By Dwight Golann

Dropped Medical Malpractice Claims: Their Surprising Frequency, Apparent Causes, And Potential Remedies

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ABSTRACT Most medical malpractice claims are neither settled nor adjudicated. Instead, they are abandoned by the plaintiffs who bring them. This study measured the frequency and cost of abandoned claims and gathered opinions from attorneys and other experts on why plaintiffs drop claims. Plaintiffs in the study abandoned 58.6 percent of claims against defendants, while settling only 26.6 percent and adjudicating 14.8 percent. Claims are not dropped because a large percentage of them are frivolous, but for other reasons. The most important is that as plaintiffs acquire more information in the course of a lawsuit, they often conclude that a claim is weaker than they had first thought. The author recommends that insurers and hospitals adopt new procedures to encourage both plaintiff attorneys and defense representatives to exchange information more efficiently, discuss the merits of malpractice cases more candidly, and resolve cases quickly. Such reforms would greatly reduce both the frequency and the duration of cases that are dropped, and thus the cost of malpractice litigation.

Approximately 70 percent of all malpractice claims brought against US doctors and hospitals fail, in the sense that the patient recovers nothing[1] but the legal process imposes large costs on both sides. It is well known that only a small percentage of plaintiffs recover money in malpractice lawsuits. But few people realize that more than half of all malpractice claims are not won, lost, or settled. Instead, they simply disappear, as plaintiffs abandon them.

This article investigates the incidence and nature of abandoned malpractice claims, probes why plaintiffs file lawsuits and later drop them, and recommends steps to reduce the frequency and cost of malpractice lawsuits.

Study Data And Methods

I examined a sample of 3,695 claims brought against physicians, hospitals, and other medical providers in Massachusetts and closed during the period 2006–10. The claims were administered by a single insurer, which during the study period covered 66 percent of providers who purchased malpractice policies in the state's private market (data based on an interview with Michael Kubik, vice president for marketing, Medical Professional Mutual Insurance Company, May 4, 2011).

To be included, a claim had to be asserted in writing; to be made on behalf of a patient against a medical provider; to allege professional malpractice; and to be resolved by the insurer. Ninety claims were excluded because they did not meet these criteria, leaving 3,605 claims.

To gather information about why claims are dropped, I interviewed ten plaintiff attorneys who specialize in malpractice cases, as well as three insurance claims managers and three defense attorneys. I selected the plaintiff attorneys at random.

CATEGORIES OF CLAIMS I divided the claims' outcomes into six categories, ranging from the most obvious drops to cases that reached trial (Exhibit 1). Pre-suit drops were claims that a plaintiff discontinued without receiving any money or filing a lawsuit. Voluntary dismissals were claims that a plaintiff filed in court and later asked to be discontinued, although he or she received no money. Judicial dismissals were claims that a judge dismissed on procedural grounds, usually because the plaintiff failed to provide information required by court rules, without a decision on the merits of the case.

Settlements were claims that a plaintiff agreed to dismiss in return for a financial payment, which the insurer then charged against the defendant's policy. Allocated dismissals were claims that were also part of settled cases, but for an allocated dismissal, the insurer did not charge the defendant's policy for any part of the settlement payment. Adjudications were claims that a court or arbitrator decided on the legal merits of the case.

Statistics about drops or abandonments (I use these terms interchangeably throughout this article) differ significantly, depending on whether one views the data from the plaintiff's or the defendant's perspective. The difference stems from the fact that malpractice plaintiffs often sue more than one defendant—in the sample, the typical case involved 1.72 defendants—and different claims in a case often have different outcomes. For example, patient A may sue hospital B and doctor C, later dropping the claim against B but going to trial and losing against C. The outcomes for the defendants are one dropped claim and one adjudicated claim, but the outcomes for the entire case are mixed and can be recorded in different ways.

This study assigned outcomes to such cases ranking adjudications highest, followed by settlements, allocated dismissals, judicial dismissals, voluntary dismissals, and pre-suit drops, in that order. For patient A's case, this means that the outcome would be categorized as an adjudication. A case was thus not counted as dropped unless every claim in it was abandoned—a standard that depressed the drop rate. The distinction between cases and claims, it should be noted, does not depend on whether a dispute becomes a lawsuit. Both claims and cases can be resolved either before or after a lawsuit is filed. Rather, the distinction is that a single case can contain more than one claim.

LIMITATIONS This study has several limitations. First, it is based on outcomes in a single state. However, the results are similar to those of national studies.[2,3] Second, plaintiff attorneys' assessments of why plaintiffs drop claims is inherently subjective and potentially biased, but their opinions about the primary cause of drops were quite consistent (Exhibit 2).

A third limitation is that Massachusetts law imposes a cap of $20,000 per claim on malpractice judgments against charitable institutions—a category that includes many hospitals. To avoid winning a large but uncollectable judgment, plaintiffs tend to dismiss their claims against hospitals before trial, pursuing only claims against individual providers. The existence of the cap probably increased the drop rate for hospitals and reduced the drop rate for physicians and nurses.

Finally, there is disagreement about what constitutes a drop. Plaintiff attorneys and defense representatives generally agreed that claims I categorized as pre-suit drops, voluntary dismissals, and judicial dismissals should all be considered drops, while claims categorized as settlements and adjudications should not. The two groups did not agree, however, about claims in the category of allocated dismissals, situations in which a defendant was part of a settled case but the insurer did not charge any portion of the

EXHIBIT 1

Outcomes Of Cases And Claims In Medical Malpractice Litigation

	Plaintiffs' cases (n = 2,094)		Claims against defendants (n = 3,605)	
Outcome	**Percent of cases**	**Number of cases**	**Percent of claims**	**Number of claims**
Drops				
Pre-suit drops	14.4	302	10.1	364
Voluntary dismissals	24.1	505	28.0	1,008
Judicial dismissals	7.9	165	7.4	267
Allocated dismissals	0.0	0	13.1	473
Total	46.4	972	58.6	2,112
Settlements	37.3	782	26.6	960
Adjudications	16.2	340	14.8	533

SOURCE Author's analysis of study data. **NOTE** The outcomes are explained in the text.

EXHIBIT 2

Opinions Of Ten Malpractice Attorneys About Why Plaintiffs Drop Claims

Cause	Primary	Secondary	Tertiary	Other
New information obtained during litigation	7	2	1	0
Change in the medical literature	0	4	1	0
Co-occurring condition	1	1	1	0
Plaintiff lost interest in the case	0	1	0	1
Poor decision making by nonspecialist lawyers	1	1	0	0

SOURCE Author's analysis of study data.

settlement payment to his or her policy.

Plaintiff lawyers argued that insurers sometimes charge one policy rather than another for reasons other than the merits of the claim—for example, because a defendant still in practice objects to being charged, while a retired physician does not. The insurer involved in my study responded that such decisions are made solely on the merits. This insurer explained that the law requires insurance companies to report payments to the National Practitioner Data Bank, a repository of information concerning malpractice payments and negative actions taken against health care practitioners.[4]

One way to test whether allocations are made on the merits is to compare the reserves that the insurer places on policies. Reserves are a measure of the risk an insurer sees of having to make a payment to a plaintiff. If the claims against defendants whose policies are charged in settlements are in fact weaker in terms of the merits of the claim than the claims against defendants whose policies are not charged, the charged policies should carry a higher average reserve.

The average reserve for policies charged in 2010 settlements was $411,135—more than five times as high as for policies not charged ($81,636). The frequency with which the insurer charged policies involved in settlements was also higher than the frequency for policies covering claims that did not settle (67 percent versus 25 percent). These data strongly suggest that the insurer allocated charges on the merits, and I have therefore counted claims in the category of allocated dismissals as drops.

Study Results

FREQUENCY OF DROPPED CASES In the sample, 58.6 percent of claims against defendants (95% confidence interval: 57.0, 60.2) and 46.4 percent of cases brought by plaintiffs (95% confidence interval: 44.3, 48.5) were dropped (Exhibit 1). Dropped claims were more than twice as frequent as settlements and almost four times as frequent as adjudications. The rate of dropped claims was higher for hospitals (74.2 percent) than for providers (55.5 percent; data not shown).

These results are consistent with those of other studies. A national association of medical malpractice insurers reported that 64 percent of claims (157,392 of 247,073) closed by its members from 1985 through 2009 were "dropped, withdrawn or dismissed."[2(Exhibit 6c-1)] And an analysis of malpractice litigation in the 1970s reported that 43 percent of cases were dropped.[3] However, neither report defined the terms it used.

COSTS OF DROPPED CASES Dropped claims impose costs on patients, attorneys, providers, insurers, and the medical system as a whole. Insurers typically define their cost in terms of the out-of-pocket expenses they incur to defend individual claims. In the sample, that cost in 2010 averaged $25,735 per dropped claim, or approximately $44,200 per dropped case. The average cost of defense for claims that were settled in 2010 was $39,901; for those that were adjudicated, it was $84,375.

The average cost of defense for claims dropped before a lawsuit was filed ($1,188) was a small fraction of the cost for claims abandoned after a suit had been filed ($31,890; Exhibit 3). More generally, this cost increased greatly as the duration of a claim increased. The increase was uneven, remaining under $10,000 the first two years a claim was pending but doubling in the third year and almost doubling again in the fourth year (Exhibit 3).

There are no equivalent statistics for plaintiffs' costs because most plaintiff attorneys charge based on the outcome of a case, and many do not keep track of the time they spend on a particular case. The plaintiff lawyers I interviewed drew a distinction between the cost of bringing a case in the first place and adding a defendant to an existing case. They described the marginal cost of adding defendants to a case as low, relative to the cost of suing at all.

Plaintiff attorneys typically defined this cost in

EXHIBIT 3

Average Cost Of Defense For Malpractice Claims Dropped In 2010

Type of claim	Average cost ($)
BY STATUS OF LITIGATION	
Dropped before lawsuit filed	1,188
Dropped after lawsuit filed	31,890
BY DURATION OF CASE IN YEARS	
0–1	3,274
1–2	9,607
2–3	19,967
3–4	35,009
4–5	41,028
More than 5	45,712

SOURCE Author's analysis of study data. **NOTES** Duration was calculated in days rather than years, but for economy of presentation is presented as periods of years. Thus, 0–1 years is 1–365 days; 1–2 years is 366–730 days; 2–3 years is 731–1,095 days; 3–4 years is 1,096–1,460 days; 4–5 years is 1,461–1,825 days; and more than 5 years is 1,826 days or more.

terms of the extra out-of-pocket expense required to litigate the additional claim, and they generally did not include their own time in the calculation. Viewed in this way, the cost of adding a defendant to a case in Massachusetts has three major components.

First, every malpractice claim made in the state must go before a screening tribunal.[5] To pass the tribunal, most plaintiffs must obtain an opinion from a medical expert stating that the defendant failed to meet the applicable standard of care. Getting such an opinion requires a sizable outlay—one specialist estimated the cost at approximately $2,000 per opinion. But if the tribunal issues a finding favorable to the plaintiff, the attorneys generally perceived no large cost involved in keeping an additional claim alive until the eve of trial. (If the tribunal issues a finding unfavorable to the plaintiff, he or she must file a special $6,000 bond to proceed with the claim.)

The second extra cost is the expense of a transcript if the attorneys depose the new defendant, but there is no requirement that they do so. And although the third cost—to retain an expert witness for trial—is substantial, as one lawyer noted, few malpractice cases reach trial, so this cost does not usually materialize.

Malpractice litigation also imposes indirect costs on parties, such as an insurer's expense of maintaining its claims department or a plaintiff attorney's expenditures for staff, but neither side assigns such costs to individual claims. Litigation also generates costs that are very difficult to quantify and some that are not even monetary. For example, both plaintiffs and defendants are likely to experience anxiety and distraction over being involved in a case, and a great many physicians report engaging in defensive medicine because of concern over malpractice claims.[6]

Discussion

Why do plaintiffs bring claims and later drop them? Under the contingency fee system, plaintiff malpractice attorneys are rewarded only if they recover money for their client, so they have a strong incentive not to bring claims that they will later abandon.[1] It is therefore puzzling that drops occur so frequently. The phenomenon has not been addressed in the literature.[7,8] To explore the causes, I interviewed plaintiff malpractice specialists.

The drops did not occur, it should be noted, because a large percentage of the claims were frivolous. Almost 60 percent (1,252 of 2,112) of the dropped claims in the sample had obtained a finding from the state's screening tribunal, and of these 1,252 findings, 73 percent (916) were favorable to the plaintiff.

REASONS FOR DROPPING CLAIMS Some plaintiffs abandon cases out of frustration with a process that gives them no quick resolution (the average dropped claim had been pending for 2.75 years) and that forces them to relive traumatic events. Some lawyers probably also drop claims out of frustration or because their practice priorities change. However, only two of the plaintiff attorneys I interviewed cited these as leading causes of abandonment (Exhibit 2).

The one cause cited by all the plaintiff attorneys, and named as the primary reason for abandonment by most of them, is that plaintiffs acquire information in the course of litigation that lowers their assessment of the value of their case or claim (Exhibit 2). This is confirmed in the literature. One medical study has noted "how difficult it may be for plaintiffs and their attorneys to discern what has happened before the initiation of a claim and the acquisition of knowledge that comes from the investigations, consultation with experts, and sharing of information that litigation triggers."[8(pp2030–1)] Other commentators have endorsed this view.[9]

As plaintiffs acquire more information, they often conclude that a claim is weaker than they had first thought. For instance, a medical record may suggest that a required step in treatment was not taken, but a defendant may later testify persuasively in a deposition that the step was taken but simply not recorded. Or a lawyer may file suit in reliance on an expert's opinion, only to find that as the expert sees more data, she becomes less willing to testify that malpractice occurred.

The next most frequently cited reasons for dropping cases involve unforeseeable events that occur while a case is pending. For example, the medical literature may change. This is technically irrelevant, because the applicable standard is the one in effect at the time the treatment was

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rendered. As a practical matter, however, a media report stating that a certain test is no longer considered effective would undermine an argument that the test should have been administered to the plaintiff.

The plaintiff's medical condition also may change. In a case involving a failure to diagnose cancer, for example, the disease may remain in remission while the case is pending, gradually reducing the size of the potential verdict. Alternatively, a co-occurring condition may break the causal connection between a claimed error and an injury. A patient suing over badly performed heart treatment, for example, might die of lung cancer before the cardiac condition caused serious injury.

Malpractice claims can also become weaker for reasons that might have been foreseen, had the patient been more candid or the lawyer done a better investigation before bringing suit. An attorney may sue for a spouse's loss of companionship, for example, only to learn that the couple had separated before the patient entered treatment. Plaintiff and defense attorneys alike commented that lawyers who do not bring malpractice cases regularly are more likely to assert weak claims, perhaps allowing the hope of a large verdict to blind them to the lack of a causal connection between the claimed error and the injury.

Once lawyers learn that a claim or case in which they have invested substantial money is weak, a different dynamic often sets in: the phenomenon known as "loss aversion." Most people are strongly averse to sustaining what they perceive as a loss, even when the loss exists only in reference to an unrealistic goal. Thus, for instance, people who have invested in a failing business will continue to contribute money in the hope of reviving it, long after an independent observer would conclude that the effort was hopeless.[10] As a result, some attorneys continue to pursue bad cases, hoping that weaknesses in the legal system will allow them to recoup their investment (personal communication from Richard Boothman, chief risk officer, University of Michigan Health System, May 12, 2011).

Finally, plaintiffs sometimes add marginal defendants to cases for tactical reasons. Some lawyers expressed concern that if they did not add a defendant, the provider they sued would attempt to shift blame to the absent colleague—an approach called the "empty chair" defense. Under court rules, a plaintiff who does not add a provider but later discovers evidence suggesting that the person should have been added may also find it difficult to add the new defendant late in the case.

AVOIDING CLAIMS THAT WILL BE DROPPED The fact that most claims are abandoned raises the question of whether it is possible to induce plaintiffs to file fewer such claims or to drop them more quickly. As noted above, the decision to add defendants appears to be driven primarily by plaintiffs' uncertainty about who can be proved liable and the risks they perceive in not naming marginal providers.

▶ **IMPOSE PENALTIES FOR DROPPED CLAIMS:** Legislatures could probably discourage abandoned claims by imposing a penalty on plaintiffs who drop them. However, such a penalty would discourage valid claims as well as weak ones, reducing the already small proportion of malpractice victims who receive compensation.[11] A penalty might also reinforce loss aversion, encouraging plaintiffs to keep a weak claim alive in the hope of masking its defects in the overall resolution of a case.

Finally, if plaintiffs were required to pay a penalty when they dropped a case, they would almost certainly demand in exchange that defendants pay their legal fees when they prevail—an idea that would be strongly opposed by providers. Because a proposal to penalize dropped claims would draw opposition on both policy and political grounds, it is not discussed further in this article.

▶ **CHANGE THE CULTURE:** A more promising option involves changing the process by which cases are resolved. The key is to change the culture that now dominates malpractice litigation.

Each side in malpractice cases has traditionally adopted an adversarial stance, with both sides fearing that the other will take advantage of any gesture of openness or reasonableness. To avoid being exploited, most insurers and providers employ a "deny and defend" approach,[12] disclosing information only to the extent that court rules require and making low initial settlement offers. Plaintiffs do likewise. As long as parties assume that case outcomes are limited to settlement or trial, such behavior is understandable.[13]

If, however, parties understand there is a strong chance that a case will be dropped, their incentives are different. Plaintiffs and their at-

torneys, as well as defendants and insurers, all realize savings when a case is resolved more quickly. Defense lawyers and experts on both sides who are paid by the hour are the only potential losers in a more efficient process. However, good defense attorneys will not lack for clients, and because insurers generally control the hiring of defense attorneys and pay their fees, they have the power to overcome any resistance by defense lawyers to a new approach.

▶ **CREATE A MORE EFFICIENT PROCESS:** Insurers and hospitals should focus reform efforts on plaintiff malpractice specialists rather than lawyers generally, not only because it is easier to persuade a small group than a big one but also because plaintiff specialists have a disproportionately large impact. The plaintiff malpractice bar is quite concentrated: Ten firms with the highest volume of closed cases in the sample accounted for more than one-third (754 of 2,112) of all abandoned claims. Changing the approach of relatively few lawyers would therefore have a large effect on how cases are resolved.

The key does not lie in adopting a particular sequence of steps. Rather, the challenge is to induce insurers and plaintiff lawyers to exchange information and discuss the merits of cases candidly and efficiently. A few changes could move the process in that direction.

To be willing to disclose information voluntarily and make realistic offers to resolve cases, each side must trust the other to reciprocate. How can this trust be created? Prior initiatives[12,14] that are discussed below have shown that plaintiffs and lawyers will trust defense representatives if the defense representative has a record of acting in good faith or is vouched for by someone they trust. To achieve this trust, hospitals and insurers should undertake two interrelated steps.

First, they should disclose information and make reasonable offers to settle cases that merit it. These offers need not be any larger or more frequent than those made today after years of litigation. Indeed, organizations have found that plaintiffs are willing to accept less money if it is offered early in a case's life.[14] Second, hospitals and insurers should recruit an advisory group made up of plaintiff attorneys and, ideally, defense counsel to monitor the initiative and vouch for its credibility.

Finally, to ensure that plaintiff lawyers do not exploit their good faith, insurers and hospitals should proceed on a pilot basis with a limited group of lawyers or cases. In fact, the company from which the study data were taken is currently initiating a pilot project with these features (interview with Alomar Afonso, vice president for claims, Medical Professional Mutual Insurance Company, June 3, 2011).

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Under this approach, plaintiff attorneys would contact the provider (or insurer, if they know its identity) about a potential claim before filing suit. For a limited period of time, perhaps six months, the insurer would work with the plaintiff and his or her attorney to gather and exchange information about the cause of the adverse event and its effect on the patient. If necessary, court deadlines could be suspended or the time frame extended by agreement.

After collecting as much information as is practicable in that time period, the insurer would give the plaintiff attorney its assessment of the claim and, if appropriate, make a good-faith settlement offer. The attorney could accept the offer or make a counteroffer.

If within a set period of time—for instance, one month—no settlement were reached, the insurer's offer would expire. The plaintiff would be free to sue, but the insurer would not make another offer unless it received new information that changed its assessment of the claim, or a court issued a decision in the case.

▶ **EXAMPLES OF SIMILAR INITIATIVES:** No insurer appears to have undertaken such a program. As a result, there are no hard data on whether such steps would be effective in reducing the number of dropped claims. However, some hospital systems have adopted programs to resolve malpractice cases in which early exchange of information and resolution are important elements. In 2001, for example, the University of Michigan Health System instituted a policy of investigating claims aggressively, quickly resolving those that had merit and vigorously defending ones that did not. The system also committed itself to communicating more effectively with patients and learning from mistakes in care.[12]

After the policy was implemented, the frequency of malpractice cases in the system dropped by 36 percent; the median time to resolution declined by 30 percent; and the average cost of resolving a case, including payments to

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claimants, decreased by 44 percent, from $405,921 to $228,308.[7] Children's Health Care of Atlanta adopted a similar policy and also reported sharp declines in the cost and duration of malpractice cases.[15]

It is not clear from the University of Michigan data the degree to which reductions in the frequency or duration of dropped claims contributed to the project's results. In addition, because the new policy focused simultaneously on changing underlying care and the way claims were handled, and because it did not use a control group, it is not possible to determine the relative contributions of various elements of the program.

However, Richard Boothman believes that the credibility of Michigan's new approach, and its resulting ability to persuade plaintiff lawyers to drop or forgo weak claims, has greatly reduced the number of cases that the system must litigate (personal communication from Boothman, May 12, 2011). This conclusion is supported by a survey of members of the local plaintiff attorneys' bar, which found that "57 percent admitted they declined to pursue cases…they would have pursued before the [Michigan] claims system changes."[12(p146)]

It is also not clear if the results achieved by a hospital system can be replicated by an insurer. Hospitals have special advantages, including access to patients immediately after adverse events and the ability to reach a settlement in the name of the institution, avoiding the need to report physicians to the National Practitioner Data Bank.[4,7]

On the issue of access to patients, it is worth noting that Toro, a manufacturer of products such as lawnmowers that has no ongoing relationship with injured customers, instituted a policy of aggressively settling personal injury claims and reported dramatic savings as a result.[14,16] The lack of a relationship with claimants thus should not prevent insurers from implementing programs to promote early exchanges of information and resolutions of potential lawsuits.

Insurers and others have expressed concern that if defendants provide information efficiently, then plaintiffs will find it easier to bring cases, leading to an increase in claims.[17] The University of Michigan, however, found that its initiative reduced both the number of new cases and the proportion of cases in which settlement payments were made.[7] The experience of Toro[14,16] and hospitals that have implemented transparency policies[18] is similar, which suggests that providing information does not inevitably stimulate more claims.

Conclusion

Insurers and plaintiff attorneys should reform their methods of resolving malpractice claims as outlined above. By doing so, they could reduce the number of dropped claims and settle cases more quickly, sparing both health care providers and patients the experience of being involved in litigation that ultimately benefits no one. ■

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NOTES

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In this issue of *Health Affairs*, Dwight Golann, a professor of law at Suffolk University, explores the reasons why most medical malpractice claims are abandoned by the plaintiffs who bring them. He concludes that there is no simple explanation for why cases are brought and then dropped, although many are scuttled when plaintiffs learn more background information about the case through the process of litigation. He urges plaintiff attorneys and insurers to adopt programs to exchange information and seek early resolution of these cases in order to save both sides' time and the money lost when claims are later dropped.

Golann says he was motivated to research this issue by his experience as a board member of Medical Professional Mutual Insurance Company (soon to be changing its name to Coverys), the largest malpractice insurer in Massachusetts. He wanted to explore why it took so long for the company and other insurers to resolve malpractice claims, and why so few claims were either settled or adjudicated. He says he came away from the research disappointed that claims that should be abandoned are not—because, he says, of a legal system that "gives plaintiffs no incentive to drop a weak claim once filed and imposes risks if they do."

Golann teaches alternative dispute resolution, negotiation, consumer law, and investor advocacy at Suffolk. He received his law degree from Harvard Law School.