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The courts as policy-makers : a medical malpractice case study

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The Courts as Policy-Makers: A Medical Malpractice Case Study

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Chapter 1: Introduction

It is 2 a.m. when Mary Wilson's son convinces her to go to the emergency room.[1] She is fifty-two years old, and he is concerned because she has been sick for three days. She is feverish and nauseous, unable to keep food down, and when she reaches the emergency room, she is having trouble breathing. The emergency department doctor who initially examines her runs laboratory tests and diagnoses her with bacterial pneumonia. He starts her on antibiotics, and she is admitted to the hospital. Dr. Sherry Davis, a pulmonologist, is consulted over the telephone for initial treatment options.

Around 8 a.m. a nurse on rounds notes that Mrs. Wilson is sweating and having difficulty breathing. Dr. Mark Thompson had taken over Mrs. Wilson's care when he came on duty that morning, and he is immediately paged. He finds her in respiratory distress, with a fever and elevated heart rate and blood pressure. Dr. Thompson diagnoses her with progressing pneumonia and impending respiratory failure. Mrs. Wilson needs to be intubated, and he considers doing so there, but he chooses rather to transfer her to the intensive care unit (ICU). He feels that he does not have sufficient experience with emergency intubations, and he knows that a pulmonologist has already been assigned to Mrs. Wilson's case.

It takes approximately fifteen minutes to organize and complete Mrs. Wilson's transfer to the ICU, and her respiratory distress is now more intense. Dr. Davis attempts intubation upon her arrival in the ICU, but Mrs. Wilson goes into cardiac arrest. The physicians and nurses use a bag-valve mask to keep Mrs. Wilson oxygenated and perform standard cardiopulmonary resuscitation (CPR), including two to three minutes of chest compressions and administration of atropine and epinephrine (drugs used to speed heart rate). They then defibrillate Mrs. Wilson to

1. Story adapted from Troyen A. Brennan and Michelle M. Mello, "Patient Safety and Medical Malpractice: A Case Study," *Annals of Internal Medicine* 139 (2003): 267-273.

restart her heart and afterwards are able to intubate her successfully. Her oxygen levels improve, and her cardiopulmonary status stabilizes, but she has suffered severe and irreversible brain damage from the temporary lack of oxygen.

When discharged from the hospital, Mrs. Wilson is unable to recognize her son or other family members. She also cannot perform any activities of daily living, and she is placed in a long-term care facility. Several months after the incident, Mrs. Wilson's son consults an attorney and chooses to file a medical malpractice claim against Dr. Thompson. The claim alleges that Dr. Thompson did not seek intensive care attention for Mrs. Wilson quickly enough and that this delay caused her cardiac arrest and subsequent brain damage.

This lawsuit against Dr. Thompson is an example of a tort claim for medical malpractice, and there are several reasons why Mrs. Wilson's family would want to sue. They most likely want compensation for the costs of the injury, many of which probably will not be covered by medical insurance. They may also want to punish the doctor for the injury they believe he has caused. A lawsuit thus serves the purposes of compensation and punishment for the individual. Injured patients may additionally have a desire to protect future patients in similar situations from experiencing the same trauma that they underwent. In this sense, a medical malpractice lawsuit not only resolves a dispute between individuals but it also serves a social purpose in deterring future medical mistakes. Making doctors liable for the costs of injuries they cause gives them the incentive not to be negligent when treating patients, a concept known as deterrence. This is a form of policy-making accomplished by the courts – using lawsuits to regulate patient safety.

In this thesis, I argue that the courts are not effective policy-makers because they are a channel for resolving disputes between individuals. I first present the basics of medical

malpractice litigation and some of the current literature on the courts as policy-makers. I then address the cultural trends that have made this form of individual dispute resolution common and acceptable, particularly for my case study of medical malpractice. Then I show how some of the individualized aspects of the legal system distort the deterrent effect of lawsuits. I focus on the poor fit between actual negligence and lawsuits that results in a system in which cases are initiated by individuals. I also address the unpredictability of juries when they evaluate liability and damages in cases. Because the decisions of courts are highly dependent on the individual actors in individual disputes, they are not predictable and therefore cannot produce consistent policy.

The Anatomy of Medical Malpractice and Patient Safety

Within the American common law system, a medical malpractice suit is considered a tort for negligence. Tort law refers to the body of civil law that creates and provides remedies for legal wrongs that are not encompassed by legal contracts. An individual who is legally injured can sue to recover damages from someone who is liable (legally responsible) for the injury. Although torts can be intentional acts, the concept most commonly associated with tort law is negligence. Negligence consists of a breach of a duty of care between one person and another.

In a medical malpractice case, negligence is a breach of a doctor's duty of care to his patient. In order to recover damages in a medical malpractice suit, the plaintiff must establish 1) that the relationship between her and the doctor gave rise to a duty, 2) that the doctor was negligent in that his care fell below the standard of care expected of a reasonable medical practitioner, 3) that the plaintiff actually sustained an injury that was 4) proximately caused by the doctor's negligence. The plaintiff proves these elements using medical records and documentation, her own testimony and that of the medical providers present, and the testimony

of expert medical witnesses. The defendant may deny one or all elements of the negligence case, also using documentation and the testimony of both ordinary and expert witnesses. Whereas ordinary witnesses can only testify about the facts of the evidence, expert witnesses can provide their opinions about the case. In a medical malpractice trial, expert witnesses typically include doctors who practice the same kind of medicine as the defendant physician or doctors who are experts on the particular type of injury or procedure in question. In all but rare exceptions, the medical malpractice trial is heard by a jury, who determines the doctor's liability as well as the amount of damages. The damages in a negligence case can be economic, noneconomic or both. Economic damages are the monetary costs of the injury, such as additional medical care or lost wages. Noneconomic damages are the additional costs of an injury, such as pain and suffering or the loss of consortium to the victim's spouse.

In our example case, Mrs. Wilson's attorney will need to prove to a jury that Dr. Thompson owed her a duty of care, that Dr. Thompson's care fell below the standard of care of a reasonable physician, that Mrs. Wilson was in fact injured, and that this injury was caused by Dr. Thompson's negligence. In this case, it seems relatively certain that Dr. Thompson owed Mrs. Wilson a duty of care as her attending physician and that Mrs. Wilson sustained an injury, permanent brain damage. However, it is not clear whether Dr. Thompson's decision to transfer Mrs. Wilson to the ICU rather than intubate her himself breaches the standard of care of a reasonable medical practitioner. If this does constitute negligence, it is also unclear whether that decision caused her injuries or whether she would have been permanently brain damaged regardless. Like most medical malpractice cases, the issues in Mrs. Wilson's case are complicated. Both sides will use Mrs. Wilson's medical records and the testimony of Dr. Thompson and the other physicians and nurses present to attempt to prove their respective cases.

They will also both use expert witnesses who will testify about the standard of care in incidents such as this one and about the causes of injuries like Mrs. Wilson's. The jury will decide by the weight of the evidence that each side presents whether Dr. Thompson is liable for Mrs. Wilson's injury and, if so, how much he should pay in damages. Economic damages for Mrs. Wilson's injury could include the cost of her additional hospital expenses and of the long-term care facility. Noneconomic damages could include Mrs. Wilson's pain and suffering and the loss to Mrs. Wilson's family of her presence as a mother and family member.

In theory, all civil lawsuits serve two main purposes, compensation and punishment, that operate at both the individual and the public levels. Lawsuits provide compensation at the individual level by reimbursing victims for the economic and noneconomic costs they face as a result of their injury. At the public level, compensation from lawsuits prevents society at large from having to bear the cost of an individual's injury. For example, in medical malpractice suits, patients who receive compensation from a lawsuit may not have to rely on tax-payer-funded government assistance, such as Medicaid, to cover the costs of their injuries.

Lawsuits exact punishment at the individual level by providing a means of corrective justice. Making doctors literally pay for the injuries they cause gives victims an opportunity for retribution. At the public level, civil lawsuits do not seek to provide specific punishment but rather to prevent future injuries by deterring people from being negligent in the first place. The theory of deterrence says that making doctors liable for the costs of injuries they cause (including both economic and noneconomic damages) will give them the incentive to take an appropriate amount of precaution when treating patients. This suggests that lawsuits should function as a public policy instrument to improve patient safety.

Statistics on medical errors demonstrate the need for improvement in patient safety, but there are no universal regulatory mechanisms in the United States for patient safety, leaving the courts to be the primary means of legally regulating the doctor-patient relationship. In 1999, the Institute of Medicine released a watershed report on patient safety, *To Err Is Human*. The report extrapolated from the two largest studies on medical malpractice that between 44,000 and 98,000 Americans die in hospitals each year as a result of medical errors.[2] Even when using the lower estimate, the number of deaths in hospitals due to errors exceeds the number of deaths attributable to motor vehicle accidents, breast cancer, or AIDS.[3] In that study, approximately 70 percent of the errors were estimated to be preventable.[4] Another study of patient safety reported that approximately one in ten hospital admissions result in an adverse event, which is defined as an error resulting from medical care rather than a disease process.[5] About half of those adverse events were considered preventable.[6] There are currently no universal systems in place for improving these statistics. Most existing solutions are voluntary, institutional-level responses, such as improving information technology or implementing institutional error-reporting databanks.[7] It is noteworthy that these programs address patient safety from a systems level, that is, by making changes in institutional procedures and compiling data on trends in errors rather than focusing on the resolution of single incidents. In this respect, they differ significantly from medical malpractice litigation, which addresses patient safety on an individual, case-by-case basis. Lawsuits, however, are the primary means of creating patient safety policy in the United States by compensating past injuries and discouraging future injuries.

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2. Institute of Medicine, *To Err Is Human: Building a Safer Health System*, eds. Linda T. Kohn, Janet M. Corrigan, and Molla S. Donaldson (Washington, DC: National Academy Press, 2000), 26.
3. Ibid.
4. Ibid., 36.
5. Robert M. Wachter, *Understanding Patient Safety* (New York: McGraw Hill, 2008), 10.
6. Ibid.
7. See generally Institute of Medicine, *To Err Is Human*; and Wachter, *Understanding Patient Safety*.

An Introduction to Courts as Policy-Makers

The larger question that I seek to answer in this thesis is whether courts are effective policy-makers. The answer to this question contains both a positive judgment about whether courts are capable of making policy and a normative judgment about whether they ought to make policy. The institutional structure and political culture in the United States have left an opening for courts to make policy because Americans simultaneously desire government regulation and constrained government institutions. The existing literature in this area indicates that, while the courts can accomplish policy goals more rapidly than the legislature and can provide special protection for minorities, they inefficiently rely on individual initiative to resolve complex issues and arguably operate without accountability.

The American constitutional system relies on the separation of powers, and the Founding Fathers set up a government with three branches – executive, legislative, and judicial. This was based in large part on the English Parliamentary system, but it notably made the judicial branch coequal to the others. The concept of an independently acting judiciary was new, and the practice of judicial review that was solidified in *Marbury v. Madison* (1803) reflected America's independence from its English heritage. Donald Horowitz argues that the unique combination of factors in America "sustained the creative lawmaking authority of judges."[8] In addition to the separation of powers, the written Constitution introduced the need for judicial interpretation of laws. The use of English common law as the basis for the court system further cemented the role of judges as not simply arbitrators of disputes but as creators of law. Thus, the idea of courts as policy-makers has been embedded in the American political system since its inception.

8. Donald L. Horowitz, *The Courts and Social Policy* (Washington, DC: Brookings Institution, 1977), 2.

The Founders who advocated the separation of powers reflected a uniquely American distrust of government that emphasized incorporating the will of the people into the representative system. The rhetoric of the Revolutionary War, such as the celebrated "no taxation without representation," fostered popular disdain for government that could act without the approval of its citizenry. The Articles of Confederation that were adopted before the Constitution created such a weak central government that it was unable to act independently of the states. The separation of powers ultimately written into the Constitution ensured that there would be checks on the power of each branch and on the legislative and executive branches in particular.

The formation of the American governmental system, however, also coincided with what Lawrence Friedman describes as a shift in popular expectations for "total justice,"[9] a concept I will address in greater depth in Chapter 2. These expectations emerged from a new willingness to apportion blame and an increased ability to control nature through technology. As Americans' expectations for the compensation of injuries increased, they expanded their notion of individual rights, some of which had been enumerated in the Constitution's Bill of Rights. These new expectations encouraged the use of the courts as a means of obtaining restitution, and they changed people's expectations for government in general. People came to expect the government to protect their newly expanded individual rights.

The current political system in America has evolved out of the tension between the distrust of centralized government and the expectations that government will protect individual rights. Robert Kagan states that the elements of this political system are:

> "… first, a *political culture* (or set of popular political attitudes) that expects and demands comprehensive governmental protections from serious harm, injustice, and environmental dangers – and hence a powerful, activist government – and, second, a set

9. Lawrence Friedman, *Total Justice* (New York: Russell Sage Foundation, 1985).

> of *governmental structures* that reflect mistrust of concentrated power and hence that limit and fragment political and governmental authority."[10]

Kagan argues that contemporary Americans' demands for insurance – for things such as health care, natural disaster, and unemployment – are problematic in an "anti-government," institutionally-fragmented system like that of the United States. Government that is curtailed by institutional limitations is incapable of providing the kinds of protections that people have come to expect.

The combination of a generally impotent government but a markedly independent judiciary has created an important opening for the courts to be policy-makers in the United States, however. The legislative branch often cannot accomplish policy goals because it is actually constrained by its responsiveness to the will of the people – interest group or constituency pressure. The courts do not face such incentives, and so they can play a role not only in resolving disputes between individuals and compensating victims of specific injuries, but also in areas such as sanctioning corporations and ensuring public health and safety. These activities make up the *regulatory* function of the courts, which Carl Bogus argues is in fact their primary function. The courts do provide compensation and resolution on a case-by-case basis, but this is only a secondary effect of using lawsuits to deter future undesirable behavior. Bogus says, "If compensation were, in fact, one of its objectives, the system would make need a determining factor in whether it would give parties recoveries; but that is not the case. … There are better mechanisms for compensation. The tort system is truly about something else – it is principally a regulatory system."[11] By determining how disputes between individuals are

10. Robert A. Kagan, *Adversarial Legalism: The American Way of Law* (Cambridge, MA: Harvard University Press, 2001), 15.
11. Carl T. Bogus, *Why Lawsuits Are Good for America: Discipline Democracy, Big Business, and the Common Law* (New York: New York University Press, 2001), 2.

resolved and how compensation is distributed, the courts create unwritten policy about what behaviors are acceptable and what kinds of injuries are assigned value.

Through individual conflicts expanded into class action suits, the courts have recently become agents of social change in several key areas that have not been addressed by Congress. Gerald Rosenberg asserts, "American courts seemingly have become important producers of political and social change. … Further, such litigation has often occurred, and appears to have been most successful, when the other branches of government have failed to act."[12] Rosenberg, Bogus, and Walter Olson, among others, discuss the changes brought about by lawsuits over tobacco, gun regulation, asbestos, and breast implants. These politically controversial cases all relate to the need for government regulation for public health and safety, and, in all of them, the court system ultimately determined the nature of policy. Olson argues that these cases, all of which occurred in the latter portion of the twentieth century, were facilitated by an overall shift in the nature of litigation. He says, "By the late 1970s, the mood and attitude in law schools had turned around, with litigation now widely seen as an engine of social progress."[13] Changes in the law during the same time period, which made it easier to sue and harder to defend against suit, were compatible with the American political culture that simultaneously expects strong government regulation and weak government institutions. The courts, therefore, have become an acceptable source of regulation because they favor individual dispute resolution over sweeping government intervention. They are also the only source of regulation available in situations where the other branches of government are rendered powerless by political pressure.

12. Gerald N. Rosenberg, *Hollow Hope: Can Courts Bring About Social Change?* (Chicago: University of Chicago Press, 1991), 2.
13. Walter K. Olson, *The Rule of Lawyers: How the New Litigation Elite Threatens America's Rule of Law* (New York: St. Martin's Press, 2003), 8.

While it is evident that American courts are *capable* of making policy, this does not mean that they do so effectively and therefore that they should continue to be used for that purpose. Rosenberg calls the view that the courts *do* make good decisions the "Dynamic Court" model, arguing, "Indeed, for many, part of what makes American democracy exceptional is that it includes the world's most powerful court system, protecting minorities and defending liberty, in the face of opposition from the democratically elected branches."[14] In this view, the other branches of government are not impotent but rather too powerful because their actions are dictated by the majority to the potential detriment of the minority. The courts act as policy-makers by countering the opinions of the majority, and they can do so because they are independent of the legislative and executive branches.

Bogus makes a different argument for why the courts are appropriate makers of policy. He writes, "The tort system, therefore, encourages effective self-regulation, that is, regulation not by government agencies but by entities … that know their business best."[15] Bogus argues that the justice system regulates efficiently because it eliminates the need for bureaucracy by using the same mechanism that resolves individual disputes to force parties to self-regulate. This view contends that the deterrent effect of lawsuits enables the courts to make unwritten policy from within disputes and that this is more efficient than having a government agency impose policy from without.

There is evidence, however, that the court system is actually *inefficient* at making policy decisions because it is not designed to handle the complexity of many issues, because it places the costs of regulation on the individual parties in lawsuits, because it deals in punitive rather than regulatory methods, and because it produces unpredictable decisions due to the differences

14. Rosenberg, *Hollow Hope*, 2.
15. Bogus, *Why Lawsuits Are Good*, 3.

among judges and juries. Kagan argues, "In consequence, the American legal system often is unjust – not, by and large, in its rules and official decisions, but because the complexity, fearsomeness, and unpredictability of its processes often deter the assertion of meritorious legal claims and compel the compromise of meritorious defenses."[16] Using a tool designed for individual dispute resolution is inefficient for regulation on a large scale because it depends upon the individuals involved to coordinate complex policy issues. I will further examine some of these arguments against using the courts as policy-makers later in this thesis.

Part of the rationale for courts making policy is that they can act when the other branches of government cannot. In this sense, the courts may be more effective than the legislature because lawyers, who are not constrained by the same political and institutional checks as legislators, may be able to "get things done." Olson argues, however, that this defies the very purpose of creating a system of checks and balances in the United States government:

> "If just getting things done is the main priority, why then do we go to such lengths to constrain the powers held by 'real' government officials? The answer, of course, is that we do not for a moment trust those officials to wield the intimidating powers of government office without imposing on them a high degree of transparency and predictability, because we know how likely it is that the power would otherwise soon be abused."[17]

The distrust of government that prompted creating a system to prevent the abuse of power and that still pervades American political culture today should resist using the branch of government with the least amount of popular representation. W. Kip Viscusi observes the lack of accountability in the recent lawsuits involving tobacco, guns, asbestos, and breast implants. When this is the case, "the allocation of responsibilities for policy becomes blurred, as litigation becomes the mechanism forcing regulatory changes. The policies that result from litigation

16. Kagan, *Adversarial Legalism*, 4.
17. Olson, *Rule of Lawyers*, 312.

almost invariably involve less public input and accountability than government regulation."[18] The government faces very little accountability when the courts create public policy, but this is ironic because policy-making through litigation emerged because of the desire for *constrained* government.

Existing literature thus shows that the use of the court system to make regulatory policy relies on a tool for individual dispute resolution to accomplish sweeping policy changes, and it does so without the same accountability to which the other actors in the United States government are held. American political culture reflects a tension between desires for limited government and the protection of expansive individual rights. The separation of powers (a system of checks and balances on the power of government) created a judicial branch that could act largely independent of the other branches of government. This left an opening for regulation through the courts, which was appealing to Americans because the courts are designed to resolve *individual* disputes. Americans have seized this opening in recent years to use the courts to regulate a variety of issues.

Case Study: Medical Malpractice

This is the environment within which medical malpractice litigation exists as a regulatory mechanism for patient safety policy. I use medical malpractice litigation as a case study for how effectively courts can make policy because of its pertinence to political theory and because of its prevalence. If courts are, in fact, effective policy-makers, then lawsuits should deter doctors from making medical errors and encourage them to improve patient safety by taking an appropriate amount of precaution.

18. W. Kip Viscusi, *Regulation through Litigation* (Washington, DC: AEI-Brookings Joint Center for Regulatory Studies, 2002), 1.

Medical malpractice is an excellent example of policy-making through the courts because there are currently no other viable regulatory mechanisms in the United States. William Sage argues that there are several reasons why malpractice has not been integrated into the health policies enacted by Congress or state legislatures.[19] First, the issue typically comes to the forefront of debate only during periods of crisis – when malpractice insurance premiums rise – and these crises only directly affect physicians. Furthermore, medical malpractice reform has become entrenched in the professional rivalries between doctors and lawyers, making it prohibitive for outsiders to interfere. Finally, the government administrative agency that has the largest influence in formulating health policy, the Centers for Medicare and Medicaid Services under the Department of Health and Human Services, has remained largely invisible on the topic of medical malpractice. Patient safety policy formed through medical malpractice litigation is thus a relevant instance in which the courts act because of the impotence of the other branches of government.

Medical malpractice is also an important area of tort law because of the volume of cases and the amount of money involved. There are 50,000 to 60,000 malpractice claims each year, approximately 70% of which do not reach trial.[20] About 30% of claims are closed with payment to the plaintiff, with an average payout in 2003 between $260,000 and $310,000.[21] A Department of Justice study of the 75 most populous counties in the United States indicated that the median award in medical malpractice cases is sixteen times higher than awards in other tort cases.[22] The immense national costs of medical malpractice demand some sort of regulation.

19. William M. Sage, "Malpractice Reform as a Health Policy Problem" in Sage and Kersh, *Medical Malpractice*, 30.
20. Michelle M. Mello and David M. Studdert, "The Medical Malpractice System: Structure and Performance" in Sage and Kersh, *Medical Malpractice*, 13.
21. Ibid.
22. U.S. Department of Justice, Bureau of Justice Statistics, *Medical Malpractice Trials and Verdicts in Large Counties, 2001*, by Thomas H. Cohen (Washington, DC: Office of Justice Programs, 2004).

Preventable medical injuries in the United States are estimated to produce annual costs – including additional acute care, long-term care, lost income, and lost household production – in the range of $17 billion to $29 billion.[23] These are injuries that litigation as a regulatory mechanism theoretically should prevent and thus can act as a measure of how effectively the courts enact patient safety policy.

I keep my focus in this thesis on how the nature of the legal system itself (individual initiation of suits and the unpredictability of juries) distorts deterrence, but there are other variables that can affect the deterrent function of lawsuits. Doctors are nearly universally covered by liability insurance, which covers the majority of the economic costs of liability. This has a moral hazard effect – the concept that individuals will change their behavior when they are not forced to bear the full costs of that behavior.[24] Medical malpractice insurance is also notoriously hard to experience-rate (in the way that premiums for automobile insurance are rated) because of variations among individual practitioners and geographic areas as well as because of the unpredictability of lawsuits that I address in this thesis.[25] At most, premiums vary between specialties, a trend that simply places larger burdens on doctors in riskier specialties by keeping them in small risk pools. When malpractice premiums do rise (usually across all specialties, often because of changes in the investment market that dictates insurance companies' profits[26]), doctors are able to and do pass costs along to patients through higher fees.[27] There is

23. Mello and Studdert, "Medical Malpractice System," in Sage and Kersh, *Medical Malpractice*, 13.
24. See Steven Shavell, "On Liability and Insurance," *Bell Journal of Economics* 13 (1982): 120-132.
25. See Frank A. Sloan, "Experience Rating: Does It Make Sense for Medical Malpractice Insurance?" *American Economic Review* 80 (1990): 128-133.
26. See Troyen A. Brennan, Michelle M. Mello, and David M. Studdert, "Liability, Patient Safety, and Defensive Medicine: What Does the Future Hold?" in Sage and Kersh, *Medical Malpractice*, 93-114.
27. See Patricia M. Danzon, Mark V. Pauly, and Raynard S. Kington, "The Effects of Malpractice Litigation on Physicians' Fees and Incomes," *American Economic Review* 80 (1990): 122-127; and Mark V. Pauly, "Who Pays When Malpractice Premiums Rise?" in Sage and Kersh, *Medical Malpractice*, 71-83.

very little demand-side response to this because demand for healthcare is generally inelastic and because most patients are also insured against these higher costs.

Doctors' financial incentives have also shifted with the rise of managed care in the 1980s and 1990s. Health management organizations (HMOs) developed in the 1980s and 1990s as a way to control the skyrocketing costs of healthcare. They function by paying doctors a set amount per patient (determined by the patient's characteristics and diagnosis), which discourages doctors from performing unnecessary medical procedures, since the cost of those procedures comes directly out of the doctors' paychecks. HMOs have not only strained doctor-patient relationships (an issue that I will discuss later in a wider context) but has also changed the incentives that doctors face.[28] Doctors may choose not to perform medically necessary procedures because of the financial strain that managed care places on them, which directly decreases patient safety. All of these economic aspects of the healthcare industry change the ability of lawsuits to deter future negligence, but my argument here is that the courts are inherently inefficient policy-makers.

In my study of the effectiveness of medical malpractice litigation in deterring doctors from injuring patients, I examine a variety of evidence about the legal culture, about those who do and do not bring lawsuits, and about the decisions of juries. In some cases, data is available, such as statistics about lawsuits, public opinion polls, and psychological studies. Where quantitative research does not exist, I rely on other sources, such as cultural and medical histories. This support from other social scientists, while not empirical, lends credibility to my own argument and helps demonstrate the less tangible aspects of America's legal culture.

28. See Daniel P. Kessler and Mark B. McClellan, "Malpractice Pressure, Managed Care, and Physician Behavior," in Viscusi, *Regulation through Litigation*, 183-204; and Patricia M. Danzon, "Malpractice Pressure: Comment," in Viscusi, *Regulation through Litigation*, 205-211.

In **Chapter 2**, I examine medical malpractice lawsuits in light of the generally litigious culture in the United States. The use of courts to regulate medical malpractice is part of an overall increase in Americans' willingness to resolve disputes by using lawsuits since the nineteenth century. This has occurred in part because of an increase or a shift in individualism, marked by a decline in traditional community and a decreased respect for authority. Americans have also increasingly come to expect to be treated fairly (the notion of individual legal rights) and to be compensated when something goes wrong. These expectations grew out of a declining belief in divine providence and the corresponding freedom to blame other people and out of the increasing ability of technology to control all aspects of life. The combination of individualism and expectations for justice has made people more willing to turn to the courts, which resolve disputes and provide compensation at the individual level. This has been particularly true in medical malpractice because of the vast improvements of science and technology in medicine. These have increased expectations of success in medical outcomes, creating new standards of care, and prompting people to sue when their expectations are not met. These advances have also changed the nature of the delivery of healthcare, making it less personal and increasing opportunities for error, also increasing patients' willingness to sue. The use of courts to regulate medical malpractice has evolved out of these cultural trends of increasing individualism and expectations for successful outcomes, but these trends also emphasize the individual nature of the courts.

In **Chapter 3**, I address how the United States' system of individually-initiated lawsuits is incapable of sending a predictable deterrent signal to doctors. This is the problem of poor fit, which consists of both a gap and a mismatch between patients who are negligently injured and those who actually file malpractice lawsuits. I first examine the decision process leading from an

injury to legal action. This incorporates the economic impact of an injury and the potential for compensation, which are predicted more by the severity of the injury than by the presence of negligence. This also incorporates more subjective factors like the patients' level of anger and willingness to sue, and these can be influenced by the characteristics of patients and doctors and by the quality of the doctor-patient relationship. The nature of the legal system also means that patients will pursue legal action in order to gather information about their injury or to obtain compensation for their losses. These factors are further complicated because lawyers are often the decision-makers in lawsuits. All of these variables are unrelated to negligence, meaning the cases that actually reach the court system may not signal to doctors the appropriate level of care and instances of actual negligence may go unobserved.

In **Chapter 4**, I examine the impact on deterrence of jury trials, which are the primary means of deciding those cases that do reach court and which have a trickle-down effect on whether parties choose to settle out of court, drop a case, or even file suit in the first place. The jury decides whether a doctor is liable and, if so, the amount of monetary damages. Jurors' decisions about liability are unpredictable in part because they are frequently influenced by extralegal factors, such as their own background characteristics and the psychological or emotional appeal of the parties in the case. Medical malpractice cases are also legally and scientifically complex, increasing the unpredictability of juries. Juries' decisions about damage awards are highly unpredictable as well, which distorts the signal of the appropriate level of care. While some evidence indicates that bench trials may be more accurate than jury trials, the impact seems limited. This unpredictable nature of the courts makes them ineffective at creating large-scale policy because there is no consistent deterrent signal to doctors.

In **Chapter 5**, I return to the bigger picture with a concluding analysis of my medical malpractice case study and why the courts should not be used to make policy. Medical malpractice litigation fits into the larger cultural trend of litigiousness in America, and it highlights the individual aspects of lawsuits that make them inappropriate policy tools. When combined with some of the theoretical rationales against the phenomenon of adversarial legalism, this evidence about medical malpractice shows that courts are ineffective policy-makers. I also offer some brief suggestions for improvements to the system.

Chapter 2: The American Culture of Litigiousness

People have to be willing to use the courts in order for them even to be able to make policy. The general concept of suing for medical malpractice began to develop in the nineteenth century, and its history corresponds to the larger trend of litigiousness in American culture. People's litigiousness, which I define as their propensity to sue, has increased as lawsuits have become a socially acceptable response to injury and as their expectations for recompense have expanded. Here I look at two aspects of the American culture of litigiousness: a strong sense of individualism and simultaneous expectations for what Lawrence Friedman terms "total justice."[1] Individualism, or a belief in self-reliance and independence, echoes throughout American history. Its nature has shifted, however, to focus on personal rights as communities in America have changed from small, rural towns into large, urban centers. This shift has also contributed to a general lack of respect for authority. The second aspect of the culture of litigiousness, expectations for total justice, refers to people's belief that they will be treated fairly and that someone will pay when something goes wrong. The notion of placing blame and expecting compensation has evolved from a declining belief in divine providence and the increasing ability of technology to control nature. The combination of individualism and expectations for total justice has prompted people to turn more frequently to the court system, which is a tool for resolving disputes and providing compensation on the individual level.

The culture of litigiousness is particularly applicable to understanding the use of lawsuits for medical malpractice because of the visible impact of cultural changes in medicine. The scientization of medicine since the nineteenth century has greatly increased public expectations of medical outcomes. Improvements in science and technology have created new standards of

1. Lawrence M. Friedman, *Total Justice* (New York: Russell Sage Foundation, 1985).

care to which doctors are held and new expectations of perfection, prompting people to sue when their expectations are not met. Furthermore, technological advances have depersonalized the doctor-patient relationship, a change that has corresponded to the overall trend of individualism and declining respect for authority. Thus people's willingness to sue for medical malpractice mirrors the larger trend of willingness to sue in general.

Individualism

In part, the litigiousness culture in America has resulted from the embrace of individualism. Individualism has been at the core of American society since the country's founding because those who migrated to the new colonies were struggling against the monarchical and aristocratic authority of England and other European states. The authors of the United States Constitution relied heavily on the political theories of Thomas Hobbes and John Locke, who emphasized a new kind of government that viewed the individual as existing prior to society (though living a life Hobbes termed "solitary, poor, nasty, brutish, and short").[2] Society and its government were formed through a social contract among individuals that allowed them to maximize their individual self interest.[3] This philosophy harmonized with the image of an active citizen promoted by the Puritan and sectarian versions of Reformation Christianity that had quickly taken hold in the new country.[4] The early nineteenth century's Western expansion, Jacksonian democracy, and market revolution furthered the American identity of individualism, a trend observed by Alexis de Tocqueville, who depicted Americans as always seeking their own material gain.[5]

2. Thomas Hobbes, *Leviathan* (Reprint, Indianapolis: Hackett Publishing Company, 1994).
3. John Locke, *The Second Treatise of Government and A Letter Concerning Toleration* (Reprint, New York: Dover, 2002).
4. Robert N. Bellah, *Habits of the Heart* (Berkeley: University of California Press, 1985), 142.
5. Alexis de Tocqueville, *Democracy in America* (Reprint, London: Penguin Classics, 2003).

The individualism that the Founding Fathers enshrined and that fueled the Western expansion was in many ways a cooperative, communal individualism, however. It was about self-sufficiency but within the larger community. The early settlements in America were tightly bound by family and religious ties, and the demands of economic survival encouraged cooperation.[6] Social relationships were dominated by face-to-face, personal interactions with a limited number of neighbors, and disputes were usually settled through some sort of arbitration, mediation, or mutual agreement between the parties. People were expected to protect themselves against injury and to absorb the consequences of harm should it befall them.[7] Lawsuits were considered an inappropriate means of dispute resolution because they disturbed the peace of the community and contradicted those individualistic notions of self-sufficiency by demanding compensation.[8]

Since the middle of the nineteenth century, however, there has been a shift from this collective individualism to a personal, rights-oriented individualism. Society increasingly has valued people as *individuals* with their own rights and freedoms rather than as members of a closely-knit community. This type of individualism has flourished as traditional communities have declined, creating the need for new forms of dispute resolution and diminishing respect for traditional authority. Individualism has thus reduced social pressures not to sue, creating a more litigious society.

The decline in traditional community can be measured in literal terms (a decrease in small towns and an increase in urban areas) as well as in social and cultural terms (a rise in dependence on strangers and a weakening of societal restraints that govern behavior).

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6. Kenneth De Ville, *Medical Malpractice in Nineteenth Century America: Origins and Legacy* (New York: New York University Press, 1992), 116.
7. David M. Engel, "The Oven Bird's Song: Insiders, Outsiders, and Personal Injuries in an American Community," *Law and Society Review* 18 (1984): 558.
8. De Ville, *Nineteenth Century*, 118.

Urbanization began as the Industrial Revolution made the large-scale production of goods possible and brought people into cities for factory jobs. This pattern continued into the twentieth century – by 1950, 64.2% of the United States population lived in urban areas, and by 2007, urban residents were 81.4% of the population.[9] With urbanization, people are within closer physical proximity of each other but are at a greater relational distance, which changes how disputes are typically resolved. Relational distance is the level of intimacy between parties in a social relationship,[10] with love relationships having the greatest intimacy and the smallest distance and interactions between strangers having the least intimacy and the greatest distance.[11] People are more likely to use lawsuits to resolve disputes as the relational distance between them increases.[12] This is because law replaces other forms of social control that exist in smaller communities (among families, friends, neighborhoods, villages, tribes, etc.).[13] The Industrial Revolution's division of labor made these newly urban citizens extraordinarily dependent on strangers, people with whom the relational distance was great.[14] Suing for compensation for an injury no longer implied a loss of self-sufficiency because ideas about individualism were changing. The traditional community norms and opinions that had previously discouraged lawsuits lost their influence as communities became larger and more heterogeneous and interactions more anonymous.[15]

Urbanization and its increased relational distance are still frequently cited as an explanation for a greater number of lawsuits per capita. For instance, in Patricia Danzon's study

9. United Nations, Department of Economic and Social Affairs, *World Urbanization Prospects: The 2007 Revision* (New York: United Nations, 2008), 80-81.
10. Donald Black, *The Behavior of Law* (New York: Academic Press, 1976), 40.
11. Robert A. Silverman and Leslie W. Kennedy, "Relational Distance and Homicide: The Role of the Stranger," *Journal of Criminal Law and Criminology* 78 (1987): 273.
12. Jeffery Mullis, "Medical Malpractice, Social Structure, and Social Control," *Sociological Forum* 10 (1995): 152.
13. Black, *Behavior of Law*, 6.
14. Friedman, *Total Justice*, 40.
15. De Ville, *Nineteenth Century*, 119.

of malpractice lawsuits in California in the 1970s, she found that urbanization was the most significant and most powerful predictor of frequency of claims, even after controlling for the increased density of medical services in urban areas.[16] In a 1987 survey of Florida tort lawyers, 75.8% of attorneys indicated that more impersonal relationships between claimants and potential defendants, such as doctors or manufacturers, were a reason for increased litigation in the state.[17] Another study from the mid-1980s looked at the effect of relational distance on court cases in Sander County, Illinois, a rural county that had recently started to modernize, bringing in new people and increased interactions with people outside the local community. The members of the community had a strong aversion to personal injury cases, but those cases that were filed generally involved parties separated by geographic or social distance.[18] The increased distance prevented traditional conflict resolution processes from functioning. All three of these late-twentieth century studies show that the decline in traditional communities has increased the acceptability of lawsuits to resolve disputes.

Another component of individualism that has increased since the middle of the twentieth century is a diminished respect for traditional forms of authority, making people more willing to confront authority figures and creating a need for the courts as an external arbiter of disputes. Authority in its traditional sense indicates a certain status or quality that compels trust and obedience.[19] A crisis in authority is characterized by a breakdown in the traditional mechanics of social control, by widespread protest against many different forms of authority, and by increased

16. Patricia M. Danzon, *The Frequency and Severity of Medical Malpractice Claims* (Institute for Civil Justice. Santa Monica: Rand Corporation, 1982), 27.
17. Donald G. Gifford and David J. Nye, "Litigation Trends in Florida: Saga of a Growth State," *University of Florida Law Review* 4 (1987): 869.
18. Engel, "Oven Bird's Song," 567.
19. Paul Starr, *The Social Transformation of American Medicine* (New York: Basic Books, 1982), 9.

radical sentiment.[20] The period starting in the 1960s plunged the United States (and the entire Western world) into just such a crisis, as people sensed a gap between the promise and the performance of the institutions in which they placed their trust.[21] This was the time of the anti-Vietnam War movement as well as the decline of the Catholic Church's authority and the student protests in Europe.[22] During this period, Americans became extremely distrustful of the leaders of all their major institutions. Between just 1966 and 1971, the percentage of the public expressing a great deal of confidence in the leaders of ten different institutions declined by 20 points on average in Harris polls.[23] Then, from 1981 to 1990, the World Values survey indicated that an emphasis on respect of authority was becoming less and less widespread.[24] This shift away from authority was also a shift toward personal individualism, and Americans became willing to assert their own authority as individuals.[25] This made them more willing to use the courts, which are a device for resolving individual conflicts, to assert their rights and to demand compensation for wrongs.

Expectations for Total Justice

Just as increased individualism in the United States has removed the social constraints against suing others, Americans have also come to expect "total justice." This is the sense that everyone should be treated fairly and that people can expect compensation if they are not treated fairly.[26] Expectations for total justice reflect the relatively new concept of an individual right as something that can be sued over if expectations are not met, as seen in the rights movements of

20. Seymour Martin Lipset and William Schneider, *The Confidence Gap: Business, Labor, and Government in the Public Mind* (New York: Free Press, 1983), 1.
21. Ibid.
22. Eric J. Cassell, "The Changing Concept of the Ideal Physician," *Daedalus* 115, no. 2 (1986): 195.
23. Lipset and Schneider, *Confidence Gap*, 42.
24. Ronald Inglehart, "Postmaterialist Values and the Erosion of Institutional Authority," in Nye, Zelikow, and King, *Why People Don't Trust Government*, 222.
25. Ibid., 221.
26. Friedman, *Total Justice*, 5.

the twentieth century. This notion has been developing since the nineteenth century as people's belief in divine providence declined and their belief in the ability for humans to control the environment increased, particularly because of constantly improving technology. These changes in the social environment have changed the "legal culture"[27] of America, making people more willing to use lawsuits to rectify perceived wrongs.

The "due process" revolution of the mid-twentieth century was an indicator of Americans' increasing expectations for justice.[28] The civil rights movement of the 1960s was followed in the 1970s by movements advocating the rights of women, children, prisoners, students, and a multitude of other minority groups.[29] The 1960s and 1970s also witnessed the consumer movement, which changed economic culture with its focus on buyers' rights and sellers' obligations.[30] As individuals took these demands for rights to court, they blurred the boundaries between public and private law.[31] As the courts acknowledged these perceived rights, they also raised people's expectations of what normal levels of justice ought to be[32] and increased their demands on the legal system.[33] The rights revolution of the twentieth century, however, was fueled by the cultural changes starting in the nineteenth century that also increased people's expectations for justice: a declining belief in divine providence and an increase in technology.

During the nineteenth century, the American religious environment was marked by a waning belief in divine providence but an increasing belief in the attainability of human

27. Ibid., 31.
28. Ibid., 80.
29. Starr, *Social Transformation*, 388.
30. Marie R. Haug and Bebe Lavin, "Public Challenge of Physician Authority," *Medical Care* 17 (1979): 844; Leo G. Reeder, "The Patient-Client as a Consumer: Some Observations on the Changing Professional-Client Relationship," *Journal of Health and Social Behavior* 13 (1972): 408.
31. Friedman, *Total Justice*, 91.
32. Jane Mansbridge, "Social and Cultural Causes of Dissatisfaction with U.S. Government," in Nye, Zelikow, and King, *Why People Don't Trust Government*, 144.
33. Friedman, *Total Justice*, 80.

perfection, shifting blame for misfortune from God to other humans. Traditional providence theory reflected the belief that God created the world and continuously sustained it and that nothing occurred by mere chance.[34] The proper response to misfortune was humble acceptance because it was an act of God.[35] This response was not entirely unfounded because the majority of misfortunes before the nineteenth century were naturally caused – storms, fires, disease, famine[36] – and there were no human actors to blame. However, American society gradually secularized, beginning in northern cities following the American Revolution, and people shifted away from a providential or fatalistic viewpoint.[37] By the beginning of the nineteenth century, Unitarians, deists, and various liberal Protestant clergymen were directly attacking the notion of direct providential intervention.[38] One indication that this was the case was the growth of insurance companies during the nineteenth century. These companies reimbursed losses for catastrophic events, and their prevalence reflects the notion that people no longer passively chose to accept misfortune.[39] When God was no longer to blame for misfortune, people were freed to locate human agents on whom to place blame.[40] Providence theory was replaced by a Romantic belief in the ability to perfect the individual and society[41] and by a belief in the perpetual progress of the human race.[42] These ideas were compatible with the new emphasis on individual rights and the greater dependence on strangers, and Americans turned more and more to using lawsuits to demand compensation from others for the misfortunes that befell them.

34. De Ville, *Nineteenth Century*, 120.
35. Ibid., 22.
36. Jethro K. Lieberman, *The Litigious Society* (New York: Basic Books, 1981), 10.
37. De Ville, *Nineteenth Century*, 120.
38. Ibid., 121.
39. De Ville, *Nineteenth Century*, 121; Friedman, *Total Justice*, 49.
40. De Ville, *Nineteenth Century*, 22.
41. Ibid., 125.
42. Kenneth De Ville, "Medical Malpractice in Twentieth Century United States," *International Journal of Technology Assessment in Health Care* 14 (1998): 201.

The increased willingness to blame others for unmet expectations was compounded by higher expectations as improved technology increased people's ability to control their environment. Science and technology were crucial in generating the notion that humans could control nature.[43] The huge advances in transportation, industry and the physical sciences during the nineteenth century transformed the relationship between humans and nature, and humans felt a new power over their destiny as they transcended the previous limits of their environment.[44] People felt like they and their world could be perfected, and this new sense of physical control created a new demand for social control.[45] If human technology could control the risk present in the environment, then people wanted compensation from other humans when things did not go right. Tort cases increased during the nineteenth century because technology converted natural risk into liability for the humans who created or provided the technology.[46] Improved technology thus increased people's expectations for justice and, when combined with the spirit of individualism, increased their willingness to sue if those expectations were not met.

The Litigious Culture and Medical Malpractice

The trends that have made America more litigious over the past two centuries – increased individualism and greater expectations for justice – have been particularly evident in people's willingness to sue for medical malpractice. The modern emphasis on individual rights has manifested in the patients' rights movement and a decreased respect for doctors as authority figures. Furthermore, the scientization of medicine and the influx of technology have increased

43. Friedman, *Total Justice*, 42.
44. De Ville, *Nineteenth Century*, 109.
45. Friedman, *Total Justice*, 51.
46. Mark F. Grady, "Why Are People Negligent? Technology, Nondurable Precautions, and the Medical Malpractice Explosion," *Northwestern University Law Review* 82 (1988): 297.

patients' expectations of success while simultaneously fundamentally changing the delivery of medicine so that it does not always align with those expectations.

The relationship between doctors and patients has changed over the past century because of the patients' rights movement, which reflects people's increased emphasis on individual rights, decreased respect for authority, and increased expectations for justice. The patients' rights movement emerged as part of the larger consumer movement of the 1960s,[47] and it emphasized both the right to access healthcare and rights within healthcare (such as informed consent, refusal of treatment, and access to medical records).[48] The movement was a direct challenge to the traditional authority of physicians because it demanded that patients be able to participate in their own treatment decisions as knowledgeable partners.[49] Previous attempts to reform healthcare, such as those implemented during the Progressive Era, had assumed that physicians would act in the best interests of their dependent patients, but by the 1970s, Americans were skeptical of professional authority and its institutions.[50] While people's confidence in medicine was generally higher than in other institutions, the percentage of respondents to Harris polls indicating a "great deal of confidence" in the leaders of medicine dropped from an average of 66% in the mid-1960s to an average of only 41% in the late 1970s.[51] One of the most recent Harris polls, conducted in February 2008, found that only 28% of respondents felt a "great deal of confidence" in the leaders of the medical institution.[52] Patients no longer feel a sense of loyalty, commitment or trust around their doctors, and this mirrors the

47. Mullis, "Medical Malpractice," 150.
48. Starr, *Social Transformation*, 389.
49. Ibid.,390.
50. Ibid.
51. Lipset and Schneider, *Confidence Gap*, 48-49.
52. "Survey by Harris Interactive, February 5-February 11, 2008," iPOLL Databank, Roper Center for Public Opinion Research, University of Connecticut, http://www.ropercenter.uconn.edu/ipoll.html (accessed January 15, 2009).

overall decline in respect for authority in America.[53] The patients' rights movement and the diminished respect for authority in medicine parallel the larger shift towards individual rights in America, and these have thus increased the willingness of patients to sue their healthcare providers for medical malpractice.

This notion of health and healthcare as rights rather than as privileges or chance occurrences is also connected to the scientization of medicine and introduction of new medical technology, both of which have increased expectations for success.[54] The marriage of science and medicine first occurred in the early nineteenth century, when Paris physicians began correlating clinical observations with pathological lab results.[55] The discoveries of Louis Pasteur, Robert Koch, and others demonstrated the practical abilities of science to diagnose and prevent diseases.[56] Around the same time, Ignaz Semmelweis and Oliver Wendell Holmes demonstrated that physicians could prevent obstetrical infection by washing their hands, greatly reducing the number of maternal deaths and making hospitals a safe place for childbirth.[57] The first uses of ether as anesthesia in 1842 suddenly made possible surgeries previously thought impossible or extremely dangerous.[58] Similarly, new technology allowed for improved diagnostics and improved treatments. For example, the 1830s saw a revolution in orthopedics with new techniques and methods of setting bones, allowing for complete recovery from simple fractures.[59] People came to view the treatment of fractures as a mechanical procedure that could produce perfect results every time. At the start of the twentieth century, x-rays also became an important and nearly universal tool for diagnosing fractures and other maladies. Science and

53. Cassell, "Ideal Physician," 187, 197.
54. Renée C. Fox, "The Medicalization and Demedicalization of American Society," *Daedalus* 106, no. 1 (1977): 10.
55. Cassell, "Ideal Physician," 189.
56. Leighton E. Cluff, "America's Romance with Medicine and Medical Science," *Daedalus* 115, no. 2 (1986): 137.
57. Ibid., 138.
58. Ibid.
59. De Ville, "Twentieth Century," 200.

technology thus brought new successes to medicine by improving physicians' understanding of the body and diseases and their ability to diagnose and treat patients.

These successes demonstrated to the public the power of science in the medical world, thereby increasing people's expectations of medicine, and higher expectations have made people more likely to sue for malpractice when those expectations are not met. Technology has a life cycle with regard to litigation. There is an initial technological advance, which leads to inflated expectations for success and then to litigation when those expectations are not met.[60] In part this is because patients do not always understand the risks inherent in technology, and they expect perfect results every time.[61] This cycle continues as improvements in care constantly raise both the expectations of patients (creating a technological imperative[62]), and the standard of care to which future doctors are held.[63] For instance, the improvements in orthopedics meant that the number of lawsuits related to poorly healed fractures increased,[64] and the acceptance of x-rays as a diagnostic tool also prompted their acceptance as evidence and as the standard of care in malpractice lawsuits.[65] Technology has thus transformed natural risk into potential liability for doctors.[66]

Science and technology have also changed the very organization of the medical institution, which has also increased patients' willingness to sue. During the nineteenth century,

60. Peter D. Jacobson, "Medical Liability and the Culture of Technology," in Sage and Kersh, *Medical Malpractice*, 117.
61. Ibid.
62. Cassell, "Ideal Physician," 196; David Mechanic, "Some Social Aspects of the Medical Malpractice Dilemma." *Duke Law Journal* 1975 (1976): 1191.
63. William M. Sage, "Malpractice Reform as a Health Policy Problem," in Sage and Kersh, *Medical Malpractice*, 34.
64. De Ville, "Twentieth Century," 200.
65. William J. Curran, "The Unwanted Suitor: Law and the Use of Health Care Technology," in Reiser and Anbar, *Machine at the Bedside*, 121.
66. De Ville, "Twentieth Century," 202; Grady, "Why Are People Negligent," 297.

the study of medicine came to focus on anatomy.[67] Hospitals became the locus of treatment because they could coordinate patients with technology and personnel.[68] However, these changes channeled much of the communication between doctors and patients through mechanical mediums, ranging from stethoscopes to MRIs, which have gradually eliminated many of the personal elements from the doctor-patient relationship.[69] Furthermore, increased science and technology have led more doctors to work as specialists rather than as general practitioners, and so patients will often see a given doctor for only brief and impersonal interactions. In 1928, general practitioners accounted for about 88% of the physician population in the United States, but by 1970 they accounted for only 17%.[70] This fragmentation of the healthcare system has created a structure highly conducive to litigation because it has increased the relational distance between doctors and patients, making patients more willing to sue.[71] Specialization also means that a larger number of healthcare providers are involved in any one patient's care, increasing the number of opportunities for error while further eroding the doctor-patient relationship.[72] The influx of science and technology since the nineteenth century has thus altered the entire structure of the medical institution, making doctors easily susceptible to lawsuits from patients.

The trends in medical malpractice lawsuits can be viewed within the larger cultural framework of litigiousness in the United States. The combination of individualism and expectations for total justice has made Americans more likely to turn to lawsuits to resolve disputes. This has been especially true in the medical institution because of the changes that

67. Stanley Joel Reiser, "The Machine at the Bedside: Technological Transformations of Practices and Values," in Reiser and Anbar, *Machine at the Bedside*, 6.
68. Ibid., 9.
69. Mullis, "Medical Malpractice," 153.
70. Ibid., 151.
71. Ibid., 153.
72. Friedman, *Total Justice*, 89-90.

science and technology have wrought on patients' expectations and the nature of the doctor-patient relationship. This framework helps to identify *why* Americans have chosen to use the courts to create patient safety policy, but it also hints at why the courts are largely inefficient at such. Americans turned to lawsuits because they are a means of *individual* dispute resolution, making them appealing in an individualist society expecting justice and compensation for injuries. However, the individual nature of lawsuits means they do not necessarily make predictable policy, as I show in the next chapters.

Chapter 3: The Poor Fit Phenomenon

One aspect of lawsuits that makes them appealing in a culture that expects compensation for violations of individual rights is that they are initiated *by* individuals. However, this detracts from the courts' ability to make patient safety policy efficiently because lawsuits will not send a complete deterrent signal to doctors. This is because of the poor fit between patients who are negligently injured and those who actually file malpractice lawsuits. There are a vast number of negligent injuries that do not result in lawsuits, but many of the lawsuits that are filed do not result from negligent injuries. In order to determine what causes this poor fit between malpractice incidents and malpractice lawsuits, I first look at the decision process leading from an injury to legal action. The decision to sue incorporates the economic impact of the injury and the potential for compensation, but it also takes into account anger and reluctance to sue. The first two factors are best estimated by the severity of the injury, which can change whether patients seek legal action regardless of the cause of the injury. The second two factors are evaluated even less objectively, and they can be influenced by the characteristics of patients and by the quality of doctor-patient relationships. The nature of the legal system also changes these variables for patients, and they may pursue legal action because they lack other means of obtaining information about their injury or compensation for their losses. Ultimately, lawyers frequently determine which cases will proceed to trial, and they also make decisions based on criteria other than doctors' negligence.

Defining Poor Fit

Poor fit can be defined as the simultaneous "gap" between potential and actual malpractice claims and the "mismatch" between actual negligence and actual claims.[1] There are several large-scale studies of malpractice that document this phenomenon, which I describe below. Generally, tort reform proposals address the latter issue (in the spirit of reducing "frivolous" lawsuits) by making it more difficult to pursue a lawsuit or limiting the amount of compensation that plaintiff may recover. The first issue, which reveals that there are far more incidents of medical malpractice than surface in the legal system, is frequently washed over because of its terrifying implications. However, this overall phenomenon of poor fit indicates that lawsuits are not effectively improving patient safety.

One of the initial studies of medical injuries was sponsored by the California Medical Association in the mid-1970s. The study had nurses and physicians review nearly 21,000 medical records in 21 California hospitals, identify those patients who had suffered an adverse event, and evaluate the likelihood of a jury finding liability. The reviewers found that 4.65% of people hospitalized had suffered an adverse event, while 0.79% suffered an adverse event for which they would likely be found liable.[2] In 1985, Patricia Danzon did a follow-up to this study in which she matched the California hospital data with malpractice claims data from the National Association of Insurance Commissioners' survey of claims closed by private insurers from July 1975 to December 1978. Danzon found that only 10% of victims of negligent injuries filed a malpractice claim and that only 40% of these claims resulted in payment to the plaintiff.[3] The

1. Catherine T. Struve, "Improving the Medical Malpractice Litigation Process," *Health Affairs* 23 (2004): 34.
2. Don Harper Mills, "Medical Insurance Feasibility Study: A Technical Summary," *West Journal of Medicine* 128 (1978).
3. Patricia M. Danzon, *Medical Malpractice: Theory, Evidence, and Public Policy* (Cambridge, MA: Harvard University Press, 1985).

overall ratio of paid claims to injuries was 0.039, meaning a physician who committed an error leading to injury had only a 4% chance of having to compensate the patient.[4] The California study and its follow-up thus demonstrated the large gap between the number of negligent injuries and the claims filed, but its results were limited in that Danzon could not determine the percentage of claims that did not involve negligence (the mismatch).

Later that decade, researchers in New York created the largest and most complete study of medical malpractice, the Harvard Medical Practice Study (HMPS).[5] The HMPS was modeled after the California study, and it entailed a review of more than 30,000 medical records for patients hospitalized in New York and more than 67,000 litigation records maintained by the New York Department of Health. Physicians completed in-depth reviews of 3,500 claims. The study determined that 3.7% of New Yorkers suffered adverse events, and 1% suffered adverse events due to negligence.[6] The researchers found that the ratio of negligent adverse events to malpractice claims was 7.6 to 1, or about a 14% chance that a negligent injury would lead to a claim.[7] This figure overstated the actual chance, however, which they estimated was only 1.53%.[8] These numbers indicate both a gap in the number of negligent adverse events and the number of malpractice claims and a mismatch between negligent events and claims.

A third study demonstrating poor fit was conducted by a subgroup of the HMPS investigators in the early 1990s. They examined rates of medical injuries and negligence for nearly 15,000 medical records in Utah and Colorado, finding that adverse events occurred in

4. Ibid.
5. Harvard Medical Practice Study, *Patients, Doctors, and Lawyers: Medical Injury, Malpractice Litigation, and Patient Compensation in New York* (Cambridge, MA: Harvard University Press, 1990).
6. Lucian L. Leape, et al., "The Nature of Adverse Events in Hospitalized Patients: Results of the Harvard Medical Practice Study II." *New England Journal of Medicine* 324 (1991): 377.
7. A. Russell Localio, et al., "Relation Between Malpractice Claims and Adverse Events Due to Negligence: Results of the Harvard Medical Practice Study III," *New England Journal of Medicine* 325 (1991): 245.
8. Ibid., 247.

2.9% of hospitalizations in each state.[9] In Utah, 32.6% of adverse events were due to negligence, and in Colorado, 27.4% were due to negligence.[10] However, only 2.5% of the patients injured because of negligence filed a malpractice claim.[11] Furthermore, out of the eighteen claims filed from the study sample, fourteen were made in the absence of discernible negligence and ten were made in the absence of any adverse event.[12] The Colorado and Utah study confirmed the results of the HMPS in a different area of the country, suggesting the prevalence of the poor fit phenomenon.

From Injury to Lawsuit

In order to understand what causes the gap and the mismatch between negligent injuries and malpractice claims, it is important to understand how patients make the decision to pursue legal action. There are several transformations in a patient's perceptions of events that lead from the injury to the decision to engage in a legal dispute, and there are also alternatives to legal action. Economics suggests that a patient's decision to go to trial should be based on the expected value of the verdict and legal costs, but the statistics about poor fit suggest that there are other factors that determine which cases progress to lawsuits.

The movement from injury to legal action consists of three stages: perception or recognition of a grievance; legal reaction to the grievance (including the decision to seek legal advice, the attorney's actual advice, and the decision to pursue legal action); and disposition of the dispute in settlement or trial.[13] The third stage of the process is distinct from the others in

9. Eric J. Thomas, et al., "Incidence and Types of Adverse Events and Negligent Care in Utah and Colorado," *Medical Care* 38 (2000): 261.
10. Ibid.
11. David M. Studdert, et al., "Negligent Care and Malpractice Claiming Behavior in Utah and Colorado," *Medical Care* 38 (2000): 250.
12. Ibid.
13. Roy Penchansky and Carol Macnee, "Initiation of Medical Malpractice Suits: A Conceptualization and Test," *Medical Care* 32 (1994): 814.

that its outcome relies on the external actors of the legal system, and I discuss the unpredictability of this stage in Chapter 4. The outcomes of the first two stages, however, explain how cases even reach the legal system, and these stages are where the poor fit between negligence and malpractice lawsuits will manifest.

Before an individual considers legal reaction to a situation, the experience must develop into a dispute. An experience of an injury progresses to a grievance and finally to a dispute through particular stages of processing, which can be viewed as transformations in the injured individual's understanding.[14] The first transformation is the recognition that a particular experience has been injurious, and this is called *naming*.[15] The naming of injuries is the hardest part of the process to study empirically, but the prevalence of naming is mirrored by the culture of litigiousness that I described in Chapter 2. The next transformation is *blaming*, which occurs when a person turns a perceived injury into a grievance by attributing it to the fault of another individual (or social entity).[16] A grievance is specifically a complaint against someone or something, rather than a general complaint against no one in particular. The injured person must also believe that something should be done in response to the injury. Blaming is the most indicative transformation because, on average, a person who blames another for an injury is 4.4 times more likely to sue than one who does not place blame.[17] The final transformation, *claiming* occurs when someone with a grievance voices it to the person believed to be responsible and asks for a remedy.[18] The grievance will evolve into a dispute if it is rejected,

14. William L.F. Felstiner, Richard L. Abel, and Austin Sarat, "The Emergence and Transformation of Disputes: Naming, Blaming, Claiming …" *Law and Society Review* 15 (1980-1981): 632.
15. Ibid., 635.
16. Ibid.
17. Frederick C. Dunbar and Faten Sabry, "The Propensity to Sue: Why Do People Seek Legal Actions?" *Business Economics* 42, no. 2 (2007): 37.
18. Felstiner, Abel, and Sarat, "Disputes," 635.

either in whole or in part, through delay, partial rejection or outright refusal.[19] The path from an adverse medical experience to a dispute with a doctor thus requires three distinct transformations in the perception of the patient as well as the rejection of the patient's claim by the doctor.

The movement from injury into legal action can be waylaid at any point if individuals do complete any one transformation along this path, and the seeking of legal advice is only one option faced by injured patients.[20] Some individuals will choose to lump it and do nothing about their injury. Others will exit the situation by changing doctors and therefore avoid the problem. Furthermore, when individuals reach the claiming transformation, they may choose to confront their doctor directly, to complain to a non-legal third party forum (such as a hospital review board), or to go to a lawyer for advice.

The decision to seek legal advice can be influenced by an individual's audience, the people to whom the patient turns to tell his or her story, to seek advice, and to formulate a response to the experience. The audience may consist of family, friends, other acquaintances, or more knowledgeable people, and the conversation with the audience is primarily casual.[21] Audiences serve as "brokers" or "middlemen" by helping patients define and process the transformations from experience to legal dispute.[22] They may discourage complaints and convince a patient that there is no real grievance or that nothing can be done about it. On the contrary, they may persuade the patient to voice a complaint in a legal or non-legal forum.

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19. Ibid., 636.
20. Marlynn L. May and Daniel B. Stengel, "Who Sues Their Doctors? How Patients Handle Medical Grievances," *Law and Society Review* 24 (1990): 107.
21. Ibid., 108.
22. Jack Ladinsky and Charles Susmilch, "Community Factors in the Brokerage of Consumer Products and Service Problems," in *The Challenge of Coscial Control: Citizenship and Institution Building in Modern Society*, eds. Gerald D. Suttles and Mayer N. Zald (Norwood, NJ: Ablex Publishing, 1985), 193-217.

Those who ultimately seek legal advice make active use of audiences, while audiences have less influence on those who take informal action.[23]

If individuals do seek legal advice, they must make a choice about whether ultimately to pursue a lawsuit. A simple economic model shows how a plaintiff would rationally make this decision in a situation where all other factors were equal. In our American legal system, in which each party is responsible for his or her own legal costs, the plaintiff will bring suit if and only if the expected judgment would be at least as large as the legal costs.[24] The parties in this model are risk-neutral, meaning they base their decision on the expected value of the verdict (the amount of damages multiplied by the probability of winning the case). However, the model can be adjusted to consider risk-averse parties, who value a scenario with a lower but more certain expected value more than one with a higher but less probable expected value. Factoring in risk aversion would reduce a plaintiff's willingness to bring suit because going to trial involves uncertainty.[25]

Risk aversion, however, explains only a small portion of the extremely low rate of claims (1 claim for every 7.6 negligent events), suggesting that preferences other than simply maximizing the expected value of compensation are part of the lawsuit-filing equation. The basic economics also do not explain the mismatch of poor fit—why patients who are not injured by negligence choose to file lawsuits. Determining the source of poor fit, or even explaining legal disputes in general, is difficult because the path from injury to legal action is far more complicated than these simple models suggest. Injurious behaviors are often ambiguous; norms and standards of care are uncertain for patients; memories, especially of traumatic events, are

23. May and Stengel, "Who Sues," 108.
24. Steven Shavell, "Suit, Settlement, and Trial: A Theoretical Analysis under Alternative Methods for the Allocation of Legal Costs," *Journal of Legal Studies* 11 (1982): 58.
25. Ibid., 61.

faulty and emotions change; the parties involved may have conflicting objectives and values; and the entire legal system is complex, particularly for one-time players.[26] Therefore, a fuller equation for a patient's decision to pursue legal action will be a function of not only the economic impact (income loss, legal expenses, etc.) and the potential compensation but also the patient's level of anger and the patient's general reluctance to sue.[27] A patient will seek legal action if the sum of the economic impact, potential compensation, and anger exceed any reluctance to sue.[28]

The economic impact and potential compensation for an injury may be difficult for patients to estimate, but one factor that patients take into account is the severity of the injury. More severe injuries likely create a larger economic burden on patients and prompt larger awards from juries. Therefore, patients are more likely to seek legal counsel and to sue if their injuries are more serious, regardless of whether the injuries were caused by negligence.[29] One group of researchers used a household survey and interviews conducted by the RAND Institute about injuries. They found that the severity of injury, as measured by either perceived or actual damage sustained during an accident, was positively related to the claiming rate.[30] The predicted claiming rate is 35% for serious injuries (life-threatening or long-term), but only 16% for moderate injuries and 12% for minor injuries.[31] Similarly, measuring severity of injury in terms of days of work missed was also positively related to the claim rate.[32] Severity of injury, while certainly important to the victim of an injury, may be entirely unrelated to whether the injury was negligently caused. Thus, patients with less severe but negligent injuries may not pursue legal

26. Felstiner, Abel, and Sarat, "Disputes," 638.
27. Penchansky and Macnee, "Initiation," 816.
28. Ibid.
29. May and Stengel, "Who Sues," 117.
30. Dunbar and Sabry, "Propensity," 37.
31. Ibid.
32. Ibid.

action, while those with more severe injuries not caused by negligence may inappropriately file lawsuits. This may explain some of the mismatch between incidents of negligence and actual claims filed.

The other two variables in the patient decision to pursue legal action, anger and reluctance to sue, are even less predictable than the economic impact and potential compensation because they are dependent on the individual characteristics of a given doctor-patient relationship and on the idiosyncrasies of the legal system. Changes in these elements may make patients more or less willing to sue, regardless of the presence of negligence, leading to the poor fit phenomenon. Because these factors are not dependent on negligence in a case, they detract from the ability of lawsuits to deter doctors from committing future negligence.

Patient and Physician Characteristics and Relationships

There are several factors that may affect patients' level of anger or reluctance to sue and thus the likelihood that they will file a lawsuit. These include individual patient characteristics, such as income and social status, or individual physician characteristics, such as country of origin. However, one of the largest determinants of patients' willingness to sue is the quality of the doctor-patient relationship both before and after adverse events. This large impact of how patients perceive physician behavior also warrants a brief examination of disclosure programs and their impact on patients' willingness to take a dispute to court.

When considering the characteristics of individual patients, there are interacting effects of income and social status that make patients more or less likely to sue independent of a negligent injury. Generally, low-income, working class individuals are less likely to file suits. Lower income would seem to suggest that the economic impact of a medical injury and the utility value of potential compensation would be greater, but the effect of income level is more complex.

Financial issues *are* important to patients who are considering lawsuits. One analysis of approximately 500 prospective client phone calls to two malpractice law firms found that 48% of potential plaintiffs specifically mentioned difficulties with finances in their complaint.[33] Furthermore, 45% of the potential plaintiffs with earned income had outstanding medical bills, one third of which were 50% or more of the individual's earned income.[34] Even more of the potential plaintiffs without earned income (66%) had outstanding medical bills.[35] However, the odds that a plaintiff was poor in the HMPS were only 1 in 5.[36] Likewise, the researchers in the Utah and Colorado study found that those who *did not* file claims were 6.3 times more likely to be low-income earners than those who did.[37] Low income only seems to increase the likelihood of suing if a plaintiff is unemployed. The study of phone calls to law firms found that the unemployment rate for potential plaintiffs was more than three times that for the general population in the area.[38] Another study compared 200 patients who filed a malpractice or negligence claim against a large urban teaching hospital and its physicians with a random sample of 549 patients who had never filed a claim against the hospital. In proportion to their representation in the control group, blue-collar workers brought far fewer claims than either white-collar or retired/unemployed workers.[39] While this study considered employment status rather than income level, it suggests similarly that low-income earners (as opposed to those with no earned income) are much less likely to bring suit against a doctor.

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33. LaRae I. Huycke and Mark M. Huycke, "Characteristics of Potential Plaintiffs in Malpractice Litigation," *Annals of Internal Medicine* 120 (1994): 792-798.
34. Ibid.
35. Ibid.
36. Helen R. Burstin, et al., "Do the Poor Sue More? A Case-Control Study of Malpractice Claims and Socioeconomic Status," *Journal of the American Medical Association* 270 (1993): 1697.
37. Studdert, et al., "Negligent Care."
38. Huycke and Huycke, "Characteristics."
39. Edmund G. Doherty and Carol O. Haven, "Medical Malpractice and Negligence: Sociodemographic Characteristics of Claimants and Nonclaimants," *Journal of the American Medical Association* 238 (1977): 1656.

Other socially marginalized groups, including the elderly and minorities, are also reluctant to sue. The HMPS researchers found that the elderly were 5 times less likely to sue than others.[40] Another study surveyed trial attorneys about their perceptions of the effects of various characteristics on patients' willingness to sue. Among the responses, the aged were perceived to have a high unwillingness to sue.[41] This pattern among the elderly may reflect a judgment that the potential compensation for an elderly individual is lower than for a younger person, but it also reveals a definite reluctance to sue on the part of the elderly. The same study found that minorities and foreign-born patients were also perceived as slightly unwilling to sue.[42] The study of claims against the teaching hospital indicated that whites filed significantly more claims than nonwhites, suggesting a reluctance to sue among minorities.[43]

All three of these populations (low-income earners, the elderly, and minorities) have a low social status, which may increase their reluctance to sue. Status is particularly important when considering medical malpractice lawsuits because the professional/client status differential has great significance in doctor-patient relationships.[44] The wide availability to patients of medical information in print and online sources has made patients more knowledgeable partners in their interactions with doctors, and patients' rights have come to the forefront of healthcare debate since the middle of the twentieth century. However, patients, especially those in traditionally low-status social groups, do still relate to their doctors as authority figures.[45] Importantly, patients with less knowledge about the work of health and legal professionals are

40. Burstin, et al., "Poor Sue More," 1697.
41. Penchansky and Macnee, "Initiation," 826.
42. Ibid.
43. Doherty and Haven, "Medical Malpractice," 1656.
44. May and Stengel, "Who Sues," 114.
45. Tom Delbanco and Sigall K. Bell, "Guilty, Afraid, and Alone – Struggling with Medical Error," *New England Journal of Medicine* 357 (2007): 1682.

less likely to sue.[46] The members of low-status populations are often more accepting of authority, less adversarial, and less secure in using the legal system.[47] Therefore, patients in these groups will be less likely to file suit, regardless of the presence of negligence, and this accounts for some of the gap portion of poor fit.

The characteristics of the doctor involved in a dispute can also influence a patient's willingness to sue. Traits such as age, sex, education, or country of origin are important because these are how patients judge a doctor's "worthiness" or "merit."[48] The survey of attorneys' perceptions found that patients were more willing to file suit in cases where the physician was born or trained in a non-English speaking country.[49] Patients were also slightly more willing to sue doctors who were specialists or seen on referral, doctors lacking board certification, and doctors practicing as salaried employees.[50] All of these characteristics suggest that patients are more willing to sue doctors with whom they are unfamiliar, either culturally or professionally, regardless of the presence of negligence.

Familiarity is an important component of the doctor-patient relationship, and the quality of this relationship is an important determinant of both the patient's willingness to sue and the patient's relative level of anger after an adverse event. Patients' evaluations of doctors typically consist of two general components: communication and behavior. These both must be *very* satisfactory in the case of unfamiliar doctors in order to prevent a strong negative response when an adverse event occurs.[51] There is ample evidence to demonstrate the importance of these components both before and after an adverse event.

46. May and Stengel, "Who Sues," 117.
47. Penchansky and Macnee, "Initiation," 816.
48. Ibid.
49. Ibid., 827.
50. Ibid.
51. Ibid., 816.

The behavior and communication patterns of doctors *prior* to adverse events determine whether patients evaluate experiences as grievances and whether they ultimately pursue legal action. A study of four patient focus groups in Colorado revealed that the perceived level of communication between patients and health care providers determined whether patients continued those relationships and whether they defined an event as a "mistake" or as "malpractice."[52] The analysis of phone calls made to law firms found that 53% of potential plaintiffs complained, often angrily, of a poor relationship with their health care provider prior to the adverse event.[53] Patients who more negatively evaluate a doctor's behavior (i.e. competence) or who feel that their doctors do not show personal concern for them, even before a grievance develops, are more likely to pursue legal action.[54] Similarly, the survey of attorneys showed that the variables that significantly reduced patients' willingness to sue were based on the prior doctor-patient relationship and good communication.[55] Another study that examined the patient records of over 600 physicians over several years in the 1990s found that the risk of lawsuit was directly related to patients' level of dissatisfaction with their physicians' ability to establish rapport, provide easy access, and communicate effectively.[56] Finally, a group of obstetric patients surveyed about their response to a hypothetical adverse event scenario showed increased perceptions of competence, decreased perceptions of physician responsibility for the adverse outcome, and fewer expressed intentions to file malpractice claims because of positive doctor-patient relations.[57]

52. Christine W. Duclos, et al., "Patient Perspectives of Patient-Provider Communication After Adverse Events," *International Journal for Quality in Health Care* 17 (2005): 483.
53. Huycke and Huycke, "Characteristics."
54. May and Stengel, "Who Sues," 116.
55. Penchansky and Macnee, "Initiation," 828.
56. Gerald B. Hickson, et al., "Patient Complaints and Malpractice Risk," *Journal of the American Medical Association* 287 (2002): 2951.
57. Philip J. Moore, Nancy E. Adler, and Patricia A. Robertson, "Medical Malpractice: The Effect of Doctor-Patient Relations on Medical Patient Perceptions and Malpractice Intentions," *West Journal of Medicine* 173 (2000): 248.

After an adverse event occurs, whether or not it was caused by negligence, the level and quality of communication becomes especially important in determining a patient's willingness to sue, and disclosure programs may be able to impact whether a patient chooses to file suit. A survey of over 200 patients who had chosen to pursue legal action revealed frequent complaints about a lack of clear, sympathetic explanations by doctors and a corresponding lack of recognition of the importance of patients' emotional needs apart from their physical needs.[58] The patients in the survey tended to blame their doctors more for the lack of openness or willingness to explain than for the original mistakes.[59] Another study, using 13 patient-physician focus groups in St. Louis, found that patients believed that the way an error was disclosed to them directly affected their emotional experience and that they would be less upset if the physician disclosed the error honestly and compassionately.[60] The physicians in the focus groups, however, reported feeling the need to choose their words carefully when discussing errors with patients.[61] Hospitals, insurers, and attorneys frequently advise physicians to avoid trigger words such as "error," "harm," "fault," or "mistake" when talking to patients, but patients often then perceive their doctors as impersonal or uncaring.[62] These surveys reveal that patients' level of anger may increase and their reluctance to sue may decrease if they do not feel their doctors are communicating clearly and compassionately. This makes patients more likely to take a case to trial regardless of the presence of negligence, accounting for the mismatch portion of poor fit.

58. Charles Vincent and Magi Young. "Why Do People Sue Doctors? A Study of Patients and Relatives Taking Legal Action," *Lancet* 343 (1994): 1609-1613.
59. Ibid.
60. Thomas H. Gallagher, et al., "Patients' and Physicians' Attitudes Regarding the Disclosure of Medical Errors," *Journal of the American Medical Association* 289 (2003): 1001-1007.
61. Ibid.
62. Delbanco and Bell, "Guilty," 1682.

This discussion of communication following adverse events leads naturally to a brief discussion of disclosure policies. Health care providers (and their liability insurance companies) use disclosure as a risk management tool in the belief that at least some patients who would have sued their doctors will not do so if they receive an early and candid explanation of the event.[63] They will come to understand that their injuries were not caused by negligence, will feel less angry with their doctors, or some combination of the two.[64] One of the best-known disclosure programs is the "3Rs" program at COPIC, a liability insurer directed by physicians in Colorado.[65] The program links improved doctor-patient communication with up to $30,000 in compensation. It is "no-fault" in that it does not tie compensation to negligence, and it also does not preclude a patient's right to sue. As of 2007, the 3Rs had handled more than 3000 events, approximately one quarter of which received payments averaging $5400 each.[66] There were only 23 cases subsequently resulting in litigation; the patient had received 3Rs payment in only 7 of those cases, and only 2 resulted in additional tort payments.[67]

Although there seems to be some ability to limit some patients' willingness to sue through disclosure programs, they also run the risk of making other patients aware of their injuries and encouraging litigation that would not otherwise have occurred. The success of disclosure programs rests in the net impact of size and costs between these two effects.[68] A group of experts (physicians and lawyers) were asked to evaluate the data from the HMPS and the Utah and Colorado study to determine the potential effects of a disclosure program. They predicted that disclosure would on average deter 32% of patients from suing and prompt new

63. David M. Studdert, et al., "Disclosure of Medical Injury to Patients: An Improbable Risk Management Strategy," *Health Affairs* 26 (2007): 216.
64. Ibid.
65. Thomas H. Gallagher, David Studdert, and Wendy Levinson, "Disclosing Harmful Medical Errors to Patients," *New England Journal of Medicine* 356 (2007): 2716.
66. Ibid.
67. Ibid.
68. Ibid.

claims from 31% of patients.[69] However, among patients whose injuries were not due to negligence, the deterrent impact would be greater. Disclosure would deter 57% of patients from suing and prompt 17% of patients to file suit.[70] Based on these predictions, the researchers estimated a 95% chance that the total claim volume would increase.[71] Overall, then, disclosure programs do not seem to reduce patients' willingness to sue. However, such open communication does seem to reduce patients' level of anger, and so it may have some effect in our equation for likelihood of a case going to trial.

The Legal System

In addition to the characteristics of the parties involved in a malpractice suit, some attributes of the legal system itself may lead to poor fit. The official disclosure programs that I just examined have ambiguous effects, but the desire for such programs reveals another important explanation for the poor fit phenomenon: the asymmetrical information prior to a lawsuit. Because patients lack full information about their injury prior to the discovery process, they may inappropriately use the legal system. This is especially true because there is no other means than the courts for patients to obtain compensation, regardless of the presence of negligence. Additionally, poor fit may occur in the legal system because lawyers are generally the ultimate decision-makers when determining which cases will go to trial, and they may have different incentives and perspectives than patients.

The strong support among patients for full disclosure from doctors suggests that a large reason that many patients sue is to gather information and receive explanations for the adverse event they have experienced. The use of the court system to regulate medical malpractice has

69. Studdert, et al., "Disclosure," 219.
70. Ibid.
71. Ibid.

created a "catch 22," in which doctors do not have an incentive to disclose information about an adverse event to their patients because they fear being sued. However, this gives patients no way outside of court to assess whether their doctor was negligent. Patients often do not have access to other potential witnesses or to their own medical records, and they file lawsuits in order to gain information during the discovery process.[72] In this sense, poor fit (particularly the mismatch component) is not necessarily evidence of "frivolous" lawsuits, as many critics of the system allege, but rather a sorting process for legitimate claims because of asymmetrical information.[73]

One indication that asymmetrical information leads to poor fit is the high rate of dropped or settled cases. A study of approximately 1200 medical malpractice cases in North Carolina in the late 1980s and early 1990s found that 40% were dropped and approximately half were settled before trial.[74] These statistics are consistent with the notion that patients who have become more informed through the discovery process will drop their case if they find that negligence was unlikely or settle for compensation if they find that negligence was likely.[75] Cases are resolved earlier in the process the more certain parties are, one way or the other, about the likelihood of negligence.

If patients do not drop their cases or settle before trial, it is frequently because they still lack enough information to appropriately determine the expected value of a verdict, and these patients are largely unsuccessful in court. In a study of trial outcomes in California between

72. Struve, "Improving," 34.
73. Frank A. Sloan and Chee Ruey Hsieh, "Variability in Medical Malpractice Payments: Is the Compensation Fair?" *Law and Society Review* 24 (1990): 1001.
74. Neil Vidmar, *Medical Malpractice and the American Jury: Confronting the Myths About Jury Incompetence, Deep Pockets, and Outrageous Damage Awards* (Ann Arbor: University of Michigan Press, 1995).
75. Henry S. Farber and Michelle J. White, "Medical Malpractice: An Empirical Examination of the Litigation Process," *RAND Journal of Economics* 22 (1991): 200.

1985 and 1986, only 29.2% of judgments were for the plaintiff.[76] Prior to trial, 60.3% of cases had a zero settlement offer, and only 23.7% of those cases received awards at trial.[77] More recent statistics about the nation's 75 largest counties in 2001 also indicate only a 27% win rate for plaintiffs.[78] The low plaintiff success rate in medical malpractice cases reflects the fact that asymmetry of information increases the likelihood of going to trial.[79] Combined with the drop rate, these statistics suggest that a sizable majority (perhaps as high as two-thirds)[80] of malpractice claims turn out to be meritless, corroborating the notion of poor fit.

Patients have a further incentive to use the court system to evaluate their case because there are currently no other real means of obtaining compensation for injuries. There are some examples of local "no-fault" compensation funds, such as the 3Rs program previously mentioned as well as specific programs like Virginia's Birth-Related Neurological Injury Compensation Program, but these programs are limited. An expanded no-fault system would likely lead to faster and potentially more equitable compensation without the transaction costs of the legal system, potentially limiting some of the problems of poor fit.[81] However, it would not necessarily improve patient safety because it takes away the incentives to take appropriate care.

This entire chapter has assumed, in part for convenience, that patients are the primary decision-makers when choosing whether to pursue a lawsuit, but in reality, lawyers act as the gatekeepers for the legal system. Although plaintiffs can go to court sans counsel, this is rarely

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76. Samuel R. Gross and Kent D. Syverud, "Getting to No: A Study of Settlement Negotiations and the Selection of Cases for Trial," *Michigan Law Review* 90 (1991): 334.
77. Ibid.
78. U.S. Department of Justice, Bureau of Justice Statistics, *Medical Malpractice Trials and Verdicts in Large Counties, 2001*, by Thomas H. Cohen (Washington, DC: Office of Justice Programs, 2004).
79. Randall R. Bovbjerg, et al., "Juries and Justice: Are Malpractice and Other Personal Injuries Created Equal?" *Law and Contemporary Problems* 54 (1991): 11.
80. Paul C. Weiler, "Fixing the Tail: The Place of Malpractice in Health Care Reform," *Rutgers Law Review* 47 (1995): 1162.
81. David J. Becker and Daniel P. Kessler, "The Effects of the U.S. Malpractice System on the Cost and Quality of Care," in Sage and Kersh, *Medical Malpractice*, 92.

the case, largely because it requires an expert to navigate the complicated legal system.[82] This in itself may cause poor fit because the quality of legal representation among patients can vary and some lawyers are worse than others at estimating expected values of verdicts,[83] particularly if they have limited experience with malpractice cases.[84] The system also places patients at a disadvantage because the attorneys for doctors are typically retained by their liability insurance firm and are repeat players in the system.[85] Lawyers may make more economically rational decisions than patients when deciding whether to go to court, but they are also motivated by factors other than negligence, primarily the potential amount of damages.

Like patients, attorneys typically estimate the economic impact of injuries and the expected value of damages based on the severity of those injuries. Plaintiffs' attorneys typically operate on a contingency fee basis, meaning lawyers have a direct financial incentive to pursue cases that will result in large damage awards. In the same study that analyzed phone calls to law firms from potential plaintiffs, the researchers matched prospective calls with the attorneys' dispositions of cases. Small recoverable damages (less than $50,000) were cited as one of the primary reasons that attorneys rejected cases.[86] Ultimately the attorneys retained only 3.3% of the 730 calls initially received by the firms.[87] The effects of reforms in the legal system also demonstrate how attorneys are motivated by potential damages rather than actual negligence. A study on the rate of tort filings in 19 states from 1984 to 1990 found that caps on non-economic damages reduced the number of filings, while joint-and-several liability reforms (which potentially increase the amount of damages a plaintiff may collect) increased the number of

82. David M. Studdert, Michelle S. Mello, and Troyen A. Brennan, "Medical Malpractice," *New England Journal of Medicine* 350 (2004): 284.
83. Sloan and Hsieh, "Variability," 998.
84. Struve, "Improving," 34.
85. Gross and Syverud, "Getting to No," 349.
86. Huycke and Huycke, "Characteristics."
87. Ibid.

filings.[88] This is significant because potential damages are not necessarily an indicator of the presence of negligence, and this may account for some of the mismatch between actual negligence and actual claims.

The phenomenon of poor fit illustrates that lawsuits are ineffective vehicles for enacting patient safety policy because there are far fewer claims than negligent injuries and many of the claims involve injuries not caused by negligence. These two components of a gap and a mismatch in claims result from patients (and their lawyers) facing other incentives to sue or not to sue. Low-income or low-status patient groups are less likely to pursue lawsuits, indicating that a large group of patients are unrepresented in patient safety policy. The characteristics of doctors and their relationships with patients may increase patients' relative anger and willingness to sue regardless of whether the patients' injuries were caused by negligence. Both patients and their lawyers may evaluate their cases based on the severity of patients' injuries, which is unrelated to whether those injuries were caused by negligence, and they may also use lawsuits to evaluate cases in a world of asymmetrical information. All of these variables that are unrelated to negligence mean that cases reach the court system that will not ultimately improve patient safety, while other instances of actual negligence go unobserved. This shows that lawsuits, which patients use for individual compensation, are not necessarily an effective public policy tool.

88. Dunbar and Sabry, "Propensity," 34.

Chapter 4: The Unpredictability of Juries

I have shown that the dependence on individual initiative creates a poor fit between actual negligence and actual malpractice suits, making lawsuits an inefficient tool for policy. The deterrent signal of lawsuits is further distorted by the unpredictability of those cases that do make it to trial. Medical malpractice is typically tried by civil jury, and the jury is charged with determining a defendant's liability and the amount of damages that he or she will pay. However, I show that juries' decisions about liability are often inaccurate because they are influenced by extralegal factors, because there is error built into the court system, and because medical malpractice cases are legally and scientifically complex. Juries' decisions about damage awards are unguided by the legal system and are thus often based on very different methods of calculation. The result of inaccurate assessments of liability and widely varying damage awards is that jury verdicts are highly unpredictable, which distorts the ability of lawsuits to signal to doctors the appropriate level of care. Some evidence indicates that bench trials may be more accurate and less time-consuming, and therefore less costly, than jury trials. However, the inability of the justice system to send a deterrent signal through the jury trial suggests that lawsuits are not the best means to improve patient safety.

Why Juries?

This chapter focuses on jury trials as a basis for evaluating all medical malpractice lawsuits for both theoretical and practical reasons. The jury trial allows for the application of society's values and notions of justice. The extensive use of juries is, in modern society, a uniquely American phenomenon. England has greatly reduced its use of jury trials since the nineteenth century, and Canada uses them only sparingly and primarily in Ontario and British

Columbia.[1] Americans embedded the right to a trial by jury in the Constitution, however, and it reflects the democratic philosophy of "rule by the people" by allowing a group of lay citizens, rather than a single professional judge, to administer justice.[2] In the realm of tort law, juries lie at the intersection of substantive and procedural justice. They are responsible for effecting the goals of the tort system, which are to prevent harm (deterrence) and to distribute risk appropriately (compensation) while minimizing administrative costs and giving everyone his or her "day in court."[3] By determining liability and damages, juries make the theory of the law real for the parties involved in lawsuits. Thus juries are in one sense the physical embodiment of the expectations for justice that I discussed in Chapter 2.

The research and statistics on trial verdicts that I analyze here do apply only to those claims that actually go to trial. Out of the 50,000 to 60,000 malpractice claims raised annually, only approximately 30% reach a trial.[4] An older study of malpractice cases in Florida between 1985 and 1988 indicated that only 11.5% of claims were decided at verdict or on appeal. [5] Importantly for this chapter, however, research indicates that the cases that do go to trial are not a random sample of all cases. A study of all malpractice claims filed in North Carolina between 1984 and 1987 found that the cases that typically went to trial were "borderline" ones that involved questions of liability or unusual circumstances that might justify punitive damages.[6] Therefore, my analysis of how juries affect the deterrent signal of malpractice is based on only a

1. Marc Galanter, "The Civil Jury as Regulator of the Litigation Process, *University of Chicago Legal Forum* 1990 (1990): 202.
2. George L. Priest, "The Role of the Civil Jury in a System of Private Litigation," *University of Chicago Legal Forum* 1990 (1990): 167.
3. James K. Hammitt, Stephen J. Carroll, and Daniel A. Relles, "Tort Standards and Jury Decisions," *Journal of Legal Studies* 14 (1985): 751.
4. Michelle M. Mello and David M. Studdert, "The Medical Malpractice System: Structure and Performance," in Sage and Kersh, *Medical Malpractice*, 13.
5. Frank A. Sloan and Chee Ruey Hsieh, "Variability in Medical Malpractice Payments: Is the Compensation Fair?" *Law and Society Review* 24 (1990): 1005.
6. Thomas B. Metzloff, "Resolving Malpractice Disputes: Imaging the Jury's Shadow," *Law and Contemporary Problems* 54 (1991): 71.

small portion of malpractice cases, but these cases were the ones that determined the substance of the law.

While the small percentage of claims going to trial in itself might raise questions about the ability of lawsuits to effect widespread patient safety policy, jury verdicts indirectly determine plaintiffs' willingness to sue and lawyers' willingness to settle cases. Much of the research on the workings of the legal system rests on the premise that jury trials form the tip of a pyramid or iceberg and that the remainder of cases are settled "in the shadow" of expected jury trial outcomes.[7] As I showed in the previous chapter, patients who choose to sue base that decision at least partially on the verdict and damages that they expect to receive. Furthermore, especially in medical malpractice law, plaintiffs' attorneys operate on a contingency fee basis. They finance the costs of the trial upfront on the condition that they receive a percentage (typically 35%) of the award. Therefore, attorneys base their decisions to represent a client, as well as their decision to settle before trial and the amount of that settlement, on expected jury damage awards. Defense attorneys and the insurance companies that hire them also base their settlement decisions on expected jury verdicts. The effectiveness of jury trials, then, ultimately determines the behavior of potential plaintiffs and defendants at all stages of litigation or potential litigation.

In a medical malpractice trial, the jury determines whether a defendant medical professional or institution is liable for the harm suffered by a patient and, if so, the amount of damages to be paid. A doctor is found to be liable if he did not observe the standard of care of the average, prudent provider in the given circumstances. While the standard for liability is fairly straightforward, there is very little guidance provided to jurors on how to calculate

7. Randall R. Bovbjerg, Frank A. Sloan, Avi Dor, and Chee Ruey Hsieh, "Juries and Justice: Are Malpractice and Other Personal Injuries Created Equal?" *Law and Contemporary Problems* 54 (1991): 916; Galanter, "Civil Jury," 201.

damages. Jurors are simply instructed to make the winning plaintiff "whole" again, through a combination of economic and noneconomic compensatory damages. They are also instructed that punitive damages are warranted in the case of malicious or egregious harm. However, juries' evaluations of both liability and damages in malpractice cases are frequently inaccurate and therefore unpredictable. Here I examine the factors external to and within the legal system that foster this unpredictability and evaluate its impact on the deterrence function of lawsuits.

Liability

There are many factors that influence the decision-making process of jurors and that prevent an accurate assessment of a defendant's liability. Some of these factors can be termed "human nature." Jurors' background characteristics as well as their individual attitudes and beliefs influence to some extent their likelihood of finding a defendant liable. The psychology of how jurors process information also affects their decision-making process. Jurors are also influenced by the relative emotional appeal and persuasiveness of parties or their lawyers. Verdicts can depend on how adept each side is at making use of these behavioral and psychological traits. Finally, some factors that influence jurors are more inherent to the legal system. Medical malpractice cases are complex both legally and scientifically, often making determinations of liability hazy.

The selection of an impartial jury is a complicated process because the final verdict of a jury depends at least in some part on the characteristics and beliefs of the jurors. Jurors are selected from a pool of eligible citizens (typically compiled from the voter registration or driver records in the state) called the *venire*. They are then questioned both generally and individually by the judge or attorneys (depending on the rules of the precinct) during the *voir dire* for a particular trial. The lawyers for each side may make challenges for cause, claiming that a

particular juror has an individual conflict or bias in the case, or peremptory challenges, which require no explanation. During this stage of the trial, lawyers for each side attempt to construct a jury that they feel will rule in their favor, primarily based on the background characteristics and the perceived beliefs and values of the potential jurors.

Jurors' background characteristics can have an impact on whether or not a defendant will be found liable. A mock jury trial study of 1000 jury-pool members found that those who were minorities, had less education, had a lower income level, or were women were more likely to find a defendant liable. Background characteristics together accounted for only 5.4% of the variation in recommended verdicts,[8] but these results do indicate that the determination of negligence can be influenced by variables other than the facts of the case. These particular characteristics are important in medical malpractice trials in particular because of the contrast with the typical malpractice defendants. Doctors are highly educated and have higher incomes, and this may inspire a sense of status conflict between jurors and defendants, although this effect is more pronounced for damages than liability.

Jurors' pre-standing beliefs about the legal system also have an impact on their evaluation of liability. The same study found that those jurors who typically see plaintiffs in a more favorable light, who think it is legitimate to sue, or who think it is normally difficult to win a lawsuit, were more likely to find a defendant liable, although not to a large degree.[9] These characteristics suggest adherence to the cultural trend of litigiousness that I discussed in the previous chapter, but these statistics do not necessarily indicate the prevalence of these beliefs. Furthermore, the study only attained individual jurors' recommended verdicts rather than simulating the group setting of an actual trial. However, it does show that the specific

8. Shari Seidman Diamond, Michael J. Saks, and Stephan Landsman, "Juror Judgments About Liability and Damages: Sources of Variability and Ways to Increase Consistency," *DePaul Law Review* 48 (1998): 306.
9. Ibid., 309.

background and attitudinal characteristics of jurors on a panel can impact whether the defendant will be found liable. This reveals that findings of liability would not be consistent across all juries.

Cognitive psychology reveals other "human" elements that can affect juries' finding of liability, including information bias and the effect of vivid information. Jurors are presented with an expanse of information at trial, but their preexisting knowledge of a topic will strongly influence how they receive new information, often without their awareness. Jurors will be more biased towards facts that confirm what they already know or think and against facts that contradict their thoughts.[10] A slightly different effect occurs because of the presentation of vivid information, which is "concrete, sensory, and personally relevant information, [which] may have a disproportionate impact on beliefs and inferences."[11] Vivid information at a trial may include extreme testimony about how an injury was sustained or about the resulting consequences of an injury. The effect of this vivid information may make jurors more likely to find a defendant negligent if the damages are severe rather than mild. While severity of injury logically affects the amount of damages, it should have no impact on the liability of the defendant. Both of these psychological observations influence jurors without their realization and could result in different determinations of liability from the same evidence if presented in different formats.

Jurors can similarly be influenced by the relative sympathetic appeal of the parties in a case. A personally appealing or extraordinarily needy plaintiff may influence jurors' willingness to find a defendant liable, especially if they feel that the defendant can provide compensation,

10. Elizabeth F. Loftus and Lee Roy Beech, "Human Inference and Judgment: Is the Glass Half Empty or Half Full?" *Stanford Law Review* 34 (1982): 947.
11. Ibid., 946.

regardless of the defendant's actual culpability.[12] Savvy legal teams can make use of the sympathetic nature of juries by presenting witnesses that make a good impression.[13] The same study of mock jurors referenced above found that even jurors who expressed trust in the objectivity of experts were influenced more by an expert that was considered more appealing.[14] Jury verdicts can thus be manipulated with "personnel" changes in a legal team or line-up of witnesses. The combination of effects of personal characteristics, psychological traits, and emotional appeals suggests that findings of liability are not consistent across juries and are strongly affected by influences other than the facts of a case. This pattern distorts the deterrent signal of lawsuits.

While the factors identified so far create variation in verdicts because of specific juries or legal teams, there are also factors that are inherent to the legal system that can also affect jury verdicts. The adversarial legal system in the United States functions by placing parties in opposition to each other and allowing each to pursue his or her self-interest in a case. The judge in the adversarial system serves not as a fact-finding figure but as a mediator, and both judges and juries make their decisions based on which party has presented a more convincing case. In addition to making use of emotional or psychological appeals, the lawyers for the plaintiff and defense decide what information will even be presented in court. Therefore, juries may not make their decisions with the full information available. This creates an inherent probability of error in the legal system – both in finding liability where there is no negligence (Type I errors) and in

12. Edith Greene, "On Juries and Damage Awards: The Process of Decisionmaking," *Law and Contemporary Problems* 52 (1989): 233.
13. Randall R. Bovbjerg, Frank A. Sloan, and James F. Blumstein, "Valuing Life and Limb in Tort: Scheduling 'Pain and Suffering,'" *Northwestern University Law Review* 83 (1989): 36.
14. Diamond, Saks, and Landsman, "Juror Judgments," 310.

finding no liability where there is negligence (Type II errors).[15] Having error like this built into jury trials further precludes doctors from receiving a deterrent signal.

Medical malpractice cases are particularly susceptible to variation in jury verdicts because they are both legally and scientifically more complex than other cases. Auto injury cases are frequently used as the baseline for personal injury/negligence verdicts because they typically involve a single theory of liability. Malpractice cases, in contrast, often involve multiple theories of causation and liability because of the uncertainty of medical processes and treatments.[16] Additionally, medical malpractice cases involve complicated scientific and statistical evidence. One study found that 82% of judges indicated that they sat in at least one case they considered too complicated for the jury and that juries most frequently encountered difficulty with the medical testimony in personal injury cases.[17] The expert testimony in trials often involves explanations of complex medical procedures or statistics about the likelihood of a specific injury occurring. While experts who are trained to understand this information may interpret it one way, lay people often respond differently, especially to statistics.[18] Jurors are presented with information about human physiology and anatomy, the diagnosis and treatment of disease, and varying standards of care among physicians. Jurors may misunderstand how the standard of care should be determined and applied in a case when they are presented with conflicting expert testimony.[19] Therefore, jurors with no medical or scientific background must make decisions based on incomplete understanding or actual misunderstanding of the

15. Robert D. Cooter and Daniel L. Rubinfeld, "Economic Analysis of Legal Disputes and Their Resolution," *Journal of Economic Literature* 27 (1989): 1087.
16. Neil Vidmar, "Empirical Evidence on the Deep Pockets Hypothesis: Jury Awards for Pain and Suffering in Medical Malpractice Cases," *Duke Law Journal* 43 (1993): 232.
17. Jane Goodman, Edith Greene, and Elizabeth F. Loftus, "What Confuses Jurors in Complex Cases: Judges and Jurors Outline the Problem," *Trial* 21 (1985): 65.
18. Joe S. Cecil, Valerie P. Hans, and Elizabeth C. Wiggins, "Citizen Comprehension of Difficult Issues: Lessons from Civil Jury Trials," *American University Law Review* 40 (1991): 759.
19. Bryan A. Liang, "Assessing Medical Malpractice Jury Verdicts: A Case Study of an Anesthesiology Department," *Cornell Journal of Law and Public Policy* 7 (1997): 124.

circumstances of a case. The determination of liability in medical malpractice lawsuits, then, is highly uncertain because of their legal and scientific complexity, in addition to being influenced by numerous extralegal factors.

Damages

Establishing liability is only the first portion of the jury's duties, and plaintiffs prevail in approximately 30% of cases that go to trial.[20] Juries must also determine the amount of the damage award, and the average payout in 2003 was between $260,000 and $300,000.[21] Jury damage awards have been the subject of heated criticism in the public debate about malpractice because they are perceived to be exponentially growing, and this is blamed for increasing malpractice liability insurance premiums and increasing healthcare costs overall.[22] In reality, the pattern of jury awards is more like a two-tiered structure, with modest and relatively stable awards in most cases but large and growing awards in a small subset of cases (the ones that are widely publicized).[23]

Because the legal system provides no real guidance or conceptual rationale to jurors for the amount of damages, the decisions of juries in determining awards are even more variable than their decisions in determining liability. Jurors must create their own methods for calculating monetary amounts, and they often take extralegal factors into account. In compensatory damages, jury awards reflect vertical equity, meaning awards typically increase with severity of injury, but horizontal inequity, meaning there is wide variability among comparable injuries. Juries are even more haphazard when awarding noneconomic damages,

20. Mello and Studdert, "Medical Malpractice System," 13.
21. Ibid.
22. David M. Studdert, Michelle S. Mello, and Troyen A. Brennan, "Medical Malpractice," *New England Journal of Medicine* 350 (2004): 283-292.
23. Galanter, "Civil Jury," 217.

such as those for pain and suffering, and punitive damages. There are several theories about how juries arrive at damage amounts, and psychological studies also suggest that jurors are strongly influenced by any suggested awards or caps placed on damages.

Like the assessment of liability, the calculation of damages can be affected by the background characteristics of the jurors. In a study of 147 veniremen in Wake County (Raleigh), North Carolina, when asked to recommend damage amounts in several scenarios, those who were better educated tended to give smaller awards.[24] This suggests that higher-educated jury members either may empathize with higher-educated defendants or that they may take into account the larger cost imposed on all of society by larger damage awards for defendants. More importantly, however, this demonstrates variability among awards that has nothing to do with the facts of the case.

Since the law does not specify a formula even for calculating compensatory damages, jurors must choose which factors to take into account, and their calculations may be inaccurate if they lack important information. Jurors often do lack pertinent information, such as the cost of treating specific injuries.[25] They must base their calculations of damages on the information provided to them by the attorneys in the case. This can be one-sided if defendants' attorneys do not mention damages in their arguments for fear of implying an admission of liability. Jurors are forced to make complicated guesses about the future – "'How long will the pain last?'; 'How fully will the plaintiff recover?'; 'How much will the dollar be worth in the future?'; 'How valuable will this child's life be?' – knowing that plaintiffs and defendants will have widely diverging answers to these questions.[26] In a survey of jurors about the factors they considered in a hypothetical wrongful death suit, approximately 80% listed the decedent's age, 90% the

24. Vidmar, "Deep Pockets Hypothesis," 252.
25. Sloan and Hsieh, "Malpractice Payments," 998.
26. Greene, "Juries and Damage Awards," 227.

decedent's salary at time of death, and approximately 60% the decedent's potential work life.[27] Some jurors also took into consideration the impact of inflation or the attorney's fees incurred during the lawsuit. These so-called "silent" damages (another is the income taxes paid on damage awards) are mentioned nowhere in the jury instructions but may factor into jurors' calculations. While some or all of these factors may be worthy of inclusion in damage estimates, the lack of guidance provided by the courts means that the considered factors vary in any given case or with any given jury.

One factor that seems to consistently predict the amount of jury awards is the severity of the injury, implying a high degree of "vertical" equity in awards. A study of jury findings in Florida and Kansas City between 1973 and 1987 found that severity of injury (as measured on the nine-point scale conventionally used in malpractice insurance cases) explained about two-fifths of the variation in damage awards.[28] This implies that the fairness between separate degrees of injury is good. However, jury awards remain unpredictable because of "horizontal" inequity.[29] Although the mean and median in each category in the Florida/Kansas City study were reasonable, the variation within each category seemed uncontrolled – "similar to anxiety about drowning in a pool *averaging* only two feet in depth."[30] Despite the relative correspondence of awards to injury levels, there is wide variability in awards for very similar injuries.

Much of the variability in total award amounts results from the awarding of noneconomic damages (pain and suffering) and/or punitive damages. Jurors, who are one-time players in the

27. Ibid., 237.
28. Bovbjerg et al., "Valuing Life and Limb," 918, 923.
29. Michael J. Saks et al., "Reducing Variability in Civil Jury Awards," *Law and Human Behavior* 21 (1997): 243.
30. Bovbjerg et al., "Valuing Life and Limb," 924.

legal system, are unable to value these amorphous damages consistently over time.[31] The cognitive strategy that jurors use to attempt to assess punitive damages is to first judge the "egregiousness, reprehensibility, or punishability of the defendant's conduct," and then to translate that level into a dollar value.[32] This conversion of internal judgments into numerical levels can obviously lead to large, arbitrary differences among individuals, whose internal and external value scales do not necessarily align.[33] Additionally, punitive damages are meant both to punish the current action *and* to deter future similar harms. However, jurors tend to understand better and value more the punishment role of damages than the deterrent role. In one study of 174 jury-eligible adults in Reno, Nevada, jurors were 1.5 times more likely to identify punishment than deterrence as their motive.[34] This misunderstanding of the nature of punitive damages, in addition to the ambiguous nature of both punitive and noneconomic damages, naturally leads to widely varying awards among juries for substantially similar injuries.

Efforts to understand how juries do evaluate punitive damages have revealed three potential bases: the amount of the compensatory damages, the defendant's financial status, and/or the amount requested by the plaintiff in the *ad damnum*.[35] The use of some multiple of the compensatory damages was popular among the jurors in another study of mock-jurors in Reno. Some jurors multiplied the compensatory damages by two, and others used multipliers ranging from .5 to 3.[36] This strategy, while offering some degree of mathematical certainty, fails to reflect the true purpose of punitive damages, which should *not* correlate to the actual harm caused to the plaintiff but rather to the extent of the defendant's egregious behavior. This use of

31. Metzloff, "Resolving Malpractice Disputes," 44.
32. Reid Hastie, David A. Schkade, and John W. Payne, "Juror Judgments in Civil Cases: Effects of Plaintiff's Requests and Plaintiff's Identity on Punitive Damage Awards," *Law and Human Behavior* 23 (1999): 448.
33. Ibid., 449.
34. Ibid., 457.
35. Ibid., 463.
36. Ibid.

improvised formulae unrelated to the appropriate amount of punitive damages only increases the variability of damage awards.

The second theory – using a calculation based on the defendant's ability to pay – corresponds with what is called the "deep-pockets" hypothesis or alternatively the "wealth redistribution" hypothesis. The wealth redistribution hypothesis implies that juries take into account both a defendant's comparative wealth ("deep pockets") and a plaintiff's comparative poverty ("empty pockets") when establishing a monetary award.[37] There is some evidence to suggest that jury awards are influenced by the financial status of the defendant, including doctors. In the case of malpractice, jurors may levy larger damages against doctors both because doctors are heavily insured and wealthier than many other defendants but also because of the special level of trust that patients place in their doctors.[38] A study of over 9,000 cases closed in Cook County, Illinois, between 1960 and 1979 revealed that medical malpractice awards against doctors were almost 2.5 times as large as awards against other individuals in average case types, and awards against hospitals were 85% larger.[39] Again, these awards also impact parties' expectations and willingness to settle before trial. Inflated damage awards in jury trials thus have a trickle-down effect on the behavior of all potential plaintiffs and defendants.

Finally, the use of the amount requested by the plaintiff reflects a larger psychological pattern of anchoring awards to dollar amounts named during trials. This is relevant both in cases where plaintiffs request a specific amount and in many tort reform policies that include caps on economic and/or noneconomic damages. In social psychological theory, an anchor is a position, along a continuum of responses to a dilemma, that has been given context or a frame of

37. Ibid., 449.
38. Hammitt, Carroll, and Relles, "Tort Standards," 756.
39. Ibid., 754.

reference.[40] Assimilation is the movement of the individual's response toward the anchor.[41] In part this occurs because it reduces the burden of processing information and making a decision.[42] This is especially true when individuals have no preconceived frame of reference for the decision they are making.[43]

In the case of the *ad damnum* or of a damage cap, the monetary amount named acts as an anchor that will draw jury awards toward the given level, especially because jurors typically have no preconceived frame of reference for the appropriate amount of damages. One study requesting mock jurors to name a pain and suffering award resulted in a mean award of $100,000 for all jurors but a significantly higher mean award for those jurors who heard an *ad damnum* request of $250,000.[44] Likewise, in an interview portion of the University of Chicago Jury Project, jurors in six out of the seven personal injury cases in which the plaintiff prevailed reported that damages were determined at least in part with reference to the *ad damnum*.[45] The psychological phenomenon of anchoring indicates that the amount of damages awarded by juries will be highly variable because of its dependence on the amount named by the plaintiff during trial.

The concept of anchoring has important implications for tort reforms that include caps on economic or noneconomic damages because it demonstrates the importance of the actual amount of the cap. Several studies show how jurors' awards assimilate to caps, which serve as part of the context around which they formulate their decision about damages. In one study, the median total award in a hypothetical double wrongful death case was $37,500; with a cap of $2 million,

40. Verlin B. Hinsz and Kristin E. Indahl, "Assimilation to Anchors for Damage Awards in a Mock Civil Trial," *Journal of Applied Social Psychology* 25 (1995): 992; Saks et al., "Reducing Variability," 254
41. Hinsz and Indahl, "Assimilation to Anchors," 994.
42. Ibid., 1011.
43. Ibid., 1008.
44. Diamond, Saks, and Landsman, "Juror Judgments," 319.
45. Greene, "Juries and Damage Awards," 234.

the median award rose to $775,000; and with a cap of $20 million, the median rose to $1 million.[46] The caps in this case served as anchors that drew the jury's award upward from a much lower unanchored award. Damage caps ultimately may give windfalls to those with lesser injuries by drawing their awards upward, while potentially depriving those with serious injuries (the costs of which could exceed the cap) of full compensation.[47] Particularly with injuries of low or moderate severity, the study also found that caps increased the variability of awards.[48] Naming specific monetary amounts, either through plaintiff requests or through state-imposed damage caps, anchors jury awards to amounts that may be arbitrary and thus ultimately increases their size and variability.

Predictability and Implications

These observations on the many extralegal factors that influence juries' determinations of liability and damages are important ultimately not because they may be *inaccurate* but because they are *unpredictable*. The personal and psychological characteristics that make juries malleable and the intricacies of medicine and the law that make medical malpractice cases difficult to comprehend influence doctors' estimated liability in largely unpredictable ways. Moreover, the lack of guidance for juries in determining damages and their resulting use of improvised methods of calculation (particularly for noneconomic and punitive damages) have also meant that damage awards are highly unpredictable. When doctors and their insurance companies cannot accurately predict verdicts, the deterrent function of lawsuits fails. One result of this may be defensive medicine, the over- or under-provision of medical services due to doctors' fear of malpractice lawsuits. Other implications of the unpredictability of jury trials are

46. Saks et al., "Reducing Variability," 245.
47. Ibid.
48. Ibid., 253.

a lack of fairness, an erosion of confidence in justice, and increased expense of the entire malpractice system. Bench trials may superficially improve some of these deficiencies, but the problem is ultimately that lawsuits, a means of individual justice, are not the best tool for encouraging doctors to improve patient safety.

The inability of doctors and insurers to predict the outcome of jury trials, which are the flagship of the malpractice system, has been demonstrated in several studies. A North Carolina study comparing jury damage awards with insurance companies' pretrial predictions showed that awards were rarely within the companies' estimated ranges.[49] While sometimes awards were higher than expectations and other times they were lower, their predictability was severely questioned. Similarly, in a study of the anesthesiology department at a primary teaching hospital of Harvard Medical School, physicians were asked to evaluate a series of medical malpractice cases for medical errors and then to predict the jury's verdict in each cases.[50] The physicians predicted the verdicts correctly only 57% of the time, a statistically significant result. For cases in which the majority of physicians indicated that they could not tell whether there was medical negligence, the physicians correctly picked the actual jury verdicts only 55% of the time. Doctors' (and their insurance companies') ability to understand when juries will find them negligent (i.e. what the legal standard of care is) is necessary for the deterrent signal of lawsuits to function.

Predictability is, in fact, more important than accuracy for the effectiveness of deterrence because doctors must be able to change their behavior *before* errors occur. The standard of care establishes the level of patient safety that the community deems acceptable as that level of care at which the reasonably prudent physician acts. In order for lawsuits to encourage this level of

49. Metzloff, "Resolving Malpractice Disputes," 85.
50. Liang, "Malpractice Jury Verdicts," 129.

patient safety, both jurors and doctors must know and make use of the same standard of care when evaluating doctors' behavior. If physicians believe that some of the actions they deem medically appropriate will coincide with jury verdicts while others do not, they will not be able to determine what their actions should be in a given scenario, and, if they are risk-averse, they will overestimate the probability of being sued and found liable.[51]

Doctors who overestimate the likelihood of being sued will often practice defensive medicine, which exhibits as either assurance behaviors (taking too many costly precautions) or avoidance behaviors (withdrawal from risky activities). The over-provision of care results in higher costs both directly in paying for the additional services and indirectly by increasing patients' risk of additional iatrogenic injury.[52] The under-provision of care can harm patients when they are unable to access care.[53] Anecdotal evidence of defensive medicine during the insurance crisis of the 1980s included obstetricians reportedly refusing to deliver babies.[54] A study in Pennsylvania, a state known for its high malpractice liability insurance premiums, took a random sample of doctors in six high-risk specialties. In examples of assurance behaviors, 59% of the physicians reported often ordering more tests than were medically indicated; 52% reported often referring patients to other specialists in unnecessary circumstances; 33% reported often prescribing more medications than medically indicated, and 32% reported suggesting invasive procedures in clinically inappropriate circumstances.[55] Examples of avoidance behavior were that 32% of the doctors reported forgoing certain kinds of procedures and interventions, and 39% reported avoiding high-risk patients.[56] Additionally, about 4% reported that they would

51. Ibid., 144.
52. Ibid.
53. Ibid., 145.
54. Bovbjerg et al., "Juries and Justice," 925.
55. Troyen A. Brennan, Michelle M. Mello, and David M. Studdert, "Liability, Patient Safety, and Defensive Medicine: What Does the Future Hold?" in Sage and Kersh, *Medical Malpractice*, 105.
56. Ibid.

definitely relocate out of Pennsylvania because of professional liability insurance; 7% planned to retire early; and 43% had personally reduced or eliminated high-risk aspects of their practice.[57] Even if the results of this study are an overestimate or cannot be generalized to other parts of the country, they do reveal doctors' fear of the uncertainty of the medical malpractice system. Because lawsuits do not send a consistent signal about the standard of care to which doctors should conform their behavior, doctors are forced to guess and often guess inaccurately.

While the deterrent function of lawsuits is my primary focus in this thesis, there are other implications of fairness, justice, and cost that result from the unpredictable nature of jury trials. First, notions of fairness operate on an individual level in the justice system. While jury verdicts may exhibit vertical equity by reflecting severity of injury on average, the horizontal inequity that results in widely varying verdicts for similar injuries has large consequences for the individuals whose suits are valued so differently.[58] Corresponding to this sense of individual fairness in the court system is people's sense of justice in their larger society. When the courts are used to compensate monetarily individuals for injuries, the inequalities among verdicts are magnified by external players, such as insurance companies and medical providers.[59] Finally, the unpredictability of jury trials only exacerbates the high costs of the litigation system. Some estimates of the administrative costs of compensating medical malpractice victims through the court system are as high as fifty cents out of every dollar.[60] Lawsuits are initiated by individuals and tried individually, and therefore each case of medical malpractice involves new start-up costs. Furthermore, the more variable each side's expectations about a potential jury verdict, the

57. Ibid.
58. Bovbjerg et al., "Juries and Justice," 924.
59. Ibid.
60. Ibid., 925.

more likely they are to go to trial rather than to settle out of court.[61] More than twice the proportion (11% versus 5%) of medical malpractice suits go to trial than other types of personal injury cases, and this is largely due to the huge variations in jury awards that make it difficult for parties to find room for compromise and settlement.[62] Unpredictable jury awards also raise the costs of the healthcare system in general by raising malpractice liability insurance premiums.[63] Evidence indicates that physicians pass on the increase in their own insurance premiums by raising fee levels, essentially covering 100%+ of their own cost increase.[64] The unpredictable nature of jury trials thus has an effect on multiple aspects of the medical and legal systems, ultimately raising the costs of both systems.

Some of the problems created by jury trials could be resolved through the use of bench trials, which might increase predictability and lower costs. Having a judge rather than a jury decide medical malpractice trials could increase the predictability of verdicts by using a professional decision-maker, who sits continuously and whose opinions could have a more direct effect on future verdicts.[65] The increased predictability would encourage more out-of-court settlements, thereby lowering the administrative costs of the system. However, one study found that judges and juries agreed on liability in 79% of cases, suggesting that the improvements in predictability would be small.[66] The University of Chicago Jury Project also found (by controlling for the number of witnesses and by surveying trial judges and lawyers) that bench trials are on average 40% less time-consuming than jury trials.[67] This reduction in trial time would further reduce the administrative costs of the system. Finally, the social costs of the

61. Ibid., Sloan, and Blumstein, "Valuing Life and Limb," 11.
62. Paul C. Weiler, "Fixing the Tail: The Place of Malpractice in Health Care Reform," *Rutgers Law Review* 47 (1995): 1163.
63. Bovbjerg et al., "Juries and Justice," 926.
64. Mark V. Pauly, "Who Pays When Malpractice Premiums Rise?" in Sage and Kersh, *Medical Malpractice*, 77.
65. Priest, "Role of the Civil Jury," 199.
66. Galanter, "Civil Jury," 218.
67. Ibid.

system would decrease because judges typically assign lower damage awards than do juries. In a study of the tort dispositions in 24 metropolitan trial courts for one month in 1988, the median bench award was $8500 while the median jury award was $26,500.[68] This does reflect in some part a selection bias, but other studies have compared the hypothetical verdicts of judges and juries in the same cases. In the same study comparing judge and jury verdicts, jury awards averaged 20% higher than judges' awards, and in 52% of the cases in which the judge and jury agreed that the defendant was liable, the jury awarded more in damages.[69] The primary benefit of bench trials, then, is a streamlined version of the jury trial that slightly improves the predictability of verdicts.

Ultimately the ineffectiveness of the deterrent signal in medical malpractice lawsuits is a result of using an individual means of justice for public policy ends. Deterrence requires that determinations of liability and damages be predictable over time and space, but each medical malpractice trial is a new event. While some parties may be repeat players (such as judges and attorneys), each case involves new circumstances that are heard and evaluated by a new jury of lay citizens. This system is adequate, and even beneficial, for resolving disputes between individuals. However, it lacks the ability to send a consistent signal of the appropriate standard of care to which doctors will be held accountable.

68. Ibid.
69. Greene, "Juries and Damage Awards," 228.

Chapter 5: Conclusions

When an adverse event occurs – such as Dr. Thompson's decision to wait to intubate Mrs. Wilson – it is highly traumatic for the individuals involved. Mrs. Wilson's family was angry, afraid, and unsure about what had happened to their loved one. The wanted somebody to *pay for* what had happened – in terms of both financial compensation and retributive punishment. They filed a lawsuit against Dr. Thompson because they, as individuals, placed blame on another individual for the unique circumstances surrounding Mrs. Wilson's injury.

The courts are designed to deal with cases such as Mrs. Wilson's at the individual level. They in fact thrive off of the unique details of individual cases,[1] as the common law system operates by drawing parallels and making distinctions with past precedent. I have looked at medical malpractice litigation from a social perspective, however, through the lens of deterrence theory. Using liability to encourage doctors to improve patient safety ultimately turns the courts into policy-makers of sorts. This is a concept Robert Kagan refers to as "adversarial legalism," and which he defines as "policy-making, policy implementation, and dispute resolution by means of lawyer-dominated litigation."[2] I have used medical malpractice as a kind of case study for whether deterrence theory holds and, more generally, whether the courts are capable of effectively making policy. As a case study, it shows both the cultural rationale for using lawsuits for policy-making as well as the individualized nature of lawsuits, which make them poor implements of policy-making.

The historical development of medical malpractice litigation encapsulates the development of the larger culture of litigiousness in America. The nineteenth century saw a rise

1. Donald L. Horowitz, *The Courts and Social Policy* (Washington, DC: Brookings Institution, 1977), 33.
2. Robert A. Kagan, *Adversarial Legalism: The American Way of Law* (Cambridge, MA: Harvard University Press, 2001), 3.

in the number of medical malpractice lawsuits as it became increasingly acceptable to sue other people. One component of this litigiousness was a shift in the nature of American individualism. The Industrial Revolution brought urbanization and with it a decline in traditional communities. Although urbanization brings people within closer physical proximity, it increases the relational distance and makes people highly dependent on strangers. Dispute resolution with strangers required some sort of external arbitration, and people turned to the courts. Increased individualism also corresponded with a decreased respect for authority, which manifested in a greater willingness to challenge authority figures such as doctors. A second component of the increasingly litigious culture was increased expectations for justice. This was in part a new willingness to blame other people, a change from the former belief in divine providence. It also reflected the new ability of technology to control the environment, and in this regard, medical malpractice was a prime example. Science and technology opened up new possibilities for success in medicine, which increased people's expectations and thereby increased doctors' potential liability.

All of these cultural changes made people more willing to sue, which ultimately made the courts a viable option for policy-making. The combination of increased individualism and greater expectations for justice created a new role for the courts as the protectors of individual rights. In the realm of medical malpractice, this came about with the patients' rights movement, which mirrored the larger rights movements and consumer movement of the 1960s and 1970s. People turned to the courts to define and enforce these individual rights and thus acknowledged the role of the courts as policy-makers. This type of policy-making through litigation ("adversarial legalism") is in many ways uniquely American, and it reflects the tension in American political culture between a desire for government protection of individual rights and

distaste of large government structures. Individual rights were an important segue into the use of courts as policy-makers, however, because they emphasize the very individual nature of the courts.[3]

My case study of deterrence theory and medical malpractice emphasizes the individualized nature of the courts and demonstrates their weaknesses as policy-makers. The first relevant aspect of the legal system is that cases are individually initiated. Donald Horowitz calls this the "passivity of the judicial process," and he argues that it has two important consequences on policy-making.[4] First, even though the courts are the "policy-makers" in litigation, they must rely on the timing and whims of the individual litigants. Second, judicial policy-making becomes a "chance occurrence," with no guarantee that the cases that come before the courts are representative of the problem they purport to represent. This is the problem of extrapolating policy from the unique characteristics of individual cases. In medical malpractice, this is the problem of poor fit. This simultaneous gap and mismatch between actual negligence and actual claims shows how dependent patient safety policy is on the details of individual cases. The characteristics of patients and doctors and the quality of the doctor-patient relationship all change a patient's relative anger towards a doctor and his or her willingness to sue. Additionally, patients and their lawyers may base their decision to sue on the severity of the injury rather than the doctor's negligence, and they may use the legal system to be able to gather more information about the incident. All of these factors prevent medical malpractice lawsuits from sending a consistent signal to doctors about their likelihood of being sued or, through this, the appropriate level of care they should take.

3. Horowitz, *Courts and Social Policy*, 34.
4. Ibid., 38.

A second highly individualized aspect of the legal system is the unpredictable nature of jury trials. Juries are responsible for determining the liability and damages in the vast majority of medical malpractice cases that go to trial, and these cases in turn affect the decisions of other potential plaintiffs and defendants. When determining doctors' liability, juries are often influenced by their own background characteristics and by their preexisting beliefs about the circumstances in a case or the legal system in general. Additionally, basic human psychological traits, such as the relative emotional appeal of each party or the vividness of information presented, can sway jurors' opinions. Finally, medical malpractice trials require jurors to sort through complicated legal and medical information that they may not understand. When estimating damages, jurors must make calculations with no real guidelines from the court. Although awards reflect vertical equity (increasing as the severity of injury increases), they vary widely horizontally, making them largely unpredictable. Jurors' estimates of noneconomic damages may reflect the amount of economic damages or may reflect an amount named by the plaintiff or mentioned in a damage cap, demonstrating the psychological effect of anchoring. While bench trials may eliminate some of the unpredictability of jury trials, these effects are probably limited. This unpredictability can have huge effects on the costs of medical malpractice litigation as well as on its fairness and justice, and these effects all bring into question the effectiveness of policy implemented by the courts.

Both of the major problems that I identify with medical malpractice trials – the poor fit phenomenon and the unpredictability of juries – relate to the fact that lawsuits are tools for *individual* dispute resolution. The use of the courts as makers of policy about patient safety depends on deterrence theory. In order for deterrence theory to hold, doctors must receive a consistent signal about when they will be held liable so that they can maintain the appropriate

level of care. Consistency over time (i.e. predictability) is the key element here – it is what makes policy *public* rather than individual. Therefore, the very nature of the lawsuit makes it inappropriate for implementing policy on a large scale.

When combined with some of the theoretical or philosophical arguments against using the courts as policy-makers, this evidence presents a clear case against using the courts as policy-makers. One of the reasons that Americans turned to using the courts was an inherent opposition to unaccountable government authority. The judicial branch was created coequal to the other two branches as part of a system of checks and balances on the government's power. Americans have enshrined the notion of individual rights, both in the Bill of Rights in the Constitution and in a market economy that depends on the self-interested behaviors of individual actors.[5] In such a political system, however, there should be more fear of allowing the courts to incrementally create policy without any real check on its authority.[6] Americans have blurred the distinction between the responsibilities of the different branches of government by allowing litigation to serve as regulation.[7]

Some of the other methods for dealing with medical malpractice and regulating patient safety, although currently only local and voluntary, suggest better routes for public policy. First, patient safety change needs to happen at the systems level. Hospital review boards recognize this, and they compile data to learn what behavior changes can be accomplished from the top down. For example, until the mid-1980s, there were many intraoperative injuries and deaths caused when an oxygen tube bent and cut off oxygen supply to the brain. After operating rooms began installing alarms on the blood oxygen level monitor, the number of accidents dropped

5. Gerald N. Rosenberg, *The Hollow Hope: Can Courts Bring About Social Change?* (Chicago: University of Chicago Press, 1991), 2.
6. Horowitz, *Courts and Social Policy*, 35.
7. W. Kip Viscusi, *Regulation through Litigation* (Washington, DC: AEI-Brookings Joint Center for Regulatory Studies, 2002), 1.

threefold.[8] Changes such as this one can alter patterns of human behavior that typically lead to error and thereby increase patient safety without incorporating litigation. Policy relating to patient safety cannot ignore the consequences of errors that do occur, and there needs to be some sort of compensation for patients who suffer from adverse events. Although some of the no-fault compensation schemes that currently exist are not financially sound, they do show promise in limited capacities.

Ultimately, broad changes to the current system are not going to be politically feasible, at least in the short term. However, some things can be done to improve the problems of poor fit and unpredictable juries that I have addressed. Policies such as "I'm sorry" statutes or open-disclosure programs that allow for improved doctor-patient communication without necessarily placing doctors at greater risk of liability may reduce litigation or at least reduce some of the mismatch between actual negligence and claims. The mismatch could likewise be improved by implementing pretrial screening panels of experts. Within the legal system, some things could be done to reduce the unpredictability of trials by shifting away from jury trials. Although this may be politically unfeasible, courts could provide better guidance for juries when determining liability and negligence. Another option is court-appointed expert witnesses that could provide an opinion on the complex medical and legal scenarios without the bias of either party. All of these policy alternatives begin to address some of the problems with using the courts to improve patient safety, and they provide some starting points for further exploration of the topic.

The litigious culture in America has created a system in which we use individual court cases to try to implement policy on a grand scale. The very individual aspects of these cases, however, make them inappropriate for this purpose. In medical malpractice, this use of

8. John H. Eichhorn, "Prevention of Intraoperative Anesthesia Accidents and Related Severe Injury Through Safety Monitory," *Anesthesiology* 70 (1989): 572.

adversarial legalism creates policy that is unfair and inconsistent for both doctors and patients in situations that really are "life or death." The courts are not only inefficient, but they also act largely without accountability, and this makes the problems with their policies even more egregious. Medical malpractice exemplifies what *not* to do in public policy-making, and it is an issue that deserves change.

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