

MEDICAL MALPRACTICE LITIGATION IN NORTH CAROLINA: WHAT CLAIMS GET PAID, AND FOR HOW MUCH?

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Medical malpractice litigation lends itself to empirical research. This article draws on a unique dataset consisting of all the filed cases closed by a major medical malpractice insurer over a two-year period. Using this data, this article addresses two questions. First, what factors drive indemnity payments made in settlement of claims? Second, what factors drive the amount of those indemnity payments? We were able to assess a number of potential factors affecting case resolution that are rarely available to researchers. We find that the insurer's internal assessment of potential liability, along with the number of experts designated by the parties, is a strong predictor of payment. We also find that once the decision to seek a settlement is made by the insurer, non-medical factors become significant. Specifically, the plaintiff's age and marital status, as well as the number of experts designated by the plaintiff, are the most important predictors of the amount of payment. The severity of the plaintiff's injury is not a reliable predictor of the amount of payment.

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INTRODUCTION

The topics of medical malpractice litigation and medical malpractice reform just don't seem to go away. Several bills meant to reform the current system were introduced in the 115th Congress in 2017.¹ The topics continue to receive academic attention.² One might question the need to talk about medical malpractice reform at a time when no insurance crisis exists, and at a time when neither the number nor amount of paid indemnity claims is increasing.³ Still, as Mello et al.⁴ suggest, because there is no crisis, this is an appropriate time for thinking objectively about medical malpractice, and for reviewing what we know and what we don't know.

This article takes an empirical approach to two questions. First, what factors lead to a monetary recovery for medical malpractice plaintiffs? Second, if a payment is made, what factors affect the amount of the payment? In answering those two questions, we introduce factors rarely seen when analyzing medical malpractice litigation. We are able to do this thanks to our access to a closed claims database maintained by a medical malpractice insurer doing business in North Carolina.

We also approach the data from a *case* perspective rather than a *claim* perspective. This is a less frequently traveled path in medical malpractice research.⁵ As Rahmati et al. have observed, this approach necessarily examines success rates from the plaintiff's perspective, rather than from the defendant's perspective.⁶ The distinction arises from the fact that a single lawsuit may name more than one defendant, whereas a claim always involves a single defendant.

1. See, e.g., American Healthcare Reform Act, H.R. 277, 115th Cong. (2017) and Saving Lives, Saving Costs Act, 115th Cong. (2017). See generally Michelle M. Mello et al., *Medical Liability—Prospects for Federal Reform*, in 376 N. ENGL. J. MED. 1806 (2017); Anand Parekh and G. William Hoagland, *Medical Liability Reform in a New Political Environment*, in 317 JAMA 1311 (2017).

2. See, e.g., Lydia Nussbaum, *Trial and Error: Legislating ADR For Medical Malpractice Reform*, 76 MD. L. REV. 247 (2017); Daniela Talmadge, *Keeping Medical Liability Costs Down: How Captive Insurance and Damages Caps Could Help Control Rising Healthcare Costs*, 43 J. CORP. L. 201 (2017); Patricia Born and J. Bradley Karl, *The Effect of Tort Reform on Medical Malpractice Insurance Market Trends*, 13 J. EMP. LEG. STUDIES 718 (2016); Mohammad Rahmati et al., *Medical Malpractice Claiming in Illinois, 1980-2010*, 13 J. EMP. LEG. STUDIES 183 (2016); Jason A. Stamm et al., *Medical Malpractice Reform for Today's Patients and Clinicians*, 129 AM. J. MED. 20 (2016).

3. Mello, *supra* note 1.

4. *Id.*

5. Mohammed Rahmati et al., *Screening Plaintiffs and Selecting Defendants in Medical Malpractice Litigation: Evidence from Illinois and Indiana*, Working Paper 2017 at 5 (hereinafter "Screening Plaintiffs").

6. *Id.* at 35.

LITERATURE REVIEW

The number of medical malpractice claims and volume of medical malpractice litigation has been in decline for more than a decade.⁷ The average payout per physician has also declined.⁸ Liability insurance seems to be available, although the premiums for some specialties will be higher than for others (as they have always been). A number of factors may help explain these trends, but tort reform—damage caps in particular—does not appear to be the principal factor. Meanwhile, fewer physicians are engaged in traditional private practice, with a practice unaffiliated with a hospital or medical center.⁹ Perhaps one or more of these trends will change, and medical malpractice litigation will again take center stage in the tort reform debate. History suggests that it will, given the various malpractice insurance crises of the past forty years.¹⁰ Regardless of what happens, this is a good time to review what we know, and what we don't know, about medical malpractice litigation.

When analyzed at the level of claims payment, without regard to the amount of payment, medical malpractice is a quite rational process, as researchers have frequently noted.¹¹ Meritorious claims are paid, and non-meritorious claims are not paid. A more difficult question arises with the amount of payment. Do the amounts paid to resolve a claim follow a pattern, or are they just random?

Almost thirty years ago, Sloan and Hsieh analyzed both indemnity payments and the amount of those payments, relying on several sets of data.¹² Comparing payment amounts to the level of the alleged severity of the injury, Sloan and Hsieh concluded that payments, in general, rose with severity of injury.¹³ They also noted, however, that payments within a given level of severity were quite variable.¹⁴ In this article, we also examine what factors are associated with payment, as well as what factors are associated with the amount of payment.

7. Mello, *supra* note 1; Paik, Bernard S. Black and David A. Hyman, *The Receding Tide of Medical Malpractice Litigation: Part 1- National Trends*, 10 J. EMP. LEG. STUDIES 612, 614 (2013).

8. *Id.* at 614.

9. Stamm, *supra* note 2.

10. See Nussbaum, *supra* note 2 at 263-264.

11. Patricia M. Danzon, *Medical Malpractice: Theory, Evidence, and Public Policy* (Harvard University Press 1985); Frederick W. Cheney *et al.*, *Standard of Care and Anesthesia Liability*, 261 JAMA 1599 (1989); Mark I. Taragin *et al.*, *The Influence of Standard of Care and Severity of Injury on the Resolution of Medical Malpractice Claims*, 117 ANNALS OF INT. MED. 780 (1992); Frank A. Sloan, *Suing for Malpractice* (1993).

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

13. *Id.*

14. *Id.*

THE DATA

We collected data from the closed files of a major North Carolina medical malpractice insurer. Our data consists of all filed lawsuits¹⁵ involving one or more of the company's insured physicians closed between 2013 and 2015. As a result, we have information on 229 separate lawsuits involving 339 defendants.

We were given access to the same information available to the company's claims adjusters. We thus have extensive data over a wide variety of categories, many of which are rarely, if ever, made available to researchers. Our data is rich in detail. It is more extensive and more nuanced than the information typically provided to state insurance regulators, the sort of information many researchers rely on.

Our data includes information on things such as the duration of the lawsuits, the outcome of the lawsuits, the severity of the injuries alleged, the medical specialties of the individual defendants, the amount (if any) paid to the plaintiff, and the expenses incurred by the insurer in defending each claim. We also collected information on the system and part of the body involved, the specific medical allegation made, the nature of the allegation made, and the specific allegations made by plaintiff's counsel. We have information about the individual defendant's involvement (e.g., attending, consulting, on-call) as well as the number of co-defendants. We collected demographic information as to the plaintiff's gender, marital status, race, age, and type of insurance. We also counted the number of experts designated by plaintiff and defendant in each case. We have limited information about the number and amount of offers made by each side. Finally, we have the insurer's internal assessment of liability for each case.

In the tables below, we describe the data by several different attributes:

1. Severity of alleged injury.

We used the standard scale used by the National Association of Insurance Commissioners. That scale allows injuries to be classified on an ascending scale of severity. In Table 1, we report on the number of filed cases within each category, and the frequency with which claims in each category received an indemnity payment.

15. It is important to distinguish between "claims" and "lawsuits." "Claims," as tracked by the insurer, may or may not lead to indemnity payments, and may or may not develop into "lawsuits." In addition, "lawsuits" may or may not begin as "claims." We encountered a number of cases in which the filing of a lawsuit was the first indication the insurer had that a plaintiff was seeking compensation for his or her alleged injury. In this article, we report only on lawsuits—whether they first appeared as claims or not.

Table 1
Lawsuits By Severity of Injury.

Severity Level	Description	No.	Pct.	No. Paid	Percentage	Average/Median Amount Paid
1	Emotional Only	6	2.6	0	-	-
2	Insignificant	11	4.8	0	-	-
3	Minor Temporary	18	7.9	6	33.3	\$97,056/ \$42,500
4	Major Temporary	31	13.5	9	29.0	\$314,722/ \$225,000
5	Minor Permanent	6	2.6	4	66.7	\$306,629/ \$223,750
6	Major Permanent	52	22.7	16	30.8	\$939,679/ \$750,000
7	Significant Permanent	19	8.3	6	31.6	\$414,916/ \$287,250
8	Grave	8	3.5	5	62.5	\$709,900/ \$500,000
9	Death	78	34.1	25	32.1	\$242,271/ \$162,500
Total		229	100.0	71	31.0	

Table 1 suggests several things. First, most of the alleged injuries were quite serious in nature: 157 of the 229 cases (68.6%) were graded at severity levels 6-9. This is not surprising. Pursuing a medical malpractice claim is expensive and time consuming.¹⁶ The potential recovery has to justify the time and money spent seeking it. The top-heavy nature of the alleged injuries is consistent with previous findings by Rahmati *et al.*¹⁷ Second, two categories, “major permanent” and “death,” alone accounted for more than half of the cases. Third, while the average and median amounts recovered increase from severity level 3 (“minor temporary”) to severity levels 8 and 9 (“grave” and “death”), the increase overall can hardly be described as a straight line. For example, the average and median recoveries for severity level 6 (“major permanent”) are greater than the average and median recoveries for severity levels 8 (“grave”) and 9 (“death”). Finally, the likelihood of obtaining payment, overall, is low (30.1%).

16. Stephen Daniels *et al.*, *It Was the Best of Times, it was the Worst of Times: The Precarious Nature of Plaintiffs' Practice in Texas*, 80 TEX. L. REV. 1781, 1798 (2002); Paul C. Weiler, *The Case for No-Fault Medical Liability*, 52 MD. L. REV. 908, 915 (1993).

17. Rahmati, *supra* note 2 at 184.

2. Specialty of Primary Defendant

Some specialties were more frequently the subject of a lawsuit than others. Table 2 lists the ten medical specialties most often sued, using the specialty of the primary defendant.¹⁸

Table 2
Medical Specialties of Defendants

Specialty of Primary Defendant	Number of Lawsuits	Percentage
Radiology (diagnostic and internal)	21	9.2
General Surgery	19	8.3
Internal Medicine	18	7.9
Family Practice	17	7.4
Orthopedic Surgery (including spine)	17	7.4
Emergency Medicine	17	7.4
Vicarious (employer or practice)	13	5.7
Orthopedic Surgery (no spine)	12	5.2
Urology	11	4.8
OB-GYN	10	4.4
Total	155	67.7

Twenty-five other specialties accounted for the remainder of the cases. While it is common in medical malpractice litigation to name the practice or the employer as an additional defendant, in only 13 cases was the practice or the employer in fact the primary defendant.

3. Expenses Paid

Defending a malpractice case is usually expensive. Expenses paid by the insurer varied greatly from case to case, from a low of \$1,269 to a high of \$3,335,633. The mean expense paid was \$166,986 and the median expense paid was \$90,599. The bulk of these expenses were attributable to the fees paid to defense counsel.

18. When multiple defendants were named in a single lawsuit, we defined the "primary defendant" on the basis of two questions. First, if an indemnity payment was made, we treated the defendant on whose behalf the highest payment was made as the primary defendant. Second, if an indemnity payment was not made, we treated the defendant to whom the highest expenses were charged as the primary defendant.

4. *Indemnity Paid*

Sixty-nine of the 229 cases (30.1%) resulted in an indemnity payment to the plaintiff. As with expenses, the amount of indemnity paid varied greatly, from \$4,618 to \$2,479,384. The mean payment was \$442,986 and the median payment was \$237,500. Of these sixty-nine cases, only one was the result of a plaintiff's verdict at trial. A second was the result of binding arbitration. The remaining sixty-seven cases in which an indemnity was paid were settlements.

5. *Attorneys*

Plaintiffs in the 229 cases were represented by 128 different attorneys. In sixteen of the cases, the plaintiff appeared *pro se*.¹⁹ In contrast, the defendants were represented by only 25 different attorneys from fourteen law firms. Five of those 25 defense attorneys accounted for more than half (119) of the 229 cases.

6. *Medical Allegation and Nature of Allegation*

The specific allegations made in the complaint were translated by the insurer into "medical allegations." A total of 36 different medical allegations appeared in the data. The most frequently occurring medical allegations were "treatment, inappropriate or incomplete" (n=46), "failure to recognize complications" (n=24), and "treatment, injury apart from intended treatment of care" (n=23). The specific allegations made in the complaint were also categorized by "nature of allegation." More than 80% of the cases fell into three categories. Seventy of the cases were described as "surgery related," 68 cases were described as "treatment related," and 54 cases were described as "diagnosis related."

7. *Demographics*

Plaintiffs were almost evenly divided by gender (111 males, 117 females), and ranged in age from less than one year old to 91. The mean age of plaintiffs was 49.7 and the median age was 52.

Tables 3, 4, and 5 describe the marital status, race, and the plaintiffs' type of medical insurance. However, because marital status, race, and type of insurance of the plaintiff were not always recorded, we are unable to account for all plaintiffs.

19. In only one of those sixteen cases did the *pro se* plaintiff recover.

Table 3
Marital Status of Plaintiffs

Marital Status	Number	Percentage
Single	18	7.9
Married	118	51.5
Divorced	15	6.6
Widowed	10	4.4
Child Under 18	6	2.6
Infant (under 1 year)	9	3.9
Unknown	53	23.1
Total	229	100.0

Table 4
Race of Plaintiffs

Race	Number	Percentage
Caucasian	124	54.1
African-American	35	15.3
Hispanic	2	0.9
Other	5	2.2
Unknown/ No Record	63	27.5
Total	229	100.0

Table 5
Type of Medical Insurance

Type of Insurance	Number	Percentage
Private	73	31.9
Medicaid	19	8.3
Medicare	65	28.4
Military	1	0.4
Workers' Compensation	4	1.7
None	3	1.3
Unknown/ No Record	64	27.9
Total	229	99.9

8. *Number of Experts*

Typically, experts are called to describe the relevant standard of care for the defendant physicians.²⁰ In fact, North Carolina law requires the plaintiff to assert in the complaint that he or she has obtained a favorable opinion from an expert in the relevant medical field.²¹ As a result, expert testimony is common in medical malpractice litigation.²² However, because we collected data on all *filed* medical malpractice cases, not all of the cases we examined involved the use of experts. Most of these cases were simply dismissed before experts had to be designated. In addition, a few cases relied on a “res ipsa loquitur” theory, in which an expert might not be necessary.

In 184 of the cases, defense experts were identified. The number of defense experts designated per case ranged from 1 to 14; the mean was 3.44 and the median was 3. Plaintiff’s experts were identified in 170 of the cases. The number of plaintiff’s experts ranged from 1 to 29; the mean was 2.80 and the median was 2.00. Thus, defense experts generally outnumbered plaintiffs’ experts.

9. *Venue, Trials, and Appeals*

All of the cases were filed and concluded in North Carolina. Lawsuits came from 51 of North Carolina’s 100 counties. The three most frequent venues were Wake County (Raleigh) (n=31); Mecklenburg County (Charlotte) (n=23); and New Hanover County (Wilmington) (n=20). Twenty-six cases (11.4%) went to trial, but only seventeen ended in a verdict. One case was arbitrated. Three defense verdicts were appealed. All three were affirmed.

10. *Outcomes*

Table 6 describes the final outcomes of the 228 lawsuits.

20. Catherine T. Struve, *The Adversary System and Procedural Reform in Medical Liability Litigation*, 72 *FORDH. L. REV.* 943, 976 (2004).

21. N.C.GEN.STAT. section 90-21.12; N.C.R. C.P. 9(j).

22. Tom Baker, *The Medical Malpractice Myth* 16 (2005); Frank A. Sloan *et al.*, *Suing for Medical Malpractice* 5-6 (1993).

Table 6
Final Outcome of Cases Filed

Outcome	Number	Percentage
Involuntary Dismissal	13	5.7
Voluntary Dismissal, no Money Received	102	44.5
Summary Judgment for Defendant(s)	5	2.2
Defense Verdict Following Trial	16	7.0
Settled for Costs	20	8.7
Voluntary Dismissal, Money Paid to Plaintiff	71	31.0
Plaintiff's Verdict Following Trial	1	0.4
Binding Arbitration, Award for Plaintiff	1	0.4
Total	229	100.0

The results in Table 6 are not surprising.²³ Voluntary dismissals, with no money paid by the defense, were the most frequent outcome (n=102, 44.5%). Plaintiffs recovered money in only 31% of the cases, regardless of the amount recovered. Treating binding arbitration as a trial, defendants prevailed at trial over 91% of the time (21 of 23 cases).

11. Liability Rating

After a lawsuit has been filed, the insurer reviews the relevant medical records and makes an internal determination of the insured's liability. Liability is then rated according to a five-category scale: clear, probable, questionable, unknown, and none. Table 7 summarizes the liability assessments made by the insurer.

23. These results are comparable to results reported in other studies from other states.

Table 7
Liability Assessments of Insurer

Liability Rating	Number	Percentage
Clear	10	4.7
Probable	36	16.7
Questionable	26	12.1
Unknown	44	20.5
None	99	46.0

N=215. In 14 cases, a liability rating was not available.

FINDINGS

We set out to answer two questions: first, what factors predict an indemnity payment²⁴ to the plaintiff and second, when a payment is made, what factors predict the *amount* of that payment.

Predicting Payment

Overall, 69 of 229 plaintiffs (30.1%) received an indemnity payment. We found a very strong correlation between the insurer's internal assessment of liability (Table 7) and the payment of money to the plaintiff. A simple linear regression using only liability rating as an independent variable was highly significant ($p = .000$, R-square = .640).²⁵ When two additional independent variables were added (number of plaintiff's experts and number of defense experts) the model remained highly significant, and the R-square increased to .669. However, "liability

24. By "indemnity payment," we mean money actually paid to the plaintiff. As noted in Table 6, twenty cases were "settled for costs," meaning that the insurer agreed to pay some or all of the plaintiff's counsel's expenses, but did not pay money to the plaintiff.

25. "R-squared," also known as the coefficient of determination, is a statistical measure of the relationship between two variables. It is a measure of the extent to which the behavior of one variable can predict the behavior of a second variable. By convention, it can vary between 0 and 1.00. Our reported R-squared value of .640 indicates a strong correlation between the insurer's internal assessment of liability and the eventual payment of a claim. Our reported R-squared value of .669 suggests an even stronger correlation between the insurer's internal assessment of liability, the number of plaintiff's experts, and the number of defense experts with the eventual payment of a claim. The inference is that these variables drive the decision by the insurer to make an indemnity payment. Regression analysis (reported at Tables 9 and 10, *infra*) is closely related to the concept of R-squared. Regression analysis determines the relationship between one or more independent variables and a dependent variable (in this paper, the amount of payment made to the plaintiff). See generally Alan Agresti and Barbara Finlay, *Statistical Methods for the Social Sciences* 394 (3d ed. 1997).

rating” was the strongest single predictor. Table 8 shows the relationship between “liability rating” and payment.

Table 8
Liability Rating and Payment

Liability Rating*	Indemnity Paid	Indemnity Not Paid	Percentage Paid	Total
Clear	10	0	100	10
Probable	34	2	94.4	36
Questionable	16	10	61.5	26
Unknown	6	38	13.6	44
None	2	97	2	99
Total	68	147	31.6	215

*A liability rating was not available for 14 of the cases.

Further evidence of the predictive value of the insurer’s internal liability rating comes from the 22 cases that went to trial and the one case that went to binding arbitration (Table 6). Defendants won five motions for summary judgment and obtained 16 defense verdicts. Plaintiffs prevailed only once at trial and once in binding arbitration.

Of the 21 cases won by the defendant, the insurer’s liability rating included one “questionable” case, three “unknown” cases, and 17 “no liability” cases. In contrast, the single plaintiff’s verdict and the binding arbitration award were both from cases with liability rated as “probable.”

Predicting The Amount of Payment

The fact that the insurer concluded that its insured is likely liable in a claim for malpractice tells us very little about the amount that will be necessary to settle the case. A simple linear regression indicates that the relationship between “liability rating” and the amount of the indemnity paid is statistically insignificant. Once the determination to seek a settlement has been made, other factors become important in answering the question of “how much?” Table 9 describes the factors that affect the amount of the indemnity paid, using multiple regression analysis.

Table 9
Factors Affecting Amount of Indemnity Paid

Independent Variables	Standardized Coefficients	t	p
<i>Demographic</i>			
Age of plaintiff	-.272	2.020	.048
Is plaintiff married?	.243	2.266	.027
Is plaintiff a child under 18?	-.170	-1.205	.233
Gender	.063	.599	.552
<i>Medical</i>			
Severity of injury	-.074	-.705	.484
Nature of allegation-diagnosis related	.204	1.822	.073
Nature of allegation treatment related	-.085	-.803	.425
<i>Legal</i>			
Number of plaintiff's experts	.482	4.405	.000
<i>Constant</i>		1.988	.051
R-squared = .419			
Model significance = .000			

When race of the claimant is added as a demographic factor, the results stay significant, and the R-squared increases, but at a price: the race of the claimant was available in 166 of the 229 cases (72.5%). Of the 166 cases in which race was identified, 124 claimants were classified as Caucasian, and 42 were classified as non-Caucasian.

Table 10
Factors Affecting Amount of Indemnity Paid

Independent Variables	Standardized Coefficients	t	p
<i>Demographic</i>			
Age of plaintiff	-.322	-2.294	.026
Is plaintiff married?	.198	1.773	.082
Is plaintiff a child under 18?	-.187	-1.262	.212
Gender	.091	.849	.400
Is plaintiff Caucasian?	.107	.998	.322
<i>Medical</i>			
Severity of injury	-.087	-.790	.433
Nature of allegation-diagnosis related	.206	1.782	.080
Nature of allegation treatment related	-.099	-.908	.368
<i>Legal</i>			
Number of plaintiff's experts	.480	4.316	.000
<i>Constant</i>			
		1.150	.255
R-squared = .445			
Model significance = .000			

Comparing Tables 9 and 10, two variables remain significant: the age of the plaintiff and the number of plaintiff's experts. Neither race nor gender are significant predictors. Marital status is a significant predictor in Table 9, but not in Table 10. None of the medical variables are significant predictors, although the variable "nature of allegation diagnostic related" approached significance in both models.

Severity of injury was not a significant predictor of the amount of payment in either of the two models described above. In that sense, our findings are at variance with Sloan and Hsieh's findings, discussed earlier.²⁶ One reason for this is the fact that the highest severity level—death—resulted in lower average and median payments than those associated with all other severity levels, except severity level 3 (“minor temporary”).²⁷ When death cases are removed from the analysis, “severity of injury” is not a significant predictor of the amount of payment, but the R-squared result improves to .553. While there is some evidence of “vertical equity” in the indemnity payments (Table 1), the average and median payment amounts do not increase in orderly fashion. This may be due, however, to the relatively small numbers we report.

We found large disparities in the amount of indemnity payments within given levels of severity. For example, the six indemnity payments made for severity level 3 (minor temporary injuries) ranged from \$4,618 to \$395,000 (\$97,056 mean, \$42,500 median) and the twenty-five indemnity payments for severity level 9 (death) ranged from \$10,000 to \$750,000 (\$242,271 mean, \$162,500 median). These results echo Sloan and Hsieh's finding about the lack of “horizontal equity” in indemnity payments.²⁸ However, an examination of the attributes of the cases within those two levels of severity provide plausible reasons for the disparity of payment. For the twenty-five death cases, the age of the claimant ranged from infant under one year old to 91. The liability ratings also varied, suggesting that the insurer and plaintiff's counsel adjusted the amounts offered and demanded in light of the probable outcome at trial.

DISCUSSION

It is no accident that out of twenty-two trials and one arbitration, the plaintiff prevailed only twice—a success rate of 8.7%. The insurer acts rationally, settling the cases it believes it may lose, and refusing to settle cases it believes it will win. The strong correlation between the insurer's liability rating and the eventual outcome of the cases (Table 8) bears this point out.

The overall payment rate noted in Table 1 (30.1%) is lower than that reported in other studies.²⁹ This is somewhat surprising because the data consist of filed civil lawsuits, cases in which plaintiff's counsel at least

26. Sloan and Hsieh, *supra* note 12.

27. “Death” cases indemnities are typically less than indemnity payments for major permanent, significant permanent, and grave injuries. Charles Silver *et al.*, *Policy Limits, Payments and Blood Money*, 5 UC IRVINE L. REV. 559, 572 (2015).

28. Sloan and Hsieh, *supra* note 12.

29. Rahmati, *Screening Plaintiffs*, *supra* note 5.

initially felt had a chance of success. However, in sixteen of these cases the insurer incurred defense costs of less than \$5,000, suggesting that plaintiff's counsel abandoned those cases early in the litigation process.³⁰ When those cases are removed, the overall payment rate improves to 33.3%. A liability rating was available for 13 of these 16 cases. Twelve were rated as "no liability" and one was rated as "unknown liability." It comes down to case-picking, and some plaintiff's counsel are clearly better at that than others.³¹

The strong connection between the insurer's internal liability rating and eventual payment of an indemnity reflects the fact that medical malpractice litigation is seldom a contest between equally matched opponents. The insurer has access to internal reviews from physicians practicing in the state along with an experienced set of adjusters. Put more broadly, the insurer is a repeat player working with access to a substantial history of claims, their disposition, and what they may be worth. In addition, the insurer relies on a small number of defense counsel (25 in this study) to defend 229 lawsuits, or an average of over nine lawsuits per attorney. Thus, in the context of medical malpractice litigation, defense counsel are themselves repeat players. The same cannot be said about plaintiff's counsel. The 229 plaintiffs were represented by 128 different lawyers, an average of less than two lawsuits per attorney. As a result, plaintiff's counsel can expect to be opposed by defense counsel of at least equal, and probably greater experience in medical malpractice litigation. Once again, astute case-picking seems to be the critical skill for a plaintiff's lawyer to have.

The number of plaintiff's experts was the strongest predictor of the amount of the indemnity paid. This, too, makes sense. The number of experts a plaintiff can recruit depends upon the strength of the plaintiff's case. It also depends upon the amount of money plaintiff's counsel is willing to spend, and the amount of money plaintiff's counsel believes can be recovered. The number of defense experts, relative to the number of plaintiff's experts, had little impact on the amount paid. In only 13 of the 71 cases in which money was paid did the number of plaintiff's experts exceed the number of defense experts. In the remaining "indemnity paid" cases, the number of plaintiff's experts was either less than or equal to the number of defense experts.

30. *Id.*

31. Plaintiff lawyers who specialize in medical malpractice are notoriously picky about the cases they take on, but some plaintiff's lawyers are pickier than others. See David A. Hyman, *Medical Malpractice Litigation and the Market for Plaintiff-Side Representation: Evidence from Illinois*, 13 J. EMP. LEGAL STUDIES 603 (2016).

CONCLUSION

There is evidence of rationality not only in the fact of payment, but in the amount of payment made. The determination of what claims will be paid is largely a function of the insurer's assessment of liability. The determination of amount of payment seems to be affected by non-medical factors, specifically the number of plaintiff's experts, the plaintiff's age, and the plaintiff's marital status. These results should not be surprising. Medical factors, as reflected in the insurer's liability rating, are taken into account in making the determination to settle the claim. Once that decision is made, non-medical factors become more important, such as the apparent strength of the plaintiff's case (the number of experts), the plaintiff's age, and the plaintiff's marital status. In light of the relatively small number of cases examined in this study, further research would be useful.