

**American Bar Association
Tort Trial & Insurance Practice Section**

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**Report on Contingent Fees
In Medical Malpractice
Litigation**

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Report on Contingent Fees In Medical Malpractice Litigation

Summary

Attorney contingent fees have become the focus of efforts by medical professionals and allied organizations to address medical liability problems. These efforts, mounted in legislatures, courtrooms and the media, seek to impose limits on the fees lawyers may charge clients in successful medical malpractice claims and actions. They are premised on the beliefs that there is excessive medical malpractice litigation (and resulting awards and contingent fees) and that such limits will ultimately reduce the costs of medical practice.

In fact, medical malpractice litigation is relatively uncommon, when compared to other tort litigation or to the potential number of medical liability claims. Only about one out of fifty valid medical malpractice events in this country is ever made the subject of a claim for injury. As a practical matter, physicians are seldom exposed to claims arising from professional negligence.

Medical malpractice victims have a right in an equitable system of justice to seek redress for their injuries, and a reasonable contingent fee is essential to preserve that right. Because medical malpractice claims are highly complex and expensive to pursue, competent counsel often decline to accept legitimate cases because of the high cost of pursuing a claim. Against this backdrop, limiting contingent fees by the formulae recently proposed in Florida and elsewhere will make it more difficult for medical malpractice victims' to obtain justice in the legal system. Consequently, limiting contingent fees will serve only to reduce further the incidence of meritorious medical malpractice claims, to the benefit of those who actually commit medical malpractice.

In any case, lawyers' fees must be reasonable for clients. Although contingent fees rates in medical malpractice actions are not fixed, they often cluster around traditional percentages. To prevent unreasonable fee agreements, clients would be well served by additional protective measures, some of which are already in practice in states such as Florida, to educate them about fee and dispute resolution alternatives and to foster bargaining symmetry. Furthermore, courts and

bar associations should increase their fees vigilance and step up enforcement of the procedural and ethical rules designed to protect clients and the judicial system from professional defalcations.

I. Introduction

Attorney contingent fees have again become the focus of efforts by medical professionals and allied organizations to reduce the costs of medical liability. These efforts, mounted in legislatures, courtrooms and the media, and orchestrated principally by state medical associations, seek to impose limits on the fees lawyers may charge clients in successful medical malpractice claims and actions.¹ They are premised on the belief that such limits will ultimately reduce costs associated with medical negligence claims. Although honorable, well-meaning persons are heard on both sides of the issue, they disagree vociferously on many of the assertions, assumptions and conclusions that fuel these efforts:

Depending on one's perspective, there is too much medical malpractice litigation or not enough; contingent fee arrangements can create an obscene form of bounty hunting or are absolutely necessary to ensure justice; physicians should not be second-guessed by those too dumb to avoid jury service or the jury system works just fine; and legislators who enact tort reform are protecting fat-cat doctors or have prudently restrained a tort system run amok.²

In response to earlier cries for relief from claims, lawsuits, judgments and insurance premiums, some states have already imposed limitations on contingent fees as one component of more general tort reform efforts. Most of those have adopted so-called "sliding scales" of limitations on contingent fees. Such limits apply the largest contingency percentage to an initial portion of a recovery and increasingly smaller percentages to additional increments of recovery.³ A few jurisdictions establish a maximum percentage applicable to the entire recovery.⁴

Although mindful of the broader issues that constitute tort system critiques and reform proposals, and cognizant of the relationship between fees and general tort litigation practice, the Task Force seeks in this report to segregate and address only issues pertinent to contingent fees in medical malpractice actions. Nonetheless, because contingent fees dwell within the tort litigation system, it is necessary to examine their use within the context of that system.

It must be emphasized at the outset that this contingent fee debate concerns *only* the reasonable terms of contingent fee agreements and their possible influence on medical liability cases. No one, not even the most ardent proponents of contingent fee limitations, seriously challenges the fundamental social utility of contingent fees in our legal system: "Contingency fees are vital to the vindication of important legal rights in that they enable accident victims and other injured

persons to have access to both legal counsel and the courts which would not be otherwise feasible.”⁵ Others agree:

[The contingent fee] allows victims who cannot afford hourly rates to still hire top quality counsel. It should also encourage lawyers to take on risky cases that otherwise would not be worth pursuing. Finally, in a typical case it places attorneys incentives in line with their clients[incentives] the more recovery for the client, the greater the fee.⁶

The principal proponent of the “early offer” proposal also agrees:

Common Good does support attorney contingent fees generally. They serve an important function of providing lawyers to injured persons who would otherwise not be able to afford one. Nonetheless, contingent fees do raise some troubling issues, including their reasonableness . . . In general contingent fees have no problems. . . In fact, I prefer contingent fees myself. I like to bet on myself in any case. The core question is how to regulate contingent fees so as to protect clients and not to cast the profession into disrepute. I can think of no category of case other than . . . domestic relations and criminal defense in which their use is inappropriate.⁷

There is also general recognition that contingent fees, though usually associated with plaintiffs’ tort litigation, are enjoying increasingly broad application. Contingent fees are appropriate in a variety of cases and not limited to use by plaintiffs’ lawyers:

Contingent fees are no longer, if ever they were, limited to personal injury cases. Nor are contingent fees limited to suits involving tortious conduct.

Contingent fees are now commonly offered to plaintiff-clients in collections, civil rights, securities and anti-trust class actions, real estate tax appeals and even patent litigation. Nor is this compensation arrangement limited to plaintiffs. In this Committee's recent Formal Opinion 93-373, the Committee considered the ethical issues raised by the increasingly employed so-called "reverse contingent fees," in which defendants hire lawyers who will be compensated by an agreed upon percentage of the amount the client saves. The Committee concluded that as long as the fee arrangement reached between the lawyer and client realistically estimates the exposure of the defendant client, such a fee is consistent with the Model Rules.

Moreover, contingent fees are not limited to litigation practice. Fees in the mergers and acquisitions arena are often either partially or totally dependent on the consummation of a takeover or successful resistance of such a takeover. Additionally, fees on public offerings are often tied to whether the stocks or bonds come to market and to the amount generated in the offering. Banks are also hiring lawyers to handle loan transactions in which the fee for the bank's lawyers is dependent in whole or part on the consummation of the loan.

ABA Formal Opinion 94-389 (December 5, 1994).

The debate is, then, only about whether contingent fee limitations or alternative lawyer compensation regimes might better serve the public than the current regimes.⁸ That debate and this report do not challenge the application of contingent fees generally or address the many other kinds of legal representation in which contingent fees are often charged. As noted, this report focuses only on the use of contingent fees in the context of medical malpractice claims.⁹

On one side of the issue, physicians and their professional organizations characterize the contingent fee as a loose cannon and lawyers who employ them as often no better than mercenary brigands.¹⁰ They charge that contingent fee arrangements induce lawyers and their clients to bring unnecessary, often frivolous lawsuits, and that these lawsuits have caused medical liability insurance costs to spiral out of control, imposing unbearable burdens on health care systems. Physicians seek to tether the cannon tightly to a regulatory deck, even though, or perhaps because, the proposed contingent fee limitations would likely leave the patients they injure without effective recourse or remedy. Their animus to contingent fees arises in part from differences in professional cultures. Physicians prohibit contingent fees in medical practice, equating their use to an unethical guarantee of success.¹¹ And because medical costs and physicians fees are usually paid by health insurance, managed care programs, state and federal tax-supported programs, or the patients themselves, physicians have no need for or appreciation of contingent fees. Their patients have access to medical care, and they are typically assured of payment no matter the outcome.

Medical professionals acknowledge the existence of medical error, but they assert that the justice system distorts medical practice by encouraging unnecessary medical procedures and forcing physicians to practice so-called “defensive medicine.” Further, they see little reason for medically injured patients to share large percentages of settlements and judgments with lawyers. As noted, they complain that unnecessary procedures and excessive judgments and fees have caused medical insurance costs to rise astronomically, along with the premiums

that support those payouts. They believe that growing insurance costs have, in turn, caused physicians to leave practice and communities to go without important medical specialists.

Leading the defense of contingent fees are plaintiffs' trial lawyers, who deal personally with victims of medical malpractice. They argue that injured patients who seek redress for their injuries must pay for justice themselves because no insurance plan pays the necessary medical experts, investigation costs and lawyer required to prosecute a medical malpractice action. Plaintiffs' lawyers claim that these costs as extraordinary, that claims take years to resolve, that no interest is recovered on the cost outlay and that the typical malpractice victim lacks adequate resources to fund them. For these reasons, they assert, the contingent fee regime is essential. Further, they emphasize that lawyers are paid a percentage of the recovery only after they assist their clients to recover a settlement or judgment; they receive nothing if they fail.

Because they risk their own time, effort, fees and reputation on their ability to judge to good case from the bad, contingent fee lawyers ask that society trust their expertise and good faith to sift the meritorious from the non-meritorious claims, to bring only good claims. They claim that the costs of medical malpractice claims investigation and litigation are so high that bringing weak or frivolous cases would entail certain bankruptcy. Further, they claim that because expenses are so high, they preclude bringing cases of manifest malpractice for which the injuries are not grievous; many victims are therefore left without effective redress for their injuries.

Plaintiffs' lawyers also argue that negligent physicians should bear the same responsibility as anyone else in American society for negligently causing injury – that physicians are not a special class deserving of immunity. Lawyers assert that without the contingent fee, malpractice victims would have nowhere to turn for relief, that because our legal system provides no alternative avenue for remedy for a medical malpractice victim, the contingent fee in medical malpractice cases is all that stands between a negligent physician and effective immunity from legal liability.

Plaintiffs' lawyers make a further claim, that the medical profession's recent efforts to limit contingent fees would have virtually the same effect as prohibiting them. The special requirements of bringing and proving a medical malpractice case entail such costs that lawyers could not afford to bring such actions under proposed fee limits. To limit fees in the ways proposed, they say,

would also bar the courthouse door and provide effective immunity for negligent medical professionals.

Finally, lawyers argue that limiting contingent fees will not reduce medical liability insurance costs. Plaintiffs' lawyers believe that those costs have risen for other reasons and the real motivation for physicians in seeking new contingency fee limits is simply to reduce their exposure to tort liability.

Unfortunately, much of this battle has been fought through the media, with both sides hoping to enlist public support for their cause, casting the public as the real victims of the other profession's predations. The media for their part tend to sensationalize the issues, often parroting propaganda rather than providing systematic assessment of the various opinions and factual claims. To further polarize the professions and make suing for peace unlikely, matters have increasingly become grist for state and national politics.¹² Among the first casualties of the debate has been truth. To paraphrase one scholar, who is both a physician and a lawyer, the underlying misunderstanding between the two professions, and indeed in the public mind, is fueled by "anecdote and urban legend."¹³

Editorial writers, policy analysts, and legislators typically [pick one side of the debate], pair it with a few highly salient (and invariably unrepresentative) anecdotes, and then offer their preferred policy initiative as the solution du jour. Lobbyists for physicians and trial lawyers will then descend on the legislature and vigorously advocate their respective positions.¹⁴

The Task Force believes that both the medical profession and the plaintiffs' lawyers describe legitimate grievances and make justifiable claims to improved systems, both legal and medical. But because the debates rely heavily on misinformation and misunderstanding, the proposed solutions especially the limitations on contingent fees would only sacrifice justice at the altar of expedience.

This report examines contingent fees relating to medical malpractice relying upon verifiable fact as opposed to anecdote and exaggeration. By doing so, the objective of this Task Force is to improve the parties' and the public's understanding of the nexus, if any, between contingent fees and any perceived national crisis created by medical malpractice litigation. Toward this end, the Task Force also proposes solutions designed to keep the focus on the public whom both sides serve, namely patients and clients. Although wholesale, radical changes

might be warranted to address medical liability and health industry problems, this Task Force was not charged with the task of recommending improvements in the health industry. Our charge is to study the interaction of contingent fees and medical malpractice litigation and determine whether changes in current rules and practices might serve the interests of the public and of individual victims of medical malpractice.

II. Conclusions

- A. Limitations on fees by the formulae recently proposed in Florida and elsewhere risk compromising access to justice by medical malpractice victims. Without the prospect of reasonable fees, competent counsel would be unwilling to assume the high cost burden associated with typically complex medical malpractice actions
- B. The right of people who have suffered injury as a result of medical malpractice to seek redress for their injuries in the courts must be ensured. A fair and reasonable contingent fee is essential to preserve that right.
- C. A small percentage of true medical malpractice events in the United States ever becomes the subject of a claim. Practically speaking, most physicians have only marginal exposure to medical malpractice claims.
- D. Limiting fees by the formulae recently proposed in Florida and elsewhere by physicians' associations would reduce the incidence of meritorious medical malpractice actions and further reduce legal exposure for those who commit medical malpractice.
- E. Contingent fees rates in medical malpractice actions are not fixed but often cluster around traditional percentages. To prevent unreasonable fee agreements and to foster more efficient claim resolution, clients would be well served by additional measures, some of which are already in practice in states such as Florida, to educate and protect them and to promote bargaining symmetry in lawyer-client fee agreements.

III. Background and Scope of Task Force Study

A. Creation of Task Force

Recognizing that the debate over contingent fees in medical malpractice litigation was heating up once again,¹⁵ in fall 2003, Linda Klein, then Chair of the Tort Trial & Insurance Practice Section (TIPS) of the American Bar Association, empanelled the Contingent Fee Task Force (the Task Force or CFTF) to study the impact of contingent fees on the American judicial system generally. Providing impetus for the study was the current effort of various state medical associations and of Common Good, among other organizations, to introduce by legislation or by ethical rule severe limits on contingent fees.

TIPS appointed to the Task Force attorneys engaged in private practice, corporate in-house counsel, insurance company representatives and academics.¹⁶ To maintain objectivity, TIPS appointed as Task Force chair Steven B. Lesser, a construction lawyer with no significant ties to contingent fee practice and as reporters Chris Wells and Patrick Longan of the Mercer Law School faculty, neither of whom had taken prior positions on contingent fee practice.

TIPS asked the Task Force to meet with interested persons and organizations and from those meetings to make findings of fact about contingent fee practice. It requested the Task Force to publish its findings in a form that could serve as a resource for all persons and organizations that might consider proposals to regulate contingent fees. If appropriate, the Task Force would also suggest improvements in contingent fee practice.

Early on, the Task Force concluded that contingent fee practice issues including the nature of fee agreements, the existence of identifiable or controlling clients and the judicial supervision of fee awards vary from practice area to practice area. Accordingly, the Task Force focused its efforts on three differing areas: medical malpractice, securities class actions, and general tort litigation, including employment and housing discrimination and mass torts. This report addresses only the first of those areas, the effect of contingent fee practices on medical malpractice actions. The Task Force welcomes comments on its findings and conclusions and invites readers to address comments to reporters Chris Wells and Patrick Longan.¹⁷

B. Meetings

To date the Task Force has met formally six times. At five of these meetings one or more invited guests¹⁸ made presentations and answered members questions on the subject of contingent fees in medical malpractice actions. The Task Force maintained minutes of each meeting.¹⁹

1. October 2003, Savannah, Georgia (Organizational meeting):

Overview of Utah Effort to Limit Contingent Fees

By Robert Peck, Center for Constitutional Litigation

2. December 2003, Columbia University, New York City:

Contingent Fees in Securities Class Actions

Professors Jill Fisch (Fordham Law School)

Professor John Coffee (Columbia Law School)

John J. Degnan (Vice Chairman and Chief Administrative Officer of The Chubb Corporation)

Contingent Fees in Medical Malpractice Actions

Professor William Sage (Columbia Law School)

Professor David Hyman (University of Maryland College of Law)

3. February 6, 2004, San Antonio, Texas:

Texas Contingent Fee Rule History

Hon. Nathan Hecht (Associate Justice, Texas Supreme Court)

Contingent Fee Empirical Studies

Professor Bert Kritzer (University of Wisconsin)

State Experiences with Medical Malpractice Litigation and Reform Efforts

Linda McMullen (General Counsel, Mississippi Medical Association)

Michael Hull (General Counsel, Texas Alliance for Patient Access (TAPA))

4. April 30, 2004, Napa Valley, California

The Common Good Proposal to Limit Contingent Fees

Philip Howard (founder, Common Good)

5. June 23, 2004, Boca Raton, Florida:

The Florida Experience with Medical Malpractice Litigation Reform

Walter G. "Skip" Campbell, Jr. (Florida State Senator)

Jeffrey D. Kottkamp (Florida State Representative)

Arthur M. Simon (former Florida State Representative and former counsel to health care industry)

In addition to the information provided by the invited guests, the Task Force has studied other reports, law review articles, proposed legislation and other materials in preparation for this report.

C. The Tort Context: Medical Malpractice

According to expert presentations to the Task Force and independent studies, one of every 25 or 30 persons who enter a hospital will fall victim to medical error that causes injury or death. In percentage terms, between 3 and 4 percent of hospitalizations result in a significant “adverse event,” a health care injury that is not an ordinary concomitant of treatment.²⁰ At least one-quarter of these hospital deaths and injuries are preventable, as the product of negligence by physicians or other health care workers. In short, about 1% of hospitalizations result in an occurrence of actual medical malpractice. Reducing this percentage could save lives and prevent injury for many thousands.

Depending on how conservative a definition of “negligence” is adopted, somewhere between 100,000 to 200,000 persons die each year as a result of these iatrogenic (induced by physician or hospital) causes. That puts medical mistakes somewhere between the third and the eighth leading cause of death in the U.S., ahead of car accidents, breast cancer and AIDS, a total that equates to about two 747 crashes every three days.²¹ Medical mistakes also seriously injure another 1,000,000 people each year.²² These and other data suggest that there are real problems in the quality of health care delivery.²³ According to experts, the problems can affect everyone, everywhere, poor, middle-class and wealthy alike. Even physicians and their families are not immune. One study found that over a third of physicians report errors in their or their families’ health care, half of them described as serious errors.²⁴

Medical experts informed the Task Force that other evidence of this health care quality deficit is also found in assessments of actual treatment procedures against Medicare procedural standards.²⁵ For example, in treating six common medical conditions, there is general agreement that 22 clinical processes should always be followed. Experts cited a comprehensive study that found that of that number an average of only 73% (range: 11-100%) were followed. Furthermore, there is no correlation between the quality of health care and the amount of money spent.²⁶ Regions that spend more money or have more medical disciplines do not receive better health care.

D. Seeking the Facts

Those wishing to impose new limitations on contingent fees premise their efforts on several key assertions of fact. Similarly, defenders of the contingent fee status quo offer up their own facts in rebuttal. The Task Force has identified the principal assertions by both sides and has tested them for accuracy. Not all relate directly to contingent fees, but all share responsibility for describing a context – real or imagined – in which contingent fees, and any proposal to limit them, must be assessed.

Physician Claims of Fact:

- Contingent fees have caused an explosion in medical malpractice litigation, and much of it is frivolous.
- Even meritorious lawsuits involve excessive, ethically “unreasonable” fees paid to lawyers.
- Lawyer contingency fees are a significant factor causing a rise in medical liability premiums.

Plaintiffs’ Lawyer Claims of Fact:

- Lawyers bring only meritorious actions because prosecuting medical malpractice actions is very costly, and lawyers who prosecute non-meritorious or frivolous cases will soon bankrupt themselves.
- Limits on contingent fees would significantly impede access to justice for medical malpractice victims.
- Malpractice litigation benefits society by bringing medical error to light and by providing a deterrent effect.

Let’s examine each of these claims in turn.

IV. Physician Claims of Fact

A. “Contingent fees have caused an explosion in medical malpractice litigation, and much of it is frivolous.”

Given the high number of iatrogenic injuries and the potential number of resulting lawsuits, one would predict that medical malpractice lawsuits are common. This would be especially true if injured patients and lawyers were as aggressive as they are often portrayed. But although the medical profession and much of the public apparently holds this truth as self-evident, the Task Force found little objective support for it.²⁷ Studies show that there are relatively few medical malpractice lawsuits, whether compared to other types of litigation or compared to the potential medical malpractice claims.²⁸

Nor are lawsuits in general on the rise. To the contrary, recent national studies of state court data show that tort filings are declining.²⁹ These conclusions find support also in individual state studies. In a study of the Georgia civil court systems, the authors noted that

There have not been any increases in the number of tort filings between 1994 and 1997. When adjusted for population changes, the rate of tort filings actually declined slightly³⁰ . . .

[T]here is no evidence that there was or is an explosion in the number of tort claims filed in Georgia courts . . . The combination of data pertaining to plaintiffs’ success rates, median compensatory damage awards, and frequency and size of punitive damage awards belie the popular image of a system beset with runaway juries.³¹

The same study also found that of all lawsuits filed in Georgia, less than seven percent were personal injury actions, of that small number only about five percent were medical malpractice actions. Putting those two numbers together reveals the medical malpractice litigation comprised less than 0.4% of all civil lawsuits in Georgia during the mid-90s. In a Texas study, data from the decade earlier supported similar conclusions, that there was no empirical support for claims of increased lawsuit frequency or exaggerated verdicts.³²

Such findings are confirmed even by Common Good:

We [Common Good] do not believe in the ‘litigation explosion.’ My focus is on people’s predictability instead of people’s perception of liability.

The facts are that more often than not doctors prevail in litigation, even ones who have done something wrong. That is inconsistent with people's perceptions.³³

Somewhere between one in eight and one in ten detected cases of hospital injuries results in a malpractice claim.³⁴ More remarkable, according to the presentations of experts before the Task Force, is that only about one in fifty actual malpractice incidents results in a claim.³⁵ In percentage terms, victims bring claims in only about two percent of the cases where medical malpractice occurs.³⁶ The remaining 49 of the 50 cases of actual medical malpractice either go undetected by the victim or, even if detected, do not result in a legal claim. Detected cases that do not result in legal claims are often those where the potential damages do not justify the high cost of investigation and litigation.³⁷

It is also widely believed that plaintiffs nearly always win, and that they win through large negotiated settlements or by huge judgments. Claims of high average awards – \$1 million or more – tend to focus on large initial jury verdicts and ignore unsuccessful actions, bench verdicts, pre-trial settlements and other resolutions.³⁸ It is also difficult to determine whether appeals of high verdicts result in reductions or lead to settlements at lower figures.

Information provided the Task Force indicated that in medical malpractice actions taken to trial defendants usually win. This is confirmed by federal government statistics that indicate medical malpractice defendants win about three out of four cases at trial.³⁹ That compares to data which show that typical tort defendants prevail about half the time. The disparity does not necessarily suggest that the unsuccessful cases should not have been brought, but rather that juries are often reluctant to find against defendant physicians or in scientifically complicated cases, as are most medical malpractice cases.⁴⁰ But even if all the lost cases were the result of attorney or expert misjudgment about the existence of actual negligence, according to the Harvard study, “for every doctor or hospital against whom an invalid claim is filed, there are seven valid claims that go unfiled.”⁴¹

Nor does this mean that doctors have a high chance of being sued in the absence of negligence. The vast majority of medical events do not involve negligence. Therefore, one could expect that even small degrees of error in judgment about the existence of negligence would produce numbers of false positives greater than true positives.⁴²

The public often has the impression that anyone, assisted by any lawyer, can bring a medical malpractice claim without substantial foundation – a frivolous

lawsuit. That fact is that all jurisdictions impose requirements on the lawyer to investigate and verify a factual basis for a lawsuit. Some states, such as Florida, go further and impose special requirements for filing a medical malpractice action, such as having another physician swear under oath that the facts demonstrate malpractice.⁴³ Those procedural safeguards, combined with the practical fact that medical malpractice cases are costly to investigate and difficult to win, ensure that few if any frivolous cases are brought: “Florida’s procedural requirements, added in 1985, 1986, 1988 and 2003 virtually preclude frivolous suits.”⁴⁴

According to some analysts, the assertion that contingent fees spawn vexing and frivolous lawsuits not only lacks empirical foundation but has the logic exactly wrong: Contingent fees work in just the opposite way. They shift the risk of failure to the attorney from the client (who would bear the risk of failure if an hourly fee were charged.) Contingent fee attorneys, better positioned through experience and education to assess cases on their merits, will serve both the clients’ and their own interests to reject weak and frivolous cases.⁴⁵ Economic modeling has shown that hourly fees are more likely to engender frivolous suits.⁴⁶

Legislative hearings in Florida failed to document the existence of “frivolous lawsuits” in medical malpractice:

[Senator Campbell’s] Senate committee took a great deal of testimony from all interested parties. He noted that the catchphrase such as “frivolous lawsuits” were common as a justification for pursuing legislative action. To determine the extent of the problem, his committee put witnesses under oath. After that, no one- physician or other person – could cite a single example of a frivolous lawsuit. In fact, one [witness] admitted that “there are no frivolous lawsuits in medical malpractice.”⁴⁷

The Florida Medical Association, sponsor of the proposed Florida constitutional amendment to restrict contingent fees in medical malpractice cases was unable to document the existence of frivolous lawsuits:

When questions about frivolous lawsuits arose, Sandra Mortham, the chief executive of the Florida Medical Association, told the [legislative] panel, “I don’t feel that I have the information to say whether or not there are frivolous lawsuits in the state of Florida.”⁴⁸

The Task Force concludes that the claims that describe an “explosion of medical malpractice litigation” – frivolous or not – fail for want of empirical or logical support.⁴⁹ Having found no evidence of a medical malpractice litigation

explosion, the Task Force concludes that contingent fees have not caused such an explosion.⁵⁰ Logic suggests that contingent fees actually prevent frivolous suits. Further, there is no reason to believe that keeping the current contingent fee regime will cause a future litigation explosion or impetus for bringing frivolous suits.⁵¹

That is not to say, however, that limitations on contingent fees would have no effect on the number or quality of medical malpractice actions that are filed. As shown in the discussion below, imposing such limitations will likely preclude many medical malpractice actions from being filed because the prospective damages and resulting attorneys' fees will not justify the expected time and expense associated with the litigation. Only those most grievously injured by the grossest medical negligence would likely be able to bring an effective action.

B. “Even meritorious medical malpractice lawsuits often involve unreasonable fees paid to the lawyers.”

Everyone who reads the local newspaper probably remembers a story about a lawyer whose fees were reported as high, perhaps even greater than the amount of the recovery left to a client. Publicized examples seem to occur most often in class actions and mass torts, but the occasional example occurs also in medical malpractice litigation. Some of that reportage is likely accurate. Nonetheless, some fails to examine the history of such cases through post trial or post-settlement to determine how much the lawyers really charged. In any event, such reportage raises in the minds of many whether the lawyers have charged an unreasonable fee.

State rules of professional ethics prohibit lawyers from charging “unreasonable” fees by imposing “appropriate and reasonable” criteria:

In addition to the requirement that a fee be appropriate, Model Rule [of Professional Conduct] 1.5 requires that the fee, whether based on an hourly rate, a contingent percentage or some other basis, "shall be reasonable." Similarly, DR 2-106 prohibits a "clearly excessive fee," which is in turn defined as a "fee ... in excess of a reasonable fee."

In deciding whether a contingent fee arrangement is reasonable the lawyer must consider the following factors set forth in Model Rule 1.5(a):

(1) the time and labor required, the novelty and difficulty of the questions involved, and the skill requisite to perform the legal service properly;

(2) the likelihood, if apparent to the client, that the acceptance of the particular employment will preclude other employment by the lawyer;

(3) the fee customarily charged in the locality for similar legal services;

(4) the amount involved and the results obtained;

(5) the time limitations imposed by the client or by the circumstances;

(6) the nature and length of the professional relationship with the client;

(7) the experience, reputation, and ability of the lawyer or lawyers performing the services.

We stress that the lawyer should take all these factors into account in evaluating every case. See ABA Formal Opinion 329 (1972).⁵²

Although contingent fees, as all lawyer fees, must be appropriate and reasonable, and studies show that most contingent fees approximate hourly fees.⁵³ Nonetheless, critics assert, lawyers often ignore the requirements.⁵⁴ They level two related charges: (1) that lawyers often charge a fee in excess of the level of

risk inherent in the case; and (2) that lawyers fix contingent fee percentages (by custom if not collusion) and do not allow clients to bargain about fees or to explore fee alternatives.

1. The Question of Risk

The core rationale for contingent fees is the risk borne by lawyers who take cases for which they advance costs and invest their own time and skill. As noted in the Introduction, the current dispute concerns the wisdom of imposing further limitations on how much a lawyers can charge a client on a contingent fee basis. Although the proposed fee limitations vary, and can include a sliding scale formula based upon the amount of recovery, none of these mechanisms addresses the important social utility of contingency fees.

As a justification for imposing low ceilings on contingent fees, proponents of limitations often refer to “riskless” or “low-risk” cases, proposing that such cases compel lawyers to charge reduced contingency percentages to meet the “reasonableness” standard. That argument requires looking carefully at what kinds of risk are inherent in tort suits, specifically medical malpractice actions, and what factors contribute to judgments about the “reasonableness” of contingent fees.

The primary risk inherent in bringing a lawsuit is of course the possibility that the suit will be unsuccessful and that neither the client nor the lawyer will be compensated. In medical malpractice cases, when compared to tort cases in general, this risk is extraordinarily high. As noted, Bureau of Justice statistics show that while plaintiffs prevail in over half of all tort cases, they prevail in only a little over a quarter of medical malpractice actions. According to a recently published Rand study, the percentage is only about 22% in California.⁵⁵ In a contingent fee case, a defense verdict means that the plaintiff walks away without a recovery and the plaintiff’s lawyer with no fee for professional services, for investigation costs, for experts witness fees, etc. Although the out-of-pocket costs of the action can be charged back to the client, the clients’ financial conditions usually preclude that. Indeed, in recognition of this fact, the ethical rules now allow contingent fee agreements to make repayment of expenses also contingent upon the successful outcome of the case.⁵⁶

The net result in such cases for the lawyers is that they are compensated neither for their professional time and services nor for the other costs associated with the action that they incurred on behalf of the client. Because these costs are especially high in a malpractice action, and because the likelihood of prevailing is

especially low, the typical malpractice action will involve a significant level of risk.

To be sure, some plaintiff claims can appear from the outset to be quite likely to prevail, and others less so. Lawyer experience and expertise allow at least gross judgments of this sort and, consequently allow for the possibility of negotiating contingent fee percentages accordingly. Even so, litigation outcomes are never certain, thus there is always the risk of misjudgment.

Other risk factors can transform cases of even “clear” liability into cases of effective non-liability or greatly reduced recovery. Presentations before the Task Force identified at least four: cross-claims or similar “finger-pointing” between multiple defendants, which can delay discovery and settlement; defendants and insurers can become insolvent, which can eliminate the chance of full, or any, recovery; developments in a case, including death of the victim, which can lower predicted damages⁵⁷; other reasons, from uncertainty about applicable law to docket delays to appeals from plaintiffs’ verdicts, where the time value money increases the risk successful settlement, litigation or other vehicle for recovery.⁵⁸ There are undoubtedly other examples.

Under the Model Rules of Professional Conduct, even in a so-called “riskless” case -- one where liability is apparent and recovery certain – a contingent fee can still be appropriate because it will require lawyer expertise and time or genuine risk suddenly arises. In the words of the ABA Standing Committee on Ethics:

[T]he Committee is of the view that the argument may rest on a faulty notion as to the number of cases regarding which at the onset of the engagement the lawyer can say with certainty that the client will recover. Defendants often vigorously defend and even win cases where liability seems certain. Additionally, a previously undiscovered fact or an unexpected change in the law can suddenly transform a case that seemed a sure winner at the outset of representation into a certain loser. See, e.g., *Central Bank of Denver v. First Interstate Bank of Denver*, 114 S.Ct. 1439 (1994) (where the Supreme Court held that a private plaintiff may not maintain an aiding and abetting suit under § 10(b) of the Securities Act of 1934, overruling every circuit court which for decades had allowed such suits).

Moreover, even in cases where there is no risk of non-recovery, and the lawyer and client are certain that liability is clear and will be conceded, a fee arrangement contingent on the amount recovered may nonetheless be

reasonable. As the increasing popularity of reverse contingent fees demonstrates, for almost all cases there is a range of possible recoveries. Since the amount of the recovery will be largely determined by the lawyer's knowledge, skill, experience and time expended, both the defendant and the plaintiff may best be served by a contingency fee arrangement that ties the lawyer's fee to the amount recovered.⁵⁹

Proponents of contingent fee limitations argue that early settlement will reduce much of the risk inherent in litigation, which then justifies severe limitations where such early settlements occur. Setting fixed limits on such early settlements may fail to account for much of the value added by the professional services in such cases:

Also, an early settlement offer is often prompted by the defendant's recognition of the ability of the plaintiff's lawyer fairly and accurately to value the case and to proceed effectively through trial and appeals if necessary. There is no ethical reason why the lawyer is not entitled to an appropriate consideration for this value that his engagement has brought to the case, even though it results in an early resolution.

Given the foregoing, the Committee concludes that as a general proposition contingent fees are appropriate and ethical in situations where liability is certain and some recovery is likely.⁶⁰

Thus, even where liability is "certain," the contingency is the amount of recovery. The value the lawyer brings to the case, which justifies a contingent fee, is the ability to affect that amount and to improve the recovery the client receives.

The Task Force agrees with early settlement proponents that time can be the enemy of both parties. A principal goal of dispute resolution should be adopting methods for efficient resolution. But the early settlement proposal is not a panacea. It features a serious weakness. By offering low marginal contingent fees where no settlement ensues, it could create an incentive for clients to settle early – not discouraged by their lawyers – without sufficient attention to the facts or value of the case that would be brought to light by more thorough, and expensive, negotiation and research.

Experts appearing before the Task Force, including Philip Howard, founder of Common Good, agreed that the premise of early-settlement-offer proposals (that there are cases involving minimal risk of non-recovery, and minimal attorney time, labor and skill⁶¹) does not usually apply to medical malpractice litigation. The

costs of presenting a credible medical malpractice claim to a defendant and insurer are simply too high. Their credibility and the statutory litigation procedures require more than minimal attorney time, labor and skill. Lawyers must assume that every case will go to trial, and prepare accordingly, even though they know that very few will actually be tried. Failing to prepare for trial will cost lawyers credibility and potentially cost their clients in settlement.⁶²

Given the foregoing, the Committee concludes that as a general proposition contingent fees are appropriate and ethical in medical malpractice cases even where liability is reasonably certain and some recovery is likely. The Task Force agrees that contingent fees ought to vary with the risk assumed by the lawyer: usually the lower the risk assumed, the lower the contingent fee percentage. The Task Force concludes that, as a general matter, there is no such thing as a riskless case, and that lawyers and clients lack sufficient prescience to predict the quantum of risk cases with accuracy and consistency. In medical malpractice, low risk cases are rare events, but even in cases leading to quick settlement, the negotiations and drafting involved might be worth more than the 10% fee contained in the most common limitations proposals.⁶³ In any event, designing a limited contingent fee compensation regime around the notion of medical malpractice cases devoid of significant risk is unwarranted and unwise.

2. The Question of Fixed Contingency Rates

There is genuine debate as to whether lawyer contingent fees are “fixed” by convention⁶⁴ or “conscious parallelism” so as to preclude the real possibility of client fee negotiation and choice. Of course, consciously fixing contingent fee rates or colluding with others to standardize a fee violates professional ethics, whether one lawyer applies the same percentage in all his or her cases or multiple lawyers apply varying but standardized fees to categories of their cases.⁶⁵ But critics do not charge lawyers with collusive price-fixing.

This assertion of price fixing, however conscious or unconscious it might be, is probably the most difficult of the factual assertions to assess. On the one hand, Professor Lester Brickman has argued for a decade or more, in several cogent articles, that lawyers fix fees.⁶⁶ Drawing his conclusions largely from circumstantial evidence, he builds a case for the existence of price fixing by custom, if not by active collusion. Brickman asserts that empirical and historical observations, such as the following, suggest uniform fee pricing:

the absence of price advertising; the enormity⁶⁷ of the increases in effective hourly rates over the past forty years . . . ; the historical

derivation of the standard one third (or higher) contingent fee; the absence of economic justification for uniform pricing . . .; inelasticity in the pricing of tort claiming services . . [and] payment of referral fees⁶⁸

Although data do support the claim that a one-third fee is commonly used, at least as a starting point for fee arrangement discussions, the Task Force was unable to find unequivocal empirical data to support the critics' allegations of fee fixing. The two leading scholars of contingent fee practices dispute the real-world data. One leading scholar doing empirical studies of lawyer fee practices, Professor Bert Kritzer, disputes the allegations of price fixing and has found that contingent fee percentages vary, but that 33% is most common, applied in about half the cases he studied.⁶⁹ Professor Brickman disputes Kritzer's data, methods and conclusions and relies heavily on the absence of competitive fee information in lawyer advertisements and other observations. He concluded from that absence that no competition existed, but he apparently did so without asking the lawyers – including those who advertised -- what their fees were.⁷⁰ It also seems obvious that lawyers' omission of specified fees could just as well suggest willingness to negotiate. The Kritzer-Brickman debate continues, and until additional studies are completed focusing especially on medical malpractice actions, it is difficult for the Task Force to conclude where the truth lies with the ultimate question of whether and how clients negotiate fees in such cases.

Brickman and others asserting fee fixing also point out that the real world of lawyer-client relationships includes factors that “inhibit the emergence of a price competitive market”:

asymmetrical knowledge with respect to the value of claims; the lack of sophistication of most purchasers of tort claiming services; the utility of uniform pricing in misleading consumers as to the risk being assumed by the lawyer; and the signaling functions of uniform pricing including the branding of price cutters as slackers or as inferior in quality.⁷¹

The Task Force agrees that asymmetrical knowledge and sophistication about the realities of tort litigation create serious potential for lawyer overreaching. It is also quite possible that price (fee) cutting by lawyers might be interpreted by clients as indicating that the lawyers are inferior or will cut corners while handling the case. If these assertions are true, the question arises how national and state bar organizations should respond to correct the asymmetries. In Section VI below, the Task Force offers some suggestions, focusing around improved client information and education. It does not believe that applying artificial and ultimately arbitrary

caps on fees provides an answer that both protects clients against lawyer overreaching and against reducing the already minimal exposure of medical professionals to legal liability for their negligence.

Professor Brickman observes and experts agree that fee negotiation and competition occur in airline crash litigation.⁷² In such cases, contingent fee percentages fall in the 14-17% range, as opposed to twice that in typical tort litigation. That is not because there is no risk in airline crash cases, but rather because liability is more certain and perhaps the value of the case more apparent to both lawyers and clients. This observation supports the conclusion that increased client information and sophistication can have a beneficial effect on contingent fees.

Professor Brickman also identifies professional rules and other structures that effectively preclude free markets for fees from developing:

I attribute the persistence of uniform pricing to market failures . . . actions of the bar designed to prevent a competitive market from emerging . . . includ[ing] the maintenance of barriers to entry into the tort claiming market, prohibitions against the outright purchase of tort claims and adoption of rules of ethics effectively prohibiting price competition including prohibitions against providing financial assistance to clients and brokerage of lawyers' services for profit.⁷³

It is true that the Bar regulates entry into the profession and monitors the unauthorized practice of law. It is also true that lawyers' ethical rules preclude brokerage and purchasing others' claims. Eliminating such restraints on lawyer behavior would be a radical departure from well-established norms of professional behavior. Eliminating barriers to entry and similar restrictions in, say, the medical profession or prescription drugs might also produce more active markets and reduce prices, but the social costs would likely be enormous. The Task Force believes that jettisoning excising professional norms is neither necessary nor prudent. Again, the Task Force concludes that clients are protected by current ethical rules and can be further protected from distorted markets by less radical measures.

Client protection starts with fiduciary behavior by lawyers. This is required by all professional codes and is exhorted by trial lawyers themselves. For example, the Association of Trial Lawyers of America advises lawyers and potential clients in its pamphlet, "Key to the Courthouse," as follows:

The percentage charged in contingent fees may vary from case to case depending on the circumstances, including but not limited to, the risk of recovery, the impact of the expense of the prosecution, and the complexity of the case. . . Attorneys should exercise sound judgment and use a percentage in contingent fee contracts that is commensurate with the risk, cost, and effort required. . . . Attorneys should discuss alternative fee arrangements with their clients.⁷⁴

The Task Force found that Florida practice is exemplary for requiring lawyers to admonish clients of their rights, including their right to negotiate fee matters.⁷⁵ The Task Force concludes that asymmetric information lies at the heart of potential problems with client negotiating power, which, in turn increases the chance for a standardized or excessive fee regime. Therefore, efforts to provide clients with more information can result in more competitive and equitable fees. Price caps are not a long-term solution and precipitate their own market distortions.

C. **“Lawyer contingency fees are a significant factor causing a rise in medical liability premiums.”**

The Task Force has discovered no data that support the assertion that contingent fees are a substantial factor in the increase of medical malpractice insurance premiums. Medical liability experts and others appearing before the Task Force consistently opined that contingent fees have little if any effect on medical liability premiums.⁷⁶ For example, Senator Campbell, who had studied the problems of medical liability insurance for many years said that “There is no reason to believe that contingent fees are driving up the costs of anything.”⁷⁷ On the other hand, they and others also noted that other factors have had such an effect, including improved medical technologies, higher patient expectations, and the longer human lifespan. They also noted that in many markets only a small percentage of physicians purchase medical liability insurance, often those with the highest risk specialties.⁷⁸ For example, in Florida, only about sixty percent of physicians are insured.⁷⁹ Because risk is spread so narrowly, premiums are believed to be higher than they otherwise would be.⁸⁰

Given this absence of evidence,⁸¹ the Task Force concludes that contingent fees have not themselves caused the spike in medical liability premiums. Nonetheless, the Task Force agrees that materially limiting contingent fees – especially to the ultimate 10% suggested by the Florida proposal, could have a tempering effect on such premiums. The reason is simple, medical malpractice victims will not find lawyers to assist them in their claims.

Several incontrovertible economic and litigation realities of lawyers' fees help to demonstrate this. First, contingent fees are by definition a percentage of the plaintiff's recovery. They are not added onto or paid as a separate claim. For this reason, limiting the allowable contingent fee percentage will not directly reduce the defendants' liability or the amount of the liability that is paid under a medical liability policy.

Second, price controls distort markets for products and services. Limitations on lawyer fees are a form of control on the price of lawyer services. If prices for lawyer services are fixed below what the market would yield, lawyers will have incentive to employ their services elsewhere, where their expertise and skills match the demand for them. That is especially true where their litigation costs –including lawyer time and effort – are high, as in medical malpractice litigation.

Third, current fee-limitation proposals apply only to plaintiffs' lawyer contingent fees; they do not apply to defense lawyers' fees. Defense lawyers would remain unconstrained by law. There would be no limit on the number of lawyers the defense could employ or the amount of fees those lawyers could charge. That creates a potential imbalance in favor of the defense. Thus, even where medical malpractice victims could find representation, the law would say to them, "you are not allowed to use a lawyer whose market valuation is equivalent to those who might represent the defendant."

Given these facts, and assuming that there is a connection between liability premiums and contingent fees, it must be for the second and third of these facts, not the first. Limiting contingent fees will likely squeeze lawyers out of medical malpractice litigation, leaving some, perhaps many, victims with no representation. Fewer claims could mean lower overall insurance payouts and the elimination of defense lawyers and their fees. Both could mean reduced premiums.

The Task Force concludes that limiting contingent fees has the potential for reducing medical liability premiums, but at the societal cost of barring access to justice for serious and legitimate victims of medical negligence.⁸²

V. Plaintiffs' Lawyer Claims of Fact:

A. **“Lawyers bring only meritorious actions because prosecuting medical malpractice actions is very costly, and lawyers who prosecute non-meritorious or frivolous cases will soon bankrupt themselves.”**

The Task Force heard anecdotal estimates ranging from a low of \$50,000 to a high of \$500,000 to prosecute a single case of medical malpractice.⁸³ Whether or not such estimates would hold up in the face of controlled studies, the Task Force heard from no one who asserted that investigating and bringing a medical malpractice claim was inexpensive. Nor has anyone made it aware of others who make such an assertion. On the contrary, the typical assertion was consistent with Professor Shaffer's conclusion:

[E]very case require[s] hundreds of hours of work and a huge outlay of money to pay for the investigation evaluation by experts, deposition testimony, travel, etc. . . . While I have heard the claim that many of these cases settle quickly, with little time or effort on the part of the plaintiff attorney, I can unequivocally say that I have never see or heard of such a case [with but a single exception].⁸⁴

The Task Force concludes that there may be no such thing as an “inexpensive” medical malpractice action. Even if there were, the overwhelming majority of cases require a significant investment of lawyer time, expertise and investigatory costs. In fact, plaintiffs' costs, borne initially by the plaintiffs' lawyer, include paying the defendants' expert witnesses for their time during the discovery phase, such as sitting for depositions.

As shown in Section IV.A., a large pool of unnoticed injury cases or cases do not result in a claim, many for lack of legal representation.⁸⁵ A number of victims are eliminated from the claim pool because the very high costs of investigation and litigation require very high damages potential to justify the litigation as a matter of economics.⁸⁶ They cannot retain lawyers because plaintiffs' lawyers reject cases that lack sufficient damages to warrant the litigation expense. In addition, medical malpractice specialists cannot effectively spread the risk among clients, even if they were allowed to do so by professional ethics. The cases are so time intensive and expensive that only a few can be handled at a time. For these reasons, many malpractice victims are left without legal remedy. These problems are only exacerbated by damage caps, already in place in Florida and other states, which artificially reduce plaintiffs' damages.

Also, as discussed above, plaintiffs already have a tough row to hoe in medical malpractice cases. Especially in states such as Florida, where they encounter special procedural hurdles, cases are difficult to win: “Florida has already slanted the field greatly against plaintiffs in medical malpractice actions. They have the shortest statute of limitations. They have numerous additional procedural requirements. For those reasons, plaintiffs usually lose.”⁸⁷

B. “Limits on contingent fees would significantly impede access to justice for medical malpractice victims.”

This assertion has already been discussed in part in Sections IV.A. and V.A. above. Its accuracy depends largely on two issues: (1) whether there exists such a thing as a simple, inexpensive medical malpractice claim and (2) whether there is a pool of lawyers willing to bear the up-front costs and accept the risks inherent in medical malpractice actions for materially reduced compensation.

The resolution of both issues stems largely from one fact: There is already a very large pool of unclaimed injury cases that exists because the costs of investigation and litigation exceed the likely return. Information provided the Task Force suggests that a medical malpractice claim must amount to \$100-200,000 simply to break even. Anything less means that, at typical rates of return, the case will be refused. The economic barriers – the investment of time and money to establish a valid claim – are simply too high to allow much of the pool of medical malpractice victims to be served:

Elimination of, or significant constraints on, contingent fees would make legal assistance available only to those injured persons who are wealthy. The poor, the retired, African Americans, and women especially will suffer because they are often unable to afford hourly fees. The contingent fee is often their key to the courthouse. The only goal of people who want to eliminate contingent fees is to reduce the incidence of lawsuits. To do so would be unfair to those who need a lawyer.⁸⁸

In addition, according to reliable studies, because they would reduce the number of victims who could afford a lawyer, limitations on fees would likely reduce optimal compensation for all victims and, in effect, reduce the deterrent effect on medical negligence.⁸⁹ Thus, even those victims who enter the system and find a lawyer might be short-changed when it comes to appropriate remedies.

In the words of a prominent patient rights advocate in Florida: “The call for a cap on contingency fees for medical malpractice cases does not help the patient . . . The idea of placing caps does nothing to reduce medical errors and improve patient safety.”⁹⁰

This conclusion is echoed in the recent Florida Supreme Court case that determined the proposed Florida constitutional amendment will be allowed on the ballot. Justice Pariente noted in concurrence that “If approved, the amendment may well hamper citizens' ability to press their medical liability claims because its

ceiling on contingency fee percentages would discourage the participation of knowledgeable and experienced counsel.”⁹¹ Justice Lewis’s dissent, concurred in by Justice Anstead, was stronger:

The chief purpose of the proposed amendment is to render it economically impossible for claimants and their legal representatives to proceed with actions to redress legitimate injuries. With the artificial percentages of recovery mandated by the proposed amendment, unquestionably, legal counselors will be unable to accept responsibility for processing medical actions. Due to the complex nature of medical negligence claims, including the requisite statutory screening process, injured citizens will be unable to navigate the field alone. Moreover, health care providers will not be similarly handicapped, as the proposed amendment will in no way impact their rights to retain counsel on any terms or limit the funds available to secure defense counsel.

These three Florida justices agreed that the true effect of the amendment would be to erode the rights of medical malpractice victims to seek legal redress.

Limitations do not simply serve to ignore medical error and to eliminate medical malpractice victims from the system, they also would shift meritorious cases to less experienced (and therefore less expensive) lawyers. This could have the effect of reducing the likelihood or amount of recovery. Plaintiffs would not really be able to have the counsel of their choice and might have to settle for counsel unfamiliar with the procedural intricacies of the specialized area of practice.⁹²

Again, in the words of Florida Supreme Court Justice Lewis:

[B]efore a claim is ever filed or a trial may begin . . . a litigant with a medical negligence claim must proceed through a lengthy, time-consuming, and certainly, costly process. This mandatory pretrial screening process will remain in effect even if the proposed amendment is adopted. Florida citizens need, and are entitled to, assistance to guide them through this process. As evidenced by the numerous decisions concerning the pretrial medical negligence process, the existing law has been a series of traps and a minefield for many Floridians.⁹³

Indeed, even Common Good agrees that caps on contingent fees, especially because they are placed only on the plaintiffs' lawyers, can be harmful to our system of justice: "Caps will deny plaintiffs access to justice."⁹⁴

C. **“Malpractice litigation benefits society by tending to improve the quality of health care.”**

If the health industry’s claims were generally on the mark – that there is excessive and unnecessary medical malpractice litigation, that claims made have played a part in the spike in medical liability insurance premiums, and that physicians are leaving practice, the question arises, “Why not eliminate medical malpractice claims directly, perhaps by granting physicians immunity from liability for negligence?” In other words, do medical malpractice actions have societal utility so that severely restricting or eliminating them would be harmful to the public interest?

Medical malpractice litigation can have two main beneficial influences on the delivery of health services. First, claims themselves, whether successful or not, can cause health care providers and their insurers to review and tighten procedures. Second, a successful case might deter the negligent health care provider from repeating the mistake. This is called specific deterrence. Publication of the case might cause other providers to avoid the same mistake. That is called general deterrence.

Some in the medical community believe that legal liability plays no significant role in improving the quality of medical care.⁹⁵ The Task Force has found a legitimate difference of opinion on this question. On the one hand, there is good evidence that recognizing that one can be potentially liable for medical malpractice results in modest deterrence, meaning exercise of increased care and avoidance of medical error.⁹⁶

On the other hand, liability costs might be spread too broadly to produce either a general or specific deterrent effect among physicians. In other words, physicians guilty of malpractice usually do not pay damages out of their own pockets. Victim damages are paid by the physicians’ liability insurers, by the hospital’s insurers or are covered less directly by others in the health care system. Plaintiffs rarely pursue defendant physicians’ personal assets beyond insurance coverage limits. In any case, such assets are subject to bankruptcy court protection and are often sheltered from liability in other ways.

On balance, the Task Force accepts the conclusion of those experts associated with the so-called Harvard Study: “[W]e believe that for purposes of practical policy-making, the safest course is to accept the indication . . . that malpractice litigation does have an injury prevention effect, however statistically fragile the specific point estimate might be.”⁹⁷

Physicians also claim that litigation has led to increased medical costs, through the phenomenon of “defensive medicine.” Physicians are said to employ tests and procedures that are not medically necessary simply to protect themselves against a charge that they did not do all that was required. Again, there is mixed information and contrary interpretations of the data that support this claim. If physicians employ unnecessary procedures – such as caesarian deliveries in lieu of natural ones – the question arises whether they would consciously subject a patient to a more dangerous procedure – whichever it is – and if they do not, whether a peer medical expert would support a conclusion that they were negligent in doing so.

Similarly, there is little or no evidence that fear of liability will always impede improvement in care by encouraging silence and cover-ups. Data about whether physicians practice excessively defensive medicine are inconsistent. Physicians in specialties that employ few “procedures” – such as family medicine, psychiatry and endocrinology – privately accuse the procedures-oriented specialists of ordering extra procedures following Willie Sutton’s advice: “because that’s where the money is.”

Eliminating sanctions, including money damages, for negligence, would likely accentuate another aspect of the health care market. As it is, physicians have defective incentives. In technical terms, their “compensation is quality and outcome invariant.” Simply put, they get paid for the service and not for results. Two things suggest they will employ care in the process: their medical ethos and their belief that their errors will be discovered and they will be sanctioned.

In the opinion of the founder of Common Good, improvements in the health care system and the judicial system as it deals with medical malpractice will come not from capping attorney’s fees, but from other approaches: enforcing the “reasonable fees” requirement of the attorneys’ ethics code; enhancing judicial oversight of fee agreements and awards; and allowing more, not less, access to justice for injured persons.⁹⁸

VI. Proposals Regarding Attorneys' Contingent Fees

The medical profession and allied groups have in recent years lobbied in numerous jurisdictions for adoption of either of two types of contingent fee limitations. The first type of limitation is simply a new but more severe, Florida version of the "sliding-scale" already in place in Florida and other states.⁹⁹ The more common proposal, so far unsuccessfully introduced for adoption in some fourteen states, is the "Common Good" or "early offer" proposal.

For the reasons discussed below, the Task Force concludes that neither approach to contingent fees serves the interest of the public or the victims of medical malpractice. The Task Force also concludes that suggestions designed to assist client negotiating power are premature and unwise. Instead, the Task Force offers suggestions of its own for protecting victims as well as physicians.

A. Medical Association Proposals

1. The Florida Proposal

The Florida proposal is cast in the form of an amendment to the Florida State Constitution. Its proponents, most notably the Florida Medical Association, call it a "fair share" proposal.¹⁰⁰ Under the Florida proposal, which by its terms applies only to "medical liability" cases, lawyers' contingent fees would be limited to 30% of the first \$250,000 of the net recovery and to 10% of anything above that amount. The goal, say its supporters, is to assure that medical malpractice victims receive their fair share of any recovery, and that the lawyer does not take too much of it. Some, including justices of the Florida Supreme Court, are skeptical not only of the design of the proposal but also of the FMA's stated altruistic goal. In dissenting from the Court's decision to allow the proposed Florida constitutional amendment on the November ballot, Justice Lewis wrote that the amendment:

attempt[s] to "hide the ball" from the voters and disguise a very clear end. . . [with] false promises of benefits when [it] really restrict[s] existing rights. . . Clearly, the proposed amendment as written portrays that it will provide protection for citizens by ensuring that they will actually personally receive a deceptive amount of all money determined as damages in any medical liability action. However, the amendment actually has the singular and only purpose of impeding a citizen's access to the courts and that citizen's right and ability to secure representation for a redress of injuries. Its purpose is to restrict a citizen's right to retain counsel of his or her

choice on terms chosen by the citizen and selected counsel and to thereby negatively impact the right of Florida citizens to seek redress for injuries sustained by medical malpractice. This is truly a wolf in sheep's clothing.¹⁰¹

[The FMA] should not falsely claim they are providing a benefit to those injured by medical malpractice when they are in fact restricting their rights to secure adequate legal representation. There really is no other purpose of this proposed amendment.”¹⁰²

Long-time Florida legislator and business lobbyist, Art Simon, believes that the proposed amendment is “the wrong thing, wrong time and wrong vehicle.”¹⁰³ He also believes that true rationales for the proposal are not so patient oriented:

[R]ationalists at least have some logic at the root of their proposal: ‘reducing contingent fees will reduce premiums.’ They are told this by medical malpractice insurers. If lawyers have less incentive to bring a case, there will be fewer cases, lower claims and therefore lower premiums.¹⁰⁴

On the other hand, he says that

The irrationalists’ argument is as follows: attorneys are the enemy; they pursue jumbo judgments; they block legislative action; so hit ‘em where it hurts – in the back pocket. Even just driving attorneys crazy is good. . . Doctors insist that attorneys haven’t given enough, so it’s now time to hit attorney fees. . . The proposal is unconscionably arbitrary and vindictive.¹⁰⁵

The amendment’s proponents have met the procedural requirements to have the Florida proposal appear on the November election ballot. Although the voters may be presented with a simple, intelligible version of the proposal on their ballots, the underlying issues and potential impacts are anything but simple and intelligible. As noted, the proposal will not describe its most salient feature: it will reduce the opportunity for victims of medical negligence to secure justice.

It is no small irony that medical malpractice actions in Florida are already the most highly regulated in the country, largely in favor of the physician.¹⁰⁶ Florida has long been among the leaders in addressing medical malpractice issues and limiting claimants’ rights in such cases, including addressing a number of the key issues raised in this report. The Task Force heard presentations from several

current and former Florida legislators, all of whom had worked in significant ways over many years with the recurring crises of malpractice insurance.¹⁰⁷ (Unfortunately, the Task Force was unable to convince the Florida Medical Association to explain the rationale of its proposal.¹⁰⁸) They described important several important procedural and ethical rules adopted in Florida to encourage client negotiation of fees, to protect against lawyer overreaching, to protect against frivolous lawsuits, to encourage reasonable settlement, and to limit contingent fees.

a. Encouraging Fee Negotiation

Florida requires that before a lawyer and client arrive at a contingent fee arrangement, the client must receive and understand a “Statement of Rights.”¹⁰⁹ The first paragraph of the Statement admonishes the prospective client that

“You . . . have the right to talk with your lawyer about the proposed fee and to bargain about the rate or percentage as in any other contract. If you do not reach an agreement with one lawyer you may talk with other lawyers.”¹¹⁰

This provision, especially when coupled with the general ethical requirement that lawyers discuss alternative fee arrangements with prospective clients, increases the likelihood that tort victims will act to inform themselves as consumers of legal services, to compare lawyers, to compare alternative fee structures and to negotiate contingent fee percentages and other terms in their interest.

b. Other Florida Client Protections

Among other things, clients must also be advised in writing of their rights:

- to a three-day “cooling off” period for withdrawing from a contract for representation
- to be informed of any fee-sharing arrangement by the lawyer retained
- to be informed of any referral and to have a new contract if that occurs
- to know of how all expenses and legal fees will be calculated and paid whether the case is settled, won or lost
- to be kept abreast of progress in their case

- to make final decisions regarding settlement and their right to learn of all offers of settlement
- to report to the Florida Bar any concerns over an illegal or excessive fee, including how to lodge a complaint.¹¹¹

c. Protecting Against Weak and Frivolous Lawsuits

Physicians, as would anyone, fear the possibility they will be named defendants in a lawsuit. A greater fear is that they will be sued for something they did not do; that is, to be the object of a weak or frivolous suit. As discussed above, the typical investigative and time costs to the lawyer in an unsuccessful action renders this unlikely. Nonetheless, Florida requires an additional procedural step that inures principally to the benefit of the potential physician-defendant. Whenever a medical malpractice action is filed in Florida, it must be accompanied by an affidavit from a licensed physician supporting the allegations of medical negligence.¹¹² In other words, the assessments of the patient and a lawyer, no matter how obvious or subtle the matter, are insufficient.

d. Existing Limitations on Contingent Fees and Damages

As noted, the Florida proposal is a variation on the “sliding scale” approach adopted by a number of states. Interestingly, Florida itself has already adopted a sliding scale, one that falls in line with those in operation in other states.¹¹³ Depending on procedural alternatives, including arbitration, contingent fees in medical malpractice actions are limited to varying percentages, typically 33 1/3 - 40 percent of first \$1 million; 30 percent of next \$1 million; and 20 percent of any recovery over \$2,000,000).¹¹⁴

2. The Common Good or “Early Offer” Proposal

The Common Good proposal’s principal terms were described as follows by its proponents in their effort before the Utah Supreme Court:

First, if a settlement offer is made before an injured person retains an attorney, and the injured persons accepts that offer, a subsequently hired attorney may only charge an hourly fee that does not exceed 10% of the first \$100,000 and 5% of any additional recovery.

Second, if an injured person retains an attorney on a contingent fee basis, the attorney must provide a written notice of claim sufficient to allow the allegedly liable party to assess the claim and make a reasonable offer of settlement under the circumstances. If the attorney does provide that notice, the attorney may only charge an hourly fee that does not exceed the limits described above, regardless of how the case concludes.

Third, if a settlement offer is made within 60 days of the required notice, and the client accepts that offer, the attorney may only charge an hourly fee that does not exceed the limits described above. In each case, an offer of settlement must, by its terms, have an expiration date at least 30 days after the offer is made, and the limitations on fees are subject to waiver by the Court upon application by counsel.

The proposal does not require a party to make or accept an early offer, and the proposal will have no impact if no offer is made or accepted. In ensuring a reasonable fee in cases where early settlement does occur however, the proposal will encourage early settlements and engender substantial benefits to all parties and the Court.¹¹⁵

3. Task Force Conclusions Regarding Medical Association Proposals

If a principal goal of our system of justice is to preserve the rights of victims to recover for injuries from medical negligence, neither the Florida constitutional amendment proposal nor the Common Good proposal would advance that goal. For the public, both proposals might tend to further reduce the exposure of physicians to liability for actual negligence and might, in turn, increase the probability of adverse medical events. At best, they appear to offer little practical application in medical malpractice actions. At worst, they may entail unknown, unintended consequences. For actual medical malpractice victims, they can encourage uninformed settlements and discourage or effectively preclude making legal claims through counsel.

The founder of Common Good, Philip Howard, in his presentation to the Task Force, acknowledged that the early offer proposal is an ill fit with medical malpractice litigation.¹¹⁶ The reason is that such claims and cases require extraordinary effort and costs investigate and develop that any early offer would likely be uninformed and ill-founded.

Similarly, Professor Kritzer commented that proposals such as the Common Good proposal fail to take into account that a significant proportion of cases handled on a contingency basis involve small damage amounts.¹¹⁷ He cited data that showed that fee caps would have the effect of allowing the lawyer to spend very few hours on the matter. He also noted that such proposals reflect a lack of understanding of what the representation of injured parties entails. Lawyers move reasonably promptly to settle routine cases as soon as the client's medical condition has reached a suitable state; through that time, the lawyer has been monitoring the client's medical situation, collecting documentation related to expenses and other losses, and counseling the client to be sure that there is documentation and that the client has obtained appropriate treatment. By the time the case is ripe for settlement, the lawyer will have put in a "nontrivial" amount of time. He said that the time required to prepare a demand letter with the relevant documentation of loss and to negotiate the actual settlement would, for a large proportion of cases, represent a time investment worth considerably more than the 10% of the recovery as called for by the Common Good proposal. The net effect is that fee caps eliminate representation at least for smaller claimants, those with meritorious cases but non-catastrophic injuries.

The Florida legislators who appeared before the Task Force said that they did not see any useful purpose to be served by the proposed amendment, for physicians or for the general public.¹¹⁸ They also said that not only did the proposal not enjoy the support of business interests or insurers, but that the idea of limiting fees was never seriously proposed to the Florida Legislature or its pertinent committees.

For all these reasons, the Task Force opposes the proposal. In addition, it notes that according to Florida legislators and lobbyists, no hearings have ever been conducted on the design, purpose or reasonableness of the amendment. In contrast, the current, already restrictive, Florida rules affecting medical malpractice actions arose as the product of extensive hearings and debate and after factual findings on the "best practices" of the "best practitioners."¹¹⁹ In the words of Mr. Simon, who emphasized that he "had no dog in this fight," the amendment is simply "vindictive and arbitrary."¹²⁰

The Task Force is not alone in questioning the proposed Florida amendment. Among others, even the Florida Hospital Association opposes it.¹²¹

B. Task Force Proposals

The Task Force agrees with contingent fee critics on several points. First, information and sophistication imbalances between lawyer and client – asymmetric information – can create opportunities for lawyer overreaching. Lawyers can take advantage of this imbalance to extract what economists call “rents” – excessive fees – from unwitting clients. Although lawyers’ fiduciary obligations are designed to protect against this, equipping clients with the tools and skills for successful negotiation should bring more trust to the system. The most important tool is information and the most important skill is the expertise to use that information wisely. One challenge is how to equip clients with the information and expertise effectively and efficiently without introducing new dangers and inefficiencies.¹²² Another challenge is how to enhance enforcement of existing procedural and ethical rules to protect clients.

1. Bar-supported Public Information Services

The Bars of the many states already provide a great deal of advice to potential clients about finding a lawyer, negotiating fees, etc.¹²³ Some states, including Florida as noted, require lawyers to provide and discuss with prospective clients some version of a “client’s statement of rights.” Although no doubt helpful, the challenge is to ensure that its benefits enure to all potential clients, even to the relatively uninformed or uneducated. Such statements will need to be simple enough for laypersons to understand, short enough for them want to read and specific enough to provide meaningful information for specialized cases. Those criteria suggest standardized disclosure documents designed for various types of cases, including medical malpractice cases.

Public information needs also to describe clear procedures for reporting complaints, especially by clients.

2. Standardized Disclosure

A combination of on-line or published public information and private lawyer communications occurs often in the cases of mass torts, especially airline crash cases. Approved form letters are sent directly to potential clients designed to raise the level of disclosure and to caution and educate potential clients. In medical malpractice cases a variation of this idea could help potential clients. Incorporating the central principle – standardized disclosure – into all lawyer-potential client interactions also has merit for other kinds of cases, medical malpractice among them.

Such standardized disclosure letters should provide, among other information:

- details about how medical malpractice cases are typically handled,
- predicted costs of litigation, including expert fees, investigation, discovery, etc.,
- alternative fee arrangements, including how fees, including contingent fees, are calculated,
- admonish clients to seek out experienced, perhaps specialized firms,
- acknowledge that net costs of the litigation to them could be less if they interview several firms, perhaps even ask for written bids.

3. Improved Enforcement of Procedural and Ethical Rules

A number of persons appearing before the Task Force emphasized that procedural and ethical rules already exist that are designed to protect clients, prospective litigants, and the integrity of the judicial system. They expressed concern that bar associations and judges do not always enforce such rules with adequate vigor.¹²⁴ To the degree that is true, such passivity arises in many cases from lack of judicial and bar resources. The time and expense necessary to investigate ethical and procedural complaints is not insignificant.

The Task Force agrees that courts and bar associations should enforce rules requiring, for example, established factual bases for complaints, such as Rule 11, and reasonableness of attorneys' fees, such as ethical Rule 1.5, rigorously and vigorously. Lawyers who overreach or otherwise skirt their professional obligations to their clients, their peers and the judicial system ought to be sanctioned. Courts and bar associations responsible for such sanctions need the support of their members and of the public fisc to make enforcement resources available. Otherwise, lawyers will enjoy the limited exposure to liability for professional negligence that this report finds to exist for most physicians.

4. Alternative Dispute Resolution

Alternative dispute resolution techniques – mediation, arbitration, mini-trial, etc. – have the potential to reduce the costs of pursuing medical malpractice claims and to shorten the route to resolution. Bar associations should educate their

members about such techniques and encourage their use in appropriate cases. Lawyers ought to inform clients about such techniques and discuss with them the possible applicability in individual cases. Where alternative dispute resolution approaches suggest reduced risk and more efficient resolution, contingent fee percentages should reflect that. Also, these approaches avoid some of the extraordinary costs of pursuing medical malpractice claims, they offer the possibility of legal representation for victims whose potential damages do not rise to the high levels that justify full litigation.

These four suggestions, if adopted by lawyers and their professional associations, should not only improve client access to justice but also enhance the ability of clients to establish fair and informed terms of legal representation, including reasonable contingent fee arrangements.

Endnotes

- 1 The origins of the most common proposal are academic. See Brickman, Horowitz & O'Connell, Rethinking Contingency Fees (Manhattan Inst. Monograph Series No. 1, 1994). It proposed an “early offer” fee limitation under which an offer of settlement would limit lawyers fees to about 10% of the first \$100,000 of recovery and 5% of any amount over that. Early offer proposals apply generally to all tort litigation, not just medical malpractice litigation. Versions of this proposal have in recent years been endorsed by Common Good and offered for adoption unsuccessfully in some fourteen states. A recent Florida constitutional amendment proposal departs from the Common Good proposal by applying a different “sliding scale” fee limit only to medical liability actions. This report discusses both proposals below in Section VI.
- 2 Hyman, “Medical Malpractice and System Reform: Of Babies and Bathwater,” 19 Health Affairs 258 (Jan/Feb 2000). For a historical prospective on the problem, Hyman cited Mohr, “American Medical Malpractice Litigation in Historical Perspective,” 283 JAMA 1731 (2000).
- 3 E.g., [Cal. Bus. & Prof. Code § 6146\(a\) \(2002\)](#) (“MICRA”) (contingent fees in medical malpractice actions limited to 40 percent of the first \$50,000; 33 percent of the next \$50,000; 25 percent of the next \$500,000; and 15 percent of any amount over \$600,000); [Conn. Gen. Stat. § 52-251c \(b\)\(2001\)](#) (contingent fees in personal injury, wrongful death and property claims limited to 33 percent of the first \$300,000; 25 percent of the next \$300,000; 20 percent of the next \$300,000, 15 percent of the next \$300,000; and 10 percent of any amount over \$1,200,000); Florida Bar Rule 4-1.5 (contingent fees in medical malpractice actions limited to varying amounts depending on arbitration, admission of liability, and other factors, 33 1/3 - 40 percent of first \$1 million; 30 percent of next \$1 million; and 20 percent of any recovery over \$2,000,000);
- 4 E.g., [Okla. Stat. tit. 5 § 7 \(2003\)](#) (contingent fees limited to 50 percent of the net recovery); [Tenn. Code Ann. § 29-26-120 \(2002\)](#) (contingent fees in medical malpractice actions limited to 33 percent of all damages awarded); [Tex. Lab. Code Ann. § 408.221](#) (Vernon 2002) (contingent fees in workers compensation cases limited to 25 percent of the plaintiff’s recovery); [Wis. Stat. § 655.013 \(1986\)](#) (contingent fees in medical malpractice actions limited to 25 or 33 percent of the first \$1 million, depending on a statutory deadline for stipulation of liability; and to 20 percent of any amount over \$1 million).
- 5 Brickman, “ABA Regulation of Contingency Fees: Money Talks, Ethics Walks,” 65 Fordham L. Rev. 247, 270 (critique of Formal Opinion 94-389).
- 6 Memorandum in Support of the Petition for Rulemaking to Revise the Ethical Standards Relating to Contingency Fees, submitted to the Supreme Court of the State of

Utah, May 6, 2003 (hereinafter, the Utah Common Good Memorandum) at 16-17.

7 Philip Howard, President of Common Good, Meeting Minutes Appendix (Exhibit 3) at 34-35. Even the Florida Medical Association, the main advocate for limiting them in medical malpractice actions, has a use for contingent fees in other contexts. When it engaged Florida Senator Walter Campbell to represent it in a litigation against HMOs, it did so on a contingent fee basis. Campbell, Meeting Minutes Appendix (Exhibit 3) at 46 .

8 Interestingly, this debate finds supporters on both sides within the legal community itself. As noted by the ABA Committee on Professional Responsibility:
The term contingent fees evokes an almost instantaneous visceral response among lawyers. Some view the contingent fee as the salvation of the impecunious, a means to redress great wrongs, vindicate rights and reform the law. Others view it as an inducement to frivolous lawsuits which abuse tort laws, and a means of exacting outrageously high fees for already overpaid lawyers.
ABA Formal Opinion 94-389 (December 5, 1994) [footnotes omitted].

9 The Task Force plans to issue a later report that addresses contingent fees in class actions.

10 E.g., Lawyer contingent fees limited by a proposed Florida constitutional amendment should be enough for “greedy trial lawyers.” Sandra Mortham, Executive Vice president and CEO of the Florida Medical Association VP, quoted in *Florida Medical Business*.

11 Dr. William Sage: Physicians have a longstanding ethical aversion to accepting contingent fees for medical services because such fees suggest to patients that success is guaranteed. Meeting Minutes Appendix (Exhibit 3) at 20.

12. E.g., In 2003, the United States House of Representatives passed H.R.5, a tort reform bill that would preempt state law and impose, among other things, a \$250,000 cap on non-economic damages and limits on attorneys fees in medical liability actions. The Senate rejected the legislation. President Bush has also taken a side in this debate. See, e.g., “President Bush “Dis-Torts” the Truth About Impact of Lawsuits on Health Care and the Economy, Public Citizen Corrects Bush's Misstatements on Tort Reform, Releases Briefing Book on the Facts about Medical Malpractice Lawsuits,” (fact sheet of “eight glaring misstatements” by the president about lawsuits by consumers and medical patients). <<http://www.citizen.org/congress/civjus/medmal/articles.cfm?ID=%2012173>>

13. Dr. David Hyman, Meeting Minutes Appendix (Exhibit 3) at 17. Dr. Hyman cited one common myth in his article on the same subject: “If you don’t do this [medical] test, it will cost you a ton of money and your reputation by the time the legal

system is done with you. Anyone can sue you for anything; they just want to settle the case and move on. Juries don't like doctors, and they hand out money solely based on sympathy for the plaintiff. It doesn't matter what you said or did; what matters is what is in the chart. etc." "Medical Malpractice and the Tort System: What Do We Know and What (If Anything) Can We Do About It?", 80 Texas L. Rev. 1639, 1640 (2002) (hereinafter, "Hyman Comment").

14 Hyman Comment at 1640.

15 Tort reform in general and contingent fees in particular tend to reappear periodically as social issues, often hand-in-hand with recurring insurance crises. See, e.g., Wall Street Journal, June 24, 2002.

16 A list of Task Force members, with their professional affiliations and brief biographical descriptions, is attached as Exhibit 1.

17 Comments can be sent by email to Chris Wells at <wells_dc@mercer.edu> or to Patrick Longan at <longan_p@mercer.edu>.

18 A compilation of brief biographies of each guest is attached as Exhibit 2.

19 The Meeting Minutes Appendix (hereinafter "Meeting Minutes"), attached as Exhibit 3, is a compilation of the minutes of the Task Force meetings, summarizing guest presentations.

20 The studies supporting these assertions were presented in summary form to the Task Force by Professors Sage and Hyman. In commenting upon the "best available empirical studies of medical injury and medical malpractice," Professor Hyman summarizes the data in Hyman Comment. See also Sage, "Medical Liability and Patient Safety," 22 Health Affairs 26 (July/August 2003). Other published analyses and summaries of similar data can be found in Mello & Brennan, "Deterrence of Medical Errors: Theory and Evidence for Malpractice Reform, 80 Texas L. Rev. 1595 (2002); Danzon, Medical Malpractice: Theory, Evidence and Public Policy (1985); Weiler et al., Medical Malpractice on Trial (1991); Institute of Medicine, To Err of Human: Building a Safer Health System (1999); Saks, "Medical Malpractice: Facing Real Problems and Finding Real Solutions," 35 Wm. & Mary L. Rev 693 (1994)(hereinafter "Saks"). Most such studies and analyses draw upon the Harvard Study, described to the Task Force as the best available empirical study on medical injury and claims. The study, which covered more than a decade, analyzed over 100,000 medical, legal and insurance claims from New York, Utah and Colorado and interviewed thousands of physicians and patients. See Harvard Medical Practice Study, Patients, Doctors and Lawyers: Medical

Injury, Malpractice Litigation, and Patient Compensation in New York. The Report of the Harvard Medical Practice Study to the State of New York (1990).

21 Hyman Comment at 5. These estimates are based on somewhat conservative definitions of medical error. According to a new national review of Medicare records by a Denver-based health care ranking group, HealthGrades, if medical errors such as failure to respond to signs of infection or other serious problems were to be included, medical error would rise to the third leading cause of death. Boston Globe, July 27, 2004. The Institute of Medicine “shocked the American Public in late 1999 with a report that found medical error to be the fourth-to-eighth-largest cause of preventable death in the United States.” Hatlie & Sheridan, “The Medical Liability Crisis of 2003: Must We Squander the Chance to Put Patients First?,” 22 Health Affairs 37, note 1 (July/August 2003).

22 Id.

23 According to a report in *Laryngoscope*, 45% of otolaryngologists who responded to a survey reported errors in their medical practice. Over a third of the errors caused major harm to patients and 4% caused death: “The largest category of errors -- 19% of the total reported -- was technical mistakes during procedures, and 56% of those caused major injury or harm, the study said. About 14% of errors reported were related to medication, and approximately 10% were testing errors, including ordering incorrect tests, failing to review tests or not acting on results. . . Researchers said they believe the proportion of physicians encountering an error is an ‘underestimate,’ suggesting that many physicians may not be trained to recognize errors.” *Modern Physician*, August 2004.

24 Blendon, Views of Practicing Physicians and the Public on Medical Errors, 347 N.E.J. of Medicine 1933, 1934 (2002).

25 Hyman, Meeting Minutes at 18.

26 Id.

27 One atypical situation was described by Linda MacMullen, who related Mississippi’s “unique experience” in finding that one-half of the state’s physicians had been sued for malpractice in 2003.

28 E.g., “Medical malpractice claims comprised 8% of [federal] tort trial cases” in 1994-95. Bureau of Justice Study. <<http://www.ojp.usdoj.gov/bjs/abstract/fttv95.htm>>. The figure was 11.7% of state tort cases in 1996 (75 largest counties). <<http://www.ojp.usdoj.gov/bjs/pub/pdf/ttvlc96.pdf>>

29 National Center for State Courts, Examining the Work of State Courts, 1993: A National Perspective from the Court Statistics 22 (1995)(data available from 27 states showed decline of 6% in tort filings); National Center for State Courts, Tort and Contract Caseloads in the State Trial Courts, Examining the Work of the State Courts, 1999-2000: A National Perspective from the State Court Statistics Project, 2001) (http://www.ncsonline.org/D_Research/csp/1999-2000_Tort-Contract_Section.pdf) (decline in tort filings from 1991-2000).

30 Eaton et al., “Another Brick in the Wall: An Empirical Look at Georgia Tort Litigation in the 1990s,” 34 Ga. L. Rev. 1049, 1058.

31 Id. at 1095.

32 Sanders & Joyce, “Off to the Races: The 1980s Tort Crisis and the Law Reform Process,” 27 Houston L. Rev. 207, 234-255 (1990).

33. Howard, Meeting Minutes at 36.

34 Hyman Comment at 5; California Study at 63; Weiler at 69-75. These data are generally consistent with a Rand study that only one in ten persons who are victims of accidental injury bring a legal action. Hensler et al., Compensation for Accidental Injuries in the United States, at 173 (Rand Institute for Civil Justice, Doc. No. 3999-HHS/ICJ, 1991)(hereinafter cited as the Rand Study).

35 Hyman, Meeting Minutes at 17.

36 The figure may well be lower. A 1991 study found that only 1.53% of patients who fell victim to medical malpractice filed a claim. Relation Between Malpractice and Adverse Events Due to Negligence: Results of the Harvard Medical Practice Study III, 325 New England Journal of Medicine 245-51, July 1991, cited in Dept. of Health and Human Services, confronting the New Health Care Crisis, at 8, July 2002.

37 Howard, Meeting Minutes at 35 (“\$250,000 medical malpractice case is “untakeable.”); Campbell, at 45; Kritzer, at 23.

38 See, e.g., “Insurers Missteps Helped Provoke Malpractice Crisis,” Wall Street Journal, June 24, 2002. See also, Gunnar, “Is There an Acceptable Answer to Rising Medical Malpractice Premiums?”, 13 Annals Health L. 465, 477-78 (2004) (“U.S. News and World Report reported the findings of the Physician Insurers Association of America in 2002: in a sample of 5524 malpractice cases, 0.9% resulted in jury verdicts for the plaintiff, 27.4% were settled before trial, 67.7% were dropped or dismissed, and 4% ended in a verdict for the defendant. . . . In other words, when a malpractice case goes to

trial, the injured party has only a 20% chance of a verdict returned in his favor. The total number of cases resulting in a jury verdict for the plaintiff has remained stable over recent years at around 400 cases annually, as reported to the federal National Practitioner Data Bank (NPDB). Between 1995 and 2000, the median national jury award in malpractice cases doubled from \$500,000 to \$1 million. However, the NPDB reported the sum of all jury awards against physicians increased only 20% from \$143 million in 1993 to \$172 million in 2002.”)

39 Bureaus of Justice findings for 2001 from survey of trials in largest U.S. counties. <<http://www.ojp.usdoj.gov/bjs/abstract/mmtv1c01.htm>>.

40 The most reliable, often cited comprehensive study of actual patients and claims found that a minority of filed claims arise from the incidents of actual malpractice. In that study, from the 1980-s and now somewhat dated, majority of filed claims arose from an actual iatrogenic injury, but not one that involved true medical malpractice, or from no adverse event at all. Although further analysis of the data shows that many of the so-called false positives still involved evidence of medical error, it might be said that the tort system at the time of the study was inaccurate – too often pursuing false positives while at the same time it too often ignores valid claims, resulting in many false negatives. In short, some physicians and hospitals were made defendants in cases not involving wrongdoing as a matter of law. Procedural requirements for expert verification of claims and the disastrous impact on the plaintiff’s lawyer who misjudges a claim have probably gone a long way to correcting this problem

41 Id at. 703.

42 “The number of cases in which no negligent adverse event occurred vastly outnumbers the negligent injuries (about one hundred to one), and even a ninety-nine percent accurate system would produce more invalid than valid filings on so skewed a distribution. This problem is regularly faced in biomedical testing, and therefore should present no surprise or confusion to the medical profession. Thus, in the legal context as well, false positives can outnumber true positives (by five times, based on the data in Table 2). Yet at the same time, the system targets negligent injuries with sufficient accuracy that a doctor who causes a negligent injury stands a far greater chance of being claimed against than one who has not (better than twenty-two to one odds). Both of these dramatic and important facts about malpractice litigation are overshadowed by a third fact, which perhaps has the greatest bearing on the system's level of deterrence. Underlying the odds in the preceding paragraph are the probabilities of becoming a defendant at all. That twenty-two to one ratio comes from a probability of being sued given a negligent injury of .029 and a probability of being sued given no negligent injury

of .0013.” Saks at 714-715.

43 E.g., Georgia, O.C.G.A. 9-11-9.1.; Florida Stat. §766.203(2) (2002) (In Florida, medical malpractice actions require the attorney filing suit to have made a reasonable investigation to determine that there are grounds for a good faith belief that there has been negligence in the care or treatment of the client. The pleading must contain a certificate of counsel to that effect. Good faith can be shown by a written professional opinion that there appears to be evidence of medical negligence. The consequences of not showing good faith or any justiciable issue against a health care provider, may subject counsel to attorney's fees, costs and disciplinary repercussions. In addition the complaint must include a medical expert's sworn affidavit that the claim involves medical negligence).

44 Simon, Meeting Minutes at 48.

45 See Inselbuch, “Contingent Fees and Tort Reform: A Reassessment and Reality Check,” 64 Law & Contemp. Probs. 175, 181-182 (2001) and authorities cited therein.

46 Id. At note 31, citing Miceli, “Do Contingent Fees Promote Excessive Litigation?,” 23 J. Legal Stud. 211, 223 (1994).

47 Campbell, Meeting Minutes at 44.

48 New York Times, June 25, 2004.

49 That conclusion notwithstanding, it does appear that plaintiffs' lawyers sometimes misjudge which claims involve true malpractice and which do not. Those who do will likely suffer the disastrous consequences of a failed suit and no recovery of fees or expenses. The results are Darwinian for lawyers. Those who lose risk bankruptcy.

Because charging negligence where none occurred serves no one's interest – the physician's, the lawyer's, the client/patient's, the insurer's or that of the other participants in the legal and health systems – improvements in making accurate assessments about negligence would serve the public interest and the society's pocketbook.

50 According to one expert, physicians' belief that medical malpractice claims are frequent might have a salutary effect. Even though there are few medical malpractice claims made, misperception of the severity and frequency of claims may be just the right thing to offset the infrequency of filings and the greater infrequency of plaintiff success, even when negligent injury did indeed occur. Saks, fn 25.]

51 “No change to the contingent fee rules will not be harmful to medical malpractice deterrence.” Sage, Meeting Minutes at 20. But limitations on fees might well change the quality of the legal actions: “Whether or not a lawyer is willing to take a case on a contingency fee basis provides a strong signal to plaintiffs about the quality of their case. But an hourly fee encourages lawyers to advise their clients that the client's case is worth pursuing no matter how low the true chance of recovery. As a result, we find that when contingency fees are limited, plaintiffs file suit in many cases that they end up later dropping--an indication that limits on contingency fees cause a reduction in legal quality.” Helland & Tabarrok, “Contingency Fees, Settlement Delay, and Low-Quality Litigation: Empirical Evidence from Two Data Sets,” 19 J.L. Econ. & Org. 517, 540 (2003).

52 ABA Formal Opinion 94-389 [footnote omitted].

53 According to Kritzer, 90% of contingent fee cases generate an average fee premium of 25-30% over what an hourly fee would generate, which helps to account for the marginal risk associated with contingent fee cases. Lawyers’s fees, whether hourly or contingent are about the same as those of a Twin Cities’ plumber. Meeting Minutes Appendix at 22.

54 E.g., “The ethical standards of Rule 1.5 are often disregarded in personal injury litigation.” Utah Common Good Memorandum at 5.

55 Pace, et al., “Capping Non-Economic Awards in Medical Malpractice Trials: California Jury Verdicts Under MICRA,” Rand Institute for Civil Justice (2004), at xviii.

56 A lawyer shall not provide financial assistance to a client in connection with a pending or contemplated litigation, except that: (1) a lawyer may advance court costs and expenses of litigation, the repayment of which may be contingent on the outcome of the matter.” Model Rule of Professional Conduct 1.8(e)(1).

57 For example, the death of a medical malpractice victim usually reduces the damages by reducing both economic and non-economic losses. This is especially true where the victim dies without survivors. In fact, death can sometimes save the defendant from having to pay anything, rather than damages for a severe injury.

58 See, e.g., Kritzer, Meeting Minutes at 23.

59 ABA Formal Opinion 94-389 [footnotes omitted].

60 Id.

- 61 Utah Common Good Memorandum at 1, 3. Howard, Meeting Minutes at 40.
- 62 Meeting Minutes at 41.
- 63 See, e.g., Kritzer, 80 Wash, U. L. Q. 739, 777-78 ([T]he time required to prepare a demand letter with the relevant documentation of loss to negotiate the actual settlement will, in a large proportion of cases, represent a time investment worth considerably more than 10% of the recovery).
- 64 Even the harshest critics allow that lawyers do not actively conspire by meeting to fix fees. “[Lawyers have] a strong incentive for acting collusively to maintain a uniform price. By "collusive," I do not mean that lawyers meet together, clandestinely or otherwise, to agree on a uniform price. Rather, I mean that lawyers act in the same manner as do gas stations owners on adjacent corners who recognize that if any of them lower the price, the others will respond by lowering their prices.” Brickman, “The Market for Contingent Fee-Financed Tort Litigation: Is it Price Competitive?” 25 Cardozo L. Rev. 65, 99 (2003).
- 65 “[A] lawyer who always charges the same percentage of recovery regardless of the particulars of a case should consider whether he is charging a fee that is, in an ethical context, a reasonable one. One standard fee for all cases may have the effect, given the difference among cases, of both over- and under- compensating the lawyer. Cf. In re Recorder's Court Bar Association v. Wayne Circuit Court, [503 N.W.2d 885](#) (Mich.1993) (finding that a fixed fee system for compensating attorneys who represented indigent defendants that did not take into account the particulars of the case was unreasonable).” ABA Formal opinion 94-389.
- 66 His most recent article directly on point is “The Market for Contingent Fee-Financed Tort Litigation: Is it Price Competitive?” 25 Cardozo L. Rev. 65 (2003).
- 67 The accusation of evil and wickedness denoted by this term is consistent with Professor Brickman’s harsh critiques of contingent fees, plaintiffs’ lawyers and the ABA.
- 68 Brickman, Price Competitive at 73-74. See also Utah Common Good Memorandum at 5, citing O’Connell et al., “Yellow Pages Ads as Evidence of Widespread Overcharging by the Plaintiffs’ Personal Injury Bar and a Proposed Solution, 6 Conn. Ins. L.J. 423, 427 (2000), among other sources.
- 69 Kritzer, Meeting Minutes at 24.
- 70 Utah Memorandum in Opposition at 11.

71 Id. At 74.

72 Brickman, “Price Competitive?” at 107-112 ; Meeting Minutes at 39.

73 Id.

74 Cited in Utah Memorandum in Opposition, at 12.

75 See below, Section VI.A..

76 E.g., Sage, Meeting Minutes at 20; Campbell, at 44. Thorpe, “The Medical Malpractice ‘Crisis’: Recent Trends and the Impact of State Tort Reforms,” Health Affairs–Web Exclusive (January 21, 2004)
<<http://content.healthaffairs.org/cgi/reprint/hlthaff.w4.20v1>> Thorpe’s analysis of the effects of tort reforms across the United States found no association between the adoption of various limitations on attorneys’ fees and reduced insurance premiums or improved loss ratios. The Thorpe study was discussed and cited for this proposition in the recent Congressional Budget Office Paper, “The Effects of Tort Reform: Evidence from the States” (June 2004).

77 Campbell, Meeting Minutes at 44.

78 Campbell, Meeting Minutes at 44; Simon, at 47.

79 Id.

80 In Florida, a total of \$380,000,000 was paid out by insurers for the costs of medical liability, including defense costs, settlements and judgments. There are 38,000 physicians in Florida. That works out to only \$10,000 per physician. Because so few are insured, there are too few to spread the risks appropriately. Also in the current cycle, insurers are moving out of state. Campbell, Meeting Minutes at 44.

81 The Task Force did invite the Florida Medical Association to present data to support this link, but it declined the invitation.

82 See below Section V.B. for further discussion. In addition: “Slowing the increase in physician premium costs does nothing to improve the system’s deterrence of medical error.” Hatlie & Sheridan, “The Medical Liability Crisis of 2003: Must We Squander the Chance to Put Patients First?” 22 Health Affairs 37 (July/August 2003).

83 E.g., Campbell, Meeting Minutes at 45. One published estimate puts the figure somewhat lower, but uses an “average”: “The attorney’s cost of bringing the case of an

injured plaintiff to trial can average in the range of \$35,000 to \$50,000.” Gunnar, “Is There an Acceptable Answer to Rising Medical Malpractice Premiums?”, 13 *Annals Health L.* 465, 479 (2004).

84 Affidavit of Thomas A. Schaffer, cited in Memorandum in Opposition to Petition for Rulemaking to Revise the Standards Relating to Contingency Fees, at 5-6.

85 Sage, Meeting Minutes at 20. Also see note 34 and the associated text.

86 E.g., Howard: “[E]ven with unlimited contingent fees, a \$250,000 medical malpractice case is ‘untakeable.’” Meeting Minutes at 35.

87 Campbell, Meeting Minutes at 44.

88 Campbell, Meeting Minutes at 43. The statement was agreed with by Florida State Representative Jeffrey Kottkamp, a defense lawyer in private life (Meeting Minutes at 45).

89 See P. Danzon, Rand Corporation Institute for Civil Justice, *Contingent Fees for Personal Injury Litigation*, Govt. Publication No. R-2458-HCFA at viii (June 1980). See also Report of the Secretary's Commission on Medical Malpractice, U.S. Dep't. of Health Education and Welfare, *The Medical Malpractice Legal System* at 87, 154 (Jan. 16, 1973).

90 Professor Jay Wolfson, Director of the University of South Florida's Suncoast Center for Patient Safety Research, “Med-Mal War Hits the Ballot: Florida Lawyers, Doctors Push Dueling Amendments,” ABA eReport, July 30, 2004.

91 Advisory Opinion to the Attorney General re: The Medical Liability Claimant's Compensation Amendment, July 15, 2004, at 12.
<http://www.flcourts.org/sct/sctdocs/ops/sc04-310.pdf>

92 See, e.g., *Wells v. Sullivan*, [907 F.2d 367, 369-370](#) (2d Cir.1990) (“[A]bsent fraud or overreaching, courts must enforce such private contingency fee agreements, which are, after all, embodiments of the intentions and wishes of the parties . . . [T]o deny [plaintiffs] the option of entering contingent fee arrangements would tend to defeat the general remedial purpose of the statute by unnecessarily restricting claimants' options in securing adequate counsel or counsel of their choice.”).

93 Advisory Opinion to the Attorney General re: The Medical Liability Claimant's Compensation Amendment, July 15, 2004, at 19-20.
<http://www.flcourts.org/sct/sctdocs/ops/sc04-310.pdf>

- 94 Howard, Meeting Minutes at 38.
- 95 Hyman, Meeting Minutes at 18.
- 96 “The conventional wisdom that liability has no useful role in addressing medical liability is wrong.” Id.
- 97 Saks, quoting Weiler, at 132.
- 98 Howard, Meeting Minutes at 39.
- 99 See notes 3 and 4 above.
- 100 Owing to another provision of the Florida Constitution, limitations on attorneys’ fees cannot be made by statute alone, but must have equivalent constitutional basis.
- 101 Advisory Opinion to the Attorney General re: The Medical Liability Claimant’s Compensation Amendment, July 15, 2004, at 17-18.
<http://www.flcourts.org/sct/sctdocs/ops/sc04-310.pdf>
- 102 Id at. 25-26.
- 103 Simon, Meeting Minutes at 49.
- 104 Simon, Meeting Minutes at 48.
- 105 Id.
- 106 Justice Lewis of the Florida Supreme Court recently summarized the many Florida protections afforded medical professionals charged with medical malpractice and the negatively synergistic implications of the proposed amendment:

Pursuant to Florida law, medical negligence actions are currently highly regulated, and, unquestionably, Florida's citizens require the assistance of knowledgeable and experienced attorneys to navigate through the extensive and complicated process. . .

Prior to filing a legal action, a claimant is required to notify all prospective defendants of the claims. See § 766.106, Fla. Stat. (2003). At times, it is often difficult to initially identify those responsible for clear injuries. Once a claimant has filed notice with the prospective defendants, there are specific time periods and limitations that must be precisely followed before the actual legal action is considered timely filed. See § 766.106, Fla. Stat. (2003). Unlike all other

areas of Florida law, our law now mandates that prior to initiating a medical negligence action, a claimant must conduct an entire presuit investigative process as a condition precedent to proceed with any claims. See §§ 766.203-766.206, Fla. Stat. (2003). Failure to follow this required presuit screening process constitutes a basis to defeat any claim even if the claim is absolutely valid and the damages enormous. See § 766.106, Fla. Stat. (2003).

Once an action has been filed, the court may require, upon motion by a health care provider, that the claim be submitted to an arbitration process that is totally nonbinding. See § 766.107, Fla. Stat. (2003). In the alternative, the parties may mutually agree to binding arbitration. See § 766.207, Fla. Stat. (2003). If the parties do not agree to binding arbitration, section 766.108 of the Florida Statutes (2003) requires that the parties participate in mandatory mediation and settlement conference activities prior to any trial. See § 766.108(1)-(2)(a), Fla. Stat. (2003). Clearly, before a claim is ever filed or a trial may begin or damages are awarded, a litigant with a medical negligence claim must proceed through a lengthy, time consuming, and certainly, costly process. This mandatory pretrial screening process will remain in effect even if the proposed amendment is adopted. Florida citizens need, and are entitled to, assistance to guide them through this process. As evidenced by the numerous decisions concerning the pretrial medical negligence process, the existing law has been a series of traps and a minefield for many Floridians. See, e.g., *Goradesky v. Hickox*, 721 So. 2d 419, 420 (Fla. 4th DCA 1998) (affirming dismissal of claim for failing to file corroborating expert affidavit and failure to conduct reasonable presuit investigation before filing notice of intent); *Kukral v. Mekras*, 647 So. 2d 849, 850-51 (Fla. 3^d DCA 1995) (affirming dismissal of claim and holding no reasonable investigation was conducted), quashed, 679 So. 2d 278 (Fla. 1996); *Archer v. Maddux*, 645 So. 2d 544, 547 (Fla. 1st DCA 1994) (affirming dismissal of claim for failure to provide corroborating expert opinion within statute of limitations). The district courts have recognized that the presuit investigation requirements are "complex and confusing," *Coffaro v. Hillsborough County Hosp. Auth.*, 752 So. 2d 712, 713 (Fla. 2^d DCA 2000), approved, 829 So. 2d 862 (Fla. 2002), and that the "interrelationship of [the] tolling and extension periods has produced [a] type of mathematical puzzle." *Id.* at 714. Further, they have recognized that while the procedures were not designed to function as traps for the litigants, they have nonetheless become just that—a trap. See *id.* at 715; *Zacker v. Croft*, 609 So. 2d 140, 141-42 (Fla. 4th DCA 1992). Unquestionably, without competent counsel, the process is impossible.

It is also vital to note the damage caps which now exist within the medical negligence statutory provisions, which are rarely mentioned but will continue to remain in effect should the proposed amendment be adopted. If the parties agree to binding arbitration pursuant to section 766.207, economic damages, including past and future medical expenses and eighty percent of wage loss and loss of

earning capacity can be awarded, offset, however, by collateral source payments. In this process, noneconomic damages are capped at \$250,000 with future economic losses available, but they must be paid in periodic installments. Punitive damages are not available no matter how egregious the conduct may be. See §766.207, Fla. Stat. (2003). If a claimant rejects a medical provider's offer to enter voluntary binding arbitration, the only damages awardable at trial are limited to net economic damages and noneconomic damages are absolutely capped not to exceed \$350,000 per incident. See § 766.209, Fla. Stat. (2003). If the parties proceed to trial, and damages are awarded to a claimant, noneconomic damages for the negligence of practitioners, regardless of the number, are capped at \$500,000 per claimant if the negligence resulted in personal injury or wrongful death, and \$1 million for all practitioners if the negligence resulted in a permanent vegetative state or death. See § 766.118, Fla. Stat. (2003). Similarly, noneconomic damages for the negligence of nonpractitioners are capped at \$750,000 per claimant if the negligence resulted in personal injury or wrongful death, and \$1.5 million from all nonpractitioners if the negligence resulted in a permanent vegetative state or death. See § 766.118, Fla. Stat. (2003). Finally, for the negligence of practitioners providing emergency services, noneconomic damages are capped at \$150,000 per claimant, and a total claim of \$300,000. See § 766.118, Fla. Stat. (2003). [fn3: It should also be noted that the Legislature has created the Florida Birth-Related Neurological Injury Compensation Plan. The purpose of this plan, as expressed by the Legislature, is to provide compensation, on a no-fault basis, for birth-related neurological injuries. The compensation plan is the exclusive remedy for such injuries, and limits recovery to \$100,000. See § 766.303, Fla. Stat. (2003); § 766.31(1)(b)1., Fla. Stat. (2003).] All of these seldom discussed damage caps demonstrate that injured claimants are not eligible to receive enormous sums of money even if they are totally correct, suffer the consequences of absolutely clear negligence, and have been egregiously injured. In this highly specialized field, damages are currently artificially limited, and if the proposed amendment is adopted, these damage caps, along with the expensive and time consuming pretrial process, will remain in effect.

Several statutes which relate to the rights of third parties to enforce hospital liens and receive reimbursement or subrogation are also substantially implicated by the enactment of the proposed constitutional amendment. Pursuant to chapter 27032, Laws of Florida (1951), (commonly known as the "Hospital Lien Act") many of Florida's counties have adopted hospital lien acts that entitle hospitals to liens upon all causes of action for all reasonable charges for hospital care, treatment and maintenance. See, e.g., ch. 78-552, Laws of Fla. (Lee County's hospital lien act); ch. 57-1688, Laws of Fla. (Palm Beach County's hospital lien act); ch. 57-1644, Laws of Fla. (Orange County's hospital lien act); ch. 30615, Laws of Fla. (1955) (Broward County's hospital lien act). Additionally, there are both state and federal laws pertaining to the reimbursement of Medicaid and Medicare payments and the right of insurance and health maintenance organizations to be reimbursed for payments to subscribers who suffer injury, disease, or illness by virtue of the negligent act of a third party. See, e.g., 42

U.S.C. § 1395; § 409.910, Fla. Stat. (2003); § 641.31(8), Fla. Stat. (2003). If the proposed amendment is adopted, these provisions for payments to entitled third parties may be impacted, and due to the statutory damage caps, damage awards in some situations may not be sufficient to ensure that all eligible third parties receive full payment after the claimant receives seventy percent of the first \$250,000 and ninety percent of all damages over \$250,000, as mandated by the amendment. Common law and traditional subrogation rights are also implicated. Most importantly, the true purpose of the proposed amendment is truly revealed in the convergence of the proposed amendment, the unique presuit process, the statutes pertaining to the rights of third parties, and the damage cap statutory provisions. All converge to leave little, if any, funds remaining for Florida citizens to obtain counsel. Without knowledgeable and experienced attorneys to provide representation, the citizens of Florida will have no meaningful access to the courts, and the end result will be that the courthouse door will be open to only those wealthy enough to afford to compensate an attorney on some non-contingency fee basis.

Advisory Opinion to the Attorney General re: The Medical Liability Claimant's Compensation Amendment, July 15, 2004, at 19-24.
<http://www.flcourts.org/sct/sctdocs/ops/sc04-310.pdf>

107 E.g., Simon, Meeting Minutes at 47: "Medical malpractice is unequivocally the toughest issue ever encountered by legislators. This is true now and is was true before. In 1985, as a supporter of 'patients' rights' I received two death threats. . . No other issue has engendered one complete and four partial special sessions of the [Florida] legislature."

108 The Florida Medical Association (FMA) was invited but declined to speak with the Task Force or otherwise to provide information supporting its proposal. The invitation to Mr. John Knight, General Counsel of the FMA, read in part:

Your participation could be valuable to our work in several ways. First, you might help us understand the facts that underlie the Florida insurance crisis for health professionals. We would like to discover, for example, what the role of the contingent fee has played in that crisis. Second, you might help us to imagine alternative contingent fee regimes, ones that would better serve the goals of the health professions to improve the delivery of high-quality health care. You might also help us to understand the current proposal to amend the Florida constitution.

On August 10, 2004, the Task Force requested that FMA clarify the reasons for its proposal in writing, with the following message:

Dear Mr. Knight:

Last week the ABA Task Force on Contingent Fees met in conjunction with the ABA Annual Meeting in Atlanta. Among the topics discussed was the proposed Florida constitutional amendment regarding lawyer contingent fees and three basic propositions believed to underlie it:

1. Contingent fees have caused an explosion in medical malpractice litigation, much of it frivolous.
2. Even meritorious medical malpractice lawsuits involve excessive, unreasonable fees paid to lawyers.
3. Lawyer contingency fees are a significant factor causing a rise in medical liability premiums.

Task Force members want to make sure they do not misunderstand the basis of the proposal. Does the FMA agree with these propositions? Is the FMA aware of data that support them? Are they the basis for the proposed amendment? If not, which factual propositions are? And what data supports them?

The FMA has not responded.

109 The written Statement of Client's Rights is found in Florida Rule 4-1.5:

STATEMENT OF CLIENT'S RIGHTS FOR CONTINGENCY FEES

Before you, the prospective client, arrange a contingent fee agreement with a lawyer, you should understand this statement of your rights as a client. This statement is not a part of the actual contract between you and your lawyer, but, as a prospective client, you should be aware of these rights:

1. There is no legal requirement that a lawyer charge a client a set fee or a percentage of money recovered in a case. You, the client, have the right to talk with your lawyer about the proposed fee and to bargain about the rate or percentage as in any other contract. If you do not reach an agreement with 1 lawyer you may talk with other lawyers.
2. Any contingent fee contract must be in writing and you have 3 business days to reconsider the contract. You may cancel the contract without any reason if you notify your lawyer in writing within 3 business days of signing the contract. If

you withdraw from the contract within the first 3 business days, you do not owe the lawyer a fee although you may be responsible for the lawyer's actual costs during that time. If your lawyer begins to represent you, your lawyer may not withdraw from the case without giving you notice, delivering necessary papers to you, and allowing you time to employ another lawyer. Often, your lawyer must obtain court approval before withdrawing from a case. If you discharge your lawyer without good cause after the 3-day period, you may have to pay a fee for work the lawyer has done.

3. Before hiring a lawyer, you, the client, have the right to know about the lawyer's education, training, and experience. If you ask, the lawyer should tell you specifically about the lawyer's actual experience dealing with cases similar to yours. If you ask, the lawyer should provide information about special training or knowledge and give you this information in writing if you request it.

4. Before signing a contingent fee contract with you, a lawyer must advise you whether the lawyer intends to handle your case alone or whether other lawyers will be helping with the case. If your lawyer intends to refer the case to other lawyers, the lawyer should tell you what kind of fee sharing arrangement will be made with the other lawyers. If lawyers from different law firms will represent you, at least 1 lawyer from each law firm must sign the contingent fee contract.

5. If your lawyer intends to refer your case to another lawyer or counsel with other lawyers, your lawyer should tell you about that at the beginning. If your lawyer takes the case and later decides to refer it to another lawyer or to associate with other lawyers, you should sign a new contract that includes the new lawyers. You, the client, also have the right to consult with each lawyer working on your case and each lawyer is legally responsible to represent your interests and is legally responsible for the acts of the other lawyers involved in the case.

6. You, the client, have the right to know in advance how you will need to pay the expenses and the legal fees at the end of the case. If you pay a deposit in advance for costs, you may ask reasonable questions about how the money will be or has been spent and how much of it remains unspent. Your lawyer should give a reasonable estimate about future necessary costs. If your lawyer agrees to lend or advance you money to prepare or research the case, you have the right to know periodically how much money your lawyer has spent on your behalf. You also have the right to decide, after consulting with your lawyer, how much money is to be spent to prepare a case. If you pay the expenses, you have the right to decide how much to spend. Your lawyer should also inform you whether the fee will be based on the gross amount recovered or on the amount recovered minus the costs.

7. You, the client, have the right to be told by your lawyer about possible adverse consequences if you lose the case. Those adverse consequences might include

money that you might have to pay to your lawyer for costs and liability you might have for attorney's fees, costs, and expenses to the other side.

8. You, the client, have the right to receive and approve a closing statement at the end of the case before you pay any money. The statement must list all of the financial details of the entire case, including the amount recovered, all expenses, and a precise statement of your lawyer's fee. Until you approve the closing statement your lawyer cannot pay any money to anyone, including you, without an appropriate order of the court. You also have the right to have every lawyer or law firm working on your case sign this closing statement.

9. You, the client, have the right to ask your lawyer at reasonable intervals how the case is progressing and to have these questions answered to the best of your lawyer's ability.

10. You, the client, have the right to make the final decision regarding settlement of a case. Your lawyer must notify you of all offers of settlement before and after the trial. Offers during the trial must be immediately communicated and you should consult with your lawyer regarding whether to accept a settlement. However, you must make the final decision to accept or reject a settlement.

11. If at any time you, the client, believe that your lawyer has charged an excessive or illegal fee, you have the right to report the matter to The Florida Bar, the agency that oversees the practice and behavior of all lawyers in Florida. For information on how to reach The Florida Bar, call 850/561-5600, or contact the local bar association. Any disagreement between you and your lawyer about a fee can be taken to court and you may wish to hire another lawyer to help you resolve this disagreement. Usually fee disputes must be handled in a separate lawsuit, unless your fee contract provides for arbitration. You can request, but may not require, that a provision for arbitration (under Chapter 682, Florida Statutes, or under the fee arbitration rule of the Rules Regulating The Florida Bar) be included in your fee contract.

_____ Client Signature	_____ Attorney Signature
_____ Date	_____ Date

110 Id.

111 Id.

112 Florida Stat. §766.203(2) (2002) .

113 See note 4 above.

114 As described more thoroughly in note 106 above, since the late 1980s, Florida has limited damages in medical malpractice cases. For example, prospective defendants can limit damages to 80% of economic loss and \$250,000 non-economic loss by admitting liability and submitting to binding arbitration during the 90-day pre-filing, screening period. In addition, the defendant pays a small portion of the plaintiff's fees. These measures are clearly designed to encourage early resolution of medical malpractice cases.

If suit is filed, caps remain in place; non-economic damage caps limitations vary from \$350,000-\$500,000. Florida also has low caps on neurologic damage to newborns. Apparently, these statutory caps so limit potential damages that few such cases are brought in the state.

115 Utah Brief in Support at 2-3.

116 Howard, Meeting Minutes at 35-38.

117 Kritzer, Meeting Minutes at 23.

118 E.g., Art Simon, who worked with a business coalition that urged the FMA not to proceed with the amendment. The same group had favored contingent fee limitations in class actions, but "FMA had the wrong thing, wrong time and wrong vehicle. . . The proposal is unconscionably arbitrary and vindictive." Meeting Minutes at 49.

119 Id.

120 Id.

121 Id.

122 Three other proposals have come to the Task Force's attention: Lawyer "brokers," extended engagement contract revocation periods, and "health courts." The first would introduce expert intermediaries into the process of lawyer selection. Clients would, in effect, hire one lawyer to assist them in hiring another. A informal version of this system already exists in practice, by the mechanism of referrals, usually with fee sharing. In the best of such cases, clients rely on a trusted local lawyer to secure them an expert lawyer to handle a difficult case. In the worst of such cases, lawyers hustle clients in high volume, and farm out the matters to others who will do them cheaply, often taking the lion's share of the fees although they did little in the way of legal work. The Texas Supreme Court has recently studied referral fee issues and, finding potential harm, has recommended restrictions on the practice. See Justice Hecht, Meeting Minutes at 27.

Referring lawyers can offer important efficiencies. They can provide an alternative to the potentially ineffective approach of educating laypersons to choose counsel and negotiate a fee. Instead, potential clients would rely on professionals who possess the requisite information and expertise, not just in general tort practice, but in the precise specialties in which the clients need legal assistance. Going further than the current referral practices, a more efficient system would have the referring lawyer (whom some refer to as a “broker”) negotiate lower fees (and perhaps other, better terms) for the client, charge a modest fee for the service, and thereby reduce the overall contingent fee percentage and potential cost to the client. It might also involve sealed bids that specify all the terms of the engagement, especially fees. Currently, “brokerage” services of this sort are not sanctioned by professional rules. Referrals, to the extent allowed, require referring counsel to remain involved with the client as “co-counsel.”

Unfortunately, unrestrained referral practices already present opportunities for collusive practices and lawyer overreaching and do not ensure efficiency. Unless effectively regulated, so-called “brokerage” services might simply present new such opportunities. If, as critics charge, some lawyers extract excessive fees in contingent cases, there is no certainty that client ability to choose a good broker will preclude the possibility that the combination of broker and lawyer fees will not equal or exceed those that would otherwise be charged. Also, if unscrupulous lawyers currently breach their fiduciary duties and professional ethics to clients by overreaching with fee agreements, a broker system might simply present the opportunity for two unscrupulous lawyers to do so.

The second suggestion is an extended engagement letter revocation or “cooling off” period. Permitting clients to revoke a contingent fee contract for a period of time after it is executed so that clients could reflect on the arrangement, consult with others – including other lawyers – and perhaps even conduct an auction. The original, now replaced, lawyer would receive a fee based on a stated hourly rate, and contingent upon ultimate recovery, for hours actually worked prior to the revocation. Although a carefully structured revocation rule could provide some marginal client protection it is difficult to assess whether that protection is worth its potential costs, including the uncertainties and complications of contract revocation and resulting fee-sharing obligations.

The third proposal, a special health court, would effectively scrap the current tort litigation system and replace it with a streamlined set of rules and tribunals. Although the Task Force endorses the notion of a more efficient and accurate system of justice for victims, it has not studied any detailed proposals along these lines and therefore withholds judgment on such a proposal.

123 See, e.g., the ABA Public < <http://www.abanet.org/public.html> >; Georgia Bar Public Resources < <http://www.gabar.org> >; Florida Bar Online, Consumer Pamphlets and Client FAQ, at <<http://www.flabar.org>>;

124 E.g., McMullen, Meeting Minutes at 28-29; Howard, 38-39.