

DOCTORS & JURIES

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Physicians widely believe that jury verdicts are unfair. This Article tests that assumption by synthesizing three decades of jury research. Contrary to popular belief, the data show that juries consistently sympathize more with doctors who are sued than with patients who sue them. Physicians win roughly half of the cases that expert reviewers believe physicians should lose and nearly all of the cases that experts feel physicians should win. Defendants and their hired experts, it turns out, are more successful than plaintiffs and their hired experts at persuading juries to reach verdicts contrary to the opinions of independent reviewers.

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INTRODUCTION

Legislation is pending in both houses of Congress to transfer medical malpractice cases from civil juries to administrative health courts.¹ The Institute of Medicine also wants to take malpractice cases away from juries and endorses experiments with both health courts and a system of binding early settlement offers.² Each of these proposals is premised in part on the intuitive assumption that juries lack the capacity to resolve medical malpractice disputes fairly. This Article evaluates that premise. It collects and synthesizes three decades of empirical research on jury decision-making, updating the seminal review done by Neil Vidmar over a decade ago.

Four important findings emerge from the data. First, negligence matters. Weak cases rarely win, close cases do better, and cases with strong evidence of medical negligence fare best. Second, the agreement rate between juries and experts is very high in the class of cases that most worries critics of malpractice litigation, that is, cases with weak evidence of negligence. Juries agree with expert reviewers in eighty to ninety percent of these cases. That is a better agreement rate than physicians typically have with each other. Third, the agreement rate is much lower in cases with strong evidence of negligence. Doctors consistently win about fifty percent of the cases that experts believe the plaintiffs should win. Fourth, the consistently low success rate of malpractice plaintiffs in cases that expert reviewers feel they should win strongly suggests the presence of one or more factors that systematically favor medical defendants in the courtroom, such as better litigation teams or pronounced jury reluctance to find doctors liable. From the perspective of defendants at least, jury performance is remarkably good.

This Article proceeds as follows. Part I reviews the widespread criticism of jury performance and the range of views on this issue held by academic experts. Part II examines the data showing that defendants win most medical

1. Fair and Reliable Medical Justice Act, S. 1337, 109th Cong. (2005) (authorizing pilot demonstrations of alternatives to litigation, including health courts); Medical Liability Procedural Reform Act, H.R. 1546, 109th Cong. (2005) (authorizing grants to up to seven states to establish health courts).

2. INSTITUTE OF MEDICINE, FOSTERING RAPID ADVANCES IN HEALTH CARE: LEARNING FROM SYSTEM DEMONSTRATIONS 10 (Janet M. Corrigan et al. eds., 2002), available at <http://www.nap.edu/books/0309087074/html/> (recommending demonstration projects testing both reform proposals).

malpractice jury trials. It compares those findings with the data indicating that most trials involve cases with weak evidence of negligence.

Part III synthesizes the studies which have compared jury verdicts with the opinions of expert reviewers. These studies have consistently found a direct correlation between the strength of the plaintiff's case as evaluated by an expert and the likelihood of a plaintiff's verdict. However, the studies also show that jury performance is not perfect, especially in cases with strong evidence of negligence.

Part IV reviews the reasons why juries and reviewers sometimes reach different conclusions about the same case and then identifies the factors most likely to explain the unique pattern of disagreement found in medical malpractice cases. Those factors are (1) the normal variation that occurs when multiple individuals are asked to evaluate the same conduct (inter-rater variability), (2) the superior litigation resources sometimes available to one of the parties, usually the defendant, (3) jury antipathy toward people who sue their physicians, and (4) jury reluctance to find a doctor liable when the proper outcome is unclear. At present, we lack the data needed to estimate the relative influence of each of these factors.

The studies reveal that juries treat physicians very favorably, perhaps unfairly so. The data also justify the surprising conclusion that juries are more likely to defer to the judgment of a physician defendant than other physicians are. As a consequence, politicians and critics of jury performance in medical malpractice cases should think twice before concluding that doctors will be treated more favorably in health courts.

I. JURIES

Hapless juries have become the symbol of a civil justice system run amok.³ Critics claim that juries render irrational and unjust verdicts.⁴ The jury trial, claims critic Peter Huber, is really "a generous sort of charity."⁵

3. STEPHEN DANIELS & JOANNE MARTIN, CIVIL JURIES AND THE POLITICS OF REFORM 1-2 (1995).

4. *Id.*; NEIL VIDMAR, MEDICAL MALPRACTICE AND THE AMERICAN JURY: CONFRONTING THE MYTHS ABOUT JURY INCOMPETENCE, DEEP POCKETS, AND OUTRAGEOUS DAMAGE AWARDS 122-23 (1995) (reciting complaints about jury incompetence to determine cases of professional liability). Both the AMA and the Physician Payment Review Commission have concluded that lay juries reach different decisions than physicians would. *Id.* at 162; PHYSICIAN PAYMENT REVIEW COMM'N, ANNUAL REPORT TO CONGRESS, 1992, at 186 (1992); Kirk B. Johnson et al., *A Fault-Based Administrative Alternative for Resolving Medical Malpractice Claims*, 42 VAND. L. REV. 1365, 1367-73 (1989); see AMA/Specialty Soc'y Med. Liab. Project, *A Proposed Alternative to the Civil Justice System for Resolving Medical Liability Disputes: A Fault-Based Administrative System*, 52 MEDICINE 347, 347-48 (1988).

5. PETER W. HUBER, LIABILITY: THE LEGAL REVOLUTION AND ITS CONSEQUENCES 12 (1988). President George W. Bush stated the charge this way:

Doctors and hospitals realize . . . it's expensive to fight a lawsuit, even if it doesn't have any merit. And because the system is so unpredictable, there is a constant risk of being hit by a massive jury award. So doctors end up paying tens of thousands, or even hundreds of thousands of dollars to settle claims out of court, even when they know they have done nothing wrong.

According to this account, malpractice insurers are frightened into paying substantial sums to settle frivolous lawsuits because they dread the “lottery” of a jury trial. Those settlements then spawn a new wave of frivolous claims.⁶ Through this domino effect, jury incompetence poisons the entire civil justice system.

Even respected legal scholars are skeptical of the jury’s capacity to decide malpractice cases fairly. Clark Havighurst, for example, has said that “realism compels recognition that juries are often poorly positioned to choose reliably between the well argued, but often highly confusing, theories of the two sides’ experts” and “often fall back on such irrelevancies as the witnesses’ demeanor and style of presentation or sympathy for the plaintiff’s plight or the defendants’ reputation.”⁷ Stephen Sugarman also doubts the ability of jurors to choose between competing experts “whose scientific credibility the jurors are unlikely to accurately appraise.”⁸

Is that picture accurate? The most recent extended review of the literature appears in Neil Vidmar’s classic 1995 book *Medical Malpractice and the American Jury*.⁹ In this book, Vidmar summarizes some of the empirical studies, including his own, that compared jury verdicts to the ratings given to the plaintiff’s medical care by independent physicians.¹⁰ From this body of data, he concludes “that there is reasonable concordance between jury verdicts and doctors’ ratings of negligence. On balance, juries may have a slight bias in favor of doctors.”¹¹

For some scholars, however, empirical evidence of a statistically significant relationship between jury verdicts and expert opinion is too thin a basis for concluding that juries do their job well. Mark Hall rightly notes that “[f]inding a statistical association between jury results and expert opinions means only that jury verdicts as a whole are not entirely random or unpredictable.”¹² Thomas Metzloff used similar caution in 1993 to describe the empirical evidence then available, noting only that jury verdicts were not

TOM BAKER, THE MEDICAL MALPRACTICE MYTH 13 (2005) (quoting a January 2005 speech in Collinsville, Illinois).

6. DANIELS & MARTIN, *supra* note 3, at 4–5; VIDMAR, *supra* note 4, at 3 (citing claims that jury errors encourage frivolous claims); Thomas B. Metzloff, *Resolving Malpractice Disputes: Imaging the Jury’s Shadow*, LAW & CONTEMP. PROBS., Winter 1991, at 43, 46 (1991) (noting the signaling function of jury verdicts).

7. CLARK C. HAVIGHURST ET AL., HEALTH CARE LAW AND POLICY 1018 (2d ed. 1998).

8. Stephen D. Sugarman, *The Need to Reform Personal Injury Law Leaving Scientific Disputes to Scientists*, 248 SCI. 823, 823 (1990).

9. VIDMAR, *supra* note 4.

10. *Id.*; see also Neil Vidmar, *The Performance of the American Civil Jury: An Empirical Perspective*, 40 ARIZ. L. REV. 849, 858–59 (1998) [hereinafter Vidmar, *American Civil Jury*]; Neil Vidmar, *Are Juries Competent to Decide Liability in Tort Cases Involving Scientific/Medical Issues? Some Data from Medical Malpractice*, 43 EMORY L.J. 885, 903–06 (1994) [hereinafter Vidmar, *Are Juries Competent*] (also reviewing much of the literature).

11. VIDMAR, *supra* note 4, at 182.

12. MARK A. HALL, MARY ANNE BOBINSKI & DAVID ORENTLICHER, HEALTH CARE LAW & ETHICS 269 (6th ed. 2003).

“random.”¹³ Based on his own empirical research, he concluded that “[m]ost of the time, jury outcomes represent a fair resolution of the claim, but the risk that the result will not be fair is real and troubling.”¹⁴

If that is the best that can be said in defense of jury performance, then critics of jury decision-making have a powerful basis for complaint. However, the body of empirical data currently available offers insights into jury behavior that are both more complex than the public rhetoric and, at least for physicians, more reassuring.

II. PLAINTIFF WIN RATES

Although juries are widely believed to be biased against physicians, patients lose twice as many medical malpractice verdicts as they win. Does this refute the charge that juries favor injured claimants? Not necessarily. Standing alone, win rates tell us very little about the fairness of jury verdicts. According to a convincing body of empirical research on medical malpractice trials, weak claims dominate the mix of cases that go to trial. The poor quality of the pool of cases that go to trial means that it is inappropriate to expect a fifty-fifty split in verdicts.

Yet the intuitive appeal of this benchmark is so powerful that the Supreme Court and prominent legal scholars have employed it to evaluate the fairness of adjudicative processes. That is a mistake. Although the poor success that malpractice plaintiffs have in front of juries does place a ceiling on the magnitude of any pro-plaintiff bias that might exist, the low plaintiff win rate does not tell us whether the right claims win or even whether the right fraction does.¹⁵

A. *The Fifty Percent Hypothesis*

The belief that a fair adjudicatory process will produce a roughly even split in verdicts is widely held, even by sophisticated observers. Harry Kalven, for example, believed that the fifty-five percent plaintiff win rate that he found in his large study of personal injury cases showed that juries are not “monolithically pro-plaintiff.”¹⁶ Similarly, the Supreme Court inferred that a disability benefits process was procedurally fair from the fact

13. Metzloff, *supra* note 6, at 115.

14. *Id.* Metzloff called for “meaningful procedural reforms within the context of the current system.” *Id.*

15. See Kevin M. Clermont & Theodore Eisenberg, *Do Case Outcomes Really Reveal Anything About the Legal System? Win Rates and Removal Jurisdiction*, 83 CORNELL L. REV. 581, 583–92 (1998) (explaining how win rates can be influenced by selection effects).

16. Harry Kalven, Jr., *The Dignity of the Civil Jury*, 50 VA. L. REV. 1055, 1072 (1964); cf. Shari Seidman Diamond & Mary R. Rose, *Real Juries*, 1 ANN. REV. LAW & SOC. SCI. 255, 262 (2005) (noting favorably that plaintiffs win about half of the time, but also acknowledging that “it is not clear what the win rate ought to be”).

that nearly fifty percent of the benefits denials were reversed.¹⁷ Win rates are an appealing measure of substantive fairness. The more balanced the outcomes, the more evenhanded the process seems.

The intuition that a fair process will produce an even split in verdicts also has powerful theoretical support. According to the “fifty percent hypothesis” of negotiation theory,¹⁸ the cases most likely to settle are those in which liability is either clearly present or clearly absent.¹⁹ Because these “easy” cases are likely to settle, the cases that go to trial will tend to be “close” cases.²⁰ In the trials of those toss-up cases, plaintiffs and defendants should win a roughly equal number of verdicts.

The fifty percent hypothesis also has empirical support. In their landmark study of the settlement process, George Priest and Benjamin Klein gathered data on all civil jury trials in Cook County, Illinois from 1959 through 1979. The overall plaintiff win rate stayed in the vicinity of the fifty percent mark for virtually the entire period.²¹ Although other scholars have questioned the applicability of this model to individual fields of litigation,²² the fifty percent hypothesis retains considerable vigor. Consistent with the hypothesis, for example, a 2001 survey by the Bureau of Justice Statistics found a win rate in all tort trials of fifty-two percent.²³

Surprisingly, the fifty-fifty split anticipated by negotiation theory should be present even in courts that are systematically biased against one side. As long as the bias is foreseeable, the parties can be expected to take this bias into account when they make their settlement decisions.²⁴ The “close” cases

17. *Richardson v. Perales*, 402 U.S. 389, 410 (1971). *But see Mathews v. Eldridge*, 424 U.S. 319, 346 (1976) (stating that “[b]are statistics rarely provide a satisfactory measure of the fairness of a decisionmaking process,” yet accepting general inference).

18. *See* George L. Priest & Benjamin Klein, *The Selection of Disputes for Litigation*, 13 J. LEGAL STUD. 1, 17–25 (1984) (predicting that win rates will converge to fifty percent as the parties’ abilities to predict trial outcomes improve).

19. *See* Metzloff, *supra* note 6, at 63.

20. Priest & Klein, *supra* note 18, at 14–15 (predicting that the vast majority of the cases which go to trial will be the borderline cases); FRANK A. SLOAN ET AL., *SUING FOR MEDICAL MALPRACTICE* 168 (1993) (treating this as an accepted premise). Over time, the parties will become adept at predicting trial outcomes and the win rate will converge to fifty percent. *See* Priest & Klein, *supra* note 18, at 17–25.

21. Priest & Klein, *supra* note 18, at 32 tbl.4 (showing a win rate between forty-five and fifty-five percent in all but two years, 1972 and 1977).

22. *E.g.*, Theodore Eisenberg, *Testing the Selection Effect: A New Theoretical Framework with Empirical Tests*, 19 J. LEGAL STUD. 337, 339–40, 352 (1990) (stating that the fifty percent hypothesis is a plausible description of tort litigation, but not of all civil litigation and also producing data suggesting that the fifty percent hypothesis may only apply to overall tort rates that are an amalgam of deviant win rates in the respective subfields). Priest and Klein themselves had found that some fields of litigation departed from the fifty percent prediction (including medical malpractice litigation). Priest & Klein, *supra* note 18, at 38–39.

23. THOMAS H. COHEN, BUREAU OF JUSTICE STATISTICS, *MEDICAL MALPRACTICE TRIALS AND VERDICTS IN LARGE COUNTIES, 2001*, at 1 (2004), available at <http://www.ojp.usdoj.gov/bjs/pub/pdf/mmtvlc01.pdf>.

24. *See* Priest & Klein, *supra* note 18, at 5, 7 & n.24.

in those jurisdictions will be the cases that the parties believe could go either way in front of a biased fact-finder.²⁵ As long as the court's bias is foreseeable, the plaintiff win rate at trial should still hover around fifty percent.²⁶ Although the tribunal's bias will produce unjust outcomes, that unfairness will not be evident from the bare win rate.²⁷ Instead, the unfairness will be reflected in the terms of the pretrial settlements and in the fate of cases that ought to prevail at trial.

Conceivably, the low win rate in malpractice cases could be attributed to the predominance of weak cases in the overall pool of lawsuits. According to negotiation theory, however, the fifty percent hypothesis should survive this imbalance in the initial pool of claims. The weak claims should still settle more frequently than the toss-up cases because the parties have a relatively easy time estimating the expected value of these cases and agreeing on a settlement.²⁸ As a result, the "selection effect" of the settlement process should wash out asymmetries in the underlying pool of disputes and yield a trial win rate close to fifty percent.²⁹

B. *The Win Rate in Malpractice Cases*

The win rate in medical malpractice trials consistently departs from the fifty percent hypothesis and has done so for decades. In an exhaustive review of decades of research and dozens of empirical analyses, Valerie Hans and Neal Vidmar concluded that medical malpractice plaintiffs win roughly 30% of their jury trials.³⁰ The most recent comprehensive review of the data comes from the Bureau of Justice Statistics, which systematically sampled malpractice jury verdicts in 1992, 1996, and 2001 from the seventy-five

25. Initially, prediction errors might result in win rates that depart materially from a fifty-fifty split, but the size of this departure should diminish as the parties become better at predicting the jury's decisions. *Id.* at 18–19.

26. *Id.* at 5 (“[P]laintiff victories will tend toward 50 percent whether the legal standard is negligence or strict liability, whether judges or juries are hostile or sympathetic.”).

27. The settlement data strongly suggest that defendants have superior bargaining power, but provide no clues about the contribution of anticipated prodefendant jury bias to that bargaining power. See Philip G. Peters, Jr., *What We Know About Malpractice Settlements*, 92 IOWA L. REV. (forthcoming July 2007) (manuscript at 40–53), available at <http://ssrn.com/abstract=891120>.

28. See Priest & Klein, *supra* note 18, at 17–20. By settling, each party saves the costs of preparing for and participating in a trial.

29. See Eisenberg, *supra* note 22, at 340. While an extraordinary number of weak claims in the initial pool could theoretically produce a trial mix dominated by weak cases simply by virtue of their raw numbers, even though they settle at a higher rate than closer cases, this probably does not explain the low win rate in malpractice cases. Indeed, meritless claims actually settle less regularly than strong claims and, as a result, are overrepresented in the trial mix. The 2006 findings of David Studdert and his colleagues are typical. Claims lacking merit constituted thirty-seven percent of their total sample of claims, but fifty-six percent of the cases that went to a jury verdict. See David M. Studdert et al., *Claims, Errors, and Compensation Payments in Medical Malpractice Litigation*, 354 NEW ENG. J. MED. 2024, 2030 tbl.2 (2006).

30. VALERIE HANS & NEIL VIDMAR, *JUDGING THE JURY* (1986).

most heavily populated counties in the United States.³¹ Over that period of time, the plaintiff win rate dropped from 30% to 27%.³² In the 2001 sample of 1,038 trials, “[t]he overall win rate for medical malpractice plaintiffs (27%) was about half of that found among plaintiffs in all tort trials (52%).”³³ A number of studies have found that malpractice cases have the lowest plaintiff success rate of any category of tort litigation.³⁴

The poor success rate of malpractice plaintiffs is made even more evident when cases with contested damages, but admitted liability, are excluded from the calculation.³⁵ In his study of North Carolina malpractice verdicts, Thomas Metzloff found that plaintiffs received a significant award of damages in only 11% of the cases in which liability was genuinely at issue.³⁶ In her earlier landmark study, Patricia Danzon also found that the win rate shrank materially when uncontested cases were excluded.³⁷

C. Selection Effect

Opponents of tort reform often argue that the very limited success of malpractice plaintiffs at trial proves that juries are neither biased against wealthy physicians nor readily manipulated into rendering verdicts based on their sympathy for badly injured patients. Some have even suggested that the difficulty of obtaining a plaintiff’s verdict demonstrates that juries are

31. COHEN, *supra* note 23; CAROL J. DEFANCES & MARIKA F.X. LITRAS, BUREAU OF JUSTICE STATISTICS, CIVIL TRIAL CASES AND VERDICTS IN LARGE COUNTIES, 1996 (1999); CAROL J. DEFANCES ET AL., BUREAU OF JUSTICE STATISTICS, CIVIL JURY CASES AND VERDICTS IN LARGE COUNTIES (1995).

32. See COHEN, *supra* note 23, at tbls.1 & 3. Materials from the Jury Verdict Research website show win rates between 29% and 38% for each year between 1995 and 2000. http://www.juryverdictresearch.com/Press_releases/medmal_01.html (May, 10 2002). However, jury verdict reporting services tend to oversample significant plaintiffs’ victories and, thus, to overstate both plaintiff success rates and average verdict size. Frank Sloan and Chee Ruey Hsieh, for example, found an actual win rate of 22% in the trials of the claims they studied in Florida, where a jury verdict reporting service had reported that plaintiffs won 66% percent of their verdicts. Frank A. Sloan & Chee Ruey Hsieh, *Variability in Medical Malpractice Payments: Is the Compensation Fair?*, 24 LAW & SOC’Y REV. 997, 1007 (1990).

33. COHEN, *supra* note 23, at 1. Those rates are consistent with the findings of the most recent small-scale study, published in 2006, which found a win rate of twenty-one percent for medical malpractice plaintiffs. Studdert et al., *supra* note 29, at 2026.

34. E.g., DEFANCES & LITRAS, *supra* note 31, at 6 tbl.5; Stephen Daniels & Lori Andrews, *The Shadow of the Law: Jury Decisions in Obstetrics and Gynecology Cases*, in 2 MEDICAL PROFESSIONAL LIABILITY AND THE DELIVERY OF OBSTETRICAL CARE 161, 173–75 & tbl.3 (Victoria P. Rostow & Roger J. Bulger eds., 1989) (finding that the plaintiff success rate for malpractice was below the overall rate in all but two of forty-six counties surveyed and that those two counties had few malpractice verdicts); Priest & Klein, *supra* note 18, at 38 tbl.7 (finding malpractice cases had the lowest success rate among the categories of tort litigation analyzed).

35. See Diamond & Rose, *supra* note 16, at 262 (noting that the usual figures on plaintiff win rates are “inflated because liability is either uncontested or only partially contested in some percentage of the cases counted as plaintiff wins”).

36. Metzloff, *supra* note 6, at 52.

37. See PATRICIA M. DANZON, MEDICAL MALPRACTICE: THEORY, EVIDENCE, AND PUBLIC POLICY 24, 38–39 (1985).

prejudiced against people who sue their doctors, a bias suggested by research showing that potential jurors are skeptical of medical malpractice plaintiffs.³⁸ However, the data suggest an equally plausible alternative: weak claims dominate the trial docket.

Taragin's study of 976 malpractice verdicts is by far the largest. He and his colleagues found that only 10% of the trials involved negligent care and eleven percent were too close to call. Thus, 78% of the trials involved weak claims.³⁹ The weak claims outnumbered the strong ones 8 to 1.

The other studies are considerably smaller, but they, too, have found that weak claims outnumber strong ones at trial. In Thomas Metzloff's study of 48 trials, the defense insurer believed that only 23% of the tried cases had sufficient evidence of negligence to support a jury verdict, while 42% did not, and the remaining 35% were unclear.⁴⁰ As a consequence, Metzloff concluded that the trial pool consists "of a solid core of marginal claims in which the insurers routinely prevail."⁴¹ Danzon reached the same conclusion in her study of malpractice litigation, stating that the cases that go to trial are "a small, atypical subset" in which the evidence for the plaintiff is weak.⁴²

Other studies are in agreement. In their analysis of 26 malpractice trials, Henry Farber and Michelle White found that 57% involved good care while only 19% involved poor care.⁴³ In a separate study of thirteen trials, they found that 69% of the trials involved good care and only 8% involved poor care.⁴⁴ Ralph Peebles, Catherine Harris, and Metzloff found a similar imbalance in their examination of 19 trials—there were over 5 times as many weak claims as strong.⁴⁵

However, other studies have failed to find a substantial imbalance in the trial mix. A study of 37 Florida jury verdicts by Frank Sloan and his

38. See, e.g., VIDMAR, *supra* note 4, at 182 ("The evidence in fact indicates that . . . [o]n balance, juries may have a slight bias in favor doctors."); Metzloff, *supra* note 6, at 83 (noting that a possible explanation for defendants beating the odds more often than plaintiffs is the operation of a jury bias in favor of doctors).

39. Mark I. Taragin et al., *The Influence of Standard of Care and Severity of Injury on the Resolution of Medical Malpractice Claims*, 117 ANNALS INTERNAL MED. 780, 783 tbl.3 (1992).

40. See Metzloff, *supra* note 6, at 69 tbl.6.

41. *Id.* at 76–77.

42. DANZON, *supra* note 37, at 51 ("[Malpractice] cases that are actually litigated to verdict constitute a small, atypical subset, 'self-selected' to that stage of disposition precisely because the outcome was unpredictable to the litigants, the potential award was large, and the evidence for the plaintiff was weak.')

43. Henry S. Farber & Michelle J. White, *A Comparison of Formal and Informal Dispute Resolution in Medical Malpractice*, 23 J. LEGAL STUD. 777, 802 (1994).

44. See Henry S. Farber & Michelle J. White, *Medical Malpractice: An Empirical Examination of the Litigation Process*, 22 RAND J. ECON. 199, 204 (1991).

45. Ralph Peebles et al., *The Process of Managing Medical Malpractice Cases: The Role of Standard of Care*, 37 WAKE FOREST L. REV. 877, 899 tbl.6 (2002) (recording eleven weak claims versus two strong claims). Care quality was largely determined from the opinions of physician consultants. *Id.* at 884–85.

colleagues found an equal number of strong and weak claims.⁴⁶ And a 2006 study by David Studdert and his colleagues found only 1.3 weak cases in the trial sample for each strong claim.⁴⁷

Taken together, the studies show a wide variety of trial mixes. The weak cases outnumber the strong in every study but one, but the ratios range from 1.3-to-1 to 9-to-1. As a result, the exact ratio of weak to strong claims remains in considerable doubt. Our inability to calculate this ratio with more specificity makes it impossible to determine from this data whether the thirty percent plaintiff win rate typically observed in medical malpractice cases is too high, too low, or exactly right. In order to make that determination, the verdicts in specific cases must be matched against the strength of the evidence of negligent conduct. Fortunately, several studies have tried to collect that data. They are reviewed in Part III.

The obvious theoretical question raised by these findings is why the mix of malpractice cases taken to trial departs so substantially from the predictions of the fifty percent hypothesis. Although scholars have offered several promising hypotheses, the study of this question is still in its infancy. It is hampered, no doubt, by the difficulty and expense of obtaining detailed data about private settlement outcomes and strategies.

At present, several factors seem especially likely to account for the unusual preponderance of weak cases in the set of malpractice disputes that reach a jury. Most obviously, malpractice litigation may not conform to one or more of the simplifying assumptions on which the fifty percent hypothesis is built. The hypothesis incorporates assumptions that the parties have an equal tolerance for risk,⁴⁸ that the stakes for both parties are identical,⁴⁹ and that they have equal access to the skills and information needed to predict the likely outcome at trial.⁵⁰ Each of these assumptions has been challenged by at least one legal scholar and the failure to conform to that assumption has been identified as the most likely cause of the low plaintiff win rate in malpractice litigation.⁵¹ Other factors that could skew the trial mix include a

46. SLOAN ET AL., *supra* note 20, at 167 tbl.8.2 (showing that thirty percent of the trials that resulted in a verdict involved poor care and twenty-seven percent involved good care; the rest were "uncertain").

47. Studdert et al., *supra* note 29, at 2030 tbl.2 (showing 91 claims involving an error in treatment and 117 not involving medical error).

48. See, e.g., Metzloff, *supra* note 6, at 62-63; Priest & Klein, *supra* note 18, at 27.

49. See, e.g., Metzloff, *supra* note 6, at 63; Priest & Klein, *supra* note 18, at 7.

50. See Priest & Klein, *supra* note 18, at 13, 19; see also Robert D. Cooter & Daniel L. Rubinfeld, *Economic Analysis of Legal Disputes and Their Resolution*, 27 J. ECON. LITERATURE 1067, 1074 (1989). If the parties share an incorrect perception of what juries are likely to do, that too will lead to verdicts that depart from a fifty-fifty split. See Clermont & Eisenberg, *supra* note 15, at 590; Kevin M. Clermont & Theodore Eisenberg, *Trial by Jury or Judge: Transcending Empiricism*, 77 CORNELL L. REV. 1124, 1131, 1156, 1170-72 (1992).

51. On unequal risk tolerance, see Farber & White, *supra* note 44, at 208 (concluding that the bargaining process favors defendants because plaintiffs are more risk averse), and Stephen J. Spurr & Walter O. Simmons, *Medical Malpractice in Michigan: An Economic Analysis*, 21 J. HEALTH POL. POL'Y & L. 315, 340 (1996) (attributing the difference between expected value and

shared, but mistaken, assumption that juries will be pro-plaintiff, the incentives created by the different ways in which plaintiffs' and defendants' lawyers are compensated, and the unusually severe damages common in malpractice cases.⁵² Although we currently lack the data needed to evaluate the role played by each of these plausible contributing factors, the evidence does suggest that defendants are reluctant to make settlement offers of any size in "frivolous" cases and are anxious to settle claims backed by strong evidence of negligence, especially if they can extract a discount from a risk-averse or less well-represented plaintiff.⁵³ These proclivities probably explain much of the imbalance in the malpractice trial mix.

Because weak cases dominate the malpractice trial mix, the poor trial success of malpractice plaintiffs tells us nothing about the fairness of the jury verdicts. In this setting at least, the intuitive assumption that a fair process will produce a roughly even split in verdicts is simply wrong.

III. JURY-EXPERT AGREEMENT

Fortunately, social scientists have attempted to measure the fairness of jury verdicts more directly. Over the past three decades, seven studies have compared the verdicts rendered in individual malpractice cases with independent evaluations of each claim by medical or legal experts. Although the methodologies have varied, the studies have consistently found that the odds of a plaintiff's verdict increase as the evidence of negligence improves. At the same time, the studies show that the correlation between jury verdict and expert opinion is imperfect, especially in cases in which expert reviewers believe that the patient was injured by medical negligence.

The most common strategy used in these studies has been to compare the jury's verdict in an individual case with the evaluation of that case made by one or more physicians at the request of defendant's liability insurer. While this approach poses the risk that the ratings given to the case will be biased in favor of the defendant and, thus, will overstate the frequency of

settlement amount to either plaintiffs' risk aversion or "their disadvantage in bargaining"). On asymmetrical stakes, see Samuel R. Gross & Kent D. Syverud, *Getting to No: A Study of Settlement Negotiations and the Selection of Cases for Trial*, 90 MICH. L. REV. 319, 365-66 (1991) (suggesting that self-esteem is an especially important reason why physicians refuse to settle weak cases, forcing plaintiffs to drop them or take them to trial); Priest & Klein, *supra* note 18, at 40 (stating a "hunch" that the adverse effect of judgments on physician reputation explains the low plaintiff win rate); and Sloan & Hsieh, *supra* note 32, at 1018 (suggesting that defendants and their insurers tend to fight the defensible cases vigorously in order to preserve their reputations and avoid bad precedents). On unequal resources, see Marc Galanter, *Why the "Haves" Come Out Ahead: Speculations on the Limits of Legal Change*, 9 LAW & SOC'Y REV. 95, 97-98, 107 fig.1, 110 (1974) (noting that personal injury insurers are typically repeat players while personal injury plaintiffs are not and that repeat players will ordinarily have greater expertise and better access to specialists), and Catherine T. Harris et al., *Who Are Those Guys? An Empirical Examination of Medical Malpractice Plaintiffs' Attorneys*, 58 SMU L. REV. 225, 237 (2005) (reporting that defense counsel in their sample had handled an average of over twice as many malpractice cases as their counterparts).

52. See Priest & Klein, *supra* note 18, at 39 n.77.

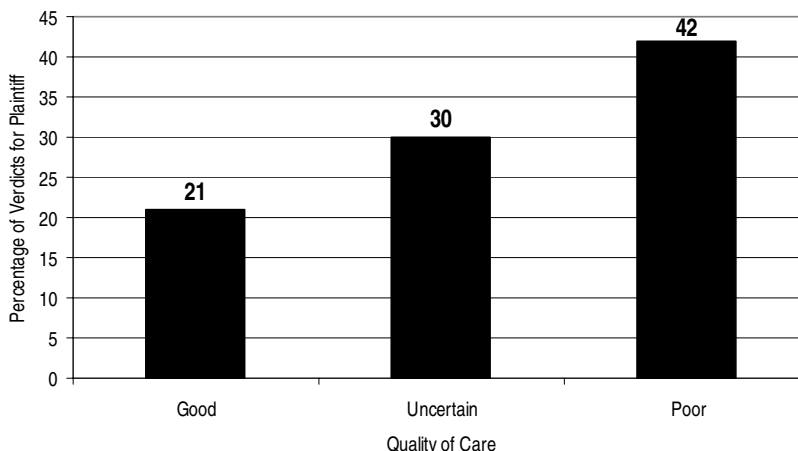
53. See Peters, *supra* note 27, at 42-47.

jury error, this strategy is much less expensive than paying for a truly independent review of the cases. A few important studies have avoided this weakness by asking independent physicians to rate the quality of care given to each plaintiff. The remainder of the studies has relied on ratings given by insurance claims adjusters, lawyers, and presiding judges.

Although these methodological differences could potentially have affected the findings, the studies actually yielded surprisingly similar results. Plaintiffs win about 10% to 20% of the cases with weak evidence and 50% of the cases with strong evidence of negligence.

A. *Taragin et al.*

FIGURE I
TARAGIN ET AL. (PLAINTIFF WIN RATE)



In the largest study of malpractice verdicts, Mark I. Taragin and his colleagues reviewed 976 malpractice cases that had resulted in a jury verdict between 1978 and 1992.⁵⁴ The cases came from the files of a single large New Jersey insurance company that insured roughly 60% of the physicians in New Jersey.

As part of its normal litigation procedure, the insurance company had asked one or more physicians to evaluate each of these claims shortly after its receipt. The reviewers gave each claim a rating of “defensible,” “indefensible,” or “unclear.”⁵⁵ When the Taragin team compared each evaluation with

54. Taragin et al., *supra* note 39.

55. See *id.* at 780–81. These ratings were produced using a multi-step process. First, the defendant-physician was contacted, and if the physician admitted error, the claim was labeled “indefensible.” Otherwise, the claims representative reviewed the claim. If she deemed the claim “clearly medically defensible,” then no further review was performed. If not, a physician from the same

the jury verdict rendered in the case, it found that the jury verdict conformed to the insurance company's rating in 79% of the cases rated as "defensible."⁵⁶ Plaintiffs, thus, won 21% of those cases. They also won 30% of the cases rated as "unclear," and 42% of the cases thought by the reviewers to be "indefensible."⁵⁷

The researchers felt that the 21% discrepancy rate in cases rated as defensible could be explained by several features of the study's design:

First, the determination about physician care was made very early after a claim was generated and may have been inaccurate as more information became available. Second, a physician-based review process may be biased toward assessing physician performance in the physician's favor. Third, the insurance company may err toward an initial determination of physician care as defensible to avoid unnecessary [settlement] payments.⁵⁸

The study, therefore, probably produced an overestimate of the number of defensible claims. As a consequence, the researchers concluded that "our data suggest that inappropriate payments are probably uncommon."⁵⁹

specialty was chosen to give an opinion. This external reviewer discussed the case with the claims representative, the defense attorney, and the defending physician before classifying the claim. In orthopedic and neurosurgery cases, the process was different: a panel of outside physicians was employed and a majority vote determined the classification. The researchers obtained the ratings information from a standardized computer database created by the insurer. *Id.*

56. *Id.* at 781.

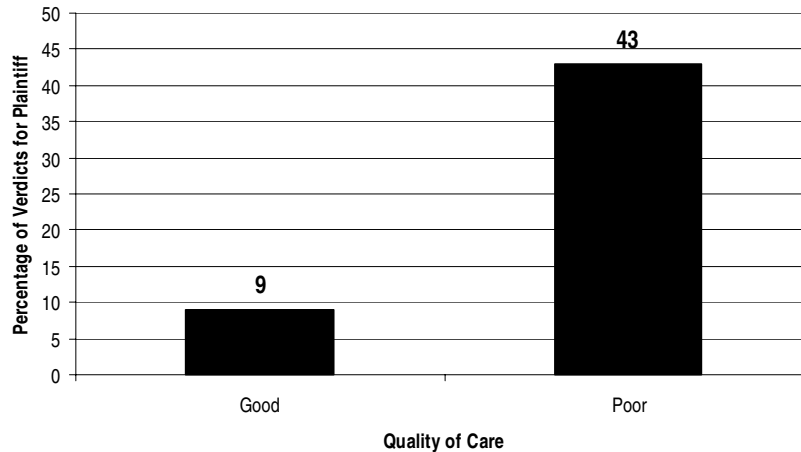
57. *Id.*

58. *Id.* at 782. They could have added two other potential sources of bias. First, the insurer may want to maintain a favorable relationship with its customers until it becomes absolutely necessary to disagree. Second, roughly half of the cases in which the medical care was deemed defensible were reviewed only by a claims representative, rather than by an outside physician. *Id.* at 781 tbl.1. By contrast, all initial determinations of poor quality were reviewed by consulting physicians. This asymmetry in the evaluation procedure may have biased the ratings in favor of defendants.

59. *Id.* at 782.

B. Studdert et al.

FIGURE 2
STUDDERT ET AL. (PLAINTIFF WIN RATE)



In a very recent study, David Studdert and his colleagues at the Harvard School of Public Health examined the outcomes of 208 malpractice trials.⁶⁰ They located these trials in a sample of malpractice claims that had been randomly drawn from the closed claims files of five major malpractice insurers. To reduce the risk of biased reviews, they retained their own physicians to do the evaluations. Physicians in the relevant specialties were hired and trained to review each file in its entirety and to determine whether the claimant's injuries had been caused by medical error.⁶¹ No separate category for unclear cases was used.

The study found that plaintiffs won nine percent of the trials in which the medical care had been deemed proper and forty-three percent of the cases in which the reviewer felt that the physician had made an error ($P < 0.001$).⁶² Evidence of negligence may also have played a role in the jury's award of damages as plaintiffs were awarded an average of \$326,009 in no-error cases and \$765,486 in the cases thought to involve medical error, even though injury severity was roughly the same ($P = 0.24$).⁶³

60. Studdert et al., *supra* note 29.

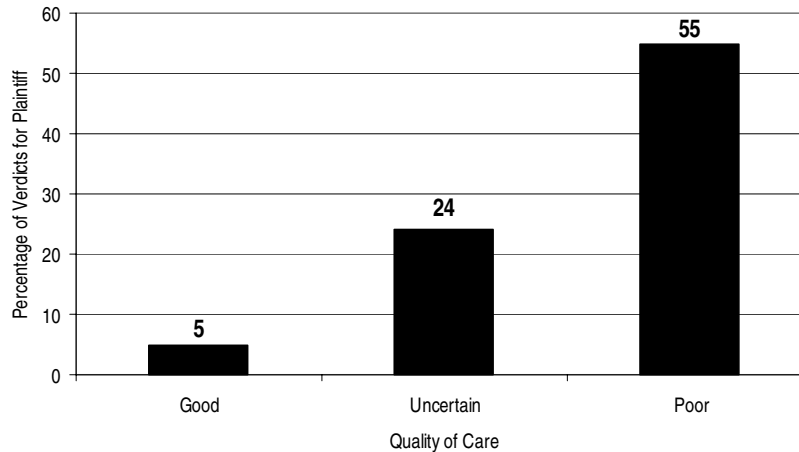
61. *Id.* at 2025. Because their sampling criteria focused on four types of clinical mishaps—obstetrical, surgical, misdiagnosis, and medication—they used specialists in obstetrics, surgery, and internal medicine. Reviewers recorded their judgments using a six-point confidence scale. The study classified the medical care as erroneous if the claim had received a score of four or above. *Id.* at 2025–26. A single reviewer rated each file.

62. *Id.* at 2028, 2030 tbl.2.

63. *Id.* at 2030 tbl.2.

C. Metzloff

FIGURE 3
METZLOFF (PLAINTIFF WIN RATE)



In this study, Thomas Metzloff analyzed all the cases filed against physicians who had been insured by the three largest malpractice insurers in North Carolina between 1984 and 1987.⁶⁴ Among the cases that had gone to a jury verdict, he found forty-eight where the insurer's file contained an estimate of the odds of a defense verdict.⁶⁵ Using these probabilities, he divided the cases into three categories: (1) cases that the insurer felt the plaintiff would win (odds better than 60%), (2) cases the plaintiff was likely to lose (odds worse than 40%), and (3) "toss up" cases (where the probability estimate fell between 40% and 60%).⁶⁶

When Metzloff compared the eventual jury verdicts to the insurer's predictions, he found that the plaintiffs had won one of the nineteen cases that they were expected to lose (5%) and six of the eleven cases that they were expected to win (55%).⁶⁷ They also won verdicts in four of the seventeen

64. Metzloff, *supra* note 6, at 45, 48. Metzloff identified all of the medical malpractice cases filed in North Carolina's state and federal courts over a three-year period (July 1, 1984 to June 30, 1987). *Id.* at 47.

65. *Id.* at 68.

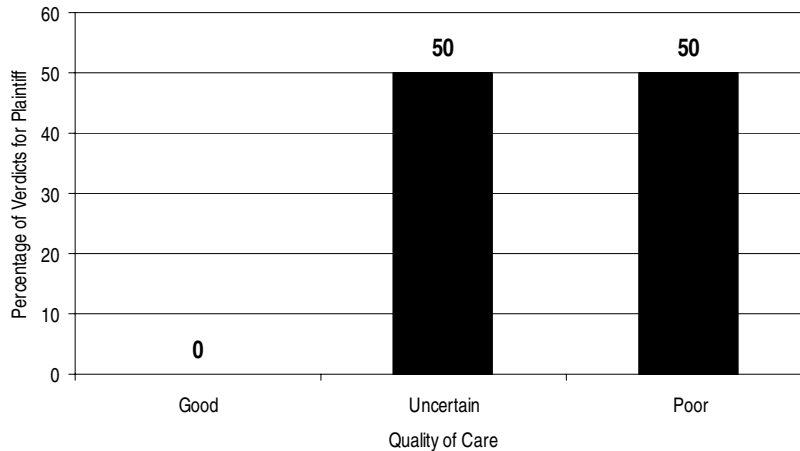
66. *Id.* at 68. The principal shortcoming of the study is its apparent reliance on ratings that were intended to predict the odds of a favorable jury verdict, rather than to assess the quality of care given. These two metrics will not always be identical because strategic factors, like attributes of the parties, attorneys, and witnesses, may have a bearing on the probability of success even though they do not have a bearing on the objective merits of the case.

67. *Id.* at 83 tbl.9.

“toss up” cases (24%), but effectively lost two of those four because they were awarded only nominal damages.⁶⁸

D. *Farber and White*

FIGURE 4
FARBER & WHITE (PLAINTIFF WIN RATE)



Henry Farber and Michelle White examined the files of 252 lawsuits against a single large hospital filed between 1977 and 1989, thirteen of which were tried to a verdict.⁶⁹ In each case, the hospital asked multiple experts to determine whether the defendant had met the professional standard of care. The experts who provided these evaluations included supervising physicians, other hospital physicians in the relevant specialty, and independent physicians.⁷⁰ Care was coded as “good” or “bad” if all the experts agreed and as “ambiguous” if the reports were unclear or divided.⁷¹ The study does not state when the expert reports were written.

The researchers found “a strong relationship between care quality and disposition (p-value < .0001).”⁷² Payments, whether due to trial verdict or settlement, were least likely to be made in cases with good medical care, more likely to be made in cases with ambiguous care, and most likely in cases with bad medical care. Looking exclusively at trials, however, they found no relationship between outcome and care quality because defendants

68. *Id.* at 83 & tbl.9.

69. Farber & White, *supra* note 44, at 203.

70. *Id.* at 204.

71. *Id.* at 204–05.

72. *Id.* at 205.

won all thirteen of the jury trials,⁷³ even though one involved care that had been rated as poor and three were ambiguous.⁷⁴

In a later study, Farber and White examined a larger sample of files from the same hospital over roughly the same time period.⁷⁵ This sample had 26 jury trials, and plaintiffs won 4 of them.⁷⁶ Plaintiffs won none of the 13 trials involving care that had been rated as “good” by the hospital’s reviewers.⁷⁷ However, plaintiffs won 2 of the 4 trials involving medical care rated as ambiguous (50%) and 2 of the 4 cases in which the defendant’s care had been rated as “bad” (50%).⁷⁸ The correlation between quality of care and trial outcome was statistically significant ($p=0.035$).⁷⁹

73. *Id.* at 203. Twenty cases went to trial, but six were settled and one was dropped. *Id.* at 203 n.10.

74. *Id.* at 204 tbl.1.

75. Farber & White, *supra* note 43. They looked at the files of 355 complaints which had been made to a single large hospital between 1976 and 1989 concerning the hospital or its providers (half of which were resolved without a lawsuit) and also the files of 242 additional disputes which were initiated by the filing of a lawsuit. *Id.* at 786. The researchers had available to them the files of the hospital’s patient relations office and its legal affairs office, including the opinions of the experts asked by the hospital to assess the quality of medical care. *Id.* at 786–87. When informal complaints were received, the hospital would get an evaluation from a supervisor or provider in the same specialty. When lawsuits were filed, the hospital also retained outside experts. *Id.* at 787.

76. *Id.* at 802.

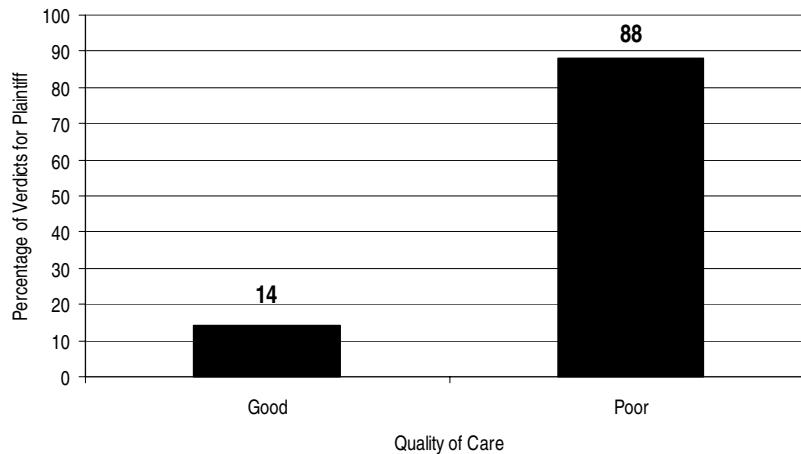
77. *Id.*

78. *Id.* at 802, 795 tbl.6. The text indicates that plaintiffs won four cases, but then only identifies three of them. Table 6, however, indicates that two involved ambiguous care and two arose out of bad care.

79. *Id.* at 802.

E. Daniels and Andrews

FIGURE 5
DANIELS AND ANDREWS (PLAINTIFF WIN RATE)



In this study, Stephen Daniels and Lori Andrews reviewed the trials of twenty-three labor and delivery cases alleging the misuse of oxytocin, a drug used to induce labor.⁸⁰ Because the drug had been used since 1910, the circumstances for safe use were well understood by the medical profession. Daniels and Andrews analyzed the trial transcripts to determine whether the drug had been used on patients when contraindicated. They found that plaintiffs won fourteen of the sixteen trials in which evidence of contraindications had been presented at trial (88%),⁸¹ and only one of the seven cases in which evidence of contraindication was absent (14%).⁸² While their finding of a low win rate in cases with weak evidence of negligence is consistent with the other studies, their finding that plaintiffs won 88% of the cases with poor medical care is quite unusual.

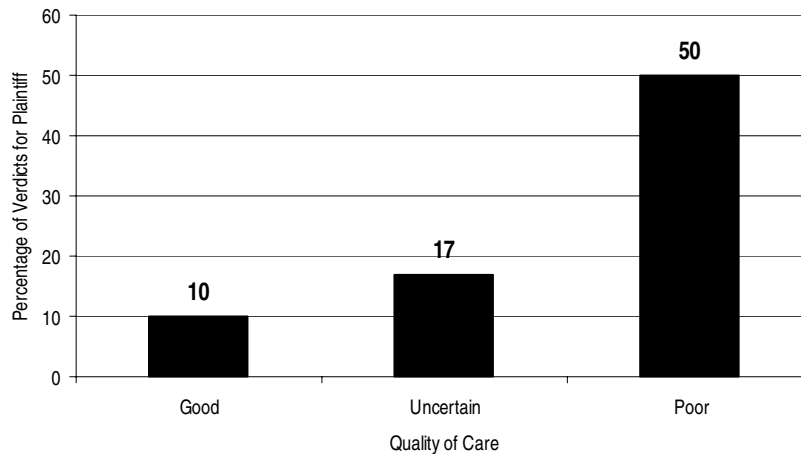
80. Daniels & Andrews, *supra* note 34, at 189.

81. All cases involving contraindications had resulted in permanent injury or death. *Id.* at 191. Both losses involved grave permanent injury. *Id.*

82. *Id.* at 190.

F. Peeples, Harris, and Metzloff

FIGURE 6
PEEPLS ET AL. (PLAINTIFF WIN RATE)



This study examined eighteen jury verdicts from North Carolina state courts involving claims filed between 1991 and 1995.⁸³ In each case, the insurer obtained expert evaluations from one or more physicians in the same specialty, usually from the same state.⁸⁴ The authors used these expert reviews to divide the cases into three categories: (1) probable liability, (2) uncertain liability (when experts disagreed), and (3) unlikely liability.

They found that plaintiffs won 10% of the trials in which the defendant's care had been rated as good, 16.7% of the trials involving care rated as uncertain, and 50% of the trials involving care rated as poor.⁸⁵

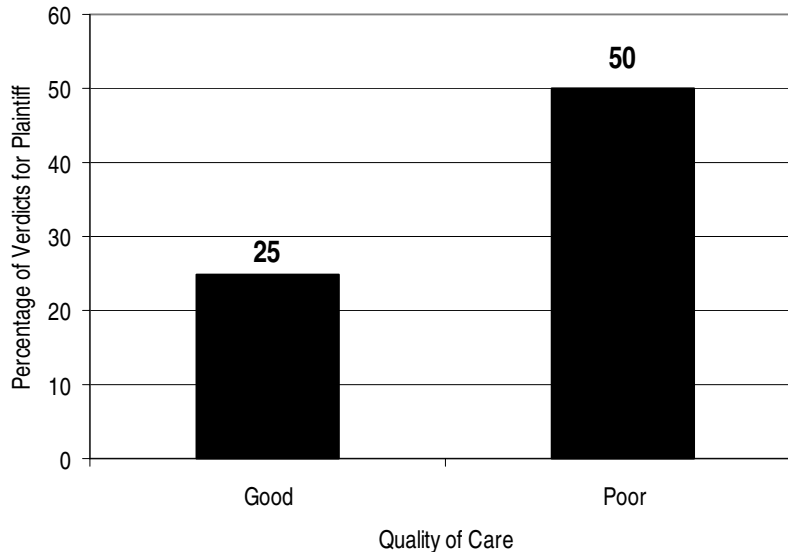
83. Peeples et al., *supra* note 45. The trials were culled from eighty-one closed claims files obtained from a North Carolina teaching hospital and one of the state's principal liability insurers. They reviewed both the entire insurance file and the court records. *Id.* at 881-82. The insurance files included expert and physician review summaries as well as witness deposition summaries.

84. *Id.* at 884.

85. *See id.* at 888.

G. Liang

FIGURE 7
LIANG (PLAINTIFF WIN RATE)



In this unusual study, Bryan Liang asked 11 anesthesiologists who practiced in an academic medical center to review 12 summaries of actual jury trials.⁸⁶ Liang's results show that plaintiffs won 1 of the 4 cases in which the reviewers concluded that no negligence had occurred (25%), and 4 of the 8 cases rated as having negligent care (50%).⁸⁷

This study is often cited for its finding that the overall correlation between jury verdicts and physician ratings is barely better than random.⁸⁸ Liang reached this conclusion because the reviewers agreed with the jury verdict in only seven of the twelve cases. Yet, this interpretation oversimplifies the insights that can be gleaned from Liang's data. On closer examination, it is apparent that the high rate of overall disagreement in this study was not produced by jury willingness to compensate undeserving

86. Bryan A. Liang, *Assessing Medical Malpractice Jury Verdicts: A Case Study of an Anesthesiology Department*, 7 CORNELL J.L. & PUB. POL'Y 121, 129 (1997). In five of the twelve cases, the anesthesiologists significantly disagree with the jury's verdict. *Id.* The validity of the ratings provided by the anesthesiologists turns on the even-handedness and accuracy of the case summaries provided to them by the researchers. In addition, academic anesthesiologists may be harsher on their peers than clinicians from other settings. The physician ratings gain strength, however, from the fact that eleven physicians rated each case. Of course, the sample of cases is tiny.

87. *See id.* at 157-160 tbls.2A, 2B, 2C, 2D, 2E & 2F.

88. *Id.* at 129 (finding fifty-eight percent and fifty-six percent agreement in two surveys).

claimants, but by the reluctance of juries to render verdicts for the plaintiffs when the evidence of negligence was strong. Liang's results show that plaintiffs lost half of the eight cases that the consulting physicians felt they should win,⁸⁹ while they won only one of the four cases that the reviewers felt they should lose.⁹⁰ When the data are disaggregated in this way, they reveal the same pattern that was observed in the larger and more reliable studies.. Juries are more skeptical than medical reviewers of medical malpractice lawsuits.

H. Judge-Jury Agreement

No studies have compared the verdicts reached by juries in medical malpractice cases with the verdicts that the presiding judges would have recommended. However, a number of important studies have examined the judge-jury agreement rate in personal injury lawsuits more generally. The most famous and largest of these studies was undertaken in the 1960s by Harry Kalven and Hans Zeisel.⁹¹ They reviewed approximately 4000 civil trials and found that the judge and jury agreed in 78% of them.⁹² When they looked only at personal injury cases, they found a similar rate of agreement.⁹³ A more recent, but much smaller, study by Larry Heuer and Steven Penrod examined 67 civil trials from 33 states and found agreement in 71.4% percent of the cases.⁹⁴

Kalven and Zeisel also analyzed the cases in which judge and jury had disagreed to ascertain whether these disagreements reflected systematic favoritism toward one side or another. The judge and jury had disagreed in 22% of the cases and those disagreements were about evenly split between cases in which the jury rendered a verdict for the plaintiff (12%) and those in which the jury found for the defendant (10%).⁹⁵ Heuer and Penrod did a similar analysis with similar results. In the cases on which judge and jury had disagreed (37% of the total set of cases), judges disagreed with jury

89. *Id.* at 129, 157–160 tbls.2A, 2B, 2C, 2D, 2E & 2F; *cf. id.* at 135 (finding that respondents were “extremely critical of the defendant” physicians).

90. *See supra* note 88.

91. HARRY KALVEN, JR. & HANS ZEISEL, *THE AMERICAN JURY* (1966).

92. *Id.* at 63.

93. *Id.* at 64 n.12.

94. Larry Heuer & Steven Penrod, *Trial Complexity: A Field Investigation of Its Meaning and Effects*, 18 *LAW & HUM. BEHAV.* 29, 48 tbl.13 (1994). In addition, researchers have found similar rates of judge-jury agreement in criminal trials. *See, e.g.*, KALVEN & ZEISEL, *supra* note 91, at 58 tbl.12 (78%); Heuer & Penrod, *supra*, at 48 tbl.12 (73%). Two other surveys of judicial opinion have found similar or higher estimates of the rate of judge-jury agreement. *See* John B. Attanasio, *Forward: Juries Rule*, 54 *SMU L. REV.* 1681, 1684 (2001); R. Perry Sentell, Jr., *The Georgia Jury and Negligence: The View from the Bench*, 26 *GA. L. REV.* 85, 97–98 (1991); R. Perry Sentell, Jr., *The Georgia Jury and Negligence: The View from the (Federal) Bench*, 27 *GA. L. REV.* 59, 70–71 (1992) [hereinafter Sentell, *Federal Bench*].

95. KALVEN & ZEISEL, *supra* note 91, at 63–65.

defense verdicts (19%) as frequently as they disagreed with jury verdicts for plaintiffs (18%).⁹⁶

Thus, the judge-jury agreement rate in tort cases is even stronger than the jury-reviewer agreement rate observed in the medical malpractice studies previously discussed, especially in the cases that jurors feel have strong evidence of negligence. These reassuring findings are also consistent with the many surveys that have found that judges generally hold a positive view of the jury.⁹⁷

It would be even more informative, of course, if these studies had separately reported the judge-jury agreement rate for medical malpractice cases. Because they did not, the only studies that shed light on the judge-jury agreement in medical malpractice cases are the few that have compared how judges and juries decide the malpractice cases that are actually assigned to them. When Kevin Clermont and Theodore Eisenberg looked at the win rates for all federal civil trials between 1979 and 1989, they found that malpractice claimants had significantly less success in front of juries than they had before judges.⁹⁸ While malpractice plaintiffs won 50% of their bench trials, they won only 29% of their jury trials.⁹⁹ The findings of the Bureau of Justice Statistics, using 2001 data from the country's 75 largest counties, were very similar. The Bureau found that medical malpractice plaintiffs won 50% of their bench trials but only 26% of their jury trials.¹⁰⁰

Overall, malpractice plaintiffs appear to win half as often in front of juries as they do in front of judges. This sizeable discrepancy rate is atypical of most personal injury litigation. In most civil litigation, other than malpractice and product liability litigation, Clermont and Eisenberg found that bench and jury success rates were roughly the same.¹⁰¹ The Bureau findings also suggest that malpractice litigation is unusual. The judge-jury discrepancy rate was much larger in medical malpractice cases than it was in civil litigation generally (24% compared to 14%).¹⁰² These findings raise the possibility that juries are more deferential to physicians and more skeptical of patients who sue them than judges are.

96. Heuer & Penrod, *supra* note 94, at 48 tbl.13.

97. In the Kalven and Zeisel study, for example, the judges typically believed that a jury that decided the case differently had reached a reasonable decision. See Vidmar, *American Civil Jury*, *supra* note 10, at 853. A Georgia survey of state and federal judges found 94% of the judges felt the jury understood the case, and 87% believed that juries are not pro-plaintiff. Sentell, *Federal Bench*, *supra* note 94, at 116 tbls.16 & 17. All of the federal judges and 98% of the state judges felt that jury performance was satisfactory or would be if some procedural reforms were adopted. *Id.* at 117 tbl.18. Over 97% of both groups said that they agreed with jury verdicts more often than was reported in the Kalven and Zeisel study. *Id.* at 115 tbl.14.

98. Clermont & Eisenberg, *supra* note 50, at 1137, 1174.

99. *Id.* at 1137.

100. Thomas H. COHEN, Bureau of Justice Statistics, Tort Trials and Verdicts, in Large Counties, 2001, at 4 tbl. 3, available at <http://www.ojp.usdoj.gov/bjs/pub/pdf/ttvlc01.pdf>.

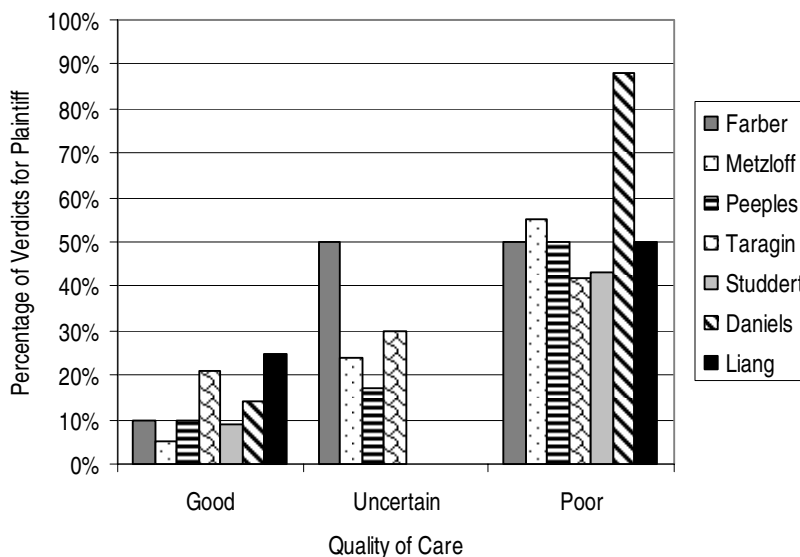
101. Clermont & Eisenberg, *supra* note 50, at 1137.

102. COHEN, *supra* note 100, at 4 tbl. 3. (finding 65 versus 51% in civil litigation generally).

Still, it would be a mistake to give significant weight to the studies comparing bench trials with jury trials because we do not know whether malpractice attorneys systematically direct a different mix of malpractice cases to judges than to juries.¹⁰³ Because the difference in win rates could simply reflect a different mix of cases, the studies comparing bench trial outcomes with jury trial outcomes provide a less appropriate basis for evaluating jury performance than the studies that compare jury verdicts with the verdicts that judges or experts would have reached in the same cases.

I. Synthesis of the Findings

FIGURE 8
CARE QUALITY AND TRIAL OUTCOME



The studies that compare jury verdicts with the conclusions reached by experts are startlingly consistent. Each indicates that the probability of a plaintiff’s verdict grows as the evidence of negligence improves. Patients with claims that the reviewers believe to be weak are highly unlikely to win a jury verdict. Patients with “close” cases are roughly twice as likely to win their cases as those with weak cases. Finally, patients with strong evidence of negligence are the most likely to prevail before a jury. These findings are collected in Figure 8.

The studies also consistently find that juries are deferential to physicians. While they are very likely to find for the defendant when the

103. See Clermont & Eisenberg, *supra* note 50, at 1174.

reviewers believe that the plaintiff's evidence is weak, they are just as likely to find for the defendant as for the plaintiff when the evidence of negligence is strong. Thus, juries are several times more likely to depart from the judgment of the reviewers when doing so will exonerate the defendant than they are to disagree when doing so will lead to liability. The jury verdicts in cases rated as toss-ups also show this deference. Despite expert ratings consistent with a fifty-fifty split in the verdicts, juries rendered defense verdicts in about seventy percent of the cases. The repeated finding that juries rule in favor of defendant physicians more often than physician reviewers do is remarkable given the documented reluctance of physicians to label another physician's care as negligent.¹⁰⁴

To the extent that jury bias in favor of plaintiffs is the perceived danger, these findings should be reassuring. The studies show that juries favor doctors even more than physician reviewers do. The empirical literature, therefore, does not support the view that juries are biased in favor of injured plaintiffs and are easily manipulated by plaintiffs' lawyers.

Furthermore, the consistency of these findings across multiple studies offsets the otherwise legitimate concern that most of these studies are small. Moreover, researchers reached similar results despite differences in the population of cases being examined and in the choice of reviewers. Some studies were state-specific and others national. Some targeted selected clinical specialties, and some did not. Some had multiple reviewers, while others relied on a single reader. Most used the ratings of physician reviewers, but some relied on the opinions of lawyers, judges, or insurance company claims evaluators. Some used two categories (negligent or not) to classify the quality of care rendered, and others added a third category for toss-up cases. Yet the consistency of their findings is extraordinary. Juries favor defendants.

Although these findings should be welcomed by physicians, the fit between external ratings and jury verdicts is not perfect. Plaintiffs win some of the cases that raters think they should lose. In the largest study, this rate reached twenty-one percent.¹⁰⁵ To be sure, that study took place before the media campaign of the past decade. A 2006 study with the second largest sample found only a nine percent plaintiff win rate in the cases experts rated as lacking merit, despite the fact that this study used a two-category design which allocated half of the close cases to the no-merit category. Still, doctors facing the risk of an adverse judgment that could materially change their lives may see a ten to twenty percent "error" rate as catastrophic. Plaintiffs have an even stronger basis for complaining about the current rate of disagreement. They lose fully half of the trials that expert reviewers feel

104. See *infra* text accompanying note 110.

105. See Liang, *supra* note 86. Although the discrepancy rate in the Liang study was twenty-five percent, that entire rate was attributable to a single discrepant verdict. The study examined only twelve cases.

they should win, along with most of the close cases. What accounts for these disagreements is the subject of Part IV.

IV. DISAGREEMENT

This Part examines the factors most likely to explain the observed discrepancies between jury verdicts and the ratings given by external reviewers. The most plausible explanations include inter-rater variability, reviewer bias, asymmetric information, scientific complexity, procedural restrictions on the ascertainment of truth, jury bias, unequal litigation resources, and the burden of proof. The discussion which follows examines each of these potential influences and offers a working hypothesis that most of the discrepancies between jury verdicts and external reviews are produced by a combination of inter-rater variability, jury respect for the burden of proof, jury reluctance to hold physicians liable, and superior defense resources.

A. Inter-Rater Variability

Whenever individuals are asked to evaluate the quality of someone else's performance, a certain amount of disagreement is inevitable. Even when researchers ask physicians to rate the quality of care provided by other physicians, the participants disagree among themselves. The frequency of these disagreements is surprisingly high. Several studies, including the Harvard Study of New York Hospitals and a more recent study by Peeples, Harris, and Metzloff, have found that physicians who evaluate the quality of care provided by other physicians disagree in about 30% of the cases.¹⁰⁶ Reasonable professionals often reach different conclusions about the same evidence.

In a fascinating review of the literature, Shari Diamond collected data on the agreement rates of people who make complex decisions in a variety of other settings. She found that a disagreement rate of 25%–30% was persistent across all fields. The disagreement rate for scientists engaged in peer review was 25%, the rate for employment interviewers was 30%, for psychiatrists diagnosing psychiatric illness it was also 30%, and for physicians diagnosing physical illness it was 23%–34%.¹⁰⁷ Diamond and Hans Zeisel found a similar rate of disagreement among judges. In their study of the recommendations of judges participating in sentencing councils, they found a

106. See, e.g., Farber & White, *supra* note 44, at 204–05 (finding 30% disagreement or ambiguous findings); Peeples et al., *supra* note 45, at 884 (finding that reviewers disagreed in 34.3% of the cases).

107. Shari Seidman Diamond, *Order in the Court: Consistency in Criminal-Court Decisions*, in 2 THE MASTER LECTURE SERIES: PSYCHOLOGY AND THE LAW 119, 125 (C. James Scheirer & Barbara L. Hammonds eds., 1982).

30% or greater rate of disagreement on whether the offender should be sentenced to prison.¹⁰⁸

It is now well established that a modest, but significant, level of disagreement is inherent in the nature of performance assessment. That is hardly surprising, given the frequent presence of disputed facts and the subjective nature of quality assessment. In medicine, the potential for disagreement is further compounded by frequent uncertainty among physicians and regional variation over the appropriate standard of care.¹⁰⁹

Consequently, a significant fraction of the jury-reviewer disagreements may be inherent in the nature of these decisions. The studies suggest that normal inter-rater variability causes discrepancy rates of roughly 25% to 30%. Yet, the discrepancy rate in the malpractice cases with relatively weak evidence of negligence is only 10% to 20%. Because a certain level of inter-observer disagreement is inevitable, and because the discrepancy rate observed in malpractice cases is much lower than the rate found in other settings, virtually all the disagreement between juries and reviewers occurring in cases with relatively weak evidence of negligence is probably the product of routine inter-observer variability. In this set of cases, jury performance is exceptional.

At the same time, further improvement is both possible and desirable. Courts should continue to experiment with innovative efforts to make scientific proof more comprehensible to lay jurors, such as early jury instruction, jury note-taking, ongoing jury deliberations, and jury submission of questions. They should also continue their search for better ways to distinguish legitimate experts from professional actors. However, the relatively high agreement rate that already exists between juries and physician-reviewers in low-odds cases probably means that only a modest improvement is possible.

By contrast, inter-rater variability provides a much less complete explanation for the disagreement rate in cases with strong evidence of negligence. The fifty percent discrepancy rate found in these cases means that additional factors are at work.

B. Reviewer Bias

Another possible explanation for jury-reviewer disagreement is that the physicians whose ratings were used by the studies were biased in favor of the defendant physicians. Research has shown that physicians are very reluctant to label the conduct of another physician as negligent. One study found a “pronounced reluctance to label as negligent those treatment deci-

108. Shari Seidman Diamond & Hans Zeisel, *Sentencing Councils: A Study of Sentence Disparity and its Reduction*, 43 U. CHI. L. REV. 109, 119–20 (1975).

109. See David M. Eddy, *Variations in Physician Practice: The Role of Uncertainty*, 3 HEALTH AFF. 74 (1984) (outlining the sources of uncertainty); Philip G. Peters, Jr., *The Role of the Jury in Modern Malpractice Law*, 87 IOWA L. REV. 909, 946–48 (2002) (reviewing the evidence).

sions that, *ex post* at least, were clearly erroneous.”¹¹⁰ When faced with scenarios that had been previously judged by a panel of senior physicians to be clearly negligent, only thirty percent of the participants in the study said that the patients should receive compensation. In the Farber and White study, the risk of bias was even more acute because some of the raters were coworkers and supervisors of the defendants.

In addition, the processes used by insurance companies to rate the quality of claims against their insureds are often skewed in favor of the insured. For example, some insurance companies take more precautions to avoid an erroneous attribution of negligence to their insured than they do to prevent an erroneous exoneration.¹¹¹ In addition, the fact that many major insurers are physician-sponsored corporations increases the risk that the claims adjustment process will favor physicians.

However, the jury verdict data simply do not substantiate the fear that pro-physician bias is a significant cause of jury-reviewer disagreement. If the reviewers' ratings reflected a substantial pro-physician bias, we would expect to see a high jury disagreement rate in cases rated by the reviewers as lacking merit. That is because less biased juries would be expected to rule for the plaintiffs in a significant fraction of these cases. Pro-defendant reviewer bias should also produce a low rate of disagreement in the cases rated as having merit because reviewers would give that rating only when negligence was indisputable. Yet, the studies show a dramatically different pattern of disagreement. They reveal that disagreement is most common in the cases rated as having merit and least common in cases rated as lacking merit. This pattern is inconsistent with the presence of systematic pro-defendant bias in the external reviews. That, in turn, makes it unlikely that we can explain a significant fraction of the plaintiffs' verdicts in low-odds cases as the jury's correction of a biased rating.

C. *Asymmetric and Incomplete Information*

Both juries and expert reviewers rely on incomplete information. The evidence available to the external reviewers, in particular, will often be less complete than the evidence produced at trial. It may also be more one-sided.

110. PAUL C. WEILER ET AL., *A MEASURE OF MALPRACTICE* 125 (1993) (“We found 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.”).

111. See Peeples et al., *supra* note 45, at 884 (finding that the liability insurer was more likely to seek additional reviewers if the initial review suggested breach of duty than if that review exonerated the sued physician). The insurer's average number of reviews grew from 3.07 to 3.27 and then to 4.43 as the evidence of breach got stronger. *See id.* The authors concluded “that the insurer proceeds more carefully in those cases in which liability appears likely.” *Id.* Similarly, in the Taragin study, only about half of the cases in which the medical care was initially deemed defensible by a claims representative were reviewed by an outside physician, while all initial determinations of poor quality were reviewed by consulting physicians. *See Taragin et al.*, *supra* note 39, at 781 tbl.1 (deeming twenty-nine percent defensible with “[n]o peer review”).

The hospital chart, for example, is controlled by prospective defendants and may paint a very different picture than the story that emerges when all of the witnesses have testified.¹¹² If so, juries can be expected to disagree occasionally with the ratings given by insurance reviewers.

At present, however, we do not know whether a significant fraction of the jury-reviewer disagreements arises out of access to different information about the patient's treatment. Given the strong agreement rate in low-odds cases, however, it is unlikely that pro-defendant ratings errors caused by incomplete information are as large a problem as many observers would have expected. Instead, the more interesting question is whether, contrary to expectation, the jury's access to more complete information helps to explain why the jury finds for the plaintiff in only fifty percent of the cases that the reviewers rated as indefensible. We currently lack the data needed to answer that question.

D. Scientific Complexity

Many critics of jury decision-making charge that juries are unable to understand complex medical evidence. Doctors fear that the ensuing confusion works to the plaintiffs' advantage, making the jurors vulnerable to manipulation by plaintiffs' attorneys, sympathetic plaintiffs, and dishonest expert witnesses. Although several studies have attempted to determine the jury's capacity to digest complex evidence and to decide difficult cases fairly, the results have been inconclusive.

Some of the findings are reassuring.¹¹³ For example, researchers have found that greater case complexity does not produce more disagreement between juries and presiding judges.¹¹⁴ In the largest and most famous of the studies, Kalven and Zeisel concluded that their findings of strong judge-jury agreement were "a stunning refutation of the hypothesis that the jury does not understand."¹¹⁵

At the same time, other studies have documented the limitations of a lay jury in complex cases.¹¹⁶ The most clearly established weakness lies in the

112. See VIDMAR, *supra* note 4, at 59–67 (containing case studies that reveal how estimates of case strength change as information is uncovered).

113. See, e.g., Vidmar, *Are Juries Competent*, *supra* note 10 (reviewing the literature and concluding that juries are competent to decide scientific tort cases).

114. See, e.g., Diamond & Rose, *supra* note 16, at 271 (collecting and reviewing the studies); Neil Vidmar & Shari Seidman Diamond, *Juries and Expert Evidence*, 66 BROOK. L. REV. 1121 (2001).

115. KALVEN & ZEISEL, *supra* note 91, at 157 ("While, as we can see, jury disagreement is greater in close cases than in clear ones, there is virtually no difference between the frequency of disagreement when the case is easy and when the case is difficult.")

116. See, e.g., Joe S. Cecil et al., *Citizen Comprehension of Difficult Issues: Lessons from Civil Jury Trials*, 40 AM. U. L. REV. 727, 755–60 (1991) (reviewing the literature); Joseph Sanders, *Scientifically Complex Cases, Trial by Jury, and the Erosion of Adversarial Processes*, 48 DEPAUL L. REV. 355, 365 (1998) (concluding that the research shows jurors have trouble comprehending complex evidence).

comprehension and application of probabilistic evidence.¹¹⁷ For example, people tend to overestimate the significance of some low probability risks.¹¹⁸ This could cause them to overestimate, in hindsight, the riskiness of a physician's clinical decisions.

Although the literature on jury comprehension is voluminous and far more nuanced than this brief summary can reflect, it provides neither a basis for concluding that juries commonly err in medical malpractice cases nor a basis for concluding that they do not. Perhaps the most revealing data comes from the studies on jury-reviewer agreement. The exceptionally high rate of agreement between juries and physician reviewers in the low-odds cases is inconsistent with the theory that the case complexity produces unfair plaintiffs' verdicts.

In fact, the studies on jury-reviewer agreement raise the surprising possibility that case complexity favors defendants. As will be discussed further below, the complexity and ambiguity of the scientific evidence in conjunction with the burden of proof could explain why juries find for defendants in half of the cases rated by experts as indefensible and in seventy percent of the borderline cases. Juries may be reluctant to hold a defendant liable when jurors are uncertain or confused about the evidence.

E. Procedural Barriers to the Ascertainment of Truth

Our adversary system relies on the parties to produce all of the relevant evidence for the jury. Yet, the parties actually have a very different objective. They are trying to prevail in a zero-sum game.¹¹⁹ Neither is interested in presenting the "whole" truth. Instead, each presents a partial picture that it hopes will be taken as the truth. This objective aligns awkwardly with the jury's twin goals of ascertaining the truth and reaching a just verdict.

The obstacles placed in the search for truth are not limited to the system's reliance on the parties to adduce the evidence. The civil justice system impedes the search for truth in other ways as well. Consider, for example, the protection of attorney work-product and the many restrictions placed on access to information about experts consulted by an opposing party, some of whom may have opinions inconsistent with that party's theory of the case.¹²⁰

117. See Reid Hastie & W. Kip Viscusi, *What Juries Can't Do Well: The Jury's Performance as a Risk Manager*, 40 ARIZ. L. REV. 901, 909–10 (1998) (reviewing the psychological literature).

118. See David L. Faigman & A.J. Baglioni, Jr., *Bayes' Theorem in the Trial Process: Instructing Jurors on the Value of Statistical Evidence*, 12 LAW & HUM. BEHAV. 1 (1988) (finding that mock jurors underestimated the Bayesian significance of statistical evidence about blood typing); Brian C. Smith et al., *Jurors' Use of Probabilistic Evidence*, 20 LAW & HUM. BEHAV. 49, 60–70 (1996). See generally Cecil et al., *supra* note 116, at 755–60 (reviewing the literature).

119. Joel Levin, *Tort Talk*, 40 TORT TRIAL & INS. PRAC. L.J. 1019, 1020 (2005).

120. The work of Stephen Easton maps out some of that territory. E.g., Stephen D. Easton, *That Is Not All There Is: Enhancing Daubert Exclusion by Applying "Ordinary" Witness Principles to Experts*, 84 NEB. L. REV. 675 (2006); Stephen D. Easton, "Red Rover, Red Rover, Send That Expert Right Over": Clearing the Way for Parties to Introduce the Testimony of Their Opponents' Expert Witnesses, 55 SMU L. REV. 1427 (2002); Stephen D. Easton, *Can We Talk?: Removing*

In situations like these, where courts have placed the protection of other important values above an unfettered search for the truth, the process itself may place an upper limit on the accuracy of its outcomes. As a result, the incentives and rules of the adversary process may produce some of the cases in which juries and extra-judicial reviewers disagree.¹²¹

However, the relatively low discrepancy rate in the low-odds cases suggests that any reforms enacted to improve the process, such as refinements in the rules governing expert witnesses, will have at most a very modest effect on that set of cases. Yet those are the cases that most concern the critics of tort law.

F. Jury Bias

Jury bias, like reviewer bias, could explain some of the cases in which juries and reviewers disagree. Jury bias in favor of injured claimants could be responsible for some of the low-odds cases that plaintiffs win. At the same time, other juries may be biased in favor of medical defendants, potentially explaining much of the success that defendants have in cases rated as toss-ups or indefensible.

Unfortunately, the role played by jury bias in malpractice cases has not been measured directly. Nevertheless, the studies of jury-reviewer agreement provide some promising clues about the role that jury bias plays in malpractice litigation. First, the low level of jury-reviewer disagreement in low-odds cases suggests that pro-plaintiff jury bias produces very few indefensible plaintiffs' verdicts. Second, the surprising level of defense success in cases deemed indefensible by expert reviewers cannot be explained by inter-rater variability alone. As a result, jury verdicts in these cases must be driven by one or more factors that systematically favor defendants at trial. Pro-defendant jury bias is one of the likely factors, along with the defense's superior resources, and jury respect for the burden of proof.

The possibility that juries are biased in favor of physicians runs counter to conventional wisdom. Juries, we are told, sympathize with injured patients and penalize wealthy physician defendants. However, jury reticence to hold physicians liable is consistent with public opinion research indicating that the public is deeply concerned about excessive litigation and high liability insurance premiums.¹²² In one study, four of five potential jurors agreed

Counterproductive Ethical Restraints Upon Ex Parte Communication Between Attorneys and Adverse Expert Witnesses, 76 IND. L.J. 647 (2001).

121. However, studies comparing adversarial and inquisitorial styles of adjudication suggest that no major gains would be achieved by moving toward a more European model. See Diamond & Rose, *supra* note 16 (reviewing the literature). Each system has its own shortcomings.

122. See VIDMAR, *supra* note 4, at 171; David M. Engel, *The Oven Bird's Song: Insiders, Outsiders, and Personal Injuries in an American Community*, 18 LAW & SOC'Y REV. 551, 553, 559-61 (1984) (finding that citizens in a rural Illinois county disapproved of "cashing in" via personal injury lawsuits and characterized those who did sue as "people looking for the easy buck"); Edith Greene et al., *Jurors' Attitudes About Civil Litigation and the Size of Damage Awards*, 40 AM. U. L. REV. 805, 809 (1991); Valerie P. Hans & William S. Lofquist, *Jurors' Judgments of Business Liabil-*

that “[p]eople are too quick to sue” and that “[t]here are far too many frivolous lawsuits today.”¹²³ Only one-third felt that “[m]ost people who sue others in court have legitimate grievances.”¹²⁴ In Texas, lawyers report that the “going rate” for settlement of tort claims has gone down.¹²⁵ In Wisconsin, defendants are now requesting jury trials in soft tissue cases.¹²⁶

This mood of public skepticism extends to lawsuits against physicians. In his study of potential jurors, Neil Vidmar found that members of the jury pool often made remarks during voir dire revealing their skepticism about malpractice litigation. Many made comments like “too many people sue their doctors” and “it is just going to raise the health insurance rates for the rest of us.”¹²⁷ In another study of potential jurors, one-third of the respondents believed that medical malpractice plaintiffs were looking for easy money.¹²⁸ Respondents were even more skeptical of plaintiffs’ lawyers. Two-thirds felt that these lawyers pressured clients into suing their doctors.¹²⁹ Many felt that medical malpractice litigation was ruining the health care system.¹³⁰

This widespread skepticism¹³¹ toward claimants and protectiveness toward physicians could have several causes, including (1) the media

ity in Tort Cases: Implications for the Litigation Explosion Debate, 26 LAW & SOC’Y REV. 85 (1992); ELLEN L. LEGGETT, JURY RESEARCH INSTITUTE, IDENTIFYING JUROR BIAS AND THEIR IMPACT ON CASES (1999) (finding that one-third of the respondents believed that medical malpractice plaintiffs are looking for easy money). Medical sociologists also point out that a low win rate is to be expected when lower status individuals make demands on persons with higher social status. See Jeffery Mullis, *Medical Malpractice, Social Structure, and Social Control*, 10 SOC. F. 135, 142, 145, 149 (1995).

123. Hans & Lofquist, *supra* note 122, at 93. This study asked about tort cases against corporations.

124. *Id.* Some of the skepticism about plaintiffs may be the product of cognitive dissonance—we do not want to think poorly of the people to whom we entrust our lives and well-being. Another possible explanation has been suggested by medical sociologists who believe that the poor success of malpractice plaintiffs in court is a predictable consequence of their lower social status relative to physicians. See Mullis, *supra* note 122, at 142, 145, 149.

125. Stephen Daniels & Joanne Martin, *It Was the Best of Times, It Was the Worst of Times: The Precarious Nature of Plaintiffs’ Practice in Texas*, 80 TEX. L. REV. 1781, 1783, 1796 (2002).

126. HERBERT M. KRITZER, RISKS, REPUTATIONS, AND REWARDS: CONTINGENCY FEE LEGAL PRACTICE IN THE UNITED STATES 300 n.33 (2004) (reporting on anecdotal statements by counsel).

127. VIDMAR, *supra* note 4, at 169.

128. LEGGETT, *supra* note 122.

129. *Id.*; see also Greene et al., *supra* note 122, at 817 (finding that most jurors believe attorneys encourage people to file frivolous lawsuits).

130. See LEGGETT, *supra* note 122 (discussing the findings).

131. Further complicating this analysis is the realistic possibility that jury bias may vary materially from one locale to another. We know already that plaintiffs’ win rates vary substantially across the country and even across states. See, e.g., Mary R. Rose & Neil Vidmar, *The Bronx “Bronx Jury”: A Profile of Civil Jury Awards in New York Counties*, 80 TEX. L. REV. 1889, 1896 (2002) (studying the so-called “Bronx effect” and finding that Bronx County ties with Brooklyn for the highest plaintiff win rate in the metropolitan New York area—at or above 50%); DANIELS & MARTIN, *supra* note 3, at 139 tbl.4.6 (finding that the win rate in Dallas was roughly 20% from 1970 to 1990, while the win rate in Cook County, Illinois, went from 42% down to 26% and then back up to 41% over the same time period). However, no study has attempted to separate the role

campaigns undertaken to create a political climate favorable to tort and malpractice reform legislation, (2) “Main Street” social norms against playing the tort lottery, and (3) the credibility, authority, and trustworthiness that are commonly attributed to high-status positions, like physicians.

1. *Media*

Most obviously, the media coverage of three medical malpractice crises in the mid-1970s, mid-1980s, and early 2000s has made the public very sensitive to the costs of malpractice litigation. On the heels of those crises, the political and public-relations campaigns in support of reform legislation further shaped public perceptions. In Texas, for example, the settlement value of tort cases has declined because the tort reform movement has changed the courtroom environment.¹³²

In their important study of the public tort reform debate, Stephen Daniels and Joanne Martin point out that rhetoric is often more important than reality.¹³³ Critics of tort law have mastered that rhetoric far better than its defenders. Cumulatively, they have created a widely shared picture of juries who are biased in favor of injured claimants and who pick the pockets of insured defendants in order to provide the claimants with generous recoveries.¹³⁴

2. *Social Norms Against Claiming*

A question not yet asked in the malpractice literature is why the public has been so receptive to this message. The answer may lie in norms about claiming. Many Americans have decidedly mixed feelings about tort claimants. While they are sympathetic to people who have been badly injured, many are also uncomfortable with attempts to “profit” from that injury.

These underling attitudes toward tort litigation were first revealed by the pioneering work of David Engel. His 1984 article *The Oven Bird's Song*¹³⁵ summarized two years of fieldwork studying community attitudes toward personal injury litigation in a small, predominantly rural Illinois county he called “Sander County.”¹³⁶ Although personal injury litigation rates were low

played by local norms from the role played by regional differences in the kinds of cases that are selected for trial. Thus, plaintiffs may win more verdicts than they should in some communities and less in others. If so, the unexpected plaintiffs' verdicts found in the jury verdict studies may be concentrated in different venues than those that produce the unexpected defendants' verdicts.

132. See generally Daniels & Martin, *supra* note 125 (reporting on interviews with many plaintiffs' lawyers).

133. DANIELS & MARTIN, *supra* note 3, at 2.

134. *Id.* at 11.

135. Engel, *supra* note 122. Engel did his fieldwork between 1978 and 1980. *Id.* at 557 (describing his data gathering methods).

136. *Id.* at 552. Although more than half of the population lived in the county seat, agriculture continued to play a central role in county life. *Id.* at 554.

there, residents of Sander County strongly disapproved of personal injury lawsuits. Claimants were characterized as “very greedy,” “quick to sue,” and “looking for the easy buck.”¹³⁷

Engel found the explanation for these beliefs in the culture of Sander County. Residents shared a brand of individualism that emphasized self-sufficiency and personal responsibility.¹³⁸ In this farming community, the risk of injury was ever-present.¹³⁹ People were expected to “provide their own protection against injuries” and “absorb the consequences of harms they fail[ed] to ward off.”¹⁴⁰ Money was earned through hard work, not the courts. Against this norm of stoicism, “cashing in” on misfortune was considered highly inappropriate.¹⁴¹ Most local residents were hesitant to file lawsuits.¹⁴² When they took a case to court, awards were low and suspicion of plaintiffs high.¹⁴³ Jurors felt that they had been “out there slaving away for every penny they’ve got and they [weren’t] about to just give it away to make that free gift to anybody.”¹⁴⁴

Social attitudes like these could provide at least a partial explanation for the difficulty that malpractice plaintiffs frequently experience in jury trials. It would be easy to dismiss the “Sander County” views as those of an isolated and small rural community many years ago, but that would be unwise. The last quarter century has seen a resurgence of voter support for politicians seeking to reinvigorate “traditional” social values like those held in Sander County.¹⁴⁵ This broader political zeitgeist may spill over into jury deliberations.¹⁴⁶ For community members who share these values, tort reform may closely resemble welfare reform, each ending an era of unearned

137. *Id.* at 553.

138. *Id.* at 558–59.

139. *Id.* at 558.

140. *Id.* at 558–59. For the traditionalists, transforming an injury into a lawsuit was “an attempt to escape responsibility.” *Id.* at 559.

141. *Id.* at 559. The community treated contract lawsuits far more approvingly. Contract actions, usually involving collections for sales, services, or loans, were nearly ten times as common in Sander County as personal injury lawsuits. *Id.* at 574–75. Yet community members voiced no complaints about this litigation as it enforced the sanctity of a promise. As one person observed, “a farmer’s word is good.” *Id.* at 576. Contract actions insured that promises were kept, debts honored, and payment received for work performed. *Id.* (noting that even violent self-help by creditors was tolerated). As a consequence, contract actions reinforced the existing social order, while tort claims challenged it.

142. *Id.* at 561. When they wanted to file a claim, it was hard to find a local lawyer willing to take the case. Although members of the local bar filed 72.5% of all non-tort lawsuits in the county, they filed only 12.5% of the personal injury claims. *Id.* at 565.

143. *Id.* at 560.

144. *Id.* (quoting an insurance adjuster).

145. In addition, now, as then, contract litigation is growing more rapidly than tort litigation. Malpractice lawsuits are actually declining on a per capita basis.

146. See Ted Schneyer, *Empirical Research with a Policy Payoff: Market Dynamics for Lawyers Who Represent Plaintiffs for a Contingent Fee*, 80 TEX. L. REV. 1829, 1836 (2002) (pointing out the potential role of Texas politics on decreases in the going settlement rate).

giveaways.¹⁴⁷ Where these views are prevalent, plaintiffs will face a demanding burden of proof.¹⁴⁸

3. Challenging Privileged Members of Society

Malpractice claimants also face another potential barrier to success that differentiates malpractice lawsuits from most other categories of tort litigation. Patients who file malpractice claims directly challenge the competency and authority of an upstanding member of the community with high social standing. A theory in legal sociology called “status expectations theory” contends “that the influence attempts of high-status individuals succeed, and those of lower-status people fail, due to socially shared cognitions and expectations that link social status to attributions about personal ability and worth.”¹⁴⁹ Higher-status individuals have more cultural capital than individuals with lower status because of cultural beliefs about their character and reputation.¹⁵⁰

This theory was first formally articulated in 1976 by Donald Black, who argued that the relative social standing of the defendant and his victim significantly influence the outcome of both criminal and civil cases.¹⁵¹ Marshaling the studies then available, he claimed that low-status individuals who injure high-status victims are treated more harshly by the law than high-status individuals who injure low-status victims. He also believed that

147. This particularly American brand of individualism probably helps explain why the pleas of tort reformers have resonated so strongly with the public. Advocates of tort reform have chosen their terms wisely. Complaints about “frivolous claims,” “lottery mentality,” and “windfall recovery” are likely to have considerable salience for Americans who share the creed of individualism and self-sufficiency.

148. Further complicating this analysis is the realistic possibility that the direction of jury bias varies with locality. Usually, defendants favor rural juries and plaintiffs favor urban. Because local norms and attitudes vary, plaintiffs may win more verdicts than they should in some communities and less than they should in others. Thus far, however, there is no useful data on this topic because the few studies comparing local win rates have not controlled for case quality. See, e.g., DANIELS & MARTIN, *supra* note 3, at 127; Theodore Eisenberg & Martin T. Wells, *Trial Outcomes and Demographics: Is There a Bronx Effect?*, 80 TEX. L. REV. 1839 (2002); Mary R. Rose & Neil Vidmar, *The Bronx “Bronx Jury”: A Profile of Civil Jury Awards in New York Counties*, 80 TEX. L. REV. 1889, 1896 (2002). If the folklore is correct, however, the data on jury-reviewer disagreement suggests that the rural counties favored by defendants may be just as unfair to plaintiffs as urban juries reputedly are to defendants.

149. Karyl A. Kinsey & Loretta J. Stalans, *Which “Haves” Come Out Ahead and Why?*, in IN LITIGATION: DO THE “HAVES” STILL COME OUT AHEAD? 137, 140 (Herbert M. Kritzer & Susan S. Silbey eds., 2003).

150. *Id.*

151. DONALD BLACK, *THE BEHAVIOR OF LAW* 11 (1976) [hereinafter BLACK, BEHAVIOR]. See generally DONALD BLACK, *SOCIOLOGICAL JUSTICE* (1989) [hereinafter BLACK, SOCIOLOGICAL JUSTICE].

the more intimate the personal relationship between the defendant and the victim, the less harshly the defendant would be treated.¹⁵²

The reception of Black's theory has been mixed. Some studies confirm his predictions, but others do not.¹⁵³ In addition, the applicability of this research to malpractice trials remains uncertain because nearly all of it involves criminal justice and race, rather than civil liability and occupational privilege. The impact of social status on malpractice outcomes is further complicated by the possibility that malpractice plaintiffs can materially raise their effective social standing by retaining attorneys and experts with better social pedigree than their own.¹⁵⁴ As a result, we lack the data needed to know whether the social standing of physicians explains any of the surprising success that physicians have when the evidence against them is strong, but the social status of the patient is not.

Despite these uncertainties, however, there are good reasons for leaving open the possibility that social status affects malpractice outcomes. Most importantly, the gulf in social power and prestige between physicians and ordinary patients is massive.¹⁵⁵ This chasm provides ample raw material for the operation of subtle differences in the attribution of credibility and authority to doctors and patients. The tendency to favor the doctor may be further deepened by the social relationship out of which the lawsuits arise. Every malpractice case is a lawsuit by an ill patient against the healer who tried to make her well.

Black's theory is also supported by a recent study of tax audits which found that auditors accept the oral testimony of high-status taxpayers more

152. BLACK, BEHAVIOR, *supra* note 151, at 11. For example, intrafamily abuse is less likely to be prosecuted than violence against strangers. Their degree of interdependence also matters. *Id.* at 13, 73.

153. Compare David F. Greenberg, *Donald Black's Sociology Of Law: A Critique*, 17 LAW & SOC'Y REV. 337, 347, 357–59 (1983) (conceding that individual attributes and relationship “unquestionably influence outcomes” but arguing that subsequent studies refute Black's specific predictions), with Allan V. Horwitz, *Resistance To Innovation In The Sociology of Law: A Response To Greenberg*, 17 LAW & SOC'Y REV. 369, 379–81 (1983) (questioning Greenberg's critique). For example, scholars debate whether studies showing that blacks and whites receive similar sentences have any bearing on this claim that crimes committed by blacks against whites will be treated differently than crimes committed by whites against blacks. *See id.* at 380.

154. BLACK, SOCIOLOGICAL JUSTICE, *supra* note 151, at 13 & n.75 (“[L]awyers homogenize and equalize the treatment of cases . . .”). However, lawyers vary in social status. *Id.* For an introduction to the evolving status of plaintiffs' lawyers see JEROME E. CARLIN, LAWYERS' ETHICS: A SURVEY OF THE NEW YORK CITY BAR (1966); Herbert M. Kritzer, *Rhetoric and Reality . . . Uses and Abuses . . . Contingencies and Certainties: The American Contingent Fee in Operation* 48–49 (Disputes Processing Research Program, Working Paper 12-2, 1996), available at <http://www.polisci.wisc.edu/~kritzer/research/contfee/rhetoric.pdf>; and Galanter, *supra* note 51, at 116 (summarizing the research).

155. See, e.g., ELIOT FREIDSON, PROFESSION OF MEDICINE: A STUDY OF THE SOCIOLOGY OF APPLIED KNOWLEDGE 368–69 (Univ. of Chicago Press 1988) (1970) (describing medicine as a “dominant profession” by virtue of the autonomy it has demanded and been given).

often than that of low-status taxpayers.¹⁵⁶ The authors concluded “that taxpayers of a low occupational prestige face a higher burden of proof than either middle- or high-prestige taxpayers.”¹⁵⁷ Auditors use clues about social status to make inferences about the competence and credibility of the taxpayers.¹⁵⁸

Experiments have also shown “that the credibility of people in court increases if they testify in a style characteristic of high-status people.”¹⁵⁹ High-status people seem more competent and trustworthy.¹⁶⁰ According to one review, “witnesses such as professionals and executives generally have more credibility than manual laborers or clerks, whites more than blacks, men more than women, and so on.”¹⁶¹ Information about social status is communicated not only by occupation, speech patterns, race, and gender, but also by other signals such as hairstyle, jewelry, and grooming.¹⁶²

These clues make it unwise to rule out the possibility that the occupation, education, income, and social standing of physicians matter in the courtroom, even though we cannot currently estimate the size and practical significance of this advantage. At the very least, our respect for, and reliance upon, physicians may make us more receptive to the media campaigns waged on their behalf.

G. Unequal Litigation Resources

Some of the success that defendants have in cases with strong evidence of negligence is likely to be the product of superior resources.¹⁶³ Money can be used to buy the services of more talented and more experienced attorneys. It can be used to hire more and better expert witnesses.¹⁶⁴ In these ways and others, superior resources can yield verdicts that were not warranted by the evidence.

156. Kinsey & Stalans, *supra* note 149, at 153 (reporting that auditors accepted oral testimony from twenty-two percent of low-status taxpayers, forty-three percent of middle-prestige taxpayers, and fifty-nine percent of high-prestige taxpayers).

157. *Id.* The significance of this finding is weakened, however, by the failure to find an association between oral testimony and favorable audits. *Id.*

158. *Id.* at 154.

159. BLACK, SOCIOLOGICAL JUSTICE, *supra* note 151, at 18 & n.98 (noting, for example, that high-status individuals make less use of “um” and “uh” and “sort of”). The evidence also “suggests that status-based expectancies especially influence decisions or judgments about people under conditions of ambiguity or lack of information.” Kinsey & Stalans, *supra* note 149, at 140. Ambiguity apparently provides an area of discretion within which sociological “tie breakers” can operate.

160. BLACK, SOCIOLOGICAL JUSTICE, *supra* note 151, at 18 & n.100.

161. *Id.* at 18–19.

162. *Id.* at 69.

163. See RUSSELL KOROBKIN, NEGOTIATION THEORY AND STRATEGY 154–56 (2002) (noting that resources can be deployed to improve the odds of success at trial).

164. *Id.* at 156 (noting that it is not always cost-effective to do so).

The theory that superior resources contribute to the jury-reviewer discrepancy rate is consistent with what we know about the relative resources of malpractice plaintiffs and defendants. Most importantly, defendants usually have more experienced attorneys. Neil Vidmar found that virtually all medical defendants were represented by attorneys with significant malpractice experience, while sixty-two percent of the patients were represented by attorneys with relatively little experience.¹⁶⁵

The extra experience matters. Catherine Harris and her colleagues found that plaintiffs won fifty percent of their trials when a seasoned plaintiff's attorney was matched against a less seasoned defense counsel, but only ten percent when the mismatch favored the defendant.¹⁶⁶ They also found that defendants benefited from mismatches four times as often as plaintiffs.¹⁶⁷ However, the findings should be viewed only as suggestive because the study did not control for the quality of cases in each attorney's portfolio.¹⁶⁸

Of course, the plaintiff sometimes has the more experienced lawyer. Perhaps, these mismatches account for some of the plaintiffs' verdicts in low-odds cases.¹⁶⁹ However, defendants benefit from mismatches far more often than plaintiffs do.

In addition, physicians probably have access to more and better expert witnesses. Physicians are widely believed to have less difficulty convincing well-respected practicing physicians to testify on their behalf. If true, this advantage would allow defense attorneys to be more selective, choosing the best witnesses for their side.

Defendants also hire more expert witnesses. Despite the fact that plaintiffs, unlike defendants, must offer expert testimony on the issue of damages and, thus, offer this testimony far more often than defendants,¹⁷⁰ defendants still offer more total experts than plaintiffs do at trial.¹⁷¹ Malpractice defendants also benefit from the experience that their liability insurers bring to the litigation team. Experienced insurance representatives can assist their attorneys in identifying and exploiting strategic advantages.

165. VIDMAR, *supra* note 4, at 54–55 (finding that sixty-two percent had handled fewer than four such cases during a four year study).

166. Harris et al., *supra* note 51, at 243.

167. *Id.*

168. However, a different study found that experienced attorneys had larger, but not more defensible, cases. See SLOAN ET AL., *supra* note 20, at 185–86. It also found that defense counsel spend considerably more money on trial preparations when they are defending against another specialist. *Id.* at 216.

169. See Catherine T. Harris et al., *Placing "Standard of Care" in Context: The Impact of Witness Potential and Attorney Reputation in Medical Malpractice Litigation* 28–29 (Wake Forest Univ. Sch. of Law Pub. Law & Legal Theory Research Paper Series, Paper No. 02-14, 2002), available at http://papers.ssrn.com/sol3/papers.cfm?abstract_id=333560 (suggesting that strategic factors may explain why plaintiffs with "non-meritorious" claims sometimes receive compensation).

170. See SLOAN ET AL., *supra* note 20.

171. See Vidmar, *Are Juries Competent*, *supra* note 10, at 902.

Finally, defendants typically possess better access to information about the circumstances surrounding the plaintiff's treatment than plaintiffs do. Some of this advantage probably survives discovery. If so, defendants can exploit this information asymmetry to win cases they should lose.

Thus, it seems reasonable to accept the working assumption that defendants benefit from superior resources more often than plaintiffs. In addition, the findings of the Harris study make it reasonable to posit that superior resources affect trial outcomes, though the magnitude of this advantage is unclear. Thus, it seems likely that some of the indefensible cases that end in defense verdicts reflect the influence of superior resources.

H. *Medical Uncertainty and the Burden of Proof*

Scholars have overlooked the possibility that much of the difficulty that malpractice plaintiffs experience in the trial of their strongest cases may stem from jury reluctance to hold a physician liable when the evidence is unclear or conflicting. The individuals who sit in the jury box will hear and rely on experts hired by the respective parties to advance their view of the case. If the defendant's expert is credible, jurors may find it difficult to determine whether the defendant has been negligent and, thus, may decline to hold the defendant legally responsible. This deference in the face of doubt could explain why juries rule for defendants in many cases that experts feel the plaintiff should win and in most of the cases thought by the expert reviewer to be toss-ups.

In legal terms, this deference can be understood as strict insistence that the plaintiff meet her burden of proof. As a result, plaintiffs only win if they have convinced the jury that the defendant violated the standard of care. If the jury has genuine doubts after hearing the defendant's experts, then that burden has not been met.

In addition to the burden of proof, the "two schools of thought" rule may also help to explain the deference that juries pay to medical defendants. In most states, the jury will be instructed to rule in favor of the defendant if it finds that respectable medical opinion is divided and the defendant's care falls within one of the reputable schools of thought.¹⁷² This rule is premised on the judicial belief that juries are not competent to choose the "better" school of thought when physicians themselves are unable to do so.¹⁷³ If the jury finds the defendant's experts credible, then it may feel obliged to conclude that the defendant's conduct falls within a reputable school of thought. By contrast, expert reviewers may feel fewer obligations to refrain from

172. See, e.g., *Downer v. Veilleux*, 322 A.2d 82, 87 (Me. 1974) ("[A] physician does not incur liability merely by electing to pursue one of several recognized courses of treatment."); *Jones v. Chidester*, 610 A.2d 964, 969 (Pa. 1992) (endorsing the "two schools of thought" doctrine); 1 BARRY R. FURROW ET AL., *HEALTH LAW* 382-84 (1995) (describing the doctrine).

173. See Philip G. Peters, Jr., *The Quiet Demise of Deference to Custom: Malpractice Law at the Millennium*, 57 WASH. & LEE L. REV. 163, 168 (2000).

judgment because they are medical experts themselves and are making their judgments in a very different setting.

Jury respect for the burden of proof and the two schools of thought rule would explain the observed pattern of jury verdicts. When the jury is in doubt, the benefit of that doubt goes to the defendant. This caution gives shelter to physicians who, in the eyes of their peers, have violated the standard of care.¹⁷⁴

If this hypothesis is correct, then juries understand the limits of their expertise, and this awareness favors the defendant. That is precisely the opposite of the effect that the jury's lack of expertise is commonly thought to have on jury verdicts. Critics assume that the "battle of the experts" frees juries to award unjustified recoveries. The data suggest that it is more likely to shelter negligent physicians. Thus, the common presence of clinical uncertainty and professional disagreement may actually help defendants in the courtroom, rather than create confusion that the plaintiff's attorney can exploit.

Although this hypothesis has not yet been tested, it is consistent with both the poor success of plaintiffs in cases rated by experts as indefensible and also their unexpectedly poor success in cases rated as toss-ups, only twenty to thirty percent of which are won by plaintiffs. It may help explain why malpractice plaintiffs fare better in front of judges than before juries. Judges may be more confident than jurors in their ability to determine when an expert's foundation is thin and, thus, more willing to conclude that a defendant's experts are unconvincing. If this explanation for the low plaintiff win rate in cases with strong evidence of negligence is true, then it is not necessary to develop more detailed ex ante standards of care, as some scholars have recommended, in order to protect physicians from unfair verdicts.¹⁷⁵

I. Synthesis

Inter-rater variability is almost certainly the least appreciated and least escapable source of jury-reviewer disagreement. It probably explains most of the discrepancy rate of ten to twenty percent in low-odds cases, suggesting that further improvements will be very difficult. Its presence is neither a cause for alarm nor a basis for celebration. Instead, the presence of a modest level of inter-observer disagreement simply reflects our limited capacity to reconstruct the past and agree on its propriety.

Two of the factors that can produce jury-reviewer disagreement actually improve the fairness of trial outcomes. Thus, we should welcome

174. Jury deference in the face of apparent medical disagreement may also help to explain why plaintiffs fare better in front of judges. Perhaps judges are more confident in their ability to determine when the defendant has manufactured a superficial medical disagreement.

175. See Michelle M. Mello, *Of Swords and Shields: The Role of Clinical Practice Guidelines in Medical Malpractice Litigation*, 149 U. PA. L. REV. 645, 668–77 (2001) (reviewing the literature and separating the proposals into three categories: the ex ante contract model, the judicial notice model, and the affirmative defense model).

those jury-reviewer disagreements that arise when a rating given by the insurance company's experts is biased against the plaintiff. Similarly, disagreements that stem from the jury's access to more complete information simply mean that the system is working as it should.¹⁷⁶ However, the existing data do not provide a basis for estimating the frequency with which these corrections occur or the portion of the jury-reviewer disagreements that they explain.

Other likely causes of jury-reviewer disagreement are decidedly unwelcome. They include jury inability to understand complex evidence, one party's access to superior litigation resources, barriers to truth posed by some of the rules of trial and pretrial practice, pro-plaintiff jury bias, and pro-defendant jury bias. Although none of these factors appears to play a substantial role in the resolution of low-odds cases, several appear to infect jury decision-making in cases with strong evidence of negligence.

CONCLUSION

Over the past thirty years, three medical malpractice "crises" have come and gone. In reaction to these crises, three generations of malpractice reform legislation have been enacted across the country. Yet, the subject of jury competence remains a front-page issue. Today, it serves as a prime justification for proposals to make fundamental changes in malpractice litigation, such as the legislative authorization of binding early offers and the creation of administrative health courts.

It is time to stop relying on intuitions and anecdotes when debating jury performance. Three decades of research provide an ample evidentiary basis for evaluating jury decision-making. The findings revealed by that data are mixed and, in some ways, paradoxical. On the one hand, negligence matters, weak cases are decided correctly, and juries appear to take the burden of proof seriously. On the other hand, juries are so reluctant to hold physicians liable that they render defense verdicts in half of the cases that medical experts think plaintiffs should win. Given the well-established reluctance of physicians to label other physicians as negligent, this is a remarkable finding that deserves further research.

On one criterion, juries perform well. The stronger the plaintiff's evidence of negligence, the greater the likelihood of a plaintiff's verdict. Plaintiffs win 10% to 20% of the cases that reviewers feel they should lose, 20% to 30% of the cases rated as toss-ups, and roughly 50% of the cases with strong evidence of negligence.

Of most importance to critics is the finding that meritless cases rarely win. In fact, doctors win a larger percentage of these cases (80% to 90%) than would be predicted from the data on inter-rater variability. As a result,

176. This factor is likely to play a more important role when the expert review is performed soon after receipt of the claim than when the review is performed after the case has been closed by independent experts who have access to the entire case file, especially if it includes a transcript of the trial testimony.

the disagreements observed in the low-odds medical malpractice cases can be fully explained by normal inter-observer disagreement. In addition, some of these disagreements can probably be attributed to reviewer bias in favor of physicians and jury access to more complete and stronger evidence of medical negligence. It is, therefore, unlikely that a significant fraction of the plaintiffs' verdicts in these cases constitute genuinely erroneous verdicts caused by factors such as pro-plaintiff jury bias, superior plaintiff's counsel, and the jury's inability to understand the evidence. In fact, it is possible that the unexpectedly high agreement rate indicates a pro-defendant bias.

Of course, many physicians will be alarmed by a 10% to 20% chance that they will be found liable in a case that lacks merit in the eyes of the liability insurer and the defendant. Yet that agreement rate already reveals more deference by juries to medical defendants than is usually given by other physicians. If an 80% to 90% agreement is still not good enough, then the cure is unlikely to lie in piecemeal reforms of a fault-based tort system or even in more fundamental changes, such as the creation of specialized medical courts. A nontrivial discrepancy rate is inevitable unless the issue of fault is removed entirely from the case, as would happen in a no-fault compensation regime. Even then, causation is likely to be a frequently contested issue.

By contrast, the high rate of disagreement in cases thought by reviewers to be indefensible (50%) is too large to be explained entirely by inter-rater variability. Jury access to better information may explain some of that discrepancy rate, but it probably accounts for a small portion of those disagreements because defendants ordinarily have better access to information about the plaintiff's treatment than plaintiffs do. The rest is probably produced by factors that systematically favor defendants. The finding that defendants win roughly 70% of the cases rated as toss-ups also suggests the operation of pro-defendant factors.

Although the data are not sufficiently detailed to permit a definitive assessment, several explanations are especially promising. First, juries may be skeptical of patients who sue their doctors. Second, the preliminary evidence, though scanty, suggests that defendants are much more likely than plaintiffs to have more experienced attorneys and superior experts. Third, juries may take the burden of proof very seriously in medical malpractice cases, giving physicians the "benefit of the doubt" when the experts for both sides are credible. Of the three influences, only the last produces fair outcomes. Unfortunately, the data on jury-reviewer disagreement do not provide a basis for estimating the relative importance of each of these three pro-defendant forces. However, they do establish that the cumulative impact of these factors provides doctors with a significant advantage in front of the juries.

Collectively, these forces make it quite difficult for malpractice plaintiffs to win even their strongest cases. Because this finding is contrary to our usual assumptions about the allocation of risk in the courtroom, little scholarly thought has been given to reforms that might level the playing field. One important exception is the intriguing suggestion made by Frank Sloan

and his colleagues that we make it easier for plaintiffs to locate experienced plaintiffs' attorneys by creating a certified specialty in malpractice litigation.¹⁷⁷

Health courts are another reform that could potentially produce fairer outcomes for claimants. Because juries are more deferential to the defendant physicians than expert reviewers are, it is conceivable that medical courts will rule in favor of claimants in a larger percentage of the cases that independent reviewers think plaintiffs should win. Other attributes of health courts could also aid plaintiffs. For example, the use of trained judges might reduce the advantage associated with defendants' superior resources. Similarly, the elimination of hired-gun experts has potential to help plaintiffs more than defendants because the data show that defendants and their hired guns are more successful than plaintiffs and their hired guns at persuading juries to render verdicts at odds with the opinions of medical experts.¹⁷⁸ If health courts actually operate in this fashion, then patients, not physicians, should be lobbying for them.

Of course, none of these hypotheses has been tested. Furthermore, there are good reasons to fear that health courts will treat patients unfairly. Current proposals for health courts suggest that discovery will be greatly truncated, fees of plaintiffs' attorneys will be capped, pain and suffering will be capped, and expert testimony will be restricted to "neutral" experts who risk regulatory punishment if their testimony is not "objective."¹⁷⁹ Moreover, the public setting in which these experts will render their opinions could place considerable pressure on them to demonstrate their loyalty to the profession. As a consequence, these "neutral" experts may show the same reluctance to label another physician's care as negligent that physicians have exhibited in other settings. As noted above, researchers have found that physicians are so unwilling to label another physician's care as negligent that they refuse to do so even when the treatment given to the patient was "clearly erroneous."¹⁸⁰

There is an obvious tension between the finding that physicians are loath to indict one another and the evidence that physician reviewers who work for insurers and researchers are more willing to condemn the tort defendants than juries are. Setting seems to matter. The relevance of role and context is most clearly demonstrated by the principal study measuring physician willingness to criticize peers. In this study, the subjects were asked, among other things, whether the injured patient deserved compensation. Yet the same scenarios had been deemed "clearly erroneous" by consultants to the re-

177. SLOAN ET AL., *supra* note 20, at 215–17.

178. However, health courts would lack the democratic legitimacy associated with jury verdicts. See Peters, *supra* note 109, at 958–59.

179. *Innovative Solutions to Medical Liability: Hearings Before the Subcomm. on Health of the H. Comm. on Energy and Commerce*, 109th Cong. 6 (2006) (statement of Paul Barringer, General Counsel of Common Good).

180. See *supra* note 110.

search team. In that study, the role played by the physicians mattered. Context may also explain why physicians who perform case reviews for malpractice insurers and social science researchers are relatively willing to make negative judgments about other physicians. If they were asked to do that in the more public setting of health courts, they might be much less willing to criticize their peers. As a result, our initial experiments with health courts should be small pilot projects during which researchers collect the data needed to evaluate the fairness of their outcomes.

In recap, the data demonstrate that juries treat physicians very fairly, perhaps with too much deference. Given the limits of human capacity to reconstruct past events and the inevitable subjectivity of judgments about the quality of past performance, it is probably not possible to design a fault-based adjudication system that will have a substantially higher agreement rate in the cases with weak evidence of negligence. At most, modest improvements may be possible through careful refinements of trial procedure and the supervision of expert witnesses. As a consequence, both piecemeal reforms and more fundamental alternatives to malpractice litigation should not be driven by the mistaken assumption that juries treat physicians unfairly. Although the current system of resolving malpractice claims has many shortcomings, neither randomness nor favoritism toward injured patients is among them.

