Medical Malpractice and Wrongful Death: Some Lives Are Worth More Than Others

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Abstract

We examined the outcomes and case characteristics of all the wrongful death lawsuits defended by a medical malpractice insurer in Virginia and North Carolina from 2009 through 2014. We derived our data from the insurer’s closed claims files. Our goal was to identify the factors that affected whether compensation was paid, as well as the factors that affected the amount of compensation, when that occurred. Using multivariate analysis, we found that four variables had predictive power: the claims adjuster’s assessment of liability, the age of the deceased, the marital status of the deceased, and whether the primary physician-defendant was engaged either as a specialist, or in primary care.

I. Introduction

Medical malpractice litigation does not suffer from a lack of scholarly attention. Much is known about the process. Numerous studies have demonstrated, for example, that medical malpractice litigation is a largely rational system. Meritorious claims (if made) usually receive compensation, and non-meritorious claims usually don’t receive compensation.\(^1\) In general, as the severity of the injury increases, the level of compensation increases as well- an effect known as “vertical equity.”\(^2\)


Large issues have been identified, if not addressed. For example, only a small minority of “avoidable medical injuries” ever become the subject of a claim against the provider. Given the small number of claims relative to the number of avoidable medical injuries, and the wide variation in amounts when compensation is paid for injuries of similar severity, medical malpractice litigation can be criticized for failing to perform either of the two basic functions of tort law: deterrence and compensation. There is reason to believe that compensation, when it occurs, tends to be inadequate even when only economic damages are considered.

The overhead associated with the claims resolution process is very high. The claims resolution process is often slow. Bringing a medical practice lawsuit is an expensive proposition. Most claims go unpaid. Plaintiffs seldom win medical malpractice trials.

The number of medical malpractice suits filed has been decreasing over the past several years, although observers disagree over the reasons for the decline. Many observers believe that the widespread use of caps on damages discourage

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3 Studdert et al., supra n. 1. “Avoidable medical injuries” is a term used primarily in the medical literature. As explained by Sloan and Hsieh, an “avoidable medical injury” is an injury that “could have been prevented with good medical care.” Sloan and Hsieh, supra n. 1 at 1010.


6 Frank Sloan et al., SUING FOR MEDICAL MALPRACTICE at 206 (1993).

7 Studdert et al., supra note 1.

8 Studdert et al., supra n. 1; Lieber, supra n. 1 at 521.

9 Shepherd, supra n. 5 at 165 (survey results indicating an average cost of $100,000 to bring a malpractice suit to trial).

10 Anupam Jena et al, Malpractice Risk According to Physician Specialty, 365 NEW ENGL. J. MED. 629 (2011) (hereinafter “Jena et al.”); but see Studdert et al., supra n. 1 (reporting a payment rate of 56% for all claims made).

11 See, e.g., Sloan and Hsieh, supra n. 1 at 1007 (reporting that plaintiffs win at trial about 22% of the time; Shepherd, supra n. 5 at 183 (reporting that plaintiffs won at trial of about 27%).

attorneys from bringing at least certain types of medical malpractice lawsuits.\textsuperscript{13} Other observers point out that the costs of prosecuting a medical malpractice lawsuit have the effect of making any claims for small or modest damages simply not worth the trouble.\textsuperscript{14}

It is easy, and tempting, to think of medical malpractice in binary terms: the defendant is either liable, or the defendant is not liable. The standard for determining liability does not vary greatly by jurisdiction: did the defendant breach the appropriate standard of care?\textsuperscript{15} Determination of the appropriate standard of care usually depends upon expert testimony as to “custom.” Physicians are judged in terms of what other physicians would do in similar circumstances.\textsuperscript{16}

This binary question of liability is only the first question, however. While the claim is pending, a second, equally difficult\textsuperscript{17} question arises. If a determination of liability is made, what are the damages? On this question, less is known. Twenty-five years ago, Sloan and Hsieh took on this question by examining reports filed by medical malpractice insurers with the Florida Department of Insurance as well as jury verdict reports from five states.\textsuperscript{18} They found evidence of vertical equity, but not for horizontal equity. In other words, as the severity of injury increased, so did the amount of compensation (vertical equity); but within a given level of severity,\textsuperscript{19} compensation varied considerably (horizontal inequity).\textsuperscript{20} This was not surprising. As the authors explained, injuries within the same level of severity can nonetheless justify a wide range of damage

\textsuperscript{13} See, e.g., Hyman and Silver, \textit{supra} n. 12; Frakes, \textit{supra} n. 5 at 330.
\textsuperscript{14} Shepherd, \textit{supra} n. 5 at 153-4.
\textsuperscript{15} There is, however, variation among the states as to whether the standard of care should be assessed in terms of the defendant’s community, the defendant’s community or similar communities, or in terms of a national standard of care. See Dobbs, Hayden and Bublick, \textit{THE LAW OF TORTS} 2nd Ed. 297, 303 (West 2011).
\textsuperscript{16} Dobbs, Hayden and Bublick, \textit{THE LAW OF TORTS} 2nd Ed. section 292 (West 2011).
\textsuperscript{17} If the case goes to trial, and liability is established, the amount of damages becomes a jury question. The process of arriving at an appropriate number can be difficult. See Mark Geistfeld, \textit{Putting a Price on Pain and Suffering: A Method for Helping Juries Determine Tort Damages for Nonmonetary Injuries}, 83 CAL. L. REV. 773 at 783 (1995); “jurors report that determining damages is more difficult for them than is deciding on liability” (quoting Shari Diamond). See also David Leebron, \textit{Final Moments: Damages for Pain and Suffering Prior to Death}, 64 N.Y.U. L. REV. 256, 264-270 (1989).
\textsuperscript{18} Sloan and Hsieh, \textit{supra} n. 1 at 1003.
\textsuperscript{19} Sloan and Hsieh used the injury scale adopted by the National Association of Insurance Commissioners. The scale classifies severity of injury by relying on nine levels of injury: emotional only; temporary insignificant; temporary minor; temporary permanent; permanent minor; permanent significant; permanent major; grave; and death. The NAIC injury scale is widely used by insurers.
\textsuperscript{20} Id. at 999. See also Geistfeld, \textit{supra} n. 17 at 784.
awards. One level of severity, however, is the same for all claimants—death. In this paper, we examine wrongful death claims and awards in order to assess the “horizontal equity” within that category of claims.

II. Procedure

We obtained closed claims files from a medical liability insurer doing business in North Carolina and Virginia. Closed claims files are a rich and reliable source of information about the malpractice claims resolution process. The files covered the years 2009 through 2014. We examined all the closed files (n=256) in which a patient had died, and a lawsuit against one or more of the company’s insureds had been filed as a result. The closed files contained information on the gender and marital status of the deceased, and usually the deceased’s age. The files also indicated the number of defendants and their medical specialties, along with the specific medical allegations made by the plaintiff. The files contained information about the final disposition of the claim, as well as the amount (if any) paid to the claimant. In addition, the files contained the claims adjuster’s assessment of liability, accompanied by detailed descriptions of the alleged injuries. In short, we had access to the same information that the insurer had, rather than summaries of claims received and paid, and submitted to a state regulator.

Because claims for medical malpractice can be asserted against more than one provider, we then identified the files (n=123) in which only the company’s insureds were involved, or in which we knew the outcome for all co-defendants not insured by the company. We did this in order to capture only those files which included all potential defendants. Since one of our goals was to gather data on the value of a life wrongfully taken, we wanted to examine only “complete” lawsuits.

The Relevant Law

21 Sloan and Hsieh, supra n. 1 at 1026. For example, severity level 6 on the NAIC scale (“significant permanent” includes injuries such as “deafness, loss of limb, loss of eye, loss of one kidney or lung.”
22 Schwartz, supra n.1 at 1231.
23 The insurer files usually indicated the presence or absence of a non-insured co-defendant. However, to determine if a case was in fact “complete,” we read through all the text provided in the closed files for indications that an additional party might be a co-defendant.
The substantive law of medical malpractice is similar in North Carolina and Virginia. Liability in both states turns on whether the defendant physician deviated from the standard of care. In both states the standard of care is essentially a “same or similar locality” standard. In both states the standard of care is usually determined with expert testimony from other physicians practicing in the same field or specialty. Both Virginia and North Carolina are contributory negligence states, meaning that any fault on the part of the plaintiff will bar his or her recovery. Both states have caps on damages, but they differ in type and amount. The Virginia damages limitation is a “hard cap,” since it limits the total amount a plaintiff may recover, including both economic and non-economic damages. From July 1, 2008 until June 30, 2012, the cap was $2,000,000. The cap then increased by $50,000 every year, so that by the end of 2014 the cap was $2,150,000. In contrast, since 2011 North Carolina has imposed a cap on non-economic damages, but not on economic damages. The “soft cap” on non-economic damages in North Carolina was set at $500,000 in 2011. Beginning in 2014, the cap is tied to changes in the Consumer Price Index. It is doubtful whether the caps in either state affected the amounts paid. If the caps had any effect on the settlement amounts we report on, they seem to have depressed awards in both states. The highest Virginia settlement paid was $1,700,000, substantially below the cap. The highest North Carolina settlement was $1,500,000.

Characteristics of the Closed Files

The plaintiffs in the “complete” cases consisted of 54 males and 69 females. The ages of the plaintiffs ranged from newborns to 91 years old. The average age

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24 N.C.GEN. STAT. § 90-21.12(a); VA. STAT. § 8.01-581.20.
25 Id.
26 North Carolina: Smith v. Whitmer, 150 N.C. App. 192, 582 S.E. 2nd 669 (2003); see also N.C. GEN. STAT. 8C-1, Rule 702(b); Virginia: VA. STAT. 8.01-581.20(A); see generally Hyman and Silver, supra n. 12 at 554.
28 VA. STAT. § 8.01-581.15.
29 Id.
30 Id.
32 Id
33 There were no plaintiff’s verdicts in either state during the study’s time period.
was 52.9 years with a median of 54 years.\textsuperscript{34} Six plaintiffs were under the age of 18; 10 were single adults; 61 were married; four were either separated or divorced, and four were widowed. For thirty-eight plaintiffs, this information was unavailable.\textsuperscript{35}

The injury severity level for all the files was of course the same—death. North Carolina claims predominated; there were 89 lawsuits filed in North Carolina and 34 filed in Virginia. Sixty different venues in the two states were represented. The most frequent North Carolina venue was Mecklenburg County (Charlotte) (n=12). The most frequent Virginia venue was Norfolk (n=6). Wrongful death plaintiffs fared better in Virginia than in North Carolina. Plaintiffs recovered an indemnity payment in 18 of the 34 Virginia cases (52.9\%), while plaintiffs recovered an indemnity payment in 29 of the 89 North Carolina cases (32.6\%).

The 123 plaintiffs were represented by 91 different attorneys. Only two attorneys handled more than four cases, and only five attorneys handled more than two cases. In three cases, the plaintiff did not have an attorney.\textsuperscript{36} In contrast, defendant physicians were represented by only 29 different attorneys. On the defense side, six attorneys accounted for more than half (68) of the cases. Forty-two of the 91 plaintiff’s attorneys recovered an indemnity payment for at least one of their clients.

Most of the time, only a single physician and his or her practice were sued. Thirty-four of the 123 cases named more than one physician as defendants. The three specialties most frequently sued for wrongful death were medical specialties: family practice (n=21); radiology (both internal and diagnostic) (n=11) and internal medicine (n=11). The most frequently sued surgical specialty was general surgery (n=5), followed by OB/GYN, urology and bariatric surgery (n=4).\textsuperscript{37}

Fifty-eight of the cases were either dropped or involuntarily dismissed by the court. Five cases were dropped in exchange for payment, in whole or in part, of the

\textsuperscript{34} Information about the plaintiff’s age was unavailable in 50 of the cases.
\textsuperscript{35} Likewise, information about the plaintiff’s race was unavailable.
\textsuperscript{36} In each of those three cases, the plaintiff was unsuccessful in obtaining compensation.
\textsuperscript{37} In a larger study of medical malpractice claims and payments, Jena et al. reported that claims against surgical specialties such as neurosurgery, thoracic-cardiovascular surgery and general surgery were much more frequent than claims against medical specialties such as family practice and pediatrics. That study looked at claims at all levels of injury severity; our study considers only claims at a single level of severity. Jena et al., \textit{supra} n.10.
plaintiff’s counsel’s costs, but without any money being paid to the plaintiff. Forty-seven cases were settled with money paid to the plaintiff at some point before a verdict. Thirteen cases went to trial. All resulted in defense verdicts. Two of those cases were appealed and affirmed by the appellate court.

Table 1
Case Outcomes

<table>
<thead>
<tr>
<th>Case Outcome</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Involuntarily Dismissed</td>
<td>8</td>
<td>6.5</td>
</tr>
<tr>
<td>Dropped by Plaintiff</td>
<td>50</td>
<td>40.6</td>
</tr>
<tr>
<td>Dropped for Costs</td>
<td>5</td>
<td>4.1</td>
</tr>
<tr>
<td>Settled before Verdict</td>
<td>47</td>
<td>38.2</td>
</tr>
<tr>
<td>Tried to Verdict</td>
<td>13</td>
<td>10.6</td>
</tr>
</tbody>
</table>

Payments to the plaintiff (indemnities) were not frequent, occurring only 38.2% of the time. Nonetheless, this payment rate is higher than the rate of payment for all claims. Of equal importance is the fact that over the six year period studied, there were no plaintiff verdicts at all. This finding should not be surprising; one would expect a repeat player such as a liability insurer to settle cases it believes it will not win, and to try only those cases it believes it will win.

The 47 indemnity payments varied considerably, ranging from $50,000 to $1,700,000, with a mean of $494,777 and a median of $395,000.

Table 2
Indemnity Payments

<table>
<thead>
<tr>
<th>Amount Recovered</th>
<th>Number of Cases</th>
<th>Average Amount</th>
</tr>
</thead>
</table>

38 See Jena et al., supra, figure 2; see also U.S. Dept. of Justice Bureau of Justice Statistics, Majority of Medical Malpractice Claims in Seven States Closed Without Compensation Payments, available at www.bjs.gov/index.cfm?ty=pbdetailiid=783.
40 The amount recovered in “death” cases is usually less than the amount recovered in cases involving injuries described as “grave,” particularly when the plaintiff will require long-term medical care. Sloan and Hsieh, supra n. 1 at 1008, 1019.
The severity of the injury was the same in all cases (death) and each case involved only one individual. Why the wide disparity in results? That is the central problem this paper addresses.

III. Results

Eighteen of the fifty-four males received an indemnity payment (33.3%). The payments ranged from $50,000 to $1,700,000, with a mean of $526,361 and a median of $325,000. Twenty-nine of the sixty-nine females received an indemnity payment (42%). The payments ranged from $50,000 to $1,500,000, with a mean of $475,172 and a median of $395,000. A one-way ANOVA analysis was not significant (p=.712). Gender, in short, did not explain the different levels of payment.41

Marital status mattered more than gender. We sorted the plaintiffs into five categories: single; married; separated or divorced;42 widowed; and child under eighteen.43 The results in Table 3 summarize the outcomes.

Table 3

<table>
<thead>
<tr>
<th>Marital Status</th>
<th>Number of Cases</th>
<th>Number of Cases with Paid Indemnity</th>
<th>Percentage Paid</th>
<th>Average Amount of Paid Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single</td>
<td>10</td>
<td>3</td>
<td>30</td>
<td>315,000</td>
</tr>
<tr>
<td>Married</td>
<td>61</td>
<td>23</td>
<td>37.7</td>
<td>561,304</td>
</tr>
</tbody>
</table>

41 This result is consistent with the findings of Sloan and Hsieh, supra n. 1 at 1024.
42 We chose to group “separated” and “divorced” together because the determination is made at the time of death. The fact that the plaintiff was either separated or divorced suggests the lack of a close legally recognized partner at the time of death. This in turn might affect the determination of damages.
43 We were unable to determine marital status for 38 plaintiffs.
The stage at which the lawsuit was resolved affected the amount recovered by the plaintiff. We identified four stages at which a case might settle during the lawsuit: before mediation; at mediation; after mediation but before trial; and before verdict. The amount paid in settlement grew (on average) the closer the lawsuit got to trial. (Table 4).

**Table 4**

Payments By Stage of Litigation

<table>
<thead>
<tr>
<th>Stage of lawsuit</th>
<th>Number of cases</th>
<th>Mean</th>
<th>Median</th>
</tr>
</thead>
<tbody>
<tr>
<td>Before mediation</td>
<td>7</td>
<td>377,857</td>
<td>150,000</td>
</tr>
<tr>
<td>At mediation</td>
<td>7</td>
<td>437,071</td>
<td>200,000</td>
</tr>
<tr>
<td>Before trial</td>
<td>30</td>
<td>530,833</td>
<td>400,000</td>
</tr>
<tr>
<td>Before verdict</td>
<td>3</td>
<td>541,667</td>
<td>600,000</td>
</tr>
</tbody>
</table>

This result makes sense. The insurer would be expected to pay more to resolve a claim that has survived at least a motion to dismiss for failure to state a claim, and perhaps a motion for summary judgment as well. Nonetheless, the numbers in Table 4 suggest that patience on the part of plaintiff’s counsel pays off.

When a lawsuit is filed, the insurer’s claims adjuster reviews the material received, speaks with the insured, obtains and reviews the relevant medical records, and often solicits outside reviews from physicians. After compiling this

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44 As noted previously, there were no verdicts for the plaintiff over the six year study period.
45 See Sloan and Hsieh, supra n. 1 at 1019.
46 There are times, however, when plaintiff’s counsel may not have the luxury of being patient. The lawsuit may need to survive a series of potentially dispositive motions prior to trial.
47 Expert testimony is central to most medical malpractice lawsuits, because it is through their testimony that the applicable standard of care is determined. Hyman and Silver, supra n.12, at 554.
information, the adjusters also indicate their assessment of liability. This determination is made prior to the resolution of the case.

The scale used by the insurer consists of five categories. By decreasing level of anticipated liability, the scale runs from “clear” to “probable” to “questionable” to “unknown” to “none.” As Table 5 shows, the adjuster’s assessment of liability is closely related to the plaintiff’s recovery.

Table 5
Adjuster’s Assessment of Liability and Outcome

<table>
<thead>
<tr>
<th>Liability Assessment</th>
<th>Number of Cases</th>
<th>Number of Cases with Indemnity Paid</th>
<th>Percentage</th>
<th>Average Amount of Paid Claims</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clear</td>
<td>9</td>
<td>9</td>
<td>100</td>
<td>777,222</td>
</tr>
<tr>
<td>Probable</td>
<td>20</td>
<td>20</td>
<td>100</td>
<td>416,000</td>
</tr>
<tr>
<td>Questionable</td>
<td>16</td>
<td>11</td>
<td>68.8</td>
<td>501,773</td>
</tr>
<tr>
<td>Unknown</td>
<td>31</td>
<td>5</td>
<td>16.1</td>
<td>375,000</td>
</tr>
<tr>
<td>None</td>
<td>47</td>
<td>2</td>
<td>4.3</td>
<td>272,500</td>
</tr>
</tbody>
</table>

As the adjuster’s assessment of liability moved downward, the likelihood of a recovery decreased, step by step. Except for “probable” and “questionable” liability, the average amount recovered by the plaintiff decreased as well. At the extremes (“clear” liability and “no” liability), the difference is dramatic. For the same injury, cases of clear liability were worth twice what cases of unknown liability were worth, and almost three times what cases of no liability were worth. In other words, even in those rare cases in which the adjuster first decided there was no liability but then chose to settle the claim with an indemnity payment, the amount paid was still markedly less than a claim with unknown, questionable, probable or clear liability - as determined by the adjuster.

Multivariate analysis indicates that several variables have predictive power as to whether an indemnity is paid, and, if an indemnity is paid, the amount. Those variables are the insurer’s assessment of liability, the marital status of the plaintiff,
the plaintiff’s age at the time of death, and whether the primary defendant was engaged in primary care.

Table 6: Factors That Correlate With Payment and Amount of Compensation

<table>
<thead>
<tr>
<th>Independent Variables</th>
<th>Standardized</th>
<th>t</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Coefficients</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Was plaintiff a child?</td>
<td>-.182</td>
<td>-1.289</td>
<td>.204</td>
</tr>
<tr>
<td>Was plaintiff not married?</td>
<td>-.156</td>
<td>-1.361</td>
<td>.181</td>
</tr>
<tr>
<td>Age of plaintiff at death</td>
<td>-.188</td>
<td>-1.364</td>
<td>.180</td>
</tr>
<tr>
<td>Was the primary defendant engaged in primary care?</td>
<td>-.184</td>
<td>-1.698</td>
<td>.097</td>
</tr>
<tr>
<td>Insurer’s assessment of liability</td>
<td>-.680</td>
<td>-6.429</td>
<td>.000</td>
</tr>
<tr>
<td>Constant</td>
<td>6.781</td>
<td></td>
<td>.000</td>
</tr>
</tbody>
</table>

R-squared =.544 Adj. R-squared =.489

Model significance =.000

An analysis using all available cases – cases in which a physician insured by the insurer was sued, but in which there were co-defendants not insured by the insurer as well (n=252) – yielded very similar, equally significant results.

IV. Discussion

Our findings add support to the view that the outcome of medical malpractice litigation is rational. Claims of clear or probable liability are much

48 “Engaged in primary care” includes, for example, family practitioners, internists, and pediatricians.
more likely to be paid than claims of questionable, unknown, or no liability.\textsuperscript{49} Otherwise, the fact that assessment of liability predicts payment outcomes may seem unremarkable. If a claims adjuster concludes that the insured physician faces certain or probable liability, it makes sense for the insurer to negotiate for a smaller amount in settlement rather than risk a jury award that will likely be much higher.\textsuperscript{50} Likewise, if an adjuster concludes that the insured physician is not liable for the plaintiff’s death, a settlement offer will rarely be made. This common-sense observation takes on more meaning, however, when the situation is viewed from the perspective of the plaintiff’s attorney. The plaintiff’s attorney functions as a gatekeeper.\textsuperscript{51} He or she decides whether to accept the plaintiff’s case. Since the attorney is under no obligation to accept every case offered, and since the attorney will be compensated only if money is recovered, plaintiff’s attorney will accept only those cases he or she believes have monetary value.\textsuperscript{52} But how does plaintiff’s attorney determine which cases have monetary value? He or she can rely on instinct or on the emotional impact the case would have at trial, but those are not good measures. Our results instead indicate that the key for a plaintiff’s attorney is to “think like a claims adjuster.” The plaintiff’s attorney needs to determine whether the case in front of him or her is a case of clear, probable, or at least questionable liability. The data we report indicate that accepting a case of either no or unknown liability (as determined by the claims adjuster) will result in no payment at all. It is, in short, a matter of astute case-picking. The data we report indicate that some attorneys are much better than others at this skill. Given the strong results for plaintiffs when the adjuster assesses liability as “clear” or “probable” and the poor results for plaintiffs when the adjuster assesses liability as “unknown” or “none,” (Table 5) it may be that the traditional skills of advocacy and persuasion that would ordinarily be valued by a client don’t really matter that much in this context. Instead, room for advocacy and persuasion seems to exist only for “questionable” cases- the only category in which the outcome was not

\textsuperscript{49} See authorities collected at n. 1, supra. See also Ralph Peeples, Catherine Harris and Thomas Metzloff, \textit{The Process of Managing Medical Malpractice Cases: The Role of Standard of Care}, 37 WAKE FOREST L. REV. 877 (2002).

\textsuperscript{50} Sloan and Hsieh, \textit{supra} n. 1 at 1000.

\textsuperscript{51} Catherine Harris, Ralph Peeples and Thomas Metzloff, \textit{Does Being a Repeat Player Make a Difference? The Impact of Attorney Experience and Case-Picking on the Outcome of Medical Malpractice Lawsuits}, 8 YALE J. HEALTH POLICY, LAW AND ETHICS 253, 157 (2008).

\textsuperscript{52} There is reason to believe that the overall acceptance rate of medical malpractice cases by plaintiff’s counsel is substantially less than 50%. See Shepherd, \textit{Uncovering the Silent Victims of the American Medical Liability System}, 67 VAND. L. REV. 151, 183 (2014).
lopsided. Overall, in light of the results in Table 5, what seems to happen is that plaintiff’s counsel becomes “educated” about the case, on the basis of the claims’ adjuster’s superior information, as the case progresses.

The idea that a successful plaintiff’s attorney needs to “think like an adjuster” leads to another point. The reason why a plaintiff’s attorney needs to “think like an adjuster” is that the insurer’s assessments hold up. The way in which these assessments might be challenged is by going to trial. That is an option seldom taken, and probably for good reason. The adjuster’s assessment is based not only on the medical records, but also on reviews of physicians practicing in the same specialty as the defendant. As a result, the adjuster will usually have a much better idea of how the case would be decided than will plaintiff’s counsel. While bargaining between plaintiff’s counsel and the insurer certainly occurs, our data suggest that the insurer holds the high cards— even when liability is deemed probable or clear.

Other variables also affect payment, and the amount of payment, including the marital status and age of the deceased, and whether the primary defendant was engaged in primary care. The negative beta scores indicate that in general, the amount recovered decreases as the plaintiff-decedent grows older. Plaintiffs who were married at the time of their death receive more money than plaintiffs who were not married, or who were under the age of eighteen. Plaintiffs who sue a specialist, rather than a primary care provider, tend to recover more money. These results make some sense. One would expect that, in general, the value placed on the life of a 21 year old would be greater than the value placed on the life of a 63 year old on the verge of retirement. One might also expect the value placed on the life of a married plaintiff would be higher than that of an unmarried plaintiff, since the married plaintiff will leave a widowed spouse behind. The connection between payment and the amount of payment to the primary physician’s type of practice is a little more puzzling. Perhaps the causal connection between negligence and injury seems more clear when a specialist, performing a particular procedure, loses a patient. A primary care physician, in contrast, would usually be faulted for missing a diagnosis, or for not acting quickly enough. These alleged failings

53 The plaintiff’s chances at trial are usually not good. See n.11, supra.
54 The asymmetry of information between plaintiff and defendant in medical malpractice litigation has been noted frequently in the literature. See, e.g., Sloan and Hsieh, supra n. 1 at 1002.
(typically diagnosis-related) are less vivid than the alleged failings of a specialist (typically performance-related).

Factors other than the ones we have identified certainly exist. For example, in light of the Virginia and North Carolina wrongful death statutes, the earnings potential of the decedent would likely make a difference.\textsuperscript{55} Perhaps the reputation of the plaintiff’s counsel matters. Perhaps the negotiating skill of the plaintiff’s counsel matters. Since the ultimate question in any wrongful death case is, what would a jury decide, perhaps the venue of the case matters as well.

Our study suggests that more research is needed as to the second question that a medical malpractice lawsuit poses: if the defendant is liable, what amount of damages would be appropriate? Our approach has been empirical, gathering information on the actual amounts paid in compensation for wrongful death cases in which medical malpractice is alleged. Our sample size is relatively small, although it includes every closed case in the insurer’s records for the study period. A larger study would provide new insights into the question of the appropriate amount of damages.

\textsuperscript{55} Both statutes require, among other things, a calculation of the decedent’s earning potential. See N.C.GEN.STAT. § 28A-18-2(b) and VA. CODE § 8.01-52.