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**Expertise in  
Medical Malpractice Litigation:  
Special Courts, Screening Panels,  
and Other Options**

Catherine T. Struve

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# Table of Contents

<b>Exhibits</b> .....	iii
<b>Acknowledgments</b> .....	v
<b>Executive Summary</b> .....	1
<b>Introduction</b> .....	7
Expertise and Procedural Reform .....	8
The Roots of Physicians' Distrust of the Legal System .....	11
Self-Defense and Self-Regulation .....	12
The Drive Toward Public Accountability .....	14
Implications for the Current Debate .....	16
<b>Expertise in the Litigation Process</b> .....	19
Purposes of the Civil Justice System .....	19
An Overview of Decision-making in Malpractice Litigation .....	20
Deciding Whether to Claim .....	21
Discovering Information About the Claim .....	23
Resolving the Claim Prior to Trial .....	24
Trying the Case .....	25
The Judge's Role at Trial .....	25
The Judge's Role After the Verdict .....	26
Expertise in Bringing Claims .....	26
Evidence on Claiming .....	27
Plaintiffs' Need for Information .....	29
Specialist and Non-Specialist Attorneys .....	30
Expertise in Settling Claims .....	30
Expertise in Evaluating Experts .....	32
Expertise in Assessing Liability .....	34
Liability Issues in Malpractice Cases .....	35
Evidence Concerning Jury Determinations of Liability .....	37
Expertise in Calculating Damages .....	41
Damages Issues in Malpractice Cases .....	42
Evidence Concerning Jury Awards of Damages .....	42
Judicial Review of Jury Awards .....	44
Summarizing the Need for Expertise in Malpractice Litigation .....	46
<b>Current or Proposed Reforms</b> .....	47
Certificate of Merit Requirements .....	48
Empirical Data on Certificate of Merit Provisions Are Scarce .....	50
Designing a Certificate of Merit Provision .....	50
Pennsylvania's Certificate of Merit Provision .....	54
Screening Panels .....	55
How Screening Panels Work .....	58
Studies Linking Panels to Claims Frequency Are Mixed .....	59
Panel Requirements May Discourage Some Claims .....	61

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Studies Find Little Effect on Severity of Paid Claims . . . . .	64
Studies Find No Consistent Effect on Malpractice Premiums . . . . .	65
Panels are Not an Optimal Way to Provide Expertise to the Jury . . .	66
Overall, Panels are Unpromising . . . . .	67
Specialized Courts . . . . .	68
The Concept of a Specialized Court . . . . .	68
Pennsylvania’s Court System . . . . .	70
Proposals for a Medical Liability Court in Pennsylvania . . . . .	71
Advantages of a Specialized Court are Questionable . . . . .	72
Disadvantage: Politicization . . . . .	73
Disadvantage: Narrowed Judicial Perspective . . . . .	75
Disadvantage: Cost to Litigants . . . . .	76
The Issue of Juries and Damage Awards . . . . .	77
Alternatives to a Specialized Court . . . . .	80
<b>Possibilities for Expertise-enhancing Reform . . . . .</b>	<b>83</b>
Use of Experts . . . . .	83
Promoting Active Learning by Jurors . . . . .	86
Guidance Concerning Noneconomic Damages . . . . .	87
<b>Conclusion . . . . .</b>	<b>91</b>
<b>References . . . . .</b>	<b>95</b>
<b>The Author . . . . .</b>	<b>107</b>
<b>About the Project . . . . .</b>	<b>Inside Back Cover</b>

# Exhibits

1. Current Reform Proposals Aimed at Enhancing Expertise
2. Goals of the Civil Justice System
3. Selected Stages of Malpractice Litigation
4. Outcomes, Claims and Payments
5. Certificates of Merit May Help Screen Out Weak Claims
6. Screening Panel Provisions Have Been Repealed and/or Invalidated in Roughly One Third of the States That Adopted Them
7. Screening Panels Seem Unlikely to Improve Most Aspects of Medical Malpractice Litigation
8. Pennsylvania's Court System
9. The Costs of a Specialized Medical Malpractice Court Would Outweigh the Benefits





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# Executive Summary

Plaintiffs' lawyers, judges, and juries stand at the center of the dispute over medical malpractice reforms. Critics of the present system charge that plaintiffs' lawyers bring meritless claims, that judges allow testimony by ill-qualified expert witnesses, and that juries make unwarranted findings of liability and award excessive damages.

These criticisms sometimes give rise to proposals to change substantive malpractice law—as by imposing a cap on noneconomic damages. But the notion that the current system fails to display sufficient technical expertise also leads reformers to seek changes in the procedures by which parties enforce their substantive rights. This report focuses on proposals for expertise-enhancing procedural reform, and asks whether the most-discussed reforms are likely to improve the system. It considers the following aspects of the current debate:

- Physicians' experiences with the legal system, and their critiques of it
- The need for expertise at various stages of malpractice litigation
- Implemented and proposed procedural reforms
- Alternative possibilities for enhancing expertise

## **THE CONTEXT OF DOCTORS' CRITIQUES**

Many doctors distrust the civil justice system. They believe that juries are not competent to assess malpractice liability; that jurors are eager to award damages, even against innocent doctors, in order to compensate sympathetic plaintiffs; and that judges fail to protect defendants against unjustified verdicts. These beliefs have serious consequences, including high levels of wasteful and potentially harmful “defensive medicine.” Though physicians' distrust stems most directly from well-publicized, large awards in recent cases and from the mounting costs of malpractice insurance, the roots of their critique extend back to experiences with litigation and lawyers in the mid-to-late nineteenth century.

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## **THE NEED FOR EXPERTISE IN MALPRACTICE LITIGATION**

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Though some malpractice claims present simple disputes, others raise difficult and complex questions concerning the standard of care, causation of injury, and amount of damages. Plaintiffs' lawyers have an incentive to screen cases carefully because they generally are paid only if they win a judgment or settlement. Lawyers who specialize in bringing malpractice cases are likely to screen expertly and accurately. Lawyers with less experience in medical malpractice, however, may be less skilled in evaluating potential claims.

Judges play three key roles in malpractice litigation: they oversee the pretrial process, they determine whether the parties' expert witnesses are qualified to testify, and they decide whether there is sufficient evidence to submit a case to a jury, and whether any resulting jury verdict should stand. Pretrial management may not require expertise specific to malpractice cases. Ruling on the admissibility of expert testimony, however, requires familiarity with medical evidence, and available data suggest that judges' understanding of scientific principles is imperfect. In addition, judicial review of jury verdicts requires expertise concerning the appropriateness of damages awards.

Studies indicate that juries deal better with complex cases than their critics sometimes charge, but that there is room for improvement. Jurors' determinations of liability tend to correlate with independent medical assessments. Likewise, although jury damages awards vary in size, much of that variability can be explained by factors such as the severity of the plaintiff's injuries. On the other hand, juries have difficulty with technical information, statistical evidence in particular.

## **CURRENT AND PROPOSED REFORMS**

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The report evaluates in detail one existing reform and two current proposals:

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- Certificate of merit requirements
  - Medical screening panels
  - Specialized medical malpractice courts

The certificate of merit requirement may provide some benefits, but screening panels and specialized courts are less promising.

Roughly a third of the states—including Pennsylvania—have adopted certificate of merit provisions. These provisions typically require the plaintiff to certify—at or near the outset of the suit—that a medical expert has reviewed the claim and found it to be potentially valid. Such a requirement is unlikely to have a dramatic effect on the practices of attorneys who specialize in representing malpractice plaintiffs, because those attorneys already obtain an expert evaluation prior to suing. Non-specialist plaintiffs’ attorneys, however, may not always obtain such an evaluation, and a certificate of merit requirement could help prevent the assertion of weak claims by such attorneys. The certificate of merit requirement should be carefully structured to obtain this benefit without imposing undue burdens on plaintiffs.

Twenty states currently provide for medical screening panels; in eleven other states, screening panel provisions previously existed but have been invalidated or repealed. Though panel schemes vary in their details, the basic notion is to send malpractice claims to a panel composed partly or wholly of physicians. After hearing evidence and argument concerning the claims, the panel renders an opinion on liability and (in some states) damages. The panel’s determination is not binding, and the parties can subsequently proceed to trial. Proponents contend that the panel can screen out weak claims and encourage settlement of valid claims, and that in the cases that go to trial, putting the panel’s determination before the jury can provide a neutral and reliable source of expert knowledge. Unfortunately, studies suggest that screening panels may fail to accomplish these goals.

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Though negative panel findings may deter some plaintiffs from pressing their claims further, some of those claims might never have been brought if the panels themselves did not exist. Panels may contribute to the resolution of claims prior to trial, but one possible reason is that they increase the cost and delay of litigation, and thus they may deter even plaintiffs with valid claims. Finally, panels seem an ineffective method for providing non-partisan expertise at trial.

The third proposed reform considered in this report—for specialized medical liability courts—does not currently exist in any state. A medical liability court system has recently been proposed in Pennsylvania, and the national reform organization Common Good supports specialized medical malpractice courts as a way to provide “expert judges ruling on standards of care.” In the abstract, a specialized court may seem like a promising way to increase judicial expertise and consistency. An examination of the court proposed for Pennsylvania, however, reveals serious risks of increased politicization, narrowed judicial perspective, and greater costs to litigants.

### **POSSIBLE ALTERNATIVE REFORMS**

The report surveys other possibilities for expertise-enhancing reform in malpractice litigation. Three types of reforms may offer significant improvements:

- Alternative approaches to expert testimony
- Reforms to reduce jury passivity
- Guidance for judges and juries concerning noneconomic damages

Changes in the use of expert testimony address the concern that juries may be unduly swayed by unreliable and partisan experts. In addition to applying stricter rules for the qualification of experts (such as those recently adopted in Pennsylvania), courts may also wish to seek out nonpartisan expert advice and/or testimony in particularly complex cases.

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Jury reforms hold the promise of improving jurors' ability to absorb and process information. Some jurisdictions have already adopted reforms designed to promote active learning by jurors, and the experience in those jurisdictions may provide insight into the advisability of adopting similar reforms in Pennsylvania.

A large part of the variability of noneconomic damage awards likely results from the lack of clear standards for either juries or judges to use in awarding or reviewing such damages. Proposals recently put forward by Governor Rendell, which would require judges to reduce awards that deviate materially from reasonable compensation, and which advocate the development of standards to guide judicial oversight of jury awards, might be beneficial.

## **CONCLUSION**

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Though judges and juries function reasonably well in handling medical malpractice cases, their performance could be improved. Certificates of merit are a reasonable step. However, screening panels and specialized courts are unpromising. In considering procedural changes, policymakers should focus instead on reforms that better educate existing judges and juries.

# Introduction

Substantive law sets the rights of the parties involved in a dispute, whereas procedural law shapes the methods by which the legal system resolves that dispute. Though recent malpractice reform efforts have focused principally on substantive questions, the

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**The procedures for adjudicating malpractice disputes deserve close attention as well. ... Physicians perceive that the determination of malpractice liability and damages requires expertise, and they question the current system's capacity for expertise.**

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procedures for adjudicating malpractice disputes deserve close attention as well. To take a prominent example, a cap on damages is a substantive rule that alters a plaintiff's right to recover money from a defendant. By contrast, a requirement that a malpractice plaintiff submit an expert's certificate attesting that the claim has merit is a procedural requirement – but it affects the plaintiff's ability to enforce substantive rights.

This fact has not escaped the attention of malpractice reformers, many of whom view the litigation system as seriously flawed. In particular, many physicians rightly perceive that the determination of malpractice liability and damages requires expertise, and they question the

current system's capacity to incorporate such expertise. Further, litigation procedures can have a profound impact on the division of authority between lay judges and juries, on one hand, and experts such as physicians on the other. As Jay Gold has pointed out, a key question in the design of procedures for malpractice litigation concerns how and to what extent decisional authority should be delegated to medical professionals rather than exercised by laypersons (Gold 1981-82).

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## **Expertise and Procedural Reform**

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Expertise underlies several recent proposals for procedural malpractice reform. Doctors believe that plaintiffs' lawyers assert meritless claims, that generalist judges fail to curb the use of unqualified "expert" witnesses, and that juries, influenced by dubious testimony, find unwarranted liability and award excessive damages. These views have prompted the suggestion that plaintiffs provide a certificate of merit when filing a claim, have

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revived proposals for medical screening panels staffed in whole or in part by physicians, and have led to calls for a specialized medical liability court (see Exhibit 1).

The central questions in some malpractice cases are relatively simple and straightforward, but other cases will require difficult judgments concerning the physician's conduct and the cause of the plaintiff's injuries. Proponents of these reforms argue that enhanced expertise will result in more accurate determinations of liability and damages, which in turn will more fairly distribute the financial burden of malpractice insurance and send a clearer signal to the health care system about how to improve safety.

Expert dispute resolution, they claim, may reduce defensive medicine as well. Physicians who undertake unnecessary medical procedures for fear of being sued do so not only because of the substantive rules of liability, but because they question the ability of the current system to apply those rules accurately.



This report assesses the degree to which each of these proposals is likely to improve the process of medical malpractice litigation. The report’s focus is on Pennsylvania, but the issues discussed should be relevant to other states as well. Because it is their competence that

<b>Exhibit 1. Current Reform Proposals Aimed at Enhancing Expertise</b>		
<b>PROPOSAL</b>	<b>CITE</b>	<b>KEY POINTS:</b>
<b>PA screening panel proposals</b>	<b>H.B. 22 H.B. 476</b>	<ul style="list-style-type: none"> <li>■ Panels that include physicians review the merits of malpractice claims prior to trial</li> </ul>
<b>Common Good's medical courts proposal</b>	<b>Howard (2003)</b>	<ul style="list-style-type: none"> <li>■ Specialized medical liability courts</li> <li>■ Judges, not juries, decide standard of care</li> </ul>
<b>PA medical courts proposals</b>	<b>H.B. 23 H.B. 1199 S.B. 204</b>	<ul style="list-style-type: none"> <li>■ Specialized medical liability courts</li> </ul>
<b>Remittitur proposals</b>	<b>H.B. 1719 S.B. 862 Rendell (2003)</b>	<ul style="list-style-type: none"> <li>■ Reduction of jury awards that deviate materially from reasonable compensation</li> <li>■ Guidelines for reduction of noneconomic damages</li> </ul>

is challenged by proponents of the reforms under consideration, this report concentrates on the role of plaintiffs’ lawyers, judges and juries, and does not closely scrutinize other groups whose conduct is central to malpractice litigation – defendants, liability insurers, and defense lawyers. Typically, malpractice insurers retain their own experts to assess potential liability, and those assessments will shape the course of any subsequent settlement negotiations (Peeples, Harris, and Metzloff 2002). However, the problem of the non-specialist attorney is unlikely to arise with respect to defense counsel, since insurers tend to select experienced attorneys.

As described in detail below, a close look at the performance of lawyers, judges and juries reveals a mixed picture. Though plaintiffs’ lawyers have incentives to scrutinize potential claims before deciding to assert them, lawyers with less experience in medical

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malpractice may be doing a relatively poor job. The role of the judge in malpractice cases includes assessing the qualifications and testimony of medical experts, and reviewing motions to set aside or reduce a jury award in the event that the jury finds for the plaintiff. Judges may be helped in these tasks by greater knowledge of basic principles of scientific inquiry and probabilistic evidence, and by familiarity with the size of awards in similar cases. Some evidence indicates that juries have difficulty with complex cases, but there is also evidence that juries do a better job of resolving such cases than their critics claim. Juries' liability determinations in malpractice cases are not random; rather, studies find some degree of correlation between jury outcomes and medical reviewers' findings of negligence and causation. Moreover, a substantial portion of the variability in damage awards is due to legitimate factors such as the severity of the plaintiff's injury—though some variation remains unexplained by current studies. As with judges, a number of possible measures could improve the performance of juries.

Based on these assessments, this report argues that a certificate of merit requirement may have a positive impact, but that the screening panel and specialized court proposals are unpromising. To the extent that inexperienced plaintiffs' lawyers fail adequately to assess the strength of the cases they bring, a certificate of merit requirement may help to discourage the filing of some weak claims. Medical screening panels, by contrast, seem less useful and more costly. The available data provide little indication that panels are a preferable way to screen out weak cases or to promote dispute resolution. To the extent that a neutral expert opinion is needed at trial, other measures could provide that input more efficiently. Likewise, though specialized medical malpractice courts might develop useful expertise, specialization has potential disadvantages that likely offset its benefits.

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## **The Roots of Physicians' Distrust of the Legal System**

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In order to understand why expertise-enhancing devices appeal to physicians, it is helpful to review the nineteenth-century origins of physicians' current complaints about the

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legal system. Relatively rare before 1835, malpractice claims rose sharply in the mid-nineteenth century. Popular antipathy to doctors and other professionals, the destigmatization of litigation, and the decline of faith-based resignation to illness likely contributed to the change. Some practitioners, competing fiercely for business, facilitated claims against others (De Ville 1990). Improvements in medicine fueled the growth as well: broken limbs that once would have been amputated could instead be saved, and imperfections in their healing could give rise to a suit for malpractice. Popular expectations outstripped

medical advances, and the contrast between actual results and expected outcomes may have increased the rate of claims (Mohr 1993).

The increase in malpractice suits caught doctors' attention, and with good reason. Nineteenth-century doctors did not have malpractice insurance, damages might be substantial if the plaintiff won, and in any event the cost of litigation was daunting. Malpractice trials could become popular spectacles, which would be all the more damaging because a doctor's livelihood depended in large part on his standing within his community.

Physicians grew to dislike and distrust the court system even when they encountered it as expert witnesses rather than defendants. James Mohr has identified a number

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of reasons for this phenomenon. The vigorous cross-examination to which medical witnesses were subjected could be personally risky as well as highly unpleasant: a physician whose reputation was damaged on the witness stand could see his practice shrink as a result. Some physicians worried that the justice system presented medicine in a bad light by publicizing differences of opinion within the medical profession. Courts were willing to admit a wide range of testimony by alternative practitioners as well as conventionally trained physicians, so that expert physicians could find themselves contradicted in court by less-qualified practitioners. Early on, physicians complained that courts forced them to provide expert testimony but gave them no greater compensation than ordinary witnesses. As parties turned to paid experts, a different concern surfaced: litigants with money were able to retain experts to support even dubious medical contentions.

### **Self-Defense and Self-Regulation**

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During the late nineteenth and early twentieth centuries, doctors banded together to counter the danger of malpractice litigation, and their efforts met with some success. The medical profession undertook to regulate itself, and most regulatory authority gravitated to medical societies and other local medical organizations.

Paul Starr has described a number of factors that cemented the authority and raised the status of the medical profession during the end of the nineteenth century and the beginning of the twentieth (Starr 1982). Various medical groups drew together in support of professional licensing. Professional societies, including the American Medical Association, grew in size and influence. A reformed system of medical education produced doctors with shared standards and concerns. Advances in science and public health encouraged reliance on medical expertise. The profession's voice became increasingly authoritative with respect to prescription of medication. Although diverse groups of

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reformers outside the medical profession supported stringent oversight of both drugs and doctors, the profession ultimately succeeded in asserting authority on medical questions and control over the credentialing and discipline of physicians.

The trend toward medical self-regulation continued during the first half of the twentieth century. Professional regulation largely focused on the applicant's qualifications to practice, such as licensing, rather than on actual performance. Further oversight of a physician's qualifications took place in hospital credentialing committees, if the physician applied for clinical privileges. It was unusual for state medical boards to revoke or suspend a doctor's license; instead, local bodies disciplined doctors informally (Ameringer 1999).

Though the local medical community sometimes exercised disciplinary authority over incompetent physicians, it more often protected its members from malpractice liability. The principle that the standard of care for physicians was set by customary medical practice in the defendant's locality enabled the medical profession to determine whether care in a given case was negligent. Moreover, medical societies had gained increasing control over the activities of their members, and discouraged physicians from testifying in support of claims that were seen as unjustified (De Ville 1990). Early in the twentieth century, local medical societies began to provide for the defense of their members against malpractice claims, and "it became almost impossible for patients to get testimony against a physician who was a member" (Starr 1982: 111).

By the middle of the twentieth century, one could view the informal, local system of physician oversight either as a model of professionalism and collegiality, or as something more sinister. Various groups began to question physicians' willingness and ability to regulate themselves. The profession's failure to discipline errant doctors prompted some to assert the existence of a "conspiracy of silence." Medical societies' formation of grievance

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committees in the 1950s can be seen as a response to such charges, but such committees also demonstrated physicians' continuing preference for local, informal self-regulation.

### **The Drive Toward Public Accountability**

The 1970s and 1980s brought major alterations in physicians' accountability. A string of court decisions in the late 1950s to early 1970s defined the modern legal notion

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of "informed consent," and this development began to reorient the profession from a model of deference to physicians' judgment to a model of patient choice (Faden and Beauchamp 1986). Health care institutions developed a growing interest in monitoring the quality and controlling the expense of medical treatment. The incidence of malpractice litigation rose, and caused some to question the medical profession's capacity to regulate itself. In addition to tort reform, states also adopted measures designed to increase the medical profession's accountability to the public.

Professional discipline by state medical boards offers an example. Only a handful of physicians were disciplined for malpractice during the mid-1960s. Robert Derbyshire (a former president of the Federation of State Medical Boards) observed even in 1983 that "many disciplinary bodies seem more interested in protecting their medical colleagues than in safeguarding the public" (Derbyshire 1983: 196). More recently, Timothy Jost writes:

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Perhaps the most important factor limiting the effectiveness of medical boards in addressing incompetence is the fact that most licensure boards are still composed predominantly of physicians. Physicians are reluctant to criticize each other for technical and judgment errors. ... If rehabilitative sanctions are available, these may be more palatable, as may disciplinary actions not disclosed to the public. But physicians are clearly unenthusiastic about the use of serious licensure actions to sanction medical errors (Jost 1995: 862-64).

In the aftermath of the 1970s and 1980s malpractice crises, some states increased lay participation on medical boards and/or decreased the role of medical societies in the selection of board members. Boards began to sanction physicians for substandard care. By the late 1980s and early 1990s, both the absolute numbers and the proportion of disciplinary actions due to substandard care had markedly increased. It may not be coincidental that in California—which has seen relative success in keeping malpractice premiums low and preserving tort reforms adopted in the 1970s—the state medical board has enjoyed a higher operating budget than in many other states (Ameringer 1999).

Recent years brought new kinds of accountability and new perspectives on improving care. Frances Miller argues that “a shift to a more market-oriented health sector, and dramatic advances in health care information technology and collection methods,” have pushed “the locus of ‘disciplining’ doctors ... away from traditional government licensure and medical malpractice litigation toward purchasers of medical services” (Miller 1997: 32). In addition, the current emphasis on quality improvement focuses on altering the systems through which health care is provided, in order to diminish the opportunities for human error (Institute of Medicine 1999).

Physicians have accepted these forms of accountability with difficulty, but remain uncomfortable with the imposition of malpractice liability even where an error in judgment did result in injury. Physicians, Jost argues, “generally view ... bad outcomes as

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largely random events” (Jost 1995: 856). Because “[d]iagnostic decisions are probabilistic” and the choice of treatment “will often vary depending on the patient’s characteristics,” determining whether appropriate care was provided is “highly problematic.” In light

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**Physicians remain uncomfortable with the imposition of malpractice liability even where an error in judgment did result in injury.**

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of this difficulty, “normative failures—violations of professional responsibility—are perceived by professionals to be more serious than errors of judgment or of application of skill. Errors of judgment and of technique are inevitable and are expected” (Jost 1995: 843-45; Bosk 1979).

#### **Implications for the Current Debate**

The trends discussed above help to explain why the question of expertise in medical malpractice litigation resonates with physicians. Doctors’ distrust of the legal system has deep roots in nineteenth-century medico-legal battles, but it also reflects doctors’ current perspective on bad medical outcomes. Physicians naturally feel discomfort at the prospect that non-physicians will judge whether they are liable for malpractice (Sage 2001; Weiler 1991). They are likely to prefer a system in which care is evaluated by physicians, and they may also prefer a system in which disputes are settled informally and confidentially. When allegations are already public, on the other hand, some physicians may prefer litigation to settlement, in order to clear their names (Gross and Syverud 1991, 1996).

At the same time, the history of medical self-regulation suggests countervailing concerns. The longstanding notion of a medical “conspiracy of silence” concerning incidents of malpractice, juxtaposed against recent reports of an epidemic of medical errors,



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may render the notion of self-regulation unappealing to the public. The contest between self-regulation and public accountability centers not just on expertise but also on information. Patients who have suffered adverse results after medical treatment want information about what happened to them; indeed, this desire may be a major reason for lawsuits.

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**Patients who have suffered adverse results after medical treatment want information about what happened to them. ... Accordingly, the assessment of proposed procedural reforms should attend both to doctors' impulse towards self-regulation and to the public's wish for increased accountability.**

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Although the mere fact of suit or settlement does not demonstrate that a particular doctor provides substandard care, some members of the public might also wish to know whether a particular doctor has settled or lost malpractice claims. The call for increased disclosure of doctors' malpractice histories cuts against informal settlement of disputes.

Accordingly, the assessment of proposed procedural reforms should attend both to doctors' impulse towards self-regulation and to the public's wish for increased accountability. For example, doctors might favor the notion of 'medical panels' or 'medical courts' because they view such measures as returning to them some degree of self-regulation. On the other hand, that rationale might find little support among members of the public.

This report proceeds in three parts. The first section looks at the malpractice litigation system, at common issues in malpractice cases, and at plaintiffs' attorneys, judges, and juries as participants. The second section assesses the specific procedural reforms

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mentioned above: certificate of merit requirements, medical screening panels, and specialized courts. The final section considers alternative ways to enhance expertise within the litigation process.

# Expertise in the Litigation Process

Each major step in malpractice litigation requires participants to make judgments concerning the plaintiff's claims and evidence. Those judgments require expertise of varying sorts. Although substantive law defines the elements that a plaintiff must establish in order to win at trial, procedural law sets the framework within which decision-making takes place.

## **Purposes of the Civil Justice System**

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As shown in Exhibit 2, the litigation system in the United States has a number of functions (James, Hazard and Leubsdorf 2001). It serves the goals of the substantive law by providing a means for parties to seek enforcement of that law. In tort law, including malpractice law, those goals are compensation, deterrence, and justice. At the same time, litigation procedure gives private parties a means of resolving their disputes. Cases usual-

**Exhibit 2. Goals of the Civil Justice System Include:**

- √ **Enforce substantive law**
- √ **Resolve disputes**
- √ **Provide fair process and results**
- √ **Operate efficiently**
- √ **Inform the public**

ly settle prior to trial, but the possibility of trial serves both to focus the settlement discussions and to supply an ultimate resolution if those discussions should fail. The litigation process seeks to be fair, and also to give the appearance of fairness. Thus, its rules are designed to offer each party an opportunity to gather the evidence it needs, and to be heard by a neutral, unbiased decision-maker. The process seeks to achieve these objectives in an efficient and economical manner, without imposing undue cost or delay on the parties. In addition, trials, verdicts, and judicial decisions all may provide the public with useful and important information, both about the events that gave rise to the litigation and about the civil justice system itself.

Litigation in the United States pursues these goals through an adversarial model

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**Private legal disputes are shaped primarily by the parties – plaintiff and defendant – who define the claims, uncover relevant information, engage in settlement discussions, and (if those discussions are fruitless) move the case to trial.**

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of justice. Private legal disputes are shaped primarily by the parties – plaintiff and defendant – who define the claims, uncover relevant information, engage in settlement discussions, and (if those discussions are fruitless) move the case to trial. At trial, moreover, the traditional adversarial notion is that the judge and jury are neutral, relatively passive recipients of evidence and arguments presented by the parties. In practice, of course, judges help shape the definition of claims, the progress of discovery, the nature of settlement discussions, and the presentation at trial. For present purposes, however, the model is still significant because some reformers blame the adversary system for shortcomings in medical

malpractice litigation. As the final section of this paper will discuss, potential improvements to the system therefore may entail a shift away from the pure adversarial model to one in which the judge more strictly oversees expert testimony, and in which the jury is encouraged to learn actively instead of listening passively.

### **An Overview of Decision-making in Malpractice Litigation**

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As a medical malpractice claim proceeds through litigation, the participants involved in judging its merits vary (see Exhibit 3). At the initial stages, the patient and the patient’s lawyer will evaluate the claim’s potential, frequently with the help of a medical expert. After the claim is asserted, those on the defense side (including the defendant’s lia-

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bility insurer) will perform their own evaluation, again with the help of one or more experts. Each side may revise its estimate in light of information obtained in the discovery process. Most claims are settled, dropped, or dismissed. The remainder proceed to trial, where the judge will determine the qualifications of the parties' experts and the jury will weigh expert testimony and other evidence to determine whether the defendant is liable to the plaintiff and, if so, the amount of damages. Most, though not all, malpractice verdicts are rendered by juries rather than judges (Clermont and Eisenberg 1992). However, the jury verdict is subject to review by the trial judge for compatibility with law, and the trial judge's decision, in turn, is subject to review by one or more appellate courts. This section provides a brief overview of these stages of the process.

### *Deciding Whether to Claim*

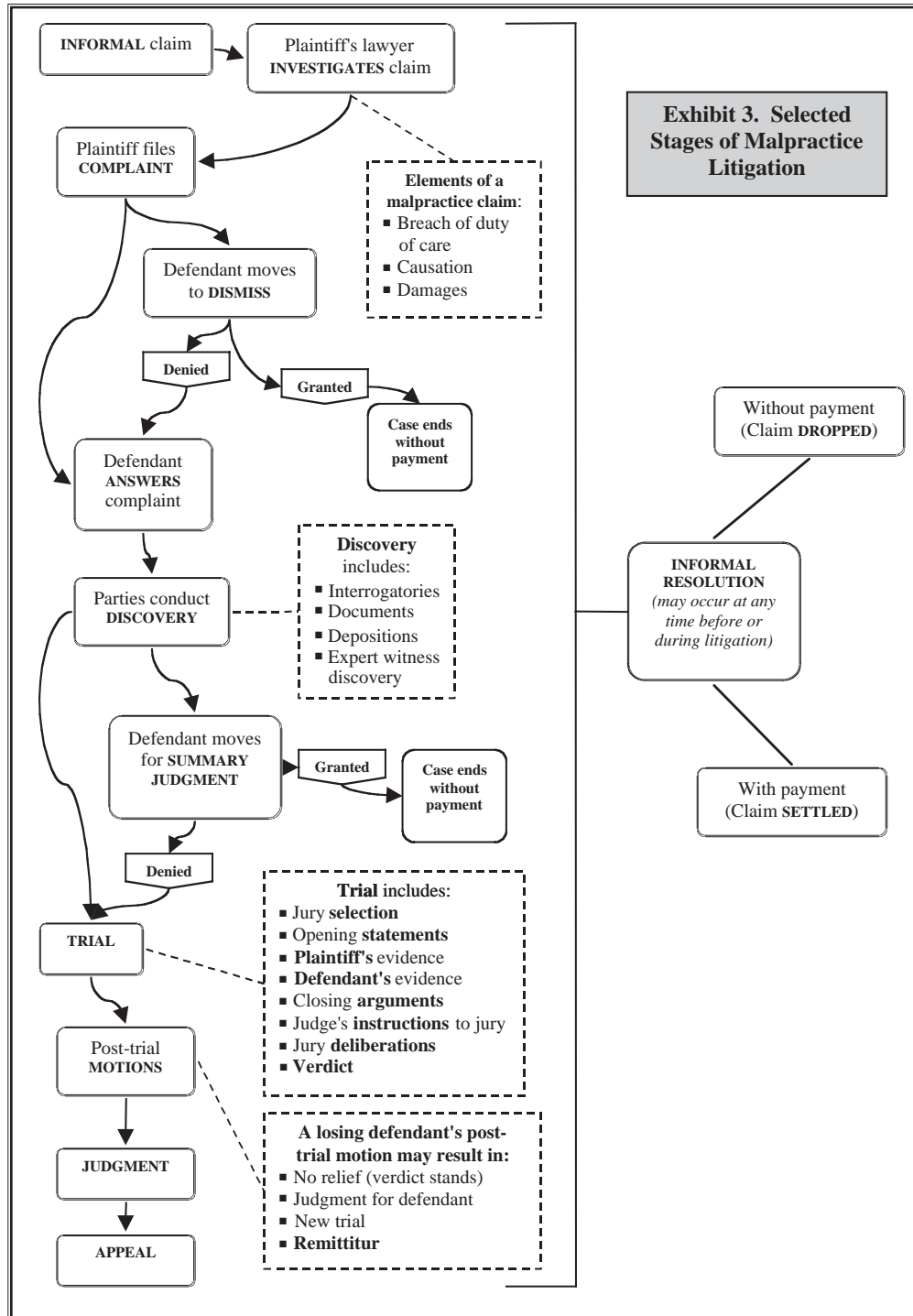
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Most patients injured by medical negligence never seek compensation. Some who do pursue redress informally, without resorting to legal action. Subsequently, or alternatively, the patient may consider suing. Lawyers typically represent medical malpractice claimants on a "contingent fee" basis; the lawyer is paid a percentage of the plaintiff's recovery if the plaintiff wins a judgment or settlement, but otherwise is not paid at all. The lawyer thus has an incentive to screen cases before agreeing to take them, in order to avoid investing time and money in clients who are likely to lose (Kritzer 2002). Most claimants who recover money do so via settlement, but obtaining a favorable settle-

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**The lawyer has an incentive to screen cases before agreeing to take them, in order to avoid investing time and money in clients who are likely to lose.**

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ment is partly a function of the parties' assessment of the likelihood that the plaintiff would win if the case went to trial. Thus, the lawyer will assess the case in light of the elements that the plaintiff would have to prove at trial.

In order to recover money damages from a health care provider, the plaintiff ordinarily must establish that the provider failed to provide appropriate care, that this failure caused harm, and the monetary value of the injury. In many instances, the claimant may initially lack much of the information necessary to answer these questions. Indeed, the wish to find out what caused an adverse result may be one of the claimant's motives for litigation. Nonetheless, the plaintiff's lawyer has an obligation to perform a reasonable investigation into the facts and the applicable law prior to suing.

After this investigation, the lawyer initiates the lawsuit by means of a complaint that outlines the plaintiff's legal claims and gives notice of the factual assertions on which they are based. The defendant may move to dismiss the suit on the ground that the claims lack a legal basis; if that motion is denied, or if the defendant does not make such a motion, the defendant will answer the complaint (by denying or admitting each of the complaint's allegations), and the case will proceed into the discovery phase.

### ***Discovering Information About the Claim***

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In the discovery phase, the parties have the opportunity to ascertain facts that are relevant to their claims or defenses. Parties may seek documents from each other and from third parties, and may take depositions in which a witness is questioned under oath and a transcript is made of the questions and answers. Other discovery tools, such as interrogatories and requests for admissions, may also help to establish facts and to identify key areas of disagreement. In a malpractice case, each side will likely name one or more expert witnesses to testify on questions that may include the standard of care, whether the

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defendant breached that standard, whether the breach caused the plaintiff's injury, and the extent of the plaintiff's current and future damages. The pretrial phase will include expert witness discovery, in the form of expert witness reports and depositions.

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**Settlement usually is seen as a desirable way to resolve disputes without the cost and delay of a trial. On the other hand, settlement may deprive the public by permitting a culpable defendant to keep damaging information secret, or may deprive an innocent defendant of the opportunity for public vindication.**

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### *Resolving the Claim Prior to Trial*

Courts in all jurisdictions encourage settlement using some form of "alternative dispute resolution." Settlement usually is seen as a desirable way to resolve disputes without the cost and delay of a trial. On the other hand, settlement may deprive the public by permitting a culpable defendant to keep damaging information secret, or may deprive an innocent defendant of the opportunity for public vindication (Sage 2003a).

Assuming the case does not settle, it may nonetheless be resolved prior to trial. Some plaintiffs drop their claims during the pretrial phase, either because discovery causes them to revise their view of the case, or because the

expense of proceeding has become prohibitive. Moreover, once there has been an opportunity for discovery, the defendant may move to dismiss the case on the ground that the plaintiff lacks sufficient evidence to establish the elements of the claim. If the defendant convinces the court that, on the evidence put forth by the plaintiff, no rational jury could find for the plaintiff, the court will grant summary judgment.



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### *Trying the Case*

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For the small subset of claims that are not dropped, dismissed, or settled, the case will proceed to trial, usually before a jury. At trial, the plaintiff will use witness testimony and other evidence to establish the elements of the malpractice claim; in most jurisdictions, the plaintiff must prove each element by a preponderance (i.e., greater than

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**In a jury trial, the judge is not the factfinder. Instead, the judge performs a “gatekeeping” role by determining whether particular evidence may be presented to the jury.**

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50%) of the evidence. Though the defense does not bear the burden of proof, the defendant will usually put in evidence (including expert testimony) to try to counter the plaintiff’s evidence.

### *The Judge’s Role at Trial*

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In a jury trial, the judge is not the factfinder. Instead, the judge performs a “gatekeeping” role by determining whether particular evidence may be presented to the jury. For example, the judge will decide whether an expert witness is qualified to testify. The judge also decides whether the plaintiff’s case is strong enough to warrant consideration by the jury. When all the evidence has been presented, the defendant may seek judgment as a matter of law based on a standard similar to that used earlier at the summary judgment stage. If the court grants that motion, the case is dismissed; if not, the judge will instruct the jury on the relevant legal principles and will direct the jurors to deliberate and reach a verdict.

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### *The Judge's Role After the Verdict*

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After the jury reaches a verdict, the trial judge again performs an oversight role. The losing party may argue that prejudicial errors occurred at the trial or that the evidence

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**The judge may grant judgment to the defendant notwithstanding the verdict, or may grant a new trial, or may conditionally grant a new trial if the plaintiff refuses to accept a reduced award of damages (a practice known as “remittitur”).**

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does not support the verdict. In resolving a post-trial motion by a losing defendant, the judge may under appropriate circumstances grant judgment to the defendant notwithstanding the verdict, or may grant a new trial, or may conditionally grant a new trial if the plaintiff refuses to accept a reduced award of damages (a practice known as “remittitur”).

Judicial oversight of jury verdicts does not end at the trial court level. In every jurisdiction, the losing party may appeal the judgment to an appellate court, which will reverse the judgment if it finds prejudicial error. In most court systems, appellate review is relatively limited – appellate courts typically defer to the

jury’s findings of fact and to many of the trial court’s rulings.

### **Expertise in Bringing Claims**

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Noting that a substantial number of medical malpractice claims ultimately fail, critics charge that plaintiffs’ lawyers sue indiscriminately, without regard to the merits of the case. The evidence, however, discloses a more complex picture (see Exhibit 4).

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*Evidence on Claiming*

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Defendants win a majority of the malpractice cases that produce a jury verdict. In Philadelphia County in 1999-2001, the plaintiff win rate in cases averaged 44% (Bovbjerg and Bartow 2003). Studies of other jurisdictions at varying times between the 1960s and 1990s have yielded a range of plaintiff win rates, “from 13.5 percent to 53 percent, with a median win rate of around 29 percent” (Vidmar 1995: 38-39). Low plaintiff win rates at trial do not prove that plaintiffs bring meritless cases. The proportion of cases that go to

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**Lawyers who do not specialize in malpractice cases may lack sufficient skill to assess the merit of potential claims.**

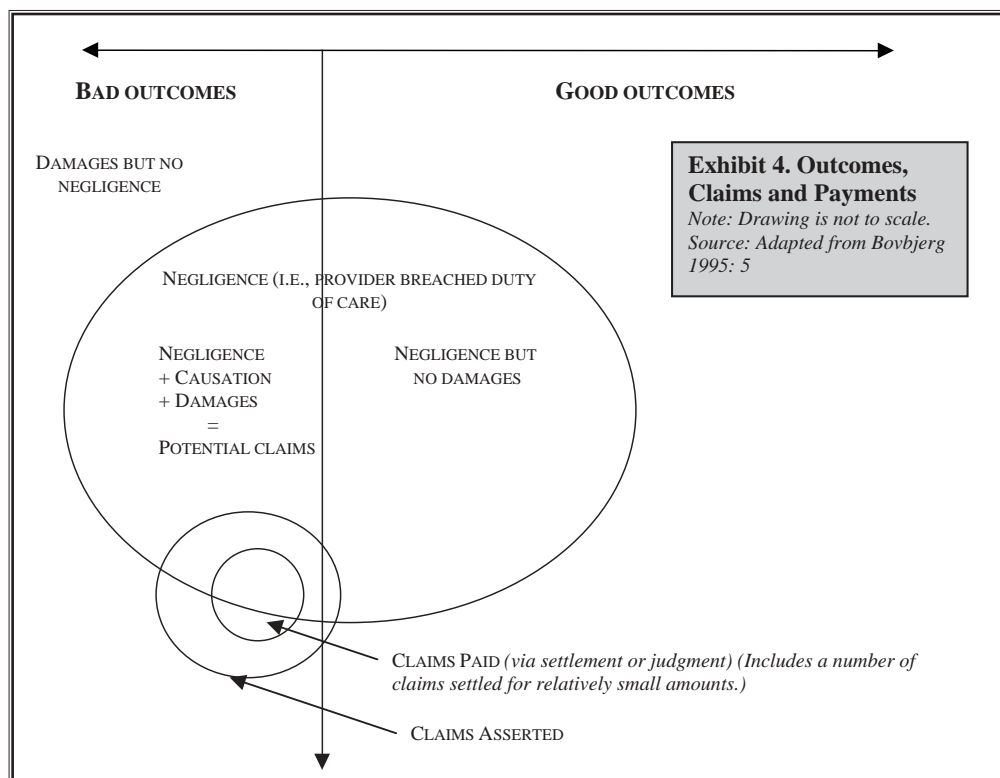
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verdict is very small in comparison to the cases that are resolved prior to trial, and various theories may explain why the mix of cases the litigants select for trial tends to produce large numbers of defendant verdicts (Vidmar 1995; Gross and Syverud 1991).

On the other hand, the fact that a substantial number of malpractice claims are terminated prior to trial with no payment to the plaintiff does bring into question the judgments plaintiffs’ lawyers make in selecting cases (Metzloff 1988). Claims dropped without payment may reflect previously unavailable information gained over the course of discovery; but it is also possible that some lawyers bring claims without adequate investigation. In particular, lawyers who do not specialize in malpractice cases may lack sufficient skill to assess the merit of potential claims.

It is clear that there are far more potential than actual malpractice claims. Based on hospital and insurance records, the Harvard Medical Practice Study estimated that some 27,000 patients in New York State were injured in 1984 as a result of negligent med-

ical care, but that fewer than 3,800 patients asserted malpractice claims. The study revealed not only a gap between potential and actual claims, but also a mismatch. Researchers were able to connect only 47 claims from malpractice insurance files to hospital records, and determined that harm from negligent care occurred in only 8 of these cases (Weiler et al. 1993). Although the researchers cautioned that their medical record review might not reveal some types of malpractice (such as a failure to diagnose), the apparent mismatch does raise questions. More recently, a study by the same research group examining adverse events and claims in connection with incidents in Utah and Colorado in 1992 found both a similar gap and a similar mismatch (Studdert et al. 2000).



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*Plaintiffs' Need for Information*

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Data drawn from a nationwide sample of claims closed in 1984 indicate that some 40% of malpractice claims end without ever reaching litigation. Of these claims, roughly

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**A desire for information can lead people to assert malpractice claims. In a study of birth-related injuries and deaths in Florida, parents were more likely to file a malpractice claim if they had not been told that there might be difficulties with the baby.**

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a third settle with some payment to the claimant (GAO 1987). These statistics suggest that in many instances, patients may simply want to know why they suffered an adverse result, and may drop their claims (without filing suit) after gaining that information. Other data support the theory that a desire for information can lead people to assert malpractice claims. For example, in a study of birth-related injuries and deaths in Florida, researchers found that parents were more likely to file a malpractice claim if they had not previously been told that there might be difficulties with the baby (Sloan and Hsieh 1995).

Close to 90% of claims that proceed to litigation are resolved prior to trial; roughly half with some payment to the plaintiff. These data are consistent with the view that some malpractice plaintiffs initially lack information concerning the merits of the claim and must sue to obtain it. This would be true, for example, if necessary evidence were contained not just in medical records but also in the recollections of those present during a medical procedure (which the plaintiff might not be able to ascertain without formal discovery). Predictably, many claimants will drop their suits when it becomes apparent that the claims lack merit (Farber and White 1991, 1994). Moreover, a plaintiff might drop a valid claim

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because the cost of pursuing the claim becomes prohibitive, or because the litigation proves emotionally stressful (Metzloff 1988).

### ***Specialist and Non-Specialist Attorneys***

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It may also be the case that some plaintiffs' lawyers take inadequate steps to probe the merits of the claim prior to bringing suit. As noted above, plaintiffs' attorneys are paid only if their client obtains a judgment or settlement, which should make them select cases carefully. A lawyer might file a low-merit suit in the hopes of obtaining a nuisance settlement with a minimum of effort, but liability insurers that defend malpractice suits are repeat litigants and have a strong incentive not to pay. A more likely scenario is that experienced plaintiffs' attorneys are better than inexperienced ones at evaluating malpractice claims. A general lawyer accustomed to litigating smaller claims is likely to handle considerably fewer medical malpractice cases over the course of a career than a medical malpractice specialist does (Daniels and Martin 2002). Overall, however, data suggest that a substantial number of malpractice claims are handled by non-specialists (Metzloff 1991). When non-specialists bring malpractice cases, which are complex and expensive to litigate, they are at a disadvantage. For example, a study of medical malpractice claims in North Carolina found that specialist attorneys are more likely than non-specialists to bring cases which the insurer (based on the assessments of the insurer's outside reviewers) perceives as potentially valid (Peeples, Harris, and Metzloff 2002).

### ***Expertise in Settling Claims***

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A party's willingness to settle prior to trial normally depends on the likelihood of the plaintiff's winning at trial, the projected amount of damages, and the expected costs of litigating the claim (Priest and Klein 1984). The discovery process may change each

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party's valuation of the case by providing information concerning the evidence, the other side's valuation, and the competence of the other side's lawyers. As the parties' valuations come closer together, settlement is more likely. The judge may take an active role in

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**The judge may take an active role in encouraging settlement discussions. Although this function arguably can be performed better by a judge who has insight into the technical merit of the claim, general case management experience may be just as useful.**

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encouraging settlement discussions. Although this function arguably can be performed better by a judge who has insight into the technical merit of the claim, general case management experience may be just as useful.

Other factors also influence the parties' settlement preferences. In their study of California civil trials, Gross and Syverud found that instances in which defendants made no settlement offer to the plaintiff were much more common in medical malpractice than in other types of cases, and suggested that "the high rate of zero offers in medical malpractice cases is best explained by the desire of physicians for vindication at trial" (Gross and Syverud 1996: 58; Gross and Syverud 1991). Some "repeat

play" litigants—notably insurers—may bargain with an eye toward the effects that settling or litigating a particular case would have on other cases. On the one hand, a repeat player might wish to settle in order to avoid the risk of generating a bad judicial precedent; on the other, such a player might offer little or no money in order to deter other claimants from pursuing litigation in the future.

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## Expertise in Evaluating Experts

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One of the trial judge's key functions is to determine the admissibility of expert testimony, and this task itself requires expertise. How is the judge to know whether an expert is qualified? The two major approaches to the admissibility of expert testimony

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**One of the trial judge's key functions is to determine the admissibility of expert testimony, and this task itself requires expertise.**

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illustrate alternative answers to this question.

The older *Frye* test delegates the decision to the medical community, while the more recent *Daubert* test requires the judge to make an independent assessment of the expert's testimony.

Typically, each side in a malpractice case will present expert medical testimony on the standard of care, causation, and physical injury. The parties may also present economic expert testimony on damages such as lost earn-

ings or future medical expenses. Each party, of course, will seek experts who support their side of the case; the result often is a contest between witnesses who present very different views of critical questions. Some commentators challenge the quality of expert testimony in malpractice cases, noting that lawyers on each side can canvass a number of potential experts until they find one willing to testify favorably. Other observers point out that this may be less of an option for plaintiffs because there is a smaller pool of medical experts willing to testify in their behalf.

Ultimately, the jury will decide which witnesses it believes. In cases with complex evidence and warring experts, this can be a daunting assignment. The judge can aid the jury in this task by ensuring that only qualified experts testify, and by structuring the presentation of evidence so as to make it as comprehensible and helpful as possible. The ques-



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tion of witness qualifications is discussed here, and possibilities for structuring the presentation of expert testimony will be discussed in a later part of this report.

In evaluating expert testimony, some state courts continue to use the test set forth in *Frye v. United States*, 293 F. 1013 (D.C. Circuit 1923). Under *Frye*, courts need not attempt to determine whether an expert's approach is scientifically valid. Rather, they need only determine whether it is generally accepted in the relevant scientific community. Like the medical custom test for the standard of care, the general acceptance test for scientific evidence may decrease the need for judicial expertise by reducing the amount of independent analysis required of judges. On the other hand, the *Frye* test may exclude some helpful and reliable testimony solely because the expert's approach has not yet gained general acceptance within the relevant community.

By contrast, the *Daubert* test returns authority to the trial judge. In states that follow *Daubert v. Merrell Dow Pharmaceuticals*, 509 U.S. 579 (1993), the judge assesses whether the expert's proposed testimony is "scientifically valid" by considering factors such as whether the expert's method generates a hypothesis that is falsifiable, whether the expert's method has been peer reviewed, whether there are standards governing the method's use, the probability of error, and the degree to which the method is accepted in the relevant scientific community (*Daubert* at 593-94). This test has the advantage that it should admit testimony based on methods that are reliable but not yet generally accepted by the relevant community, and it should also exclude testimony based on methods that are generally accepted but that can be shown to be unreliable. The judge will weigh the relevant community's views as a factor in the analysis, but those views will not be determinative. Thus, the *Daubert* approach is less vulnerable than the *Frye* approach to the charge that it unduly delegates authority to the medical community in malpractice cases. However, the *Daubert* test can function well only if the judge understands the relevant

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**The Daubert approach is less vulnerable than the Frye approach to the charge that it unduly delegates authority to the medical community, but can function well only if the judge understands the relevant principles and applies them accurately.**

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principles and applies them accurately (Rai 2002). For example, some researchers have questioned judges' understanding of the falsifiability and error rate concepts (Gatowski et al. 2001).

*Daubert's* applicability to medical malpractice cases is unclear. Even in states that have adopted *Daubert*, appellate decisions give some reason to question the extent to which judges use the *Daubert* factors to scrutinize medical malpractice expert testimony (Shuman 2001). Moreover, as noted, some states continue to follow *Frye*. In Pennsylvania, the state's highest court has left open the question of *Daubert's* applicability (*Grady v. Frito-Lay, Inc.*, 800 A. 2d 294 (Pa. 2002). *Blum ex rel. Blum v. Merrell*

*Dow Pharmaceuticals, Inc.*, 764 A. 2d 1 (Pa. 2000). Ultimately, the choice between the two tests should take account not only of the potential benefits of the *Daubert* test, but also of the need to train judges to apply that test.

### **Expertise in Assessing Liability**

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In malpractice cases that reach trial, a jury will be asked to determine whether the physician is liable and, if so, the amount of damages. With respect to liability, critics argue that juries are predisposed toward compensating sympathetic plaintiffs, are subject to cognitive biases that lead them to blame bad outcomes on negligence, and lack the capacity

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to understand expert testimony, especially if that testimony concerns probabilistic evidence. As this section will demonstrate, juries may have difficulties performing these tasks in some complex cases, and appropriate guidance from the court can help. In particular, juries should understand that often there is not a single “right” approach to a particular medical problem (Peters 2002b). However, the available data suggest that overall,

juries perform fairly well in malpractice cases, though aspects of their work could be improved.

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**Critics of the litigation system sometimes charge that all medical malpractice cases involve complex scientific questions. In reality, malpractice cases tend instead to fall along a spectrum of complexity that ranges from the very difficult to the readily approachable.**

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#### *Liability Issues in Malpractice Cases*

Critics of the litigation system sometimes charge that *all* medical malpractice cases involve complex scientific questions (Sugarman 1990). In reality, malpractice cases tend instead to fall along a spectrum of complexity that ranges from the very difficult to the readily approachable (Vidmar 1994b). The key liability questions in a malpractice case concern the applicable standard of care and the issue of causation. In assessing each of these questions, the jury will need to rely on specialized knowledge, which is usually provided by the parties’ expert witnesses.

The first major set of issues in a malpractice case concerns the nature of the physician’s duty of care to the patient, and whether the physician breached that duty. Outside of medical malpractice, the law of negligence usually asks whether a “reasonable person” in

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the defendant's position would have taken a particular precaution. In general, an industry's practices do not define the standard of care, though they may be relevant to it (Kelley and Wendt 2002). Medical malpractice is a notable exception: the standard of care has traditionally been set by reference to "medical custom," meaning what doctors within the relevant community normally do.

Recently, however, Philip Peters has noted that a minority of states have replaced the "medical custom" standard with a "reasonable physician" standard, which permits the jury to find liability even when a physician followed a standard medical practice (Peters 2000). According to Peters, it is unclear whether Pennsylvania uses the "medical custom" or "reasonable physician" standard. In jurisdictions that follow the "reasonable physician" standard, expert testimony may be directed explicitly to the expert's own view of appropriate care. In other words, expert testimony may seek to establish the standard of care by reference to the risks and benefits of the relevant precaution, without having to show that the physician deviated from prevailing medical custom (Peters 2002a).

A traditional justification for the "medical custom" standard is that lay decision-makers are better equipped to ascertain what physicians actually do than what they should do. On closer examination, either task can prove challenging. A jury applying the "medical custom" standard will need expert testimony to determine what the customs are. However, experts nominally opining on medical custom frequently base their testimony more on their own views of appropriate care than on systematic knowledge of the relevant community (Hall 1991). Even if the parties present empirical data concerning what doctors do in practice, as some commentators advocate (Meadow and Sunstein 2001; Cramm, Hartz & Green 2002; Hall et al. 2002), there is often wide variation in appropriate treatment (Peters 2002b). To address this problem, many jurisdictions, including Pennsylvania, have adopted a "two schools of thought" doctrine which permits doctors to argue that they

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should not be held liable if they comply with a standard endorsed by part, but not all, of the relevant medical community.

In addition to establishing the standard of care and the physician's breach of that standard, the plaintiff must show that the breach caused the plaintiff's injury. In some instances—for example, where a surgeon operated on the wrong limb—the determination

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**Research supports the belief that jurors may experience difficulty processing complex information and evaluating the strength of statistical evidence.**

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of causation will be straightforward. In others, establishing causation may require examining many similar cases—more than a single practitioner is likely to see personally—to ascertain how often injuries occur in the absence of negligence (Meadow 2002). In other words, a showing of causation often will be based on probabilistic evidence (Brennan 1988). Moreover, it may be hard to untangle the defendant's actions from the patient's preexisting medical problems (Bovbjerg 1995).

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*Evidence Concerning Jury Determinations of Liability*

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Critics argue that liability questions invite a contest of partisan expert witnesses, with juries serving as underqualified referees. Their concern is that juries lacking technical competence will choose between contending experts based on relatively superficial factors such as witness demeanor, rather than the substance of the testimony. Some commentators assert that jurors are confused by complex evidence; are unlikely, in particular, to give due weight to probabilistic evidence; and exhibit cognitive biases, such as hindsight bias, that tilt their determinations in favor of the plaintiff.

Research supports the belief that jurors may experience difficulty processing

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complex information and evaluating the strength of statistical evidence. Reviewing an aggregate study of juror performance in 29 lengthy civil trials, as well as other case studies of complex trials, one group of researchers concluded that jurors show varying degrees of understanding (Cecil, Hans and Wiggins 1991). However, they observed that jurors with higher levels of understanding took a leading role in deliberations, and they suggested that modifications in trial procedure—such as narrowing or sequencing issues, using court-appointed experts, and permitting jurors to take notes and ask questions—might improve overall jury performance. Similarly, jury simulation studies suggest that jurors

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**Despite these potential difficulties, there are some reasons for optimism concerning jury performance.**

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may misperceive the persuasiveness of statistical evidence and have difficulty spotting faulty reasoning in probabilistic testimony, although one of those studies presented a more positive view of jury comprehension than the others.

Cognitive biases also affect jury findings on liability. “Hindsight bias”—the human tendency to view an event as having been more probable because it in fact occurred—and “outcome bias”—the tendency to view a decision as poorer quality because the decision in fact led to a bad outcome—have been found in various populations, including potential jurors. Thus, the fact that a medical malpractice plaintiff suffered harm may make juries more inclined to find a breach of the standard of care. However, to the extent that juries rely on evidence of medical custom rather than reasonableness, hindsight bias may play a smaller role (Rachlinski 1995).

Despite these potential difficulties, there are some reasons for optimism concerning jury performance. For one thing, whole juries may tend to perform better in assessing

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liability than their members would individually. Although group deliberation probably will not eliminate the effects of hindsight bias, deliberation should improve juries' ability to process complex information, particularly if better informed jurors take a leadership role.

Studies of jury performance find some degree of correlation between case strength and liability determinations (Sloan et al. 1993; Vidmar 1998). Sloan and colleagues elicited expert physicians' views of negligence and causation in 37 malpractice cases that went to a jury verdict. In the 24 cases that ended with a plaintiff recovering damages (through a judgment or a post-verdict settlement), the physician reviewers were twice as likely to have found the defendants "liable" as they were to have found them "not liable." Conversely, in the 13 cases which ended with no damage recovery, the reviewers were twice as likely to have found the defendants "not liable" as they were to have found them "liable."

Farber and White also found evidence of correspondence between jury verdicts and prior expert assessments (Farber and White 1994). They studied hospital records concerning claims made against the hospital or its staff with respect to incidents that occurred between 1976 and 1989, including confidential evaluations of quality of care used to determine litigation strategy. Cases were coded either "bad" (raters perceived clear negligence), "good" (raters perceived clear absence of negligence), or "ambiguous" (ratings were ambiguous or inconsistent). Comparing jury verdicts to internal ratings, Farber and White determined that juries found for the defendant in all the cases that the hospital had rated "good," found for the plaintiff in two of the four cases that the hospital had rated "bad," and found for the plaintiff in one of the four cases that the hospital had rated "ambiguous."

Liang's more recent study found less correspondence between juries and experts, but the divergence arose largely from the tendency of juries to exculpate defen-

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dants whom expert reviewers believed negligent (Liang 1997). Liang provided the facts of 12 actual cases to academic anesthesiologists. The physicians' evaluations

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**Liang's more recent study found less correspondence between juries and experts, but the divergence arose largely from the tendency of juries to exculpate defendants whom expert reviewers believed negligent.**

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accorded with the juries' verdicts only 56-58% of the time, and in five of the twelve cases there was "significant" disagreement. Notably, however, in four of those five cases the disagreement arose because the physicians tended to find negligence and the jury had not.

By contrast, one study suggests that parties' *settlement* decisions may fail to reflect actual liability. In a follow-up to the Harvard Medical Practice Study, Brennan and colleagues examined 51 malpractice cases (the 47 cases discussed above, and four additional cases that were subsequently found in missing records).

Only one of the 46 claims closed by the end of 1995 reached trial; in that case, which experts had identified as involving a negligent medical error, the jury found for the defendant. Of the other 45 claims, 24 closed without payment and 21 settled with a payment by the defense. The researchers found that "neither the presence of an adverse event nor that of an adverse event due to negligence was associated with the outcome of the litigation"; rather, the plaintiff's degree of disability "was the only significant predictor of payment" (Brennan et al. 1996: 1965). Although settlement payments reflect defense lawyers' expectations of what a jury would do at trial, the defense's projected cost of litigating a case to verdict also influences settlement, even if the defense expects to win at trial. In this regard, it is suggestive that eight of the 21 set-



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tled cases involved payments less than \$25,000, which the insurers described to the researchers as nuisance settlements.

### **Expertise in Calculating Damages**

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Critics argue that jury awards in malpractice cases are unpredictable, and some are inordinately high. Although only a tiny fraction of malpractice cases reach verdicts, the argument continues, the threat of erratic, unwarranted awards forces defendants and their

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**Much of the variability in jury awards correlates with legitimate factors such as the severity of the plaintiff's injury. On the other hand, significant inconsistency remains, particularly with respect to noneconomic damages.**

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liability insurers to settle cases for more than they are actually worth. Available evidence suggests that juries do better than some of these critics assert, but that there is room for improvement. The question of damages in a malpractice case may present difficult issues, and usually will require expert testimony. Despite these challenges, much of the variability in jury awards correlates with legitimate factors such as the severity of the plaintiff's injury. On the other hand, significant inconsistency remains, particularly with respect to noneconomic damages. However, calculating noneconomic damages is unlikely to require a close scrutiny of medical evidence. Rather, the most useful expertise with

respect to such damages may be knowledge of what juries have tended to award, and what courts have tended to uphold, in similar cases.

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### *Damages Issues in Malpractice Cases*

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Determining damages in a medical malpractice case is not simply a matter of totaling the plaintiff's past medical bills and lost wages. The jury also will need to assess the degree and duration of the impairment a surviving plaintiff will suffer in the future. Estimating the cost of lifetime care for a permanently injured plaintiff will require expert testimony on life expectancy, on the plaintiff's future medical needs, and on the projected costs of that future care. In addition, calculations concerning the amount of the plaintiff's loss of future earning power will be necessary. Ordinarily, the plaintiff will seek damages for noneconomic losses as well, which will require the jury to assign a monetary value to the plaintiff's prospective pain and suffering. The plaintiff may also request punitive damages, which are designed to punish willfully wrongful behavior on the part of the defendant. However, punitive damages are rarely awarded in medical malpractice cases (Koenig and Rustad 2001).

### *Evidence Concerning Jury Awards of Damages*

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Group deliberations may increase damages awarded by juries. In a study of punitive damages using six-person mock juries, jury awards were both higher and more variable than the pre-deliberation amounts that individual mock jurors would have awarded (Schkade et al. 2002). An earlier study of six-person mock juries to examine the effects of deliberation on damages for economic loss and for pain and suffering had similar results: mean jury awards tended to be higher than the amounts individual jurors would have awarded absent deliberation. However, the researchers also found that “[a]s a percentage of mean award ... jury variability was lower than juror variability for both types of damage awards” (Diamond, Saks, and Landsman 1998: 317). Another study comparing awards by 6- and 12-person mock juries with awards by individuals found an opposite effect (i.e.,

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average jury awards were smaller than average awards by individuals) though the difference was only weakly significant (Davis et al. 1997).

In any event, larger juries tend to reach less variable results than smaller juries (Vidmar 1998). Thus, at least one previous proposal for medical malpractice reform advocated 12-person juries (Saks 1996). Pennsylvania provides for 12-person juries, though the

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**Problems other than jury incompetence or irresponsibility may be to blame for unexplained variation. ... Most importantly, legal doctrine and trial practice combine to deprive juries of guidance on appropriate damages amounts.**

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verdict in civil cases need not be unanimous. (See *Blum v. Merrell Dow Pharmaceuticals, Inc.*, 626 Atlantic Reporter Second Series 537, 538 (Pa. 1993); 42 Pa. Consolidated Statutes § 5104.)

Studies suggest that the severity of the plaintiff's injuries explains a considerable portion of the variation in jury verdicts (Sloan and Hsieh 1990). However, significant variability may remain, particularly with respect to noneconomic damages. In their jury experiment, Diamond, Saks, and Landsman found that the amounts juries awarded for pain and suffering were about twice as variable as the juries' awards for economic damages. Likewise, a study of actual jury verdicts in personal injury cases in

Florida and Kansas City from 1973-1987 found that awards of noneconomic damages were more variable than total awards (Bovbjerg, Sloan, and Blumstein 1989).

Problems other than jury incompetence or irresponsibility may be to blame for unexplained variation. In many jurisdictions, juries are not permitted to question witnesses or take notes; though these practices have potential drawbacks, they might improve

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jurors' understanding and retention of relevant evidence (Cecil, Hans, and Wiggins 1991). Jury instructions sometimes are phrased in confusing language. Most importantly,

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**The amount initially awarded by a jury often is not the amount the plaintiff ultimately recovers. For this reason, jury verdict reporters that recount only the jury award, and not any post-trial reductions, can be misleading.**

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legal doctrine and trial practice combine to deprive juries of guidance on appropriate damages amounts. In Pennsylvania, for example, the parties' lawyers are not allowed to name a suggested figure for the amount of noneconomic or punitive damages. The lack of guidance is exacerbated by the fact that defendants' lawyers sometimes choose not to put in evidence on damages, for fear of appearing to concede liability (Vidmar 1995). One treatise criticizes this practice: "Post-verdict interviews ... with jurors who heard a full damages defense presented by economic experts called by the defense ... revealed that jurors rarely felt that the defense was conceding liability by offering

an alternative damages presentation" (Zaremski and Heckman 1997: 287). Other options for providing benchmarks to the jury are discussed later in this report.

### ***Judicial Review of Jury Awards***

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The amount initially awarded by a jury often is not the amount the plaintiff ultimately recovers. For this reason, jury verdict reporters that recount only the jury award, and not any post-trial reductions, can be misleading. Post-trial reductions may occur for a variety of reasons: because the parties settle for a smaller amount than the jury awarded;

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because the jury finds the plaintiff partially at fault for the injury (which, in comparative negligence jurisdictions, means that the award must be proportionally reduced); because the jurisdiction has a damage cap or a rule requiring reduction of awards to reflect payments from collateral sources; or because the judge finds that the size of a jury award was against the weight of the evidence and orders a new trial unless the plaintiff agrees to accept a reduced award (a mechanism known as remittitur).

In some jurisdictions, both the frequency and size of such reductions can be substantial. In a study of 293 medical malpractice plaintiff verdicts described in a jury verdict reporter for New York City and neighboring counties from 1985-1997, at least 96 awards were subsequently reduced: 46 through post-verdict settlement, 23 through remittitur, 17 due to comparative negligence, and 10 for unknown reasons (Vidmar, Gross, and Rose 1998). Three awards were *increased*: two from post-verdict settlements, and one from additur (the converse of remittitur). Netting these effects, the mean adjusted award was only about 62% of the mean original jury award. The researchers noted that these figures likely underestimate the total number of post-verdict reductions, since the results of appeals were not included.

However, a comparative sample by the same researchers of verdicts from Florida and California revealed a smaller rate of post-verdict adjustments. One distinctive aspect of New York's remittitur practice is that since 1986, courts have been directed by statute to "determine that an award is excessive or inadequate if it deviates materially from what would be reasonable compensation," N.Y. Civil Practice Law and Rules § 5501(c); *Shurgan v. Tedesco*, 578 N.Y.S. 2d 658 (App. Div. 2d Dept. 1992). The "deviates materially" standard is easier to meet than the traditional test, under which a court would grant remittitur only if the jury's award "shocked the conscience."

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### **Summarizing the Need for Expertise in Malpractice Litigation**

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This section of the report has shown that the issues that arise in malpractice cases—and the skills they demand from the participants—vary depending on the stage of the litigation. Expert knowledge will be necessary to determine the appropriate standard of care, whether the physician breached that standard, whether the breach injured the plaintiff, and the extent of the plaintiff’s damages. Plaintiffs’ attorneys have the incentives to seek an expert evaluation at the outset of the case, but non-specialist plaintiffs’ attorneys may fail to do so. Such omissions may contribute to the number of malpractice cases that end without payment. As legitimate cases progress, however, the likelihood of settlement rises as the parties gain information and their assessments of the value of the claim converge.

In connection with pretrial motions for summary judgment, and in the small percentage of malpractice cases that proceed to trial, the judge will determine whether the parties’ experts are qualified to testify. The competing tests for admissibility pose a choice between ease of application and accuracy of result. Compared to the *Frye* test of general acceptance, *Daubert’s* standard for allowing expert testimony holds the promise of greater accuracy and avoids the risk of delegating too much authority to the medical community, but requires more knowledge and skill on the part of the judge.

At trial, jury performance appears to be better than critics assert. However, juries’ liability determinations might be aided, in complex cases, by a neutral and understandable exposition regarding standard of care and causation of injury. In addition, the consistency of jury determinations of noneconomic and punitive damages might improve if juries were provided with benchmarks. Judges can use the remittitur mechanism to reduce unwarranted variability in damages awards, but they also would benefit from information about comparable awards in prior cases.

## Current or Proposed Reforms

This section of the report discusses three reforms. A certificate of merit requirement (adopted in Pennsylvania) requires plaintiffs to obtain an expert assessment of their claims at the outset of the suit. A medical screening panel system (recently proposed for Pennsylvania) would send cases to a panel composed partly or wholly of physicians for a pretrial assessment of liability and perhaps damages. A specialized medical court system (such as that proposed in Pennsylvania or that put forward, at the national level, by Common Good) would channel the adjudication of malpractice cases to experienced judges. Such reforms might provide benefits by increasing the expertise of participants in malpractice litigation and, relatedly, by restoring physicians' confidence in the fairness and predictability of litigation outcomes.

Accordingly, the report assesses the extent to which these reforms can improve decision-making by plaintiffs' attorneys, judges, and juries. Non-specialist plaintiffs' attorneys might fail to assess claims properly before filing them. Would a certificate of merit requirement deter such attorneys from bringing weak cases? Judges may face challenges in determining whether parties' experts are qualified to testify, and the conflicting testimony of partisan experts may prove confusing to juries. Would medical screening panels alleviate both difficulties by providing another source of expert knowledge? Both the screening of expert testimony and the review of jury awards requires skill on the part of judges. Would judges on a specialized court be better positioned to develop such abilities?

Reforms that improve participant expertise might also have broader effects on the malpractice system and the health care system. Reforms that screen out meritless claims, or that increase the predictability of liability and damages determinations, might ameliorate the problem of defensive medicine. Reforms that encourage the assertion of valid claims would help deserving plaintiffs gain compensation and otherwise vindicate the

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rights conferred by substantive tort law. On the other hand, reforms that reduce the frequency or severity of claims might stabilize malpractice insurance premiums. However, reductions achieved by discouraging or reducing valid claims will also under-compensate deserving plaintiffs.

### **Certificate of Merit Requirements**

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Some 17 states currently impose certificate of merit requirements in medical malpractice actions.<sup>1</sup> The goal in each state appears similar: to deter plaintiffs from filing meritless claims. Each state's certificate of merit provision requires the plaintiff to provide a certification that the case has been reviewed by an expert and that the expert has concluded there is some basis for the claim. Beyond this essential similarity, however, the provisions vary significantly. Most apply only to medical malpractice claims, but a few

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**Some 17 states currently impose certificate of merit requirements in medical malpractice actions.**

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apply to other professional negligence claims as well. In some states, the expert must provide the certification; in other states, the attorney must certify that the expert has reviewed the claim. The content of the certification also varies. Some states require specificity concerning the standard of care, how the defendant breached that standard and how the breach caused the plaintiff's injury; others simply require a state-

ment that, in the expert's view, the claim is not unjustified.

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<sup>1</sup> Certificate of merit requirements applicable to medical malpractice actions exist in Colorado, Connecticut, Florida, Georgia, Illinois, Maryland, Michigan, Minnesota, Missouri, Nevada, New Jersey, New York, North Carolina, North Dakota, Pennsylvania, Texas, and West Virginia.



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Most states require the plaintiff to provide the certification either with the complaint or within a specified time thereafter. Most states authorize the court to grant extensions to enable the plaintiff to gather information relevant to the certificate, and some suspend the requirement if the defendant fails to provide access to medical records or other information. Some states specify that the sanction for noncompliance is dismissal of the claim, either with or without prejudice; a few states also provide for the imposition of sanctions on the party and/or attorney for unjustified certifications. In some states, the expert's identity and the contents of the expert's evaluation are not disclosed to the defendant, and a few states specifically bar the defendant from using the expert's evaluation later in the litigation. Three states impose certificate of merit requirements on the defendant as well as the plaintiff, in at least some circumstances.

In Pennsylvania, the courts recently adopted a certificate of merit requirement for malpractice claims. Plaintiffs' attorneys must file a "certificate of merit" within 60 days after filing the complaint, attesting that the attorney has obtained the written opinion of "an appropriate licensed professional" finding "a reasonable probability" that the defendant was negligent and that the negligence caused the plaintiff's injury. (See Pa. Rule of Civil Procedure 1042.3.) A written opinion need not be obtained if expert testimony is unnecessary for pros-

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**In Pennsylvania, plaintiffs' attorneys must file a "certificate of merit," attesting that the attorney has obtained the written opinion of "an appropriate licensed professional" finding "a reasonable probability" that the defendant was negligent and that the negligence caused the plaintiff's injury.**

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ecution of the claim—but this will rarely be the case in medical malpractice suits. Pennsylvania also recently strengthened its standards for general litigation. Pennsylvania’s rules now direct attorneys to perform a reasonable investigation as to the factual and legal basis of assertions made in litigation papers, and authorize sanctions for violations.

### ***Empirical Data on Certificate of Merit Provisions are Scarce***

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Empirical information on certificate of merit provisions is scarce. The major multistate studies of the effects of tort reforms on malpractice claiming and malpractice insurance did not examine certificates of merit. One study considered malpractice filings in Maryland before and after Maryland’s 1986 imposition of a certificate of merit requirement (Morlock and Malitz 1993). Although the researchers cautioned that their sample size and controls were inadequate to draw ironclad conclusions, they noted that significantly fewer claims were voluntarily dismissed by the plaintiff in the post-reform period than earlier. They also concluded that Medicaid recipients and the uninsured were underrepresented among claimants following reform, and expressed the concern “that reforms have depressed claim filings by restricting access to the legal system” (Morlock and Malitz 1993: 25). However, the study does not establish that either effect stems from the certificate of merit requirement. For example, other 1986 and 1987 reforms—especially the 1986 imposition of a \$350,000 cap on noneconomic damages for personal injury claims—may explain the apparent disproportionate effect on low-income plaintiffs.

### ***Designing a Certificate of Merit Provision***

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Despite the lack of empirical data, one can draw inferences concerning how best to design a certificate of merit provision by considering both the goal of the provision and its potential adverse effects (see Exhibit 5). As noted, the goal of the certificate of merit

requirement is to screen out weak malpractice claims. Even without a legal requirement, plaintiffs' lawyers who specialize in medical malpractice claims routinely obtain an expert evaluation before undertaking litigation. For inexperienced plaintiffs' attorneys who are

less skilled in assessing the strength of malpractice claims, however, a certificate of merit requirement may deter the assertion of weak claims. Moreover, to the extent that malpractice claimants turn to

<b>Exhibit 5. Certificates of Merit May Help Screen Out Weak Claims</b>	
<b>TYPE OF PLAINTIFF'S LAWYER</b>	<b>LIKELY EFFECT OF A CAREFULLY DRAFTED REQUIREMENT:</b>
<b>Medical malpractice specialist</b>	<ul style="list-style-type: none"> <li>■ Minimal</li> <li>■ Specialist already uses expert to evaluate claim</li> </ul>
<b>Non-specialist plaintiff's lawyer</b>	<ul style="list-style-type: none"> <li>+ Will help screen claims</li> <li>+ May provide information to plaintiff</li> <li>- Will raise cost of bringing suit</li> </ul>

litigation in order to find out what caused their injuries, the expert review sometimes may provide information that satisfies that need. To achieve these benefits, a certificate of merit law should require the plaintiff's attorney to certify that he or she has consulted an expert and that the expert, on the basis of the available information, has concluded that there is a reasonable likelihood that the defendant negligently caused the plaintiff's injury.

One risk of unfairness to the plaintiff relates to the availability of information (Parness and Leonetti 1997). At the outset of the suit, the plaintiff may be able to access documentary evidence such as medical records but probably will not be able to interview the defendant and other potential witnesses. Even the medical records may not be immediately available, since health care providers are not always prompt in providing them (McClellan 1994). Regulations recently adopted pursuant to the Health Insurance Portability and Accountability Act of 1996 set time limits within which covered healthcare

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providers must respond to a patient’s request for access to medical records, but the time limits are not particularly tight: the presumptive time limit is 30 or 60 days (depending on the accessibility of the information) and the provider may obtain one 30-day

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**A certificate of merit law should not require the plaintiff’s expert to state with certainty that the claim is valid but merely that, based on the information reasonably available, there is a reasonable likelihood that the plaintiff will be able to show negligence and causation.**

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extension. (See 45 Code of Federal Regulations § 164.524(b)(2)). Thus, a certificate of merit law should not require the plaintiff’s expert to state with certainty that the claim is valid but merely that, based on the information reasonably available, there is a reasonable likelihood that the plaintiff will be able to show negligence and causation. In addition, the certification requirement should not apply in cases where the defendant fails to timely provide pertinent records after a request by the plaintiff.

Another potential risk involves increased expense. No matter how the requirement is designed, it will raise the initial cost of suit for plaintiffs whose attorneys would not otherwise have obtained such an evaluation, and may thus deter some claims with modest expected val-

ues—including claims that would turn out to be valid. More importantly, some certificate of merit requirements might significantly increase the plaintiff’s costs by making it harder to find experts or by leading the plaintiff to hire twice as many experts—one to provide the initial certification and another to testify at trial. Plaintiffs’ lawyers may prefer to have the same expert do both. However, disclosure to the defense of the certifying expert’s iden-

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tity and evaluation could discourage the plaintiff from using the same expert at trial, because the defense might argue that the expert had prematurely made up his or her mind (Kopstein 2003).

There are ways to minimize these risks. One approach is to provide that the certifying expert will remain anonymous and that the contents of the certification evaluation

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**If the plaintiff is required to disclose an expert's certification evaluation, the law should specify that the defendant is not permitted to impugn the same expert's in-court opinion by asserting that the certification opinion evinced a rush to judgment.**

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need not be disclosed to the defendant.

Admittedly, if the certifying expert is later identified as a testifying expert, the defendants will contend that they should have access to the certification evaluation as well as to materials relating more directly to the later expert report. If the plaintiff is required to disclose the expert's certification evaluation under these circumstances, the law should specify that the defendant is not permitted to impugn the expert's in-court opinion by asserting that the cer-

tification opinion evinced a rush to judgment.

As noted above, some states impose sanctions, such as attorneys' fees and costs, against plaintiffs and/or plaintiffs' attorneys who have failed to comply with the certification requirement. Some disclosure of the expert's identity and evaluation may ultimately be required in order to ensure compliance. However, compliance can be investigated at the conclusion of the suit. At that point, the identity of the expert and the contents of the expert's report could be disclosed if necessary.

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*Pennsylvania’s Certificate of Merit Provision*

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Pennsylvania’s certificate of merit requirement addresses most, though not all, of these concerns. Pennsylvania requires the lawyer to obtain a written statement by the expert that “there exists a reasonable probability” of negligence and causation. This formulation recognizes that the certifying expert need not reach a final and certain determination but only make an initial and provisional assessment. The notes to the Pennsylvania rules anticipate the possibility that the plaintiff may have difficulty obtaining the information needed for the expert evaluation. The notes direct the court to “give appropriate consideration to the practicalities of securing expert review” when considering a plaintiff’s request for an extension of time, and they instruct the court to “allow any discovery which is required” for the plaintiff’s expert evaluation. (See Notes to Pa. Rules of Civil Procedure

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**Pennsylvania’s rule does raise a question of asymmetry, in that it targets plaintiffs and not defendants.**

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1042.3(d) & 1042.5.) Pennsylvania’s rule does not require the attorney’s certification to identify the expert or describe the contents of the expert’s evaluation. Thus, the Pennsylvania requirement may not increase unduly the difficulty or expense associated with the initial expert evaluation.

Pennsylvania’s rule does raise a question of asymmetry, in that it targets plaintiffs and not defendants. Plaintiffs’ lawyers have an incentive to bring strong rather than weak cases—because they are paid only if they obtain a settlement or judgment—but some plaintiffs’ lawyers may not have sufficient expertise. By contrast, defendants’ lawyers are usually paid by the hour, and may have incentives to contest claims they know to be valid. On the other hand, the defense of most malpractice claims is

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guided by insurers, and insurers are likely to work repeatedly with a set of lawyers experienced in defending malpractice claims. Thus, with respect to problematic litigation conduct, inexperience may play a more significant role on the plaintiffs' side, and incentives a more significant role on the defense side. A symmetrical certificate of merit requirement might address both types of problems, and might be a useful improvement over the plaintiffs-only version. Some jurisdictions have chosen to impose a heightened investigation requirement on both sides in malpractice cases. Florida and Maryland, for example, require the defendant to provide an expert certification regarding negligence and causation in connection with the denial of liability. (See Fla. Statutes § 766.203; Md. Code, Courts & Judicial Proceedings § 3-2A-04.) Like Pennsylvania, however, most states with certificate of merit provisions for plaintiffs have not imposed a similar requirement on defendants.

In summary, a certificate of merit requirement is unlikely to change how specialist plaintiffs' lawyers evaluate cases, because those lawyers already seek expert advice when evaluating a potential claim. However, by inducing non-specialist attorneys to obtain expert validation prior to filing a claim, the requirement may lower the number of weak claims filed. In this respect (so long as plaintiffs gain access to the information they need in order to evaluate the claim), the certificate of merit requirement may be a useful way to inject expertise into the process of case selection by inexperienced plaintiffs' attorneys.

### **Screening Panels**

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At first glance, medical screening panels might seem a promising way to address the issues raised above. A physician defendant might have more confidence in the legal system if that system incorporated a judgment by the doctor's peers. Panels might remedy the mismatch problem by identifying and discouraging weak claims. Panels might address the underclaiming problem by encouraging valid complaints to be brought. Panels

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might provide a relatively low-cost venue for helping patients find out what went wrong. Panels might reduce the time, money and stress involved in litigation by encouraging early

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**Unfortunately, neither theory nor experience strongly supports proponents’ optimistic view of screening panels. Panels may accomplish some of the desired goals. Because certain goals conflict with others, however, success in one quarter may bring frustration in another.**

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resolution of claims. For cases that go to trial, panels might provide the jury with a neutral source of expertise. Finally, perhaps, panels might lower liability insurance premiums.

Unfortunately, neither theory nor experience strongly supports proponents’ optimistic view of screening panels. Panels may accomplish some of the desired goals. Because certain goals conflict with others, however, success in one quarter may bring frustration in another. As discussed in detail below, the available data on states with panel systems suggest that panels have not brought much overall improvement in malpractice litigation. Indeed, as shown in Exhibit 6, panel systems have been repealed in at least seven states and overturned by courts in another five. A major reason for some repeals and judicial invalidations was that the

panels caused undue delay.

A mid-1980s study of Indiana found that a physician group, the state bar association and the state department of insurance “agreed that the panel process had decreased the number of claims that go to trial” (GAO, Case Study on Indiana: 12). The state medical association also believed that the panel system “decreases the time required to close claims,” and a large insurance company “attributed its much lower legal costs to defend



STATES THAT ADOPTED PANELS	REPEALED	INVALIDATED	CURRENTLY IN EFFECT
Alaska			•
Arizona	1989		
Connecticut			•
Delaware			•
Florida <sup>1</sup>	1983	1980	•
Hawaii			•
Idaho			•
Illinois <sup>2</sup>	1979 1990	1976 1986	
Indiana			•
Kansas			•
Louisiana			•
Maine			•
Maryland			•
Massachusetts			•
Michigan			•
Missouri <sup>3</sup>		1979	
Montana			•
Nebraska			•
Nevada	2002		
New Hampshire			•
New Jersey	1989		
New Mexico			•
New York	1991		
North Dakota	1981		
Pennsylvania <sup>4</sup>		1980	
Rhode Island <sup>5</sup>	1981		
Tennessee	1985		
Utah			•
Virginia			•
Wisconsin			•
Wyoming <sup>6</sup>		1988	

**Exhibit 6. Screening Panel Provisions Have Been Repealed and/or Invalidated in Roughly One Third of the States That Adopted Them**

<sup>1</sup>Florida repealed a panel provision in 1983, but the repeal followed the judicial invalidation of that provision in 1980. *Aldana v. Holub*, 381 So.2d 231 (Fla. 1980) (invalidating panel system because, as implemented, it deprived doctors of their right to mediation since proceedings in many cases did not conclude within the statutory deadline, and extending that deadline would deprive malpractice plaintiffs of their right of access to the courts). Subsequent to the 1983 repeal, Florida adopted new provisions permitting procedures that have some aspects of a medical screening panel.

<sup>2</sup>Illinois instituted two different panel systems and repealed them both; however, to list Illinois as a repeal state might be viewed as double-counting, since both provisions were judicially invalidated prior to their repeal. *Wright v. Central Du Page Hosp. Assoc.*, 347 N.E.2d 736 (Ill. 1976) (striking down panel provision because it mixed lay and judicial functions in violation of state constitution); *Bernier v. Burris*, 497 N.E.2d 763 (Ill. 1986) (striking down subsequent panel provision on similar grounds).

<sup>3</sup>*Cardinal Glennon Mem. Hosp. v. Gaertner*, 583 S.W.2d 107 (Mo. 1979) (holding that panel provision violated state constitutional right of access to the courts).

<sup>4</sup>*Mattos v. Thompson*, 421 A.2d 190 (Pa. 1980) (invalidating panel system because, as implemented, it resulted in long delays so as to violate state constitutional right to a jury trial).

<sup>5</sup>*Boucher v. Sayeed*, 459 A.2d 87 (R.I. 1983), is sometimes described as striking down a panel provision. However, Rhode Island had repealed its medical screening panel provision in 1981. The provision invalidated by the *Boucher* court was not a panel provision, but rather one that provided for a preliminary finding by judge on the merits of the case. *See id.* at 89-90.

<sup>6</sup>*Hoem v. State*, 756 P.2d 780 (Wy. 1988) (holding that panel provision violated state constitutional guarantee of equal protection).

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claims in Indiana to the panel process.” In a similar survey of interest groups in Florida, however, an official of a trial lawyers’ association recounted that plaintiffs’ lawyers viewed panels as biased by the presence of physicians, and therefore tended to pursue claims that the panels rejected. On the other hand, a physician group, a hospital association, a defense lawyers’ association, and the state insurance department “strongly supported” panels. As one insurance company executive argued, “[o]ur tort system cannot supply a jury that is truly comprised of the defendant’s peers” (GAO, Case Study on Florida: 35). In New York, the state bar association, a trial lawyers’ association and a hospital underwriters’ association all opined that panels led to undesirable delay (GAO, Case Study on New York).

Admittedly, historical evidence on panel performance provides only limited guidance for current policymaking if malpractice litigation has changed (Sage 2003b). Of the available multistate studies that looked at panel performance, one analyzes data from 1992, four others cover the mid-1980s and earlier, and the rest use data from the 1970s. Some of these studies may not capture the full impact of panel systems; for example, data from the 1970s only gives a sense of panels’ short-term effects, and not their longer-term significance. Other studies’ results may be blunted by the fact that researchers lumped varying panel systems together under one or only a few categories (e.g., panel versus no panel, mandatory versus voluntary panels, admissible versus non-admissible panel findings).

### ***How Screening Panels Work***

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Thirty-one states have enacted screening panels (see Exhibit 6); in 11 of those states, panel provisions subsequently were repealed or invalidated. In light of the many possible purposes for screening panels, it is unsurprising that states have adopted systems that vary in a number of important ways. The basic concept is that a body composed at least partly of physicians will review evidence concerning a malpractice claim and provide

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**Thirty-one states have enacted screening panels; in 11 of those states, panel provisions subsequently were repealed or invalidated.**

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an opinion regarding its merit. Some panel systems are mandatory, while others are voluntary. Some screen claims prior to the filing of a legal complaint while others screen claims after filing. Panels typically have from three to seven members, and panel composition varies. Some panels are composed exclusively of physicians, while others include lawyers, judges, and/or laypeople. Other significant variations affect the amount of discovery permitted, the types of evidence

allowed, the extent of the panel proceedings, and the scope of the panel findings (liability only, or liability and damages). Some systems provide that panel findings are admissible at a later trial, and some permit the panel members to be called as witnesses. Finally, some systems attempt to discourage the party who loses before the panel from proceeding further, by providing for the imposition of costs or other fees (Macchiaroli 1990).

#### *Studies Linking Panels to Claims Frequency are Mixed*

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In theory, panels might provide a less costly alternative to litigation for patients with smaller claims and for those who simply want information. This would be particularly true if the plaintiff does not present an expert witness, and relies instead on the panel's expertise. Thus, a claimant whose primary motive is to find a cause for an injury may take advantage of the panel procedure, perhaps *pro se*, in order to obtain an expert assessment of what went wrong. In addition, for some claims that would otherwise be too small to justify the cost of litigation, panels might provide patients with a low-cost evaluation (Sloan 1985) and—in the event of a positive panel assessment—with a cheap expert

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witness for trial if the panel system in question permits the parties to call panelists as witnesses (Danzon 1986). Such a witness would be less strategically appealing than a privately retained expert, since the plaintiff would not be able to prepare the panelist witness

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**In theory, panels might provide a less costly alternative to litigation for patients with smaller claims and for those who simply want information.**

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to testify at trial (Aronie 1992), but the cost savings might offset this disadvantage for some claimants.

Consistent with this notion, some studies indicate that the availability of a panel system may increase the number of legal claims asserted. To assess whether this increase is desirable, however, it is necessary to know how much is attributable to the assertion of valid claims. Unfortunately, available data do not provide this information. Researchers at the National Center

for State Courts examined state court data on the frequency of medical malpractice claim dispositions in 21 states during 1992, and found that states with mandatory panels had a significantly greater rate of litigation (Hanson, Ostrom, and Rottman 1996). Because the study did not examine changes over time, it is possible that the causal link runs the other way—i.e., that states with higher litigation rates might have been more likely to adopt mandatory panel systems. A decade earlier, a study of Arizona’s panel system using insurance claim file data from 1972-1979 (Arizona instituted panels in 1976) found that the yearly rate of claim files opened per doctor was significantly higher after the start of the panel system than before. The authors surmised that the increase in claim frequency arose from the fact that panels “lower the expected cost to plaintiffs of acquiring information about the outcome of their lawsuits” (Shmanske and Stevens 1986: 533).

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Other research, however, has concluded that panels have no systematic effect on claims frequency. In an early study, Danzon analyzed insurance company data on claims

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**One reason that panels' net effect on claim frequency may be small is that even if panels encourage claiming by some plaintiffs, panels may discourage claiming by others. The available data provide no direct way to tell whether the claims that are deterred are meritorious.**

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closed in 1970 and 1975-1978. She found that pretrial screening panels had no significant effect on malpractice claims frequency or severity, but cautioned that many claims in the later sample were filed before the effective dates of the changes in question (Danzon 1984; Danzon 1982). Yet she reached similar conclusions after updating her analysis to include data covering 1975-1984 (Danzon 1986: 78).

*Panel Requirements May Discourage Some Claims*

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One reason that panels' net effect on claim frequency may be small is that even if panels encourage claiming by some plaintiffs, panels may discourage claiming by others. The available data provide no direct way to tell

whether the claims that are deterred are meritorious. However, it seems likely that an increase in the cost and length of litigation would deter valid as well as invalid claims.

Panel proceedings will not always be quick or low-cost. Panels often will need to hold live hearings in order to reach an accurate assessment (Howard 1981). In many instances, the parties will need to conduct discovery in order to gather the necessary evidence. (Restrictions on pre-panel discovery would be particularly unfair to plaintiffs, who

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are less likely to have informal access to information.) In jurisdictions where the panel's findings are admissible at trial, it is particularly likely that the parties will feel the need to

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**In jurisdictions where the panel's findings are admissible at trial, it is particularly likely that the parties will feel the need to engage in exhaustive discovery and a plenary presentation. Unfortunately, such endeavors will "entail the costs and delay that panels are intended to prevent."**

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engage in exhaustive discovery and a plenary presentation (Sloan 1985). Unfortunately, such endeavors will "entail the costs and delay that panels are intended to prevent" (Danzon 1985: 199). For example, a 1981 study of panels in Arizona asked attorneys to estimate the additional expense attributable to panel hearings; the mean cost (counting time and out-of-pocket expenses) reported by survey respondents was between \$3,000 and \$4,000 (Howard 1981). Plaintiffs who must go through a panel proceeding in order to litigate their claims will, in effect, face the prospect of having to 'try [their] case twice' (McClellan 1994:90), and this will increase the expected cost of litigation.

Panel proceedings may also lower plaintiffs' expected returns by delaying the resolution

of claims. Different panel systems have varying effects on litigation processing time. One study found that the existence of a panel system appeared to speed claim resolution (measured from filing) 'by about a year' (Sloan, Mergenhagen, and Bovbjerg 1989:677). On the other hand, some states have had severe problems with delay. For example, the Pennsylvania panel system was held unconstitutional in *Mattos v. Thompson*, 421 A. 2d 190, 196 (Pa. 1980), because the delay it caused impermissibly burdened the right to a jury

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trial. Reports from other states, including Arizona, Indiana, New York, and Rhode Island, also indicate problems with panel delay (Shmanske and Stevens 1986; Howard 1981;

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**Different panel systems have varying effects on litigation processing time. ... The Pennsylvania panel system was held unconstitutional because the delay it caused impermissibly burdened the right to a jury trial.**

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Kemper 1986; Rosen 1986). Scheduling difficulties appear to be a frequent hindrance: coordinating the availability of physicians and other professionals is challenging, and the challenge increases with greater numbers of panelists.

Proponents hoped that panels would facilitate settlements by bringing the parties' valuations of the case closer together (Hughes 1989). In this respect, a screening panel might perform a function analogous to "early neutral evaluation" (Metzloff 1992). At least a few defense attorneys have stated that a panel's finding of liability can help to persuade the physician defendant to consent to settlement, which is

required by some liability insurance policies (Klein 1984). On the other hand, panels sometimes delay settlement talks because parties may be inclined to hold off until they obtain the panel's assessment of the case (Goldschmidt 1991).

If panels promote pretrial resolution of claims, they may do so more often by leading the plaintiff to drop the claim than by facilitating settlement. An analysis of insurance company data on 'claims closed between 1975 and 1978' found that the presence of a panel system 'significantly increased the probability' that the plaintiff would drop the claim (Hughes 1989:57, 75). Panels were also associated with a small decrease in the probability that claims would settle, but combining the probabilities of the claim being

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dropped or settled still produced an increased likelihood of pretrial resolution.

Some critics of malpractice litigation might argue that encouraging plaintiffs to drop claims is beneficial. However, that would be true only if the claims that are dropped lack merit. Plaintiffs may drop valid claims if the size of the claim is insufficient to justify the additional expense and delay. Moreover, even if panel findings help to eliminate weaker claims, as proponents suggest (Carlin 1980), it is possible that plaintiffs only brought those claims because the panel procedure was available (Metzloff 1988). If panels encourage an increase in claiming, if many of the additional claims are weak, and if the panel findings then discourage those weak claims from proceeding, there would be little net benefit from panels in this respect.

#### *Studies Find Little Effect on Severity of Paid Claims*

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In states where panels opine on damages as well as liability, and where the jury is told of the panel's determination, one might expect this information to regularize jury decisions. The data on claim severity do not provide sufficient detail to assess whether panels improve the accuracy, or reduce the variability, of jury awards. However, panels do not seem to affect the overall severity of paid claims.

As noted above, Danzon found no evidence that panels had a consistent effect on the size of payments. Other researchers used Danzon's 1975-1984 data, plus 1985 and 1986 insurance company data, to study the effect of various factors on claim frequency, claim severity, and insurance premiums (Zuckerman, Bovbjerg, and Sloan 1990). With respect to claims-made liability policies (which cover claims filed within the policy year), they found that panels had no statistically significant effect on claim frequency or severity. When they combined claims-made policies with occurrence policies (which cover claims arising from health care provided during the policy year), however, they found that



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panels were associated with a statistically significant increase in claim severity. In another study, the same authors used insurance company data on claims closed in 1975-1978 and 1984 to analyze three variables: whether a state had panels at all, whether panels were mandatory, and whether panel findings were admissible in subsequent court proceedings (Sloan, Mergenhagen and Bovbjerg 1989). They found that mandatory screening panels were associated with a statistically significant increase in the mean payment per paid claim. They also found that regimes that made the panel findings admissible in court were associated with a statistically significant reduction in mean payments per paid claim, but that if the cost of defending the claim were factored in the statistical significance of the reduction disappeared. Thus, overall, the data do not indicate that panels reduce claim severity.

### *Studies Find No Consistent Effect on Malpractice Premiums*

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In light of the above, it is not surprising that panels have little effect on malpractice insurance premiums. In an early study, Sloan analyzed premium data for 1974-1978, and found that the presence of a panel system was associated with a statistically significant decrease in premium levels. However, Sloan stressed the “need for more ‘hard’ empirical evidence on how insurers *really* form expectations and set premiums” (Sloan 1985: 643). Data from the longer run provide less support for the notion that panels reduce premiums. Working with data from 1974-1986, Zuckerman, Bovbjerg, and Sloan found no statistically significant effect on premiums for general practitioners or general surgeons (though they did find that panels were associated with a statistically significant reduction in premiums for obstetrician-gynecologists) (Zuckerman, Bovbjerg, and Sloan 1990).

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**Panels have little effect on malpractice insurance premiums.**

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*Panels are Not an Optimal Way to Provide Expertise to the Jury*

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In general, panels seem ill-designed to provide expertise to a jury if claims proceed to trial. Requiring all claims to go through panel proceedings seems an inefficient way to generate an expert opinion for use in the relatively small number of cases that actually get to a jury. Indeed, not all cases that reach trial will need a neutral expert's opinion. As noted above, moreover, rendering the panel's findings admissible will tend to make panel deliberations costlier and more protracted. The prospect of being called to testify also may make

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**Requiring all claims to go through panel proceedings seems an inefficient way to generate an expert opinion for use in the relatively small number of cases that actually get to a jury.**

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physicians less eager to serve on panels, which could increase the already pronounced difficulties of finding panelists.

Finally, in the subset of tried cases where a neutral expert opinion could be useful, it is questionable whether screening panels provide the best source. Medical screening panels—as this report defines them and as they are commonly understood—include at least one physician, presumably in order to bring medical expertise to bear on the issues. It is not obvious, however, to what extent the presence of doctors on the review panels improves the panels' accuracy. Doctors

will understand medical concepts more readily than most lawyers, judges, or laypeople. On the other hand, if the duty of care is set according to medical custom, doctors may not have much of a comparative advantage, since few practicing physicians will have more than an anecdotal sense of the practices of other doctors—especially doctors outside their specialty or locality. However, requiring panelists to share the defendant's specialty would decrease

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the potential pool of panelists, thus increasing problems of availability and scheduling. Members of the defendant's specialty might also be more likely than other doctors to be professionally connected with the defendant and therefore biased.

There is some question, as well, concerning practicing physicians' ability to judge other doctors objectively. Discussing a survey of New York physicians, Weiler et al. "found a marked variation among physicians in their willingness to label certain kinds of medical outcomes as iatrogenic, and an even more pronounced reluctance to label as negligent those treatment decisions that, *ex post* at least, were clearly erroneous" (Weiler et al. 1993: 125). More generally, studies in other contexts have raised questions concerning the degree to which multiple physicians are likely to agree on the quality of care in a given case. Goldman reviewed twelve studies that provided data on the inter-rater reliability of physicians' assessments of quality of care, and found only two in which agreement was consistently better than poor (Goldman 1992).

### ***Overall, Panels are Unpromising***

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In sum, it seems that by attempting to serve dispute resolution, claim screening, and neutral expert goals simultaneously, medical panels tend to fail in all three aims (see Exhibit 7). To screen claims well and provide expertise at trial, panels must reach accurate assessments—but the cost of accuracy is that the panel proceeding will tend to become longer and more costly than other alternative dispute resolution mechanisms. Claim screening, moreover, may be encouraged through other means, such as a certificate of merit requirement. Finally, in cases where a court concludes that a neutral expert would help the jury assess questions of liability or damages, other measures discussed in the final section of the report may be more promising.

**Exhibit 7. Screening Panels Seem Unlikely to Improve Most Aspects of Medical Malpractice Litigation**

ASPECT OF LITIGATION		LIKELY EFFECT OF PANELS:
Doctors' view of the system	+	<ul style="list-style-type: none"> <li>■ Doctors are likely to prefer panels</li> </ul>
Claim frequency		<ul style="list-style-type: none"> <li>■ Panels may encourage claiming by some, and discourage claiming by others</li> <li>■ Overall effect is unclear</li> </ul>
Screening out meritless claims		<ul style="list-style-type: none"> <li>■ Panels may screen out some meritless claims,</li> <li>■ But some of those claims might not have been brought if the panel system did not exist</li> </ul>
Cost of litigation	-	<ul style="list-style-type: none"> <li>■ Panels increase overall litigation costs with respect to some claims</li> </ul>
Delay	-	<ul style="list-style-type: none"> <li>■ Panels have caused significant delay in some states</li> </ul>
Severity of paid claims		<ul style="list-style-type: none"> <li>■ Panels have no consistent effect on severity of paid claims</li> </ul>
Insurance premiums		<ul style="list-style-type: none"> <li>■ Panels have no consistent effect on premiums</li> </ul>
Providing expertise at trial	-	<ul style="list-style-type: none"> <li>■ Most cases do not reach trial</li> <li>■ Panel physicians' evaluations may not be accurate</li> </ul>

**Specialized Courts**

Proposals for a discrete medical malpractice court focus explicitly on the perceived need for specialization and expertise among judges. Though a specialized court might provide some improvement in judicial performance, it would come at a cost. This section examines the potential benefits and risks of a specialized court, and concludes that it may be preferable to increase expertise through means other than court specialization. Moreover, an unspoken goal underlying some specialized court proposals is to change the pool from which malpractice juries are drawn. If the real concern is that damages awarded in urban areas are too generous or too variable, however, other approaches might better address that issue.

***The Concept of a Specialized Court***

The possible advantages of a specialized medical liability court include expertise,

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speed, and uniformity and coherence of outcomes. Not only might the judges

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**The possible advantages of a specialized medical liability court include expertise, speed, and uniformity and coherence of doctrine.**

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initially be selected for their experience with medical liability cases, but once on the bench, the judges would have the incentive and opportunity to develop additional expertise in relevant areas (Dreyfuss 1995; Currie and Goodman 1975). Expert judges might be better equipped to evaluate the qualifications of expert witnesses (Gross 1991). Moreover, specialized judges reviewing jury calculations of damages would be better acquainted with the amounts that had

been awarded and upheld in prior, similar cases. Expertise might also help judges to manage cases more actively, with a view to resolving them quickly. In addition, the exclusivity of the court's jurisdiction over medical liability cases would reduce the number of judges hearing those cases, and thus might tend to increase somewhat the uniformity and consistency of decisions.

Common Good's proposal for a specialized medical court system focuses on the notion of heightened expertise. Relatedly, Common Good asserts that the standard of care in a medical malpractice case should be a question of law for the court, rather than a question of fact for the jury to decide. In Philip Howard's words, "[a] reliable system of medical justice could take many forms, but ... the key element must be expert judges ruling on standards of care" (Howard 2003.) Underlying this assertion are the arguments that judges can do a better job than juries in determining the standard of care, and that if the standard of care is a question of law, judges' decisions concerning the standard of care can set precedents that can guide physicians' future conduct. Though a full discussion of these

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contentions lies beyond the scope of this report, the nature of medical practice raises questions about the feasibility of developing a body of legal precedent concerning the appropriate standard of care. In many medical contexts, there exist multiple treatment approaches rather than a single standard of care. Further, the specific circumstances of each case may render it difficult to draw general conclusions concerning the appropriate standard of care, and as medical knowledge and technology rapidly advance, a “precedent” concerning the standard of care could quickly become obsolete.

### *Pennsylvania’s Court System*

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The true costs and benefits of a specialized court system will depend on its details and those of the court system it supplements. Accordingly, the remainder of this section focuses on the specialized court proposals currently pending in Pennsylvania. In order to

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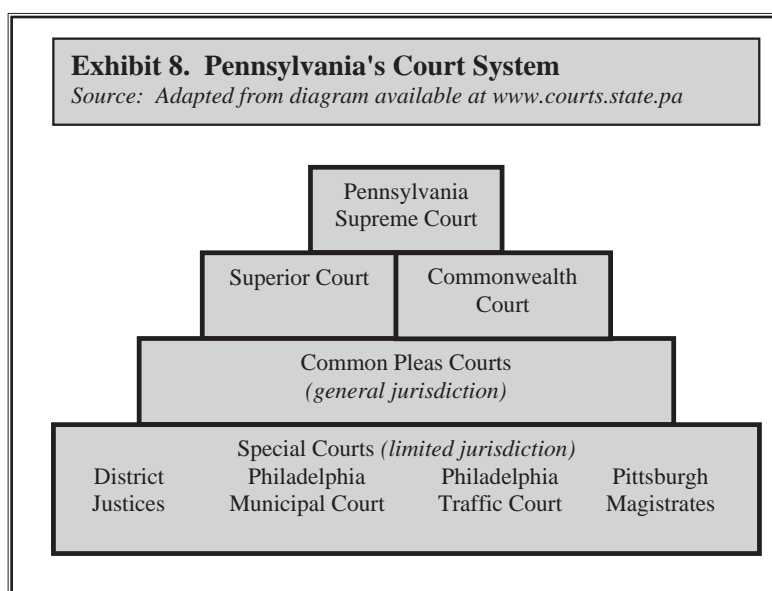
**The true costs and benefits of a specialized court system will depend on its details and those of the court system it supplements.**

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assess those proposals, a brief discussion of Pennsylvania’s existing court system is necessary (see Exhibit 8). Currently, Pennsylvania has few discrete specialized courts for particular kinds of disputes. Of these, the Commonwealth Court is the most significant for present purposes; it “deals only with cases in which state or local government agencies or nonprofit corporations are parties or that involve review of administrative adjudications by governmental tri-

bunals” (Craig 1995: 323). Apart from some trial-level courts of limited jurisdiction,<sup>2</sup> the remaining specialization in the Pennsylvania courts occurs within the Courts of Common Pleas (Pennsylvania’s trial courts of general jurisdiction). The Philadelphia County Court

of Common Pleas, for example, is defined by statute to have a trial division, an orphans' court division, and a family court division. The trial division is subdivided into criminal and civil divisions. The civil division, in turn, encompasses several specialized programs, including the Commerce Case Management Program, the Complex Litigation Center, the Arbitration Appeals Program, and the Discovery Court.



### ***Proposals For a Medical Liability Court in Pennsylvania***

The medical liability court proposed in currently pending bills would have exclusive original jurisdiction over all medical malpractice claims. It would be staffed by 18 elected judges, and would sit regularly in six cities—two each in the western, middle and eastern parts of the state – holding sessions in other locations as necessary. The eastern cities would include one city outside Philadelphia, but would not include Philadelphia

<sup>2</sup> Within Philadelphia, the Municipal Court has jurisdiction over a limited range of criminal matters, and the Traffic Court handles vehicular offenses. In Pittsburgh, the Magistrates Court handles a limited range of criminal matters, and its magistrates also serve on Pittsburgh's housing and traffic courts. In other areas of the state, district justices handle a range of summary offenses, landlord-tenant actions, and small claims.

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itself. In two of the three pending proposals, there would be intermediate appellate review by panels of specialized trial judges, and there would be discretionary review in the Pennsylvania Supreme Court; in the third proposal, there would instead be a right of direct review in the Pennsylvania Supreme Court.

### *Advantages of a Specialized Court Are Questionable*

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An analysis of the Pennsylvania proposal shows that each of the potential advantages of a specialized court—skill, speed, and consistency—is open to question. Specialized judges would undoubtedly gain expertise in dealing with malpractice claims. However, generalist judges may already be adequately equipped to deal with many such claims, and appropriate training could help them to deal with the more difficult cases. In addition, courts need not be specialized in order to implement strategies to reduce delay, such as active case management and the imposition of deadlines on discovery and dispositive motions. Nor is it clear whether Pennsylvania has such a serious problem with delay that creation of a specialized court would be justified for that reason. According to data from the National Practitioner Data Bank, the mean time from incident to payment in Pennsylvania malpractice cases between 1990 and 2001 was 5.96 years—more than a year longer than the mean time nationwide (Bovbjerg and Bartow 2003). However, this measure does not directly reflect the speed with which a claim proceeds through litigation, since it does not take into account potential variations in the time from incident to assertion of the claim.

Moreover, to the extent that Pennsylvania’s mean time to resolution was higher than the nationwide average during 1990-2001, this may reflect the facts that a high proportion of Pennsylvania malpractice claims were filed in Philadelphia County, and that the Philadelphia County Court of Common Pleas experienced a significant backlog in its case-



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load during the early to mid 1990s. That court has since made significant strides in eliminating its backlog and accelerating case resolution; thus, cases in Philadelphia may be resolved more expeditiously in the future. In addition, the recent restrictions on venue in medical liability actions will somewhat reduce the proportion of cases that are brought in Philadelphia County.

Likewise, it is not self-evident that a specialized court would contribute significantly to decisional consistency. At the trial level, there could be some gains in uniformity because cases would be heard by 18 specialized judges rather than by the numerous judges in the 60 judicial districts of the Court of Common Pleas. At the appellate level, however, the gains are much less clear. A single court (the Pennsylvania Superior Court) already hears appeals from the Court of Common Pleas, including medical liability actions, which implies that uniformity (though not necessarily expertise) would be unchanged by shifting appellate jurisdiction to a specialized appellate division.

#### ***Disadvantage: Politicization***

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While the benefits of the specialized court are questionable, its costs seem substantial. One cost relates to the politicization of the bench. Commentators have long pointed out that the more specialized a court is, the greater the incentives and opportunities for interest groups to seek to influence the court's decisions, both by lobbying to select judges who will favor the desired position and by exerting pressure on the court in connection with particular cases (Revesz 1990; Posner 1983). The risk of politicization is greatest when judges are elected. It is possible that a specialized court with appointed judges could avoid the problem, at least to some extent. However, it seems unlikely that Pennsylvania would embrace that idea.

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Although interest groups on both sides of the medical liability debate have strong opinions about the qualifications and conduct of judges on the Court of Common Pleas,

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**The more specialized a court is, the greater the incentives and opportunities for interest groups to seek to influence the court’s decisions, both by lobbying to select judges who will favor the desired position and by exerting pressure on the court in connection with particular cases.**

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their incentives to influence judicial selection in the current system are dampened by the fact that any single judge will likely hear a relatively small number of malpractice cases. Moreover, since the Court of Common Pleas, the Superior Court and the Supreme Court are all (relatively) generalist courts, a judicial candidate will be judged not only on her position on medical liability issues but also on her stance on many other questions. By contrast, the incentives are likely to be quite different with respect to the 18 judges of a specialized court—both because the number is much smaller, and because the court’s jurisdiction extends only to medical liability issues. Also, in contrast to a field such as patent law, where a repeat litigant will likely be on different sides in different disputes (Dreyfuss

1989), a repeat player in the medical malpractice field will be habitually on one side or the other—thereby increasing the player’s incentive to seek the selection of judges favorable to the player’s expected position.

Recent developments in judicial selection underscore the potential dangers of politicization. A report by the American Bar Association’s Commission on the 21<sup>st</sup> Century Judiciary notes that in a number of recent state judicial elections, campaigns have been

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politicized due to the involvement of “interest groups that formed to promote a specific political issue” (ABA Commission 2003: 22). The ABA Commission focused its discussion of this trend on elections for state high courts; but the same concern would apply to

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**Another disadvantage of a specialized court is that judges’ perspectives may become narrowed.**

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a specialized lower court. Moreover, recent changes to the rules for judicial election campaigns seem likely to exacerbate the problem. Last year, the U.S. Supreme Court held that a Minnesota provision ‘prohibiting candidates for judicial election from announcing their views on disputed legal and political issues violates the First Amendment.’ (Republican Party of Minnesota v. White, 536 U.S. 765, 788 (2002).)

The ABA Commission noted, “the *White* case is likely to politicize judicial elections as never before” (ABA Commission 2003: 90). Subsequently, Pennsylvania amended its Code of Judicial Conduct—which previously contained a provision similar to Minnesota’s— to bar, instead, “statements that commit or appear to commit the candidate with respect to cases, controversies or issues that are likely to come before the court” (Pa. Code of Judicial Conduct Canon 7(B)(1)(c)).

***Disadvantage: Narrowed Judicial Perspective***

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Another disadvantage of a specialized court is that judges’ perspectives may become narrowed. Since specialist judges’ knowledge of their field comes at the expense of familiarity with other doctrinal areas, such judges may fail to draw relevant analogies to other bodies of doctrine, with the result that the specialists’ field may diverge from the larger body of law and may also lose the benefit of experience in other fields (Currie and

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Goodman 1975; Revesz 1990). It is worth noting, in this respect, that the medical liability court would have a far narrower field of specialization than the Commonwealth Court. The latter’s subject matter jurisdiction – “public sector cases” – includes a fair range of matters within its scope (Craig 1995).

One potential disadvantage of specialization might not apply to a medical liability court. Commentators have warned that judges who specialize in a technical area might be less willing to question accepted wisdom in the relevant field. However, courts adopted medical custom as the standard of care in malpractice cases precisely *because* judges were viewed as unqualified to question accepted medical wisdom. Thus, to the extent that compliance with medical custom determines malpractice liability, judges on a specialized court could be well qualified to apply that standard. On the other hand, if Peters is correct that jurisdictions such as Pennsylvania are moving towards a “reasonable physician” standard of care, generalist judges may be better positioned to apply that standard because they would have experience with the reasonable care standard as it applies in other areas of tort law and because they might be less likely to defer unduly to established medical practices. (Even without adopting Common Good’s proposal that the standard of care be regarded as a matter of law, not fact, a judge’s understanding of that standard will influence the disposition of many disputes.)

#### ***Disadvantage: Cost to Litigants***

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The costs to particular litigants are potentially significant. Currently, a medical liability plaintiff must sue in “a county in which the cause of action arose.” (See Pa. Rule of Civil Procedure 1006(a.1)). For a plaintiff who received allegedly negligent medical care near home, this venue provision will place the suit in the plaintiff’s local county, which can help to contain the costs of litigation. The specialized courts, by contrast, will

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**The discussion thus far neglects one possible rationale for creating a specialized court. It may be the case that some view the creation of such a court as a way to change not judges, but the jury pool.**

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hold regular sessions in only six venues—the nearest of which will in many instances be quite far from the plaintiff’s home county. Although the proposal also contemplates sessions in other locations as necessary, it seems unlikely that this would provide the same convenience as the current system. Admittedly, litigating in a distant forum may increase costs for both plaintiff and defendant, but malpractice plaintiffs tend to have more limited resources than defendants and therefore may feel the burden more acutely. (On the other hand, if a specialized court system concentrated medical liability litigation in a few areas of the state, it might increase the likeli-

hood that a plaintiff’s case would be handled by experienced medical malpractice counsel. This, in turn, might increase the plaintiff’s chance of prevailing.)

### *The Issue of Juries and Damage Awards*

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The discussion thus far neglects one possible rationale for creating a specialized court. It may be the case that some view the creation of such a court as a way to change not judges, but the jury pool. Proponents of the recent change to Pennsylvania’s venue law—the requirement that medical liability suits be brought in a county in which the cause of action arose—were motivated largely by a desire to reduce the number of medical liability suits brought in Philadelphia County. Notwithstanding the new venue restrictions, however, many cases will still be filed in Philadelphia due to the large number of hospi-

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tals and physicians located there. The specialized court proposal may be designed to further divert litigation from that city.

As noted, the proposals pending in the Pennsylvania legislature contemplate regular sessions of the medical liability court in six cities, not including Philadelphia. Each proposal does contemplate a regular court location in the greater Philadelphia area (either in Media or Norristown), but it is likely that the jury pool for a specialized court would be considerably different from the jury pool for the Philadelphia Court of Common Pleas. For example, two of the proposals divide Pennsylvania into three districts and provide for jury selection in each district from a district-wide list. It would likely be impracticable to have truly district-wide selection under such a system, since each district covers a third of the state. However, it seems clear that the jury pool for a specialized court sitting in Norristown, for example, would include large numbers of people from suburban and rural areas in addition to residents of Philadelphia itself.

The impetus to alter the jury pool for medical liability actions arises from the belief that Philadelphia juries award unduly large amounts in damages. Anecdotal accounts of misdeeds by “Philadelphia juries” have figured in broader critiques of the liability system. For example, Peter Huber—introducing his argument that juries are incapable of evaluating expert testimony—related that “a soothsayer who decided she had lost her psychic powers following a CAT scan persuaded a Philadelphia jury to award her \$1 million in damages” (Huber 1991: 4). Huber noted that the trial judge set aside that verdict; he did not point out that the plaintiff—who claimed that severe headaches resulting from an allergic reaction to dye used in a CAT scan had prevented her from continuing her work as a psychic—ultimately lost because her expert was held to be unqualified (Galanter 1998).

It does appear to be the case that large malpractice verdicts occur with greater frequency in Philadelphia than in other parts of the state. Data from the Philadelphia Court

**Exhibit 9. The Costs of a Specialized Medical Malpractice Court Would Outweigh the Benefits**

ASPECT OF LITIGATION		LIKELY EFFECT OF SPECIALIZED COURT:
Judicial competence	+	<ul style="list-style-type: none"> <li>■ Specialized judges may be more expert, but not all cases require expertise</li> </ul>
	+	<ul style="list-style-type: none"> <li>■ Specialized courts would enhance uniformity of decisions at the trial level but not at the appellate level</li> </ul>
	-	<ul style="list-style-type: none"> <li>■ Specialization could narrow judges' perspective</li> </ul>
Judicial efficiency		<ul style="list-style-type: none"> <li>■ Levels of delay have decreased in recent years</li> <li>■ Measures other than specialization (e.g., active judicial case management) can help reduce delay</li> </ul>
Judicial neutrality	-	<ul style="list-style-type: none"> <li>■ Small number of judges and specialized subject matter would increase politicization</li> </ul>
	-	<ul style="list-style-type: none"> <li>■ Recent change in rules governing judicial candidate speech will exacerbate the problem</li> </ul>
Cost of litigation	-	<ul style="list-style-type: none"> <li>■ Cost of litigating in distant forum likely to impact plaintiffs</li> </ul>

of Common Pleas for 1999-2001 indicate that juries awarded damages in 44% of cases that went to verdict, and that more than half the awards exceeded \$1 million. However, Bovbjerg and Bartow note that these data “do not present a complete picture,” because “[t]hey fail to reveal what types of cases go to trial, or whether jury awards are reduced by judges or settled for lesser amounts to avoid lengthy appeals” (Bovbjerg and Bartow: 33). Similarly, cross-county comparisons are problematic, since the frequency and level of jury awards in a particular court are affected by the mix of cases that juries see—i.e., by the pool of potential claims that could be brought in each jurisdiction, the claims actually asserted, and the parties’ decisions as to which of those claims to take to trial. If juries in different areas are seeing materially different cases, it would be unsurprising that they reach differing results (Vidmar 1994a). To the extent that reforms are targeted at large jury awards, moreover, demographics may play a lesser role than is generally assumed. For

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example, when researchers in a large-scale jury study in Cook County, Illinois presented mock jurors with a simulated asbestos products liability trial, they found that background characteristics (including age, gender, race, politics, education and income) explained only 5.4% of the variation in the mock jurors’ liability determinations, and that none of those characteristics were “systematically related” to jurors’ damages awards (Diamond, Saks, and Landsman 1998: 306, 314).

### *Alternatives to a Specialized Court*

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On the whole, then, the stated rationales of expertise, speed and consistency provide little reason to create a specialized medical liability court (see Exhibit 9). The following section of this report discusses other possibilities offering comparable benefits at less potential cost. For example, if trial judges lack skill in assessing the admissibility of

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**If the support for specialized courts arises mainly from the perceived failings of Philadelphia juries, that debate should be more openly engaged.**

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expert testimony, judicial training sessions could improve their understanding of the scientific method, probabilistic evidence, and other relevant topics. If specialized judges remain desirable, a separate court is not the only way to provide them. A specialized medical malpractice division could be created within a particular county’s Court of Common Pleas, and judges could rotate into and out of that division. This option could reduce the politicization and perspective-narrowing problems identified above,

while providing an opportunity for judges to gain concentrated experience in malpractice litigation. A specialized division, moreover, would not force litigants to travel large dis-



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tances in order to pursue medical liability claims. If the support for specialized courts arises mainly from the perceived failings of Philadelphia juries, that debate should be more openly engaged. Those concerned principally with variations in jury awards, rather than judicial competence, might consider other reforms that tackle the jury issue directly, such as benchmarks to guide damage calculations.



# Possibilities For Expertise-Enhancing Reform

Although the issues considered so far all relate, in some way, to the need for increased expertise in the adjudication of malpractice suits, it should be clear from the discussion above that different cases will require expertise of varying kinds and in varying degrees. This section describes measures that hold promise for improving malpractice litigation in appropriate cases. Two possible reforms would modify the adversarial nature of

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**One approach would be to tighten the standards for admissibility of partisan expert testimony. Another possibility would be to encourage judges to seek out expert advice or testimony from neutral sources.**

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litigation by altering the court's approach to expert witnesses and by promoting active learning by jurors. A third reform would provide more guidance for the determination of noneconomic damages.

## Use of Experts

Critics of malpractice litigation often accuse juries of crediting unreliable expert testimony. Such critics charge that unscrupulous scientists and physicians can be found to testify for any position, and that the adversary system presents juries with dueling experts whose testimony the jury is ill-qualified to assess. Measures to

address these concerns could take at least two forms. One approach would be to tighten the standards for admissibility of partisan expert testimony. Another possibility would be to encourage judges to seek out expert advice or testimony from neutral sources.

Recent Pennsylvania legislation provides an example of minimum qualification requirements for expert witnesses. Pennsylvania now requires that a medical expert in malpractice cases generally must be a licensed physician who has engaged in "active clin-

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ical practice or teaching” within the past five years. (See 40 Pennsylvania Statutes § 1303.512(b).) In order to testify concerning the standard of care, the expert must be “substantially familiar with the applicable standard of care” at the relevant time and generally must practice in “the same subspecialty as the defendant physician” (or a subspecialty with a similar standard of care) and have the same board certifications as the defendant physician. (See 40 Pennsylvania Statutes § 1303.512(c)-(e).) The court may waive these requirements under certain circumstances.

Standards for expert testimony also can be heightened through changes in the substantive law. For example, amending the standard of care will lead to alterations in the content of expert testimony, and the requirements for admissibility will shift accordingly. As discussed above, some jurisdictions permit experts to testify concerning what a reasonable doctor should do, without reference to medical custom. Other commentators advocate the use of empirical data, rather than impressionistic expert opinion, to establish patterns of medical practice. If a jurisdiction were to adopt the latter approach, expert testimony on standard of care might include testimony on the gathering and interpretation of statistical data.

In addition, the standards for admission of expert testimony depend on the law of evidence. Jurisdictions that retain the *Frye* test require the judge to consider whether a scientific expert’s method is generally accepted in the relevant scientific community. Jurisdictions that have adopted the *Daubert* approach, by contrast, have the judge make an independent assessment of the methodological validity of the expert’s testimony. A consideration of the relative merits of the *Frye* and *Daubert* approaches lies beyond the scope of this report. As noted above, however, the *Daubert* approach—with its scrutiny of the expert’s methodology—requires more technical knowledge on the part of judges. In light of evidence suggesting that many judges lack technical proficiency (Gatowski et al. 2001),

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jurisdictions that adopt *Daubert* should also consider adopting a judicial training program to provide judges with a grounding in basic scientific concepts.

In selected cases, courts might wish to appoint a nonpartisan expert to testify at trial. It is likely that “the need for such appointments will be infrequent and will be characterized by evidence that is particularly difficult to comprehend, or by a failure of the adversarial system to provide the information necessary to sort through the conflicting claims and interpretations” (Schwarzer and Cecil 2000: 61). If the process is carefully structured, a court-appointed expert may prove useful in cases presenting particularly difficult or contentious scientific issues. Alternatively, the judge might consider using a court-appointed expert to aid in the assessment of the qualifications of the parties’ experts. A court-appointed expert can educate the judge and jury, add to the information already

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**Another problem with the adversarial model is that it views jurors as passive recipients of information presented by the plaintiff and defendant.**

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presented, offer an independent view, and ‘analyze the conflicts between the party experts’ (Deason 1998: 84, 93). Courts should be wary of presenting such an expert’s testimony as definitive, and care should be taken to involve the parties in the selection process, to assess the expert’s neutrality, and to control the circumstances under which the expert communicates with the judge, the parties, and other experts.

A number of resources exist to help judges make use of court-appointed experts.

Examples include the American Association for the Advancement of Science’s Court Appointed Scientific Experts project (<http://www.aaas.org/spp/case/case.htm> (last visited June 23, 2003)), and Duke University Law School’s Registry of Independent

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Scientific and Technical Advisors ([www.law.duke.edu/PAC/registry/index.html](http://www.law.duke.edu/PAC/registry/index.html)) (last visited June 23, 2003)).

### **Promoting Active Learning By Jurors**

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Another problem with the adversarial model is that it views jurors as passive recipients of information presented by the plaintiff and defendant. Social scientists dispute

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**[J]ury reformers argue that the promotion of active learning by jurors can improve jury performance. ... Some reforms address the timing of trial presentations. ... Other proposals seek to enhance jurors' understanding and retention of relevant law and facts by providing them with tangible aids.**

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the notion of juror passivity, and jury reformers argue that the promotion of active learning by jurors can improve jury performance (Hans 2002; Munsterman, Hannaford and Whitehead 1997). Recent studies have generated a number of proposed reforms. Moreover, the adoption of such reforms in jurisdictions around the country provides the opportunity for empirical study of their effects.

Some reforms address the timing of trial presentations. For example, judges could instruct jurors on the substantive law before as well as after presentation of the evidence, and could permit lawyers to make statements periodically during the trial to introduce or summarize portions of the evidence. In cases involving complex expert testimony, the court could direct the defendant's expert to testify immediately

after the plaintiff's expert. Other proposals seek to enhance jurors' understanding and

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**Because of the potential anchoring effect, a cap might raise the amounts recovered by plaintiffs with less severe injuries at the same time that it limited the amounts recovered by the most severely injured plaintiffs.**

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retention of relevant law and facts by providing them with tangible aids, such as written copies of the jury instructions and juror notebooks containing copies of key exhibits. Jurors might also be permitted to take notes and to submit questions for the court to pose to witnesses.

Social science research on these proposals is ongoing (ForsterLee et al. 1993; Bourgeois et al. 1995; ForsterLee and Horowitz 1997). Moreover, jurisdictions including Arizona, Colorado, and the District of Columbia have implemented or encouraged the use of various reforms (American Judicature Society 1999). Although a complete assessment of these reforms is beyond the scope of this report, the

current attention being paid in Pennsylvania to malpractice jury verdicts suggests that it would be useful to study the measures adopted in other jurisdictions.

### **Guidance Concerning Noneconomic Damages**

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A central concern in malpractice litigation is the size and variability of noneconomic damages awards. A number of commentators have argued that caps on damages are unfair to the most severely injured plaintiffs. Moreover, research suggests that caps might actually *increase* both the size and variability of jury awards in some cases because of the potential anchoring effect. In a recent experiment, the mean award for a low-severity injury by mock jurors who were told of the existence of a \$250,000 cap on damages was

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significantly higher than by jurors who were not told of the cap, and awards by jurors told of the cap were significantly more variable (Saks et al. 1997). In other words, a cap might raise the amounts recovered by plaintiffs with less severe injuries at the same time that it limited the amounts recovered by the most severely injured plaintiffs. Although jurors in an actual trial setting might not be told of the existence of a cap, the publicity surrounding legislative deliberation over caps makes it likely that at least one juror would be aware of the cap's existence, and that information could be communicated to other jurors during deliberations.

Alternative methods exist for reducing the variability of awards. Reforms that structure juries' and judges' assessment of noneconomic damages appear particularly promising. For example, lawyers could be permitted to frame their arguments concerning damages around prior awards in cases they consider comparable (Diamond, Saks, and Landsman 1998). Likewise, juries could be given one or more stylized scenarios and associated valuations to use as benchmarks in considering how much to award (Bovbjerg, Sloan, and Blumstein 1989). Alternatively, awards could be set by means of "a matrix of values that would award fixed damage amounts according to the severity of injury and age of the injured party," or could be constrained by "a system of flexible floors and ceilings that vary with injury severity and victim age" (Bovbjerg, Sloan, and Blumstein 1989: 938-39).

Instead of arguing damages to the jury in this fashion, lawyers could be required to make a similar case to the judge. Traditionally, judges in Pennsylvania and most other jurisdictions have had the power to order remittitur based on a finding that the jury's damages award was so large that it "shocked the conscience" of the court. (See *Haines v. Raven Arms*, 652 A. 2d 1280, 1281-82 (Pa. 1995).) Last year, Pennsylvania's legislature altered the remittitur standard in medical malpractice cases by requiring the trial court to



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“consider evidence of the [verdict’s] impact, if any, upon availability or access to health care in the community.” (See 40 Pennsylvania Statutes § 1303.515(a).) However, the new statute provides no guidance to the court concerning the method by which to assess such impact. Moreover, neither the “shocks the conscience” standard nor the newer provision explicitly requires the court to compare the verdict under review to verdicts approved in previous cases.

Governor Rendell’s malpractice reform plan includes a provision that would direct the judge to order remittitur if the judge determines that the jury’s award “deviates materially from what would be reasonable compensation” (Rendell 2003: 31). Bills to implement this requirement have been introduced in both houses of the legislature. The proposals apparently are modeled on a New York state statute, N.Y. Civil Practice Law and Rules § 5501(c), that was enacted in 1986. Courts have interpreted New York’s provision to entail a comparison of the award in question with prior awards in similar cases. (See *Geressy v. Digital Equipment Corp.*, 980 F. Supp. 640, 653-76 (E.D.N.Y. 1997.) Detailed proposals exist for comparative judicial review of jury awards (Baldus, MacQueen, and Woodworth 1995).

Two additional aspects of the Pennsylvania proposals warrant comment. Governor Rendell’s proposal, though not the bills pending in the legislature, includes among the factors to be considered in assessing a remittitur motion the “[h]istory of the negotiations and any judicial recommendations before the trial” (Rendell 2003: 31). Such a provision would conflict with Pennsylvania Rule of Evidence 408, which provides that evidence of settlement negotiations “is not admissible to prove liability for or invalidity of the claim or its amount.” It is questionable whether the Pennsylvania Supreme Court would countenance such a legislative abrogation (Geyh 1995). More importantly, having judges consider the course of prior settlement negotiations in resolving remittitur motions would not

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help determine whether the jury award deviates from reasonable compensation. The practice might also have a chilling effect on settlement negotiations.

Another way in which New York's provision differs from the Pennsylvania proposals is that the New York statute is symmetrical. In New York, an award that deviates materially from reasonable compensation will result in remittitur if the jury award is excessive, but will result in additur if the jury award is inadequate. By contrast, the Pennsylvania proposals operate in only one direction: to reduce excessive awards. Considerations of fairness suggest that a symmetrical provision would be preferable.

# Conclusion

Critics of the current malpractice litigation system are correct to suggest that the system would benefit from increased expertise. However, the proposals growing out of that insight vary in their likely effectiveness. The certificate of merit requirement may

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**Procedural reform should focus on supporting the efforts of judges and juries to assess scientific and medical questions and on providing guidance for the award and review of noneconomic damages.**

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reduce (to some degree) the number of weak malpractice claims filed. However, medical screening panels and specialized medical malpractice courts seem unpromising. This report suggests that procedural reform should focus instead on supporting the efforts of judges and juries to assess scientific and medical questions and on providing guidance for the award and review of noneconomic damages.

Three final points should be made about this report. First, the report assesses litigation procedures assuming no change in the substantive law of medical malpractice. Some commen-

tators advocate major changes in substantive law. One proposal would replace the current system of fault-based liability with a system in which claimants are compensated if their injury falls within “avoidable classes of events” (“ACEs”): errors or omissions in medical care that are clearly preventable (Institute of Medicine 2002; Bovbjerg 1993). “Avoidable classes” would be specified in advance by experts using empirical data on medical safety, in many cases removing the need for individual determinations of whether a physician breached the standard of care and whether the breach caused the claimant’s injury.

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ACEs-based reform would obviate a number of the liability-focused concerns that motivate this report, though it would still be necessary to develop guidelines for the determination of damages.

Second, in past decades, medical malpractice reforms have foreshadowed broader, “trans-substantive” reforms that apply generally to tort litigation. Critics of special malpractice reforms sometimes argue that they unfairly single out and disadvantage a narrow class of plaintiffs, while defense interests, for their part, have seized upon malpractice-oriented reforms as providing both a model and an opportunity for pursuing “tort reform” generally. It is worth asking whether the reforms examined in this report might usefully be applied to other types of claims. Certificates of merit seem useful only in types of cases where expert testimony is needed to establish the plaintiff’s claim, and where at least a segment of the relevant plaintiffs’ bar lacks expertise in assessing the claim. The report’s conclusion that medical screening panels are unpromising suggests reason to hesitate before applying a screening model to other contexts. Specialized courts may be more useful, and may present smaller risks, in areas other than medical malpractice. In particular, specialized courts may be less problematic for disputes (such as patent cases) in which repeat litigants and their counsel tend over time to be both plaintiffs and defendants, rather than areas such as medical malpractice where any given litigant is always on one side. Proposals to improve guidance for juries and judges with respect to noneconomic damages awards may be helpful beyond medical malpractice litigation; e.g., in personal injury litigation generally.

Finally, the improvements suggested in this report do not directly address one of the most important reasons for the medical community’s interest in expertise-enhancing

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reforms: none of the recommendations made here would place the resolution of malpractice litigation in the hands of physicians. Nonetheless, physicians can play a critical role

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**Physicians can play a critical role in addressing the malpractice situation by providing the public, and their patients in particular, with relevant information in advance of receiving care and after the fact if an unanticipated injury has occurred.**

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in addressing the malpractice situation by providing the public, and their patients in particular, with relevant information in advance of receiving care and after the fact if an unanticipated injury has occurred. Better communication *ex ante* may temper unrealistic expectations; modern medical procedures carry risks of poor outcomes even with the best of care. Better communication *ex post* will help patients understand what happened to them and why, improving the interpersonal aspects of medical care and likely reducing the incidence of malpractice litigation.



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## About the Project

The Project on Medical Liability in Pennsylvania ([www.medliabilitypa.org](http://www.medliabilitypa.org)) is a two-year program of research, consultation, and communication funded by The Pew Charitable Trusts that seeks to provide decision-makers with objective information about the ways in which medical, legal, and insurance-related issues affect the medical liability system, to broaden participation in the debate to include new constituencies and perspectives, and to focus attention on the relationship between medical liability and the overall health and prosperity of the Commonwealth.

The Pew Charitable Trusts ([www.pewtrusts.com](http://www.pewtrusts.com)) support nonprofit activities in the areas of culture, education, the environment, health and human services, public policy and religion. Based in Philadelphia, with an office in Washington, D.C., the Trusts make strategic investments to help organizations and citizens develop practical solutions to difficult problems. In 2002, with approximately \$3.8 billion in assets, the Trusts committed over \$166 million to 287 nonprofit organizations.

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