Patterns of Specialization in Medical Malpractice Among Contingency Fee Attorneys

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SUMMARY

Previous research and commentary have suggested that the American plaintiffs’ bar is heterogeneous, and populated by firms with a range of characteristics, portfolio management strategies, and client recruiting techniques. Medical malpractice has been characterized as a narrow specialty within an already specialized segment of the legal profession. The purpose of this study is to examine patterns of specialization among plaintiffs’ firms that handle medical malpractice cases or have an interest in doing so, using data from 965 plaintiffs’ attorneys who responded to a 2006 national survey. We find significant bivariate and multivariate associations between measures of specialization in medical malpractice and firm-level characteristics, including firm size, case-taking selectivity, use of dollar-value thresholds in screening cases, and fraction of clients living near the firms’ offices. Our results suggest that: (1) specialization in medical malpractice involves a somewhat different set of professional attributes than does specialization in plaintiff-side contingency work more generally; (2) specialization in medical malpractice is significantly associated with several of the firm-level characteristics listed above; but (3) specialization is nevertheless difficult to predict with any confidence from any of these characteristics, either singly or in combination.
ACKNOWLEDGMENTS

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1. INTRODUCTION

Previous scholarship and commentary regarding plaintiffs’ attorneys generally, and medical malpractice attorneys in particular, has reflected both strong interest and strongly held beliefs regarding who these professionals are and how and why they do what they do. The policy debate over statutory tort reform notably includes lots of claims about plaintiffs’ attorneys, their behavior, and how they operate (Crane 1988; White House National Economic Council 2006). Stepping back from the debate, however, empirically based knowledge about contingency-fee lawyers, including medical malpractice specialists, is actually fairly limited. Over the past 2 decades, a series of studies have been conducted of contingency-fee lawyers in Texas, Wisconsin and Indiana examining some aspects of their professional backgrounds, firm organizations, and business practices. These and other studies suggest that specialization in contingency fee practice represents a different kind of professional trajectory than, for example, general practice oriented toward individual consumers or corporate practice oriented toward institutional clients. But here again, fundamental descriptive information regarding the practice of contingency-fee lawyers, and particularly those who further specialize into substantive areas like medical malpractice, is sparse.

The current study examines patterns of law firm specialization in plaintiff-side medical malpractice work, drawing on data from a national survey of plaintiffs’ attorneys undertaken in 2006. This study provides basic descriptive data on attorneys and firms that do plaintiff-side medical malpractice work or had expressed some interest in doing so, and examines bivariate and multivariate relationships between the degree of firm specialization and various other firm-level characteristics.

At the outset, we observe that specialization among plaintiff law firms is a multi-tiered phenomenon: Plaintiff-side personal injury work itself represents one level of legal specialization; medical malpractice work another; and specialization within medical malpractice (say, e.g., on particular types of injuries) represents a third. Presumably, succeeding at any of these levels of specialization involves related investments and opportunity costs, since lawyers are foregoing other types of work. The question of how much specialization in medical malpractice there truly is among plaintiffs’ firms, and how such specialization is associated with other aspects of firm practice, is potentially important for understanding
the economics of the plaintiffs' bar – and more concretely, for understanding how medical malpractice lawyers actually operate. In the next section, we review the recent empirical literature describing contingency-fee law practice in general and that of medical malpractice lawyers in particular.
II. EMPIRICAL LITERATURE ON CONTINGENCY FEE LAW PRACTICE

In the past decade there have been several studies investigating contingency fee law practice, but few of the existing studies have focused on firm specialization in medical malpractice. For example, Kritzer undertook an important series of studies looking at a range of aspects of contingency fee law practice among plaintiffs’ attorneys in Wisconsin (Kritzer 2001a, 2001b, 2004), not focusing on medical malpractice specialists, some of whom were presumably included in his samples. Kritzer’s studies have described professional stratification within the bar (Kritzer 1998, 2001b, 2004); sources of client referrals and attorney advertising (Kritzer and Krishnan 1999); and contingency fee arrangements (Kritzer 2002). Daniels and Martin have also undertaken a series of empirical studies of contingency-fee practice among personal injury attorneys, focusing on attorneys from Texas (Daniels and Martin 1999, 2001a, 2001b, 2006a, 2006b, 2009). Some of their research has touched on specialization among malpractice attorneys (Daniels and Martin 2006a), but most of it has had a broader scope within the plaintiffs’ bar. Daniels’ and Martins’ research has included studies on entrepreneurship and innovation (Daniels and Martin 2001b); stratification among legal practitioners (Daniels and Martin 2001a); on plaintiff attorney marketing efforts (Daniels and Martin 1999); and the impact of statutory tort reform on plaintiffs’ lawyers (Daniels and Martin 2006b, 2009). Finally and in a complementary vein, Van Hoy undertook a major study of personal injury attorneys in Indiana, examining a range of issues such as their case-taking behavior, fee arrangements, advertising and financing practices, and specialization (Van Hoy 1996, 1999).

We review the findings of these various studies relating to specialization presently. By way of overview, several basic observations and important insights have come out of this work. First is simply the recognition that the plaintiffs’ bar is heterogeneous. Plaintiffs’ attorneys are varied in the kinds and values of cases that they handle, in how they obtain clients, and in their marketing strategies and behavior. By implication, the opportunities and incentives that plaintiffs’ attorneys face may also vary substantially. Second is the idea that an essential aspect of any plaintiffs’ law practice is succeeding as a business (Kritzer 2004). By extension, lawyers and law firms can be understood as economic actors – whatever their other motivations, they need to make money in order to remain financially viable. For plaintiffs’ attorneys, the
business of law practice involves managing risk (i.e., investment in cases). Heterogeneity within the
plaintiffs’ bar suggests that strategic responses to this basic business necessity are varied. Third is the
observation that plaintiffs’ lawyers do not perform their functions in a vacuum. These lawyers are very
much affected by the legal and business climate within which they operate, and as conditions grow more
difficult and challenging (e.g., through tort reform), their willingness and ability to take cases, and their
decisions about which cases to take, are also sensitive to change (Daniels and Martin 1999, 2006b, 2009;
Garber et al. in press).

With regard to specialization of plaintiffs’ firms, previous research has provided several more
specific findings. Kritzer’s most recent analysis of survey data on Wisconsin attorneys suggested that
specialization in contingency fee work tended to skew toward somewhat larger law firms, as compared to
unspecialized “general practice,” which was more frequently associated with solo practitioners in his
sample (Kritzer 2004). Kritzer offered a similar observation in one of his earlier studies, namely, that
specialization among contingency-fee practitioners tends to be associated with an upper tier of the
plaintiffs’ bar, and with greater attorney experience in doing related contingency-fee work, access to
broader geographic markets for clients, and the opportunity to focus on higher-value cases (Kritzer 2001b).
Daniels and Martin offered some complementary findings, and particularly so in observing an association
between the geographic extent of a firm’s client base and its tendency to specialize: Urban firms and firms
with larger geographic client bases were more likely to focus on narrower, specialty practice areas (Daniels

Van Hoy offered similar observations in his 1999 interview study of Indiana plaintiffs’ attorneys:
he found that specialization in medical malpractice in particular was associated with somewhat larger
plaintiffs’ law firms, and not surprisingly, with plaintiffs’ firms that were better able to finance expensive
cases on contingency (Van Hoy 1999). Van Hoy also observed that specialization in medical malpractice
cases was associated with more rigorous case screening, and particularly with rejecting cases where the
anticipated value was less than $100,000 – a practice Van Hoy did not observe more generally among
Indiana plaintiffs’ attorneys. Finally, Van Hoy offered a complementary observation to that of Daniels and
Martin in suggesting that densely populated urban settings seem better-suited to lawyers who pursue
specialized areas of plaintiffs’ work, such as medical malpractice cases or high-value personal injury cases more broadly (Van Hoy 1999).

The most recent work on specialization among plaintiffs’ attorneys involved two studies published by Daniels & Martin in 2006, again drawing on samples of Texas attorneys. Their major findings include the observation that more specialized contingency-fee plaintiff firms in Texas tend to skew toward having higher value cases (Daniels and Martin 2006b), compared to their less specialized counterparts. Daniels & Martin also did a study focusing particularly on attorney specialization in medical malpractice work, and addressing the basic question whether “repeat play” plaintiff specialists in medical malpractice truly exist (Daniels and Martin 2006a). They did find evidence to document the existence of such specialists, and they also observed that specialization in medical malpractice was associated with prospective case screening by more specialized office staffs, higher volume of inquiries by prospective clients, greater selectivity in case taking, and reduced likelihood of accepting low-value malpractice cases (Daniels and Martin 2006a).

In sum, we offer the following observations about the literature on plaintiffs’ attorney specialization. First is that this is a fairly small empirical literature. Of the handful of studies that have been conducted in this area over the past 20 years, virtually all have drawn heavily on data from surveys, interviews, or both, collected for a single state. Most of the studies have focused on lawyer or firm specialization only implicitly, and at the level of plaintiff-side contingency fee practice. Few studies have focused on medical malpractice more specifically, much less on specialties within medical malpractice. Much of the scholarly interest and attention has instead focused on important but distinct questions having to do with stratification of the plaintiffs’ bar, firm marketing and client selection practices, etc. Thus, many basic descriptive questions about specialization in medical malpractice work among plaintiff firms remain to be explored, and particularly so with data that go beyond the confines of any single state.

The current study seeks to add to the existing empirical literature in several ways. By undertaking a national survey, we have collected more geographically varied data on plaintiff-side law practice than has previously been attempted. Focusing on medical malpractice practitioners and aspirants in particular, we address a narrower segment of the bar, and a different type of professional specialization, than in studies of plaintiffs’ personal-injury attorneys more generally. And by investigating specialization patterns among a
national sample of attorneys, as well as some of the associated organizational and practice characteristics of
t heir law firms, we provide a different perspective on malpractice specialization, what it looks like and
what it truly means, building on the important prior work of Daniels and Martin, Kritzer, and Van Hoy.
III. METHODS

The data used in this study are from a national mail survey of plaintiffs’ attorneys. The survey was made possible by help from the Center for Constitutional Litigation (CCL) and the American Association for Justice (AAJ); known at the time as the Association of Trial Lawyers of America (ATLA).1

In this section, we begin by describing the survey process and instrument. We then discuss the items that underlie the data used in this study, and particularly our primary variable of interest, which is a 5-point categorical scale describing firm-level specialization in medical malpractice work. We then briefly describe our methods for exploring the data.

SAMPLE

During 2006, we surveyed large numbers of attorneys whom we believed to be active in representing medical negligence plaintiffs or else who had indicated interest in doing such work. Our initial mailing list included 4,404 members of ATLA during 2005, based in 42 selected states and the District of Columbia. The eight states in which we did not field the survey included the three Gulf states, Alabama, Louisiana, and Mississippi (which we omitted because of post-Hurricane Katrina dislocations), and the five smallest U.S. states by population, Alaska, North Dakota, South Dakota, Vermont and Wyoming. Further details regarding the design of the survey sample, instrument development, and survey administration are available in Garber, Greenberg et al., in press.

SURVEY ADMINISTRATION

The authors of this article developed a 67-item questionnaire addressing many aspects of plaintiffs’ attorney practice, firm organization, and case selection and screening procedures. The survey was in the field from late May to mid-November 2006.2 The initial mailing to 4,404 attorneys in late May

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1 CCL is a for-profit law firm, and AAJ is one of its clients.

2 Personnel at the University of Florida Survey Research Center (SRC) in Gainesville formatted and printed the questionnaire and enclosures. In addition, SRC personnel distributed the survey, verified
was followed up with postcard reminders roughly three weeks later. These activities yielded 644 completed questionnaires, leaving 3,760 (4,404 – 644) non-responders from the original mailing list. We then followed up with second mailings of the questionnaire to the 3,204 non-respondents for whom we could confirm addresses in either or both of the Findlaw or Martindale Hubble directories. We then followed-up with up to five attempts to reach nonrespondents by telephone, for the 2,662 of the non-respondents for whom we were able to obtain telephone numbers from one or both of the directories.

When we closed out data collection in November 2006 we had obtained a total of 965 completed questionnaires.\(^3\) This number of completed responses represents 22 percent of the initial list of 4,404 attorneys, which we think of as the lower bound on our true response rate (i.e., the response rate among those attorneys who could be reached by mail using the ATLA name and address information). An upper bound on our true response rate is 29 percent (= 965/3296). The denominator of this rate (i.e., 3,296) is the number of attorneys on the initial mailing list (i.e., 4,404) minus the number for whom we were unable to verify mailing addresses and obtain telephone numbers.

**SURVEY INSTRUMENT AND ITEMS**

The questionnaires used in this study included several scenario-vignettes (described elsewhere; see Garber, Greenberg et al., in press), and 56 items pertaining to information about each respondent (e.g., demographic characteristics, experience in law practice and in medical malpractice work), the characteristics of his or her law office and law firm (e.g., number of attorneys), and degree of specialization in plaintiff-side medical malpractice work. Additional items pertained to a range of client selection and fee arrangement issues.

The primary variable of interest in this study is firm specialization in medical malpractice work (hereinafter, “Firm Specialization”), which we captured through a 5 point categorical scale (see Table 1 below). We asked respondents to select the statement that best described their firm’s workload, from

\(^3\) The survey offered attorneys the option of completing the questionnaire on line. Only twenty of our 965 respondents did so.
among five choices that ranged from the greatest specialization in medical malpractice cases (i.e., virtually all of our work is in medical malpractice), to the least specialization in medical malpractice cases (i.e., medical malpractice is not one of our top two areas of law practice). We designed the answer choices for our Firm Specialization variable to be mutually exclusive, exhaustive, and ordinally ranked (moving down the rows of Table 1).

Other survey items that we examine in this study include Firm Size, Number of Firm Offices, Firm Location (Urban/ Suburban/ Rural), Fraction of Firm Clients within 30 Minute Drive of Office, Fraction of Cases Accepted, and Threshold Value of Case-Taking. In each instance, we measured these variables using 3-, 4-, or 5-point categorical scales, in which the specific answer options are labeled in our tabular presentation of results below.

Table 1. Primary Measure: Firm Specialization in Medical Malpractice

<table>
<thead>
<tr>
<th>Option</th>
</tr>
</thead>
<tbody>
<tr>
<td>Virtually all of our work is in medical malpractice.</td>
</tr>
<tr>
<td>Most, but not all, of our work is in medical malpractice</td>
</tr>
<tr>
<td>Medical malpractice is our most important practice areas.</td>
</tr>
<tr>
<td>Medical malpractice is one of our top two most important practice areas</td>
</tr>
<tr>
<td>None of the above</td>
</tr>
</tbody>
</table>

DATA ANALYSIS

We conducted several summaries and analyses of our survey data. First, we generated univariate descriptive summaries on a series of measures, including the firm-level variables listed above, as well as several respondent-level variables concerning the demographic and professional characteristics of attorneys in our sample.

Second, we performed several cross-tabulations to examine bivariate relationships between firm specialization in medical malpractice and the other firm-level characteristics described above. For each of the bivariate cross-tabs, we also conducted a Pearson Chi-Square test, to examine statistical dependence of
specialization in medical malpractice with each of several other firm-level variables. We present the bivariate findings through a series of bar charts.

Third, we examined the multivariate relationships between firm specialization in medical malpractice and other firm-level characteristics through an ordered-logistic regression model ("ordered logit"), with the dependent variable being *Firm Specialization*. Our estimates were computed using the ordered logistic regression package in Stata/SE version 9.2 for Windows.
IV. RESULTS

UNIVARIATE DESCRIPTIVE STATISTICS

With regard to the characteristics of the survey sample, of the 965 persons who responded to the survey, the vast majority were male, equity stakeholders in their firms, and lawyers with substantial past experience in the field (see Table 2). Both the mean and median response on the year of graduation from law school was 1982, and thus on average reflected about 24 years of work experience prior to receiving the survey. Most (83.4 percent) of the respondents to the survey indicated that they spent the substantial majority of their time over the preceding 2 years doing plaintiff-side contingency fee legal practice. By contrast, only 37 percent of the respondents indicated that they spent more than half of their time on plaintiff medical malpractice cases. Notably, about 15% of respondents indicated that they had a substantive specialty area within medical malpractice, such as (we presume) neurological, pediatric, or surgical cases (see Table 2).

<table>
<thead>
<tr>
<th>Table 2: Characteristics of Survey Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>% Female</td>
</tr>
<tr>
<td>% Partners, Shareholders, or Sole Proprietors</td>
</tr>
<tr>
<td>% of Respondents Who Worked at Least 75% of Their Time on Plaintiff Contingency Fee Work in Past 2 Years</td>
</tr>
<tr>
<td>% of Respondents Who Worked More than Half Time on Plaintiff Medical Malpractice Cases in Past 2 Years</td>
</tr>
<tr>
<td>% of Respondents Who Said They Had A Specialty Within Medical Malpractice</td>
</tr>
</tbody>
</table>

4 If we further assume that the average respondent graduated from law school at age 26, then the age of that average respondent would be 50.
Table 3 below shows the distribution of the fraction of time respondents reported devoting to plaintiffs’ medical malpractice work over the preceding 2 years. Notably, more than 40 percent of the respondents described spending less than one quarter of their time doing medical malpractice cases, while 20 percent described spending more than three quarters of their time doing medical malpractice cases. Again, this suggests that there is substantial diversity among the lawyers who do medical malpractice work: Some appear to be far more specialized than others.

Table 3: Respondent Time Spent on Plaintiff MM Cases in Preceding 2 Years

<table>
<thead>
<tr>
<th>Attorney Time Spent on Plaintiff MM Last 2 Years</th>
<th>Freq.</th>
<th>%</th>
<th>Cum.</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>25</td>
<td>2.63</td>
<td>2.63</td>
</tr>
<tr>
<td>Some, but less than 25%</td>
<td>371</td>
<td>38.97</td>
<td>41.6</td>
</tr>
<tr>
<td>Between 25% and 50%</td>
<td>205</td>
<td>21.53</td>
<td>63.13</td>
</tr>
<tr>
<td>Between 50% and 75%</td>
<td>160</td>
<td>16.81</td>
<td>79.94</td>
</tr>
<tr>
<td>More than 75%</td>
<td>191</td>
<td>20.06</td>
<td>100</td>
</tr>
</tbody>
</table>

Moving to the firm-level variables, the survey responses generally suggest that about two-thirds of respondents work in small law firms (of 5 or fewer lawyers), four-fifths in firms with only one office, and almost two-thirds in firms located in urban settings (see Table 4). Few respondents work in firms larger than 10 attorneys, or in offices based in rural settings (less than 7 percent). Only a small fraction (less than 9 percent) of the respondents reported working at firms in which a physician (or physician-attorney) was employed by the firm, while a somewhat larger fraction (24 percent) reported working at firms in which a registered nurse (or nurse-attorney) was employed.
Table 4: Characteristics of Respondents’ Firms

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Freq.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>% Respondents Who Work in Small Firms (5 or Fewer Attorneys)</td>
<td>640</td>
<td>67.7%</td>
</tr>
<tr>
<td>% Respondents Who Work in Small Firms (5 to 10 Attorneys)</td>
<td>176</td>
<td>18.6%</td>
</tr>
<tr>
<td>% of Respondents Who Work in One Office Firms</td>
<td>759</td>
<td>78.7%</td>
</tr>
<tr>
<td>% of Respondents Who Work in Law Offices in Urban Settings</td>
<td>619</td>
<td>64.7%</td>
</tr>
<tr>
<td>% of Respondents Who Work in Law Offices in Suburban Settings</td>
<td>274</td>
<td>28.6%</td>
</tr>
<tr>
<td>% of Respondents Who Work in Law Offices in Rural Settings</td>
<td>64</td>
<td>6.7%</td>
</tr>
<tr>
<td>% of Respondents Who Work at Firms with A Physician</td>
<td>81</td>
<td>8.4%</td>
</tr>
<tr>
<td>% of Respondents Who Work at Firms with a Registered Nurse</td>
<td>231</td>
<td>23.9%</td>
</tr>
</tbody>
</table>

The main variable of interest in this study is Firm Specialization in medical malpractice work. Table 5 shows that only a very small fraction of respondents reported working for firms that exclusively focus on medical malpractice cases. For the substantial majority of respondents (83%), medical malpractice was not described as the top practice area for their law firm as a whole.

Table 5: Firm Specialization in Medical Malpractice

<table>
<thead>
<tr>
<th>Firm Specialization in MM</th>
<th>Freq</th>
<th>%</th>
<th>Cum.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Virtually All of Our Work is in MM</td>
<td>41</td>
<td>4.27</td>
<td>4.27</td>
</tr>
<tr>
<td>Most of Our Work is in MM</td>
<td>61</td>
<td>6.35</td>
<td>10.61</td>
</tr>
<tr>
<td>Our Most Important Practice Area is in MM</td>
<td>61</td>
<td>6.35</td>
<td>16.96</td>
</tr>
<tr>
<td>MM is One of Our Top 2 Practice Areas</td>
<td>337</td>
<td>35.07</td>
<td>52.03</td>
</tr>
<tr>
<td>None of the above</td>
<td>461</td>
<td>47.97</td>
<td>100</td>
</tr>
</tbody>
</table>

Finally, we also consider three other firm-level variables in this study: Fraction of Firm Clients within 30 Minute Drive of Office, Fraction of Cases Accepted, and Threshold Value of Case-Taking. Table 6 shows that firms vary considerably in the geographic concentration of their client base, with respondents spread fairly evenly across the four response categories. Table 7 shows that respondents’ firms also vary
considerably in the degree of selectivity with which they accept medical malpractice cases, although across the board, the substantial majority of firms are described as rejecting the substantial majority of prospective cases. Finally, Table 8 shows that most (about 85 percent) of the respondents’ firms are screening the cases they take based on assessments of the likely values of those cases, but that the minimum case value for which accepting a client will be considered varies quite a bit across the respondents’ firms.

Table 6: Fraction of Firm Clients within 30 Minute Non-Rush-Hour Drive of Office

<table>
<thead>
<tr>
<th>Fraction of Clients in 30 Minute Non-Rush Hour Drive of Office</th>
<th>Freq.</th>
<th>%</th>
<th>Cum.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 25%</td>
<td>180</td>
<td>18.91</td>
<td>18.91</td>
</tr>
<tr>
<td>Between 25% and 50%</td>
<td>265</td>
<td>27.84</td>
<td>46.74</td>
</tr>
<tr>
<td>Between 50% and 75%</td>
<td>266</td>
<td>27.94</td>
<td>74.68</td>
</tr>
<tr>
<td>More than 75%</td>
<td>241</td>
<td>25.32</td>
<td>100</td>
</tr>
</tbody>
</table>

Table 7: Fraction of Medical Malpractice Cases Accepted by Firm

<table>
<thead>
<tr>
<th>Fraction MM Cases Accepted</th>
<th>Freq.</th>
<th>%</th>
<th>Cum.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 1%</td>
<td>100</td>
<td>10.5</td>
<td>10.5</td>
</tr>
<tr>
<td>Between 1% and 5%</td>
<td>373</td>
<td>39.18</td>
<td>49.68</td>
</tr>
<tr>
<td>Between 5% and 10%</td>
<td>261</td>
<td>27.42</td>
<td>77.1</td>
</tr>
<tr>
<td>Between 10% and 25%</td>
<td>170</td>
<td>17.86</td>
<td>94.96</td>
</tr>
<tr>
<td>More than 25%</td>
<td>48</td>
<td>5.04</td>
<td>100</td>
</tr>
</tbody>
</table>

Table 8: Threshold Value Rule for Rejecting Medical Malpractice Cases

<table>
<thead>
<tr>
<th>Case Values for Which MM Cases are Rejected</th>
<th>Freq.</th>
<th>%</th>
<th>Cum.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than $100,000</td>
<td>197</td>
<td>20.85</td>
<td>20.85</td>
</tr>
<tr>
<td>Less than $250,000</td>
<td>307</td>
<td>32.49</td>
<td>53.33</td>
</tr>
<tr>
<td>Less than $500,000</td>
<td>241</td>
<td>25.5</td>
<td>78.84</td>
</tr>
<tr>
<td>Less than $1,000,000</td>
<td>62</td>
<td>6.56</td>
<td>85.4</td>
</tr>
<tr>
<td>No Such Rule</td>
<td>138</td>
<td>14.6</td>
<td>100</td>
</tr>
</tbody>
</table>
BIVARIATE RELATIONSHIPS

We examined several hypotheses regarding the bivariate relationships between Firm Specialization in medical malpractice, and several other variables of potential interest. For each of these relationships, we present our results in the form of a set of bar charts. Specifically, in the charts Firm Specialization appears as a set of categories on the horizontal axis in decreasing order of degree of specialization, and corresponding sets of bars depict the distribution of responses on a second variable for each particular specialization category. Where the distribution of the second variable differs systematically with the value of Firm Specialization, that suggests an association (lack of independence) between the two variables of interest. For each pair of variables, we also report the results of a $\chi^2$ test for statistical independence.

The first relationship considers how firm specialization in medical malpractice is associated with the respondent attorney specialization in medical malpractice cases. Figure 1 shows the cross-tabulation of these two variables, and not surprisingly, it suggests that attorneys who spend more of their time doing medical malpractice cases are also more likely to work at firms that specialize similarly (an association that is highly statistically significant, $X^2 = 647.6, p < 0.001$). Although intuitive, this result is not tautological – one could imagine, for example, a plausible world in which specialist malpractice attorneys tend to join larger, diversified firms, as a strategy for managing portfolio risks.
Next, we investigated the relationship between firm specialization in medical malpractice and firm size (measured by the number of lawyers), with the hypothesis that larger firms tend to be more specialized—a pattern suggested by the findings of Kritzer and Van Hoy regarding specialization in contingency-fee law practices generally. Contrary to that hypothesis, Figure 2 shows what looks like a very modest relationship between specialization and firm size, such that the most specialized MM firms include none larger than 10 attorneys, in marked contrast to all of the less specialized firms—an association that is marginally statistically significant ($\chi^2 = 24.8, p = 0.073$). As we discuss below, this is an interesting result, in that it appears to diverge from extension of the findings of Kritzer (2004) and Van Hoy (1999), suggesting a positive association between firm size and specialization in contingency fee plaintiff work more generally.
Next, we looked at the association between firm specialization in medical malpractice and respondents’ office location (urban/suburban/rural). Again drawing on prior literature, our hypothesis was that there would be a positive association between urbanicity and specialization. Figure 3 indicates at most a weak relationship here, although less specialized firms and offices do appear somewhat more likely to be based in rural areas than their more specialized counterparts (a marginally significant association, $X^2 = 13.4, p = 0.100$). A different suggestion emerges when we examine the relationship between specialization and proportion of firm clients living nearby, as measured by Fraction of Firm Clients within 30 Minute Drive of Office: Prior literature suggests that more specialized firms should also be associated with a broader geographic client base. Specifically, Figure 4 does show that firms that specialize in medical malpractice tend to be less local (hence less geographically concentrated) in their market areas from which they draw their clients, when compared with firms that are less specialized. This is a highly significant result ($X^2 = 40.1, p = 0.001$). Both of these patterns seem only loosely consistent with previous literature, in suggesting that urban firms and firms with broader geographic client bases may be more likely to specialize (Daniels & Martin, 1999, 2001; Van Hoy, 1999).
Next, we considered two other hypotheses connecting firm specialization in medical malpractice to other firm level characteristics. First, we investigated the association between firm specialization and firm selectivity in taking medical malpractice cases, and the hypothesis that more specialized firms might also be more selective in case taking – a hypothesis suggested to us by the trade literature, which emphasizes the importance of careful case screening as a prerequisite for success in doing medical malpractice work (Fagel 2004; Trine and Luvera 1993, 1994). Figure 5A, cross-tabulating firm selectivity by firm specialization,
does not show any strong, interpretable pattern. A somewhat clearer picture emerges when we consider the reverse cross-tabulation, which shows the distributions of firm specialization as a function of firm selectivity (see Figure 5B). Here, we see a complex relationship, in which the most selective firms (top two categories) tend either to be highly specialized in medical malpractice or else not at all specialized (a “U-shaped” distribution), and in which the less selective firms (bottom three categories) tend to be moderately specialized (a bell-shaped distribution). We do not view these patterns as being consistent with our original hypothesis, even though there is a statistically significant association between firm specialization and selectivity ($X^2 = 29.7, p = 0.020$).

**Figure 5A: Fraction of MM Cases Accepted by Firm Workload in MM**
Lastly, we investigated the association between firm specialization in medical malpractice and the use by firms of case-value rules for screening prospective cases. Although prior literature has dealt with this issue only tangentially (Van Hoy, 1999), we hypothesized that more specialized medical malpractice firms would tend to screen out their cases using higher minimum values. Figure 6 again shows a somewhat mixed pattern of results that does not confirm the hypothesis, despite the fact that independence can be rejected ($\chi^2 = 27.4, p = 0.037$).
MULTIVARIATE ANALYSIS

In order to explore predictors of our measure of firm specialization in medical malpractice in a multivariate context, we used an ordered logit model, using as the dependent measure Firm Specialization in Medical Malpractice, and entering as predictors a series of indicators of categories of the firm-level variables Firm Size, Number of Firm Offices, Firm Location (Urbanicity), Fraction of Firm Clients in 30 Minute Drive of Office, Fraction of Cases Accepted, and Threshold Value of Case-Taking. This analysis is used to identify what the best predictors of firm specialization in medical malpractice are when considering multiple variables jointly.

We began by recoding Firm Specialization as a numeric variable, in which each categorical response was assigned to a corresponding ordinal value. The least specialized MM firms were assigned the value of 1, the next least specialized were assigned the value of 2, and so on, up to the most specialized MM firms, which were assigned the value of 5.

For each of the predictors in the model, we created a series of indicator variables corresponding to the different categories that the predictor was capable of taking on. With respect to each predictor, we then specified the model by omitting the indicator variable for the category that we hypothesized as most likely to be positively associated with firm specialization in medical malpractice cases. Thus, we dropped from the estimating equation the indicator variables corresponding to “one-office firms,” “1-5 attorney firms,”
“urban firms,” “firms with less than 25% of clients within a 30 minute drive of the office,” “firms that accept less than 1% of MM case inquiries,” and “firms with no threshold dollar value rule for screening cases.” Results from the ordered logit estimations are reported in Table 9 below:

### Table 9: Ordered-Logit Estimates of Predictors of the Degree of Firm Specialization in Medical Malpractice

<table>
<thead>
<tr>
<th>Predictor Variable</th>
<th>Coef.</th>
<th>S.E.</th>
<th>P Value</th>
<th>95% Confidence Interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>Between 2-3 offices</td>
<td>0.00</td>
<td>0.17</td>
<td>1.00</td>
<td>-0.34 to 0.34</td>
</tr>
<tr>
<td>Between 4-5 offices</td>
<td>0.89</td>
<td>0.46</td>
<td>0.05</td>
<td>-0.01 to 1.80</td>
</tr>
<tr>
<td>More than 5 offices</td>
<td>-0.63</td>
<td>0.65</td>
<td>0.33</td>
<td>-1.90 to 0.65</td>
</tr>
<tr>
<td>5-10 attorneys</td>
<td>-0.16</td>
<td>0.17</td>
<td>0.36</td>
<td>-0.50 to 0.18</td>
</tr>
<tr>
<td>10-15 attorneys</td>
<td>-0.41</td>
<td>0.29</td>
<td>0.15</td>
<td>-0.97 to 0.15</td>
</tr>
<tr>
<td>15-20 attorneys</td>
<td>-0.16</td>
<td>0.34</td>
<td>0.64</td>
<td>-0.82 to 0.51</td>
</tr>
<tr>
<td>20+ attorneys</td>
<td>-1.04</td>
<td>0.38</td>
<td>0.01</td>
<td>-1.79 to -0.28</td>
</tr>
<tr>
<td>Suburban</td>
<td>-0.08</td>
<td>0.15</td>
<td>0.57</td>
<td>-0.37 to 0.20</td>
</tr>
<tr>
<td>Rural</td>
<td>-0.50</td>
<td>0.28</td>
<td>0.07</td>
<td>-1.04 to 0.04</td>
</tr>
<tr>
<td>Between 25% and 50% in 30 minute drive</td>
<td>0.27</td>
<td>0.20</td>
<td>0.18</td>
<td>-0.12 to 0.66</td>
</tr>
<tr>
<td>Between 50% and 75% in 30 minute drive</td>
<td>0.32</td>
<td>0.20</td>
<td>0.11</td>
<td>-0.07 to 0.71</td>
</tr>
<tr>
<td>More than 75% in 30 minute drive</td>
<td>-0.54</td>
<td>0.21</td>
<td>0.01</td>
<td>-0.95 to -0.14</td>
</tr>
<tr>
<td>Between 1% and 5% cases accepted</td>
<td>0.20</td>
<td>0.24</td>
<td>0.40</td>
<td>-0.27 to 0.68</td>
</tr>
<tr>
<td>Between 5% and 10% cases accepted</td>
<td>0.46</td>
<td>0.25</td>
<td>0.07</td>
<td>-0.03 to 0.95</td>
</tr>
<tr>
<td>Between 10% and 25% cases accepted</td>
<td>0.40</td>
<td>0.27</td>
<td>0.14</td>
<td>-0.13 to 0.93</td>
</tr>
<tr>
<td>More than 25% cases accepted</td>
<td>0.92</td>
<td>0.37</td>
<td>0.01</td>
<td>0.20 to 1.64</td>
</tr>
<tr>
<td>Predictor Variable</td>
<td>Coef.</td>
<td>S.E.</td>
<td>P Value</td>
<td>95% Confidence Interval</td>
</tr>
<tr>
<td>------------------------------------</td>
<td>-------</td>
<td>------</td>
<td>---------</td>
<td>-------------------------</td>
</tr>
<tr>
<td>Reject cases less than $100K</td>
<td>0.17</td>
<td>0.23</td>
<td>0.45</td>
<td>-0.28 to 0.63</td>
</tr>
<tr>
<td>Reject cases less than $250K</td>
<td>0.48</td>
<td>0.22</td>
<td>0.03</td>
<td>0.06 to 0.91</td>
</tr>
<tr>
<td>Reject cases less than $500K</td>
<td>0.61</td>
<td>0.23</td>
<td>0.01</td>
<td>0.17 to 1.06</td>
</tr>
<tr>
<td>Reject cases less than $1M</td>
<td>0.60</td>
<td>0.32</td>
<td>0.06</td>
<td>-0.02 to 1.23</td>
</tr>
<tr>
<td>Cut 1</td>
<td>0.52</td>
<td>0.32</td>
<td></td>
<td>-0.11 to 1.15</td>
</tr>
<tr>
<td>Cut 2</td>
<td>2.23</td>
<td>0.33</td>
<td></td>
<td>1.58 to 2.88</td>
</tr>
<tr>
<td>Cut 3</td>
<td>2.80</td>
<td>0.34</td>
<td></td>
<td>2.14 to 3.46</td>
</tr>
<tr>
<td>Cut 4</td>
<td>3.76</td>
<td>0.36</td>
<td></td>
<td>3.06 to 4.46</td>
</tr>
</tbody>
</table>

Model Pseudo $R^2 = 0.031$

The multivariate results in Table 9 suggest several inferences. First, with regard to *Number of Firm Offices*, firms with 4-5 offices were significantly more specialized in medical malpractice work than were 1 office firms, after controlling for all other variables in the model. Large firms (i.e., those with more than 20 attorneys), by contrast, were significantly less specialized in medical malpractice work than were the smallest firms (those with between 1 and 5 attorneys). Likewise, very local firms (i.e., those with more than 75% of their client base within a 30 minute drive of the office) were significantly less specialized in medical malpractice than were the firms with the broadest client base (i.e., those drawing less than 25% of their clients from within a 30 minute drive of the office). *Fraction of Cases Accepted* appears to have an almost monotonic association with firm specialization in medical malpractice, other things equal: The less selective a firm, the more specialized in medical malpractice it is predicted to be.\(^5\) Finally with regard to *Threshold Value of Case-Taking*, firms that screen prospective malpractice cases by using case-value thresholds of $250K and $500K were significantly more specialized in medical malpractice, when compared to firms that do not screen cases based on rules of thumb focused on case values.

\(^5\) The estimated difference with the (omitted) most selective category is statistically significant only for the least-selective firms, however.
In sum, the results seem clear in suggesting that firm size, geographic client base, selectivity in case taking, and threshold value rules for case taking are significantly associated with the degree of specialization in medical malpractice, among firms with lawyers who do (or aspire to do) medical malpractice work. Given the fairly low value of the model Pseudo $R^2$ measure of only 0.031, however, the results also suggest that firm specialization in medical malpractice is difficult to predict from any of these characteristics, whether taken singly or in combination. We next consider the implications of these findings.
V. INTERPRETATION AND DISCUSSION

Results from this study suggest that specialization in medical malpractice by plaintiffs’ attorney firms is a complex phenomenon, and that as with the contingency-fee bar more generally, these firms and their lawyers are fairly heterogeneous. Even among a sample of lawyers recruited based on contingency-fee work and interest in medical malpractice cases, there is considerable variation in the degree to which lawyers (and their firms) actually specialize in doing malpractice case work. In some respects, our findings on medical malpractice specialization run counter to the earlier empirical literature on contingency-fee lawyers in Wisconsin, Texas and Indiana. Perhaps most notably, our data suggest that firms that are more specialized in medical malpractice tend to be smaller, while previous literature has suggested that specialization in contingency-fee work or in malpractice tends to skew somewhat toward larger firms (Kritzer, 2004; Van Hoy, 1999). In part, the source of this discrepancy may lie in the comparison group – the current study is implicitly comparing malpractice specialists to other contingency-fee practitioners, whereas Kritzer’s study in particular involved comparing contingency fee practitioners to “generalists” (i.e., personal lawyers who offer a broad menu of services to consumers, potentially including trusts and estates work, divorce, criminal defense, etc.).

In some important respects, our findings echo some of the earlier empirical studies of the plaintiffs’ bar. For example, our data suggest that more specialized malpractice firms are more likely to be located in urban areas and also tend to draw their clients from larger geographic areas. The latter pattern emerges from both our bivariate and our multivariate analyses. Both patterns are consistent with the preceding literature, and the observation that specialization among plaintiffs’ lawyers tends to be associated with urban office settings and geographically broader client pools (e.g., Daniels & Martin 1999, 2001; Kritzer 2001a).

Some of our findings on specialization explore ground unexplored by previous researchers. Thus, for example, only a small proportion of our survey respondents reported having specialty areas within medical malpractice (15%), or in working at firms that employ physicians (or attorney-physicians) in-house (8%). These may be important practice attributes for the small group of plaintiff firms that possess them,
but even among firms that spend significant time on medical malpractice work, these attributes are fairly rare.

Two of our most striking findings involve the relationships of specialization to threshold dollar values for screening of prospective cases and to firm selectivity in case taking. The bivariate relationships do not reveal clear patterns in line with our preliminary hypotheses, which were that greater specialization in malpractice work would be associated both with greater selectivity in case-taking and with screening prospective cases using higher minimum values. Multivariate analysis, by contrast, produces a clearer picture. The ordered-logit estimates suggest that firms that use two particular levels of threshold values in case screening (at $250K and $500K) are significantly more specialized in medical malpractice, when compared to firms that use no threshold value rule to screen cases. This is a result that seems at least broadly consistent with Van Hoy’s earlier findings (Van Hoy, 1999).

With regard to selectivity in case-taking, the ordered-logit estimates surprisingly suggest that firms more specialized in medical malpractice are actually less selective in taking malpractice cases, as compared to their less specialized counterparts (when all other model predictors are considered jointly). This result seems to contradict the trade literature, which emphasizes the importance of selectivity in case-taking for successful medical malpractice ventures (Fagel 2004; Trine and Luvera 1993, 1994). However, our data pertain to firms and lawyers the vast majority of whom specialize in contingency-fee work, but who vary in their degree of focus on medical malpractice. Is it obvious that more diversified plaintiffs’ firms that do substantial amounts of malpractice work necessarily ought to be less selective in taking malpractice cases than their narrower, more specialized counterparts? Perhaps not. Conservatively interpreted, our results seem to call into question the intuition that greater firm specialization in malpractice is usually associated with greater selectivity in taking cases.

The results of our ordered-logit analysis are also striking for having generated a very modest goodness-of-fit statistic (pseudo $R^2 = 0.031$). This indicates that even when we consider several firm-level characteristics as predictors at the same time, the predictive power is quite limited. Thus it seems that specialization in medical malpractice is simply difficult to predict from these sorts of firm-level characteristics, at least among a group of contingency-fee respondents some of whom may specialize in
other sorts of cases (e.g., products liability). Indeed, it could be that specialization in medical malpractice would be difficult to predict from any set of firm-level characteristics.

The current study has several strengths, including its national scope, its focus on contingency-fee lawyers, and its investigation of specialization in multiple, rather than only two, categories. To the best of our knowledge, our study is unique as a survey effort in that it involves plaintiffs’ medical malpractice attorneys in more than one state. All of the previous studies of the plaintiff contingency-fee bar have relied on surveys or interviews of lawyers in a single state – raising the question of external validity of earlier findings. For the most part the existing literature has examined not medical malpractice, but contingency-fee legal practice more generally; the current study offers a valuable, different, perspective. Finally, another strength of our study is measurement of specialization in multiple, rather than only two, categories.

The current study also has some weaknesses. We discuss four, namely, (1) that the population from which we sampled is not ideal for the purposes of studying specialization in medical malpractice, (2) that non-random response from that population could introduce biases in making inferences from the population from which we sampled, (3) that we sampled attorneys, not firms, but our analyses are at the firm level, and (4) that inferring anything about causality in determining specialization patterns from our data seems effectively impossible. We discuss these points in turn.

Our survey population is a subset of ATLA members during 2005. The extent to which ATLA members are representative of all U.S. contingency-fee lawyers—which, given our focus in this article would be a more attractive population from which to sample—is far from clear. We offer two observations that may help readers think about the nature of our population. First, because AAJ membership can be expensive, we imagine that our population may disproportionately include more successful plaintiffs’ attorneys and attorneys who work at more profitable firms. Second, since ATLA was (and AAJ is) active in promoting legal policies that would benefit personal-injury lawyers and their clients, members may tend to be more concerned about legal-policy issues than non-members. In any event, to be feasible given any

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6 AAJ annual membership dues are computed based partly on the length of time that a practicing lawyer has been in the field, and in 2009 range from $50 for a newly licensed practitioner, to $495 for a lawyer who has been in practice for more than 25 years.
plausible level of available resources, the kind of national survey we undertook required cooperation from
ATLA, which provided names and mailing addresses of attorneys who fit our sampling criteria and
encouraged their members to fill out the questionnaire.

We cannot rule out the possibility that non-random non-response to our survey imparts biases in
our estimates (in relation to the patterns in the population from which we did sample), but we know of no
particular source of such biases. As reported above, our survey response rate is somewhere between 22
and 29 percent, which we think of as somewhat disappointing, but not surprisingly low given that
contingency-fee lawyers tend to be very busy and, thus, even the 30 or so minutes required to fill out and
return the questionnaire involved more than trivial costs to respondents. Theoretically, our plaintiffs’
lawyers would be expected to be less likely to respond to the survey for two reasons. First, attorneys might
be expected to be less likely to respond if they value their time more highly. But it seems doubtful that this
would induce a bias in our analyses of predictors of firm specialization in medical malpractice, since we
found no strong, interpretable pattern between firm specialization and firm selectivity (the latter of which
may be associated with higher incomes of their lawyers). Second, since respondents were encouraged to
respond by vague references to the potential for our study (i.e., Garber, Greenberg et al., in press) to affect
public policy, attorneys who are more concerned about policy developments may have been more likely to
respond. We have not identified any reason to suspect that such policy concerns are systematically related
to the degree of specialization in medical malpractice.

We sampled attorneys, not firms and, in fact, our sample may contain multiple observations for
some particular firms. The information available to us does not allow us to identify any such duplicates,
however. The statistical implication of such duplication—if there is, indeed, any—would be to understatement of the true sampling variation in our estimators because our sample size (and estimators of sampling
variability) would tend to overstate the amount of independent information in our data.

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7 A more extensive discussion of potential for non-random response to our survey is contained in
Garber, Greenberg, et al. (forthcoming).

8 Another reason that lower response rates, other things equal, can be a concern is reduction in the
precision with which relationships can be estimated. In this regard, we emphasize that despite the response
rate of 30 percent or less, we still have data for more than 950 attorneys, so that our estimates are not
plagued by hopelessly large sampling variation associated with much smaller samples.
Lastly, our data do not permit inferences about causes of firm specialization in medical
malpractice. This is because specialization is jointly determined along with many other firm
characteristics, some of which we have measured to some extent, and others about which we have no
information at all. For example, specialization seems best thought of as being simultaneously determined
with factors such as firm sizes, the degree to which firms expand to in response to excess demand for their
services, and the nature and extent of firms’ marketing efforts to attract clients. Thus, we think of our data
as being interesting for purposes of description and prediction of the extent of specialization, but being
silent on causal explanation of that phenomenon.
VI. CONCLUSION

Based on data from the first national, research survey to focus on contingency-fee plaintiffs’ lawyers who do medical malpractice work or are interested in doing so, we observe that the attorneys in our sample tend to work in small, urban and suburban firms, and that they tend to be quite experienced. We also observe two other key phenomena.

First, both the lawyers and their firms vary significantly in the degree to which they actually specialize in malpractice cases, and even among contingency-fee “specialists,” only a minority deal exclusively with malpractice. This finding underlines the reality that “specialization” is both hierarchical and occurs on a continuum. Lawyers and their firms may choose to specialize in contingency-fee work, in medical malpractice work, or in specific kinds of malpractice cases – and none of these “tiers” of specialization is likely to involve an all-or-nothing distinction.

Second, although specialization in medical malpractice among contingency-fee firms is not statistically independent of several other firm-level characteristics, the predictive power of those associations is quite low. In this regard, much of the earlier empirical literature on contingency-fee law practice is qualitative in orientation, and has not involved any formal examination of effect size. Future studies—and discussions—of medical malpractice specialization, and of other attributes of contingency-fee law practice, should recognize the heterogeneity of plaintiffs’ firms—for example, in avoiding broad generalizations, in constructing measures and study samples, and in making analytically informative comparisons.
REFERENCES


