975. In 2005 dollars, that cap was worth \$899,281. In short, the MICRA cap at the time it was passed was almost nine-tenths of a million dollars. However, during the past three decades the cap has never been adjusted for inflation. Thus, patients with pain and suffering awards in California have progressively lost ground due to inflation. What the California legislature decided was fair compensation in 1975 has, in real terms, been reduced by 72%. This insight adds to the issue of whether the cap is fair.

### **The Ineffectiveness of Caps**

Research on the effectiveness of caps in reducing medical malpractice premiums lends, at best, equivocal support to the argument that they are effective.

A United States Government Accounting Office (GAO) report in 2003 showed that states with caps on medical malpractice damages tended to have lower premiums for doctors and that rate increases were lower in states with caps.<sup>86</sup> However, the report also concluded that it is not possible to show a direct link between caps and premiums because there are other factors that distinguish states with and without caps. Moreover, some states without caps had the lowest premiums of all. Importantly, the GAO concluded that there are *no data to establish the proposition that damage caps have an effect on the number of malpractice claims, losses by medical insurers, litigation expenses, or the rates charged doctors for insurance.*

In the same year, Weiss Ratings, Inc., a highly respected insurance rating company, also concluded that caps do not have an effect on physicians' the insurance premiums.<sup>87</sup> Indeed, Weiss found that in comparison to states without caps, states with caps had greater increases in median annual insurance premiums for practices involving internal medicine, general surgery and obstetrics-gynecology.

An analysis of statistical information for 2003 by the Kaiser Family Foundation, another highly respected organization dedicated to health care, showed that the number of paid claims per 1000 active physicians was unrelated to whether a state had caps on pain and suffering.<sup>88</sup>

Catherine Sharkey analyzed medical malpractice jury verdicts from 22 states for the years 1992, 1996 and 2001 that were collected by the National Center for State Courts.<sup>89</sup> Sharkey found no statistically significant relationship between the presence or absence of caps and compensatory damages in jury verdicts and trial court judgments.

Kessler, Sage and Becker studied the impact of malpractice reforms on the number of physicians in states with malpractice reforms and states without such reforms.<sup>90</sup> The study did not specifically separate caps from other reforms. Overall, a combination of tort reforms was associated with a slightly greater number of physicians. The study did not examine the effects of reforms on malpractice premiums or on the frequency of claims or the amounts of awards. The authors of the study acknowledged that malpractice climate is one of many determinants of the physician workforce and that the reforms they studied had only a “modest impact” on the number of physicians. Moreover, the authors acknowledged that there were possible alternative explanations for their findings.<sup>91</sup>

Vidmar analyzed a sample of Illinois jury verdicts that provided breakdowns of the verdicts into their specific components, including pain and suffering.<sup>92</sup> The analysis showed that a \$500,000 cap on pain and suffering would functionally affect very few cases.

The Wisconsin Supreme Court decision analyzed a substantial body of empirical research bearing on caps with specific reference to the state of Wisconsin.<sup>93</sup> The Court drew a number of conclusions that included:

“Based on the available evidence from nearly 10 years of experience with caps on non-economic damages in medical malpractice cases in Wisconsin and other states, it is not reasonable to conclude that the \$350,000 cap has its intended effect of reducing medical malpractice insurance premiums.”

“The available evidence indicates that health care providers do not decide to practice in a particular state based on the state’s cap on non-economic damages.”

“We agree with those courts that have determined that the correlation between caps on non-economic damages and the reduction of medical malpractice premiums or overall healthcare costs is at best indirect, weak and remote.”

In 2003, GE Medical Protective Company, the nation’s largest medical malpractice insurer, reported to the Texas Department of Insurance as follows:

“Non-economic damages are a small percentage of total losses paid. Capping non-economic damages will show loss savings of 1.0%.”<sup>94</sup>

The company also said that a provision in Texas law allowing for periodic payments of awards would provide a savings of only 1.1%. Medical Protective eventually raised the rates on its physician policyholders.<sup>95</sup>

In California in 2003, despite the cap of \$250,000, GE Medical Mutual sought an increase of 29.2% in liability insurance premiums. Thus, the cap did not prevent insurers seeking a major increase in liability insurance rates.<sup>96</sup>

## **Potential Reverse Effects of Caps**

One experiment has raised the possibility that caps could actually have an effect that is the reverse of what is intended by caps if one or more jurors are aware of the cap legislation and inform the other jurors. Michael Saks conducted an experiment in which some simulating jurors were informed that there was a \$250,000 cap on pain and suffering. These jurors’ verdicts were compared to jurors who did not learn of a cap.<sup>97</sup> When the plaintiff’s injury was modest, jurors with knowledge of caps gave awards that were significantly higher and more variable than those without such knowledge.

While jury simulation studies must be treated cautiously, the data are consistent with an explanation that the caps provided an upward psychological anchor for the jurors when they decided the pain and suffering com-

ponent. In today's educated society, it is likely that some jurors will be aware of the caps limitation, although they will not be told of it at trial. The implication of the Saks et al. findings is that the damage verdicts in trials with relatively modest injuries, of which there are many, could increase if jurors are aware of caps.

## **Explanations for the Ineffectiveness of Caps**

The rationale for caps is predicated on the following two assumptions: (1) juries are irresponsible and excessive in awarding pain and suffering; and (2) the fear of large jury awards for pain and suffering cause doctors and hospitals to settle cases for more than they are actually worth.

The first problem with the caps rationale is that, as discussed elsewhere in this report (Chapters 4 and 5), it ignores the fact that most cases with large jury awards are settled for much less than the verdict, often for amounts close to the plaintiff's economic losses. Functionally, the plaintiff does not typically receive the large award for pain and suffering.

The second problem with the rationale is that it assumes that jury awards drive settlements. More than 90% of cases are settled without jury trial, with some estimates indicating that the figure is as high as 97%. In a study of 831 Florida malpractice cases between 1990 and 2003, more than 92% of claims with million-dollar payments were settled without a jury trial. Thirty-seven cases resulted in payments over \$5 million. Only two of these cases were decided by a jury. Five of the 831 cases exceeded \$10 million dollars, but only one was the result of a jury trial. Of the remaining four cases, one settled in pre-litigation negotiations.

The Saks et al. experiment may offer another explanation for the lack of impact of caps on overall payouts: namely, while caps may reduce the amounts awarded to plaintiffs suffering the most serious injuries, patients with lesser injuries may be compensated more.

A study of closed claims in Texas from 1966 through 2002 showed that plaintiff verdicts averaged only 3% of paid claims over \$10,000.<sup>98</sup> In any year, jury verdicts never accounted for more than 5% of paid claims.

To be sure, the prospect of a jury award is possible if the case is not settled before trial, but if the case does go before a jury, data from many studies show that at trial doctors win between six and eight times out of ten. Defense lawyers and their insurers are aware of these odds because they are repeat players in the litigation process. They also know that when there is a jury award, the case frequently settles for less than the verdict amount. Research on why insurers actually settle cases indicates that the driving force in most instances is whether the insurance company and their lawyers conclude, on the basis of their own internal review, that the medical provider was negligent.<sup>99</sup> If they conclude negligence occurred, an attempt is made to settle; the case proceeds to trial only if the plaintiff monetary demand is unreasonable or if there is a strong disagreement over whether liability exists. Payments are typically not made in cases in which the defense concludes there is no liability.

Finally, the rationale for caps ignores other possible tort system changes that may reduce payments and it ignores other factors, such as problems associated with the insurance business cycle that may be responsible in whole or in part for the costs of insurance premiums.

## **Summary**

From a public policy perspective, caps on pain and suffering need to be evaluated against the answers to two questions: are the caps fair to injured persons and are they effective in reducing insurance rates? There is data bearing on each of these questions. The data strongly suggest that caps tend to discriminate against women, elderly persons, children and persons who are the most seriously injured from medical negligence. Other data contradict the claims that caps reduce liability insurance premiums.

Pennsylvania has been identified as a “crisis state” by the American Medical Association.<sup>100</sup> Antitrust hearings before a special committee of the U.S. Congress’ House Committee on Energy of Commerce in 2003 reported that since 2001, more than 900 physicians in Pennsylvania had closed their practices, moved out of state, or refused to do high-risk procedures.<sup>101</sup> A media release in 2005 by the Pennsylvania Medical Society claimed that a survey:

...discovered one in four Pennsylvanians lost their doctors due to the rising costs of liability insurance. According to the poll, 26 percent said they saw their doctors move, give up certain procedures, or stop practicing medicine as liability insurance costs skyrocketed.<sup>102</sup>

A survey of obstetricians and gynecologists drew the conclusion that the high cost of medical malpractice insurance is a major reason why medical residents said that they planned to leave Pennsylvania after they completed their residencies.<sup>103</sup>

In this chapter, we explore Pennsylvania’s position in relation to current per capita physician supply, changes over time and Pennsylvania in relation to other states. The source of data is American Medical Association official statistics, supplemented by licensing statistics of the Federation of State Medical Boards.

### **Prior Research on Access to Health Care in Pennsylvania**

In 2003, Bovbjerg and Bartow published a report on Pennsylvania’s medical malpractice crisis.<sup>104</sup> The research was supported by the Pew Charitable Trust and contained a chapter on Pennsylvania’s health care system, including research on access to health care. Among their findings was the fact that Pennsylvania has high rates of health insurance coverage with only 9% of residents being uninsured.<sup>105</sup> Pennsylvania ranks relatively high in the supply of hospitals. While hospital beds nationwide declined about 29% between 1980 and 1987, Pennsylvania’s bed supply declined by only 21%.<sup>106</sup> Pennsylvania had almost 20% more beds per thousand people than the nation at large and ranked 18th largest among the states.

Personal health care expenditures per capita in Pennsylvania were consistently about 11% higher than the national average, according to 1998 data provided by the Centers for Disease Control.<sup>107</sup> Both Pennsylvania and the U.S. figures increased about 4.9% annually through the nineties. Medicare expenditures accounted for 24.8% of the total in Pennsylvania, compared to 20.6% nationally. Pennsylvania is joined by Mississippi and Louisiana in this range, with only Florida claiming a bigger slice of the Medicare pie at 28% of their total medical expenditures.

Using statistics from the Center for Disease Control, Bovbjerg and Bartow concluded that Pennsylvania had about 10% more medical doctors (M.D.s) than the nation at large.<sup>108</sup> From 1975 through 1995, Pennsylvania gained patient care physicians, both in absolute terms and relative to the national average. During 1995 through 2000, the state’s edge over the nationwide per capita number of physicians declined marginally, but the authors noted that this period was also marked by consolidation among health insurers and hospitals. Physicians were not spread evenly across Pennsylvania, but the authors cautioned that uneven spread does not necessarily reflect service areas since patients may see doctors in different areas and doctors may practice in more than one location. Pennsylvania’s doctors were slightly younger on average. Pennsylvania produced a high share of its physicians in its own medical schools.

The data from the Bovbjerg and Bartow study presents a healthy picture of physician supply in Pennsylvania. The problem from the perspective of 2006 is that the report does not cover data beyond 2000 when the crisis in obtaining affordable professional liability insurance reportedly escalated. The report also did not address specialties such as obstetrician-gynecologists and neurosurgeons, two of the practice areas reportedly most heavily affected by the insurance crisis.

## Data Sources

We used two data sources in the present research. The primary source was the American Medical Association's (AMA) official statistics, published annually in *Physician Characteristics and Distribution in the U.S.*<sup>109</sup> This publication provides a number of important statistics about doctors, including breakdowns by region, state, and county, participation information on certain specialties, and state-by-state comparisons of physician-to-population ratios. The second data source was statistics on medical licensing reported by the Federation of State Medical Boards.<sup>110</sup>

There is a two-year time lag between the date of the publication and the AMA statistics. Thus, for example, the 2006 edition presents data on doctors as of December 31, 2004.<sup>111</sup> Consequently, the data reported in this chapter begin with 1993 and end at 2004. The AMA data cannot speak to changes in the number of Pennsylvania doctors after that period. There are additional qualifications. First, our analysis is limited to non-federal "Total Patient Care Physicians." Some physicians are federal employees, such as those associated with military bases, Veterans Administration Hospitals, and the Public Health Service. These physicians are not affected by the liability insurance crisis since the United States Government assumes tort liability for these providers, and malpractice claims are adjudicated under the Federal Tort Claims Act. This Act provides for trial by judge alone and thus verdicts are unaffected by jury outcomes. Other physicians are employed by insurance carriers or pharmaceutical companies or are in academics only. Some other physicians list themselves as inactive and a few remain unclassified in the AMA statistics.

It is important to point out that the AMA classification of "treating physicians" excludes physicians who declared themselves inactive, who were engaged in other activity, and who were not classified. In other words, *the statistics on treating physicians refers to actively working doctors whose practice is primarily treating patients*. On the other hand, some of these physicians may be working part-time only and others may have limited their practices, e.g. abandoned surgery, certain types of surgery, or stopped delivering babies. The statistics provide some general breakdowns as to how physicians classify their practice, but these are self-designations and do not provide estimates of types of actual patient care. Thus, an obstetrician/gynecologist may not deliver babies as part of his or her practice or may refer difficult, high-risk cases to another obstetrician. A surgical specialist may conduct only routine low-risk surgery and avoid high-risk operations. On the other hand, a physician whose classification is "Family Medicine/General Practitioner" may conduct surgery or deliver babies.

Data from the Federation of State Medical Boards varies slightly from the AMA data and is probably due to differences in sampling and estimates from samples, but the two sources are generally consistent. While doctors may hold licenses and not practice in a particular state, the Medical Board data that was used in this report involve licensed doctors who practice in Pennsylvania.

## Changes in Physicians in Pennsylvania

In 2004, Pennsylvania had a total of 40,832 physicians. Of these, 31,741 (or 78%) classified themselves as non-federal physicians engaged in patient care. In 2004, 79% of private physicians across the United States were self-classified as patient care physicians.

Table 7.1 allows examination of trends in the total number of active patient care physicians, active patient care physicians per 100,000 persons in Pennsylvania and comparative data involving the nation as a whole. The final column is the number of licensed practicing physicians in Pennsylvania taken from the separate data source, the Federation of State Medical Boards. These latter data were used as an additional check against the AMA data and are current to 2004.

The first column of Table 7.1 shows that, although there were fluctuations from year to year,<sup>112</sup> the absolute numbers of physicians in Pennsylvania in 2004 was 11 percent more than in 1994. The important issue, of course, is the degree to which the number of treating physicians relates to changes in the population of Pennsylvania. Column 3 shows that in 2004 there were 8 percent more physicians per 100,000 persons than in 1994. From 1994 through 2004 there has been an annual average increase of 0.7% in the number of treating physicians, albeit there were year-to-year fluctuations in the numbers. Column 2 compared to Column 3 shows that Pennsylvania is substantially above the nationwide numbers. Pennsylvania has 8.9% more patient care doctors per capita than the U.S. average, and ranks tenth overall among the 50 states. The final column, licensed physicians practicing in Pennsylvania, shows a trend similar to the AMA statistics reported in Column 1.

**Table 7.1: Active Patient Care Physicians, Active Patient Care Physicians in Relation to Population in Pennsylvania and the Nation, and Licensed Physicians Practicing in Pennsylvania: 1994-2004**

<i>Year</i>	<i>AMA Pennsylvania Total Patient Care Physicians</i>	<i>Pennsylvania Patient Care Physicians Per 100,000 Persons</i>	<i>National Patient Care Physicians Per 100,000 Persons</i>	<i>Pennsylvania Licensed Practicing Physicians</i>
2004	31,741	256	235	33,000
2003	31,788	257	235	31,247
2002	31,496	259	234	29,221
2001	31,704	262	235	30,292
2000	31,230	254	230	29,043
1999	30,371	253	224	28,963
1998	30,699	280	230	26,877
1997	30,611	255	227	27,474
1996	29,859	248	217	26,830
1995	29,666	246	216	29,337
1994	28,551	237	207	27,401

### **Physicians in Obstetrics-Gynecology and Neurosurgery Specialties: 1994-2004**

Obstetrician-gynecologists and neurosurgeons are frequently discussed as two medical specialties particularly negatively affected by of the litigation climate. Table 7.2 reports the total number of patient care obstetrician-gynecologists, as well as their numbers per 100,000 persons in Pennsylvania and the U.S. by year from 1994 through 2004.

**Table 7.2: Patient Care Physicians in Obstetrics-Gynecology in Pennsylvania and Per Capita Trends Compared to the United States: 1994-2004**

<i>Year</i>	<i>Obstetrics-Gynecology</i>	<i>OBGyn per 100,000 Population</i>	<i>U.S. OBGyn per 100,000 Population</i>
2004	1637	13.39	13.85
2003	1661	13.43	13.94
2002	1676	13.59	13.60
2001	1710	13.90	13.75
2000	1728	14.06	13.61
1999	1692	14.11	13.78
1998	1723	14.36	13.95
1997	1711	14.24	13.97
1996	1704	14.16	13.75
1995	1679	13.94	13.59
1994	1594	13.24	13.31

Table 7.2 shows that the number of obstetrician-gynecologists per 100,000 persons in 2004 was slightly above what it was in 1994, but has declined from its high in 1998. This trend might be reflected from consolidation of medical practices.

Importantly, calculating the number of obstetrician-gynecologists in per capita terms may be misleading because of a shift in Pennsylvania’s age demographics. If, for example, there are fewer women of childbearing age as the population ages, or there is a proclivity of couples to have smaller families or there are fewer births for other reasons, there would be less need for as many baby doctors. Various official statistics are consistent with this supply and demand hypothesis.

Pennsylvania is home to about 4.4% of the national population. Over the decade of the 90’s, the state experienced a significant shift in population from rural to urban areas. In 1990, 31.1% of Pennsylvania’s residents were considered to be living in rural areas. In 2000, that number had dwindled to 22.9%, much more in line with the national average of 21%.<sup>113</sup> Pennsylvania’s population is slightly older than the U.S. population.<sup>114</sup> The median age in Pennsylvania is 38, compared to 35 nationally. The median age in Pennsylvania also increased from 35 to 38 in 2000. Family size in 1990 was 3.30 children per family, but in 2000 it was 3.04 children per family. Even among Pennsylvania’s rural population the number of births is at a 40-year low. According to the Pennsylvania Department of Health, there was a 17% decline in live births to mothers between 1992 and 2002.<sup>115</sup> Women of childbearing age (15-44) comprise 20.9% of Pennsylvania’s population compared to 21.9% of the national population. The slight decline in obstetrician-gynecologists in Pennsylvania *may* be explained by these trends. The word “may” is italicized because these data do not allow drawing con-

clusions about a causal connection. Nevertheless, the data appear consistent with the hypothesis that the decline in obstetrician/gynecologists is due to a declining birth rate.

### Neurosurgeons in Pennsylvania

Table 7.3 reports the number of physicians engaged in neurosurgery in Pennsylvania between 1994 and 2004. It shows that the absolute number of neurosurgeons in 2004, namely 237, was six less than the mean of 243 over the years 1994 through 2003. Table 7.3 also shows that the number of neurosurgeons in Pennsylvania per 100,000 persons declined to 1.91 from an average of 2.01 for the previous ten-year period. However, comparing the third and fourth columns shows that in 2004 Pennsylvania still had more neurosurgeons per capita than the nationwide average of 1.71.

**Table 7.3: Patient Care Physicians in Neurosurgery in Pennsylvania and the United States: 1994-2003**

<i>Year</i>	<i>Neurological Surgery</i>	<i>NS per 100,000 Population</i>	<i>U.S. NS per 100,000 Population</i>
2004	237	1.91	1.71
2003	240	1.94	1.71
2002	222	1.80	1.66
2001	242	1.97	1.68
2000	248	2.02	1.69
1999	245	2.04	1.72
1998	243	2.02	1.75
1997	246	2.05	1.75
1996	254	2.11	1.76
1995	263	2.18	1.77
1994	234	1.94	1.68

### Discussion and Conclusions

Official statistics by the American Medical Association and the Federation of Medical Licensing Boards are not consistent with claims that Pennsylvania is losing doctors. Over the past decade, both the absolute and the per capita number of treating doctors have increased in the state. There have been slight declines in the number of obstetrician-gynecologists and neurosurgeons, but with respect to this latter group Pennsylvania nevertheless has more neurosurgeons per capita than the national average.

Attention has been given to a survey of obstetrician-gynecologist medical residents in Pennsylvania that suggested their reasons for planning to leave the state were primarily because of the decreasing availability of affordable liability insurance.<sup>116</sup> The authors of that report conceded that other factors affect decisions about where to locate and it is quite possible that the doctors who responded to the survey were simply responding to

the publicity about medical liability insurance rates. The same study also found that medical program directors reported more medical residents are leaving the state than in the past. The findings of the study should be considered because they suggest a possible future problem with physician supply. However, the findings reported in this chapter indicate that as of 2004 the decline in the number of obstetrician-gynecologists is slight and may partially be ascribed to other market forces: specifically, the data suggest that the number of doctors needed in this specialty may be declining because of falling birth rates in Pennsylvania.

Another study published in the same medical journal issue as the survey of residents found no significant differences in the overall supply of obstetrician-gynecologists in the AMA's identified crisis and non-crisis states or in the level of premiums charged for liability insurance.<sup>117</sup> However, the authors of the report claimed that some of their findings were consistent with their hypothesis "that high malpractice premiums may have had an influence on the decision of younger doctors to practice in these states." The authors appear to have stretched their findings to fit with their hypothesis since birth rates were higher in low premium states, suggesting an alternative explanation of supply and demand. Moreover, those authors also found that their data supported a conclusion that in most counties in the United States, there was "an improvement in the supply of obstetrical care."<sup>118</sup>

The discussion about obstetrician-gynecologists raises a limitation of the findings in this chapter: they cannot project to the future. On the other hand, the claims about doctors leaving the state because of liability insurance premiums have been made since about the year 2000. The statistics reported in this chapter are not consistent with those claims.

Even considering the possibility that some physicians may have decided to abandon certain high-risk procedures, the claim that one in four Pennsylvanians lost their doctor seems unsupportable on its face. It is possible that some doctors have left the state and medical residents moved to other states but, if so, they were replaced by other doctors.

It is important to reiterate that this report does not challenge the claim that professional liability premiums were a serious problem for Pennsylvania doctors in the first part of the 2000 decade. Nevertheless, the liability insurance crisis notwithstanding, the data indicate that Pennsylvania has had a modest gain in actively practicing doctors, both in absolute numbers and in relation population growth.

# Endnotes

## Chapter 1

- 1 *See generally*, Catherine Struve, EXPERTISE IN MEDICAL MALPRACTICE LITIGATION: SPECIAL COURTS, SCREENING PANELS, AND OTHER OPTIONS (2003), at 7-18, available at [www.medliabilitypa.org](http://www.medliabilitypa.org).
- 2 An excellent and recent review of the debate is contained in Tom Baker, THE MEDICAL MALPRACTICE MYTH (2005)
- 3 CONSTITUTION OF PENNSYLVANIA, September 28, 1776.
- 4 Roger Mecum, press release, Pennsylvania Medical Society, May 2, 2005.
- 5 The Pennsylvania Medical Society has said: “unfortunately, as payouts skyrocket, it’s clear that more work needs to be done to lower the cost of our expensive legal system.”
- In an April 21, 2005, the President of the Pennsylvania Medical Society put forth three main points:
- Patients are losing their doctors due to the state’s medical liability insurance crisis;
  - There are too many frivolous lawsuits; and
  - Jackpot paydays are skyrocketing. Press release, Pennsylvania Medical Society, April 21, 2005.
- 6 PENNSYLVANIA MEDICAL SOCIETY, THE STATE OF MEDICINE IN PENNSYLVANIA: AN OVERVIEW OF PENNSYLVANIA’S PHYSICIAN MARKETPLACE (2005).
- 7 PENNSYLVANIA RULES OF CIVIL PROCEDURE (2005), at <http://members.aol.com/RulesPA/Civil.html>.
- 8 MEDICAL CARE AVAILABILITY AND REDUCTION OF ERROR ACT, (2002) PA ALS 13, Chapter 5. What follows is a summary of the main elements of the reforms. The reader is directed to the legislation itself for more details.

## Chapter 2

- 9 <http://www.courts.state.pa.us/index/MedicalMalpractice>.
- 10 Neil Vidmar et al., *Uncovering the “Invisible” Profile of Medical Malpractice Litigation: Insights from Florida*, 54 DEPAUL LAW REVIEW 315 (2005).
- 11 *Id.* at 348-349.
- 12 Bernard Black et al., *Stability, Not Crisis: Medical Malpractice Claim Outcomes in Texas, 1998-2002*, 2 JOURNAL OF EMPIRICAL LEGAL STUDIES 207, 250 (2005).
- 13 Neil Vidmar, MEDICAL MALPRACTICE AND THE AMERICAN JURY (1995), at Chapters 2 and 3.
- 14 Neil Vidmar et al., *Uncovering the “Invisible” Profile of Medical Malpractice Litigation: Insights from Florida*, 54 DEPAUL LAW REVIEW 315 (2005), at 332.
- 15 See [www.issuesPennsylvania.net/print/articles/13615?p=1](http://www.issuesPennsylvania.net/print/articles/13615?p=1) (accessed April 29, 2006).
- 16 Pennsylvania Medical Society, THE STATE OF MEDICINE IN PENNSYLVANIA: AN OVERVIEW OF PENNSYLVANIA’S PHYSICIAN MARKETPLACE (2005) at 106.
- 17 The incidence of negligence could have dropped, but it is unlikely that such dramatic change occurred over a few years. It is possible that in the years 2000 through 2002, plaintiff lawyers were anticipating tort rule changes and hurriedly filed lawsuits so they could be litigated under the old rules. Without systematic data on filings in the years before 2000, we cannot eliminate this hypothesis, but it seems unlikely.

### Chapter 3

- 18 HARVARD MEDICAL PRACTICE STUDY, PATIENTS, DOCTORS, AND LAWYERS: MEDICAL INJURY, MALPRACTICE LITIGATION AND PATIENT COMPENSATION IN NEW YORK (1990). *See also* Paul C. Weiler et al., A MEASURE OF MALPRACTICE: MEDICAL INJURY, MALPRACTICE LITIGATION, AND PATIENT COMPENSATION (1993).
- 19 *Id.* at 44, Table 3.2.
- 20 Eric J. Thomas et al., *Incidence and Types of Adverse Events and Negligent Care in Utah and Colorado*, 38 *Medical Care* 261, 261 (2000).
- 21 Lori Andrews, *Studying Medical Error in SITU: Implications for Malpractice Law and Policy*, 54 *DEPAUL LAW REVIEW* 357 (2005).
- 22 *See* Lucian Leape, Institute of Medicine, *Medical Error Figures Are Not Exaggerated*, 284 *JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION* 95 (2000) [citing R.W. DuBois and R. Brook, *Preventable Deaths: Who, How Often and Why?* 109 *ANNALS INTERNAL MEDICINE* 582 (1988)]; Kathryn B. Kirkland et al., *The Impact of Surgical-Site Infections in the 1990s: Attributable Mortality, Excess Length of Hospitalization, and Extra Costs*, 20 *INFECTION CONTROL & HOSP. EPIDEMIOLOGY* 725 (1999).
- 23 Thomas M. Julian et al., *Investigation of Obstetric Malpractice Closed Claims: Profile of Event*, 2 *AM. J. PERINATOLOGY* 320 (1985).
- 24 Institute of Medicine, *TO ERR IS HUMAN: BUILDING A SAFER HEALTH CARE SYSTEM* (Linda Kohn et al., eds. 2000), [http://books.nap.edu/catalog/9728.html?onpi\\_newsdoc112999](http://books.nap.edu/catalog/9728.html?onpi_newsdoc112999); Lucian L. Leape, Institute of Medicine, *Medical Error Figures Are Not Exaggerated*, 284 *JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION* 95 (2000).
- 25 Reuters, *Report Says 195,000 Deaths Due to Hospital Error*, *WL REUTERS ENG. NEWS SERV.*, July 27, 2004, 22:23:11.
- 26 HealthGrades, *Third Annual Patient Safety in American Hospitals Study*, April, 2006.
- 27 For criticism of the Harvard study or controversy over some of the findings, *see* Rodney A. Hayward and Timothy P. Hofer, *Estimating Hospital Deaths Due to Medical Errors*, 286 *JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION* 415 (2001); Clement J. McDonald et al., *Deaths Due to Medical Error Are Exaggerated*, in Institute of Medicine Report, 284 *JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION* 93 (2000).
- 28 *See* Nancy Udell and David Kendall, *Health Courts: Fair and Reliable Justice for Injured Patients*, *Progressive Policy Institute*, February 2005 at [www.ppionline.org](http://www.ppionline.org); David Wenner, *Lawsuits Illuminate Debate over Malpractice*, *THE PATRIOT-NEWS*, April 10, 2005.
- 29 Pennsylvania Patient Safety Authority, *2004 Annual Report*, April 29, 2005.
- 30 The clinical director for the Authority strongly cautioned that not all serious events were due to unsafe actions! Thus, for example, an allergic reaction is not the result of an unsafe action if the patient was not aware of any allergies; a patient's unanticipated death from a disease (rather than medical error) would also likely be reported as a serious event. The Director also drew attention to the fact that the purpose of the statistical reporting is to improve system level medical care, not uncover medical negligence.
- 31 *Id.* at page 19.

32 *Id.* at 31.

33 *Id.* at 24.

34 Frank A. Sloan and Stephen S. VanWert, *Cost of Injuries*, in Frank A. Sloan et al., *SUING FOR MEDICAL MALPRACTICE* 123, 139-40 (1993).

35 Neil Vidmar et al., *Uncovering the “Invisible” Profile of Medical Malpractice Litigation: Insights from Florida*, 54 *DEPAUL LAW REVIEW* 315 (2005).

36 For the Kaiser study, see <http://statehealthfacts.org/r/malpractice.cfm>.

37 Joseph Hallinan, *Doctor is Out: Attempt to Track Malpractice Cases is Often Thwarted — Deleting a Physician’s Name from a Suit Before Settling Keeps it Out of Data Bank*, *WALL STREET JOURNAL*, August 27, 2004 at A1.

38 This example is taken from Neil Vidmar, *Medical Malpractice Lawsuits: An Essay on Patient Interests, the Contingency Fee System, Juries, and Social Policy*, 38 *LOYOLA OF LOS ANGELES LAW REVIEW* 1217 (2005).

39 §1303.509(b)(5).

40 HARVARD MEDICAL PRACTICE STUDY, *PATIENTS, DOCTORS, AND LAWYERS: MEDICAL INJURY, MALPRACTICE LITIGATION AND PATIENT COMPENSATION IN NEW YORK* (1990).

41 Michael Saks, *Medical Malpractice: Facing Real Problems and Finding Real Solutions*, 35 *WILLIAM & MARY LAW REVIEW* 693, 702, 703 (1994), presents one of the clearest expositions of these findings. In further calculations, Saks points out that the probability of a health care provider being sued for a negligent injury is 0.029 whereas the probability of being sued for a non-negligent injury is 0.0013.

42 These issues are discussed in greater detail in Neil Vidmar, *Medical Malpractice Lawsuits: An Essay on Patient Interests, the Contingency Fee System, Juries, and Social Policy*, 38 *LOYOLA OF LOS ANGELES LAW REVIEW* 1217 (2005); and Neil Vidmar, *MEDICAL MALPRACTICE AND THE AMERICAN JURY* (1995).

43 Frank A. Sloan and Chee Ruey Hsieh, *Injury, Liability, and the Decision to File a Medical Malpractice Claim*, 29 *LAW & SOCIETY REVIEW* 413 (1995).

44 *Id.* at 430.

45 Herbert M. Kritzer, *RISKS, REPUTATIONS, AND REWARDS: CONTINGENCY FEE LEGAL PRACTICE IN THE UNITED STATES* 289 n. 20 (2004).

46 David M. Studdert et al., *Claims Errors, and Compensation Payments in Medical Malpractice Litigation*, 354 *NEW ENGLAND JOURNAL OF MEDICINE* 2024 (May 11, 2006).

47 *Id.* at 2031.

48 See Catherine Struve, *EXPERTISE IN MEDICAL MALPRACTICE LITIGATION: SPECIAL COURTS, SCREENING PANELS, AND OTHER OPTIONS* (2003), available at [www.medliabilitypa.org](http://www.medliabilitypa.org).

## Chapter 4

49 Parts of this chapter are modified from Neil Vidmar, *Medical Malpractice Lawsuits: An Essay on Patient Interests, the Contingency Fee System, Juries, and Social Policy*, 38 *LOYOLA OF LOS ANGELES LAW REVIEW* 1217 (2005).

- 50 Carol J. DeFrances et al., *Civil Justice Survey of State Courts, 1992: Civil Jury Cases and Verdicts in Large Counties* BUREAU OF JUSTICE STATISTICS, No. NCJ-154346, (1995); Carol J. DeFrances and Marika F.X. Litras, *Civil Justice Survey of State Courts, 1996: Civil Trial Cases and Verdicts in Large Counties, 1996* BUREAU OF JUSTICE STATISTICS, No. NCJ 173426, (1999); Thomas H. Cohen, *Civil Justice Survey of State Courts, 2001: Tort Trials and Verdicts in Large Counties, 2001* BUREAU OF JUSTICE STATISTICS, No. NCJ 206240, (2004).
- 51 Neil Vidmar, *MEDICAL MALPRACTICE AND THE AMERICAN JURY* (1995).
- 52 Valerie P. Hans, *BUSINESS ON TRIAL: THE CIVIL JURY AND CORPORATE RESPONSIBILITY* 127-29 (2001).
- 53 For a review of this research, see Hans in note 44.
- 54 Neil Vidmar, *Empirical Evidence on the Deep Pockets Hypothesis: Jury Awards for Pain and Suffering in Medical Malpractice Cases*, 43 *DUKE L.J.* 217 (1993).
- 55 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 (1992).
- 56 Harry Kalven, Jr. and Hans Zeisel, *THE AMERICAN JURY* (1966); Larry Heuer and Steven Penrod, *Trial Complexity: A Field Investigation of Its Meaning and Its Effects*, 18 *LAW & HUM. BEHAVIOR* 29 (1994).
- 57 These surveys are reviewed in *Brief of Amici Curiae Neil Vidmar et al., at Kumho Tire Co. v. Carmichael*, 526 U.S. 137 (1999) (No. 97-1709), 1998 WL 734434.
- 58 See 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, 885-91 (1994).
- 59 Neil Vidmar and Shari Seidman Diamond, *Juries and Expert Evidence*, 66 *BROOKLYN LAW REVIEW* 1123 (2001); Sanja Kutnjak Ivkoviæ and Valerie P. Hans, *Jurors' Evaluations of Expert Testimony: Judging the Messenger and the Message*, 28 *LAW & SOC. INQUIRY* 441 (2003).
- 60 Randall R. Bovbjerg et al., *Valuing Life and Limb in Tort: Scheduling "Pain and Suffering,"* 83 *NORTHWESTERN UNIVERSITY LAW REVIEW* 908 (1989).
- 61 Neil Vidmar et al., *Jury Awards for Medical Malpractice and Post-Verdict Adjustments of Those Awards*, 48 *DEPAUL L. REV.* 265, 287 (1998).
- 62 Thomas H. Cohen, *Civil Justice Survey of State Courts, 2001: Tort Trials and Verdicts in Large Counties, 2001* BUREAU OF JUSTICE STATISTICS, No. NCJ 206240, (2004).
- 63 Neil Vidmar, Felicia Gross and Mary Rose, *Jury Awards for Medical Malpractice and Post-Verdict Adjustments of Those Awards*, 48 *DE PAUL LAW REVIEW* 265 (1998).
- 64 Neil Vidmar, *Juries and Jury Verdicts in Medical Malpractice Cases: Implications for Tort Reform in Pennsylvania*, unpublished report, January 28, 2002 (on file with the author).
- 65 Neil Vidmar, *MEDICAL MALPRACTICE AND THE TORT SYSTEM IN ILLINOIS* (May 2005).
- 66 Ivy E. Broder, *Characteristics of Million Dollar Awards: Jury Verdicts and Final Disbursements*, 11 *JUSTICE SYSTEM JOURNAL* 349 (1986); Michael G. Shanley and Mark A. Peterson, *RAND: THE INSTITUTE FOR CIVIL JUSTICE, POSTTRIAL ADJUSTMENTS TO JURY AWARDS* (1987); Brian Ostrom et al., *So the Verdict Is In — What Happens Next?: The Continuing Story of Tort Awards in the State Courts*, 16 *JUST. SYS. J.* 97 (1993); Deborah Jones Merritt and Kathryn Ann Barry, *Is the Tort System in Crisis? New Empirical Evidence*, 60 *OHIO ST. LAW JOURNAL.* 315, 353-55 (1999).

## Chapter 5

- 67 Randall Bovbjerg and Anna Barrow, *Understanding Pennsylvania's Medical Malpractice Crisis*, PROJECT ON MEDICAL LIABILITY IN PENNSYLVANIA OF THE PEW CHARITABLE TRUST (2003), at 32.
- 68 Thomas Cohen, *Tort Trials and Verdicts in Large Counties, 2001*, BUREAU OF JUSTICE STATISTICS BULLETIN, CIVIL JUSTICE SURVEY OF STATE COURTS, 2001, November 2004, NCJ 206240.
- 69 Michael Riccardi, *First District Statistics Dispel Myth*, 220 THE LEGAL INTELLIGENCER, No. 90 (May 11, 1999).
- 70 Neil Vidmar, *Juries and Jury Verdicts in Medical Malpractice Cases: Implications for Tort Reform in Pennsylvania*, unpublished report, January 28, 2002 (available from the author).
- 71 Supreme Court of Pennsylvania web site at <http://www.courts.state.pa.us>.
- 72 The report on Judge Herron's findings gave only the number of plaintiff wins and reported that the win rate was "nearly two-thirds of all trials." The 1998 figures in Table 7.1 are estimated from this finding.
- 73 The data for 2003 was for only available for the last six months, but there is no especial reason why the first six months should be different from the last six months.
- 74 Note that in 1998, the number of trials in which plaintiffs prevailed was 50 compared to an average of 37.6 for the other five years. One possible explanation for this difference is that the MCARE data do not address cases in which the amount at stake is less than the limits of the physician's liability coverage. Judge Herron's data included all cases, not just those that fall into the range of MCARE liability. There is no especial reason why win rates for lesser claims should be different than for MCARE liability claims.
- 75 See Neil Vidmar, *Pap and Circumstance: What Jury Verdict Statistics Can Tell Us about Jury Behavior and the Tort System*. 27 SUFFOLK UNIVERSITY LAW REVIEW 1205 (1994/1996); Neil Vidmar, *MEDICAL MALPRACTICE AND THE AMERICAN JURY* (1995), at Chapter 8.
- 76 Neil Vidmar, *Juries and Jury Verdicts in Medical Malpractice Cases: Implications for Tort Reform in Pennsylvania*, January 28, 2002 (report available from the author).
- 77 Details of both the injury and the verdict have been altered to protect confidentiality of the data.
- 78 Neil Vidmar, *MEDICAL MALPRACTICE AND THE AMERICAN JURY* (1995).
- 79 See Tom Baker, *Blood Money, New Money, and the Moral Economy of Tort Law in Action*, 35 LAW & SOCIETY REVIEW, 275, 284-85 (2001); Neil Vidmar, *Medical Malpractice and the Tort System in Illinois: A Report to the Illinois State Bar Association*, May 2005.

## Chapter 6

- 80 See Howard Richter, *Statement of the Pennsylvania Medical Society Liability Insurance Company before the Pennsylvania Senate Banking and Insurance Commission Regarding the Medical Malpractice Market in Pennsylvania*, March 26, 2003; David Wenner, *Lawsuits Illuminate Debate over Malpractice*, THE PATRIOT-NEWS, April 10, 2005.
- 81 Nicholas Pace et al., *Capping Non-economic Awards in Medical Malpractice Trials: California Jury Verdicts Under MICRA*, RAND INSTITUTE FOR CIVIL JUSTICE (2004).

- 82 David Studdert, Tony Yang, and Michelle Mello, *Are Damage Caps Regressive? A Study of Malpractice Jury Verdicts in California*, 21 HEALTH AFFAIRS 54 (2004).
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## Chapter 7

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