

Medical Malpractice and the Tort System in Illinois

A Report to the Illinois State Bar Association

May 2005

By

**Neil Vidmar, Ph.D.
Russell M. Robinson II Professor of Law
Duke Law School
and
Professor of Psychology
Duke University**

Durham, North Carolina

I am indebted to the following persons for invaluable assistance on this project: My research assistant, Kara MacKillop; Judy Nelson and Matt Melucci of the Madison County Circuit Clerk's Office; John Kirkton of the *Cook County Jury Verdict Reporter*, and Dr. Paul Lee of Duke Medical School.

The opinions and conclusions in this report are my own and are not necessarily the opinions and conclusions of Duke Law School.

Executive Summary

To examine the incidence, frequency, size of verdicts and other aspects of the medical malpractice system in Illinois, this study looked at statewide data where available, and concentrated on two regions: Cook and DuPage counties, which comprise almost half the population of the state of Illinois and two-thirds of its doctors; in addition it examined Madison and St. Clair counties, which have been characterized as “judicial hellholes.”

For Cook and DuPage counties:

- The data show no upward trends in filings or in filings per 100 treating physicians from 1994 through 2004, when adjusted for population growth.
- By one measure there was a modest decrease in medical malpractice trials between 1996 and 2001. Plaintiff win rates increased, but this change may be ascribed to other factors related to how cases are selected for trial.
- A different set of data showed no increase in jury trials or in plaintiff win-rates between 2001 and 2004.
- Settlement mechanisms such as pre-verdict high-low agreements, acceptance of the limits of the doctor’s insurance policy and other devices showed that many jury verdicts were substantially reduced in the post-verdict phase of the lawsuit.

A similar analysis in Madison and St. Clair counties reveals the following:

- Over a 14-year period from 1992 through the first part of 2005, only 11 jury verdicts favoring the plaintiff in medical malpractice cases were found in Madison and St. Clair county courts. Only two verdicts exceeded \$1 million.

- There is no evidence to support the perception that medical malpractice jury trials in these counties are frequent or that jury verdicts for plaintiffs are outrageous.
- Insofar as medical malpractice litigation is concerned, the reputation of Madison and St. Clair counties as “judicial hellholes” is not justified.

An analysis of the data from Cook and DuPage counties revealed that a \$500,000 cap on non-economic damages would have resulted in a minimal reduction in overall payouts to plaintiffs and would be unlikely to affect doctors’ liability insurance premiums. But such a cap would result in significantly reduced compensation for some individual plaintiffs who suffered catastrophic injuries through medical negligence.

An analysis of data from the American Medical Association does not support the claims that Illinois in general and Madison and St. Clair counties in particular are losing doctors:

- There has been a steady increase in the absolute number of Illinois’ total patient care physicians, including OB-GYNs and neurological surgeons.
- American Medical Association statistics through 2003 do not support claims of a loss of doctors in Madison and St. Clair counties.

The Illinois tort system does not appear to be the cause of the undisputed fact that doctors’ liability insurance premiums showed dramatic rises. It is time to consider other causes of the insurance premium increase.

Chapter 1

Investigating the Tort System as the Cause of Medical Liability Insurance Increases

Let us be clear from the beginning. There is no dispute about the fact that, beginning about the year 2001, the medical liability insurance premiums for some doctors rose very dramatically in Illinois as they did elsewhere in the U.S. Thus, it is reported that one obstetrician-gynecologist saw his malpractice liability insurance premium jump from \$138,031 in 2003 to \$230,428 in 2004.¹ Such increases are a serious impediment to practicing doctors and ultimately could have major effects not only on their incomes, but also on the viability of their practices and the health care of the patients they serve.

The cause of the problem is hotly contested. Physicians, insurance companies and business organizations assert that the cause of the problem is the tort system in which patients file lawsuits against their doctors claiming medical negligence resulted in a serious injury. Then, they say, attempts to settle the lawsuit center on the likelihood that juries will be unfairly biased in favor of finding negligence and awarding unjustified large sums of money to the patient. In particular, they say, there is great fear of an outrageous award for “pain and suffering” above and beyond money for any incurred medical costs and lost income. Doctors and their liability insurers are forced to agree to inflated settlements because of fear that if the case goes to trial they will likely suffer even greater economic losses. This is called the “shadow effect” of jury trials.

The President of the Illinois Hospital Association is quoted as saying that large awards have risen dramatically in both size and frequency since the year 2000 and hospitals in Cook County said that their situation was especially dire.²

¹ Georgina Gustin and Phil Dine, *Lax Insurance Regulation is Core of Malpractice Crisis*, SAINT LOUIS POST DISPATCH, January 1, 2005.

² Daniel Vock, *Legislators take Med-Mal Deadlock Head-on*, CHICAGO DAILY LAW BULLETIN February 23, 2005.

Madison and St. Clair counties in southwestern Illinois have received particular attention and have been characterized as “judicial hellholes” where juries have made unjustified awards.³

In contrast, plaintiff lawyers and consumer groups offer a different explanation for the problem. These groups assert that the cause lies with the business cycle in the medical insurance industry, claiming that the cycles are recurrent. In their view the problem is that insurers under-price premiums in good economic times and under-estimate future payouts. In addition downturns in the bond and stock markets where insurers invest their reserves add to the financial problems. The end result, these groups claim, is that when economic fluctuations in the business cycle squeeze income, the insurers raise their rates and blame plaintiff lawyers and juries.⁴

The Illinois State Bar Association, with 30,000 members, is the largest bar association in Illinois. It is a voluntary-membership association that provides a wide range of professional services for lawyers, and education and services for the public. Its membership includes lawyers representing plaintiffs and defendants in civil matters, as well as lawyers practicing in many other fields of law. This organization commissioned me to research the tort system as it pertains to medical malpractice litigation in Illinois. The tort system is only one part of the debate, but providing information about certain questions can shed important light on contentious issues: Have medical malpractice claims increased? Have jury trials increased? Have jury awards for medical malpractice increased? Have Madison and St. Clair counties earned their reputation as “judicial hellholes” insofar as medical malpractice claims are concerned? Is there evidence that doctors are leaving the state or certain areas of the state as a result of jury awards?

I was chosen to undertake this research because I have been studying and writing about medical malpractice litigation since 1990. In addition to

³ Anonymous, *Madison County: Bush in the “Hellhole*, ST. LOUIS TODAY, January 5, 2005; William Lamb, *Illinois Trauma Cases Surge at SLU*, STL TODAY, January 10, 2005.

⁴ Joseph Treaster and Joel Brinkley, *Behind those Medical Malpractice Rate Hikes*, 151 CHICAGO DAILY LAW BULLETIN (February 22, 2005),

various articles in scholarly journals and law reviews, I wrote a book on the subject, *Medical Malpractice and the American Jury: Confronting the Myths about Jury Incompetence, Deep Pockets and Outrageous Damage Awards*, University of Michigan Press (1995).

Writing books and articles does not come without the possibility of being perceived to have a bias. Although, as the title of the book implies, I drew the conclusion that many claims about irresponsible juries in medical malpractice trials were unwarranted, my conclusions were based on careful, systematic empirical research. Plaintiff lawyers, not surprisingly, liked the book's conclusions, but I also received praise in the *Journal of the American Medical Association*, which said: "Tort reformers have often portrayed juries in medical malpractice cases as overly generous and irresponsible.... In *Medical Malpractice and the American Jury*, the author successfully counters this portrayal with a well-reasoned, painstaking analysis of jury verdicts and damage awards...."

When I agreed to undertake the present research, the Illinois State Bar Association understood that I would draw conclusions based on whatever the evidence led me to conclude and that no restrictions would be placed on what I wrote in the report.

Because the topic is contentious and interpretations open to questions, I undertook the research with a safeguard: transparency. All of the research data will be made available to any person or group that requests it. This is actually an easy task since I drew most of my conclusions from data sources that are readily available to the public or, in the case of verdict reports, can be obtained with little effort by interest groups.

Data Sources

In the chapters that follow I describe the data sources, but a brief recitation here will be helpful. One primary source was verdict reporters. These included the *Cook County Jury Verdict Reporter* and the *Southwestern Illinois*

Jury Verdict Reporter. These data were supplemented by databases on verdicts and appellate courts available in *Westlaw*, *Lexis*, and *Findlaw*, primary on-line commercial sources used by legal researchers. The *Cook County Jury Verdict Reporter* is one of the oldest and most comprehensive sources of data for Cook and DuPage counties and, as I discovered, more comprehensive than other verdict reporters and more comprehensive than databases on verdicts compiled by the U.S. Department of Justice's Bureau of Justice Statistics. In addition, when crucial information was missing from verdict reports, I placed telephone calls to lawyers involved in the case and obtained that information.

The *Southwestern Illinois Jury Verdict Reporter* covers Madison and St. Clair counties and is available on-line through *Westlaw* and *Lexis*. I personally checked the accuracy of the Madison County reports by traveling to Edwardsville and reviewing every one of the medical malpractice verdicts it listed, finding no errors in the summaries, although in some instances I uncovered supplemental information about the cases.

I also researched the data compiled by the Bureau of Justice Statistics of the U.S. Department of Justice. As will be described in Chapter 3, the BJS in collaboration with the National Center for State Courts, as part of its Civil Justice Survey of State Courts, conducted nationwide surveys of civil jury verdicts in 1996 and 2001. Those surveys included the courts in Cook and DuPage counties. The data are archived by the Inter-university Consortium of Political and Social Science Data at the University of Michigan. I extracted the data for Cook and DuPage counties for those years.

Another source of data was the American Medical Association's annual report, *Physician Characteristics and Distribution in the US*. This report describes all non-federal doctors by state and separately by counties, including information about general areas of the doctor's practice. I compiled data for Illinois as a whole and separately for Cook, DuPage, Madison and St. Clair counties from 1993 through 2003. Information on 2004 will not be available for another year.

Where relevant the analyses were adjusted for population and inflation using census data and the Consumer Price Index.

In addition to these sources I researched the National Practitioner Data Bank. Created as part of the 1986 Health Care Quality Improvement Act of 1986, the NPDB reports on malpractice payments made on behalf of doctors by malpractice insurers. The reports are confidential but the NPDB makes a public file available that removes personal identifying information. I extracted data for Illinois that covered the years 1991 through 2004. A *Wall Street Journal* report criticized the NPDB as omitting many important cases, raising questions about its comprehensiveness.⁵ Then, as I began to sift through the data I found so many omissions of information that I concluded it was so unreliable as to be of little use for this research.⁶ I therefore omit it from further consideration in this report.

An Unavailable Source

One important source of data is missing from this report. The Illinois Department of Insurance compiles detailed records of closed medical malpractice claims that it requires medical malpractice liability insurers to report. In 2001 the Department compiled a report covering the years 1980 through 1999.⁷ Unlike the states of Florida and Texas the data are not made available to the public. I attempted to gain access to the data collected since 1999 to bring findings up to date. Unfortunately, despite a number of requests to gain access to the data, the Department of Insurance permission was not given. The data would have provided crucial information bearing on the controversy about medical malpractice litigation. The closed claims files

⁵ Joseph Hallinan, *Doctor is Out: Attempt to Track Malpractice Cases is Often Thwarted--- Deleting a Physician's Name from a Suit Before Settling Keeps it Out of Data Bank*, WALL STREET JOURNAL, August 27, 2004 at A1.

⁶ For example, on a variable purporting to tell the forum in which a claim was settled, fully 33 percent of cases were classified in a category called "unknown /before lawsuit" or were just blank. The data are supposed to report the severity of the injury but 97% of cases had no information on this variable.

⁷ CASUALTY ACTUARIAL SECTION, ILLINOIS DEPARTMENT OF INSURANCE, MEDICAL MALPRACTICE CLAIMS STUDY (2001).

contain information about the frequency and magnitude of settlements as well as verdicts as well as the costs of defending those claims. Studies using the Florida and Texas databases demonstrate how valuable a resource closed claim data can be in shedding light on this important and controversial debate.⁸

The Remaining Chapters of This Report

Chapter 2 contains a very brief overview of information about medical malpractice litigation to provide laypersons background information about the subject and give them intellectual tools to understand data that is presented in the following chapters. The chapter presents only minimal information about a complex subject. References to sources discussing the topics in greater depth are provided in the footnotes.

Chapter 3 is about Cook and DuPage counties. These two counties contain 49 percent of Illinois' total population and approximately two-thirds of its private doctors.⁹ I examined medical malpractice filings and jury verdicts in those counties as summarized by the *Cook County Jury Verdict Reporter*, supplemented with additional research from on-line databanks and my telephone calls to the offices of lawyers involved in the cases.

Chapter 4 deals with jury verdicts in Madison and St. Clair counties. As noted above, these two counties have gained notoriety as “judicial hellholes” for defendants and have played a prominent role in the claims about the need for medical malpractice tort reform. I used the *Southwestern Illinois Jury Verdict Reporter* as my initial source, but supplemented it with a two-day visit examining the case files in the Madison County courthouse.

⁸ See Neil Vidmar et al., *Uncovering the “Invisible” Profile of Medical Malpractice Litigation: Insights from Florida*, 54 DEPAUL LAW REVIEW 315 (2005); Bernard Black et al., *Stability, Not Crisis: Medical Malpractice Claim Outcomes in Texas, 1988-2002*, 2 JOURNAL OF EMPIRICAL LEGAL STUDIES (2005, in press), available at <http://ssrn.com/abstract=678601>.

⁹ Illinois also has doctors who are employees of the federal government. The doctors are not affected by the liability insurance problem because they are insured by the federal government. And lawsuits against them must be adjudicated under the Federal Tort Claims Act, which requires trial by judge alone.

Chapter 5 turns to the very contentious and often misunderstood topic of “pain and suffering.” Using the plaintiff verdicts from Cook and DuPage counties and studies by other researchers the report explores the role of “pain and suffering” in jury verdicts and the potential impact of a \$500,000 cap on these damages.

Chapter 6 looks at changes in the availability of treating doctors in Illinois and Cook, DuPage, Madison and St. Clair counties from 1993 through 2003. The purpose of this chapter is to shed light on the question of whether the availability of treating doctors has changed over the years.

Chapter 7 discusses the conclusions and limitations of the research.

What This Report Does Not Cover

The report is descriptive and does not pass judgment on the correctness or fairness of the individual jury verdicts that are reported, although it raises issues that will assist readers in drawing their own conclusions. Nevertheless, different parties will have different interpretations of the verdicts. The same reasoning applies to data about settlements.

The report does not investigate the economics or practices of the medical liability insurance industry. That subject is beyond my research mandate and areas of expertise. The findings about the tort system will raise questions about that subject, but they will have to be made by inference. The inference will be made explicit in Chapter 7.

Chapter 2

Medical Negligence and the Tort System: A Brief Primer for Laypersons

The tort system has many facets that bear on the controversy about medical negligence. This chapter is intended to describe some of the issues and empirical findings from other states as background and context for interpreting the Illinois data that I describe in subsequent chapters of this report. Each state has its own laws and legal culture, but, nevertheless, there are many similarities across states. The reader should be aware that there is a very substantial literature bearing on each of the topics discussed in this chapter.¹⁰ It is intended only to provide guidance for other chapters in this report. Readers are encouraged to consult original sources referenced in the footnotes.¹¹

Purposes of the Tort System

There are two central purposes to the tort system: (1) to compensate persons who are injured through the negligence of others and (2) to deter future negligent behavior in (a) the person who committed the instant act of negligence and (b) deter other persons from similar negligence by informing them that they might face civil liability if they engaged in similar acts of negligence.

Compensation in tort law as it has developed in the United States involves awards of monetary damages for losses. There are two main categories of losses. In Illinois they are commonly referred to as “economic” and “non-economic” losses. For reasons that will be made clearer in Chapter 5, the latter

¹⁰ Studdert *et al.*, *Medical Malpractice*, 350 N ENGL. J. MED.283 (2004) provides an excellent review of the history of contemporary problems of medical liability insurance. See also, Michelle Mello et al. *The New Medical Malpractice Crisis*, 348 NEW ENGLAND JOURNAL OF MEDICINE 2281 (2003); Peter Akmajian, *A Fair and Balanced Look at Tort Reform*, FOR THE DEFENSE 33 (November 2004); NEIL VIDMAR, *MEDICAL MALPRACTICE AND THE AMERICAN JURY: CONFRONTING THE MYTHS ABOUT JURY INCOMPETENCE, DEEP POCKETS AND OUTRAGEOUS DAMAGE AWARDS* (1995); 54 DePaul Law Review Issue Number 2 (2005) (Whole Issue).

¹¹ Many of the footnotes contain references to my own writings because they summarize the other literature and offer citations to the original sources.

term can be a source of confusion for non-lawyers, but for now I will use both terms.

“Economic losses” are losses like medical expenses and lost income that result directly from the act of negligence. There are usually tangible hospital bills and tax receipts to prove past economic losses. Health care experts and accountants can use these records of the past to make projections about future “economic” losses and present them to a judge or jury in the form of expert testimony. The estimates of economic losses are sometimes hotly disputed, but at least it is relatively easy to calculate them using the metric of dollars.

“Non-economic losses” have a much less tangible nature and it is difficult to apply an exact dollar metric. Non-economic losses frequently are described as “pain and suffering.” How does anyone place an exact dollar figure on someone’s pain?

A primary source of confusion with the term “non-economic” losses, however, is that pain and suffering is not the only element of this category of damages. There are other elements such as disfigurement, loss of companionship or loss of consortium; loss of moral guidance; loss of sexual gratification, and survival pain.¹² Non-economic damages are called “general damages” in many states. By either name they are losses for which there is no clear dollar metric by which to judge them.

In practical fact many of the legally-recognized categories of “non-economic” damages have economic consequences. For example, if someone’s face is horribly disfigured it will probably cause social stigma and personal pain, but the injury may well have economic implications such as the person’s ability to obtain a well-paying job or finding a spouse. Should the amount differ if the disfigured person is 10-years-old or 70-years-old? “Wrongful death” is another category. To be sure there can be severe emotional pain for survivors but there may also be severe economic consequences for surviving children or

¹² Neil Vidmar, Felicia Gross and Mary Rose, *Jury Awards For Medical Malpractice and Post-Verdict Adjustments of Those Awards*, 48 DE PAUL LAW REVIEW 265,287 (1998).

for a surviving spouse or parents who were counting on the deceased person to render support and sustenance in their old age.

In our legal system the difficult task of assigning a monetary award for these less easily grasped losses has been left to the judgment of a jury. The theory behind having a jury decide is that it is composed of citizens from the community who will apply community norms to evaluate the injury's worth. The jurors are instructed by the judge to apply their "common sense and judgment" in deciding what amount is appropriate in this particular case. Community norms in Arcola, Gillespie or Cairo may be different from Rockford or Chicago.

The deterrent effect of tort law is controversial. There are some who say that were it not for the threat of lawsuits there would be more medical negligence. Other persons insist that the threat of medical malpractice causes doctors to order unnecessary tests out of fear that they may be sued if something goes wrong. No one, including doctors, disagrees with the need to take steps to prevent unnecessary injuries, but the issue is whether the threat causes costly unnecessary medicine. Empirical evidence on deterrence and over-deterrence is difficult to prove one way or the other.¹³

Medical Negligence Occurs

A Harvard University study of medical malpractice concluded that one out of every 100 patients admitted to a hospital had an actionable legal claim based on medical negligence. Some of these patients' injuries were minor or transient but 14 percent of the time the injury resulted in death and as many as another 7 percent of patients suffered a permanent disability. Generally, the more serious the injury the more likely it was caused by negligence. Some of the Harvard findings have been contested, but other studies, including one

¹³ For a review of these issues see Michelle Mello and Troyen Brennan, *Deterrence of Medical Errors: Theory And Evidence for Malpractice Reform*, 80 TEXAS LAW REVIEW 1595 (2002).

conducted in Illinois, have supported the findings and made estimates of negligence that are even higher.¹⁴

Injuries Can Have High Costs

If someone becomes paralyzed from the neck or waist down, they usually cannot work. If they are young and have children the income loss as well as medical expenses can be much more. A baby with a severe brain injury may require constant attention to avoid bedsores and other illnesses and be subject to infections. In the very recent past, many of these children had short lives. Yet, with today's advances in medicine many can be expected to live many decades. Life sustenance is an absolute moral obligation for most such instances, but there are enormous financial consequences.

A 1998 study of injuries caused by medical negligence undertaken by two economists conservatively estimated that the average economic costs for a brain-injured child was \$2.25 million in today's dollars; persons who survived serious emergency room incidents had economic losses of over \$2 million. In both of these estimates there was considerable variability between persons: some economic losses were much lower and in some cases they were much higher.¹⁵

Advances in medicine over the past decade and a half have sometimes extended survival time and improved the lives of these persons, but here again the benefits come with very major economic liabilities.

¹⁴ PAUL WEILER ET AL., A MEASURE OF MALPRACTICE: MEDICAL INJURY, MALPRACTICE LITIGATION AND PATIENT COMPENSATION (1993) . PAUL WEILER ET AL., A MEASURE OF MALPRACTICE: MEDICAL INJURY, MALPRACTICE LITIGATION AND PATIENT COMPENSATION (1993); PATRICIA DANZON, MEDICAL MALPRACTICE: THEORY, EVIDENCE AND PUBLIC POLICY (1985); LINDA KOHN, JANET CORRIGAN AND MOLLA DONALDSON, EDS., TO ERR IS HUMAN: BUILDING A SAFER HEALTH CARE SYSTEM, INSTITUTE OF MEDICINE (2000) at <http://books.nap.edu/catalog/9728.html?onpi_newsdoc112999>; Lucian Leape, *Institute of Medicine Medical Error Figures Are Not Exaggerated*, 284 JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION 95 (2000).; Lori Andrews, *Studying Medical Error in Situ;Implications for Malpractice Law and Policy*, 54 DEPAUL LAW REVIEW 357 (2005).

¹⁵ Frank Sloan and Stephen van Wert, *Costs of Injuries*, Chapter 7 in FRANK SLOAN ET AL., SUING FOR MEDICAL MALPRACTICE (1993)

The Incidence of Claims is Lower than the Incidence of Injury

The Harvard study concluded that for every person filing a claim of medical negligence, eight times as many patients injured by medical negligence did not file a claim. Other studies have yielded similar estimates. One possible reason for this low claiming rate is that the patient does not discover the medical negligence. Another reason is that plaintiff lawyers carefully screen cases and select those that have a reasonable likelihood of prevailing at trial and whose potential award justifies an investment of money, sometimes many thousands of dollars, to hire experts and many working hours before and during trial to prove the medical negligence.¹⁶

Most Cases Are Settled Without a Jury Trial

Only between 7 and 10 percent of claims go to trial by judge and jury. Somewhere between 40 to 50 percent of claims are eventually dropped by the patient during “discovery”—the pre-trial investigative stage in which the plaintiff’s lawyer obtains the medical records, hires experts, and questions the defendant’s experts. Of course, even in these no-payment cases the costs for defendants and their liability insurers can be expensive since they too have to pay for lawyers, experts and other litigation costs.¹⁷

Recent research in Florida has shown that as many as 26% of medical malpractice claims that result in payment to the claimant are settled by the health care provider through arbitration or without a formal lawsuit ever being filed. Even for claims resulting in more than a million dollars in payments 10 percent were settled without a formal lawsuit. Under 8 percent of cases with million dollar payments were settled after a jury trial. Of 34 cases resulting in payments over \$5 million only two were decided by juries.¹⁸

¹⁶ PAUL WEILER ET AL., *A MEASURE OF MALPRACTICE: MEDICAL INJURY, MALPRACTICE LITIGATION AND PATIENT COMPENSATION* (1993).

¹⁷ Neil Vidmar, *Medical Malpractice Lawsuits: An Essay on Patient Interests, The Contingency Fee System and Social Policy*, 20 *LOYOLA LOS ANGELES LAW REVIEW* 101 (2005).

¹⁸ Neil Vidmar, et al., *Uncovering the “Invisible” Profile of Medical Malpractice Litigation: Insights from Florida*, 54 *DEPAUL LAW REVIEW* 315 (2005).

Doctors and their insurance companies say that, nevertheless, they settle cases even for large amounts out of fear that if the case goes before a jury the amounts will be astronomically higher. This is called the “shadow effect” of jury trials. In contrast, some research findings suggest that insurers settle cases when their own internal investigation indicates that negligence did occur. However, even in such cases where negligence is judged to be likely, there may be great disagreement with the plaintiff about the amount of damages he or she should receive.¹⁹

Regardless of whether the claim results in payment or no payment or whether it goes to jury trial or is settled without trial, the process of resolution is slow. Between three and six years typically elapse between the filing of a lawsuit and final resolution. Some cases take even longer.²⁰

Many Malpractice Claims Have Multiple Defendants

Because of specialization in the health care field, multiple persons may treat a patient: a primary doctor, a surgeon, a radiologist, an anesthesiologist and hospital nurses and other staff. Sometimes at the beginning of a lawsuit it is not clear which health care provider is responsible for the alleged negligent injury. Later some defendants may be dropped from the claim. In other instances the lawsuit will assert that multiple parties are responsible for the alleged negligent outcome.²¹

For some cases that eventually go to trial, one or more defendants may settle with the patient before trial. What this means is that sometimes a

¹⁹ Ralph Peeples, et al., *The Process of Managing Medical Malpractice Cases: The Role of Standard of Care*, 37, WAKE FOREST LAW REVIEW 877 (2002); Mark Taragin et al., *The Influence of Standard of Care and Severity of Injury on the Resolution of Medical Malpractice Claims*, 117 ANNALS OF INTERNAL MEDICINE 1780 (1992); Neil Vidmar, *Medical Malpractice Lawsuits: An Essay on Patient Interests, The Contingency Fee System and Social Policy*, 20 LOYOLA LOS ANGELES LAW REVIEW 101 (2005).

²⁰ Id. See also, ILLINOIS DEPARTMENT OF INSURANCE, MEDICAL MALPRACTICE CLAIMS STUDY, (2001); MARK KREIDER, MEDICAL MALPRACTICE CLOSED CLAIMS STUDY, Department of Insurance Commissioner, State of Washington (February, 2005).

²¹ NEIL VIDMAR, MEDICAL MALPRACTICE AND THE AMERICAN JURY: CONFRONTING THE MYTHS ABOUT JURY INCOMPETENCE, DEEP POCKETS AND OUTRAGEOUS DAMAGE AWARDS (1995).

plaintiff who loses at trial may have received money from other parties that were sued. Very often hospitals named as defendants because their staff was indirectly involved in the patient's treatment settle for relatively small amounts. By relatively small I mean small compared to the patient's overall damages claim. The hospital may decide to settle to avoid the risk that at trial they could be held accountable for a much larger award, even though the hospital does not believe it is negligent. Often the amount of any prior settlement from one defendant will be "set off," that is, deducted from the award the jury levies against the other defendants.²²

Doctors Win Most Jury Trials

Research on medical malpractice trials across the country indicates that when the case goes to trial the juries decide in favor of the plaintiff only between 20 to 30 percent of the time. The causes of variability in win rates across states or over time are difficult to determine. While one explanation is that juries differ, other plausible explanations are that the strengths of claims differ, that lawyers vary in the cases they select for trial, and that negotiation and settlement dynamics differ over time and places. In short the data cannot tell us whether juries decide cases differently or whether juries decide different cases.

These statistics surprise many people. Part of the problem is that newspapers tend to report only cases with prevailing plaintiffs being awarded large sums of money while ignoring cases with smaller sums or cases in which defendants prevail.

Interviews with jurors who decided cases found that jurors view many claims with skepticism. They often expressed two interrelated views, namely that too many people want to get something for nothing and that doctors should not be blamed for simple human misjudgment.²³

²² Id.

²³ Id.

Deciding Negligence and Compensation in Medical Malpractice Cases

The first task of a jury or judge is to determine if negligence occurred and if that negligence was the direct cause of the injury that the patient suffered. In many areas of tort law jurors are instructed to apply a “reasonable person” test to determine negligence, but in medical malpractice claims there is a different test—the medical standard of care used by doctors in the particular area of practice. With some rare exceptions, at trial the plaintiff is required to call an expert (or experts) proficient in that field of medicine to testify that he or she has concluded that the defendant doctor violated the standard of care. The defendant doctor usually also calls experts who have a different opinion. Each side’s witnesses are cross-examined by the opposing lawyer.

There is also the issue of causation. Many medical procedures have a risk of an “iatrogenic” injury or illness. An infection may develop at the site of a surgical procedure or a prescribed drug may interact with a particular patient’s biological system no matter how careful the doctor is in following the standard of care. Many persons who seek medical care are already suffering from serious illnesses or injuries and the contentious issue is whether the bad outcome was a result of negligent treatment or the underlying disease or injury. A doctor might even admit negligence but argue that the negligence was not the proximal cause of the bad outcome.

In deciding liability the jury has the facts and arguments from both sides on the standard of care and theories of causation. The judge instructs them that to prevail the plaintiff must prove the case on the “balance of probabilities.” Unlike a criminal trial which uses a “beyond a reasonable doubt” standard, the judge explains that the balance of probabilities means “more likely than not.” Judges usually refrain from using exact figures but find interesting ways to say the jurors must be convinced that, compared to the defendant’s evidence, there is at least a fifty-one percent likelihood that the plaintiff’s evidence is correct.

If the jury decides a doctor is liable it must then assess the damages. During the trial the jury will also have heard evidence about the past and

future medical, income or other economic losses of the patient that resulted from the negligence. The jurors will also have heard evidence bearing on the plaintiff's emotional and physical experiences that are an alleged consequence of the injury.

The jurors will also be instructed to apply their best skills in determining the worth of the non-economic damages, being neither generous nor stingy. Debates can ensue about whether some elements of damages such as disfigurement are non-economic losses since serious disfigurements may affect employment or marriage opportunities.

Punitive damages, even for behavior that is wanton, malicious, or fraudulent, are not allowed in Illinois for defendants in medical malpractice cases.

Trial by Judge and Jury

The jury's task in a medical malpractice trial is not an easy one, but often overlooked in debates about jury trials is that it is really trial by judge and jury. The judge rules on the evidence that is admissible and instructs the jury on the law. Equally important, the jury's verdict does not become legitimate or enforceable until the judge enters a "judgment" on the verdict. Having seen and heard the same evidence as the jury, the judge can set part or all of the verdict aside and order a new trial, enter a directed verdict for one or all of the defendants or reduce the amount of the damages if the judge feels the verdict is inconsistent with the trial evidence. Additionally, if the case is appealed, a panel of three or more judges may overturn parts or all of the judgment. Specific examples of judicial oversight may be seen in cases summarized in Chapters 3 and 4. In short, the jury verdict is not the final word.

Jury Competence

Questions are sometimes raised about whether the jury, composed of a group of laypersons, is competent to make the complicated decisions required

in malpractice cases. Likewise, it would be absurd to claim that juries always get it right; but one study found that jury verdicts were generally consistent with evaluations of whether negligence occurred that were made by neutral doctors. Other studies, while not specifically dealing with medical malpractice, show that trial judges agree with civil jury verdicts most of the time. These studies will not satisfy every critique because the decisions are judgment calls. Each side will contend that the evidence favored their position. Chapters 3 and 4 present short summaries of a number of cases and the juries' verdicts. Even though readers will not have heard the evidence that the jury heard, the summaries allow different readers to make their own evaluations. It is noteworthy that in most cases the trial judge agreed with the jury verdict—but not always.²⁴

Jury Awards Do Not Necessarily Reflect the Final Payment to the Plaintiff

Cases are often settled for less than the jury's award. This is particularly true of very large awards. There are four main processes by which awards are reduced. The trial judge or an appeals court may reduce the award. Sometimes the two sides agree to a high-low agreement before trial, during trial or even during jury deliberations. This occurs in cases where both sides are not entirely confident about the strength of their case and become risk averse. They enter into an agreement that no matter what the jury decides the defendant will pay a certain amount to the plaintiff and if the plaintiff wins the defendant will have to pay only the agreed highest amount. Chapter 3 provides some good examples.

Sometimes a winning plaintiff will settle for less than the jury verdict in order to avoid a long delay in payment and the risk of losing if the defendant appeals. Finally, plaintiffs usually settle for the limits of the doctor(s) liability insurance coverage if the award exceeds the insurance coverage. Hospitals that

²⁴ Neil Vidmar, *Medical Malpractice Lawsuits: An Essay on Patient Interests, The Contingency Fee System and Social Policy*, 20 LOYOLA LOS ANGELES LAW REVIEW 101 (2005).

are self-insured usually have some form of excess liability insurance to protect their assets.²⁵

Chapters 3 and 4 contain examples bearing on all of these post-trial adjustments in Illinois cases.

Liens Against Recovery

If a patient is injured through medical negligence, his or her medical bills may be paid by taxpayer-supported Medicare or Medicaid, or by a private insurer like Blue Cross/Blue Shield. If the injured person cannot work, a private or public source may pay some or all of their expected wages. If the injured person subsequently receives a jury award or settlement from a negligent medical provider, that entity has a right to recover that portion of the award that it paid in benefits as a result of the injury. Medicare and Medicaid are required to seek reimbursement. There is very little accurate information on the extent to which this occurs and the degree of recovery but plaintiff lawyers deal with liens routinely even before they start a lawsuit. The amount taxpayers and private health insurers recover may amount to hundreds of thousands or even millions of dollars from malpractice settlements every year.²⁶

Doctors Who Are Federal Employees or State Employees

A number of doctors and other health care providers are employees of the federal government. Some examples are doctors on military bases or Veterans Administration hospitals. These doctors may provide regular medical services including delivering babies. They too can be sued but their employer is the self-insured United States government. The doctors do not carry private professional liability insurance. Federal employees must be sued under the

²⁵ Id.; Tom Baker, *Blood Money, New Money and the Moral Code of the Personal Injury Bar*, 35 LAW AND SOCIETY REVIEW 257 (2002).

²⁶ See HERBERT KRITZER, RISKS, REPUTATIONS AND REWARDS: CONTINGENCY FEE LEGAL PRACTICE IN THE UNITED STATES (2004); Neil Vidmar, *Medical Malpractice Lawsuits: An Essay on Patient Interests, The Contingency Fee System and Social Policy*, 20 LOYOLA LOS ANGELES LAW REVIEW 101 (2005).

Federal Tort Claims Act that provides for trial by judge alone rather than trial by jury.

Some healthcare providers are employees of the State of Illinois and are insured by the State of Illinois, for example, state mental hospital employees. The laws of Sovereign Immunity may not shield claims of medical malpractice against these employees and in such cases claims may be decided in a jury trial.²⁷

Summary

This chapter has presented a minimal sketch of important issues and concepts related to medical malpractice litigation. It is a complicated subject. The sketch will be helpful to laypersons in the chapters that follow.

²⁷ See, e.g. *Jinkins v. Lee and Medlin*, 04L-5967 (Cook County), Access Plus Jury Verdict (Tried September 27-October 7, 2004).

Chapter 3

Medical Malpractice Litigation in Cook and DuPage Counties

Cook County and DuPage County are the most populous counties in Illinois. Cook, with a population of more than 5.3 million persons, constitutes approximately 42 percent of Illinois' 12,600,000 citizens, and DuPage, with a population of over 900,000, accounts for another 7 percent.²⁸ The two combined represent almost half of Illinois' 12.6 million citizens. These two counties also accounted for 67.6% of Illinois' 30,264 non-federal "patient care" physicians in 2003.²⁹ A number of sources of data bearing on medical malpractice litigation are available for these two counties. This chapter draws upon those data sources to present a profile of case filings over time, verdicts after trial, and post-verdict adjustments to awards. Additionally, some data give insights about settlements.

Case Filings in Cook and DuPage Counties: 1994-2004

The *Cook County Jury Verdict Reporter* compiles statistics on annual filings of civil litigation. John Kirkton of the *Reporter* compiled separate statistics for medical malpractice filings in Cook and DuPage counties from 1994 through 2004.³⁰ These data shed light on the extent to which medical malpractice lawsuits have increased over the past decade.

Before presenting these data a note of caution is in order. Case filings do not always translate into settlements or jury verdicts. In some instances the filing enables a plaintiff's lawyer to obtain medical records and other material but further investigation with the help of these records persuades the lawyer

²⁸ <<http://quickfacts.census.gov/qfd/states/17/17031.html>>

²⁹ See American Medical Association, *PHYSICIAN CHARACTERISTICS AND DISTRIBUTION IN THE U.S.*, 2003 edition, AMA Press 2003. Federal physicians are those employed or supported by the U.S. Government, which is self-insured for the liability of its physicians. Lawsuits against its physicians fall under the Federal Tort Claims Act, which requires trials to be conducted by judges acting without a jury.

³⁰ Mr. Kirkton informed me that this compilation was made available to a number of parties on both sides of the tort reform issue some time before I requested the data.

that there is insufficient evidence to continue the lawsuit and it is abandoned.³¹ To the extent that this is true the statistics may overestimate the extent of medical malpractice litigation. On the other hand recent research bearing on malpractice litigation in Florida³² uncovered the fact that the parties settled over 20 percent of all cases involving payments to claimants without a formal lawsuit being filed. For settlements involving payments over \$1 million, slightly more than 10% were settled in a pre-lawsuit phase. To the extent that similar processes occur in Illinois, case filings may under-estimate payments by medical health providers and their insurers. Nevertheless, filings provide a reasonable measure of medical malpractice claiming.

Table 3.1 shows the number of filings in Cook and DuPage counties by year. In addition Table 1 also presents data on the number of non-federal treating physicians in each county per year through 2003.³³ (Physician figures for 2004 and 2005 were not available at the time this report was written.) From these two figures a third variable was constructed to show the number of lawsuits filed per number of physicians. This last statistic needs to be treated cautiously since there is a time lag between a medical incident and the filing of lawsuits. Typically, at least two years elapse between a medical incident and a claim, but in some cases the lawsuit may be filed many years after the incident. For instance, a person who was a minor when an incident occurred may file after he or she reached the age of majority, producing a long lag time.

³¹ See NEIL VIDMAR, *MEDICAL MALPRACTICE AND THE AMERICAN JURY* (1995) at 69-92.

³² Vidmar et al., *Uncovering the "Invisible" Profile of Medical Malpractice Litigation: Insights from Florida*, 54 DEPAUL LAW REVIEW 315(2005).

³³ There are also treating physicians who are federal employees, such as those associated with military bases, Veterans Administration hospitals and the Public Health Service. The federal government assumes professional liability for these physicians. In consequence, malpractice lawsuits against federal physicians do not play a role in private liability insurance premiums.

Table 3.1: Case Filings, Number of Treating Physicians and Filings Per Capita of Treating Physicians: 1994-2003

Year	Cook County			DuPage County		
	Number of Filings	Number of Physicians	Filings/ 100 Physicians	Number of Filings	Number of Physicians	Filings/ 100 Physicians
1994	1831	15,114	12.1	113	2,393	4.7
1995	1722	15,579	11.0	119	2,618	4.5
1996	1235	15,673	7.9	80	2,735	2.9
1997	1262	16,298	7.7	70	2,881	2.4
1998	1353	16,043	8.4	60	2,916	2.1
1999	1214	15,835	7.7	70	3,028	2.3
2000	1319	16,205	8.1	60	3,208	1.8
2001	1360	16,339	8.3	60	3,319	1.8
2002	1324	16,266	8.1	80	3,327	2.4
2003	1443	16,782	8.5	60	3,423	1.8
2004	1226	*	*	57	*	*

The table shows that filings from 2000 through 2004 in both Cook and DuPage counties were substantially lower than in 1994 and 1995. Except for a decrease in 2004, filings have remained relatively steady since 1998, although there are some yearly fluctuations. The second column in the table shows that filings per 100 treating physicians in Cook County remained steady at between approximately 8 and 8.5 from 1996 through 2003. DuPage County shows a similar trend although the filing rates are much lower, varying between 1.8 and 2.4 per one 100 physicians.

The much higher rate of filings per 100 physicians in Cook as opposed to DuPage County appears puzzling. However, an additional examination of physician statistics suggests a likely explanation for part of the difference. The AMA’s physician database disaggregates treating physicians into a number of separate categories and one of those categories is “hospital based practice.”³⁴

³⁴ American Medical Association, PHYSICIAN CHARACTERISTICS AND DISTRIBUTIONS IN THE US, editions 1995 –2005.

In Cook County 35 percent of treating physicians in 2003 listed themselves as engaged in hospital-based practice whereas in DuPage County only 18 percent listed themselves in this category. To the extent that claims involving medical incidents are more likely to arise in hospital settings, hospital practice may explain part of the difference. The demographics of the patients seeking health care, the types of health services provided and other factors may also contribute to the higher rate, but the data do not help us further on these hypotheses.

Once again the reader is cautioned to keep firmly in mind two caveats. First, filings do not necessarily equate to payments to claimants. Second, unpaid claims incur defense costs by liability insurers.³⁵ Nevertheless, with these caveats in mind the principal finding from this analysis is that the data show no upward trends in filings or in filings per 100 treating physicians in either Cook or DuPage counties.

Jury Verdicts Over Time: The Bureau of Justice Statistics Research, 1996 and 2001

Much of the current controversy in Illinois involves claims about jury verdicts increasing in both frequency and magnitude of awarded damages. Cook and DuPage counties are the two Illinois counties represented in a survey of nationwide civil court statistics carried out by the U.S. Department of Justice's Bureau of Justice Statistics in collaboration with the National Center for State Courts. Called the Civil Justice Survey, the civil court records of forty-six of the nation's most populous counties, statistically representing the nation's 75 most populous counties, were systematically surveyed in 1996 and 2001.³⁶ The data include identification of medical malpractice jury verdicts and

³⁵ See Vidmar et al. at note 5.

³⁶ See, CAROL DEFRANCES AND MARIKA LITRAS, BUREAU OF JUSTICE STATISTICS BULLETIN, CIVIL JUSTICE SURVEY OF STATE COURTS, CIVIL TRIAL CASES AND VERDICTS IN LARGE COUNTIES, 1996, available at < <http://www.ojp.usdoj.gov/bjs/abstract/ctcvlc96.htm>.; Thomas Cohen , Tort Trials and Verdicts in Large Counties, 2001, Bureau of Justice Statistics Bulletin, Civil Justice Survey of State Courts, 2001 , November 2004, NCJ 206240, available at < <http://www.ojp.usdoj.gov/bjs/abstract/ttvlc01.htm>>.

their outcomes. The research has resulted in various reports that focus on nationwide statistics, including jury verdicts. The raw data are archived by the Inter-University Consortium for Political and Social Research that is headquartered at the University of Michigan. These surveys purport to provide a comprehensive listing of all civil jury trials, including disaggregation of medical malpractice cases in the chosen locations.³⁷

Data supplied by John Kirkton from the *Cook County Jury Verdict Reporter* indicates that, at least in 2001, the BJS survey substantially under-reported the number of medical malpractice cases in Cook and DuPage counties. BJS reported 78 jury trials whereas the verdict reporter identified 99 jury trials.³⁸ The *Cook County Jury Verdict Reporter* data will be addressed in the next section of this chapter. However, working on an assumption that the Bureau of Justice's sampling techniques were the same in both years, the BJS data can be used to make comparisons of changes in jury verdicts between 1996 and 2001.³⁹ They also allow us to make comparisons with nationwide trends.

³⁷ In our research attempting to identify more details about the cases identified in the survey we found several cases that involved product liability claims against medical manufacturers as well as health care providers. It was not always clear that the main defendant was the health care provider. In at least two cases the health care provider was either dropped from the lawsuit before trial or was found not liable. This finding raises the possibility that the BJS statistics may slightly overstate the number of medical malpractice trials in their sample. Another possibility is that while the Cook County Verdict Reporter includes cases in which hospitals are the sole or primary defendant, the BJS sampling excluded such cases. Since the BJS data do not identify plaintiffs or defendants, it is not possible to check this hypothesis against the data.

³⁸ There was also a \$3,689,733 verdict against a chiropractic clinic (*Tews v. Stoxen Chiropractic Clinic*, Docket No. 99L-12631, involving allegations of fraud, and two dental malpractice trials, one of which resulted in an \$11,250 plaintiff win and another resulting in a defense win. These trials were eliminated from the analysis.

³⁹ Despite proceeding with this comparison, the assumption is open to challenge. The BJS data are purported to be comprehensive of all verdicts. The Cook County Verdict Reporter data clearly show that in 2001 the BJS study under-reported jury verdicts by 21 percent (99 cases in CCVR versus 78 in the BJS research). Further problems arise with the BJS data. The first BJS survey was conducted in 1992, see DEFRANCES, C. ET AL., CIVIL JURY CASES AND VERDICTS IN LARGE COUNTIES, U.S. Department of Justice, Bureau of Justice Statistics Special Report (July 1996, NCJ -154346.) Although medical malpractice cases were reported for other venues in 1992 our search of the raw data discovered that medical malpractice verdicts were not specifically distinguished from other personal injury torts in both Cook and DuPage Counties. Despite the problems that we have identified, many researchers treat the BJS data as an

Changes in the Frequency of Jury Trials

Table 3.2 reports the number of medical malpractice trials in Cook and DuPage counties over the two time periods along with adjustments for changes in the number of treating physicians. In 1996 Cook County had 15,673 non-federal treating physicians and in 2001 it had 16,339 treating physicians. DuPage County had 2735 physicians in 1996 and in 2001 there were 3319 physicians.

Table 3.2: Frequency of Jury Trials by Year and in Proportion to 1000 Treating Physicians

Year	Cook County		DuPage County	
	Number of Jury Trials	Trials/per 1000 Treating Physicians	Number of Jury Trials	Trials/1000 Treating Physicians
1996	81	5	7	3
2001	78	5	8	2

The table shows no difference between 1996 and 2001. Note again that the data address trials, not lawsuits or settlements arising out of those lawsuits. As noted in Chapter 2, based on nationwide data, trials occur in less than ten percent of all medical malpractice lawsuits. The current debate in Illinois, however, has centered on jury trials and the effect of jury awards on settlements. Thus, it is reasonable to ask about jury trial frequency.

The data in Table 3.2 do not reflect the possibility that more than one physician or health care entity, such as a hospital or clinic, was named as a defendant in the lawsuit. The data provide some insight about the complexity of litigation and its potential effect on defendants. Table 3.3, therefore, was constructed to show these differences. For ease of presentation the data for Cook and DuPage counties were combined.

authoritative source and a decision was made to report comparisons between 1996 and 2001 as a separate section in this report.

Table 3.3: Number of Defendants (and Percent of Total) Named in Jury Trials in Cook and DuPage Counties (Combined), By Year

Number of Defendants	1996 Frequency	2001 Frequency
1	27 (31%)	26 (33%)
2	19 (22%)	31 (40%)
3	13 (15%)	13 (17%)
4	9 (10%)	5 (6%)
5	8 (9%)	2 (3%)
6	3 (3.%)	1 (1%)
7	3 (3%)	--
9	1 (1%)	--
10	1 (1%)	--
11	2 (2%)	--
12	1 (1%)	--
Total	87	78

Note: percentage of total trials is rounded to nearest whole number

Table 3.3 shows that approximately one third of trials involve more than one defendant in all three time periods, but the number of trials exceeding more than three defendants declined substantially by 2001, compared to 1996. These changes may reflect changes in the litigation strategies as discussed in more detail below.

Rates at Which Plaintiffs Prevailed at Trial

How often do plaintiffs prevail when a jury decides their case? In addressing this question we again combined the data for Cook and DuPage counties. The findings are reported in Table 3.4.

Table 3.4: Plaintiff Win-Rates By Year (Frequencies and Percentages)

Year	1996	2001
Plaintiff Verdicts	15 (19%)	28 (36%)
Defense Verdicts	71 (81%)	50 (64%)
Directed Verdict for defendant	1 (1 %)	0
Other	1 (1%)	0
Total	88 (101%)	78 (100%)

Note: Percents rounded to nearest whole number

Table 3.4 shows that while the number of trials declined by 10 from 1996 to 2001, plaintiffs were more successful when they went to trial. The plaintiff's win rate trends are somewhat at variance with nationwide trends in plaintiff win rates.⁴⁰ In 1996 the national plaintiff win rate was 25.9% and in 2001 the plaintiff win rate was 27.1 %. Thus, in 1996 Cook and DuPage Counties were lower than the national average and in 2001 they were higher than the national average.⁴¹

It is not possible to ascertain the cause of these differences in plaintiff win rates, both over time and in comparison to nationwide data because there are different plausible, and not necessarily exclusive, explanations. One hypothesis is that jury attitudes toward plaintiffs and defendants changed (or are different from state to state) but there are equally plausible competing hypotheses. Laws may differ from state to state; laws may change over time within states; plaintiff lawyer strategies in the cases they choose to litigate may change; the development of alternative dispute resolution such as mediation or arbitration may affect rates of trial; both plaintiff and defense negotiation

⁴⁰ Carol DeFrances and Marika Litras, *Civil Trial Cases and Verdicts in Large Counties, 1996*, BUREAU OF JUSTICE STATISTICS BULLETIN, NCJ 173426, September 1999; Thomas Cohen, *Tort Trials and Verdicts in Large Counties, 2001*, BUREAU OF JUSTICE STATISTICS BULLETIN, November 2004 NCJ 206240; Thomas Cohen, *Medical Malpractice Trials and Verdicts in Large Counties*, BUREAU OF JUSTICE STATISTICS BULLETIN, April 2004, No. NCJ 203098

⁴¹ For comparison the COOK COUNTY VERDICT REPORTER data, discussed in more detail in the next section, shows a 2001 plaintiff win rate in Cook County and DuPage County combined for a win rate of 30 percent. The difference between the calculated BJS plaintiff win rate and the Cook-DuPage plaintiff win rate from the Cook County Verdict Reporter is thus about 4 percent.

strategies may change and thus affect whether cases are settled or go to trial; the way evidence is presented at trial may change. Posed simply, from these data *we cannot determine whether juries were deciding cases differently or whether they were deciding different cases.*⁴²

Jury Awards in Cook and DuPage Counties: 2001

What do juries award when plaintiffs prevail? We assessed this question by examining mean awards for Cook and DuPage Counties combined for the year 2001.⁴³ For these analyses we use the more comprehensive set of data from the *Cook County Jury Verdict Reporter* supplemented by additional reports of cases contained in databases reported in *Westlaw*. The mean is the arithmetic average.

A Reminder About Jury Verdicts

Before this analysis is presented several caveats that were discussed in Chapter 2 need to be repeated. First, jury verdicts are not necessarily the amount that the plaintiff actually receives. In some cases the judge may reduce that amount in entering judgment. In other cases the parties may enter into a high-low agreement prior to the verdict. Often, cases with high-low agreements are not disputes about the health provider's liability but rather about the amount of the damages. In other instances high-low agreements may reflect the fact that the two sides recognize that the issue of liability is about a fifty-fifty probability and both become risk-averse. As a consequence, they enter into a mutual agreement that prevents an extreme outcome, such as the plaintiff

⁴² See Neil Vidmar, *Pap and Circumstance: What Jury Verdict Statistics Can Tell Us about Jury Behavior and the Tort System*. 27 SUFFOLK UNIVERSITY LAW REVIEW 1205 (1994/1996).

⁴³ The trials include medical malpractice lawsuits against medical doctors defined as having MD degrees and hospitals and their employees. Malpractice lawsuits against dentists, podiatrists chiropractors, physical therapists, pharmacies and nursing homes or other healthcare providers that did not include MDs or hospitals as defendants are not included in this research. A few cases classified as medical malpractice were actually slip and fall or contract disputes and were eliminated from consideration.

receiving nothing or the defendant being faced with a catastrophic damage award.⁴⁴

Plaintiffs may settle for the limits of the defendant's medical liability insurance coverage rather than press for the full judgment.⁴⁵ In other cases the plaintiff may agree to settle for less than the judgment to avoid the defendant's appeal of the verdict, possibly losing everything if the judgment is overturned, but in any event suffering a long delay in receiving any money through the long delays as the case winds its way through the appeals courts. Additionally, an appeals court may overturn the verdict and the judgment or the amount of damages may be reduced.

A final reminder is that a plaintiff who loses at trial against one or more defendants may still receive substantial sums of money from other defendants in the lawsuit who settled prior to trial. The jury will not be aware of these agreements when they render their verdict. In some instances in which the plaintiff does prevail at trial, the amounts of prior settlements by other defendants will be deducted from the judgment, a deduction called a "set-off." The case summaries, reported below, find examples of these various settlement outcomes.

The final caution is that these data do not tell us if the jury verdict was correct on either the issue of liability or the amount of damages. There is no absolute truth about right or wrong. Cases come to trial because there is a dispute about either liability or damages or both. Under the law the resolution of the dispute is left to the jury and the trial judge who enters the judgment. In appealed cases, appellate courts review whether the decisions of the judge and jury were correct. They may overturn verdicts or awards.

The central lesson to keep in mind is that jury verdicts can be less or can be more than what is reported in the newspapers and portrayed by the parties on both sides of the dispute about tort reform. This chapter will report not only

⁴⁴ Importantly, the jury and, most likely the judge, will be totally unaware of this high-low agreement.

⁴⁵ See, Tom Baker, *Blood Money, New Money, and the Moral Economy of Tort Law in Action*, 35 LAW & SOCIETY REVIEW, 275, 284-85 (2001).

damage verdicts but separately report some of these “hidden” outcomes. The year 2001 was chosen for detailed study for several reasons. It is the year studied by the Bureau of Justice Statistics. The year 2001 is a year when the problem with medical malpractice insurance began to be publicly recognized. Most important, the three-to-four-year time gap between 2001 and 2005 allows time for post-verdict settlements and for contested verdicts to be scrutinized by appellate courts, permitting insight into final outcomes of jury trials.

Plaintiff Verdicts and Adjustments in 2001

The *Cook County Jury Verdict Reporter* data indicate there were a total of 99 medical malpractice jury trials in Cook and DuPage counties in 2001.⁴⁶ Plaintiffs prevailed in 30 of these cases, a 30 percent win rate.⁴⁷ Table 3.5 reports the name of the case, a short description of the plaintiff’s claim, the amount of the verdict, and any post-trial adjustments to the verdict. The footnotes in the table report the nature of the adjustment, but each of these cases is subsequently discussed in more detail in the paragraphs that follow.

⁴⁶ Again note that these data are more comprehensive than the Bureau of Justice Statistics data discussed in the previous section.

⁴⁷ In a small number of cases the jury was deadlocked. Deadlocked juries are treated as a defense win since the plaintiff bears the burden of proof. The plaintiff has a right to have the case retried.

Table 3.5: Plaintiff Verdicts and Adjustments in Cook and DuPage Counties, 2001

Case	Claim	Amount of Award	Award after Adjustment
Bryant v. LaGrange Memorial Hospital , Kim & others	Birth injury-cerebral palsy	\$30,000,000	\$1,100,000 ^a
Lawler v. Lamont	Delayed cancer diagnosis	\$3,800,000	\$3,800,000 ^b
Brewster v. West & two others	Foot fracture misdiagnosed : subsequent surgery	\$170,000	\$170,000
Aceves v. Orihuela	Bile duct cut-reconstructive surgery	\$467,900	\$467,900
E. Munoz v. Clemis & others	Delayed cancer diagnosis: larynx surgery; chemotherapy	\$2,495,893	\$2,495,893
D. Munoz v. Herman & others	Mis-diagnosis: testicle removed	\$150,000	\$0 ^c
McNamara v. Grimaldi	Informed consent re vasectomy: pain and suffering	\$317,000	\$317,000
Matthews v. Gottlieb Memorial Hospital	Stillborn birth	\$3,781,393	\$3,781,393
Genovese v. Caro	Cornea puncture: subsequent surgery	\$494,906	\$494,906
Willis v. Bracket & others	Hip surgery: corrective surgery	\$120,608	\$120,608
Bales v. Groya & others	Misdiagnosis: leg amputation	\$2,812,553	\$2,812,553
Washington v. Wilczynski & others	Diagnosis delay: loss of testicle	\$200,000	\$200,000
Gonzales v. Pla	Undiagnosed kidney disease requires transplant	\$1,191,256	\$950,000 ^d
Waliczek v. Gutta	Other patient's blood thinner given: Death	\$6,500,000	\$800,000 ^e
Stajsczyk v. MacNeal Memorial Hospital & others	Jugular vein puncture: death	\$801,643	\$801,643
Thomas v. Hosain & others	Antibiotic delay: death	\$835,000	\$835,000
Matei v. Patel & others	Premature discharge: infant dies	\$525,000	\$525,000
Skonieczny v. Gardner & others	Birth injury: nerve damage (Erb's palsy)	\$13,298,052	\$2,000,000 ^f
Christy v. Cavanaugh	Misdiagnosis brain disease: pain and suffering	\$2,500,000	\$2,500,000
Cork v. Cook County Hospital	Improper management of injury: child dies	\$5,300,000	\$0 ^g
Simpson v. Allswede & others	Tracheal tube damage to child burn victim	\$2,563,492	\$1,900,000 ^h
Cummings v. Suprenant & others	Excessive radiation: severe burns	\$1,250,000	\$1,250,000
Salas v. Michael Reese Hospital & others	Unnecessary surgery: death of toddler	\$2,750,000	\$2,750,000
Guerin v. Yu & others	Death of mother following C-section	\$7,622,040	\$7,000,000 ⁱ
Banis v. Loyola U Hospital& others	Surgery & misdiagnosis: amputation below elbow	\$1,710,000	\$1,710,000
Perrier v. Feinstein & others	Penile implant infection	\$218,626	\$218,626
Gonzalez v. St. Mary of Nazareth Hosp. & others	Misdiagnosis of stroke: death	\$1,250,000	\$1,255,000 ^j
Schindler v. Lipshitz	Prostatectomy & rectum puncture: eventual death	\$1, 262,748	\$1, 262,748
Macias v. St. Anthony Hosp	Absence of lab work: baby later dies	\$1,500,000	\$1,400,000
Carroll v. Barrows & others	Misdiagnosed eye cancer; toddler blind both eyes	\$7,962, 024	\$2,000,000 ^k

Notes: a: Loyola dismissed after settling for \$100,000 before trial; plaintiff accepted Kim offer of policy limits during jury deliberations. b: Appealed, judgment affirmed. c: Two defendants settled before trial; setoff leaves on \$4,000 judgment for costs. d: High-low (\$150,000-\$950,000); e. High-low (\$350,000-\$800,000 during jury deliberations. f. High-low agreement before verdict for policy limits of \$1million for two defendants. g. Reversed on appeal; remanded for new trial. h: Post-trial settlement. i: High-low agreement (\$500,000-\$7,000,000) during deliberations. j: Case settled post-trial. k: Case settled for policy

From the data in Table 3.5 a quick calculation will indicate that the mean (average) verdict was \$3,461,671. However, the last column in the table shows that at least seven of the verdicts were adjusted downward. The mean adjusted verdict when plaintiffs prevailed at trial was substantially lower, namely \$1,465, 609, forty-two percent lower than the unadjusted figure.

The downward adjustment is very likely a conservative figure since post-trial settlements of awards may occur after the verdict reporter summaries are published. Additionally some settlements are kept confidential as a condition of settlement. Nevertheless, the central finding from Table 3.5 confirms a view that the amount that the jury awards the plaintiff is frequently not the end of the story. The amount actually paid may be substantially less.

Further Exploration of the 2001 Plaintiff Awards Involving \$1 Million or Over

Table 3.5 does not give much detail about the case and its outcome. In this section short summaries of the cases over \$1 million are presented. The summaries are from the *Cook County Jury Verdict Reporter*, supplemented by research on *Westlaw* and *Findlaw* databases and calls to lawyers who represented parties in the case.⁴⁸ Note again that the summaries do not allow an assessment of whether the jury verdict was correct or incorrect by some absolute standard as to either negligence or the amount of damages. In some instances the defense or plaintiff position regarding the claim is missing from the summaries. Some of the cases may still be on appeal and in others the case may have settled in the aftermath of the verdict. Nevertheless, the summaries provide a perspective on what was at issue in the case.

⁴⁸ In the footnotes below I report the court's docket number and beginning date of trial taken from the data supplied by the *Cook County Jury Verdict Reporter*. Unless otherwise noted the summary is taken from that source. In some instances the summary is supplemented from another source and this is noted as appropriate. In appealed cases the docket number of the appellate court is provided.

*Bryant v. La Grange Memorial Hospital, Kim, Nath and Loyola University Hospital*⁴⁹ involved a claim that in 1995 Dr. Kim was negligent in delaying a Caesarian section following signs of distress in the infant and that hospital employees also were negligent. The child suffered severe cerebral palsy and cannot walk or talk and is totally dependent but cognitively intact. The jury deliberated 7 hours and found only against Dr. Kim for \$30 million. (\$15 million disability; \$4 million pain and suffering; \$4 million disfigurement; \$5.5 million for future medical expenses; \$1.4 million for lost earnings and \$116,700 for past medical expenses. Loyola University hospital and its employee, Dr. Nath, settled for \$100,000 prior to trial and the plaintiff accepted Dr. Kim's offer of his \$1 million policy limit during the jury's seven hours of deliberations. The plaintiff subsequently appealed the verdict in favor of LaGrange Memorial Hospital but a unanimous opinion of the Third Division Appeals Court affirmed the verdict favoring LaGrange.⁵⁰

*Lawler v. Lomont*⁵¹ involved a 1997 hysterectomy for cancer following a pathologist who misread Pap smears from 1994 through 1996, allowing stage 1 cancer to spread. The defense admitted liability but contested the likelihood of cancer reoccurrence and argued that the plaintiff had infertility problems before the surgery. The DuPage jury award of \$3,800,000 (\$2.5 million pain and suffering; \$1.2 million loss of a normal life; \$100,000 disfigurement) was appealed by the defendant, but the appellate court upheld the award.⁵² The case settled for the full amount of the verdict.⁵³

*Munoz v Clemis, Garcelon and Health Care Service Corp*⁵⁴ involved a 40-year-old woman who claimed that her HMO physician and a second physician failed to perform a timely biopsy following complaints of hoarseness. Due to delays the plaintiff lost confidence in her doctors and sought a new physician. The new physician diagnosed throat cancer. The plaintiff underwent surgery

⁴⁹ 96L-11679 (Tried July 16, 2001).

⁵⁰ Findlaw, Third Division, Illinois Court of Appeals, No.1-02-0518 (Dec 17,2003).

⁵¹ 99L-555 (Tried June 11, 2001)

⁵² Ill. App. Ct., 2nd District, No. 2-01-1307

⁵³ Telephone call to plaintiff lawyer on May 5, 2005.

⁵⁴ 2001 WL 34554111; JVR no. 412, 296.

that removed three-fourths of her voice box and required a tracheostomy. The jury returned a verdict of \$2,495, 893 against all defendants , broken down as follows: \$335,000 aggravation of pre-existing ailment or condition; \$500,000 disfigurement resulting from the injury: \$500,000 past and future disability: \$1,000,000 past and future pain and suffering; \$108,593 medicals; and \$52,300 lost wages. The HMO was found liable under a claim of vicarious liability. (Prior to trial the plaintiff demanded \$3,200,000 and the defense offered \$41,000.) (The specialist physician to whom the plaintiff was referred by her primary physician was not mentioned in the trial summary and may have settled separately with the plaintiff prior to trial, but no further information could be obtained.)

*Matthews v. Gottlieb Memorial Hospital*⁵⁵ involved the estate of a stillborn girl at 42 weeks gestation. The hospital admitted liability and the trial involved only the matter of damages for the parent's "loss of society." Reportedly, a judge recommended a settlement of \$600,000 to \$700,000 and counsel agreed but the parents refused preferring to have a jury decide the case. The jury awarded \$3,781,392 (\$1,875,000 for each parent's loss of society plus \$31,393 for funeral and medical expenses). The defendant appealed the verdict, but the three-judge appeals court unanimously affirmed the verdict.⁵⁶ Among other rulings, the appeals court ruled that the trial judge properly barred certain evidence because during discovery the defendant failed to disclose evidence requested by the plaintiff and ruled against a defense complaint about improper comments by the plaintiff's lawyer in closing arguments because the defense did not object in a timely manner. The court further rejected a defense argument that the trial judge inappropriately admitted certain medical expenses.

⁵⁵ 97L-12643 (Tried June 12, 2001)

⁵⁶ Appellate Division, 1st District, 4th Division No.1-02-0853, 6 ARD 36.

*Bales v. Groya, and Community Orthopedics*⁵⁷ concerned a 33-year-old-roofer who was injured in a fall and fractured his right lower leg. Surgery was performed but plaintiff claimed that a subsequent infection was improperly treated and the plaintiff was never hospitalized. A second surgery by another physician amputated the leg below the knee. The defense claimed the plaintiff had refused hospitalization after the infection developed. The jury awarded \$2,812,553 (\$750,000 for disfigurement, \$100,000 for past loss of normal life; \$350,000 for past pain and suffering; \$150,000 for future pain and suffering; \$200,000 for future medical expenses, \$52,553 for past medicals and \$500,000 for future lost lifetime earnings.)

*Gonzales v. Pla*⁵⁸ involved a claim that a primary care physician's failure to diagnose kidney disease resulted in a 43-year-old male requiring a kidney transplant. The defendant argued at trial that his care was proper and that in any event the plaintiff would have required a kidney transplant and further that the plaintiff did not make a return visit to his office as instructed. The jury returned a verdict of \$1,191,256 for the plaintiff. However, during jury deliberations the parties made a high-low agreement (\$150,000-\$950,000) on the doctor's \$1 million liability policy. Thus the plaintiff received \$950,000.

*Waliczek v. Ghandhigutta and Alexian Brothers Medical Center*⁵⁹ involved the death of a 47-year-old construction worker who was hospitalized following a construction accident. The man had multiple fractures in his arms, wrists and legs, bleeding in the stomach and a small amount of bleeding in the brain. The plaintiff's estate contended that the man was administered the blood thinning agent heparin intended for another patient. The defendants disputed both negligence and causation. On June 28, 2001 the jury rendered a verdict of \$6,500,000. However, while the jury was deliberating the parties entered into a high-low agreement of \$350,000-\$800,000.

⁵⁷ 97L-12643 (Tried June 12, 2001)

⁵⁸ 97L-9163 (Tried January 11, 2001).

⁵⁹ 2001 WL 34004686; ZARIN'S MEDICAL LIABILITY ALERT, Vol. 10, Issue 2. 97L-8110 (Tried June 15, 2001)

*Skonieczny v. Gardner, Northwest Professional Obstetrics and Gynecology, Levy and Northwest Community Hospital*⁶⁰ concerned a claim that a brachial plexus injury during delivery resulted in permanent loss of the use of the child's left arm and shoulder plus the likelihood of future arthritis and pain. The plaintiff claimed that the obstetrician applied excessive traction to the baby's head and that hospital nurses inappropriately pushed down on the mother's stomach during delivery. The jury awarded \$13, 298,052, but defendant Levy was found not liable. Defendants Gardner and Northwest Professional entered into a high-low agreement of \$1 million to \$2 million with the plaintiff before the verdict. Each defendant had a \$1 million policy limit.

*Christy v. Cavanaugh*⁶¹ involved a claim brought by the family of a man who died in 1997 from complications associated with Huntington's Chorea, an incurable disease of the nervous system. The family contended that for seven years a psychiatrist had misdiagnosed the symptoms as due to depression, therefore preventing treatment that would have abated the man's symptoms and mitigated the pain and suffering by the man and his family. They contended that the worsening symptoms should have resulted in a referral to a neurologist who would have conducted proper testing. The defendant denied negligence and contended that the physical manifestations typically associated with this rare disease were not noticeable in the patient. In May 2001 the jury awarded \$2,500,000.

*Cork v. Cook County Hospital*⁶² concerned a 12-year-old female who was admitted to the hospital in 1991 with a severe windpipe injury following a suicide attempt. She was discharged in stable condition but subsequently readmitted. The lawsuit claimed that upon readmission following breathing difficulties, inexperienced hospital personnel attempted to intubate her at bedside rather than in an operating room. As a result, it was claimed, she was deprived of oxygen, suffered irreversible brain damage and died four days later.

⁶⁰ 98L-4578 (Tried May 7, 2001).

⁶¹ 2001 WL 1855179; ZARIN'S MEDICAL LIABILITY ALERT, Vol. 10, Issue 6. 98L-4578 (Tried May 7, 2001).

⁶² 99L-14351 (Tried May 2, 2001).

The defense claimed the child died from pneumonia and other symptoms. A favorable plaintiff verdict was overturned. This was the second trial and the jury rendered an award of \$5,300,000. However, on appeal in 2003 the First District Appellate Court, Fourth Division, again reversed and remanded the case for a third trial. A rehearing was denied in 2004.⁶³

*Simpson v. Allswede and Midwest Emergency Services, Ltd.*⁶⁴ involved a claim that an emergency room physician used a wrong sized tube to intubate an eight- year-boy who was admitted with severe burns to his face and torso following explosion of an aerosol can. The plaintiff also claimed that the intubation was unnecessary because, despite the burns, there was no indication of difficulty in breathing or hoarseness. The tube remained in place for approximately a week. Ultimately the boy had to undergo a tracheostomy that remained in place for five years plus undergo three additional surgical resections. As a teenager the boy had made a good recovery and could speak normally and breathe easily. On May 8, 2001 the jury returned a verdict of \$2, 563,492 (\$1.1 million for pain and suffering; \$550,000 disfigurement; \$650,000 for loss of a normal life; \$263,492 for medical expenses). The case is reported elsewhere as settled post-verdict for \$1,900,000.⁶⁵

*Cummings v. Suprenant, Midwestern University, and Olympia Fields Osteopathic Hospital*⁶⁶ asserted that the plaintiff suffered excessive burns on his back from a fluoroscopy plus an increased risk of getting cancer. The defendant cardiologist contended that proper consent was obtained, that the exposure was limited, the radiation was in the appropriate amount and that the plaintiff was possibly unusually susceptible to radiation. The jury returned a verdict against the doctor for \$1,250,000 (\$500,000 medical expenses; \$500,000 pain and suffering; \$250,000 for disfigurement: \$0 for disability). The

⁶³ Appellate Court of Illinois First District, Fourth Division , No. 1-02-1009 (December 11, 2003); Appellate Court of Illinois First District, Fourth Division No. 1-02 1009 (February 26, 2004).

⁶⁴ 2001 WL 1855179; 10 ZARIN'S MEDICAL LIABILITY ALERT 6:34 . 96-4608 consolidated with 96L-4770 (Tried April 30, 2001).

⁶⁵ Westlaw WL 34395032, JVR No. 409, 786.

⁶⁶ 97L-7658 (Tried March 27, 2001).

hospital was dismissed mid-trial in a \$75,000 settlement that was set off against the verdict.

*Salas v. Columbia Michael Reese Hospital, Organ, Podorovsky, Carranza and Leland*⁶⁷ involved a wrongful death claim involving a two-year-old girl. The girl was developmentally delayed, had congenital heart disease and chromosomal defects. In January 1997, she developed respiratory distress and was admitted to Michael Reese Hospital because X-rays showed a collapsed left lung; she could not breathe without supplemental oxygen. A CT scan of poor quality suggested a tumor but a second scan was negative. The plaintiff's family claimed that surgery was a high risk because of the collapsed lung and pneumonia. They also claimed there was no informed consent for the procedure because the mother only signed consent for a 'mini-thoracotomy,' while the doctor performed a standard thoracotomy. Also, plaintiff claimed that the anesthesiologist, should have used singular lung ventilation to protect against secretions. The defense claimed surgery was necessary even if the CT scan was negative because the source of the compression needed to be diagnosed and that single lung ventilation was impractical on a 2-year-old. Following a fifteen-day trial the jury awarded \$2,750,000 for wrongful death against Michael Reese hospital, Organ and Podorovsky. Carranza was found not liable and Leland received a directed verdict. The plaintiff had asked the jury for \$15 million. Post-trial motions were filed in this case but no additional information was available.

*Guerin v. Yu and Rush Prudential HMO*⁶⁸ is a case in which a mother gave birth by Caesarian section. The mother was discharged from the hospital but a post-partum examination showed excess bleeding. It was alleged that the defendant was negligent in failing to test the level of hemoglobin. She eventually was rushed to a hospital and underwent four surgeries to stop the bleeding but then developed Adult Respiratory Syndrome and died, survived by her husband and newborn child. The defense argued that the doctor's actions

⁶⁷ 2001 WL 34030899; NATIONAL VERDICT REPORTER. 97L-1732 (Tried Feb 20, 2001).

⁶⁸ 96L-15058 (Tried March 19, 2001).

were not the proximate cause of death. The jury awarded \$7,622,040 against both defendants for survival pain and suffering (\$1 million), medical and funeral expenses (\$92,940), funeral expenses (\$4,100), lifetime earnings (\$750,000) loss of household services (\$275,000) loss of society to husband (\$2.5 million) and loss of society for newborn child (\$2.5 million). During deliberations the parties entered into a high-low agreement (\$500,000-\$7 million).

*Banis v. Loyola University Hospital and Dobozi*⁶⁹ involved a claim from a patient admitted to the hospital in a coma with several fractures, pulmonary contusion and a brain injury following an automobile accident. The plaintiff asserted that hospital staff did not check his forearm, which developed compartment syndrome and turned necrotic. All of the patient's left forearm muscles had to be removed and all subsequent physicians had recommended amputating the arm below the elbow. The defense argued that the compartment syndrome is an extremely rare complication in such cases and that the defendant's comatose state made diagnosis of compartment syndrome difficult. The jury awarded \$1,700,000 against both defendants for disability (\$570,000), disfigurement (\$570,000) and pain and suffering (570,000). The case settled for the amount of the verdict.⁷⁰

*Gonzalez v. St. Mary of Nazareth Hospital, Gonzalez, and Joshi*⁷¹ involved a male patient, age 61, admitted to the hospital with symptoms consistent with a transient ischemic attack or stroke. Following treatment and tests the man died. The plaintiff's estate contended that the treatment deviated from the standard of care by administering a blood thinner and not conducting sufficient tests to determine if hemorrhaging might be taking place. The hospital admitted that it failed to communicate the results of tests but denied negligence, liability or the proximate cause of the man's death. The physician's denied a duty to contact the hospital for lab results and asserted that it was

⁶⁹ 97L-3408 (Tried March 2, 2001)

⁷⁰ Telephone call to plaintiff lawyer on May 5, 2005.

⁷¹ 96L-14398 (Tried January 30, 2001).

reasonable to rely on the protocol of the hospital and its nursing staff. The jury found the two doctors not liable but awarded \$1,250,000 against the hospital: \$1,250,000 for loss of society, but nothing for pain and suffering and disability. The case settled for \$1,255,000.

*Schlindler v. Lipshitz*⁷² involved a prostatectomy on a man, age 71 in 1995. During the procedure the man's rectum was perforated. The error was immediately recognized and repaired. The patient was discharged without further tests. The man returned to the doctor's office reporting that his stool was leaking into the incision. The doctor noted the man probably had a developing fistula and sent him home with instructions to take sitz baths and change back to a soft diet. At trial a plaintiff's surgeon said that the man should have had a colostomy at that time. A colostomy was eventually performed and then reversed. However, the fistula reopened and the man died from complications. The defendant doctor asserted that all decisions that were made were judgment calls and within the standard of care. Further, the defendant contended that the decision to reverse the colostomy was solely that of the surgeon who performed it and the decision was the sole proximate cause of the subsequent injuries and death. The defense made a high-low offer during jury deliberations of \$15,000-\$1,000,000 during jury deliberations (the summary is unclear as to whether the offer was accepted). The jury returned a verdict of \$1,262,748 (\$600,000 for wrongful death, \$462,748 for medical expenses; and \$200,000 for survival pain).

*Macias v. St. Anthony's Hospital*⁷³ involved a child born in 1995. Blood samples were drawn as required by the Illinois Department of Public Health. The newborn child was not feeding well and developed jaundice. She was admitted to another hospital, transferred to the University of Chicago Hospital where she died. At trial the evidence indicated that the blood samples were not received by the Illinois Department of Health lab until 13 days after they were drawn. The results indicated that the baby had a congenital metabolic defect

⁷² 97L4830 (Tried February 2, 2001).

⁷³ 97L-6675 (Tried January 30, 2001).

that , if detected, could have saved her life. The hospital argued that the samples were sent on a timely basis and that the child died from an unrelated influenza infection (an opinion supported by the treating physician). The jury awarded \$1,500,000 (\$1 million for survival pain and suffering, \$42,705 for medical expenses and \$457, 295 for loss of society). The case was subsequently settled for \$1,400,000.

Carroll v. Barrows, Barrows and Brown ⁷⁴ was a lawsuit claiming that the defendants failed to properly diagnose abnormalities in the eyes of a child during seven visits during his first year of life. When the child was seen by the physician's partner the abnormalities were detected and the child was referred to a specialist who detected signs of cancer. The child subsequently had radiation and chemotherapy treatments but eventually lost both eyes. The plaintiff's experts testified that if the child's condition had been diagnosed earlier there was a greater than fifty percent chance that vision could have been saved. The defense maintained that a pediatrician could miss the diagnosis if a portion of the eye was normal, that the patient's form of cancer could not have been treated in any event and that an earlier diagnosis would not have changed the outcome. The jury awarded \$7,962,024 against both defendants (1 million for disfigurement; \$3.5 million for disability; 1 million for pain and suffering , \$152, 224 for medical expenses and \$2, 309,800 for lifetime earnings). The case settled for the \$2 million policy limits of the defendants.⁷⁵

Selected Defense Verdicts Involving Payments to Plaintiffs

In Chapter 2 attention was drawn to the fact that even when plaintiffs lose against some defendants at trial they may nevertheless recover money from other defendants. Of the 72 defense verdicts there are some examples to illustrate this fact.

⁷⁴ 96L-13562 (Tried January 17, 2001).

⁷⁵ Confirmed by a phone message from the plaintiff's lawyer to Vidmar on April 28, 2005

*Foley v. Lutheran General Hospital*⁷⁶ involved a third trial in a case in a wrongful death lawsuit. The other two trials involved deadlocked juries in which a majority of jurors (11:1 in the first trial and 9:3 in the second trial) favored the plaintiff. The plaintiff's estate claimed that in 1993 her bowel was perforated during a tubal ligation and she subsequently became physically distressed and died from sepsis. Although the hospital's policy was that their laboratory call a panic button when lab results showed a panic situation, the log book that would document a panic call was missing. The defense argued that the most likely cause of death was a pulmonary embolism. The plaintiff was survived by her husband and two daughters, ages 4 and 7 months. The jury sided with the defense in this third trial. However, the parties entered into a high-low agreement during deliberations of \$1 million versus \$5 million. The plaintiff's estate thus received \$1,000,000 from the hospital and \$900,000 from another original defendant who settled with the estate before trial.

*Marcial v. Michael and St. Anthony's Hospital*⁷⁷ involved a wrongful death claim from the estate of a 65-year old female who fell down stairs and was admitted to the hospital. The plaintiff's estate asserted that the treating physician made a misdiagnosis of a pulmonary embolism and administered the blood thinner Heparin. The patient developed sepsis and died after approximately four weeks. The defense argued that the diagnosis was proper as was the treatment. Although the jury sided with the defendants, the parties had a high-low agreement of \$50,000 - \$1 million. The woman's estate received \$50,000 from the defendant plus a pretrial settlement with the hospital for \$30,000.

*Jones v. Jordan*⁷⁸ involved a claim that the defendant was negligent in failing to diagnose meningitis in an 86 day-old child resulting in quadraplegia and severe mental retardation (an IQ of about 30). The plaintiff claimed that the doctor recommended giving the child castor oil rather than examine the

⁷⁶ 95L-5339 (Tried January 5, 2001).

⁷⁷ 96L-50363 (Tried March 14, 2001).

⁷⁸ 96L-13425 (Tried September 10, 2001).

child. Two persons corroborated the mother's version of events. The doctor denied that he recommended castor oil for a child under two and that even if a phone call of some kind had taken place the standard of care would not require that the child be seen immediately. The jury sided with the defense. In earlier proceedings the HMO that employed the treating doctor was dismissed from the lawsuit by the judge, but the summary judgment was reversed by the Illinois Appellate Court with an order for a new trial. Prior to the trial the HMO settled with the defendant for \$1,700,000.

*Gamboa v. Christ Hospital and Sternquist*⁷⁹ was a lawsuit alleging that a premature baby fell out of an isolet in the intermediate care nursery and suffered a skull fracture. The child now has cognitive, speech and language deficits. The defense argued that its nurse complied with the standard of care, that the child suffered only superficial bleeding from the fall, and that the deficits were associated with his prematurity. The jury supported the claims of the defendants. Just before the jury rendered its verdict the parties entered into a high-low agreement of \$1 million versus \$3 million, resulting in the plaintiff receiving \$1 million.

*Thomas v. Habid and University of Chicago Hospital*⁸⁰ was filed after a patient presented to the treating physician with a distended stomach and was treated for megacolon with several medications in 1994. The patient improved, but in 1995 was hospitalized with respiratory distress and other symptoms and was later found dead in the hospital's commode. His estate claimed the cause of death was respiratory failure caused by pressure on his diaphragm and lungs from a megacolon. The defense countered that the patient died of an unrelated cardiac problem. The defendant physician was found not liable. However, the hospital was dismissed from the lawsuit after it settled for \$1 million at the start of trial.

⁷⁹ 96L- 2442 (Tried September 17, 2001).

⁸⁰ 96L-6604 (Tried August 20, 2001).

*Allen v. Kirby and Harvey & Associates*⁸¹ involved a malpractice claim by a lawyer who alleged that he became blind after negligent treatment. In 1995 she entered the emergency room of Columbus Hospital with complaints of severe headache and blurry vision. She was diagnosed with sinusitis, her personal physician was contacted and the physician prescribed an antibiotic and Tylenol #3 by phone. The patient became worse, the doctor advised her to discontinue the Tylenol and make an office visit the next day. Instead the patient went two days later to the emergency room at Northwestern Memorial Hospital and was diagnosed with a blood clot that resulted in strangulation of the optic nerves. Plaintiff is now totally blind and needs a seeing eye dog. The physicians who subsequently treated the patient and other experts testified that had she been diagnosed earlier, vision would have been saved. The jury found both defendants not liable, but there was a high-low agreement of \$200,000 - \$1,950,000 and thus the plaintiff received \$200,000.

*Brandonisio v. Kahan and Ob-Gyne Specialists*⁸² involved a case in which an iliac artery was cut during a laparoscopy. When bleeding occurred, open surgery was conducted to repair the injury. The plaintiff claimed ongoing numbness and weakness in her left leg as a result of the surgery. The defense argued that the injury was immediately recognized and they took proper corrective action. Although the jury sided with the defendants, a high-low agreement of \$200,000-\$1 million just prior to closing arguments resulted in a payment of \$200,000.

*Hanson v. Kanuri and Hinsdale Anesthesia Associates*⁸³ concerned a claim that an anesthesiologist failed to take proper cautions involving a 63-year-old man who had recently been taking Coumadin, a blood thinner prior to undergoing surgery on his spine. The man died. The defendant anesthesiologist contended that the surgeon was responsible because he had cleared the patient for surgery and in addition had failed to alert him of the need to

⁸¹ 96L-9932, (Tried November 13, 2001).

⁸² 97L-16429 (Tried June 15, 2001).

⁸³ 98L-1361 (Tried August 13, 2001);

terminate the anesthesia sooner because of excessive bleeding. The DuPage County jury found for the defendants. However, while the jury was deliberating, the parties reached a high-low agreement of \$1 million versus \$3 million, subject to a setoff for a pretrial settlement by Hinsdale Hospital. In short the plaintiff received \$1 million despite losing at trial.

*Goodman v. University of Illinois Hospital*⁸⁴ is a case that ended in a hung jury with nine of the twelve jurors favoring the defendant. A baby born with a congenital heart defect underwent corrective surgery in 1995, but a subsequent infection developed and he died in 1996. The defense argued that the surgical treatment was appropriate. During the jury selection for a second trial the case settled for \$600,000.

*Fleming v. Murphy*⁸⁵ Involved a plaintiff who was admitted to Northwest Community Hospital for repair of an abdominal aortic aneurysm. Following the surgery the man became paraplegic, dependent on a wheelchair and leg braces. The defendant surgeon asserted that he met the standard of care and said that the paralysis is a known, though rare, complication of the surgery. The jury was deadlocked 10 to 2 and the case subsequently settled for \$300,000.

Several other defense verdicts against doctors had pre- or mid-trial settlements of \$25,000 by hospitals that had been named as co-defendants.

In *Egenou v. Elahi and Weiss Memorial Hospital*⁸⁶ the jury rendered a defense verdict in a case involving a claim that intubation left a woman in a vegetative state. The judge ordered a new trial. No other information about the case could be found.

A Multi-Million Dollar Settlement in 2001

In addition to the above jury verdicts, there was a multi-million dollar settlement in 2001 that was reported for Cook County. Settlements are important because they reflect upon the costs incurred by medical providers

⁸⁴ 97L-16429 (Tried June 15, 2001).

⁸⁴ 97L-3636 (Tried Feb 1, 2001).

⁸⁵ 98L-11451 (Tried June 11, 2001).

⁸⁶ 96L-12640 (Tried Jan 2, 2001).

and their insurers. The case is probably an exceptional case, but it gives a glimpse of the less visible side of medical malpractice litigation in Illinois.

*American National Bank and Trust v. Advocate Health and Hospitals, Corp.*⁸⁷ involved a settlement of \$12,000,000 following the birth of triplets in 1993. Two of the children were born with spastic cerebral palsy and brain damage; the third child, also suffering with cerebral palsy and brain damage, died in 1997. Of the \$12 million total, \$5.5 million was awarded for one child, \$3 million for the second child, \$2 million to the estate of the third child for wrongful death and \$1.5 million to the parents of the children under the Family Expense Act. The claim was based on the assertion that the health care providers were negligent in not informing the parents of the risks of triplet pregnancies, failing to examine the mother on a timely basis when premature labor began and failure to provide appropriate medicines on a timely basis after delivery by Caesarian section. Lutheran General Hospital was self-insured and paid \$2 million while St. Paul Insurance Company paid \$10 million for the other two defendants.

Cook and DuPage Jury Verdicts: 2002-2004

I also obtained data on jury verdicts in Cook and DuPage counties for 2002, 2003 and 2004. The problem with these data for this report is that post-verdict adjustments often take many months and are often not available in initial verdict reports. As demonstrated with the 2001 data, without these adjustments the verdicts can be quite misleading. As a consequence, I report only the frequency of jury trials and plaintiff win rates for the combined counties.

Table 3.6 reports the frequency of jury trials and plaintiff win rates for Cook and DuPage counties for 2001 through 2004.

⁸⁷ 2001 WL 34030866, 96L-05765 (2001).

Table 3.6: Jury Trial Frequency and Plaintiff Win Rates in Cook and DuPage Counties (Combined): 2001-2004

Year	Trial	Win rate
2001	99	30%
2002	110	37%
2003	99	36%
2004	97	30%

The table shows that in 2002 trial frequency changed from 99 trials in 2001 to 110 trials, an increase of 10 percent. The table also indicates that the plaintiff win rate jumped 7%. However, in 2003 frequency of trials returned to 99 although plaintiffs win rate was 36%. In 2004 there were two fewer trials than in 2001 and the win rate returned to 30%. In short, there is no evidence of increasing jury trials or increased win rates over the four-year period. Remember also that the trials in all of these years were based on lawsuits that on average were filed between three and six years earlier than the trial date.

Summary and Conclusion

The statistics and case summaries presented in this section are compilations and case summaries collected by others and checked, where possible, against other sources. The summaries of the issues in the case may contain details or omissions that parties to the actual cases may contest. Nevertheless, the *Cook County Jury Verdict Reporter* data appear to be generally accurate. With the one exception of *National Bank and Trust*, they speak only to outcomes of jury trials, which may constitute only ten percent or fewer of all malpractice claims during 2001 since the overwhelming majority of claims are settled without jury trials.⁸⁸

But since Cook and DuPage counties contain approximately one half of the population of Illinois and approximately two-thirds of its non-federal treating physicians and much of the debate about problems with the tort

⁸⁸ See Vidmar et al, *Uncovering the "Invisible" Profile of Medical Malpractice Litigation: Insights from Florida*, 54 DEPAUL LAW REVIEW 315(2005); NEIL VIDMAR, *MEDICAL MALPRACTICE AND THE AMERICAN JURY* (1995) at pages 24-25.

system focus on jury decisions, some important findings emerge from the analyses. There was a modest increase in medical malpractice case filings between 1996 and 2004, but when adjusted for the growth in physicians who treat patients there is no evidence of a medical malpractice claims increase. The data from the federal Bureau of Statistics study raise questions about comprehensiveness but they do show no increase in jury trials between 1996 and 2001.

Jury verdict reports from the *Cook County Jury Verdict Reporter* appear to be a comprehensive survey and provide more details about jury trials than other sources. These data show no increases in jury trials or in plaintiff win rates between 2001 and 2004.

Trial outcomes are a matter of judgment. The claims in many of the trials that are summarized involve very serious injuries or death. Trials occur when the plaintiff and the defendants cannot agree on legal liability or the amount of damages. Different readers could undoubtedly draw different opinions about the verdicts if they heard the same evidence that the jury heard.

What we can draw from the findings is that in cases where plaintiffs prevailed, twelve citizens of the State of Illinois, some who voted Republican and some who voted Democrat, heard the evidence and unanimously agreed on a verdict. In the vast majority of the cases a trial judge agreed with the verdict and entered judgment. We can also draw a conclusion that the judgment was not always the final word. Sometimes a trial judge or an appellate court overturned the verdict. In other instances the parties settled for much less than the verdict. Some very large verdicts actually settled for the limits of the insurance coverage. In other instances the parties entered into high-low agreements before the verdict. Although the final settlements of some cases could not be determined, the post trial adjustments that were available indicate that the mean adjusted verdict was much less than the original verdict—in one instance, from \$30 million to \$2 million. The data also show that some plaintiffs who lost at trial against one or more defendants still ended up with large settlements from other defendants.

The findings from Cook and DuPage counties account for high percentages of Illinois' population and Illinois doctors. Can they be generalized to the rest of the state, especially if, as some have claimed, there are "judicial hellholes" in certain smaller Illinois counties? Chapter 4 turns to an examination of Madison and St. Clair counties.

Chapter 4

A Close Look at Madison and St. Clair Counties and the Southern District of Illinois Federal Court

Madison and St. Clair counties have been a center of controversy in the debate about medical malpractice and doctors' liability insurance premiums. When President Bush visited Collinsville in January 2005, he blamed the problem on outsized jury awards. News reports suggest that doctors have left the area because of high malpractice insurance premiums, blaming the problem on jury awards. The American Tort Reform Association has labeled Madison County as a "judicial hellhole." Much of the controversy involves large awards in class action asbestos cases. However, by inference, claims are made that there are also large awards in medical malpractice cases.

As a consequence of the controversy, Madison and St. Clair counties and the U.S. District Court for the Southern District of Illinois were singled out for particular attention. The *Westlaw* and *Lexis* databases (which incorporate the *Southwest Illinois Jury Verdict Reporter*) were searched from 1992 through 2005 for all medical malpractice verdicts in those venues. To supplement the summary descriptions contained in the verdict reporter I personally traveled to Edwardsville, Illinois and examined the actual court files for each of the identified cases. My goal was to check them for accuracy and to discover any other relevant facts.

Madison County

Table 4.1 presents a summary of jury verdicts involving claims of medical malpractice from 1992 through 2005.

Table 4.1
Jury Verdicts in Medical Malpractice Cases:
Madison County Court, 1992-2004

Year	Case Name	Verdict	Verdict Amount
1992	Buie v. St. Elizabeth Medical Center	Defense	\$0
1992	Hungate v. Allendorph	Defense	\$0
1992	Brown v. Afuwape	Defense	\$0
1992	Marshall v. Harley	Defense	\$0
1993	Garcia v. Tulyasthien	Plaintiff	\$600,000
1993	Beets v. Mucci	Plaintiff	\$332,000
1993	Krause v. Greaves	Defense	\$0
1994	Fisher v. Friedman	Plaintiff	\$350,000
1994	Rives v. Hamilton	Defense	\$0
1995	Pruett v. Mucci	Plaintiff	\$900,000
1995	Holbert v. Malench	Defense	\$0
1996	Barnes v. St. Elizabeth's Medical Center	Plaintiff	\$402,000 -\$174,000*
1996	Grant v. Petroff	Defense	\$0
1997	Finazzo v. Hill	Defense	\$0
1998	Lanz v. Chen	Defense	\$0
1999	Arnold v. Gittersonki	Defense	\$0
1999	Roberts v. Fernandez	Defense	\$0
2000	Adams v. Marrese	Plaintiff	\$1,784,000
2000	Knight v. Miller	Defense	\$0
2001	Lemons v. Dave	Plaintiff	\$470,000
2002	Wagoner v. Gingrich	Plaintiff	\$75,000
2002	Moffitt v. Skirball	Defense	\$0
2002	Jenkins v. Dai	Defense	\$0
2002	Terry v. Hamilton	Defense	\$0
2003	Budwell v. Freeman	Plaintiff	\$25,000
2005	Grant v. Petroff	Defense	\$0

* Settled for \$174,000 versus verdict of \$400,000

Table 4.1 indicates there were 26 reported jury trials involving medical malpractice in Madison County from 1992 through 1995, an average of 1.7 trials per year. Nine of the 26 trials ended with an award for the plaintiff, a win rate of 35 percent. The average award in those plaintiff wins was \$523,333. One award (*Adams*) exceeded \$1 million and another (*Pruett*) approached \$1 million. The awards in the table are not adjusted for inflation.

Plaintiff Verdicts Summarized

Details about each of the plaintiff verdicts provide insights about the nature of the claim and its eventual settlement. These details do not speak to the issue of whether the case was decided properly. Additionally, in most instances I could not independently verify pre-trial settlement offers reported in the database. Further, in most instances, there were some exceptions; neither the verdict reporter nor the court file provided data on whether the case was finally settled for less than the jury verdict.⁸⁹

Garcia v. Tulyasthien (1993)⁹⁰ involved a claim of negligent surgery. The plaintiff, age 33, claimed that a surgeon negligently inserted a metal rod in his leg that was unnecessary, resulting in osteomyelitis, inflammation of the bone and marrow. His past medical costs were \$2500 and his wage loss was \$15,000.

Beets v. Mucci (1993)⁹¹ concerned the wrongful death of a 34 year old mother of two children, ages 4 and 16. The patient had been treated for cervical cancer and her estate claimed that Dr. Mucci had failed to remove all the cancer during surgery. The jury verdict was \$332,000.

Fisher v. Friedman (1994)⁹² involved a claim that the physician failed to detect a detached retina and or refer the patient to a specialist. The claimed result was the loss of one eye; five separate surgeries to reattach the retina were not successful. The plaintiff claimed he was legally blind as a result. The defendant physician admitted liability. Presumably the jury trial was about the amount of damages. The plaintiff had demanded \$750,000 before and during trial and the defendant offered \$600,000. The jury verdict was for \$350,000, about 58 % of the defendant's offer. The parties settled following the plaintiff's post-trial motion for a new trial on damages.

⁸⁹ The cases are identified in footnotes by the Madison County Court's docket number.

⁹⁰ 91-L-1026

⁹¹ 91-L-433

⁹² 91-L-1646

Pruett v. Mucci and St. Anthony's Hospital (1995)⁹³ involved permanent neurological damage to the brain and spinal cord of a child during her mother's labor. The plaintiff's guardian alleged failure to monitor during delivery and inappropriate use of forceps. The jury concluded that Dr. Mucci was an agent of the hospital. During trial the plaintiff demanded \$750,000 to settle and the defendant offered \$250,000. The jury verdict of \$900,000 involved the following breakdown: past and future medical expenses, \$200,000; past and future disability, \$250,000; past and future disfigurement, \$250,000; past and future pain and suffering, \$200,000. The case settled for \$875,000. Because the case involved a minor the court record contains a formal settlement distribution approved by a judge. \$500,000 of the award was invested in an annuity to provide the plaintiff with a guaranteed annual income with graduated income amounts that would eventually provide \$5600 per month for life (expected total lifetime yield from the annuity would be over \$4 million) over the plaintiff's lifetime. From the balance of \$375,000, a lien (unspecified but likely Medicaid or a private insurer) of \$28,000 for medical expenses was deducted. Expert fees and other litigation expenses amounted to slightly over \$22,000. Under Illinois fee structure the plaintiff's lawyers received \$281,000. The plaintiff received the net balance of \$43,437.

Barnes v. St. Elizabeth's Medical Center (1996)⁹⁴ involved a claim that the medical staff of the hospital had failed to provide antiseptic conditions following wrist surgery, had failed to monitor the infection, and negligence in transporting him in the hospital during which the patient's arm was "rammed" into an elevator door, thereby pushing placement pins into a bone graft. As a consequence, the plaintiff contended, an infection developed and additional surgery was required. The treating physician was listed in the claim as having knowledge of the facts but was not listed as a defendant. The plaintiff claimed lost wages as well as medical expenses. The defense was based on the alleged failure to show a proximate cause for the injuries. After the jury verdict of

⁹³ 91-L-823

⁹⁴ 92-L-994

\$402,000 the plaintiff requested the judge to increase the judgment because the defense counsel had improperly mentioned in closing arguments that the plaintiff's \$96,000 in medical costs were paid by insurance, thereby causing the jury to deduct those expenses from the award. Approximately six weeks after the verdict the trial judge entered a judgment, reducing the final award to \$228,000 on the grounds that the plaintiff's claims of wage loss were "too speculative." Shortly thereafter the parties settled the case for \$174,000.

Adams v. Mareese (2000)⁹⁵ involved a claim by a 29-year-old man that in 1992 the defendant performed three unnecessary fusion surgeries to the man's neck requiring a fourth corrective surgery with an internal fixation. The alleged result was a complete loss of range of neck motion, chronic pain, permanent disability and inability to work for the remainder of his life. The claim involved \$91,000 in past medical expenses, approximately \$140,000 in past wage loss and approximately \$400,000 in future wage loss. The defendant denied the claims of negligence, stating that the original surgeries were necessary. The jury awarded the plaintiff \$1,784,000 divided as follows: \$140,000 for past wage loss; \$400,000 for future wage loss; \$90,000 for past medical expenses, and \$1,154,000 for disability, disfigurement and pain and suffering. The trial judge affirmed the verdict and in the judgment commented on judicial restraint "in response to defendant's evasive answers, unsolicited elaborations, and assorted courtroom shenanigans." (judgment, page 26). The judgment further noted that the defendant was chastised out of the presence of the jury but threatened with chastisement in front of the jury for this behavior (judgment, page 25). The defendant appealed to the 5th District Appellate Court and then to the Illinois Supreme Court, but the appeals were denied (204 Ill.2d 655, 792 N.E.2d 305, 275 Ill. Dec. 74, June 4, 2003).

⁹⁵ 98-L-858

Lemons v. Dave (2001)⁹⁶ involved a claim of wrongful death for failure to diagnose and treat bladder cancer in a timely manner; the delay of 25 months allegedly resulted in a premature death. The mother of four children was 58 years old at the time of her death. The jury verdict was as follows: medical expenses medical \$70,000; pain and suffering, \$250,000; husband of the deceased, \$50,000 for loss of money, services, society, and sexual relations; the estate value of wife's services, \$50,000; reasonable society and loss of companionship and sex, \$50,000. Judgment affirming the jury verdict was made on Dec 7, 2001. The verdict reporter notes that the plaintiff's estate reached a confidential settlement with another defendant named in the lawsuit, suggesting that more money was recovered than reflected in the verdict.

Wagoner v. Gingrich (2002)⁹⁷ involved a claim of a birth injury to the shoulder and arm resulting in Erb's palsy (nerve damage) and partial loss of use of right arm. Medical specials were \$5000. The defendant denied negligence. Testimony indicated that, otherwise, the child was developing normally. The jury awarded \$75,000.

Budwell v. Freeman (2003)⁹⁸ involved a claim by a woman in her late thirties that the defendant performed a scheduled tubal ligation after child birth, but the incision for the tubal ligation was made too close to an existing umbilical hernia, causing post-operative complications resulting in an infection in her abdomen for about 18 months, multiple corrective surgeries, permanent abdominal scarring and pain and suffering. Medical expenses were claimed to be approximately \$12,000 and wage losses between \$6,000 to \$7,000. The jury verdict was for \$25,000.

Three Other Cases That Were Not Medical Negligence Verdicts

It is important to draw attention to the fact that three other awards were identified that involved medical malpractice plaintiffs. In 1992 a Madison

⁹⁶ 99-LM-651

⁹⁷ 98-L-780

⁹⁸ 00-L-960

County case, *Bloome v. Wiseman*⁹⁹ involved a legal malpractice award of \$3,238,000. The case concerned a lawyer who failed to properly represent a patient involved in a malpractice lawsuit. The trial judge reduced the award to \$2.6 million, reflecting an assessment that the plaintiff had potential medical damages of that amount. *Robeen v. Walgreens*¹⁰⁰ involved a pharmacy error that resulted in a person having seizures resulting in a jury verdict of \$50,840. In *Hess v. Madison County Nursing Home*¹⁰¹ in 2001 the estate of an eighty-seven-year old patient sued for burns resulting from hot tea and received an award of \$14,000. A doctor was originally named in the suit but was dismissed as a defendant before trial.

A Settlement Case

Resser v. Chand (1997)¹⁰² involved a claim that the defendant attempted but failed to complete a colposcopy examination and subsequently ordered surgery and performed an extensive conization which virtually amputated the cervix. Plaintiff had significant abdominal pain after the procedure and upon a return visit was first told of the type of surgery performed, attributing the pain to the internal sutures. Plaintiff underwent a laparoscopic examination and dilation of the cervical canal but continued to experience uterine bleeding. Subsequently, plaintiff sought another opinion from a different doctor who recommended a total hysterectomy and performed such. The plaintiff claimed defendant breached the standard of care by performing a conization, which was inappropriate for the abnormal PAP test and contended that defendant misdiagnosed her condition as severe dysplasia when the post-operative pathology report indicated no dysplasia was present. Plaintiff claimed defendant also failed to type the HPV virus to determine whether it was a specific species, which is a precursor of cancer and that the defendant failed to obtain her informed consent for the conization procedure.

⁹⁹ 91-L-189

¹⁰⁰ 93-L-1211

¹⁰¹ 98-L-931

¹⁰² 98-L-1279

The plaintiff further contended that the defendant falsified and/or negligently altered medical records to reflect plaintiff’s informed consent. The case settled for \$275,000.

St Clair County

St. Clair County jury verdicts are contained in Table 4.2.

Table 4.2: St. Clair Jury Verdicts 1993-2003

Year	Case name	Verdict	Verdict Amount
1993	Holten v. Memorial Hospital	Plaintiff	\$8,816,500 Retrial ^a
1993	Taylor v. Murphy	Defense	\$0
1994	Smith	Defense	\$0
1995	Karr v. Tschoe	Defense	\$0
1995	Eggemeyer v. Metropolitan Ref Labs and Simons	Plaintiff	\$0 ^b
1996	Earle v. Diehl	Defense	\$0
1996	Abbitt v. Price	Defense	\$0
1997	McClure v. Ramon	Defense	\$0
1997	Restoff v. S.Ill. Surgical Consultants	Defense	\$0
1998	Eck v. Prosser	Defense	\$0
1999	Trentman v. Associated Orthopedic Surgeons	Defense	\$0
2002	Sherrod v. Ramaswami	Plaintiff	\$250,000 ^c
2003	McGinnis	Defense	\$0
2003	Cretton v. Protestant Memorial Medical Center	Plaintiff	\$0 ^d

Notes: a. Reversed and remanded by Ill. S. Ct but another defendant settled pre-trial \$2,950,000; b. Doctor not liable but \$550,000 against hospital for “slip and fall;” c. Also a civil rights claim with \$150,000 in compensatory and punitive damages; d. Not medical negligence but \$950,000 against hospital for “slip and fall.”

The table shows one very large verdict of over \$8 million that was reversed by an appeals court, but the note draws attention to the fact that another defendant in the case settled before trial for \$2,950,000. Details are reported in the next section. There was one other medical malpractice verdict for \$250,000. The notes to the table indicate that in two other cases doctors were sued along with other parties but were found not liable for medical

negligence but co-defendants were found liable on other grounds and substantial damages were awarded. Details are provided in the next section. It is noteworthy that the juries in these latter cases were clearly capable of making distinctions between malpractice versus other claims.

Similar to Madison County, there is no evidence of runaway juries in medical malpractice cases, especially over the last decade.

Plaintiff Verdicts Summarized

Holten v. Memorial Hospital (1993)¹⁰³ claimed a hospital failed to properly diagnose her condition. She alleged that in 1990, she was admitted to Memorial Hospital emergency room with complaints of numbness and tingling in her lower extremities. She alleged that on the following day, the numbness and tingling progressed to paralysis which was not noticed by the nurses on the ward who took care of her. Plaintiff contended that two days after admission, she was paralyzed in her lower extremities; the defendant had failed to properly diagnose her condition and administer treatment before her condition worsened. Memorial hospital asserted that her condition was properly diagnosed at that time as being the result of a blood clot or circulation failure in the spine. Further, in a cross claim Memorial alleged that the treating physician had incorrectly diagnosed her condition to be caused by cancer, had treated her for cancer and failed to properly treat an infection in her spine which lead to the worsening of her condition. The jury awarded \$8,706,500 to the plaintiff and her spouse received \$110,000. The trial judge agreed with the verdict on liability but reduced the award by \$1,500,000. Next the appellate court affirmed the judgment on liability but reduced the award to \$4,366,500. The Illinois Supreme Court reviewed the case and ruled that the evidence supported the jury's determination that the failure of the hospital staff to report the progression of the patient's paralysis was a proximate cause of her paralysis. However, the Court further concluded that the trial court's stated belief that a defense witness had been led by defense counsel to testify falsely

¹⁰³ 91-L-900

and the plaintiff counsel's prejudicial remarks during closing arguments charging attorney misconduct denied the hospital a fair trial. In addition the Court ruled that a jury instruction on aggravation of an injury caused by another tortfeasor's (the surgeon) negligence should not have been given and that another instruction on proximate cause should not have been given. The case was reversed and remanded back to the original trial court. No further information could be found about the case, possibly indicating it settled. However, it is noteworthy that a co-defendant, the plaintiff's treating neurosurgeon, settled with plaintiff before trial for \$2,950,000. Additional on-line research uncovered no evidence of a retrial or a settlement involving Memorial Hospital.

Cretton v. Protestant Memorial Center (1993)¹⁰⁴ involved a wrongful death claim by the estate of a security guard, age 63, suffering from chronic obstructive pulmonary disease and emphysema. The plaintiff's estate claimed that Cretton told her daughter after the transfer from one hospital unit to another that, while she was being put in her bed, nurses had her stand on her own, and she fell. She subsequently died and the coroner concluded that death was caused by an injury to her brain. The defense contested the coroner's finding, claiming that the patient died of respiratory failure. The jury found that Cretton's death was not caused by medical negligence on the part of the hospital, but that the fall was, and awarded \$950,000. The plaintiffs sought noneconomic damages for the three days between Cretton's transfer and her death, and for the loss of society, guidance, and support to her heirs.

Medical Malpractice and a Civil Rights Violation

Sherrod v. Ramaswami and Shroff (2002)¹⁰⁵ is an unusual case. The plaintiff was a convicted rapist who complained of abdominal pain and was diagnosed with suspected appendicitis but the doctors did not take timely additional action for over two weeks despite many complaints of severe pain by

¹⁰⁴ 00-L-64

¹⁰⁵ 97-63-GBC

the man. Eventually a surgeon operated and found a ruptured appendix with gangreen having spread to the intestines. The surgeon had to remove the appendix, four inches of small intestine, three inches of large intestine and the cecum, leaving the patient with a large scar and a risk of future intestinal blockage. In addition to medical malpractice the plaintiff claimed a civil rights violation. The jury awarded \$250,000 for medical malpractice, \$100,000 compensatory damages and \$50,000 against Dr. Ramaswami , but found defendant Shroff not liable.

A Settled Case

Eggemeyer v. Metropolitan Reference Laboratories and Simmons (1995)¹⁰⁶ alleged an unnecessary mastectomy, pain and suffering by the laboratory defendant and a physician. The patient was about 50 years old sought treatment for a suspicious lump in her breast. A biopsy was performed but a courier for the laboratory failed to deliver the specimen or the laboratory misplaced it. Plaintiff alleged the doctor reviewed her options, which ranged from monitoring her condition to a prophylactic mastectomy. A second biopsy was not an option because virtually all suspicious tissue was removed. At some point, the doctor relocated his practice and plaintiff sought another opinion. Since plaintiff had a family history of breast cancer, the second doctor was very concerned about an undiagnosed cancer and plaintiff decided to undergo a modified radical mastectomy. However, after the procedure it was found that there was no cancer present. Before trial the laboratory settled for \$500,000 and the physician settled for \$50,000.

Federal Cases In the Southern District of Illinois

Medical malpractice cases end up in federal rather than state courts under two main circumstances. One circumstance is when one of the parties to a lawsuit resides in another state; the case may be moved to a federal court under “diversity” jurisdiction. The second circumstance is when the defendant

¹⁰⁶ 93-L-362

is a federal agency, such as a VA hospital or a military hospital. However, under this second circumstance the Federal Tort Claims Act requires that the case be decided by a judge rather than by a jury.

Table 4.3 presents medical malpractice verdicts reported for federal court of the Southern District of Illinois (located in East St. Louis).

Table 4.3 Federal Court Jury Medical Malpractice Verdicts, Southern District of Illinois: 1992- 2003

Year	Case Name	Verdict	Amount
1993	Taylor	Defense	\$0
1994	Ridenour v. Muller	Defense	\$0
1995	Cripps v. Union Pacific and Heshmatpour	Plaintiff	\$375,000
1995	Haas v. Group Health Plan	Plaintiff	\$100,000
1996	Kaufman v. Cserny	Defense	\$0
1997	Mandrell	Defense	\$0
2001	Treadway	Defense	\$0
2003	Mize	Defense	\$0

Table 4.3 shows that since 1992 there have been two plaintiff verdicts from federal court juries involving claims related to medical malpractice. There was an additional verdict involving a brain-injured child that resulted in a verdict of \$19,253,549. It was major news, but as explained below, it did not involve a jury verdict.

Plaintiff Verdicts Summarized

Cripps v. Union Pacific and Heshmatpour(1995)¹⁰⁷ involved a railroad worker who was injured on the job and alleged permanent nerve damage to his left elbow and inability to return to his job.. He alleged that the physician had been negligent in performing surgery after a work injury. The defendant contended that he had met the standard of care. Union Pacific was a defendant as part of a “loan receipt agreement” called a “Mary Carter” agreement after a 1967 case

¹⁰⁷ 93-318

involving a defendant , Mary Carter Paint Company. The verdict was for \$1,500,000 for the plaintiff against Union pacific and \$175,000 against the physician. From the \$375,000 Union Pacific received \$225,000 and the plaintiff received an additional \$155,000. Under the agreement Union Pacific paid nothing to the plaintiff.

Haas v. Group Health Plan (1995) ¹⁰⁸ involved a 45-year-old female plaintiff who went for an ear cleaning. Her eardrum was perforated resulting in temporary hearing loss and permanent high frequency loss. The plaintiff's case was based on the legal theory of *res ipsa loquitur*, that is, the injury speaks for itself. The award was \$100,000.

Trial by Judge Alone

Coleman v. United States of America and Touchette Regional Hospital (2003) ¹⁰⁹ involved a claim against a physician considered a federal employee of the United States. The plaintiff's mother alleged that during the birthing process the physician attempted to apply a vacuum extractor to the baby's head about 15 times rather than the manufacturer's recommendation of no more than three times. The result was severe brain injury to the plaintiff. The plaintiff further alleged that although a Caesarian Section was eventually performed it should have been performed much earlier. The physician denied that fifteen attempts were made with the vacuum extractor and claimed the injury was due to an arrest of labor and the injury was attributed to an infection contracted by the mother. Defendant Touchette Regional Hospital was dismissed from the suit before trial. Under the Federal Tort Claims Act the trial was by judge alone and resulted in a verdict of \$19,253,549. The plaintiff reportedly had offered to settle for \$8 million before trial and the defendant's last offer was reported as \$3.1 million. After a search of federal court cases in *Westlaw* no appeal of the verdict could be found.

¹⁰⁸ 94-231

¹⁰⁹ 01-CV-314

Conclusion

Over a 14-year period only 11 jury verdicts favoring the plaintiff were uncovered in Madison and St. Clair county courts involving medical malpractice. Only two verdicts exceeded one million dollars although a third for \$900,000 approached one million. As with cases summarized in Chapter 3, different persons can draw opposing conclusions about whether even the relatively few plaintiff awards were justified, but in any event there is no evidence to support the perception that medical malpractice jury trials in these counties are frequent and outrageous in their generosity to plaintiffs.

The data reported in this chapter do not speak to settlements resulting in payments without resort to jury trial. Research in other jurisdictions indicates that settlements outnumber jury trials by about nine settlements to one trial. The public debate has been about jury verdicts, however.

The reputation of these two counties has been affected by the linking controversy over asbestos litigation and medical malpractice litigation in mass media reports and the claims of tort-reform proponents. The reputation may have been further enhanced by media accounts of the very large award in the *Coleman* case in the Federal Court. The case was decided by a federal judge, not a jury.

The central conclusion to be drawn from this chapter is this: Insofar as medical malpractice litigation is concerned, the reputation of Madison and St. Clair counties as “judicial hellholes” is not supported by hard data.

Chapter 5

Caps on Pain and Suffering

One of the central proposals for tort reform in medical malpractice involves a cap of \$500,000 on the pain and suffering component of awards. One source, without documentation, reported that non-economic damages “...now make up more than 90 percent of the money awarded by Illinois juries.”¹¹⁰

This chapter returns to the jury awards from Cook and DuPage counties presented in Chapter 3 to examine issues related to “pain and suffering.” Its intent is to provoke deeper thought about the pain and suffering component of awards. Fundamental changes in tort law should not be taken lightly and without such consideration.

The data in Chapters 3 and 4 have challenged some widely held assumptions about jury awards, and the data in Chapter 6 will offer an additional challenge, namely that the evidence of doctors fleeing Illinois is not supported by any reliable data and in fact is contradicted by statistics collected by the American Medical Association.

Re-Examining Cook-DuPage Jury Awards in 2001

Table 5.1 describes all 30 plaintiff verdicts from Cook and DuPage counties in 2001. In most cases, although not all, the summary from the *Cook County Jury Verdict Reporter* described the various elements that made up the damage award, including the pain and suffering component. The summaries allow us to make a rough estimate of what the verdict would have been if the judge had been required to reduce the pain and suffering component of the award to \$500,000. Recall also, that in a number of cases the settlement was less than the verdict due to high-low agreements, settlements for the amount of the liability insurer’s coverage, or for other reasons.

¹¹⁰ Steve Stanek, *Doctors Flee Illinois*, HEALTH CARE NEWS, April 1, 2004.

The first column reports the case. The second column is the jury verdict. The third column reports any adjustment to the verdict that the judge would have applied if the pain and suffering component of the award exceeded \$500,000. The fourth column reports any known settlement amount that differed from the verdict. The remaining columns report the itemized verdict elements. The pain and suffering component of the award is in the fourth column, allowing the reader to see how much the jury award differed from the \$500,000 cap.

Table 5.1: Estimating Effects of a \$500,000 Cap on Pain and Suffering

Case	Verdict	Cap Adjust	Settlement	Pain & Suffering	Medical and income loss	Disfigurement	Loss of Normal Life	Loss Society/ Wrongful Death/ Loss Consortium
Bryant	\$30,000,000	\$26,500,000	\$1,100,000	\$4,000,000	\$ 16, 476,000	\$4,000,000		
Lawler	\$3,800,000	\$1,800,000		\$2,500,000		\$100,000	\$1,200,000	
Brewster	\$170,000			\$150,000	\$20,000			
Asceves	\$467,000				\$32,900			
E. Munoz	\$2,495,893	\$1,870,000		\$1,000,000	\$887,300	\$500,000		
D. Munoz	\$150,000		\$0	\$100,000		\$50,000		
McNamara	\$317,000			\$280,000	\$37,000			
Matthews	\$3,781,393				\$31,393			\$3,750,000
Genovese	\$494,906			??	??			
Willis	\$120,608			??	??			
Bales	\$2,812,553			\$500,000	\$715,723	\$750,000	\$800,000	
Washington	\$200,000			\$100,000		\$100,000	\$0	
Gonzales	\$1,191,256	\$1,091,256	\$950,000	\$600,000	\$141,256		\$450,000	
Walisczek	\$6,500,000		\$800,000	??	??			
Stajczyk	\$801,643				\$1,643			\$800,000
Thomas	\$835,000				\$835,000			
Matei	\$525,000			??	??			
Skonieczny	\$13,298,052		\$2,000,000		\$298,052			
Christy	\$2,500,000	\$2,000,000		\$1,000,000			\$1,000,000	\$500,000
Cork	\$5,300,000		\$0					
Simpson	\$2,563,492	\$1,963,492	\$1,900,000	\$1,100,000	\$263,492	\$550,000	\$650,000	
Cummings	\$1,250,000			\$500,000	\$500,000	\$250,000		
Salas	\$2,750,000							
Guerin	\$7,622,040	\$7,122,040	\$7,000,000	\$1,000,000	\$1,622,040			\$5,000,000
Banis	\$1,710,000	\$1,640,000		\$570,000	\$570,000	\$570,000		
Perrier	\$218,626			\$100,000	\$68,626	\$50,000	\$0	
Schlindler	\$1,262,748			\$200,000	\$462,748			\$600,000
Macias	\$1,500,000	\$1,000,000		\$1,000,000	\$42,705			\$457,295
Carroll	\$7,962,024	\$7,462,024	\$2,000,000	\$1,000,000	\$5,962,024	\$1,000,000		

Column 3 in the table shows that the cap would have reduced the jury's verdict in ten of the 30 cases: *Bryant, Lawler, E. Munoz, Gonzales, Christy, Simpson, Guerin, Banis, Macias, and Carroll*. But wait. Look at column 4. *Bryant* settled for \$1,100,000, far less than jury's award for economic damages. The cap made no difference in the settlement outcome. Similarly, *Gonzales* settled for less than the cap adjustment. So did *Simpson, Guerin* and *Carroll*.

Thus, five cases of the 30 would have been affected by the caps: *Lawler, E. Munoz, Christy, Banis, and Macias*. The verdicts in *Munoz, Christy, and Macias* would have been \$500,000 less. In *Banis* the cap would have reduced the jury's award by \$70,000. *Lawler* resulted in the biggest reduction, namely \$2 million.

In some cases, the breakdown of the elements of the verdict was not reported and these are noted with question marks, but the total verdicts of these cases were, in any event, below the \$500,000 limit of the proposed cap.

Readers may note that in addition to medical and income losses, jury verdicts described in Table 5.1 also included damages for disfigurement, loss of a normal life, loss of society, wrongful death, and loss of consortium. Under Illinois law these elements of damages have important economic consequences bearing on claims even though there is no fixed metric by which the amounts can be assessed. The determination of amounts is left to the jury under the supervision of the judge.¹¹¹

Recognition of the economic component to so-called "non-economic damages" is a common source of confusion about "pain and suffering."¹¹² Pain and suffering is only one component of "non-economic" damages. In some states and textbooks, alternative terms of "special" and "general" damages are

¹¹¹ See generally, Ill. Pattern Jury Instr.-Civ. 30.04.03 (2005 ed.); Ill. Pattern Jury Instr.-Civ. 34.02 (2005 ed.); WEST'S SMITH-HURD ILLINOIS COMPILED STATUTES ANNOTATED and cases cited in the annotations.

CHAPTER 740. CIVIL LIABILITIES, ACT 180. WRONGFUL DEATH ACT, 180/1. Action for damages

¹¹² For more discussion see, Neil Vidmar, Felicia Gross and Mary Rose, *Jury Awards For Medical Malpractice and Post-Verdict Adjustments of Those Awards*, 48 DE PAUL LAW REVIEW 265 (1998).

used. This partially avoids the problem of conflation of pain and suffering with other kinds of damages, such as described above. In short, the claim in one mass media report that more than 90 percent of Illinois jury awards are for “non-economic” damages ¹¹³ might be true—better data would be needed—but this does not mean that 90 percent of jury awards in medical malpractice cases are for pain and suffering.

Indeed, although data are missing for breakdowns of damages in some cases, a very rough estimate of the proportion of the total awards that pain and suffering represented in the cases reported in Table 5.1 can be obtained dividing the total of the pain and suffering (column 5) by the total of the jury verdicts (column 2). By this rough calculation “pain and suffering” constitutes only 15% of verdicts. Perhaps if the missing data were known and added in, the percentage would be higher. But even if the missing information doubled the figure - an unlikely projection - the percentage would be a far cry from 90%.

Recall that, as discussed in Chapter 2, jury verdicts constitute ten percent or less of all payments to claimants. Recall also that Cook and DuPage counties contain half of Illinois’ population and two-thirds of its doctors and that the data show that Madison and St. Clair counties yield jury verdicts less or equal to Cook and DuPage counties, so it is reasonable to assume that these findings can be generalized to all of Illinois. One conclusion to be drawn from the above discussion is that a \$500,000 cap on pain and suffering, while significantly decreasing awards to some individual plaintiffs, would have minimal impact on overall payments to claimants in medical malpractice in Illinois.

Some might argue that the above conclusion does not consider the “shadow effect” of jury verdicts. No direct answer can be given to this claim. However, given the likely minimal impact that a \$500,000 cap would have on jury verdicts, this claim would not appear to have much logical substance.¹¹⁴

¹¹³ Steve Stanek, *Doctors Flee Illinois*, HEALTH CARE NEWS, April 1, 2004

¹¹⁴ Research on malpractice liability insurer files from North Carolina led researchers to conclude that insurers and defense lawyers settle cases primarily on the basis of their own

It is important to note here that a study conducted by the U.S. Government Accounting Office in 2003 studied four states with pain and suffering caps of \$250,000, four states with caps of \$500,000 and 11 states without such caps.¹¹⁵ The study found that while medical liability insurance premiums increased in all states, they were lower in states with caps, as were claims payments. On the other hand the GAO also qualified the findings: “Moreover, differences in both premiums and claims payments are also affected by multiple factors in addition to damage caps, and we could not determine the extent to which differences among states were attributable to the damage caps or to additional factors.”

As the GAO report properly recognized, there are multiple factors that influence premiums and claim payments, and it is often impossible to separate causes or the contribution of separate factors to outcomes, such as claims and premiums.

A report by Weiss Ratings, a respected insurance analyst, found that caps on pain and suffering reduced the amounts recovered by plaintiffs but did not result in insurers reducing doctors’ insurance premiums.¹¹⁶

In 2003 GE Medical Protective Company, the nation’s largest medical malpractice insurer, reported to the Texas Department of Insurance as follows:

“Non-economic damages are a small percentage of total losses paid. Capping non-economic damages will show loss savings of 1.0%.”¹¹⁷

internal assessments of whether the standard of care was violated, Ralph Peeples, et al., *The Process of Managing Medical Malpractice Cases: The Role of Standard of Care*, 37, WAKE FOREST LAW REVIEW 877 (2002). Research by Taragin et al., *The Influence of Standard of Care and Severity of Injury on the Resolution of Medical Malpractice Claims*, 117 ANNALS OF INTERNAL MEDICINE 1780 (1992) on medical malpractice cases in New Jersey is also consistent with this view. SLOAN ET AL., *SUING FOR MEDICAL MALPRACTICE* (1993) at 89-113, conducted research on closed claims in Florida that also is supportive of such a conclusion.

¹¹⁵ GOVERNMENT ACCOUNTING OFFICE, *MEDICAL MALPRACTICE: IMPLICATIONS OF RISING PREMIUMS ON ACCESS TO HEALTH CARE*, GAO-03-836 (2003)

¹¹⁶ See MARTIN D. WEISS, WEISS RATINGS, INC., *MEDICAL MALPRACTICE CAPS: THE IMPACT OF NONECONOMIC DAMAGE CAPS ON PHYSICIAN PREMIUMS, CLAIMS PAYOUT LEVELS AND AVAILABILITY OF COVERAGE* 7-8 (2003) available at <http://www.weissratings.com/malpracticecap.asp>.

¹¹⁷ See <http://www.consumerwatchdog.org/insurance/rp/rp004689.pdf>.

The company also said that a provision in the Texas law allowing for periodic payments of awards would provide a savings of only 1.1%. Medical Protective eventually raised the rates on its physician policyholders.

Table 5.1 and the discussion associated with it cannot provide a definite answer as to whether a \$500,000 cap on pain and suffering would have an effect on claim payments and ultimately a secondary effect on doctors' liability insurance premiums, but it raises important questions about whether a cap would be effective. It also begs questions of fairness.

Fairness Considerations: Two Studies on the Effects of Caps

It is important to consider two additional studies. They address the issue of the fairness of caps and raise questions about justice for claimants. In the medical malpractice tort reform debate, most of the rhetoric on both sides has addressed the plight of doctors and liability insurers and the potential implications for availability of health care. Little of the discussion has addressed the plight of persons who are injured by medical negligence and make claims.¹¹⁸

Research by Lucinda Finley has examined the consequences of caps on the allocation of plaintiff recoveries in California, Florida, and Maryland by looking at jury verdicts and calculating the discrepancy between what the jury awarded and the amount the plaintiff would recover under caps.¹¹⁹ She found that the major effects would fall most heavily on children, women, and elderly people because their losses are more likely to be non-economic losses, albeit often devastating and tragic.

David Studdert and his colleagues conducted a study of California jury verdicts to assess the impact of California's \$250,000 cap on non-economic damages and concluded as follows:

¹¹⁸ See Neil Vidmar, *Medical Malpractice Lawsuits: An Essay on Patient Interests, the Contingency Fee System, Juries and Social Policy*, LOYOLA LOS ANGELES LAW REVIEW (2005, in Press).

¹¹⁹ Lucinda Finley, *The Hidden Victims of Tort Reform*, 53 EMORY LAW JOURNAL 1263, 1281, 1286, 1308-1312 (2004).

Plaintiffs with the most severe injuries appear to be at highest risk for inadequate compensation. Hence, the worst-off may suffer a kind of “double jeopardy.”

Analysis of proportional reductions shows that the burden of caps tends to fall on injuries that cause chronic pain and disfigurement but do not lead to declines in physical functioning that would generate lost work time or high health care costs.... Notwithstanding their limited economic impact, the injuries involved are by no means trivial.¹²⁰

The findings from these two studies raise questions about the fairness of caps on negligently injured persons. Perhaps some readers will conclude that these are less important considerations in overall health care policy, but it seems important to raise them.

To consider these fairness issues further, readers may wish to turn back to the summaries of some of the cases reported in Chapter 3. In *Carroll v. Barrows* a child in his first year of life had undiagnosed eye cancer. Despite radiation and chemotherapy treatments he eventually lost sight in both eyes. The jury awarded him \$1 million for pain and suffering. In *Simpson v. Allswede* improper intubation of an eight-year-old boy resulted in a tracheostomy followed by 30 surgical procedures. The traceostomy was in place for five years, preventing him from speaking and at 16 has permanent throat damage, although he can now speak. The jury awarded \$1.1 million for pain and suffering. In *Gonzales v. Pla* a doctor failed to diagnose kidney disease in a man, age 44. He was required to undergo dialysis when his kidneys failed and then received a kidney transplant. The jury awarded \$600,000 for pain and suffering. In *Lawler v. Lomont* a female special education assistant, age 33, suffered delayed diagnosis of cancer when a physician misread her pap smears over a two-year period. The defendant admitted liability. The cancer spread and a radical hysterectomy was required. The woman obviously cannot have

¹²⁰ David Studdert et al, *Are Damage Caps Regressive? A Study of Malpractice Jury Verdicts in California*, 23 HEALTH AFFAIRS 54 (2004). A footnote omitted in the above quotation references Frank Sloan and C.R. Hsieh, *Variability in Medical Malpractice Payments: Is the Compensation Fair?* 24 LAW & SOCIETY REVIEW 601 (1990) which also pointed out a similar inequity in pre-1990 cases.

children and suffers from fear that the cancer will recur. The jury awarded \$2.5 million for pain and suffering.

Are the amounts awarded for these injuries too much? That is a matter on which reasonable people can disagree. It is important to consider cases like the one described above. Fairness issues for patients injured from medical negligence are all too often neglected in public debate about caps on pain and suffering.

Summary

Serious issues can be raised about whether a cap on pain and suffering will reduce doctors' insurance premiums. The chapter also discusses the proportion of jury awards that are for "pain and suffering" and discusses justice issues related to the patients who might be affected by caps.

Chapter 6¹²¹

Doctors in Illinois: 1993-2003

One of the concerns about jury verdicts and the tort system is that as a result of jury verdicts and their impact on settlements doctors may be leaving the State of Illinois for other states.¹²²

To examine these claims, I researched the American Medical Association's *Physician Characteristics and Distribution in the US*, an annual publication that provides a number of important statistics about doctors, including county breakdowns by state, some information on certain specialties and state-by-state comparisons of physician-to-population ratios.

Qualifiers to the Statistics

There is a two-year time lag between the date of the publication and the statistics. Thus, for example, the 2005 edition presents data on doctors as of December 31, 2003.¹²³ Consequently, the data reported in this chapter begin with 1993 and end at 2003. The data cannot speak to changes in Illinois doctors after that period. Some of the statistics were used in Chapter 3 to assess numbers of claims in relation to treating physicians, but this chapter examines doctors as a primary variable.

There are additional qualifications to these data. The first is that I have limited the analyses to non-federal "Total Patient Care Physicians," as reported in the statistics. Some physicians are federal employees, such as those associated with military bases, Veterans Administration Hospitals, and the Public Health Service. These physicians are not affected by the liability

¹²¹ I want to thank my Duke colleague and co-author, Dr. Paul Lee, who offered comments and suggestions on a draft of this chapter.

¹²² Illinois Chamber of Commerce as of April 24, 2005 at < <http://www.ilchamber.org>>, 2005 State Interactive Systems Ranking Study, Harris Interactive, Inc. Fact Sheet: "Illinois' abusive legal climate is forcing doctors to leave the state," Press release of March 8, 2005; Editorial, Illinois Supreme Court, Buying Justice, ST. LOUIS POST DISPATCH, November 5, 2004 at B6; Patrick Powers, Doctors Flee Hospitals in the Area, BELLEVILLE NEWS DEMOCRAT, Wed March 23,2005; Georgina Gustin and Phil Dine, Lax Insurance Regulation Is Core of Malpractice Crisis, SAINT LOUIS POST DISPATCH, January 1, 2005.

¹²³ American Medical Association, PHYSICIAN CHARACTERISTICS AND DISTRIBUTION IN THE US. The editions used in this chapter begin in 1995 and end in 2005.

insurance crisis since the United States Government assumes tort liability for these providers, and malpractice claims are adjudicated under the Federal Tort Claims Act that provides for trial by judge alone. Other physicians are employed by insurance carriers or pharmaceutical companies.

Some physicians list themselves as inactive and a few remain unclassified in the AMA statistics.¹²⁴ Thus in 2003 Illinois had a total of 37,608 physicians, of whom 30,264 classified themselves as non-federal physicians focused on patient care, although of this number 3,147 classified themselves as “inactive.”¹²⁵ Some physicians may only be working part-time and others may have limited their practices, e.g., abandoned surgery, certain types of surgery, or stopped delivering babies.

Illinois Physicians: 1993-2003

Of the 37,608 private physicians in Illinois in 2003, fully 30,264 were classified as patient care physicians. The remainder were designated as “other professional activity” (1,772), “inactive” (3,147) and “not classified” (2,425). The “not classified” physicians may or may not be treating physicians and “inactive” physicians might still carry liability insurance. However, for purposes of the analyses, I chose the AMA’s definition of “Total Patient Care Physicians”

The statistics provide some general breakdowns as to how physicians classify their practice, but these are self-designations and do not provide estimates of types of actual patient care. Thus, an obstetrician/gynecologist may not deliver babies as part of his or her practice or may refer difficult cases to another obstetrician. A surgical specialist may conduct only low-risk surgery and avoid high-risk operations. A physician whose classification is “Family Medicine/General Practitioner” may conduct surgery or deliver babies.

¹²⁴ AMERICAN MEDICAL ASSOCIATION, PHYSICIAN CHARACTERISTICS AND DISTRIBUTION IN THE US, 2005 Edition, at xix-xxiii.

¹²⁵ Id at page 222, Table 3.11

Table 6.1 allows examination of trends in the total number of patient care physicians with separate breakdowns for Obstetric-gynecologists and Neurological surgeons. The two specialty groups are alleged to have been most affected by the liability insurance problem.

Table 6.1: Patient Care Physicians in Illinois: 1993-2003

Year	Total Patient Care Doctors	Obstetrics-Gynecology	Neurological Surgery
2003	30264	1814	212
2002	29,135	1774	205
2001	29,116	1769	199
2000	28,730	1796	209
1999	27,779	1715	207
1998	27,630	1800	205
1997	27,733	1785	208
1996	26,758	1734	204
1995	26,054	1669	213
1994	25,020	1547	192
1993	24,514	1596	191

Table 6.1 shows a steady increase in the absolute number of Illinois' total patient care physicians. With some year-to-year variations the trend is upward or steady for Ob-Gyns and neurological surgeons.

But how do these trends track against changes in Illinois' population? The AMA's data also provide information on the total number of physicians per 100,000 population and physician-population ratios ranked by state. These data are reported in Table 6.2 and are based on total non-federal doctors versus patient care doctors.

Table 6.2: Patient Care Physicians Per 100,000 Persons and Relative State Ranking: 1993-2003

Year	Patient Care Physicians / 100,000 persons	Rank Among States
2003	239	17
2002	235	15
2001	237	13
2000	231	11
1999	229	12
1998	233	11
1997	235	11
1996	226	11
1995	221	11
1994	213	13
1993	211	13

Table 6.1 shows that the total number of patient care physicians and physicians in obstetrics-gynecology and neurological surgery have steadily increased in Illinois since 1993. Table 6.2 shows that adjusted for Illinois population growth the ratio of patient care physicians has also increased.

Table 6.2 does show that Illinois' ranking in patient care population to physician ratios has slipped relative to other states. It is not clear what should be made of this last finding. It could be interpreted as Illinois losing out to other states. An alternative way of looking at the data in the table is that Illinois' increase in the population to physician ratio is just slower relative to other states.

The other problem with rankings is that rankings they tend to exaggerate small differences. Consider that in 2002 New Hampshire was ranked 16th with a 240 ratio; Oregon was ranked 22nd with a 235 ratio; Virginia was ranked 12th with a 244 ratio; and Washington was ranked 16th with a 237 ratio. In 2003 the rankings and ratios had changed: New Hampshire was ranked 14th with a 240 ratio; Oregon was ranked 18th with a 235 ratio; Virginia was ranked 12th

with a 244 ratio; and Washington was ranked 16th with a 303 ratio. Thus, New Hampshire increased in its ranking even though it dropped four figures in the ratio of patients to physicians. Oregon maintained the same ratio but jumped from 22nd up to 18th. A state with a small population can gain or lose a relatively small number of doctors and that will substantially alter the ratio. If a state with a large population gains or loses the same number of doctors as the small state, the ratio will hardly be affected.

In short, the rankings were included in Table 6.2 because it was proper to do so as well as to avoid any appearance that the data are not fully presented. However, as explained immediately, above rankings can be very misleading. The bottom line is that the number of patient-treating physicians in Illinois has increased, not decreased.

Patient Care Physicians: Madison and St. Clair Counties 1993-2003

Madison and St Clair counties have received special attention. A November 2003 Article in the *Belleville News Democrat* quoted a Memorial Hospital spokesman as saying “the hospital has lost 59 doctors since the beginning of the year.”¹²⁶ One report in 2004 stated: “[a]t least 60 doctors in the past two years have left or announced plans to leave Madison and St. Clair counties.”¹²⁷ In March 2005 the *Belleville News Democrat* put the figure at 136.¹²⁸ The *Springfield Journal Register*, the *St. Louis Post Dispatch*, and the *Wall Street Journal* have reported that the two counties’ hospitals have lost 161 physicians.¹²⁹ The figure of 136 is based on a study by Navin and Sullivan on

¹²⁶ Patrick Powers, Doctor Exodus Continues, *Belleville NEWS DEMOCRAT*, Nov 9, 2003 at <<http://www.Belleville.com/mld/newsdemocrat/7218042.htm>>.

¹²⁷ Steve Stanek, Doctors Flee Illinois, *HEALTH CARE NEWS*, April 2004 <<http://www.heartlend.org/Article.cfm?artId=14633>>.

¹²⁸ Patrick Powers, Doctors Flee Area Hospitals, March 23, 2005 at <<http://www.jobsillinois.us/news/contentview.asp?c=150575>>.

¹²⁹ Dean Olson, Shimkus: Chance for Malpractice Caps Getting Better, *JOURNAL REGISTER* February 24, 2005; William Lamb, Illinois Trauma Cases Surge at SLU, *POST DISPATCH*, Monday January 10, 2005; Sherman Joyce, Judicial Hellholes, *WALL STREET JOURNAL*, December 15, 2004 at A 20 .

the health Care Sector in Madison and St. Clair counties and will be discussed below.¹³⁰ It is not clear where or how the other figures originated.

Unfortunately, the AMA data do not extend into 2004 and 2005 to directly address all of these claims. Nevertheless, data up to 2003 may give insights that can prompt additional discussion.

Tables 6.3 and 6.4 provide statistics on doctors in Madison and St. Clair counties, respectively, from 1993 through 2003. These statistics deal only with non-federal physicians. They are disaggregated by the self-described practices of the physicians.

Table 6.3: Non-federal Physicians in Madison County with Breakdowns for Practice Areas: 1993-2003

Year	Total Physicians	Total Patient Care	Family/General Practice	Medical Specialties	Surgical Specialties	Other Specialties	Hospital Based Practice	Other	Inactive	Not Classified
2003	338	280	39	94	72	50	25	5	44	9
2002	341	286	37	99	72	53	25	6	39	10
2001	341	292	38	100	75	58	21	7	33	9
2000	328	282	37	98	73	58	16	7	28	11
1999	334	279	34	94	77	60	14	8	28	19
1998	332	277	34	90	78	59	16	8	28	2
1997	329	277	30	83	74	58	32	8	32	12
1996	328	281	32	87	78	59	25	8	28	11
1995	318	266	35	78	73	57	23	8	32	12
1994	316	275	37	73	74	64	27	8	29	4
1993	317	274	36	75	74	61	28	6	29	8

¹³⁰ John Navin and Timothy Sullivan, Recommended for a Healthy Economy: The Importance of the Health Care Sector in Madison and St. Clair Counties, SIU , Edwardsville, March 2005.

**Table 6.4: Non-federal Physicians in St. Clair County
with Breakdowns for Practice Areas: 1993-2003**

Year	Total Physicians	Total Patient Care	Family/General Practice	Medical Specialties	Surgical Specialties	Other Specialties	Hospital Based Practice	Other	Inactive	Not Classified
2003	526	431	72	112	85	78	84	15	60	20
2002	503	402	67	112	81	84	58	19	60	22
2001	494	402	57	116	82	87	60	19	60	13
2000	493	396	56	117	78	86	59	17	59	21
1999	456	356	48	102	82	80	44	19	60	21
1998	432	348	48	100	81	72	47	16	52	16
1997	386	320	33	95	78	72	42	15	48	3
1996	376	312	38	88	74	73	39	15	43	6
1995	354	292	37	87	72	65	31	13	43	6
1994	351	298	40	86	71	65	36	15	34	4
1993	345	297	45	79	74	60	39	11	33	4

Table 6.3 shows a slight drop in total patient care physicians in 2002 and 2003 in Madison County compared to 2001. But 2001 appears to be an anomalous year with respect to total number of treating physicians in the sense that instead of a slow rise in the number of physicians by one or two annually the number jumped by 10. On the other hand the number of “inactive” physicians increased steadily so that in 2003 fully 40 physicians stated they were inactive.

In contrast to Madison, St. Clair County shows a steady increase in both total number of physicians and the total number of patient care physicians and a big jump in the number of physicians describing themselves as having a hospital-based practice.

One could ascribe the drop in total patient care physicians and increase in inactive physicians in 2003 to increased liability insurance premiums, but the problem with this interpretation is that it is contradicted by the increase in treating doctors and the stable rate of inactive doctors in St. Clair County. Doctors in St. Clair County were presumably exposed to the same rates of liability insurance premiums as those in Madison County. Perhaps the explanation lies in shifting demographics, even including the possibility that some doctors have shifted their offices from Madison County to St. Clair

County. Perhaps another clue lies in the big jump in hospital-based practice in St. Clair in 2003.

The data do not allow conclusions on these hypotheses, but they do invite closer examination and research on issues that may arise. However, taken as a whole, the data for the combined two counties are not consistent with a sudden decrease in the availability of physicians overall. A simple calculation from data in Tables 6.3 and 6.4 shows that in 2003 there were 711 private patient care physicians in the two counties compared to 678 in the year 2000, a year just before the liability insurance premiums began to increase. Put in percentage terms in 2003 the number of patient care physicians had actually *increased* by four percent.

The data in Tables 6.3 and 6.4 do not address the claim that 56 or 60 or 161 physicians have left the Madison-St. Clair county area as of 2005 since the data extend only to 2003. But they do pose a serious need to document the claim. Does the claim include federal doctors who are transferred or otherwise move from one federal facility to another? Is the figure of 60-161 doctors a net loss or gross loss? Doctors retire or move away from areas, medical residents finish their residencies and move to different locations, but often other doctors replace them. The central issue is *net* loss not gross loss.

The data are also inconsistent with the Navin and Sullivan report on Madison and St. Clair counties¹³¹ that apparently gave rise to the claims of the loss of 136 to 161 doctors in the area. Their report was concerned with employment in the health sector, including support staff, and used two sources of data. One source was the number of physicians' offices in the counties through 2002.¹³² They concluded that the number of physician offices dropped by about 2.5% between 1998 and 2002.

¹³¹ John Navin and Timothy Sullivan, Recommended for a Healthy Economy: The Importance of the Health Care Sector in Madison and St. Clair Counties, SIU , Edwardsville, March 2005.

¹³² Id at 10.

These figures do not correspond with calculations we can make with the AMA's figures that can be calculated from Tables 6.3 and 6.4. Combining total physicians for the two counties yields the following finding: In 1998 there were 764 total physicians and in 2002 there were 844 physicians, a *gain* of 10 percent. If we limit the calculations to treating physicians, the figures for 1998 and 2002 are, respectively, 673 and 688, a gain of two percent. By either measure *the AMA figures show a gain, not a loss of physicians.*

The second measure used by Navin and Sullivan was hospital staff listings from six area hospitals for the years 2002 through 2004. After culling for duplicate names those authors identified 798 physicians listed in 2004 compared to 934 physicians, a difference of 136, or 15 percent. Their figures for 2002 again appear different from the AMA data indicating a total of 844 physicians (688 treating physicians) in 2002. One plausible hypothesis for the discrepancy probably lies in the fact that this measure from the Navin and Sullivan report is based on physicians with hospital privileges. These listings could include physicians from out of the area or even from out of the state, e.g., Missouri. Federal as opposed to non-federal physicians may also be listed in their data. The difference could also be due to changes in the way that doctors practiced medicine or how hospitals classified physicians.

There are possibly other plausible explanations, but the Navin and Sullivan data based on hospital staff listings are clearly not a good source of data for estimating the number of physicians or changes in the number of physicians.

The American Medical Association statistics are clearly the official and superior source of data. Their statistics data for 2004 will eventually allow a further comparison with the Navin and Sullivan findings and might, in the end, support their conclusions by showing a loss of physicians. Nevertheless, it should be clear that their research should not be relied on for a source of support for estimating losses or gains of physicians in Madison and St. Clair counties.

The AMA statistics for 2003 also are inconsistent with the Memorial Hospital spokesperson's claim that that hospital alone lost 59 doctors. Perhaps the statement was accurate but omitted replacement doctors. If many of the 59 doctors were medical residents finishing their period of residency, they would have been expected to leave but would be replaced by new doctors working on their residency.

In short, the AMA statistics through 2003 do not support claims of a loss of doctors in Madison and St.Clair counties.

Conclusion

As of the year 2003, the American Medical Association's statistics do not provide support for a claim that doctors are leaving the State of Illinois or that the number of non-Federal physicians has decreased in the Madison-St.Clair county area. Changes may have indeed occurred since 2003, but proponents of the claim of major losses of doctors have not substantiated their claims in any sources that I could find.

Chapter 7

Conclusions

This report opened with the assumption that the medical insurance liability premiums for Illinois' doctors have increased dramatically in recent years. Nothing in this report challenges that assumption. The findings of the research in the report, however, strongly challenge widely made claims about the role of the Illinois tort system as a cause of the increase in these premiums.

Data

Claims have been made that the number of lawsuits has increased dramatically in recent years. Data on medical malpractice lawsuit filings in Cook and DuPage counties give no support to this claim. Claims have been made that there has been an increase in jury trials. Data from the United States Bureau of Statistics study of civil litigation indicate that the number of jury trials in 2001 in Cook County and DuPage counties actually decreased when compared to 1996. Data from the Cook County Jury Verdict Reporter showed that combined data from Cook and DuPage counties showed that, with the exception of a modest fluctuation in 2002, the number of trials remained steady between 2001 and 2004. Data also showed that the actual payouts were often much smaller than the jury verdicts.

Claims have been made that Madison and St. Clair counties are “judicial hell holes” for doctors. Data showed that from 1992 through the first quarter of 2005 there was a total of 26 medical malpractice jury trials—1.7 trials per year--and that plaintiffs prevailed only 11 times in this 14-year period. Only two awards exceeded \$1 million. Claims have been made that a cap on pain and suffering will alleviate some of the large awards and lead to reduced premiums. The data suggest that the effects of caps would likely be minimal and possibly result in unfairness to negligently injured patients.

Claims have been made that doctors were leaving the state of Illinois for states with more benign litigation climates. Data from the American Medical

Association show that from 1993 through 2003 the actual number of patient care physicians has increased steadily in absolute numbers and in the ratios of population to physicians. Claims have been made that large numbers of doctors in the Madison and St. Clair counties have been fleeing or retiring from practice as a result of its litigation climate. Not according to the American Medical Association statistics through 2003. Compared to the year 2000 the number of patient care doctors actually increased by four percent.

Missing Data

The publicly available data did not allow an assessment of actual payouts from settlements, the litigation costs from claims in which no payments were made, or costs for paid cases in which payments were made. These and many other variables that could have shed additional light on the current debate exist in closed claim files of the Illinois Department of Insurance.

Clearly these data should be made available to the public as they are in Florida and Texas. Doctors and patients and interest groups on both sides of the controversy, indeed the citizens who pay taxes to have these important data collected, should have a right to know. The controversy regarding health care should be resolved with data rather than by anecdote and questionable statistics.

If Not the Tort System...?

Think of a crude analogy. A patient goes to the doctor with a sore throat and other symptoms. The doctor suspects a bacterial infection, takes a throat swab, and sends it to a laboratory. The report comes back negative. That cause eliminated, the doctor then begins to look for other causes of the ailment.

For more than a quarter century the American civil jury system and the citizens who serve on it have been defamed by variations on the claim that juries too often “act like Santa Claus handing out millions of dollars in cases

involving comparably minor injuries.”¹³³ The best data for Illinois that were available for this report indicate that juries are not to blame for the problems involving the increases in doctor’s liability premiums. It is time to look for other causes of the ailment. Some have been suggested but that is beyond the scope of this report.¹³⁴

¹³³ James D. Griffith, *What Will It Take to Resolve the Malpractice Crisis?* 27 MEDICAL ECONOMICS , 195 (1982).

¹³⁴ Dean Olsen, Doctors, *Lawyers seek Common Ground on Malpractice Reform*, THE STATE JOURNAL REGISTER, January 27, 2005; Sarah Klein, *Doc Insurer Payouts Dip*, CHICAGO BUSINESS, March 14, 2005; Daniel C. Vock, *Speaker’s Counsel Blasts Med-Mal Carrier Over Reasons for Premium Hikes*, CHICAGO DAILY LAW BULLETIN, March 1, 2005, page1; Daniel C. Vock, *Legislators Take Med-mal Deadlock Head On*, CHICAGO DAILY LAW BULLETIN, February 23, 2005; Joseph Treaster and Joel Brinkly, *Behind Those Medical Malpractice Rate Hikes*, 151 CHICAGO DAILY LAW BULLETIN, February 22, 2005.