MEDICAL MALPRACTICE AND WRONGFUL DEATH: SOME LIVES ARE WORTH MORE THAN OTHERS

RALPH PEEPLES*
CATHERINE HARRIS**

ABSTRACT

Damages in wrongful death lawsuits, like damages in all tort lawsuits, defy prediction. In order to understand the factors influencing the determination of wrongful death damages, this Article examined the outcomes and case characteristics of all the wrongful death lawsuits defended by a medical malpractice insurer in Virginia and North Carolina from 2009 through 2015. The data was derived from the insurer's closed claims files. The goal was to identify the factors that affected whether compensation was paid, as well as the factors that affected the amount of compensation, when that occurred. Using multivariate analysis, the data showed that three variables had predictive power: the claims adjuster's assessment of liability, the marital status of the deceased, and whether the primary physician-defendant was engaged either as a specialist, or in primary care.

I. INTRODUCTION

The question of wrongful death damages––the amount, if any, that a plaintiff is entitled to––is traditionally a jury question. There are no formulas to invoke. The jury simply decides, after an instruction from the court. More often, of course, the opposing sides agree on a settlement amount, often by arguing over "what a jury would do." Again, there are no formulas, and, at best, some vague statutory rules. This Article attempts to identify the factors that affect the decision to pay damages for wrongful death, as well as the factors that affect the

* Professor of Law, Wake Forest University.
** Professor of Sociology, Wake Forest University.

amount of compensation paid. This Article accomplishes this in a single context: medical malpractice.

Medical malpractice litigation does not suffer from a lack of scholarly attention. Much is known about the process. Numerous studies have demonstrated, for example, that medical malpractice litigation is a largely rational system.[1] If made, meritorious claims usually receive compensation, and non-meritorious claims usually do not receive compensation.[2] In general, as the severity of the injury increases, the level of compensation increases as well, an effect known as "vertical equity."[3]

Many issues have been identified and analyzed. For example, only a small minority of "avoidable medical injuries"[4] ever becomes the subject of a claim against the provider.[5] Given the small number of claims relative to the number of avoidable medical injuries, and the wide variation in amounts when compensation is paid for injuries of similar severity, medical malpractice litigation can be criticized for failing to perform either of the two basic functions of tort law: deterrence and

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[1] *See, e.g.*, Ethan M. J. Lieber, *Medical Malpractice Reform, the Supply of Physicians, and Adverse Selection*, 57 J. L. & ECON. 501, 522–23 (2014); Joanna C. Schwartz, *A Dose of Reality for Medical Malpractice Reform*, 88 N.Y.U. L. REV. 1224, 1299 (2013); Frank A. Sloan & Chee Ruey Hsieh, *Variability in Medical Malpractice Payments: Is the Compensation Fair?*, 24 L. & SOC'Y REV. 997, 1029 (1990); David M. Studdert et al., *Claims, Errors, and Compensation Payments in Medical Malpractice Litigation*, 354 NEW ENG. J. MED. 2024, 2031 (2006); 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, 784 (1992).

[2] Lieber, *supra* note 1, at 525; Schwartz, *supra* note 1, at 1291; Sloan & Hsieh, *supra* note 1, at 1014; Studdert et al., *supra* note 1, at 2031; Taragin et al., *supra* note 1, at 784.

[3] Sloan & Hsieh, *supra* note 1, at 999; *see also* Mark Geistfeld, *Placing a Price on Pain and Suffering: A Method for Helping Juries Determine Tort Damages for Nonmonetary Injuries*, 83 CAL.L. REV. 773, 784 (1995) (discussing the correlation between the severity of the injury and the level of compensation).

[4] Studdert et al., *supra* note 1, at 2091. "Avoidable medical injuries" is a term used primarily in the medical literature. Sloan & Hsieh, *supra* note 1, at 1009–10. As explained by Sloan and Hsieh, an "avoidable medical injury" is an injury that "could have been prevented with good medical care." *Id.*

[5] PATRICIA M. DANZON, MEDICAL MALPRACTICE: THEORY, EVIDENCE, AND PUBLIC POLICY 18–29 (1985); INST. OF MED., TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM 1–4 (Linda T. Kohn et al. eds., 2000); A. Russell Localio et al., *Relation Between Malpractice Claims and Adverse Events Due to Negligence—Results of the Harvard Medical Practice Study III*, 325 NEW ENG. J. MED. 245, 249 (1991); *see also* Michael Frakes, *The Surprising Relevance of Medical Malpractice Law*, 82 U. CHI. L. REV. 317, 327 (2015). For a summary of the various studies, see David A. Hyman, *Medical Malpractice and the Tort System: What Do We Know and What (If Anything) Should We Do About It?*, 80 TEX. L. REV. 1639, 1641–43 (2002).

compensation.[6] In addition, there is reason to believe that compensation, when it occurs, tends to be inadequate even when only economic damages are considered.[7]

Other observations also seem well established. The incidence of paid malpractice claims is not uniform; a disproportionate number of paid claims are associated with a relatively small number of physicians.[8] The overhead associated with the claims resolution process is very high,[9] and the claims resolution process is often slow.[10] Bringing a medical malpractice lawsuit is an expensive proposition.[11] Most claims go unpaid.[12] Plaintiffs seldom win medical malpractice trials.[13]

The number of medical malpractice suits filed has decreased over the past several years,[14] although observers disagree over the reasons for the decline. Many observers believe that the widespread use of caps on damages discourage attorneys from bringing at least certain types of medical malpractice lawsuits.[15] Preliminary evidence from North Carolina, which adopted a non-economic cap on damages in late 2011, indicates a substantial and persistent drop in the number of medical malpractice lawsuits filed.[16] Other observers point out that the costs of prosecuting a medical malpractice lawsuit have the effect of

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[6] Joanna Shepherd, *Uncovering the Silent Victims of the American Medical Liability System,* 67 VAND. L. REV. 151, 159–60 (2014).

[7] FRANK A. SLOAN ET AL., SUING FOR MEDICAL MALPRACTICE 206 (1993).

[8] David M. Studdert et al., *Prevalence and Characteristics of Physicians Prone to Malpractice Claims,* 374 NEW ENG. J. MED. 354 (2016).

[9] Studdert et al., *supra* note 1, at 2031.

[10] *Id.*; Lieber, *supra* note 1, at 521.

[11] Shepherd, *supra* note 6, at 165 (showing survey results indicating an average cost of $100,000 to bring a malpractice suit to trial).

[12] Anupam B. Jena et al., *Malpractice Risk According to Physician Specialty,* 365 NEW ENG. J. MED. 629, 635 (2011). *But see* Studdert et al., *supra* note 1, at 2032 (reporting a payment rate of 56% for all claims made).

[13] Shepherd, *supra* note 6, at 183 (reporting that plaintiffs won at trial of about 27% of the time); *see, e.g.*, Sloan & Hsieh, *supra* note 1, at 1007 (reporting that plaintiffs win at trial about 22% of the time).

[14] Tara F. Bishop et al., *Paid Malpractice Claims for Adverse Events in Inpatient and Outpatient Settings,* 305 J. AM. MED. ASS'N 2427, 2428 (2011); David A. Hyman & Charles Silver, *Double, Double, Toil and Trouble: Justice-Talk and the Future of Medical Malpractice Litigation,* 63 DEPAUL L. REV. 547, 553 (2014); Myungho Paik et al., *The Receding Tide of Medical Malpractice Litigation: Part 1–National Trends,* 10 J. EMPIRICAL LEGAL STUD. 612, 613–14 (2013).

[15] Frakes, *supra* note 5, at 330; *see, e.g.*, Hyman & Silver, *supra* note 14, at 548–50.

[16] *See, e.g.,* David Donovan, *Latest Data Show State's Tort Reform Act Delivered a Knock-Down Blow,* N.C. LAW. WKLY. (July 24, 2015), http://nclawyersweekly.com/2015/07/24/latest-data-show-that-states-tort-reform-act-delivered-a-knock-down-blow/.

making any claims for small or modest damages simply not worth the trouble.[17]

It is easy, and tempting, to think of medical malpractice in binary terms: the defendant is either liable, or the defendant is not liable. The standard for determining liability does not vary greatly by jurisdiction: did the defendant breach the appropriate standard of care?[18] Determination of the appropriate standard of care usually depends upon expert testimony as to "custom."[19] Physicians are judged in terms of what other physicians would do in similar circumstances.[20]

However, this binary question of liability is only the first question. While the claim is pending, a second, equally difficult[21] question arises. If a determination of liability is made, what are the damages?[22] On this question, less is known. Twenty-five years ago, Frank Sloan and Chee Ruey Hsieh took on this question by examining reports filed by medical malpractice insurers with the Florida Department of Insurance, as well as jury verdict reports from five states.[23] They found evidence of vertical equity, but not of horizontal equity.[24] In other words, as the severity of injury increased, so did the amount of compensation (vertical equity); but within a given level of severity,[25] compensation varied considerably (horizontal inequity).[26] This was not surprising. As the authors explained, injuries within the same level of severity can none-

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[17] Shepherd, *supra* note 6, at 154.

[18] There is, however, variation among the states as to whether the standard of care should be assessed in terms of the defendant's community, the defendant's community or similar communities, or in terms of a national standard of care. *See* DAN B. DOBBS ET AL., THE LAW OF TORTS 177–78 (2d ed. 2011).

[19] *Id.*

[20] *Id.* at 158.

[21] If the case goes to trial, and liability is established, the amount of damages becomes a jury question. The process of arriving at an appropriate number can be difficult. *See* Geistfeld, *supra* note 3, at 783 (finding "jurors report that determining damages is more difficult for them than is deciding on liability") (quoting Shari S. Diamond, *What Jurors Think: Expectations and Reactions of Citizens Who Serve as Jurors, in* VERDICT: ASSESSING THE CIVIL JURY SYSTEM 297 (1993)); *see also* David W. Leebron, *Final Moments: Damages for Pain and Suffering Prior to Death*, 64 N.Y.U. L. Rev. 256, 264–270 (1989).

[22] Geistfeld, *supra* note 3, at 781–82.

[23] Sloan & Hsieh, *supra* note 1, at 1003.

[24] *Id.* at 1027–28.

[25] Sloan and Hsieh used the injury scale adopted by the National Association of Insurance Commissioners. *Id.* at 1004–05. The scale classifies severity of injury by relying on nine levels of injury: emotional only, temporary insignificant, temporary minor, temporary permanent, permanent minor, permanent significant, permanent major, grave, and death. *Id.* The NAIC injury scale is widely used by insurers. *Id.*

[26] *Id.* at 999; *see also* Geistfeld, *supra* note 3, at 784.

theless justify a wide range of damage awards.[27] For example, severity level six on the National Association of Insurance Commissioners (NAIC) scale ("significant permanent") includes injuries such as "deafness, loss of limb, loss of eye, loss of one kidney or lung."[28] One level of severity, however, is the same for all claimants: death.[29] This Article examines wrongful death claims and awards in order to assess the "horizontal equity" within that category of injuries.

II. Procedure

The data was obtained from closed claims files from a medical liability insurer doing business in North Carolina and Virginia. Closed claims files are a rich and reliable source of information about the malpractice claims resolution process.[30] The files covered the years 2009 through 2015.[31] We examined all the closed files (n= 297) in which a patient had died, and a lawsuit against one or more of the company's insureds had been filed as a result.[32] The closed files contained information on the gender and marital status of the deceased, and usually the deceased's age.[33] The files also indicated the number of defendants and their medical specialties, along with the specific medical allegations made by the plaintiff.[34] The files contained information about the final disposition of the claim, as well as the amount, if any, paid to the claimant.[35] In addition, the files contained the claims adjuster's assessment of liability, accompanied by detailed descriptions of the alleged injuries.[36] In short, we had access to the same information that the insurer had and submitted to a state regulator, rather than summaries of claims received and paid.

Because claims for medical malpractice can be asserted against more than one provider, we then identified the files (n=144) in which only the company's insureds were involved,[37] or in which the outcome

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[27] Sloan & Hsieh, *supra* note 1, at 1026.
[28] *Id.* at 1004.
[29] *Id.*
[30] Schwartz, *supra* note 1, at 1231.
[31] Insurer's Closed Claims Files (2009–2015) (unpublished documents) (on file with author).
[32] *Id.*
[33] *Id.*
[34] *Id.*
[35] *Id.*
[36] *Id.*
[37] The insurer files usually indicated the presence or absence of a non-insured co-defendant. *Id.* However, to determine if a case was in fact "complete," we read through

for all co-defendants not insured by the company was known.[38] This was done in order to capture only those files that included all potential defendants. Since one of the goals of this Article was to gather data on the value of a life wrongfully taken, only "complete" lawsuits were examined.

The Relevant Law

The substantive law of medical malpractice is similar in North Carolina and Virginia.[39] Liability in both states turns on whether the defendant physician deviated from the standard of care.[40] In both states, the standard of care is essentially a "same or similar locality" standard.[41] In both states, the standard of care is usually determined by expert testimony from other physicians practicing in the same field or specialty.[42] Both Virginia and North Carolina are contributory negligence states, meaning that any fault on the part of the plaintiff will bar his or her recovery.[43] Both states have caps on damages, but they differ in type and amount.[44] The Virginia damages limitation is a "hard cap," since it limits the total amount a plaintiff may recover, including both economic and non-economic damages.[45] From July 1, 2008, until June 30, 2012, the cap was $2,000,000.[46] The cap then increased by $50,000 every year, so that by the end of 2015 the cap was $2,200,000.[47] In contrast, since 2011, North Carolina has imposed a cap on non-economic damages, but not on economic damages.[48] The "soft cap" on non-economic damages in North Carolina was set at $500,000 in 2011. Beginning in 2014, the cap is tied to changes in the Consumer Price

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all the text provided in the closed files for indications that an additional party might be a co-defendant. *Id.*

[38] *Id.*

[39] *See infra* notes 40–44 and accompanying text.

[40] N.C. Gen. Stat. § 90-21.12(a) (2015); Va. Code Ann. § 8.01-581.20 (2007).

[41] N.C. Gen. Stat. § 90-21.12(a) (2015); Va. Code Ann. § 8.01-581.20 (2007).

[42] Smith v. Whitmer, 159 N.C. App. 192, 195, 582 S.E.2d 669, 671–72 (2003); *see* Hyman & Silver, *supra* note 14, at 554; *see also* N.C. Gen. Stat. § 8C-1, Rule 702(b) (2015); Va. Code Ann. § 8.01-581.20(A) (2007).

[43] Holderfield v. Rummage Bros. Trucking Co., 232 N.C. 623, 625, 61 S.E.2d 904, 906 (1950); Moore v. Chi. Bridge & Iron Works, 183 N.C. 438, 438, 111 S.E. 776, 777 (1922); Litchford v. Hancock, 352 S.E.2d 335, 337 (Va. 1987); Fein v. Wade, 61 S.E.2d 29, 32 (Va. 1950).

[44] *Compare* Va. Code Ann. § 8.01-581.15 (2007), *with* N.C. Gen. Stat. § 90-21.19 (2015).

[45] Va. Code Ann. § 8.01-581.15 (2007).

[46] *Id.*

[47] *Id.*

[48] N.C. Gen. Stat. § 90-21.19 (2015).

Index.[49] It is doubtful whether the caps in either state affected the amounts paid. If the caps had any effect on the settlement amounts[50] we report on, they seem to have depressed awards in both states. The highest Virginia award paid (a settlement) was $1,700,000, which is substantially below the cap.[51] The highest North Carolina award was $2,093,870, and was the result of a plaintiff's verdict.[52] The highest North Carolina settlement was $1,500,000.[53]

III. Results

Characteristics of the Closed Files

Table 1 summarizes the demographic data for both the set of all cases in which a provider insured by the company was sued ("all cases") (n=297), as well as the cases in which only providers insured by the company were sued ("complete cases") (n=144).

Table 1

	All Cases	Complete Cases
Gender: Male	127	59
Gender: Female	170	85
Age: Range*	Less than 1 year to 91	Less than 1 year to 91*
Age: Mean	52.0	54.4
Age: Median	54.5	56.5
Marital Status: Single**	24	14**
Marital Status: Married	131	70
Marital Status: Separated or Divorced	14	6
Marital Status: Widowed	7	4
Child Under 18	23	6

*Information about the plaintiff's age was usually, but not always, available. For all cases, n= 176; for "complete" cases, n=86.
**Information about the plaintiff's marital status was usually, but not always, available. For all cases, n= 199; for "complete" cases, n=100

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[49] *Id.*
[50] There was only one plaintiff's verdict, in North Carolina, during the study's time period (affirming a plaintiff's verdict obtained prior to 2009). There were no plaintiff's verdicts in Virginia during the study's time period. *See* Insurer's Closed Claims Files, *supra* note 31.
[51] *Id.*
[52] *Id.*
[53] *Id.*

The injury severity level for all the files was of course the same—death. North Carolina claims predominated. In cases in which a company insured was sued (n=297), 202 were filed in North Carolina, and 95 in Virginia. In cases in which only company insureds were sued, 98 were filed in North Carolina and 46 were filed in Virginia. Ninety-one different venues in the two states were represented. The most frequent North Carolina venue was Wake County (Raleigh) (n=17). The most frequent Virginia venue was Roanoke (n=11). In terms of whether money was paid, wrongful death plaintiffs fared slightly better in Virginia than in North Carolina, as Table 2 illustrates. The difference, however, was not significant.

TABLE 2
PAYMENT RATES

	All Cases			Complete Cases		
	Money Paid	Money Not Paid	Percentage	Money Paid	Money Not Paid	Percentage
North Carolina	58	144	28.7	33	65	33.7
Virginia	31	64	32.6	17	29	37
Total	89	208	30	50	94	34.7

The 297 plaintiffs from the larger dataset were represented by 178 different attorneys. Seven cases were filed without an attorney.[54] In contrast, only thirty-four different attorneys represented defendant physicians. On the defense side, eight attorneys accounted for more than half (160) of the cases. The case per attorney ratio captures the basic point. On average, plaintiff's counsel handled less than two cases each (1.6). On average, defense counsel handled almost nine cases each (8.7). The implication is clear: most of the time, plaintiff's counsel was opposed by an attorney with more experience in this type of litigation. Sixty-nine of the 178 plaintiff's attorneys recovered an indemnity payment for at least one of their clients.

Most of the time, only a single physician and his or her practice were sued. The three specialties most frequently sued for wrongful death were non-surgical specialties: family practice, radiology (internal), and internal medicine. Surgical specialties were less frequently

[54] In all of those cases, the plaintiff was unsuccessful in obtaining compensation. *See id.*

involved in wrongful death cases. The most frequently sued surgical specialty was general surgery, followed by vascular surgery.[55]

As is true of other civil litigation, numerous outcomes are possible for a filed medical malpractice case.[56] Table 3 summarizes the outcomes for all cases, as well as for complete cases.

TABLE 3
CASE OUTCOMES

	All Cases		Complete Cases	
Case Outcome	Number	Percentage	Number	Percentage
Involuntarily Dismissed	20	6.7	9	6.3
Dropped by Plaintiff	124	41.8	56	38.9
Dropped for Costs	30	10.1	13	9.0
Settled before Verdict	87	29.3	51	35.4
Tried to Verdict	31	10.4	15	10.4
Appealed	5	1.7	0	0

As noted in Table 2, payments to the plaintiff (indemnities) were not frequent, occurring less than 35% of the time. Nonetheless, this payment rate is higher than the rate of payment for all medical malpractice claims.[57] Of equal importance is the fact that over the six-year period studied, there were only four plaintiff's verdicts in the "all cases" dataset (against twenty-seven defense verdicts), and no plaintiff's verdicts at all in the "complete" dataset (against fifteen defense verdicts). This finding should not be surprising; one would expect a repeat player such as a liability insurer to settle cases it believes it will not win, and to try only those cases it believes it will win.[58] The "repeat

[55] Jena et al., *supra* note 12, at 632. Performing a larger study of medical malpractice claims and payments, Jena et al. reported that claims against surgical specialties such as neurosurgery, thoracic-cardiovascular surgery and general surgery were much more frequent than claims against medical specialties such as family practice and pediatrics. *Id.* at 630–32. That study looked at claims at all levels of injury severity; our study considers only claims at a single level of severity). *See id.*

[56] Insurer's Closed Claims Files, *supra* note 31.

[57] *See* Jena et al., *supra,* note 12, at 629; *see also* THOMAS H. COHEN & KRISTEN A. HUGHES, U.S. DEP'T. OF JUSTICE OFFICE OF JUSTICE PROGRAMS, MEDICAL MALPRACTICE INSURANCE CLAIMS IN SEVEN STATES 2000–2004 2 (2007), www.bjs.gov/index.cfm?ty=pbdetail&iid=783 (follow PDF hyperlink).

[58] *See* Ralph Peeples et al., *The Process of Managing Medical Malpractice Cases: The Role of Standard of Care,* 37 WAKE FOREST L. REV. 877, 891 (2002); *see also* Marc Galanter, *Why the "Haves" Come Out Ahead: Speculations on the Limits of Legal Change,* 9 LAW & SOC'Y REV. 95,

player" effect is amplified by the frequency with which defense counsel handle these cases, relative to plaintiff's counsel.[59]

Indemnity Payments

The indemnity payments varied considerably, ranging from $45,000[60] to $2,093,870, with a mean of $464,657 and a median of $318,125.[61] For "complete cases" only, payments ranged from $50,000 to $1,700,000, with a mean of $488,618 and a median of $395,000.

TABLE 4
INDEMNITY PAYMENTS

	All Cases		Complete Cases	
Amount Recovered	Number of Cases	Average Amount	Number of Cases	Average Amount
$100,000 or less	17*	66,147	8	68,687
$500,000 or less	46	290,670	27	306,667
$1,000,000 or less	18	775,833	10	759,000
More than $1,000,000	7	1,484,319	6	1,416,667

*One case settled for $1. It has been excluded from the table.

In all cases, the severity of the injury was death, and each case involved only one individual. The range of indemnity payments is striking. Why the wide disparity in results? That is the central problem this Article addresses. In order to explore this disparity in a consistent way, this Article now focuses only on complete cases. It is only by looking at complete cases that we can be sure that all indemnity payments have been included.

Gender and Marital Status

In the "complete cases" dataset, eighteen of the fifty-nine males received an indemnity payment (30.5%) (26.8% in "all cases"). The payments ranged from $50,000 to $1,700,000, with a mean of $526,361

101 (1974) (contending that repeat players will tend to only try those cases it believes it will win); Sloan & Hsieh, *supra* note 1, at 998.

[59] *See supra* text accompanying note 54.

[60] One case settled prior to trial for $1. Insurer's Closed Claims Files, *supra* note 31. However, co-defendants not insured by the company were involved as well. *Id.* Whether those co-defendants settled is unknown. *Id.*

[61] Sloan & Hsieh, *supra* note 1, at 1008 (contending that the amount recovered in "death" cases is usually less than the amount recovered in cases involving injuries described as "grave," particularly when the plaintiff will require long-term medical care).

and a median of $325,000. Thirty-three of the eighty-five females received an indemnity payment (38.8%) (32.4% in "all cases"). The payments ranged from $50,000 to $1,500,000, with a mean of $468,030 and a median of $395,000. A one-way Analysis of Variance ("ANOVA") analysis was not significant (p= .718). Gender, in short, did not explain the different levels of payment.[62]

Marital status mattered more than gender. The plaintiffs were sorted into five categories: single, married, separated or divorced,[63] widowed, and child under eighteen.[64] The results in Table 5 summarize the outcomes.

TABLE 5
PAYMENTS BY MARITAL STATUS

Marital Status	Number of Cases	Number of Cases with Paid Indemnity	Percentage Paid	Average Amount of Paid Cases
Single	14	3	21.4	315,000
Married	70	26	37.1	555,789
Separated or Divorced	6	1	16.7	550,000
Widowed	4	2	50	235,000
Child Under Eighteen	6	3	50	191,500

n=100

The stage at which the lawsuit was resolved affected the amount recovered by the plaintiff. Four stages were identified at which a case might settle during the lawsuit: before mediation, at mediation, after mediation but before trial, and before the verdict. The amount paid in settlement grew, on average, the closer the lawsuit got to trial. As noted previously, among the "complete cases," there were no verdicts for the plaintiff over the six-year study period (Table 3).

[62] *See id.* at 1024 (finding consistent results that gender did not explain the different levels of payment).

[63] We chose to group "separated" and "divorced" together because the determination is made at the time of death. The fact that the plaintiff was either separated or divorced suggests the lack of a close legally recognized partner at the time of death. This in turn might affect the determination of damages.

[64] We were unable to determine marital status for forty-four plaintiffs. *See* Insurer's Closed Claims Files, *supra* note 31.

TABLE 6
PAYMENTS BY STAGE OF LITIGATION

Stage of Lawsuit	Number of Cases	Mean	Median
Before Mediation	9	434,444	200,000
At Mediation	9	384,389	200,000
Before Trial	30	530,833	400,000
Before Verdict	3	541,667	600,000

This result makes sense. The plaintiff has to prove his or her case. The insurer would be expected to pay more to resolve a claim that has survived at least a motion to dismiss for failure to state a claim, and perhaps a motion for summary judgment as well.[65] While the numbers in Table 4 suggest that patience on the part of plaintiff's counsel pays off,[66] cases that settled prior to mediation had a higher average payment than cases that settled at mediation. This may be due to a business decision by the insurer to offer settlement early when liability seems clear, thereby saving the expense of additional defense costs.

Adjuster's Assessment of Liability

When a lawsuit is filed, the insurer's claims adjuster reviews the material received, speaks with the insured, obtains and reviews the relevant medical records, and often solicits outside reviews from physicians.[67] After compiling this information, the adjusters also indicate their assessment of liability.[68] This determination is made prior to the resolution of the case.[69]

The scale used by the insurer consists of five categories.[70] By decreasing level of anticipated liability, the scale runs from "clear" to "probable" to "questionable" to "unknown" to "none."[71] As Table 7

[65] *See* Sloan & Hsieh, *supra* note 1, at 1019.

[66] There are times, however, when plaintiff's counsel may not have the luxury of being patient. The lawsuit may need to survive a series of potentially dispositive motions prior to trial.

[67] Peeples et al., *supra* note 58, at 880; *see* Hyman & Silver, *supra* note 14, at 554 (contending that expert testimony is central to most medical malpractice lawsuits, because it is through their testimony that the applicable standard of care is determined).

[68] Peeples et al., *supra* note 58, at 880.

[69] *See id.*

[70] Insurer's Closed Claims Files, *supra* note 31.

[71] *Id.*

shows, the adjuster's assessment of liability is closely related to the plaintiff's recovery.

TABLE 7
ADJUSTER'S ASSESSMENT OF LIABILITY AND OUTCOME

Liability Assessment	Number of Cases	Number of Cases With Payment	Percentage	Average Amount of Paid Complete Cases	Average Amount Paid, All Complete Cases
Clear	11	10	90.9	786,000	714,545
Probable	22	22	100	402,045	402,045
Questionable	20	12	60	482,875	289,725
Unknown	36	5	10.4	375,000	52,083
None	55	2	3.6	272,500	9,909

As the adjuster's assessment of liability moved downward, the likelihood of a recovery decreased, step by step. Except for "probable" and "questionable" liability, the average amount for paid cases decreased as well. When the average is calculated for *all* complete cases in a liability category, the average amount paid decreases steadily from "clear" to "none." At the extremes ("clear" liability and "no" liability), the difference is dramatic. For the same injury, cases of clear liability were worth twice what cases of unknown liability were worth, and almost three times what cases of no liability were worth. In other words, even in those rare cases in which the adjuster first decided there was no liability but then chose to settle the claim with an indemnity payment, the amount paid was still markedly less than a claim with unknown, questionable, probable, or clear liability as determined by the adjuster.

What Drives the Indemnity Amount?

Multivariate analysis indicates that several variables have predictive power as to whether an indemnity is paid and, if an indemnity is paid, the amount. Those variables are the insurer's assessment of liability, the marital status of the plaintiff, and whether the primary defendant was engaged in primary care.

TABLE 8
FACTORS THAT CORRELATE WITH PAYMENT AND AMOUNT OF COMPENSATION

Independent Variables	*Standardized Coefficients*	*t*	*p*
Was plaintiff married?	-.162	-.866	.389
Was plaintiff not married?	-.276	-1.586	.116
Was plaintiff a child?	-.170	-1.402	.164
Was the primary defendant engaged in primary care?[72]	-.005	-.069	.945
Insurer's assessment of liability	-.650	-8.454	**.000**
Constant		5.912	.000

R-squared =.450 Adj. R-squared =.426
Model significance =**.000**

An analysis using all available cases––cases in which a physician insured by the insurer was sued, but in which there were co-defendants not insured by the insurer as well (n=297)––yielded very similar and equally significant results (R-squared= .440, Adjusted R-squared= .425). Using either dataset, it is clear that the adjuster's assessment of liability is the most important predictor of whether money will be paid and, if so, how much money will be paid.

IV. DISCUSSION

This Article's findings add support to the view that the outcome of medical malpractice litigation is rational.[73] Claims of clear or probable liability are much more likely to be paid than claims of questionable, unknown, or no liability.[74] Otherwise, the fact that assessment of liability predicts payment outcomes may seem unremarkable. If a claims adjuster concludes that the insured physician faces certain or probable liability, it makes sense for the insurer to negotiate for a smaller

[72] *See id.* (noting "engaged in primary care" includes, for example, family practitioners, internists and pediatricians).

[73] SETH OLDMIXON, PUB. CITIZEN'S CONGRESS WATCH, THE GREAT MEDICAL MALPRACTICE HOAX: NPDB DATA CONTINUED TO SHOW MEDICAL LIABILITY SYSTEM PRODUCES RATIONAL OUTCOMES 1 (2007), http://www.citizen.org/documents/NPDB%20Report_Final.pdf (stating that "[t]he court-based compensation system is, on the whole, a rational one that provides money for valid claims and dismisses invalid ones").

[74] *See* Lieber, *supra* note 1, at 522–23; Schwartz, *supra* note 1, at 1299; Sloan & Hsieh, *supra* note 1, at 1029; Studdert et al., *supra* note 1, at 2031; *see also* Peeples et al., *supra* note 58, at 886.

amount in settlement rather than risk a jury award that will likely be much higher.[75] Likewise, if an adjuster concludes that the insured physician is not liable for the plaintiff's death, a settlement offer will rarely be made.[76] This common-sense observation takes on more meaning, however, when the situation is viewed from the perspective of the plaintiff's attorney. The plaintiff's attorney functions as a gatekeeper.[77] He or she decides whether to accept the plaintiff's case.[78] Since the attorney is under no obligation to accept every case offered, and the attorney will be compensated only if money is recovered, a plaintiff's attorney will accept only those cases he or she believes have monetary value.[79] But how does a plaintiff's attorney determine which cases have monetary value? He or she can rely on instinct or on the emotional impact the case would have at trial, but those are not good measures. The results instead indicate that the key for a plaintiff's attorney is to "think like a claims adjuster." The plaintiff's attorney needs to determine whether the case in front of him or her is a case of clear, probable, or at least questionable liability.[80] The data reported indicates that accepting a case of either no or unknown liability (as determined by the claims adjuster) will result in no payment at all. It is, in short, a matter of astute case picking. The data reported indicates that some attorneys are much better than others at this skill. Given the strong results for plaintiffs when the adjuster assesses liability as "clear" or "probable" and the poor results for plaintiffs when the adjuster assesses liability as "unknown" or "none" (Table 7), it may be that the traditional skills of advocacy and persuasion that would ordinarily be valued by a client do not really matter that much in this context. Instead, room for advocacy and persuasion seems to exist only for "questionable" cases, the only category in which the outcome was not lopsided. Overall, in light of the results in Table 7, it appears that plaintiff's counsel becomes "educated" about the case, on the basis of the claims' adjuster's superior information, as the case progresses.

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[75] Sloan & Hsieh, *supra* note 1, at 1000.

[76] *But see* Peeples et al., *supra* note 58, at 894.

[77] Catherine Harris et al., *Does Being a Repeat Player Make a Difference? The Impact of Attorney Experience and Case-Picking on the Outcome of Medical Malpractice Lawsuits*, 8 YALE J. HEALTH POL'Y, L. & ETHICS 253, 281 (2008).

[78] *Id.*

[79] There is reason to believe that the overall acceptance rate of medical malpractice cases by plaintiff's counsel is substantially less than 50%. *See* Shepherd, *supra* note 6, at 192.

[80] *See id.* at 186 (discussing the primary reasons for rejecting cases in Table 13).

The idea that a successful plaintiff's attorney needs to "think like an adjuster" leads to another point. The reason why a plaintiff's attorney needs to "think like an adjuster" is that the insurer's assessments hold up.[81] The way in which these assessments might be challenged is by going to trial.[82] That is an option seldom taken, and probably for good reason.[83] The plaintiff's chances at trial are usually not good.[84] The adjuster's assessment is based not only on the medical records, but also on reviews of physicians practicing in the same specialty as the defendant.[85] As a result, the adjuster will usually have a much better idea of how the case would be decided than will plaintiff's counsel.[86] In addition, there is the fact that plaintiff's counsel will be opposed by a defense counsel with substantial experience defending medical malpractice lawsuits—like the insurer they represent, defense counsel are themselves "repeat players."[87] While bargaining between plaintiff's counsel and the insurer certainly occurs, our data suggest that the insurer holds the high cards—even when liability is deemed probable or clear.

Other variables also affect payment and the amount of payment, including the marital status of the deceased and whether the primary defendant was engaged in primary care. Plaintiffs who were married at the time of their death received more money than plaintiffs who were not married, or who were under the age of eighteen. Plaintiffs who sued a specialist, rather than a primary care provider, tended to recover more money. These results make some sense. One would expect that the value placed on the life of a married plaintiff would be higher than that of an unmarried plaintiff, since the married plaintiff will leave a widowed spouse behind. The connection between payment and the amount of payment to the primary physician's type of practice is a little more puzzling. Perhaps the causal connection between negligence and injury seems more clear when a specialist, performing a particular procedure, loses a patient. In contrast, a primary care physician would usually be faulted for missing a diagnosis, or for not acting

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[81] *See supra* Table 7.

[82] *See* Shepherd, *supra* note 6, at 183.

[83] *Id.*

[84] *See* Jena et al., *supra* note 12, at 634.

[85] *See* Peeples et al., *supra* note 58, at 884.

[86] The asymmetry of information between plaintiff and defendant in medical malpractice litigation has been noted frequently in the literature. *See, e.g.*, Sloan & Hsieh, *supra* note 1, at 1002.

[87] *See supra* notes 54–58.

quickly enough. These alleged failings (typically diagnosis related) are less vivid than the alleged failings of a specialist (typically performance related). The absence of age as a useful predictor of the indemnity paid is also puzzling. To some extent, however, age is accounted for in the regression analysis above by asking if the decedent was a child.

Factors other than the ones we have identified certainly exist. For example, in light of the Virginia and North Carolina wrongful death statutes, the earning potential of the decedent would likely make a difference.[88] Perhaps the trial reputation of the plaintiff's counsel matters. Perhaps the negotiating skill of the plaintiff's counsel matters. Since the ultimate question in any wrongful death case is, what a jury would decide, perhaps the venue of the case matters as well.

This study suggests that more research is needed as to the second question that a medical malpractice lawsuit poses: if the defendant is liable, what amount of damages would be appropriate? This Article's approach has been empirical, gathering information on the actual amounts paid in compensation for wrongful death cases in which medical malpractice is alleged. The sample size is relatively small, although it includes every closed case in the insurer's records for the six-year study period. A larger study would provide new insights into the question of the appropriate amount of damages.

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[88] Both statutes require, among other things, a calculation of the decedent's earning potential. *See* N.C. GEN. STAT. § 28A-18-2(b)(4) (2003); VA. CODE ANN. § 8.01-52(2) (2001).