

UNCOVERING THE SILENT VICTIMS OF THE AMERICAN MEDICAL LIABILITY SYSTEM

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ABSTRACT

An often overlooked problem with the current medical liability system is the vast number of medical errors that go uncompensated. Although studies indicate that one percent of hospital patients are victims of medical negligence, fewer than two percent of these injured patients file claims. In this Article, I explain that many victims of medical malpractice do not file claims because they are unable to find attorneys willing to take their cases. I conduct the first national survey of attorneys that explores medical malpractice victims' access to the civil justice system. The results from the survey indicate that the economic reality of litigation forces many contingency fee attorneys to reject legitimate cases. In fact, over 75 percent of the attorneys in my survey indicate that they reject more than 90 percent of the cases that they screen. The attorneys explain that insufficient damages and high litigation expenses are their primary reasons for rejecting cases and that several tort reforms have reduced their willingness to accept cases. Moreover, the majority of the attorneys respond that they have threshold damage values, below which they will not even consider accepting a case. In fact, over half of the attorneys responded that, even for a case they are almost certain to win on the merits, they will not accept the case unless expected damages are at least \$250,000. For a case in which winning is less certain, most attorneys require minimum expected damages of \$500,000 to accept the case. Because of the high cost of medical malpractice litigation, contingency fee attorneys simply cannot economically justify taking cases with damages below these thresholds. To understand the extent of the access to justice problem I use private industry claims data to show that 95 percent of medical malpractice victims will find it extremely difficult to find legal representation unless their damages are significantly larger than the typical damages for their types of injuries. Thus, the medical liability system silences many legitimate victims of medical malpractice.

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INTRODUCTION

The public narrative of the American medical liability system suggests a system in crisis: frivolous lawsuits that deter doctors from performing valuable procedures, a scarcity of doctors in regions where the threat of liability is high, and pervasive defensive medicine that amplifies the overall cost of the healthcare system.² However, a routinely ignored detail is the large number of silent victims in the system—victims of medical negligence that never receive compensation for their injuries. According to the National

² For a discussion of the empirical evidence on the effect of liability on physician behavior, see Joanna Shepherd, *Tort Reforms' Winners and Losers: The Competing Effects of Care and Activity Levels*, 55 UCLA LAW REVIEW 905, 924-929 (2008).

Academy of Science's Institute of Medicine (IOM), medical errors are the leading cause of accidental death in the United States, taking the lives of "[a]t least 44,000 people, and perhaps as many as 98,000 people" each year.³ Studies on the number of injuries from medical negligence indicate that one percent of all hospital patients suffer adverse events due to medical error.⁴ Yet despite this high rate of medical negligence, fewer than 2 percent of the injured patients file claims.⁵

In this Article, I explain that many victims of medical malpractice do not file claims because they are unable to find attorneys willing to take their cases. Exorbitant litigation expenses and reforms that limit plaintiff damages have made contingent fee lawyers increasingly unwilling, and unable, to accept many legitimate medical malpractice claims. The attorneys simply cannot economically justify taking the claims because their expected recoveries will not offset the likely costs of litigating the claims. As a result, many legitimate victims of medical malpractice are left with no legal representation and no way to seek redress in the civil justice system.

I conduct the first national survey of medical malpractice attorneys that explores the problem of silent victims in the medical liability system. The results from the survey indicate that the economic reality of litigation forces many attorneys to reject legitimate cases. In fact, over 75 percent of the attorneys in my survey indicate that they reject more than 90 percent of the cases that they screen. The attorneys explain that insufficient damages and high litigation expenses are their primary reasons for rejecting cases and that several tort reforms have reduced their willingness to accept cases. Moreover, the majority of the attorneys respond that they have threshold damage values, below which they will not consider accepting a case. In fact, over half of the attorneys responded that, even for a case they are almost certain to win on the merits, they will not accept the case unless expected damages are at least \$250,000. For a case in which winning is less certain, most attorneys require minimum expected damages of \$500,000 to accept the case. Because of the high cost of medical malpractice litigation, plaintiffs' attorneys simply cannot economically justify taking cases with damages below these thresholds.

Thus, my survey provides evidence confirming that many legitimate victims of medical malpractice have no meaningful access to the civil justice system. Moreover, using a private industry claims dataset, I show that 95 percent of medical malpractice victims find it extremely difficult to find legal representation unless their damages are significantly larger than the typical damages for their types of injuries. Data also suggest that the problem of access to justice is worsening; half as many victims with low damage awards recovered in 2010 as they did twenty-five years earlier. A growing number of

³ INST. OF MED., REPORT BRIEF: TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM 1 (1999), available at <http://www.iom.edu/Object.File/Master/4/117/0.pdf>.

⁴ *Id.* at 247.

⁵ *Id.* at 248.

medical malpractice victims are being silenced by the economic realities of the medical liability system.

The Article proceeds as follows. In Part I, I explain the principal objectives of the medical liability system: to compensate patients that are injured by the negligence of medical providers and to deter those medical providers from practicing negligently. I discuss numerous empirical studies that suggest that the medical liability system performs poorly on both of these dimensions. Most victims of medical malpractice never receive compensation for their harm. The majority of victims never file a claim in the first place, and the victims that do file claims often receive inadequate compensation that does not reimburse all of their costs resulting from the malpractice. Moreover, delays in litigation and increasing litigation expenses further reduce the compensation to malpractice victims. Empirical evidence suggests that the lack of victim compensation has, in turn, reduced the deterrent effect by blunting incentives for the medical community to improve care. A significant body of empirical research examining the relationship between malpractice risk and health outcomes has generated only mixed results, and most studies have found no influence of malpractice pressure on physician behavior

In Part II, I discuss the history of tort victims' access to the civil justice system. Early American tort victims had limited access to legal representation because they were forced to pay attorneys' fees regardless of whether they won or lost a case, and few had the financial resources to do so. However, contingency fee arrangements evolved to ensure that all tort victims, regardless of their financial position, had access to legal representation in the civil justice system.

Yet, in the modern medical liability system, two factors have made contingent fee lawyers increasingly unwilling, and unable, to accept many legitimate claims. High litigation costs and tort reforms that restrict damage awards have made it economically infeasible for attorneys to take many medical malpractice cases. Plaintiffs' attorneys simply cannot justify taking cases that lack sufficient damages to warrant the litigation expense. As a result, most unrepresented victims will receive no compensation for their harms. Moreover, the economic calculus required by the contingency fee system causes attorneys to gravitate towards some types of medical malpractice cases and victims, and ignore others. Evidence shows that contingency fee attorneys disproportionately reject cases from lower-income groups such as females, the elderly, children, and racial minorities because their expected damage awards are lower.

In Part III, I discuss my national survey of medical malpractice plaintiffs' attorneys. The survey asks questions about the attorneys' experiences screening and rejecting cases and their primary reasons for rejecting the cases that they do. It asks various questions about the minimum amount of expected damages the attorneys require to accept cases with different likelihoods of winning on the merits. The survey inquires about the impact of various tort reforms on attorneys' willingness to accept cases. It also explores their typical legal expenses, clients' recoveries, and attorneys' fees in cases that close in settlements, trials, and dismissals. Finally, the survey asks a variety of questions to

establish that the attorneys and their firms are representative of the larger population of medical malpractice attorneys.

The results from my survey indicate that many attorneys are unwilling to represent legitimate victims of medical malpractice if they do not expect a sufficiently large recovery. The attorneys reject the vast majority of cases, and list economic factors as their main reason for rejecting cases. They indicate that tort reforms that reduce plaintiff recoveries have increased their rejections, and the majority indicate that they will not accept any case, even one they are almost certain to win, if expected damages are less than \$250,000.

In Part IV, I explore which victims are most likely to be silent victims in the medical liability system and how the access to justice problem has changed over time. Using a private industry dataset of claims and payments in the medical liability system from 1985-2010, I show that only the most severely injured victims will be able to easily find legal representation. In fact, my survey results imply that 95 percent of medical malpractice victims will find it extremely difficult to find legal representation unless their damages are significantly higher than the typical damages for their types of injuries. The data also reveal a worsening access to justice problem. Over the past 25 years, the number of victims recovering low damage awards has declined by half. Without legal representation, fewer and fewer of these victims receive compensation for their harms.

Thus, this Article establishes that the medical liability system has many silent victims; many legitimate victims of medical malpractice are unable to obtain legal representation and have no meaningful access to the civil justice system. Without legal representation, most of these victims will not receive compensation for the harm they suffer as a result of medical negligence. In turn, the medical liability system will fail to provide adequate precautionary incentives for healthcare providers. Without dramatic change, the access to justice problem will continue to hinder the medical liability system's ability to achieve its compensatory and deterrent functions.

I. U.S. MEDICAL LIABILITY SYSTEM: THEORY AND PRACTICE

In this section, I first briefly describe the primary functions of the medical liability system: deterrence and compensation. I then review the empirical research on whether the current system achieves these functions.

A. FUNCTIONS OF THE MEDICAL LIABILITY SYSTEM

Tort scholars have long focused on two main functions of the tort system: compensation and deterrence.⁶ The compensatory function of tort law aims to reimburse

⁶ John Goldberg, *Twentieth Century Tort Theory*, 91 GEO. L.J. 513 (2003). For a discussion of other proposed functions of tort law, such as enterprise liability and social justice, see Joseph H. King, Jr., *Pain and Suffering, Noneconomic Damages, and the Goals of Tort Law*, 57 SMU L. REV. 163, 180-201 (2004).

victims for their losses from tortuous acts, and to restore them to their pre-injury condition.⁷ In the same way, a primary goal of the medical liability system is to compensate victims of medical negligence for any harm they suffer as a result of the negligence. For example, the system aims to compel the surgeon who botches an operation to reimburse the victim for the additional medical bills, lost income resulting from time off work, pain and suffering that resulted from the surgeon's mistakes, and any other harm resulting from the medical negligence.

Tort law achieves its second main function—deterrence—by creating incentives that induce people to take precautions and avoid risky behavior.⁸ Similarly, the medical liability system aims to create incentives for medical providers to take precautions in order to reduce unnecessary risks associated with medical care.

Deterrence theories by scholars in law and economics assume that potential tortfeasors consider the costs and benefits of their actions before engaging in potentially risky behavior.⁹ For example, a surgeon who is deciding whether to perform a certain operation will consider, among other things, her potential liability if things go awry. If she decides to proceed with the operation, her potential liability will cause her to choose carefully the precautions that she will take during the operation—such as the number of assistants present and the amount of expensive tests to which the patient is subjected beforehand.

If changes in the liability system increase potential liability, and so increase the costs of engaging in dangerous activities, some potential tortfeasors may cease completely engaging in the activities, or they may reduce the number of high-risk procedures they

⁷ See, e.g., Daniel Shuman, *The Psychology of Compensation Law*, 43 U. KAN. L. REV. 39, 45 (1994) ("The commonly understood goal of tort compensation is to restore the injured to their preaccident condition, to make them whole."); Steven D. Smith, *The Critics and the "Crisis": A Reassessment of Current Conceptions of Tort Law*, 72 CORNELL L. REV. 765, 769 (1987) ("injured plaintiffs should receive an amount necessary to make them 'whole,' that is, to restore them to the position they would have occupied but for the defendant's tortious conduct"); DAN B. DOBBS, *THE LAW OF TORTS* 17 (2000) ("Compensation of injured persons is one of the generally accepted aims of tort law. Payment of compensation to injured persons is desirable. If a person has been wronged by a defendant, it is just that the defendant make compensation. Compensation is also socially desirable, for otherwise the uncompensated injured persons will represent further costs and problems for society.").

⁸ See, e.g., KENNETH S. ABRAHAM, *THE FORMS AND FUNCTIONS OF TORT LAW* 206 (2d ed. 2002); Shuman, *supra* note 7; Richard L. Abel, *Critique of Torts*, 37 U.C.L.A. L. REV. 785, 808 (1990) ("At least since Learned Hand offered his famous formula ..., judges lawyers, and legal scholars have argued that fear of liability will compel potential tortfeasors to engage in a cost-benefit analysis, taking just those safety precautions that cost less than the accidents they prevent."); PETER CANE, *ATIYAH'S ACCIDENTS, COMPENSATION AND THE LAW* 353, 361 (6th ed. 1999) (argues that deterrence is "one of the most important of the suggested functions of personal injuries compensation law").

⁹ Goldberg, *supra* note 6, at 545.

perform.¹⁰ For example, in response to increased liability, some OB/GYNs may reduce their number of high-risk deliveries, switch to a straight gynecology practice, or they may even leave the state.

Even if the increase in potential liability does not cause the potential tortfeasor to reduce or even cease the activity, she may respond by taking more precautions to reduce risks.¹¹ For example, she may more conscientiously keep current with the latest treatments or she may order more diagnostic tests.

Compensatory damages, as distinct from punitive damages, provide the crucial link between the compensatory and deterrent functions of tort law.¹² Although they are called “compensatory,” they can achieve both goals. First, they compensate the victim in order to return him to his pre-injury condition. Second, requiring the tortfeasor to pay the victim compensatory damages forces him to “internalize” the costs of his risky behavior and deters him from engaging in inappropriately risky activities. That is, because he expects to pay for the harm he imposes on others, the tortfeasor should consider the cost of that harm as he makes decisions about engaging in risky activities. The higher the expected compensatory damages he expects to pay, the greater the cost of engaging in the risky activity, and the more he will be deterred from engaging in the activity without proper precautions.¹³ Similarly, the possibility of compensatory damages in medical malpractice cases gives medical providers a financial incentive to internalize the harm they impose on patients and reduce the risks associated with medical care.

B. EMPIRICAL EVIDENCE ON THE FUNCTIONING OF THE MEDICAL LIABILITY SYSTEM

In theory, medical malpractice law should both provide compensation to injured patients and induce doctors and hospitals to take appropriate precautions against adverse medical events. In practice, however, the medical liability system performs poorly on both of these dimensions. In this section, I first present the existing evidence on how well victims of medical malpractice are compensated. Then, I discuss empirical studies that examine the medical liability system’s ability to deter adverse medical events.

¹⁰ Economists call such responses to increased liability “activity-level” responses. *See, e.g.*, ROBERT COOTER & THOMAS ULEN, *LAW & ECONOMICS* 323-28 (2004).

¹¹ Economists’ term for this is a “care-level” response. *Id.* at 368.

¹² *See id.* at 320-23.

¹³ For evidence of the tort system’s deterrent effect, *see* Gary T. Schwartz, *Reality and the Economic Analysis of Tort Law: Does Tort Law Really Deter?*, 42 *UCLA L. REV.* 377, 381–87 (1994); FRANK A. SLOAN, *DRINKERS, DRIVERS, AND BARTENDERS: BALANCING PRIVATE CHOICES AND PUBLIC ACCOUNTABILITY* (2000) (a study of the liability of bartenders for serving excessive liquor to patrons). Many other scholars doubt the effectiveness of the deterrent effect of tort liability. For a discussion, *see* King, *supra* note 6, at 188-192.

1. How Well Does the Medical Liability System Compensate Victims?

Many victims of medical malpractice never receive compensation for their harm. The majority of victims never file a claim in the first place, and the victims that do file claims often receive inadequate compensation that does not fully reimburse their harms resulting from the malpractice. Moreover, delays in litigation and increasing litigation expenses further reduce the compensation to malpractice victims.

Empirical evidence confirms that the vast majority of patients injured by medical error do not seek redress in the civil justice system. In 1990, the landmark Harvard Medical Practice Study analyzed the medical records and legal claims (when filed) of a random sample of 31,429 hospital patients in New York State.¹⁴ The researchers determined that one percent of all hospital patients suffer adverse events due to medical negligence.¹⁵ Yet despite this high rate of medical negligence, the researchers found that fewer than 2 percent of the injured patients file claims.¹⁶ More recent research largely mirrors these findings. A review of 14,700 medical records in Colorado and Utah also shows that one percent of hospital patients suffer adverse events that are the result of negligent acts or omissions in the care rendered.¹⁷ Of these victims, the data show that only 2.5 percent file a legal claim. In Part 2, I explain how victims' inability to find legal representation contributes to the low claim rate among legitimate victims of medical malpractice.

Moreover, the small proportion of malpractice victims that do file claims often go uncompensated. Empirical studies of malpractice lawsuits find that the compensation rate ranges from 32 percent to 89 percent to victims whom outside experts have determined to be legitimate victims of medical negligence.¹⁸ That is, even for plaintiffs where liability should be clear, only 32 to 89 percent of harm is reimbursed through malpractice lawsuits. Thus, even for the few malpractice victims that file claims, most claims go undercompensated.

Additionally, increasing litigation delays and legal fees undermine the compensatory function of the malpractice system. Awards for medical malpractice claimants are subject to lengthy delays which effectively reduce compensation as inflationary pressures

¹⁴ Russell Localio et al., *Relation between malpractice claims and adverse events due to negligence: results of the Harvard Medical Practice Study III*, 325 NEW ENGLAND J. MED. 245 (1991).

¹⁵ *Id.* at 247.

¹⁶ *Id.* at 248.

¹⁷ David Studdert et al., *Negligent care and malpractice claiming behavior in Utah and Colorado*, 38 MED. CARE 250, 255 (2000).

¹⁸ THEODORE EISENBERG, *THE EMPIRICAL EFFECTS OF TORT REFORM*, RESEARCH HANDBOOK ON THE ECONOMICS OF TORTS 12 (Jennifer Arlen ed., forthcoming 2012), available at <http://ssrn.com/abstract=2032740> (last visited Aug. 23, 2012).

reduce the value of damage awards. Research shows that, on average, it takes around four years to resolve a malpractice claim.¹⁹ Moreover, because of rising legal fees, tort victims generally retain only a portion of compensatory damage awards. Empirical studies show that for every dollar defendants and insurers pay to compensate medical malpractice victims, between \$.40 to \$.60 goes to the payment of litigation expenses and other transaction costs.²⁰ As a result, victims keep only 40 to 60 percent of their damage awards as compensation.

Thus, the existing empirical literature confirms that the current medical liability system is plagued by under-claiming, under-compensation, delay, and rising litigation costs. In Section II, I explore how the access to justice problem contributes to the malpractice system not achieving its compensatory goals.

2. *How Well Does the Medical Liability System Deter Adverse Events?*

Although the evidence indicates that only a small proportion of malpractice victims seek redress in the civil justice system, and an even smaller proportion are adequately compensated for their harms, tort liability remains a principal vehicle for holding healthcare providers accountable for medical errors. However, empirical evidence suggests that the lack of victim compensation has, in turn, blunted incentives for the medical community to improve care that the threat of a suit might otherwise provide.²¹ Moreover, malpractice insurance is not strongly experience-rated, so that doctors' premiums are not closely related to their claims history.²² As a result, the medical liability system provides little incentive for medical providers to take additional precautions to reduce the risk of adverse events. Indeed, a significant body of empirical research examining the relationship between malpractice risk and health outcomes has

¹⁹ TOMAS COHEN & KRISTEN A. HUGHES, MEDICAL MALPRACTICE INSURANCE CLAIMS IN SEVEN STATES, 2000–2004” NCJ 216339 (2007).

²⁰ PATRICIA M. DANZON, MEDICAL MALPRACTICE: THEORY, EVIDENCE, AND PUBLIC POLICY 187 (1985) (finding that for each dollar received by plaintiff, approximately \$.66 is spent by the parties on litigation, implying that plaintiffs' share of total expenditures is $\$1.00/\$1.66 = .60$); PETER HUBER, LIABILITY: THE LEGAL REVOLUTION AND ITS CONSEQUENCES 151 (1988) (claims that \$.60 cents of every dollar spent on malpractice liability insurance are absorbed by administrative and legal costs, implying that only \$.40 would be left for victims); David Studdert et al., *Claims, Errors, and Compensation Payments in Medical Malpractice Litigation*, 354 NEW ENGLAND J. MED. 2024 (2006) (for every dollar spent on compensation, 54 cents went to litigation expenses and other transaction costs).

²¹ Another explanation for the weak deterrent effect is that malpractice insurance is typically not strongly experience-rated, so that the premiums for that insurance do not reflect the records or practice styles of individual providers but more-general factors such as location and medical specialty. Frank A. Sloan, *Experience Rating: Does It Make Sense for Medical Malpractice Insurance?*, 80 AM. ECON. REV. 128 (1990).

²² Frank A. Sloan & Chee Ruey Hsieh, *Variability in Medical Malpractice Payments: Is the Compensation Fair?*, 24 LAW & SOC'Y REV. 997 (1990).

generated only mixed results, and most studies have found no influence of liability risk on physician behavior.

As physicians in obstetrics-gynecology are defendants in medical malpractice lawsuits at a higher rate than any other specialty,²³ the majority of empirical work has examined how these physicians respond to litigation risk. Several studies have explored the relationship between obstetrician's claims history or malpractice risk and cesarean rates to determine whether physicians prefer less risky procedures (cesareans over natural labor) when malpractice pressure is greater. The results are mixed. Some studies have found a positive correlation between cesarean rates and litigation risk,²⁴ but several others have found no relationship.²⁵ Another study found a small, short-lived increase in cesarean section rates following litigation, but rates eventually returned to the baseline level.²⁶ Thus, despite some evidence of a positive relationship, the evidence does not generally support a consistent association between liability pressure and cesarean rates. As a result, it is not clear that malpractice pressure has any influence on the behavior of obstetricians.

Other studies have examined the relationship between obstetrician's malpractice risk and actual health outcomes. Again, the results are mixed. One study found no relationship between malpractice risk and adverse birth outcomes.²⁷ However, other

²³ Studdert, *supra* note 20, at 2024.

²⁴ Stephen M. Rock, *Malpractice Premiums and Primary Cesarean Section Rates in New York and Illinois*, PUB. HEALTH REP. 103, 459–63(1988); A. Dale Tussing & Martha A. Wojtowycz, *Malpractice, Defensive Medicine, and Obstetric Behavior*, 35 MEDICAL CARE 172-191 (1997); A. Russell Localio et al., *Relationship Between Malpractice Claims and Cesarean Delivery*, J. OF AM. MED. ASS'N. 269, 366–73 (1993); Lisa Dubay et al., *The Impact of Malpractice Fears on Cesarean Section Rates*, 18 J. OF HEALTH ECON. 491–522 (1999).

²⁵ Laura-Mae Baldwin et al., *Defensive Medicine and Obstetrics*, 274 J. OF AM. MED. ASS'N., 1606–10 (1995); Beomsoo Kim, *The Impact of Malpractice Risk on the Use of Obstetrics Procedures*, J. OF L. STUDIES 36, 79–119 (2007); Gilbert W. Gimm, *The Impact of Malpractice Liability Claims on Obstetrical Practice Patterns*, HEALTH SERVICES RES. 45, 195–211 (2010); Darren Grant & McLayne Morgan McInnes, *Malpractice Experience and the Incidence of Cesarean Delivery: A Physician-Level Longitudinal Analysis*, INQUIRY 41, 170–88 (2004).

²⁶ David Dranove & Yasutora Watanabe, *Influence and Deterrence: How Obstetricians Respond to Litigation against Themselves and Their Colleagues*, 12 AM. LAW & ECON.REV. 69 (2010).

²⁷ Y. Tony Yang et al., *Does Tort Law Improve the Health of Newborns, or Miscarry? A Longitudinal Analysis of the Effect of Liability Pressure on Birth Outcomes*, J. OF EMPIRICAL LEGAL STUD. 9, 217–45 (2012).

studies have found that higher malpractice risk is associated with fewer preventable complications in labor and delivery²⁸ and a reduction in fetal deaths.²⁹

A few empirical studies have explored the influence of malpractice risk on health outcomes beyond obstetrics patients. Two widely-cited studies find that tort reforms that reduce malpractice risk are not associated with any change in the health outcomes of elderly heart patients.³⁰ Thus, in contrast to what theory would predict, higher malpractice risk does not improve outcomes and lower risk does not worsen outcomes. However, another study of elderly heart patients found conflicting results; this analysis found that increased malpractice risk is associated with improved mortality of these patients.³¹

Thus, the empirical evidence does not consistently show that the medical liability system provides incentives for appropriate care. The weakness of the deterrent signal can be at least partly attributed to the under-compensation of malpractice victims; when doctors do not expect to bear the full cost of harms caused by their negligence, they do not have sufficient incentives to take precautions that reduce the risk of harm.³² In the next section, I explore how limited access to legal representation exacerbates both the problem of under-compensation and under-deterrence inherent in the medical liability system.

II. ACCESS TO JUSTICE IN THE MEDICAL LIABILITY SYSTEM

In order for the malpractice system to provide compensation to victims and precautionary incentives for physicians, victims of medical negligence must be able to find legal representation. Contingency fee arrangements developed in the second half of the 19th century to enable tort victims to obtain legal representation that they could not otherwise afford to pay. Today, most medical malpractice claims are brought by lawyers

²⁸ Janet Currie & W. Bentley MacLeod, *First Do No Harm? Tort Reform and Birth Outcomes*, Q. J. ECON. 123, 795–830 (2008).

²⁹ Frank A. Sloan et al., *Effects of the Threat of Medical Malpractice Litigation and Other Factors on Birth Outcomes*, MED. CARE 33, 700–14 (1995); Jonathan Klick & Thomas Stratmann, *Does Medical Malpractice Reform Help States Retain Physicians and Does It Matter*, 36 J. LEGAL STUD. 121 (2007).

³⁰ Daniel Kessler & Mark McClellan, *Do Doctors Practice Defensive Medicine?*, 111 Q. J. ECON. 353 (1996); Daniel Kessler & Mark McClellan, *Malpractice Law and Health Care Reform: Optimal Liability Policy in an Era of Managed Care*, 84 JOURNAL OF PUBLIC ECONOMICS 175 (2002).

³¹ Praveen Dhankhar, *Effect of Medical Malpractice on Resource Use and Mortality of AMI Patients*, J. EMPIRICAL LEGAL STUD. 4, 163–83 (2007).

³² Daniel P. Kessler, *Evaluating the Medical liability system and Options for Reform*, 25 J. ECON. PERSP. 93, 95 (2011); EISENBERG, *supra* note 18, at 10.

working on a contingency fee basis. However, victims of medical negligence are finding it increasingly difficult to find contingency fee lawyers willing to take their cases. In this section, I discuss the historical background of tort victims' access to legal representation and the development of contingency fee arrangements. Then I explain the causes and consequences of the current access to justice problem.

A. ACCESS TO JUSTICE IN A HISTORICAL CONTEXT

Early American tort victims, including victims of medical malpractice, had limited "effective" access to legal representation in the civil justice system. Until the mid-19th century, lawyers were subject to statutory or judicial schemes regulating their compensation, and plaintiffs were required to pay the specified compensation, regardless of whether they won or lost in court.³³ Thus, although any citizen could "technically" retain legal counsel, few had the financial resources to pay for an attorney, regardless of the outcome of their case.³⁴ As a result, access to justice was effectively nonexistent for a large portion of Americans.³⁵

However, beginning with New York's enactment of the Field Code in 1848, statutes regulating lawyers' fees were repealed across the nation. Soon after the Field Code was revised to allow attorney compensation to be governed by contract, and "not restrained by law."³⁶

The precursors of the contingency fee were first seen in the mid-1800s when attorneys involved in collection matters agreed to receive as payment a percentage of the amount collected.³⁷ However, not until the Industrial Revolution produced victims of industrial accidents with legitimate claims but insufficient resources to pursue them did contingency fee contracts expand to other areas of law.³⁸ In the states that had not previously authorized contingency fee arrangements by statute, state supreme courts voiced support for such arrangements. By the end of the 19th century, most states had either judicially or legislatively sanctioned contingency fees.

³³ Lester Brickman, *Contingent Fees Without Contingencies: Hamlet Without the Prince of Denmark?* 37 UCLA L. REV. 29, 35 (1989).

³⁴ Peter Karsten, *Enabling the Poor to Have their Day in Court: The Sanctioning of Contingency Fee Contracts, a History to 1940*, 47 DEPAUL L. REV. 231, 243 (1998).

³⁵ *Id.*

³⁶ N.Y. Code of Remedial Justice Ch. 1, Tit. II, Art. 2, § 66 (1876); *see also* Brickman & Cunningham, *Nonrefundable Retainers: Impermissible Under Fiduciary, Statutory and Contract Law*, 57 FORDHAM L. REV. 149, 171-76 (1988).

³⁷ M. BLOOMFIELD, *AMERICAN LAWYERS IN A CHANGING SOCIETY 1776-1876*, at 277 (1976).

³⁸ Brickman, *supra* note 33, at 37.

The judicial supporters of contingency fees recognized that these arrangements were necessary to ensure that all tort victims, regardless of their financial position, had access to legal representation in the civil justice system. For example, Justice Samuel Harrington of the Delaware High Court sanctioned a contingency fee arrangement in 1840 proclaiming "The poor suitor may not have the present means of payment, and this policy [of voiding contingent fee contracts] may deprive him of counsel ... His rights are nothing unless he can have the means of enforcing them."³⁹

Similarly, New Hampshire's Chief Justice Samuel Bell offered the same rationale for endorsing contingency fees in 1862: "It is not uncommon that attorneys commence actions for poor people, and make advances of money necessary to the prosecution of the suit upon the credit of the cause. Thus a man in indigent circumstances is enabled to obtain justice in cases where, without such aid, he would be unable to enforce a just claim."⁴⁰ Missouri's Judge Robert Bakewell agreed in 1876: "Many a poor man with a just claim would find himself unable to prosecute his rights, could he make no arrangement to pay his advocate out of the proceeds of his suit ... If [such agreements] are immoral or illegal, there are perhaps few attorneys in active practice amongst us who have not been habitual violators of the laws."⁴¹

Thus, most states approved contingent fees because they were viewed as a financing device that enabled a client to assert and prosecute an otherwise unaffordable claim.⁴² Although most countries in the world still prohibit contingent fees,⁴³ today, all fifty U.S. states allow attorneys to enter into contingent fee contracts.⁴⁴

Plaintiffs' attorneys in medical malpractice cases work almost exclusively on a contingency fee basis.⁴⁵ As in other torts cases, contingency fees enable medical malpractice victims to obtain legal counsel that they could otherwise not afford. Because of the substantial cost of litigating medical malpractice cases, the only way that most victims can afford legal representation is to hire a lawyer on contingency. Attorneys

³⁹ *Bayard v. McLane*, 3 Del. (1 Harr.) 139, 207, 219-20 (1840).

⁴⁰ *Christie v. Sawyer*, 44 N.H. 298, 303 (1862) (quoting and paraphrasing *Shapley v. Bellows*, 4 N.H. 347, 355 (1808)).

⁴¹ *Duke v. Harper*, 2 Mo. App. 1, 10-11 (1876).

⁴² Brickman, *supra* note 33, at 43.

⁴³ Brickman, *supra* note 33, at 38.

⁴⁴ Dover, *Contingent Percentage Fees: An Economic Analysis*, 51 J. AIR L. & COM. 531, 535 (1986). Maine was the last state to eliminate barriers to contingent fees. See 1965 Me. Laws 333 (amending Me Rev. Stat. Ann. tit. 17, § 801 (repealed 1975)).

⁴⁵ Stephen Daniels & Joanne Martin, *The Texas Two-Step: Evidence on the Link Between Damage Caps and Access to the Civil Justice System*, 55 DEPAUL L. REV. 635, 647 (2006).

interviewed in previous studies of contingency fee practice have explained the necessity of contingent fee arrangements in medical malpractice cases:

Ninety percent of the people out there make their living, they pay for the kids to go to school, they pay to take care of their kids, they pay for their mortgage, they pay for their one or two cars, and at the end of the month, they may have \$ 100 left over if they're the lucky ones... And so, for someone to have the ability to go hire a lawyer on anything other than a contingency fee, you know, I think it's a fiction.⁴⁶

Another attorney explained that “The simple truth is at least 95 percent of our clients could not afford to pay the lawyer and could not finance the lawsuit. They just couldn't - at least 95 percent.”⁴⁷

Contingency fee arrangements developed to improve access to justice for the 95 percent. However, as I explain in the following sections, although contingency fees have reduced the disparity in access to legal representation between wealthy and poor plaintiffs, they have not eliminated the access to justice problem in the medical liability system.

B. CAUSES OF THE CURRENT ACCESS TO JUSTICE PROBLEM

In the modern medical liability system, two factors have made contingent fee lawyers increasingly unwilling, and unable, to accept many legitimate claims. High litigation costs and tort reforms that restrict damage awards have made it economically infeasible for attorneys to take many medical malpractice cases. As a result, many legitimate victims of medical malpractice are left with no way to seek redress in the civil justice system. In this section, I discuss how high litigation costs and tort reforms have created many silent victims in the medical liability system.

1. *Litigation costs*

Medical malpractice suits are very expensive to litigate. The American Bar Association has estimated that the cost of prosecuting a single case of medical malpractice ranges from a low of \$50,000 to a high of \$500,000: “every case require[s] hundreds of hours of work and a huge outlay of money to pay for the investigation evaluation by experts, deposition testimony, travel, etc.”⁴⁸

⁴⁶ *Id.* at 647.

⁴⁷ Stephen Daniels & Joanne Martin, *Plaintiffs Lawyers: Dealing with the Possible but not Certain*, 60 DEPAUL L. REV. 337, 347 (2011).

⁴⁸ AMERICAN BAR ASSOCIATION TORT TRIAL & INSURANCE PRACTICE SECTION, REPORT ON CONTINGENT FEES IN MEDICAL MALPRACTICE LITIGATION 30 (2004). *See also* Claire Osborn, *Many Lawyers Avoiding Malpractice Cases*, AUSTIN AM.-STATESMAN, June 14, 2004, at A1 (quoting Bill

Attorneys often assume, as a rule of thumb, that medical malpractice cases will cost at least \$100,000 to litigate: “you’re talking about \$100,000 that you’re gonna spend on technical expertise to write reports, to give depositions, you know, to explain the standard of care and how it’s been breached.”⁴⁹ Another attorney echoed that in medical malpractice litigation, “easily you can spend \$100,000 without blinking.”⁵⁰ In my own survey of medical malpractice plaintiffs’ attorneys described in the next section, attorneys responded that the average cost of taking a medical malpractice claim to trial was just under \$100,000.

Because of the high cost of medical malpractice investigation and litigation, contingency fee attorneys, who bring the majority of medical malpractice claims, cannot economically justify taking cases that lack sufficient damages to warrant the litigation expense. Under most contingency fee arrangements, the attorney agrees to pay the litigation costs if he loses the case. If he wins the case, the plaintiff pays out of his damage award both the litigation costs and the attorney’s contingency fee. The contingency fee is typically 33 percent to 40 percent of the award.⁵¹ Because attorneys bear the risk of paying the litigation costs if a case loses, contingency fee arrangements require attorneys to evaluate cases in terms of the risks and potential returns of the case.⁵² As a result, attorneys rationally reject cases that do not satisfy a sufficient risk/return tradeoff. As one attorney interviewed for my study noted: “med-mal litigation is the ‘sport of kings’ from an expense standpoint...the liability/damages mix must present sufficient strength in both measures to make economic sense.” Another attorney that participated in my survey explained that “the cake has to be worth the candle...I know if expenses will be high, I won’t take the case without the likelihood of a large recovery.”

Consider, for example, a medical malpractice case that is “cheap” to litigate, costing only \$50,000. An attorney with a standard 33 percent contingency fee rate would likely reject many cases with potential damages below \$150,000. Even with potential damages of \$150,000, the attorney is risking the same amount he stands to earn; he pays \$50,000 in litigation costs if he loses the case and he earns a \$50,000 contingency fee if he wins

Whitehurst, a prominent practitioner in Austin, Texas, as stating that “the cost of taking a medical malpractice suit to court can be up to \$ 450,000”).

⁴⁹ Stephen Daniels & Joanne Martin, “*The Juice Simply isn’t Worth the Squeeze in Those Cases Anymore: Damage Caps, ‘Hidden Victims,’ and the Declining Interest in Medical Malpractice Cases*,” AM. B. FOUND. RES. PAPER SERIES 09-01, 28 (2009).

⁵⁰ Stephen Daniels & Joanne Martin, *It Was the Best of Times, It Was the Worst of Times: The Precarious Nature of Plaintiffs’ Practice in Texas*, 80 Tex. L. Rev. 1781, 1798 (2002).

⁵¹ Herbert M. Kritzer, *Contingency Fee Lawyers As Gatekeepers in the Civil Justice System*, 81 JUDICATURE 22, Table 3 (1997).

⁵² David A. Hyman & Charles Silver, *Medical Malpractice Litigation and Tort Reform: It’s the Incentives, Stupid*, 59 VAND. L. REV. 1085, 1117 (2006).

the case. As a result, the attorney has no choice but to reject many legitimate victims of medical malpractice that do not have sufficient damages to offset the litigation expenses.

Access to legal representation becomes even more difficult as litigation costs increase. A complex case with expected costs of \$500,000 would likely be rejected unless the 33-percent contingency fee attorney expected potential damages in excess of \$1.5 million. When facing \$1.5 million in damages, the attorney risks the same amount if he loses the case that he could expect to earn if he wins the case.

Although not all lawyers charge a 33 percent contingency fee, and some lawyers employ variable fees that depend on their work load,⁵³ the basic point does not change—the expense of medical malpractice litigation eliminates many legitimate victims of medical malpractice from the claims pool. Indeed, research shows that medical malpractice attorneys accept far fewer cases than they reject. One study of attorneys' acceptance rates found that attorneys reject 80 percent or more of the medical malpractice cases they screen.⁵⁴ Another report of medical malpractice attorneys' practice patterns found that 77.1 percent of attorneys reject more than 90 percent of the cases they screen.⁵⁵ One of the primary reasons the attorneys give for rejecting cases was an insufficient expected return from these cases that are expensive to litigate.⁵⁶

2. Tort Reform

As a result of the high costs of medical malpractice investigation and litigation, many malpractice victims are left without legal remedy. These problems are exacerbated by damage caps and other tort reforms that artificially reduce plaintiffs' damages. Below I discuss the background of the tort reform movement and popular tort reforms that reduce medical malpractice awards to plaintiffs. Then, I explain how these reforms reduce contingency lawyers' willingness to accept cases.

a. Background of Medical Malpractice Tort Reforms

The "tort reform" movement can be traced back to the 1970s and 1980s when reforms were sought to address a perceived "crisis" in medical malpractice insurance.⁵⁷

⁵³ Herbert M. Kritzer, *Seven Dogged Myths Concerning Contingency Fees*, 80 WASH. U. L. Q. 739, 759 (2002).

⁵⁴ Kritzer, *supra* note 51, at Table 3.

⁵⁵ Michael Greenberg & Steven Garber, *Patterns of Specialization in Medical Malpractice Among Contingency Fee Attorneys*, RAND ICJ WORKING PAPER SERIES, 13 WR-700-ICJ (2009).

⁵⁶ LaRae I. Huycke & Mark M. Huycke, *Characteristics of Potential Plaintiffs in Malpractice Litigation*, 120 ANNALS INTERNAL MED. 792, 796 (1994).

⁵⁷ See, e.g., ACADEMIC TASK FORCE FOR REVIEW OF THE INS. & TORT SYS., PRELIMINARY FACT-FINDING REPORT ON MEDICAL MALPRACTICE 43 (1987) [hereinafter ACADEMIC TASK FORCE]; AM. MED. ASS'N SPECIAL TASK FORCE ON PROF'L LIAB. & INS., PROFESSIONAL LIABILITY IN THE '80S:

During this period, there was a rapid growth in both the number of medical malpractice claims filed and the size of awards in malpractice cases.⁵⁸ Medical malpractice premiums increased sharply, largely as a result of insurers' rising costs of defending against medical malpractice claims.⁵⁹

In response to the perceived crisis, physicians and malpractice insurance carriers began to lobby heavily for changes to reduce medical malpractice tort liability.⁶⁰ Proponents of reform argued that legislation that reduced litigation and plaintiffs' awards would solve the liability and insurance crisis and fix an imbalanced system. Although several attempts to enact federal legislation failed, many state legislatures were persuaded that medical malpractice reforms were necessary.⁶¹ By the mid-1980s medical malpractice tort reforms had been widely adopted across the nation.

State-level tort reforms have been aimed at addressing what critics view as the biggest problems with the medical liability system: excessive litigation, frivolous cases, and unjustifiably large damage awards. Although significant variation exists among individual state's chosen reforms, most states have elected to reduce damage awards in some way. Below I discuss the most common tort reforms that reduce the damages that medical malpractice plaintiffs receive.

Perhaps the loudest criticisms of the current tort system are centered on the imposition of damages for noneconomic losses. Noneconomic damages are damages for nonpecuniary losses such as pain and suffering, loss of consortium, emotional distress, and other intangible losses. Critics assert that noneconomic damage awards should be restricted because the awards serve no compensatory purpose because money cannot eliminate pain,⁶² the awards are arbitrary and unpredictable⁶³ and the awards increase

REPORT I 4-5 (1984) [hereinafter AMA Report I]; F. Patrick Hubbard, *The Physicians' Point of View Concerning Medical Malpractice: A Sociological Perspective on the Symbolic Importance of "Tort Reform"*, 23 GA. L. REV. 295, 295-98 (1989); Shirley Qual, *A Survey of Medical Malpractice Tort Reform*, 12 WM. MITCHELL L. REV. 417, 419-21 (1986) (describing how the medical malpractice insurance "crisis of availability" in the 1970s resurfaced as a "crisis of affordability" in the 1980s).

⁵⁸ ACADEMIC TASK FORCE, *supra* note 57, at 44.

⁵⁹ Hubbard, *supra* note 57, at 297. The increase in premiums was also likely linked to insurance companies' investment outcomes. See, e.g. Tom Baker, *Medical Malpractice and the Insurance Underwriting Cycle*, 54 DEPAUL L. REV. 393, 394 (2005).

⁶⁰ F. Patrick Hubbard, *The Nature and Impact of the "Tort Reform" Movement*, 35 HOFSTRA L. REV. 437, 469-479 (2006).

⁶¹ *Id.* at 483.

⁶² See, e.g., CANE, *supra* note 8, at 354 ("when all has been done to minimize the pain and suffering by medical means, any residual pain and suffering cannot be shifted: it remains with the victim, no matter what compensation is paid to that person by others"). Abel, *supra* note 8 at 803 (argues that the primary argument for torts damages "is hopelessly incoherent - money cannot restore victims to their

the cost of medical services because doctors and hospitals pass on their liability costs in the form of higher prices.⁶⁴ Thirty states have enacted reforms that cap noneconomic damages awards in medical malpractice cases.⁶⁵ The majority of these caps limit awards of noneconomic damages to between \$250,000 and \$450,000.

Proponents of tort reform raise many of these same objections to punitive damages. Punitive damages are awarded not to compensate victims, but to punish defendants for reckless or intentional conduct and to deter future conduct.⁶⁶ Critics of punitive damage awards point to recent U.S. Supreme Court decisions to highlight how punitive damages are often excessive in comparison to compensatory damages, violating the Due Process Clause of the 14th Amendment.⁶⁷ Critics also argue that the arbitrary and unpredictable imposition of the awards has distorted the settlement process.⁶⁸ Forty-two states have

status quo before the accident" and that "money is a poor equivalent for non-pecuniary loss").

⁶³ See, e.g., David W. Leebron, *Final Moments: Damages for Pain and Suffering Prior to Death*, 64 N.Y.U. L. REV. 256, 324-25 (1989) (analyzing pain-and-suffering awards in 256 wrongful death cases; concluded that there is a lack of horizontal equity in awards); Mark Geistfeld, *Placing a Price on Pain and Suffering: A Method for Helping Juries Determine Tort Damages for Nonmonetary Injuries*, 83 CAL. L. REV. 773, 777 (1995) (asserts that there is substantial variability in jury awards for pain and suffering for injuries of equal severity).

⁶⁴ John E. Calfee & Paul H. Rubin, *Some Implications of Damages Payments for Nonpecuniary Losses*, 21 J. LEGAL STUD. 371 (1992); Robert Cooter, *Towards a Market in Unmatured Tort Claims*, 75 VA. L. REV. 383, 392 (1989) ("a rational person would insure only against that pain and suffering that curtailed earnings"); George L. Priest, *A Theory of the Consumer Product Warranty*, 90 YALE L.J. 1297, 1346-47, 1352 (1981); Alan Schwartz, *Proposals for Product Liability Reform: A Theoretical Synthesis*, 97 YALE L.J. 353, 362-67 (1988).

⁶⁵ RONEN AVRAHAM, DATABASE OF STATE TORT LAW REFORMS (2011), available at <http://ssrn.com/abstract=902711> or <http://dx.doi.org/10.2139/ssrn.902711>.

⁶⁶ *BMW of North America, Inc. v. Gore*, 517 U.S. 559, 568 (1996) ("Punitive damages may properly be imposed to further a State's legitimate interests in punishing unlawful conduct and deterring its repetition").

⁶⁷ *State Farm Mutual Auto Ins. Co. v. Campbell*, 538 U.S. 408, 429 (2003) ("The punitive award of \$145 million, therefore, was neither reasonable nor proportionate to the wrong committed, and it was an irrational and arbitrary deprivation of the property of the defendant."); *Pacific Mut. Life Ins. Co. v. Haslip*, 499 U.S. 1, 42 (1991) (O'Connor, J., dissenting) ("Punitive damages are a powerful weapon. Imposed wisely and with restraint, they have the potential to advance legitimate state interests. Imposed indiscriminately, however, they have a devastating potential for harm. Regrettably, common-law procedures for awarding punitive damages fall into the latter category").

⁶⁸ See, e.g., AMERICAN TORT REFORM ASSOCIATION, ISSUES: PUNITIVE DAMAGE REFORM (2007), available at <http://www.atra.org/issues/index.php?issue=7343> ("The difficulty of predicting whether punitive damages will be awarded by a jury in any particular case, and the marked trend toward astronomically large amounts when they are awarded, have seriously distorted settlement and litigation processes and have led to wildly inconsistent outcomes in similar cases").

adopted either caps on punitive damages or more stringent evidence requirements for awarding them in medical malpractice cases.⁶⁹ The caps typically limit punitive damage awards to the greater of a fixed dollar amount (i.e. \$250,000) or 3 times the compensatory damage award. The stronger evidence requirements generally demand that defendants' reckless, willful, or intentional conduct be established by a clear and convincing evidence standard, instead of the preponderance of the evidence standard that is generally required in civil trials.⁷⁰

Critics argue that in some states, not only are noneconomic damages and punitive damages excessive, but compensatory damages are also too large. According to this view, overly-generous juries ignore facts and law and award excessive compensatory judgments.⁷¹ The result is excessive deterrence and an unfair redistribution of wealth to plaintiffs. As a result, 10 states have capped total damage award in medical malpractice cases.⁷² In these states, a plaintiffs' total recovery, including both economic and noneconomic damages, are capped at an amount, often \$500,000 or \$1,000,000.

Numerous states have also enacted reforms to collateral source rules that reduce plaintiffs' damage awards. The traditional collateral source rule prevents the admission of evidence at trial that shows that a plaintiff's losses have been compensated by other sources, such as health insurance. The rationale for the traditional rule is that a defendant should not benefit merely because the plaintiff has had the foresight to purchase insurance. Although the rule promotes efficient deterrence by requiring a tortfeasor to pay damages even when a victim has received payments from a source other than the tortfeasor, critics argue that a plaintiff's award may exceed the value of the harm he suffered.⁷³ Reforms to collateral source rules include allowing evidence of collateral source payments or completely offsetting awards by the amount of collateral source payments.⁷⁴ That is, these reforms allow a plaintiff's damage award to be reduced by the amount of reimbursement they have already received from a collateral source such as health insurance or worker's compensation. Thirty-eight states have enacted collateral

⁶⁹ AVRAHAM, *supra* note 65.

⁷⁰ Hubbard, *supra* note 60, at 501.

⁷¹ See, e.g., AMERICAN TORT REFORM ASSOCIATION, *About Atra*, <http://www.atra.org/about/> (last visited Feb. 14, 2013).

⁷² AVRAHAM, *supra* note 65.

⁷³ See, e.g., AMERICAN TORT REFORM ASSOCIATION, *Issues: Collateral Source Rule Reform*, <http://www.atra.org/issues/index.php?issue=7344> (last visited July 20, 2007) ("The collateral source rule keeps important information relevant to the determination of damages from reaching the jury. It allows plaintiffs to be compensated twice for the same injury.").

⁷⁴ AVRAHAM, *supra* note 65.

source reforms.⁷⁵

Reforms to joint-and-several liability rules aim to reduce plaintiffs' recovery in cases involving multiple defendants. Under traditional joint-and-several liability rules, a plaintiff can recover the full cost of her injury from any party who is partially responsible for the injury, no matter how small the party's responsibility. This allows plaintiffs to collect all of their damages from a "deep-pocket" defendant, even if that defendant contributed only modestly to causing the damages. The deep-pocket defendant can sue the other tortfeasors for contribution to seek reimbursement of the other tortfeasors' share of the damages, but such cross-claims are often fruitless because the other tortfeasors often lack resources. Although these rules help to ensure that victims receive full compensation, critics argue that they fail to distribute liability equitably among defendants. In addition, proponents of reform assert that they preclude optimal deterrence. The deep pocket is deterred excessively; the large damages that it must pay may cause it to pay for excessive precautions, or to cease offering the good or services completely. The other tortfeasors are deterred inadequately; because the deep pocket pays for the damages that the others cause, the other tortfeasors do not pay for the full costs that their conduct imposes.⁷⁶ Forty-one states have enacted reforms to joint-and-several liability.⁷⁷ Most reforms to the standard joint-and-several liability rule impose proportionate liability that limits liability for defendants who contributed only modestly to causing the injury.

Thus, many states have enacted tort reforms that reduce the damage awards that plaintiffs can recover in medical malpractice cases. Next, I discuss how these reductions in damages also restrict plaintiffs' access to legal representation in medical malpractice cases.

b. Tort Reform's Impact on Access to Justice

Several tort reforms lower the damage awards that plaintiffs expect to receive in medical malpractice cases. These reforms also reduce contingency fee lawyers' willingness to accept cases. Because the cost of trying cases remains the same as before tort reform, but the damages—and in turn, the contingency lawyer's expected recovery—declines, fewer cases will make economic sense for the lawyer to accept.

Consider, for example, a medical malpractice case with expected economic damages of \$50,000 and expected noneconomic damages of \$500,000. An attorney with a 33 percent contingency fee rate would likely reject this case if he expects his litigation costs to be higher than his expected fee of \$181,500 (33 percent of \$550,000). However, if the state enacts a \$250,000 cap on noneconomic damages, the attorney would reject an

⁷⁵ *Id.*

⁷⁶ For a general discussion, see AMERICAN TORT REFORM ASSOCIATION, *Issues: Joint-and-Several Liability Reform*, <http://www.atra.org/issues/index.php?issue=7345> (last visited July 20, 2007).

⁷⁷ AVRAHAM, *supra* note 65.

identical case if the expected litigation costs exceed \$99,000; after the damages cap, the attorneys' expected fee is only \$99,000 (33 percent of \$330,000).

Thus, the nature of the contingency fee system requires attorneys to weigh the expected return against the expected litigation costs of a case. Tort reform that lowers the expected return on many cases reduces access to the civil justice system by making cases financially unattractive to plaintiffs' lawyers working on a contingency fee basis.

One medical malpractice attorney interviewed for a study of plaintiffs' attorneys practices explained that he couldn't economically justify accepting many cases after his state capped noneconomic damages: "Because if it's a case that's gonna hafta be tried, and the up-end is \$200,000 to \$250,000, which is a \$100,000 fee, we're not gonna risk \$100,000 to get a \$100,000 fee. You can't do that in this business if you expect to be around very long."⁷⁸

Indeed, attorneys often lament that they have no choice but to turn down legitimate cases after their states enact tort reform:

In this state there's an epidemic at this time in terms of people who have legitimate claims going unrepresented. I have looked at cases before [before the cap] that had been seen by four or five other lawyers before they got to me. And I've looked at legitimate cases. ... Now I'm afraid what's happening is they're not really getting looked at ... they're [lawyers] making a decision, and I don't know that's an unreasonable one. I think they're just saying, "We are not gonna do any case that doesn't have the potential upside to justify the risk that we're gonna take" ... I would hate to be a plaintiff out there looking for a lawyer right now.⁷⁹

Only two empirical studies have explored the degree to which tort reform has limited victims' access to the legal system. The first study directly examined the influence of noneconomic damage caps on the willingness of plaintiffs' attorneys to accept medical malpractice clients.⁸⁰ The researchers conducted surveys of Texas plaintiffs' attorneys in 2000 and in 2006, before and after Texas instituted a \$250,000 cap on noneconomic damages in medical malpractice cases. For the 60 attorneys who participated in both surveys, the researchers compared the stated willingness to accept cases of three hypothetical potential medical malpractice clients. Although the clients had different levels of economic damages, they all suffered facial disfigurement as a result of the malpractice—indicating large noneconomic losses that could, absent a cap, result in a significant noneconomic damage award. The results revealed that the attorneys'

⁷⁸ Daniels & Martin, *supra* note 49, at 29.

⁷⁹ *Id.* at 33.

⁸⁰ Steven Garber et al., *Do Noneconomic Damages Caps and Attorney Fee Limits Reduce Access to Justice for Victims of Medical Negligence?*, 6 J. EMPIRICAL LEGAL STUD. 637 (2009).

willingness to accept all of the clients' cases declined after the cap was enacted, but it declined significantly more for the clients with low economic damages.

The second study analyzed the effects of noneconomic damages caps and attorney fee limits on attorneys' willingness to accept medical malpractice cases.⁸¹ The researchers surveyed 965 plaintiffs' attorneys from across the nation, asking their likelihood of accepting a case in three different scenarios. The results confirmed that both noneconomic damage caps and attorney fee limits substantially discouraged attorneys from representing clients.

Hence, the limited empirical work on the subject confirms that high litigation costs and tort reforms that lower damages have restricted access to the legal system for many legitimate victims of medical malpractice. The factors have made it impossible for many plaintiffs' attorneys to economically justify taking cases that lack sufficient damages to warrant the litigation expense.

C. CONSEQUENCES OF THE ACCESS TO JUSTICE PROBLEM

As litigation costs and tort reforms make it economically infeasible for attorneys to accept many medical malpractice cases, legitimate victims of medical malpractice are left without legal representation. In this section, I discuss various consequences of this access to justice problem. Not only will unrepresented victims likely receive no compensation for their harms, but victims with low economic damages will be disproportionately excluded from the legal system.

Because of the complexity and expense of medical malpractice lawsuits, employing a lawyer is critical to a successful claim. Indeed, empirical evidence confirms that an inability to attain legal representation effectively eliminates victims' ability to obtain redress in the civil justice system. According to one study of medical malpractice claims, only 0.1 percent of medical malpractice claims that result in payment are brought by victims representing themselves, without an attorney.⁸² Another study of closed claims found that the success rate of pro se and unrepresented plaintiffs was only 5.5 percent whereas the success rate for plaintiffs represented by counsel was 34 percent.⁸³

Moreover, the economic calculus required by the contingency fee system causes attorneys to gravitate towards some types of medical malpractice cases and victims, and ignore others. High litigation costs give medical malpractice attorneys little choice but to ignore smaller cases and concentrate on cases with larger expected damages; the lawyers' fee from a small case will rarely offset the expense of litigating the case. One medical malpractice attorney explained that a good case is "anything that has to do with

⁸¹ Daniels & Martin, *supra* note 49, at 28.

⁸² Hyman & Silver, *supra* note 52, at 104.

⁸³ Stephen Daniels et al., *Why Kill All the Lawyers? Repeat Players and Strategic Advantage in Medical Malpractice Claims* (Am. B. Found. Working Paper No. 9210, 1992).

neurological brain damage, something that's permanent -- young person that has a long time to live with a long life expectancy; a brain damaged baby where there's a long life expectancy that required 24 hour care. When you ... you know, where the cost of the damages are exceedingly high.”⁸⁴ Another echoed that “there’s no such thing, as far as I’m concerned, as a good small medical malpractice case.”⁸⁵

Because the majority of adverse events resulting from medical negligence do not impose serious harm,⁸⁶ many medical malpractice victims will be unable to find legal representation and their injuries will go uncompensated. In fact, because many contingency fee attorneys assume that litigation expenses average \$100,000, they could not economically justify accepting claims that most people would regard as serious. Even a \$300,000 damage award would only allow an attorney with a 33 percent contingent fee to risk the same amount he stands to earn if his litigation expenses are \$100,000. As a result, many attorneys develop minimum damages thresholds, below which they will not even consider a case. For example, one attorney interviewed for my survey replied that he would generally not consider “anything below a \$300,000.00 potential recovery.”

Although the survey I conducted for this Article is the first to explore attorneys’ minimum damages thresholds in a range of cases, along with the causes and consequences of those thresholds, one previous study of specialization among medical malpractice attorneys asked whether the respondents had a general threshold value rule for rejecting medical malpractice cases. Over half of the respondents in that previous survey replied that they would not accept a case if the expected damages were below \$250,000.

Thus, unless expected damages are large, contingency fee attorneys simply cannot justify accepting many cases because the expected fee will not offset the high litigation costs. As a result, legitimate victims of medical malpractice that have not suffered serious injury are unable to obtain legal counsel or receive compensation for their harms.

Moreover, by limiting certain types of damages relative to other damages, tort reform disproportionately reduces both compensation and access to justice for specific segments of the population. For example, existing studies show that caps on noneconomic damages disproportionately reduce compensation to females, children, the elderly, and the poor because a much greater proportion of their damage awards are in the form of noneconomic damages.⁸⁷ These demographic groups often have lower incomes

⁸⁴ Daniels & Martin, *supra* note 49, at 32.

⁸⁵ *Id.* at 33.

⁸⁶ David Studdert et al., *supra* note 17, at 254.

⁸⁷ Lucinda M. Finley, *The Hidden Victims Of Tort Reform: Women, Children, And The Elderly*, 53 EMORY L.J. 1263 (2004); NICHOLAS M. PACE ET AL., CAPPING NON-ECONOMIC AWARDS IN MEDICAL MALPRACTICE TRIALS: CALIFORNIA JURY VERDICTS UNDER MICRA 30-33 (2004); Eleanor D.

than other groups and, as a result, they have correspondingly less economic loss and relatively more noneconomic loss.⁸⁸ Thus, noneconomic damage caps act as a regressive tax on their recoveries because they reduce the recoveries of lower-income plaintiffs by a higher fraction than they reduce the recoveries of higher-income plaintiffs.

Not only do certain tort forms disproportionately reduce the compensation to these groups, they also disproportionately limit their access to the legal system. The tort reforms that disproportionately reduce the expected recoveries for lower income groups also disproportionately reduce the expected contingency fee that lawyers recover from these clients. Thus, these reforms disproportionately reduce contingency lawyers' willingness to represent lower income groups. Empirical evidence confirms that, after tort reforms that restrict noneconomic damages, attorneys disproportionately refuse to represent females, children, the elderly, and the poor on a contingency fee basis because of the low potential recovery.⁸⁹

Interviews with medical malpractice attorneys also indicate that certain tort reforms limit access to the legal system for certain demographic groups. As an attorney interviewed for my study explained: "non wage-earners, seniors, nonworking women...are the first ones to lose access to the courts when things like caps on pain and suffering awards are enacted." Similarly, an attorney interviewed in another study explained that, "the biggest problem is the cap on damages. The \$250,000 cap does nothing more than hurt the children and the housewives and the elderly the most because they don't have any economic damages. They don't have any earning capacity and they

Kinney et al., *Indiana's Medical Malpractice Act: Results of a Three-Year Study*, 24 IND. L. REV. 1275 (1991).

⁸⁸ Christian E. Schlegel, Note, *Is a Federal Cap on Punitive Damages in Our Best Interest?: A Consideration of H.R. 956 in Light of Tennessee's Experience*, 69 TENN. L. REV. 677 (2002); Michael L. Rustad, *Nationalizing Tort Law: The Republican Attack on Women, Blue Collar Workers, and Consumers*, 48 RUTGERS L. REV. 673 (1996); Mark Donald, *Access Denied: Does Tort Reform Close Courthouse Doors to Those Who Can Least Afford It?*, TEX. LAW (Jan. 10, 2005), available at http://www.law.com/jsp/tx/PubArticleTX.jsp?id=900005421359&Access_Denied_Does_Tort_Reform_Close_Courthouse_Doors_to_Those_Who_Can_Least_Afford_It&slreturn=20130114021026.

⁸⁹ Rachel Zimmerman & Joseph T. Hallinan, *As Malpractice Caps Spread, Lawyers Turn Away Some Cases*, WALL ST. J., Oct. 8, 2004, at A1 ("Caps on damages for pain and suffering ... [are] turning out to have the unpublicized effect of creating two tiers of malpractice victims... . Lawyers are turning away cases involving victims that don't represent big economic losses - most notably retired people, children and housewives..."); Catherine M. Sharkey, *Unintended Consequences of Medical Malpractice Damage Caps*, 80 N.Y.U. L. REV. 391 (2005) (showing that awards for overall damages have stayed the same while economic damages have increased possibly because plaintiffs' lawyers have screened out women, minorities, and children who are less likely to receive high economic damages); Troy L. Cady, Note, *Disadvantaging the Disadvantaged: The Discriminatory Effects of Punitive Damage Caps*, 25 HOFSTRA L. REV. 1005 (1997) ("Lawyers will become increasingly unwilling to represent plaintiffs in lawsuits that have little or no prospect of yielding adequate compensation for the large amount of time and money invested.").

don't have and lost wages.”⁹⁰ Another attorney confirmed that caps on noneconomic damages have "essentially closed the courthouse door to the negligence that would kill a child, a housewife or an elderly person. [The reason is that] there are no medical expenses, no loss of earning capacity.”⁹¹

In the next Section, I discuss the findings from my own survey of medical malpractice attorneys. My results confirm that many of the attorneys' statements quoted in this section are representative of the general sentiment among medical malpractice attorneys. Attorneys generally agree that the costs of litigating medical malpractice cases are high, that economic realities force them to reject many legitimate cases that do not have high expected damage awards, and that tort reforms further restrict the number of legitimate cases that attorneys are able to accept.

III. SURVEY

To better understand the problem of silent victims in the medical liability system, I conducted a survey of attorneys that currently represent medical malpractice plaintiffs. The survey asked various questions about each respondent and their firm (such as demographic characteristics, firm characteristics, and experience in medical malpractice work), questions about their medical malpractice practice patterns (including the respondents' experiences with case dispositions, recoveries, and expenses), and questions pertaining to case screening procedures and access to justice (such as case rejection rate, reasons for rejecting cases, and minimum damages among accepted cases). In this section, I discuss my survey methods and present data on the survey responses to various questions.

A. METHODS

I drew contact information from a list of attorneys published by Consumer Base and RSA List Services in the spring of 2012.⁹² These companies, in turn, obtain their contact lists from various sources including business directories, conference attendance lists, firm websites, and various other sources.

I developed a 35-item online survey addressing various aspects of attorneys' practices, case screening procedures, and case disposition experience. In May 2012, I sent an email with a request to participate in an online survey to all 23,026 email addresses on my contact list. The email described the following purpose of the survey:

⁹⁰ Daniels & Martin, *supra* note 45, at 661 (quoting an interview with a personal injury lawyers in Texas).

⁹¹ *Id.* (from an interview with a personal injury lawyers in Texas).

⁹² RSA List Services, available at <http://www.rsalistservices.com/> (last visited Aug. 23, 2012); Consumer Base, available at <http://www.consumerbase.com/index.html> (last visited Aug. 23, 2012).

We are developing a knowledge base of general practice patterns of medical malpractice attorneys that we can share with all trial attorneys. Although there has been much speculation about the way that factors such as case characteristics, state laws, and the nature of an attorney's practice influence litigation and case outcomes, there has been no systematic study of these influences. This study will explore how these factors influence attorney decisions to accept or reject cases at screening, and how they relate to cases that are dismissed, settled, or proceed to trial.

The email also confirmed that the survey responses were completely anonymous and provided my contact information for follow-up questions or comments. I received hundreds of comments, several of which are provided as quotes in Section 2 of this Article. Finally, the email contained a link to the online survey, with a request that the subjects voluntarily click on the link to take the survey. I sent a reminder email approximately a week after the initial request.

The online survey was open for approximately one month. Four hundred and sixty four attorneys completed the online survey during this time. Ideally, I could estimate a response rate based on the 464 responses. However, to estimate this accurately I would need to know the number of medical malpractice attorneys that received my email request and had the opportunity to take the survey. For various reasons, this is impossible to do.

First, although my initial contact list contained 23,026 email addresses, a significant number of the contacts contained incorrect or out of date email addresses. Second, not all of the attorneys on the list were medical malpractice attorneys; many attorneys replied that they had never litigated medical malpractice cases or hadn't litigated medical malpractice cases in many years. In fact, many had not practiced law at all in years and were either retired or working in a different career. Finally, my email requests got caught in an unknown number of my contacts' spam folders.⁹³ As a result, the list of 23,026 contacts significantly overestimates the number of medical malpractice attorneys that actually received my email and had an opportunity to respond.

Moreover, to determine the percentage of the total population of U.S. medical malpractice attorneys that my respondents represent, I would need to know how many attorneys are actively litigating medical malpractice cases. However, this number is impossible to estimate. There is no database that identifies all U.S. attorneys by the type of work they do. Martindale.com, the largest online index of attorneys that includes contact information for over one million practicing attorneys, is likely the closest thing to a comprehensive list of U.S. attorneys.⁹⁴ Martindale reports that, across the United States, there are 10,894 attorneys that self-identify as practicing in the area of medical

⁹³ Although I filled out hundreds of requests from email providers to skip the spam folder, many attorneys responded that they had found my email in their spam folder.

⁹⁴ Available at <http://www.martindale.com> (last visited Aug. 23, 2012).

malpractice. Only 3,493 of these attorneys are active members of the American Bar Association. Even these numbers may overestimate the true number of medical malpractice lawyers because attorneys self-report their practice area to Martindale. Thus, the Martindale index reports the type of work that attorneys would be willing to do, not the type of work in which they actually have experience. As a result, many of the 10,894 attorneys that checked the “medical malpractice” box may have little or no experience litigating medical malpractice cases.

Although it is impossible to know the true response rate to my survey, ideally I would have more responses than I did. Moreover, as with any voluntary survey, there is a potential for selection bias when respondents decide whether to respond, even if the underlying pool of attorneys to whom I sent the survey is unbiased. Because my email describing the survey suggested that the purpose of my research is to understand medical malpractice attorneys’ practice patterns and how various factors affect these patterns, attorneys that are more concerned with the state of their current practice may be more likely to respond. As a result, the responses may disproportionately reflect the concerns and practices of this group of attorneys instead of the practices of all attorneys. Nevertheless, as I show in the next section, the responses to the basic demographic questions all indicate that my sample of respondents is very representative of the larger population of medical malpractice attorneys. Moreover, all of the survey responses are consistent with other research findings, suggesting that selection bias may not be a serious problem.

B. BASIC DEMOGRAPHIC CHARACTERISTICS OF PLAINTIFFS’ ATTORNEYS RESPONDENTS

The survey asked a series of demographic characteristics about the respondents and their practices. The first question asked whether the respondents had primarily represented medical malpractice plaintiffs or defendants in the past year. Of the 464 respondents, 259 reported that they had primarily represented medical malpractice plaintiffs; the other 205 respondents reported that they had primarily engaged in medical malpractice defense. The respondents’ answer to this first question directed them to either a set of questions relevant to plaintiffs’ attorneys or a set of questions relevant to defense attorneys. As this Article is concerned with the access to justice issue among medical malpractice plaintiffs, this remainder of my discussion of the survey results will pertain only to the 259 plaintiffs’ attorneys’ responses. Future work on other topics will discuss the survey questions and responses for the defendants’ attorneys.

The survey’s demographic questions were designed to determine whether my respondents were representative of the larger population of U.S. medical malpractice attorneys. Attorneys from at least 39 states answered the online survey (because some

respondents did not provide a state answer), suggesting a great deal of geographic diversity among the survey respondents.⁹⁵

The first two questions were designed to determine whether the firm characteristics are representative of the larger population of medical malpractice attorneys. Answers to the question “Which of the following best describes the location of the office in which you work?” revealed that the great majority of the survey respondents practice in urban areas. Table 1 reports the distribution of my attorney respondents among different office locations. This distribution of locations is consistent with other studies of medical malpractice plaintiffs’ attorneys that have found that the overwhelming number practice in urban areas.⁹⁶

Table 1: Office Location of Respondents

Office Location	Percentage of Respondents
Rural	4.27%
Suburban	24.39%
Urban	71.34%

The survey also asked the question: “Approximately how many attorneys work in your law office?” The majority of respondents reported that they worked in office with fewer than 5 attorneys. Table 2 shows the distribution of the survey respondents among different firm sizes. This distribution is consistent with other reports on medical malpractice attorneys that has found that the average firm specializing in medical malpractice has only two attorneys.⁹⁷

⁹⁵ The number of respondents practicing in each state were: No Answer: 94; Alabama: 4; Arizona: 14; Arkansas: 1; California: 6; Colorado: 2; Connecticut: 4; Florida: 18; Georgia: 11; Hawaii: 1; Illinois: 7; Indiana: 3; Kansas: 4; Kentucky: 3; Louisiana: 1; Maine: 1; Maryland: 10; Massachusetts: 2; Minnesota: 2; Mississippi: 2; Missouri: 2; Nebraska: 1; Nevada: 1; New Hampshire: 1; New Jersey: 3; New Mexico: 1; New York: 7; North Carolina: 3; Ohio: 14; Oklahoma: 2; Pennsylvania: 13; Rhode Island: 1; Tennessee: 3; Texas: 5; Utah: 2; Virginia: 4; Washington: 3; Washington, D.C.: 1; Wisconsin: 1; Wyoming: 1.

⁹⁶ Greenberg & Garber, *supra* note 55 (finding that 65 percent and 29 percent of respondents worked in urban and rural settings, respectively).

⁹⁷ Stephen Daniels & Joanne Martin, *Texas Plaintiffs' Practice in the Age of Tort Reform: Survival of the Fittest -- It's Even More True Now*, 51 N.Y.L. SCH. L. REV. 285, 305 (2006).

Table 2. Firm Size of Respondents

Firm Size	Percent of Respondents
Solo practice	12.80%
2-5 attorneys	43.29%
6-10 attorneys	25.00%
11-50 attorneys	16.46%
more than 50 attorneys	2.44%

I designed the next set of survey questions to determine whether the litigation experience of my respondents is representative of the larger population of medical malpractice attorneys in the U.S. Answers to the question “How many years have you been litigating medical malpractice cases?” revealed a substantial amount of experience among my respondents. As reported in Table 3, the majority of the respondents had over 20 years of experience litigating in this area. This level of experience is consistent with other reports that have found an average of 24 years of practice experience among medical malpractice attorneys.⁹⁸

Table 3: Experience Litigating Medical Malpractice Cases

Years	Percent of Respondents
Fewer than 10 years	4.85%
10-19 years	23.64%
20-29 years	35.15%
30+ years	36.36%

The survey also asked the respondents “Approximately how many medical malpractice cases are you working on now?” As shown in Table 4, most of the respondents were handling fewer than 15 medical malpractice cases at the time of the survey. In general, the respondents that were involved in more cases tended to practice in larger firms.

⁹⁸ *Id.* at 11.

Table 4: Number of Current Medical Malpractice Cases

Number of current cases	Percent of Respondents
Fewer than 5 cases	31.90%
5-15 cases	41.10%
16 to 50 cases	22.09%
More than 50 cases	4.91%

Finally, to understand the amount of specialization in medical malpractice cases among the respondents, the survey asked “Which of the following best describes how much time you spend working on medical malpractice cases?” Table 5 shows that there is substantial diversity in the degree of specialization among the survey respondents. The majority of the survey respondents devoted either less than 25 percent of their time or more than 75 percent of their time to medical malpractice cases. Again, this distribution of specialization is consistent with other reports on the practice pattern of medical malpractice attorneys.⁹⁹

Table 5: Specialization on Medical Malpractice Cases

Percentage of Time	Percent of Respondents
Less than 25% of my time	32.72%
Between 25% and 50% of my time	19.14%
Between 51% and 75% of my time	14.81%
More than 75% of my time	33.33%

Thus, the survey respondents practice in at least 39 states and work in firms that are representative of the larger population of U.S. medical malpractice attorneys. Moreover, the respondents’ practice experience and specialization in medical malpractice work is similar to that found in other reports of medical malpractice practice patterns.

⁹⁹ Greenberg & Garber, *supra* note 55 (finding that 65 percent and 29 percent of respondents worked in urban and rural settings, respectively).

C. CASE DISPOSITION EXPERIENCE

To better understand the practice patterns of medical malpractice attorneys, the survey asked a series of questions about the attorneys' recent experience in case dispositions. Responses to the question "Approximately how many [medical malpractice] cases did you close last year?" revealed that the average respondent closed 14 cases last year. Table 6 reports the distribution of closed cases among the survey respondents.

Table 6: Medical Malpractice Cases Closed Last Year

Cases Closed	Percent of Respondents
Fewer than 5 cases	37.36%
5-10 cases	33.33%
11-50 cases	25.86%
more than 50 cases	3.45%

To explore how these cases were closed, the survey asked "Approximately what percentage of the cases that you closed last year were: dismissed without payment, settled with payment prior to trial proceedings, settled with payment during trial, and went to jury verdict?" Table 7 reports that the majority of cases were disposed by settlement.¹⁰⁰ The percentage of cases that went to trial (9 percent) is consistent with data from the largest independent medical professional liability research database that reports that 8.5 percent of medical malpractice claims went to trial in 2010, the most recent year for which data was available.¹⁰¹

¹⁰⁰ The percentages in Table 7 do not add up to 100 percent, but they exclude certain case disposition outcomes such as bench trials.

¹⁰¹ THE PHYSICIAN INSURERS ASSOCIATION OF AMERICA, CLAIM TREND ANALYSIS: A COMPREHENSIVE ANALYSIS OF MEDICAL LIABILITY DATA REPORTED TO THE PIAA DATA SHARING PROJECT AT EXHIBIT 6c (2011)[hereinafter PHYSICIAN INSURERS ASSOCIATION OF AMERICA].

Table 7: Case Dispositions Among Survey Respondents

Percent of medical malpractice cases that were:	Average Percent among Respondents
Dismissed without payment	11%
Settled with payment prior to trial proceedings	54%
Settled with payment during trial	2%
Went to jury verdict	7%

To explore plaintiffs' success at trial, the survey asked questions pertaining to plaintiff win rates and plaintiff recovery. According to the responses to the question "What percentage of your cases that went to a jury verdict last year were in the plaintiff's favor?", the average plaintiff win rate by jury was 27 percent. This plaintiff win rate is low compared to plaintiff win rates in general civil trials; a recent report on civil trial dispositions found that plaintiffs win in 56 percent of civil trials.¹⁰² However, the survey's low percentage of plaintiff wins is consistent with other data on medical malpractice trial outcomes that find that plaintiffs win in 24 percent of medical malpractice trials.¹⁰³

To further explore plaintiff outcomes, the survey also asked the question "What would you estimate was the average amount awarded to the plaintiff in your cases that settled for payment last year and resulted in a jury verdict for the plaintiff?" The respondents reported an average settlement award of \$652,060 and an average damage award from jury verdict of \$ 1,519,727. Table 8 reports the distribution of respondents indicating average award amounts for settlements and jury verdicts. Not surprisingly, awards from jury verdict tend to be much higher than settlement amounts. In fact, the majority of jury awards reported by my survey respondents were over \$1 million. Although the proportion of jury awards over than \$1 million among my responses is slightly higher than a recent report on civil trial awards, the concentration of jury awards over \$500,000 is consistent with recent research.¹⁰⁴

¹⁰² LYNN LANGTON, M.A. AND THOMAS H. COHEN, CIVIL BENCH AND JURY TRIALS IN STATE COURTS, 2005, BUREAU OF JUSTICE STATISTICS REPORT NCJ 223851 4 (2008), available at <http://bjs.ojp.usdoj.gov/content/pub/pdf/cbjtsc05.pdf> (last access Aug. 23, 2012).

¹⁰³ *Id.* reporting that plaintiffs win in 23 percent of medical malpractice trials.

¹⁰⁴ LYNN LANGTON, M.A. AND THOMAS H. COHEN, CIVIL BENCH AND JURY TRIALS IN STATE COURTS, 2005, BUREAU OF JUSTICE STATISTICS REPORT NCJ 223851, 5 (2008), available at <http://bjs.ojp.usdoj.gov/content/pub/pdf/cbjtsc05.pdf> (last accessed Aug. 23, 2012).

Table 8: Average Plaintiff Awards in Settlements and Jury Verdicts

Average Award Amount	Percent of Respondents Indicating Average Award in Settlements	Percent of Respondents Indicating Average Award from Jury Verdict
Less than \$50,000	3.38%	0%
\$50,000-\$150,000	12.16%	12.73%
\$150,000-\$500,000	48.65%	27.27%
\$500,000-\$999,999	14.86%	9.09%
\$1 million or greater	20.95%	50.91%

To explore attorneys' recovery and costs in medical malpractice cases, the survey asked questions relating to contingent fees and litigation expenses. The survey asked the question "What is your average fee as a percentage of the award in cases that settle with payment made to the plaintiff and result in a jury award to the client?" Among the respondents, the average contingent fee in cases that ended in a settlement paid to the plaintiff was 35 percent and the average contingent fee in cases that ended in a jury award to the plaintiff was 36 percent. Table 9 reports the distribution of average contingent fees among cases ending in settlement and jury awards.

Table 9: Average Contingent Fee in Settlements and Jury Verdicts

Average Contingent Fee	Percent of Respondents Indicating Average Fee in Settlements	Percent of Respondents Indicating Average Fee from Jury Verdict
less than 20%	6.38%	4.85%
20% to 29%	12.06%	7.77%
30% to 40%	73.05%	80.58%
greater than 40%	8.51%	6.80%

Finally, to understand the attorneys' expenses in various cases, the survey asked "What would you estimate are the average litigation costs of your medical malpractice cases that: were dismissed without payment, settled with payment made to the plaintiff, and resulted in a jury verdict for the plaintiff?" Table 10 reports the averages of the respondents' answers. Not surprisingly, the litigation costs are highest when cases go to

trial. Moreover, the \$97,000 average litigation cost among cases ending with a jury verdict for the plaintiff is very similar to the expected \$100,000 cost that many attorneys use as rules of thumb when screening cases.

Table 10: Average Litigation Expenses Among Different Cases

Case Disposition	Average Litigation Costs
Dismissed without payment	\$18,062.76
Settled with payment made to the plaintiff	\$58,275.89
Resulted in jury verdict for plaintiff	\$97,369.79

D. CASE SCREENING AND ACCESS TO JUSTICE

The final set of survey questions relate to the attorneys' experiences screening cases and the problem of access to justice. The responses reveal that the majority of screened cases are rejected and that even strong cases are rejected if the expected damage award is not large enough. Thus, the survey confirms that access to justice is a significant problem in today's medical liability system.

To understand the screening procedures of attorneys, the survey asked questions about the number of cases screened and the percent of those cases that are rejected. In response to the question, "Within the last year, approximately how many medical malpractice suits did you screen?" the majority of respondents answered that they screened fewer than 50 cases. Table 11 reports the number of cases screened among the survey respondents.

Table 11: Medical Malpractice Cases Screened in Last Year

Cases Screened in Last Year	Percent of Respondents
fewer than 10 cases	12.17%
10 to 50 cases	42.61%
51 to 100 cases	20.00%
101 to 500 cases	20.00%
more than 500 cases	5.22%

Next, the survey asked "Approximately what percentage of the cases that you screened did you reject?" Table 12 reports the results. The responses indicate that the majority of attorneys reject between 95 and 99 percent of the cases they screen. In fact,

76.8 percent of the attorney respondents indicate that they reject more than 90 percent of the cases they screen. This percentage is remarkably consistent with results from another report of medical malpractice attorneys' practice patterns that found that 77.1 percent of attorneys *accept* fewer than 10 percent of the cases they screen.¹⁰⁵

Table 12: Percent of Screened Cases that are Rejected

Percent of Screened Cases that are Rejected	Percent of Respondents
less than 75 %	5.21%
75% to 89%	18.01%
90% to 94%	25.59%
95% to 99%	42.18%
more than 99%	9.00%

To understand the reasons why attorneys reject so many cases, the survey asked “Which of the following was your primary reason for rejecting the cases that you did last year?” As reported in Table 13, the most common reason for rejecting cases was insufficient damages. Moreover, over half of the respondents indicated that cost factors—either insufficient damages or the expense of bringing the claim—were the primary reasons for rejecting cases.

Table 13: Primary Reasons for Rejecting Case

Reason for rejecting case	Percent of Respondents
Unclear causation	19.25%
Unclear evidence of malpractice	29.11%
Case is unlikely to settle	0.94%
Insufficient damages expected from trial or settlement	38.73%
Complexity and expense of bringing the claim	11.74%
Hospital not involved in malpractice	0.23%

¹⁰⁵ Greenberg & Garber, *supra* note 55.

To further explore the degree to which the expected damages affect attorneys' likelihood of accepting cases, the survey asked, "Do you have a minimum threshold for the potential damages award, below which you will not accept a case?" If the attorneys answered in the affirmative, they were asked the amount of the damages threshold. This question was asked with different percentage likelihoods of succeeding on the legal merits—95 percent, 51 percent and 25 percent. Table 14 reports the percent of responses that indicated different levels of damage thresholds for each of the likelihoods of winning. As expected, the minimum damages threshold, below which attorneys will not accept a case, increases as the likelihood of winning the case decreases; as case risk increases, so does the return. This risk-return tradeoff is economically rational and is seen in all areas of investment behavior.

Table 14: Damage Thresholds for Accepting Cases

Damages Threshold below which will not accept case	Percent of Respondents when likelihood of winning on the merits is 95%	Percent of Respondents when likelihood of winning on the merits is 51% ¹⁰⁶	Percent of Respondents when likelihood of winning on the merits is 25% ¹⁰⁷
less than \$50,000	1.18%	0.78%	0%
\$50,000 to \$149,000	20.71%	3.10%	4.17%
\$150,000 to \$249,000	22.49%	7.75%	4.17%
\$250,000 to \$499,000	27.81%	17.83%	8.33%
\$500,000 and over	27.81%	70.54%	83.33%
Median damages threshold	\$250,000	\$500,000	\$1,000,000

The results confirm that access to justice is a significant problem in today's medical liability system. First, virtually no attorney will accept any medical malpractice case, even if the likelihood of winning is 95 percent, if the expected damages are less than \$50,000. As the majority of medical malpractice victims do not suffer harm that equates to an exorbitant damage award, this result indicates that many victims will not be able to obtain legal representation.

¹⁰⁶ 13 percent of respondents indicated that, regardless of the expected damages, they would never accept a case with this likelihood of winning on the merits.

¹⁰⁷ 19 percent of respondents indicated that, regardless of the expected damages, they would never accept a case with this likelihood of winning on the merits.

Second, well over half of the attorneys indicated that they will not accept a case, regardless of the likelihood of winning the case, if the expected damages are less than \$250,000. This is consistent with the RAND survey that has examined whether attorneys have a damage threshold below which they will not accept a case.¹⁰⁸ Although the RAND survey did not differentiate between different likelihoods of winning the case, and it provided damage threshold categories to respondents instead of allowing them to enter their own damages threshold amount, it similarly found that 53 percent of attorneys would automatically reject a case if the expected damages were less than \$250,000.

Finally, the median thresholds in the survey responses indicate the minimum damages, below which at least half of medical malpractice attorneys will not even consider taking a case. The reported medians reveal that most attorneys won't accept a slam-dunk case (95 percent likelihood of winning) unless the expected damages are over \$250,000. Most attorneys will not accept a case that is more likely than not to be decided in the plaintiff's favor (51 percent likelihood of winning) unless the expected damages are over \$500,000. Finally, most attorneys won't accept a case that is tough to win on the merits (25 percent likelihood of winning) unless expected damages are at least \$1 million.

Finally, to determine whether tort reform has exacerbated the access to justice problem in the medical liability system, the survey asked "Which of the following reforms have reduced your willingness to accept cases?" Table 15 reports the percent of respondents that selected each choice. Over 80 percent of the respondents indicated that some tort reform had reduced their willingness to accept cases. As predicted by the theoretical literature and the two previous studies of tort reform's impact on case acceptances,¹⁰⁹ the reform that was most commonly named as affecting attorneys' willingness to accept cases was noneconomic damage caps.

Table 15: Tort Reforms' Impact on Willingness to Accept Cases

Tort Reform	Percent of Respondents
Noneconomic damage caps	31.25%
Punitive damage caps	3.87%
Reforms eliminating joint-and-several liability	12.50%
Reforms to the collateral source rule	15.77%
None	19.35%
Other	17.26%

¹⁰⁸ Greenberg & Garber, *supra* note 55.

¹⁰⁹ Daniels & Martin, *supra* note 29, at 32; Steven Garber et al., *supra* note 80, at 637.

IV. IMPLICATIONS OF THE ACCESS TO JUSTICE PROBLEM

The results from my survey indicate that many attorneys are unwilling to represent legitimate victims of medical malpractice if they do not expect a sufficiently large recovery. Without legal representation, most of these victims will not be compensated for the harm they suffer as a result of medical negligence. In turn, the medical liability system will fail to provide adequate precautionary incentives for physicians and hospitals.

In this section, I further explore the implications of this access to justice problem. First, using data on median plaintiff recoveries from 1985-2010, I show that only the most severely injured victims will be able to easily find legal representation. Then, I present data that reveals a worsening access to justice problem. These data show that plaintiffs with expected damage awards lower than \$250,000 are finding it increasingly difficult to obtain legal representation. Without legal representation, fewer and fewer of these plaintiffs are recovering any payment for their harms.

The data I employ are from The Physician Insurers Association of America (PIAA), the insurance industry trade association representing domestic and international medical professional liability insurance companies.¹¹⁰ PIAA maintains the world's largest independent medical professional liability research database, collecting data from its members that provide insurance protection to more than 60 percent of America's private practice physicians, and write approximately 46 percent or \$5.2 billion of the total industry premium. The PIAA medical malpractice data provides information on more than 274,000 medical and dental claims and lawsuits. As the PIAA data covers such a large proportion of the litigation in the U.S. medical liability system, it is frequently used to develop national overviews of claims and litigation.

A. IDENTIFYING THE SILENT VICTIMS

Drawing from the PIAA data, Table 16 reports the median payment made to plaintiffs between 1985-2010 by severity of plaintiff injury and primary allegation against the medical provider.¹¹¹ For example, the table reports that for allegations of improper performance—when either an operative or diagnostic procedure is done incorrectly—the median payment to plaintiffs suffering only emotional injury was \$20,000. In contrast, the median payment made to plaintiffs suffering grave injuries—injuries requiring lifelong care—for the same allegation was \$457,341. The payment data are from a significant number of claims; for example the data on median payments made for improper performance claims is collected from 65,603 closed claims.

¹¹⁰ PHYSICIAN INSURERS ASSOCIATION OF AMERICA, *supra* note 101.

¹¹¹ *Id.* at Exhibit 8.

Table 16: Median payment made to plaintiffs between 1985-2010 by severity of plaintiff injury and primary allegation against the medical provider

Severity of Patient's Injury	Median Indemnity for Improper Performance	Median Indemnity for Errors in Diagnosis	Median Indemnity for Failure to Supervise or Monitor a Case	Median Indemnity for Medication Error
Emotional injury only	\$20,000	\$16,625	\$36,625	\$20,000
Insignificant injury	\$17,500	\$16,278	\$12,500	\$10,000
Minor temporary injury	\$30,000	\$25,000	\$25,000	\$12,500
Major temporary injury	\$75,000	\$60,000	\$70,000	\$25,000
Minor permanent injury	\$85,000	\$100,000	\$100,000	\$60,311
Significant permanent injury	\$152,659	\$142,341	\$175,000	\$115,000
Major permanent injury	\$300,000	\$225,000	\$250,000	\$220,079
Grave	\$457,341	\$200,000	\$464,031	\$292,500
Death	\$150,000	\$150,000	\$110,000	\$100,000
Total Number of closed claims from 1985-2010	65,603	52,159	18,115	10,473

The data on median payments are for actual claims, and thus, situations when victims of medical malpractice were able to obtain legal representation. Thus, these claims likely had higher expected damage awards than the majority of cases that attorneys were unwilling to take. Nevertheless, the data reveal that, in many cases, recoveries for less serious injuries are small enough that if the attorneys expected that the final recovery in a case would equal the median recovery (and the definition of median implies that half of the cases in each category result in payments less than or equal to that median recovery), they would often refuse to take the case. Although the specific decision to take a case will depend on both the expected recovery and the expected costs—so that attorneys will take low recovery cases if they expect litigation costs to be low as well—many of the median payments in Table 16 are lower than the median minimum damage thresholds indicated in my survey results.

For example, Table 14 reported that even for a case that had a 95 percent likelihood of winning on the merits, over 98 percent of attorneys would refuse to take the case if expected damages were below \$50,000. Table 17 shows that if these attorneys expected the final recovery in such a case to be equal to the median recovery reported in the PIAA data, they would refuse to take all of the cases represented by the shaded regions. Thus, even for a slam dunk case, if attorneys expected a typical recovery, they would never accept a case that resulted in only emotional injury, insignificant injury, or minor temporary injury, regardless of the allegations against the doctor.

Table 17: Attorney Rejection of Cases if Minimum Damages Threshold is \$50,000

Severity of Patient's Injury	Median Indemnity for Improper Performance	Median Indemnity for Errors in Diagnosis	Median Indemnity for Failure to Supervise or Monitor a Case	Median Indemnity for Medication Error
Emotional injury only	\$20,000	\$16,625	\$36,625	\$20,000
Insignificant injury	\$17,500	\$16,278	\$12,500	\$10,000
Minor temporary injury	\$30,000	\$25,000	\$25,000	\$12,500
Major temporary injury	\$75,000	\$60,000	\$70,000	\$25,000
Minor permanent injury	\$85,000	\$100,000	\$100,000	\$60,311
Significant permanent injury	\$152,659	\$142,341	\$175,000	\$115,000
Major permanent injury	\$300,000	\$225,000	\$250,000	\$220,079
Grave	\$457,341	\$200,000	\$464,031	\$292,500
Death	\$150,000	\$150,000	\$110,000	\$100,000

Moreover, the PIAA data indicates that the injuries depicted in the shaded region of Table 17 make up over 24 percent of claims for medical negligence. This implies that for almost a quarter of medical malpractice victims, 98 percent of attorneys would refuse to accept their case unless the expected damages were significantly greater than the typical damages for those injuries.

The situation becomes even more dire when I analyze the cases that will be rejected using my survey's median minimum damages threshold for cases with a 95 percent likelihood of success. As reported in Table 14, most attorneys won't accept a slam-dunk case (95 percent likelihood of winning) unless the expected damages are over \$250,000.

As a result, Table 18 shows that, for at least half of the attorneys in my survey,¹¹² if the final recovery in a case is expected to equal the median recovery, they would refuse to take all of the cases represented by the shaded regions. Thus, even for cases that they are almost certain to win, at least half of the attorneys would never accept a case that resulted in any injury less severe than a major permanent injury or grave injury unless they expected damages that were considerably larger than typical damages. At least half of the attorneys would even refuse to accept a case that resulted in death if they only expected a typical recovery.

Table 18: Attorney Rejection of Cases if Minimum Damages Threshold is \$250,000

Severity of Patient's Injury	Median Indemnity for Improper Performance	Median Indemnity for Errors in Diagnosis	Median Indemnity for Failure to Supervise or Monitor a Case	Median Indemnity for Medication Error
Emotional injury only	\$20,000	\$16,625	\$36,625	\$20,000
Insignificant injury	\$17,500	\$16,278	\$12,500	\$10,000
Minor temporary injury	\$30,000	\$25,000	\$25,000	\$12,500
Major temporary injury	\$75,000	\$60,000	\$70,000	\$25,000
Minor permanent injury	\$85,000	\$100,000	\$100,000	\$60,311
Significant permanent injury	\$152,659	\$142,341	\$175,000	\$115,000
Major permanent injury	\$300,000	\$225,000	\$250,000	\$220,079
Grave	\$457,341	\$200,000	\$464,031	\$292,500
Death	\$150,000	\$150,000	\$110,000	\$100,000

Moreover, the PIAA data indicates that the shaded region in Table 18 represents over 95 percent of injury claims. Thus, 95 percent of medical malpractice victims will find it extremely difficult to find legal representation unless their damages are substantially more than the typical damages for their types of injuries.

¹¹² At least half of the attorneys indicated that their minimum damages threshold for a case with a 95 percent likelihood of success was \$250,000.

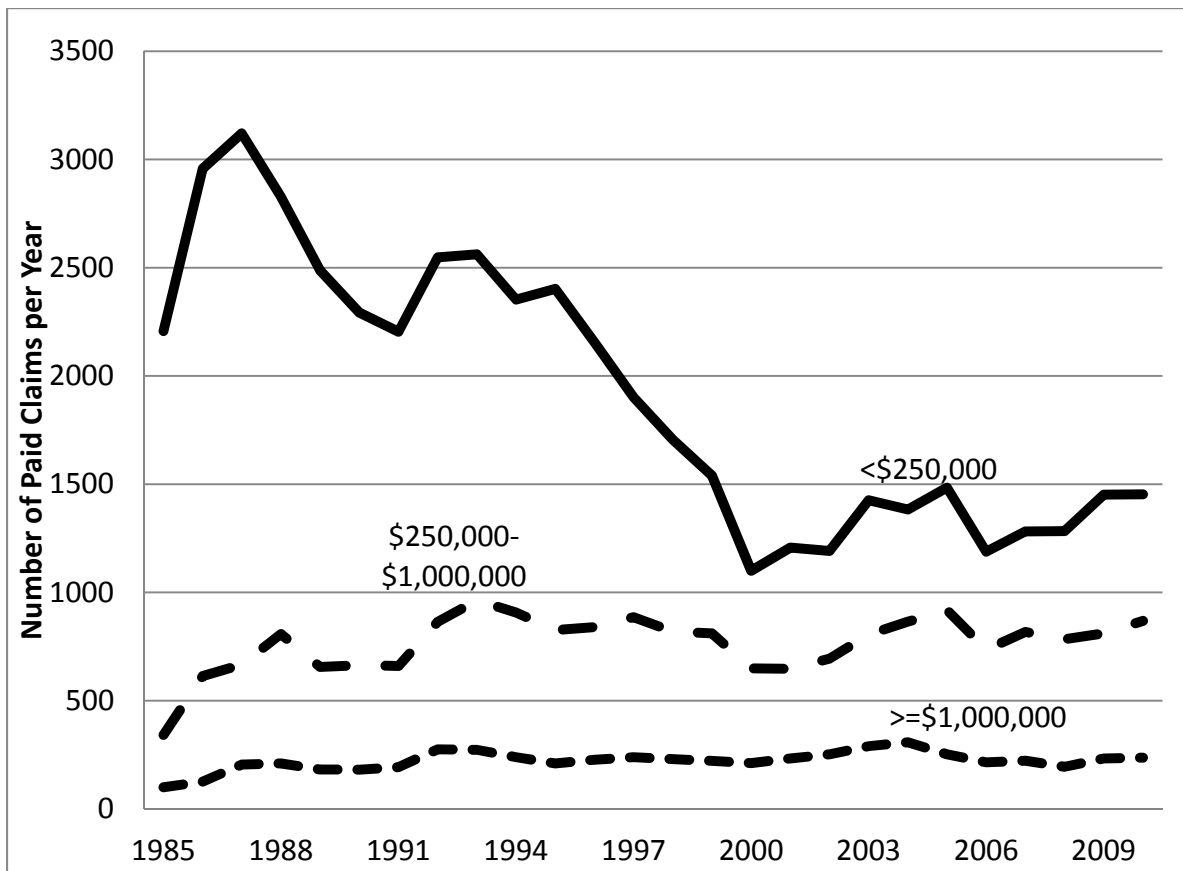
Thus, the data on median payments indicate that unless attorneys expect an unusually large recovery that is far greater than the median, they will not accept cases for anything but the most serious injuries. This finding is consistent with attorneys' claims that "there's no such thing... as a good small medical malpractice case."¹¹³

B. THE WORSENING ACCESS TO JUSTICE PROBLEM

Next I analyze data on closed claims resulting in payments of different dollar amounts from 1985 to 2010. The data suggest that the problem of access to justice is worsening.

Figure 1 reports PIAA data on the dollar values of payments to medical malpractice plaintiffs from 1985 to 2010, in 2010 dollars. The data reveal that, although the number of payments above \$250,000 has remained relatively constant over this period, the number of payments below \$250,000 has dropped dramatically. In fact, in 2010, there were fewer than half the number of payments below \$250,000 as there were at the peak in the late 1980s.

Figure 1: Trends in Dollar Value of Paid Medical Malpractice Claims 1985 to 2010; 2010 dollars



¹¹³ PHYSICIAN INSURERS ASSOCIATION OF AMERICA, *supra* note 101, at 33.

These data suggest that plaintiffs with expected damage awards lower than \$250,000 are finding it increasingly difficult to obtain legal representation. Indeed, other explanations for the dramatic drop in payments under \$250,000 seem improbable. For example, it is unlikely that the number of medical errors causing small injuries with harm under \$250,000 decreased over two decades while the number of medical errors causing larger harms remained constant. Similarly, it is improbable that plaintiffs' attorneys have become less successful at winning small cases with damages under \$250,000 while remaining consistently successful at winning larger cases. Instead, the time trend data suggest that without legal representation, fewer and fewer victims with small harms are receiving compensation for their harms.

CONCLUSION

This Article presents survey results that confirm that there are many silent victims in the American medical liability system. High litigation costs make it economically infeasible for contingency fee attorneys to accept many legitimate cases. Unless expected damages are large, the attorneys simply cannot justify accepting many cases because the expected fees will not offset the high costs of medical malpractice litigation. Moreover, the economic calculus required by the contingency fee system causes attorneys to gravitate towards some types of medical malpractice cases and victims, and ignore others. Evidence shows that contingency fee attorneys disproportionately reject cases from lower-income groups such as females, the elderly, children, and racial minorities because their expected damage awards are often relatively low.

These victims that are unable to attain legal representation are effectively excluded from the civil justice system. Because of the complexity and expense of medical malpractice lawsuits, employing a lawyer is critical to a successful claim. Thus, without legal representation, most of these victims will not receive compensation for the harm they suffer as a result of medical negligence. In turn, the medical liability system will fail to provide adequate precautionary incentives for healthcare providers.

Without dramatic change, victims' limited access to justice will continue to hinder the medical liability system's ability to achieve its compensatory and deterrent functions. Unfortunately, most legislative reforms over the past several decades have exacerbated the access to justice problem instead of improving it. Damage caps and other tort reforms that artificially reduce plaintiffs' damage awards also reduce contingency attorneys' expected recoveries. As a result, even fewer cases make economic sense for the attorneys to accept.

In order to increase victims' access to the medical liability system, future reforms should aim to either increase attorneys' willingness to accept cases or provide compensation to victims without an attorney. For example, reforms that increase legal services funding would ensure that attorneys are minimally compensated for their time.

Similarly, reforms imposing attorneys' fees awards on negligent defendants would encourage some attorneys to accept cases even if the expected damages, and in turn, the expected contingent fees, are low.¹¹⁴

Alternatively, reforms could create a system under which legitimate victims receive compensation even if they do not have legal representation. For example, several scholars have proposed an administrative compensation system under which claims for medical injuries are handled through an administrative body rather than the judicial system.¹¹⁵ Proposals for such a model indicate that the process would be simple enough that claimants would not need legal representation as their claims would be resolved by neutral adjudicators and neutral medical experts. America's experience with such a system is limited to the federal Vaccine Injury Compensation Program that covers certain vaccine-related injuries and Florida and Virginia's administrative systems that cover certain birth-related neurological injuries. However, broader administrative systems have successfully operated in other countries—Sweden, Denmark, Finland, Norway, and New Zealand—for decades. Although replacing America's current medical liability system with an administrative system would be a dramatic change, only a significant overhaul of the current system will resolve the access to justice crisis.

¹¹⁴ The Brennan Center has proposed similar reforms to increase access to justice for low-income citizens. Brennan Center for Civil Justice, Civil Justice http://www.brennancenter.org/content/section/category/civil_justice/ (last visited September 2, 2012).

¹¹⁵ See, e.g., Michelle M. Mello et al., *Administrative Compensation for Medical Injuries: Lessons from Three Foreign Systems*, ISSUES IN INTERNATIONAL HEALTH POLICY (2011).