# BELIEVING SIX IMPROBABLE THINGS: MEDICAL MALPRACTICE AND "LEGAL FEAR"

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*"Alice laughed: "There's no use trying," she said; "one can't believe impossible things."*

*"I daresay you haven't had much practice," said the Queen. "When I was your age, I always did it for half an hour a day. Why, sometimes I've believed as many as six impossible things before breakfast."*[1]

## I. INTRODUCTION

Philip Howard believes. Howard believes that "[d]octors, teachers, ministers, even [L]ittle [L]eague coaches, find their daily decisions hampered by legal fear."[2] "Legal fear" exists when "[f]ear of litigation ... undermine[s] our freedom to make sensible decisions."[3] Howard has advanced this claim in a best-selling book, in numerous op-eds and speeches, and through his disarmingly-named public-interest organization, Our Common Good.[4] Howard has many allies.

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1. LEWIS CARROLL, ALICE'S ADVENTURES IN WONDERLAND AND THROUGH THE LOOKING GLASS 230 (Collins' Clear-Type Press 1920) (1866).

2. American Academy of Family Physicians, *Group Seeks to End 'Fear of Litigation'*, 9 FP REPORT 7 (July 2003) (quoting Our Common Good Web site), *at* http://www.aafp.org/fpr/20030700/9. html. *See also* Philip K. Howard, *Is Civil Litigation a Threat to Freedom?*, 28 HARV. J. L. & PUB. POL'Y 97, 98 (2004) ("This 'open season' approach to justice has infected people's daily behavior with a kind of legal fear. This legal fear is tearing at the fabric of the culture.")

3. *Id.*

4. PHILIP K. HOWARD, THE DEATH OF COMMON SENSE: HOW LAW IS SUFFOCATING AMERICA (1994); PHILIP K. HOWARD, THE COLLAPSE OF THE COMMON GOOD: HOW AMERICA'S LAWSUIT CULTURE UNDERMINES OUR FREEDOM (2002); Philip K. Howard, *Legal Malpractice*, WALL ST. J., Jan. 27, 2003, at A16, *available at* http://cgood.org/learn-reading-cgpubs-opeds-20.html; Troyen A. Brennan & Philip K. Howard, *Heal the Law, Then Health Care*, WASH. POST, Jan. 25, 2004, at B7, *available at* http://cgood.org/learn-reading-cgpubs-opeds-28.html.

The list of co-sponsors and supporters of Our Common Good is a "Who's Who" of business and politics, public intellectuals, organized medicine, and health policy scholars.[5]

Belief is one thing; proof is quite another. Testing Howard's beliefs requires framing them as empirically falsifiable propositions and then assessing them in light of the data. Howard's recent Washington Post op-ed on medical malpractice separates his global claim ("[f]ear of litigation [is] undermin[ing] our freedom to make sensible decisions"[6]) into more manageable and concrete sub-claims—and data is available to test each sub-claim.[7] Howard's op-ed indicates he believes at least six things about medical malpractice:

1. The tort system causes physicians and other health care providers to hide their mistakes.

2. Physicians and other health care providers once dealt with mistakes more openly.

3. Liability encourages substantial defensive medicine.

4. Liability undermines access to needed medical services.

5. Liability creates an "extortion lottery."

6. A specialized medical court would be an improvement.

These individual sub-claims are at best unproven and at worst flatly wrong. This is not to suggest that the medical malpractice system is operating optimally, or that alternative institutional arrangements might not outperform it. As we have detailed elsewhere, the medical malpractice system (like the health care delivery system) has a whole series of pathologies.[8] Nonetheless, it does not follow that reform

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5. Common Good's advisory board includes Hon. Newt Gingrich, former Speaker of the U.S. House of Representatives; Hon. George McGovern, former U.S. Senator and Ambassador to the U.N. Food and Agriculture Organization; Eric Holder, former Deputy U.S. Attorney General; Harry P. Kamen, retired Chair and CEO, MetLife; George Rupp, former President, Columbia University; President and CEO, International Rescue Committee; and John C. Whitehead, Chair, Lower Manhattan Development Corp. and former Deputy Secretary of State. Our Common Good website, *at* http://cgood.org/learn-people-advisory.html (last visited Oct. 19, 2004). Howard's article in this issue notes that Common Good's healthcare coalition "includes virtually every patient safety expert and the leading healthcare consumer groups. . . ." Howard, *supra* note 2, at 100.

6. American Academy of Family Physicians, *supra* note 2.

7. Brennan & Howard, *supra* note 4. Howard's article in this issue contains many of the same assertions. As appropriate, we cross-reference them as well.

8. Our relevant writings include David A. Hyman & Charles Silver, *The Poor State of Health Care Quality in the U.S.: Is Malpractice Liability Part of the Problem or Part of the Solution?*, CORNELL L. REV. (forthcoming 2005) (hereinafter Hyman & Silver, *Malpractice Liability*); David A. Hyman, *Medical Malpractice: What Do We Know and What (If*

(whether that advocated by Howard or by anyone else) will necessarily make things better. Institutional imperfection is an unfortunate reality of public policy.[9] It is foolish to choose Policy A over Policy B by listing the deficiencies of Policy B and the virtues of Policy A; one must also consider the virtues of Policy B and the deficiencies of Policy A if the decision is to be informed by anything other than faith in one's own belief system.

## II. BELIEF AND REALITY

Medical malpractice is the best-studied area of the tort system.[10] Over thirty years of empirical studies and extensive historical inquiry have made it possible to assess the performance of the system based on empirical data, not anecdotes. This Part goes through each of Howard's sub-claims regarding medical malpractice and considers how well the sub-claims correspond to what is actually known about the performance of the medical malpractice system.

### *Assertion 1: The tort system causes physicians and other health care providers to hide their mistakes.*

Howard claims that "[t]ragic human errors occur, for example, in prescription dosage, because people fearful of legal consequences are reluctant to speak up."[11] In other words, fear of liability is encouraging a culture of silence: the higher the risk of liability, the

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*Anything) Should We Do About It?*, 80 TEX L. REV. 1639-1655 (2002); David A. Hyman & Charles Silver, *The Case for Result-Based Compensation Arrangements*, 29 J.L. MED. & ETHICS 170 (2001; and David A. Hyman & Charles Silver, *You Get What You Pay for: Result-Based Compensation for Health Care*, 58 WASH. & LEE L. REV. 1427 (2001).

9. *Id.* at 1465 n.130 (quoting Harold Demsetz, *Information and Efficiency: Another Viewpoint*, 12 J.L. & ECON. 1, 1 (1969) ("The view that now pervades much public policy economics implicitly presents the relevant choice as between an ideal norm and an existing 'imperfect' institutional arrangement. This nirvana approach differs considerably from a comparative institution approach in which the relevant choice is between alternative real institutional arrangements.")).

10. The Harvard Medical Practice Study, which examined health care delivered in the early 1980s, is the most famous study of medical malpractice litigation. *See* PAUL C. WEILER ET AL., A MEASURE OF MALPRACTICE (1991). Many other studies exist, however. *See, e.g.*, NEAL VIDMAR, MEDICAL MALPRACTICE AND THE AMERICAN JURY: CONFRONTING THE MYTHS ABOUT JURY INCOMPETENCE, DEEP POCKETS, AND OUTRAGEOUS DAMAGE AWARDS (1995); Henry S. Farber & Michelle J. White, *A Comparison of Formal and Informal Dispute Resolution in Medical Malpractice*, 23 J. LEGAL STUD. 777 (1994); FRANK A. SLOAN ET AL., SUING FOR MEDICAL MALPRACTICE (1993); 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); Henry S. Farber & Michelle J. White, *Medical Malpractice: An Empirical Examination of the Litigation Process*, 22 RAND J. ECON. 199 (1991) (hereinafter Farber & White, *Medical Malpractice*).

11. Brennan & Howard, *supra* note 4.

lower the probability of voluntary error reporting. Howard is not alone in making this claim; the Institute of Medicine asserted in a famous 1999 report that "[p]atient safety is [] hindered through the liability system and the threat of malpractice, which discourages the disclosure of errors."[12]

There is one minor difficulty with this claim: *no* systematic empirical evidence indicates that it is true, and a fair amount of evidence shows that this claim is either dramatically overstated or simply wrong. As one prominent patient safety advocate (and firm believer in error reporting) noted in a recent article in the New England Journal of Medicine, "[n]o link between [error] reporting and litigation has ever been demonstrated."[13] No empirical study finds that the frequency of error reporting falls as the likelihood of being sued increases. Instead, the empirical literature indicates that there is massive underreporting of errors throughout the health care system, regardless of the level of liability risk that providers face.[14]

Consider the incentive to report errors for physicians and nurses who work in the Veterans Administration hospital system. By statute, such health care providers are immune from liability for negligence.[15] If Howard's first sub-claim were correct, one would expect VA hospitals to be hotbeds of voluntary error reporting. Freed from the fear of individual liability, physicians and nurses in the VA should "speak up" about any and all deficiencies in care—and care in the VA should have long been dramatically better than in the rest of the health care system. Instead, studies of VA hospitals show that there is significant underreporting of errors.[16] VA hospitals have also had serious quality problems—and improvements in quality have resulted

12. INSTITUTE OF MEDICINE, TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM 37 (1999); *see also id.* at 19 ("Liability concerns discourage the surfacing of errors and communication about how to correct them.").

13. Lucien L. Leape, *Reporting of Adverse Events*, 347 N. ENGL. J. MED. 1633, 1635 (2002).

14. Although we know of no study that compares rates of error reporting across practice areas, health care researchers seem to find under-reporting wherever they look. *See* INSTITUTE OF MEDICINE, *supra* note 12, at 29 (reviewing studies of error reporting).

15. *See, e.g.*, Thomas K. Kruppstadt, *Determining Whether a Physician Is a United States Employee or an Independent Contractor in a Medical Malpractice Action Under the Federal Tort Claims Act*, 47 BAYLOR L. REV. 223, 226 (1995) ("As a U.S. employee, a physician is immune from individual malpractice liability."); Albert W. Wu, *Handling Hospital Errors: Is Disclosure the Best Defense?*, 131 ANNALS OF INTERNAL MED. 970, 971 (1999) ("[G]overnmental physicians are protected from personal liability [by the Federal Tort Claims Act].").

16. *See* Office of Inspector General (OIG), QUALITY MANAGEMENT IN THE DEPARTMENT OF VETERANS AFFAIRS VETERANS HEALTH ADMINISTRATION, 8HI-A28-072 17 (Feb. 18, 1998).

from external (Congressional) pressure and scandals, not voluntary action from within.[17]

Next, consider no-harm errors and near misses by providers that are subject to liability. It is difficult to see those kinds of errors as sources of malpractice exposure; actual damages are a necessary component of a malpractice suit. No-harm errors and near misses are important sources of learning, however; one can learn a lot about the reliability of a delivery system by studying its harmless failures. Yet no-harm errors and near misses do not appear to be reported at a higher rate than errors for which liability is a possibility.[18]

Similarly, even though different specialties face different levels of liability risk, there is no evidence of differences in error reporting rates across specialties. Nor have we found any evidence that error reporting rates vary within or across states, even though malpractice insurance premiums and liability risks clearly vary substantially within and across states.[19] Shifting to an international perspective, error tracking and reporting systems are much more highly developed in the United States than in the United Kingdom, where physicians face much lower malpractice exposure risks – an observation that suggests that liability actually encourages openness about errors.[20]

Error reporting fails to happen for a variety of reasons, but tort liability is unlikely to be a major contributor to that problem. Few people like to report their own errors, whether in a medical context or otherwise. Few people like to "rat" on their friends. There are ways to address these problems, but scrapping the tort system is not one of

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17. *See id.* at 18; General Accounting Office, VA HAS NOT FULLY IMPLEMENTED ITS HEALTH CARE QUALITY ASSURANCE SYSTEMS (1985) (finding that VA medical centers [VAMCs] had not implemented required quality assurance [QA] programs, and "that the OMI [Office of Medical Inspector] was not adequately evaluating the effectiveness of VAMCs' QA programs.")). On the role external forces played in improving the VHA, see OIG, *supra* note 16, at 49 ("[T]he several QM [quality management] processes and methodologies, and the strong centralized QM oversight and control that VHA adopted in the period from 1985 to 1995, were developed in response to Congressional and public perceptions that VA did not practice sound and effective patient care.").

18. To the contrary, they appear to be reported *less* often. *See ISMP Survey Shows Weaknesses Persist in Hospital Systems for Error Detection, Reporting and Analysis*, ISMP MEDICATION SAFETY ALERT! (Inst. For Safe Medication Practices, Huntingdon, Pa.), Nov. 15, 2000 (finding that "it is more likely for [hospital] staff to report errors that actually reach the patient and cause harm" than for them to report other mistakes).

19. *See, e.g.*, WEILER ET AL., *supra* note 10, at 124 (documenting significant variation in physicians' perceived risk of malpractice claims). Malpractice insurance premiums also vary from state to state. Yet we know of no study finding that the frequency of error reports tracks these variations.

20. *See* CHIEF PHARM. OFFICER, DEP'T OF HEALTH, BUILDING A SAFER NHS FOR PATIENTS: IMPROVING MEDICATION SAFETY 22 (2004) (discussing error rates and error reporting in the U.K.).

them.

To summarize, the available evidence is inconsistent with Howard's first sub-claim. Although "legal fear" may discourage some voluntary error reporting at the margins, it is not responsible for the rampant underreporting of errors that exists today.

*Assertion 2: Physicians and other health care providers once dealt with mistakes more openly.*

Howard puts his second sub-claim rhetorically: "[w]hat does it take to *revive* a culture of open professional interaction?"[21] Howard's question assumes that there was once a culture of open interaction between physicians and patients that the legal system killed. The evidence actually indicates precisely the opposite. Every historical study of the doctor-patient relationship indicates that physicians have *never* been forthcoming with patients, even before malpractice litigation became a common phenomenon.[22] Professor Jay Katz wrote a book on the subject called "The Silent World of Doctor and Patient"[23]—a "silent world" because there was little or no communication.[24] It was malpractice litigation that created the doctrine of informed consent to treatment.[25] It was malpractice litigation that caused the American Medical Association and Joint Commission on Accreditation of Hospitals to promulgate ethical guidelines requiring physicians and hospitals to disclose errors to patients.[26] Thus, Howard's second sub-claim has it exactly backwards: tort liability in many instances has actually encouraged more openness and information flow.[27]

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21. Brennan & Howard, *supra* note 4 (emphasis added).

22. *See* Steven Lubet, *Like a Surgeon*, 88 CORNELL L. REV. 1178, 1195 (2003). Professor Lubet goes on to suggest:

> [D]octors, being human, are simply reluctant to admit mistakes to their patients, and instead seize upon any available rationalization. Today, the excuse is malpractice liability. In the old days, it was the patients' own welfare—they would not heal as rapidly, it was said, if they lost confidence in their physicians.

*Id.*

23. JAY KATZ, THE SILENT WORLD OF DOCTOR AND PATIENT (1986).

24. *See id.* at 198–99. Although Dr. Katz focused on physicians' failure to disclose risks *before* performing medical procedures, anyone who reads his book must conclude, as Professor Lubet does, that *ex post* conversations about errors were rare as well. Katz's thesis is that physicians donned a "mask of infallibility" to encourage patients to trust them blindly.

25. WEILER ET AL., *supra* note 10, at 127.

26. *Id.*

27. *See generally* Hyman & Silver, *Medical Malpractice*, *supra* note 8.

*Assertion 3: Liability encourages defensive medicine.*

Howard's third sub-claim is that liability encourages defensive medicine (i.e., excessive medical treatment performed to avoid or limit potential liability).[28] Howard claims that Wall Street Journal article on this issue claims that defensive medicine may exceed $100 billion per year.[29] As it happens, defensive medicine has been studied extensively—with largely inconclusive results. Strikingly enough, Dr. Troyen Brennan, the co-author of Howard's Washington Post op-ed, largely disposed of the defensive medicine issue in another article. In this article, Dr. Brennan noted that defensive medicine "has long been invoked by chronic defendants [] as a rationale for enacting tort reform. However, the over deterrence rhetoric has not been firmly grounded in fact. Most defensive-medicine studies have failed to demonstrate any real impacts on medical practice arising from higher malpractice premiums."[30]

The $100 billion figure is also deeply problematic. The source cited by Howard actually pegs the cost of defensive medicine at "well over $50 billion," not over $100 billion.[31] Worse (for Howard), his source expressly states that the $50 billion figure is an extrapolation, based on the speculative assumption that their research findings (which focused exclusively on treatment patterns for heart attack patients covered by Medicare) could be generalized to cover the entire universe of patients and medical procedures.[32] Worse still (for Howard), subsequent analyses by the same economists and by the Congressional Budget Office yielded substantially smaller numbers.[33]

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28. Brennan & Howard, *supra* note 4.

29. Howard, *supra* note 2, at 103 ("One study suggests that the cost of this 'defensive medicine' may exceed $100 billion per year."). *See also* Howard, *Legal Malpractice*, *supra* note 4.

30. Michelle Mello & Troyen E. Brennan, *Deterrence of Medical Errors: Theory and Evidence for Malpractice Reform*, 80 TEX. L. REV. 1595, 1607 (2002).

31. Daniel Kessler & Mark McClellan, *Do Doctors Practice Defensive Medicine?*, 111 Q.J. ECON. 353, 387-88 (1996) ("If our results are generalizable to medical expenditures outside the hospital, to other illnesses, and to younger patients, then direct reforms [of liability] could lead to expenditure reductions of well over $50 billion per year.").

32. *Id.* No support was provided for this assumption.

33. DANIEL P. KESSLER & MARK B. MCCLELLAN, MEDICAL LIABILITY, MANAGED CARE, AND DEFENSIVE MEDICINE (Nat'l Bureau of Econ. Research, Working Paper No. 191, 2000) (re-running original study while controlling for penetration of managed care entities and finding considerably smaller impact of tort liability on levels of defensive medicine); Congressional Budget Office (CBO) Cost Estimate, H.R. 5: Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2003 (Mar. 10, 2003) (reporting that a CBO study of Medicare spending on a broad range of patients between 1989 and 1999 "found no effect of tort controls on medical spending" and "no statistically significant difference in per capita health care spending between states with and without malpractice tort limits").

The propriety of Howard's use of the $100 billion figure for lawsuit-induced defensive medicine is doubtful. The number, which one hears repeatedly in the tort reform debate, is like a mobile home caught in a tornado. It gets bounced around a lot precisely because it has no solid foundation. Although liability probably produces some level of defensive medicine, it has not been possible to quantify the amount with any certainty.

*Assertion 4: Liability undermines access to needed medical services.*

Howard claims that patients are losing access to vital health care because doctors are restricting their scope of practice, fleeing states where liability is "out of control" and even retiring.[34] This is a common claim in policy circles, usually accompanied by personal testimonials of affected physicians.[35] Such anecdotal evidence is thoroughly unreliable.[36]

It is certainly possible that some physicians have restricted the scope of their practices, moved, or retired because of liability risks, but there is little evidence that these actions have caused any pervasive shortages of services for patients. In 2003, the General Accounting Office issued a report on whether Medicare beneficiaries were experiencing access problems in states that the AMA said were experiencing crises.[37] The report used claims data and focused on services thought to entail high malpractice liability risks. The review "did not identify any major reductions in utilization of certain services some physicians reported reducing because they considered the services to be high risk." To the contrary, rates of orthopedic surgeries in Pennsylvania had increased, rates of spinal surgeries in five "crisis" states had increased, rates of joint revisions and repair in five "crisis" states had not declined, and rates of mammograms in Florida and Pennsylvania remained above the national average.[38] The study did identify some access problems, but they had more to do with the difficulties of rural practice settings than with malpractice pressures. Of course, there may be access problems that were not

34. Howard, *supra* note 2, at 102–103.

35. *See, e.g.*, A.M.A., *Medical Liability Reform Now!* (Oct. 21, 2003) (asserting that "[m]ore than 25% of health care institutions have reacted to the liability crisis by cutting back on services and/or eliminating some units").

36. *See* David A. Hyman, *Lies, Damned Lies, and Narrative*, 73 IND. L.J. 797 (1998).

37. U.S. General Accounting Office, MEDICAL MALPRACTICE: 'IMPLICATIONS OF RISING PREMIUMS ON ACCESS TO HEALTH CARE (Aug. 8, 2003), *available at* http://www.gao.gov/new.items/d03836.pdf (last visited October 30, 2003).

38. *Id.*

picked up by this study, but it is striking that the GAO was unable to identify such problems in states and specialty areas that were picked for study precisely because they were thought to be in crisis.

From an economic perspective, it would be surprising if increased malpractice liability premiums did not trigger decisions at the margin regarding scope of practice and related matters. If there were no adaptive responses of any sort, then the tort law would not be deterring malpractice, one of its principal functions. However, to view every adaptation as negative, one must start with the assumption that the best possible world is one in which every physician provides whatever services he or she desires in whatever setting he or she chooses and at whatever quality level he or she wants.[39] Otherwise, isolated changes in practice patterns are just changes, and the fourth sub-claim has no real persuasive force.

*Assertion 5: Liability creates an "extortion lottery."*

Howard's fifth sub-claim is that the ability of individual plaintiffs to specify the amount of damages that they are seeking (coupled with the uncertainties of jury decision-making) encourages an "extortion lottery."[40] This alleged lottery encourages all patients (both injured and uninjured) to sue for large amounts. Physicians are forced to settle even frivolous claims, rather than risk a substantial jury verdict.

To the contrary, many empirical researchers have observed that most medical malpractice lawsuits end without payments, that insurers often refuse to offer anything in settlement, and that a substantial majority of juries find in favor of physician-defendants.[41] If patients who demand outrageous damages force physicians to settle frivolous claims, these findings are difficult to explain.

Although objectively frivolous lawsuits can have positive nuisance

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39. For obvious reasons, we do not begin with this assumption. To do so is to imbed the conclusion of the argument in its premise. *See* David F. Levi, *In Memoriam Philip B. Kurland,* 64 U. CHI. L. REV. 1, 4 (1997) ("[T]he key to establishment of an infallible argument has been most fully developed by the Supreme Court of the United States: it is to embed the conclusion in the premise. It is always easier to get from here to here than to get from here to there.") (quoting Philip B. Kurland, Ave Atque Vale 5–6 (speech presented at First Year Students' Dinner at The University of Chicago Law School, Sept. 30, 1986) (on file with U. CHI. L. REV.)).

40. Brennan & Howard, *supra* note 4. *See also* Howard, *supra* note 2, at 102 (referring to "open season" on defendants).

41. *See, e.g.*, Farber and White, *Medical Malpractice*, *supra* note 10, at 206; Samuel R. Gross & Kent D. Syverud, *Don't Try: Civil Jury Verdicts in a System Geared to Settlement*, 44 UCLA L. REV. 1, 56–57 (1996) (documenting high zero-offer rate for medical malpractice cases).

value,[42] decades of research have failed to quantify the amount of actual nuisance litigation or to show that it is a serious problem.[43] To the contrary, research has shown that plaintiff's lawyers have strong incentives to reject weak cases and that they are quite selective in the cases that they accept.[44] The evidence also indicates that most injured patients do not sue. Indeed, the percentage of injured patients who do sue has gone down over time.[45] There is some evidence indicating that the medical malpractice system does not always accurately differentiate between the non-negligently injured and the negligently injured; nonetheless, *both are injured*.[46] Simply stated, the available evidence is inconsistent with the claim that there is a "lottery" rewarding uninjured patients, let alone an "extortion lottery" operating in the medical malpractice system.

It is also important to have a sense of proportion in assessing the performance of the liability system. Multiple studies have indicated that a hospitalized patient has a one percent chance of being negligently injured—and more than 30 million hospitalizations occur every year.[47] The total number of malpractice claims, which fell from about 90,000 in 1995 and to about 86,500 in 2000, did not even equal the predicted rate of 300,000 negligence-related injuries for hospitals alone.[48] Taking into account nursing homes, outpatient services, and

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42. For an overview of the economic analysis of nuisance suits, see STEVEN SHAVELL, FOUNDATIONS OF ECONOMIC ANALYSIS OF LAW 419–23 (2004).

43. Even law professors who write about frivolous lawsuits concede that they may not be sufficiently common to worry about. *See, e.g.*, Robert G. Bone, *Modeling Frivolous Suits*, 145 U. PA. L. REV. 519, 596 (1997). The securities class action arena may constitute an exception to this generalization. *See* James Bohn & Stephen Choi, *Fraud in the New-Issues Market: Empirical Evidence on Securities Class Actions*, 144 U. PA. L. REV. 903, 935 (1996) (finding that many securities class actions meet a test of frivolousness).

44. Herbert M. Kritzer, *Contingency Fee Lawyers As Gatekeepers in the Civil Justice System*, 81 JUDICATURE 22, 24 (1997) (examining 53,584 contacts between potential clients and Minnesota lawyers and finding a rejection rate of almost 70 percent); Farber and White, *Medical Malpractice*, *supra* note 10, at 200 ("[T]he contingency fee system gives plaintiffs' lawyers a strong incentive to screen prospective plaintiffs and to accept only cases having high expected value.").

45. Studies of claiming rates for malpractice victims are summarized in Michelle M. Mello & Troyen A. Brennan, *Deterrence of Medical Errors: Theory and Evidence for Malpractice Reform*, 80 TEX. L. REV. 1595, 1609 (2002). Overall, about 3 percent or fewer of malpractice victims are thought to file claims. *See id. See also* ROBERT M. WACHTER & KAVEH G. SHOJANIA, INTERNAL BLEEDING 305 (2004); Hyman, *supra* note 8. As Paul Weiler, an author of the Harvard Medical Practice Study, observed, "the medical setting has provided the strongest evidence that the real tort crisis may consist in too *few* claims." *See* WEILER ET AL., *supra* note 10, at 62.

46. *See* Mello & Brennan, *supra* note 45, at 1623.

47. NAT'L CTR. FOR HEALTH STATISTICS, U.S. DEP'T OF HEALTH AND HUMAN SERVICES, PUB. NO. (PHS) 2003-1724, NATIONAL HOSPITAL DISCHARGE SURVEY: 2000 ANNUAL SUMMARY WITH DETAILED DIAGNOSIS AND PROCEDURE DATA 13 (Nov. 2002).

48. MEDICAL MALPRACTICE.COM, NATIONAL MEDICAL MALPRACTICE STATISTICS, *at*

other settings in which health care is delivered would increase the injury estimate considerably, perhaps above the one million mark. Although the number of malpractice claims is numerically large, the number of malpractice-induced injuries far exceeds it.

*Assertion 6: A specialized medical court would be an improvement.*

Howard's sixth sub-claim is that specialized medical courts would solve the all the other problems he identifies.[49] Specialized medical courts certainly have the potential to ensure that civil judgments correspond to expert medical judgment, but if the evidence on geographic variation of health care services is any guide, there is a substantial degree of variability in expert medical judgment.[50] Experts are subject to some of the same disabilities that affect ordinary jurors, such as hindsight bias and ignoring base rates in assessing probabilities.[51] More broadly, it is unlikely a specialized medical court will work out quite the way Howard expects; some studies indicate that medical experts are more likely to find negligence than ordinary jurors—meaning that the frequency and size of judgments against doctors may actually rise, not fall.[52]

## III. CONCLUSION

Many criticisms can be made of the performance of the current medical malpractice system—and we have made our share of them. Ultimately, we do not believe the civil justice system is likely to be a strong force for quality control in the health care sector, regardless of how it is tweaked. The market is more likely to improve health care

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www.medicalmalpractice.com/National-Medical-Malpractice-Facts.cfm (last visited Aug. 2, 2004) (citing data on malpractice claim rates published by the National Association of Insurance Commissioners).

49. Brennan & Howard, *supra* note 4.

50. *See generally* Variations Revisited, Health Affairs Web Exclusive, http://content.healthaffairs.org/cgi/content/full/hlthaff.var.5/DC1. See also The Dartmouth Atlas of Health Care, http://www.dartmouthatlas.org/

51. *See, e.g.*, Jeffrey J. Rachlinski, *A Positive Psychological Theory of Judging in Hindsight*, 65 U. CHI. L. REV. 571 (1998).

52. According to the Insurance Information Institute, a study of 155,671 malpractice claims closed between 1985 and 1999 found that patients prevailed in about 19 percent of the tried cases, meaning that doctors, hospitals, and other providers prevailed at trial 81 percent of the time. An 80 percent success rate is pretty hard to improve upon, and academic researchers have found that medical malpractice experts are less defense-friendly than jurors. *See, e.g.*, Farber & White, *Medical Malpractice*, *supra* note 10, at 199 (finding that expert panels recommended zero payments in only 3 of the 83 cases); Stephen J. Spurr & Walter O. Simmons, *Medical Malpractice in Michigan: An Economic Analysis* 21 J. HEALTH POL., POL'Y AND L. 315 (1996) (finding that in 2,628 cases expert panels recommended awards of zero only 54 times).

quality than civil litigation is—and the tragedy of medical errors and medical injury in America will not be efficiently addressed as long as we rely on the civil justice system to carry the bulk of the load. At the same time, there are important benefits to the medical malpractice system—including its ability to protect patients from injury in the first place.[53] A balanced perspective requires one to factor both costs and benefits into the equation before diagnosing ills and prescribing remedies.

Howard indicts the medical malpractice system on a variety of grounds. The kindest thing that can be said about his position (and each of his six sub-claims) is the old Scottish verdict: not proven.[54] Those who are less generous might consider whether the Red Queen, who "believed as many as six impossible things before breakfast," was closer to the truth.[55]

53. *See* WEILER ET AL., *supra* note 10, at 133 ("The litigation system seems to protect many patients from being injured in the first place. The apparent injury prevention effect must be an important factor in the debate about the future of the malpractice litigation system."); Michelle J. White, The Value of Liability in Medical Malpractice, 13 Health Aff. 75 (1994) (finding the negligence system creates a strong financial incentive for medical providers to avoid substandard care.".).

54. The Scottish legal system has three possible verdicts for a criminal trial: guilty, not guilty and not proven. NATIONMASTER.COM, SCOTTISH LAW, *at* http://www.nationmaster.com/encyclopedia/Scottish-Law.

55. CARROLL, *supra* note 1.