



# Medical Malpractice Law in the United States

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May 2005

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This report is not intended to be and should not be considered legal advice. Rather, it is only general information about the law. For legal advice, you should consult an attorney.

## **Introduction**

Medical malpractice law and insurance have been a very visible focus of attention around the country and in Washington, DC in recent years and on a cyclical basis for decades. In some states, the problems associated with medical malpractice are called a crisis, with health care providers concerned about spikes in malpractice premiums and reductions in the availability of coverage, especially for specialists who treat high-risk patients. Some believe the tort system is at fault, blaming excessive litigation, unreasonably high settlements and judgments, and the encouragement of defensive medical practices; others blame the medical malpractice insurance market. Numerous states have enacted legislation to address various aspects of the malpractice issue. And the Bush Administration has supported legislation (introduced but not as yet enacted) to reduce the amount of litigation and restrict damage awards in medical malpractice lawsuits.

This paper provides a brief overview of the issues surrounding medical malpractice law. It begins by briefly describing how medical malpractice law works. Following sections discuss the legal changes that states have made over the past thirty years in response to periodic concerns about rising medical malpractice costs, some newer proposals for changing medical malpractice law, and trend data looking at changes in the number of claims and average and total claims costs.

## **Medical Malpractice Law and Lawsuits**

Medical malpractice law in this country traditionally has been under the authority of the states, not the federal government. And, unlike many other areas of the law, the framework and legal rules governing malpractice actions were, prior to the last thirty years, largely established through decisions in lawsuits in state courts rather than through statutes enacted by state legislatures. Legal rules established by the courts generally are referred to as “common law.” Because the legal precedents that established the case law in one state have no weight in any other state, the rules for handling medical

malpractice cases varied from state to state, although many of the principles were similar.

Medical malpractice law traces its roots back to 19<sup>th</sup> Century English common law.<sup>1</sup> The law that developed concerning medical malpractice is part of the more general body of law dealing with injuries to people or property, known as “tort law.” Medical malpractice cases are an example of one particular type of tort, the tort known as “negligence.” The concept of negligence is that people should be reasonably careful in what they do, and, if they are not, they should be held responsible for the injuries that can be reasonably foreseen as resulting from their negligent conduct.

To win a negligence lawsuit involving medical care, the injured person needs to prove that they received substandard medical care that caused their injury. This involves a number of steps. First, a person who is injured during treatment must determine whether or not they have been harmed by inadequate care. Physicians and other providers generally are not legally required to tell their patients that they were hurt by medical care that was not as good as it should have been, so patients who suffer adverse outcomes, or their families, usually must consult with others to make this determination.<sup>2</sup> Patients who were under the care of multiple health care providers need to determine which, if any, of these providers contributed to their injury, if it is possible to do so. A malpractice lawsuit must be brought within a legally prescribed period, called a “statute of limitation.” In some states, the period for filing a suit starts when the person is injured, while in other states it does not start until the person knows or reasonably should have known that they had been injured.

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<sup>1</sup> See Speiser, Stuart M., et al., *American Law of Torts*, Vol. 4, Sec. 15.10 (West, 1987).

<sup>2</sup> While physicians are not legally compelled to disclose malpractice to their patients, the American Medical Association code of ethics (8.12) requires physicians to inform patients of the facts concerning mistakes or judgments that resulted in significant medical complications. A 2001 standard of the Joint Commission on the Accreditation of Health Care Organizations, RI 1.2.2, requires similar disclosure on the part of hospitals.

Once a person brings a malpractice lawsuit, the person (called the “plaintiff”) must show that they were actually under the care of the physician (or other provider) they are suing -- in other words, that they had established a physician–patient relationship. The concept here is that physicians (or other providers) owe a duty to their patients to use reasonable care and diligence in their treatment, but do not have any duty to care for members of the general public other than their own patients.

The next requirement is the heart of a negligence lawsuit: the plaintiff must show that the physician did not provide medical care that met appropriate standards. The standards of care that physicians must meet have changed substantially over time. In earlier cases, doctors were only required to perform as well as other doctors practicing in their home community. More modern cases have moved toward holding physicians to a national standard for physicians practicing under circumstances similar to their own. For example, specialists must practice medicine as well as the average specialist in the same field, no matter where they are located.

Even if the physician is shown to have provided substandard care, the plaintiff still must prove that the substandard care caused their injury. In some cases this is not difficult, such as when surgery is performed on the wrong body part. In other cases, showing causation can be quite problematic, such as cases involving severely ill people who might have suffered complications from their disease even with good medical care. Identifying what part of the medical care caused an injury can also be a challenge when many different providers participated in the care, so many courts have special rules to deal with situations where it is not possible to pinpoint the harmful acts, yet it is obvious to a layperson that medical care must have led to the patient’s injury.

The final step in a medical malpractice case is establishing how much money should be awarded to a winning plaintiff. A person who wins a malpractice lawsuit has shown that the injury is someone’s fault under the rules of negligence, so the question then becomes how much money is needed to

compensate that person for what they have suffered.<sup>3</sup> This monetary award is called the “damages.” The rules for determining damages can be complicated and take into account both actual economic losses, such as lost wages and the costs of future medical care related to the injury, and non-economic losses, such as pain and suffering or the loss of companionship of a spouse or child. As noted below, the value to be placed on non-economic losses has been particularly contentious.

During the last three decades of the 20<sup>th</sup> Century, the traditional reliance on state courts to shape medical malpractice law started to change. As premiums for malpractice insurance climbed sharply, organized medicine began to put pressure on state legislatures to change many of the rules governing malpractice lawsuits that had been created by judges over the previous two centuries. State legislatures have responded to a number of issues concerning the malpractice tort claims system and passed statutes that changed a number of different aspects of malpractice law, some of which had dramatic effects. Those statutes are often referred to as “tort reforms.” More recently, the United States Congress has also considered legislation that would make federal laws more prominent in medical malpractice cases and would override at least some aspects of state laws. Below we describe a number of the issues that have led to statutory changes, and discuss those changes.

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<sup>3</sup> From a societal perspective, medical malpractice lawsuits also serve a preventive function by encouraging medical providers to practice in accordance with professional standards. How well the current malpractice system fulfills that role, and whether fear of malpractice action discourages providers from participating in reporting and other systems intended to identify and reduce medical errors, are contentious issues within the overall debate about the appropriateness of the current medical malpractice structure.

## **Medical Malpractice Policy Issues**

This section identifies some of the areas in which state laws have changed or clarified traditional common law rules for medical malpractice cases, focusing on:

- Who Evaluates the Adequacy of Care?
  - Expert Witnesses
  - Pre-Trial Screening of Cases
  - Alternative Dispute Resolution
- How Much Money Should Be Awarded to Plaintiffs or Paid to Lawyers?
  - Limits on Damages
  - Attorney Compensation
- How Should Damages Be Paid, and by Whom?
  - Joint and Several Liability
  - Lump Sum or Periodic Payments
  - Recoveries from Collateral Sources
- How Much Time Should People Have to Bring Lawsuits?
  - Statutes of Limitations

After discussing the areas in which state laws have been modified in recent decades, this section also identifies newer proposals for tort reform, only one of which has actually been adopted, focusing on:

- Patient Compensation Funds
- Aligning Malpractice Law and Patient Safety Concerns
- Expanding Risk Pools
- Prudent Physician Standard of Care
- Enterprise Liability

### **Who Evaluates the Adequacy of Care?**

Proving that the physician breached the standard of care has been one of the most important and contentious requirements of malpractice actions, since it involves finding fault and placing blame on a particular physician. In

negligence lawsuits involving everyday matters, the jury generally decides for itself whether the defendant was reasonably careful, but medical malpractice usually requires that medical experts testify about the required standard of care and whether or not the defendant met that standard. Getting experts was somewhat difficult when the standard was a purely local one, since only doctors in that community could testify to the standard and they were reluctant to point fingers at their fellow physicians. It became much easier to bring in outside experts as the standard changed to a more national one, making lawsuits more feasible. In turn, this led to development of the so-called “professional witness” who travels from courtroom to courtroom to testify in lawsuits. The perception that such itinerant experts will say whatever supports the side of the case that is paying for their testimony has seriously undermined confidence among physicians in the fairness of the negligence system.

In response to unease that physicians were being judged by laypersons on juries guided only by “competing experts,” states have made several types of tort law changes addressing the way that negligence is to be determined.

**Expert Witnesses.** Some states have specific standards for medical experts, requiring that they be of the same specialty as the physician being sued, or that the experts actually be practicing physicians. An example is a law providing that the expert witness must practice or have training in diagnosing or treating conditions similar to those of the patient and must devote at least 60% of his or her professional time to clinical practice or teaching in their field or specialty.<sup>4</sup>

**Pre-Trial Screening of Cases.** Another common state response is requiring malpractice cases to be screened by a medical review panel, mediation office, or some other panel or official before the cases go to court. Pre-trial review is intended to identify cases that lack merit (although the lawsuits generally are not precluded from moving forward by such a finding) and to encourage the parties to settle the case without litigation. Some states permit the results of the pretrial review to be admitted as evidence if the case

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<sup>4</sup> West Virginia Code §55.7B.7.

proceeds to court, while other states do not. Alaska, for example, requires review of filed cases by an expert panel appointed by the court, with the findings admissible at trial.<sup>5</sup>

**Alternative Dispute Resolution.** A number of states have also established alternatives to going to court, called Alternative Dispute Resolution procedures. For example, some states permit physicians to require that disputes with their patients will be resolved by arbitration rather than by judicial process. Another approach is to make arbitration voluntary, but to enforce arbitration agreements when they are made or at least permit the findings to be introduced into court. Connecticut, for example, does not require malpractice cases to go to arbitration, but if both sides agree to do so, the case will go to a screening panel of one lawyer and two physicians. The panel can make a finding as to whether or not there is any liability; if the decision is unanimous, it is admissible in any subsequent trial.<sup>6</sup>

### **How Much Money Should Be Awarded to Plaintiffs or Paid to Lawyers?**

**Limits on Damages.** Perhaps the most contentious set of issues deals with the amount of damages awarded in medical malpractice cases. The most straightforward part of the damage calculation would seem to be adding up the actual out-of-pocket losses that resulted from a negligent injury. These would include lost wages, medical care expenses, and other actual economic losses. Although it is simple in theory to measure economic losses, it in reality can become somewhat complicated when trying to estimate how much a person would have earned far into the future, or what medical or long term care they might need and how much it would cost many years after their injury.

As difficult as calculating economic losses are, the more controversial part of calculating damages is estimating the dollar value of non-economic losses. In particular, there is substantial disagreement over the way to measure

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<sup>5</sup> Alaska Statutes §09.55.536.

<sup>6</sup> Connecticut General Statutes, Chapter 697 §§ 38a-33 and 38a-36.

the “pain and suffering” that resulted from the injury. Deciding how much money it would take to compensate someone for a humiliating appearance or chronic pain or some other non-economic harm is a highly subjective determination. Consequently, the dollars that are awarded by different juries for similar injuries can vary substantially, raising the criticism that non-economic damage awards are too arbitrary to be fair. In particular, physicians often feel that juries respond to the plight of the injured person and make large financial awards irrespective of whether the person’s misfortune was actually the result of substandard medical care, simply because physicians and their insurance companies are seen as “deep pockets” that can be tapped to ameliorate that misfortune.

Another aspect of damage awards that has become highly contentious is the perception that some large awards are extraordinarily out of proportion to the injury suffered. As such, the awards appear not really to be to compensate the person, which is proper under the law of negligence, but would be to punish the physician for their behavior. In general, “punitive” damages are not supposed to be awarded in medical malpractice cases.

The size of damage awards has become a major focus of state legislative changes. The principal response has been to put a limit on the amount of money that could be awarded in a malpractice suit. These statutory limits are generally known as “caps.” Previously, juries were largely free to award winning plaintiffs as much as they thought was appropriate, limited only by constraints on sums that amounted to punitive damages. Legislated caps, however, have restricted the size of awards well below that level. Several states have limited the total recovery available to plaintiffs. A larger number of states have imposed caps on non-economic damages; in some of these states the caps are absolute for all non-economic damages (e.g., cap of \$250,000 for non-economic damages) while in others the amount that may be recovered may vary based on the injury (e.g., cap does not apply in cases of permanent loss of bodily function or substantial disfigurement) or the type of conduct (e.g., cap may not apply in cases arising out of willful or reckless conduct).

**Attorney Compensation.** The way that lawyers representing injured parties are paid in most medical malpractice cases has also generated a great deal of controversy. In this country, people on each side of a lawsuit are generally responsible for paying their own lawyers. This is also true in medical malpractice cases. But in most legal cases, each party knows that they must pay their lawyers whether they win or lose, and this serves as a financial barrier to filing frivolous or small lawsuits. In medical malpractice, however, the lawyers representing patients usually receive a fee only if their client wins the case. This is known as a “contingent fee” arrangement. In addition, the fee is not a set dollar amount or an hourly fee, but instead is a percentage of the award.

Attorneys who take these cases know that they might not get paid. This has several consequences. It means that lawyers are most likely to take cases that they think they will win and that they think will result in large verdicts. Traditionally, lawyers argued that this meant that they screened out cases that were not meritorious, since they would not want to risk wasting their time for free. But physicians feel that more often it means that lawyers will bring cases without merit but involving a seriously injured person simply because a highly sympathetic victim can lead to an award regardless of the quality of medical care involved. Moreover, physicians feel that the high costs of defending lawsuits has generated a likelihood that their own malpractice insurance company will “reward” and indeed encourage non-meritorious lawsuits by settling them when the insurer thinks settlement would be less costly than defending the case.

The contingent fee arrangement also means that lawyers must take a large enough share of the damages when they win to offset the probability that they will get nothing from other lawsuits that they lose. Typically, this means that the lawyer will end up with 33%–50% of the total award. In large cases that settle quickly, this produces substantial payouts to lawyers for what seems to be very little effort. The financial interest that lawyers have under the contingent fee system has become a major source of controversy among physicians. It has also stimulated significant opposition by lawyers to caps on damage awards or any change in the way damages are calculated. For example,

if damages were to be strictly limited to actual monetary losses, the contingent fee would reduce the injured person's recovery below their actual out-of-pocket loss by whatever amount was paid over to the lawyer.

The contingent fee arrangements have led to tort law changes that target the amount of money paid to the lawyers who brought the lawsuit. A number of states restrict the attorney's contingent fees to no more than a specific percentage of the total award, sometimes with the percentage decreasing as the size of the award increases. For example, California limits contingent fees to 40% of the first \$50,000 of damages, 33 1/3% of the next \$50,000, 25% of the next \$500,000, and 15% of damages exceeding \$600,000.<sup>7</sup>

### **How Should Damages Be Paid, and by Whom?**

**Joint and Several Liability.** Another contentious issue in the debate over medical malpractice law has been the extent to which negligent defendants can be required to pay damages for injuries caused by another negligent defendant. Traditionally in the tort system, any defendant who is found to have been responsible for a negligent injury can be required to pay the full amount of an award, regardless of how many other defendants were also at fault.<sup>8</sup> Under this rule, all negligent defendants are subjected to what is called "joint and several" liability. If one or more defendants cannot pay for their share of an injury, the rule of joint and several liability permits the injured person to collect the missing shares from other negligent defendants who can afford to pay. The principle behind the rule is that it is fairer to require a negligent party to pay more than their share of an injury than to deny compensation to the innocent (or less negligent) victim of injury.

Concerns have arisen that this rule has been applied unfairly, requiring defendants who may have played only a minor role in someone's injury to pay the entire award because they had the most money. Also, this rule is seen to

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<sup>7</sup> California Business and Professions Code §6146.

<sup>8</sup> Such a defendant can generally try to force the other defendants to reimburse them in proportion to each one's share of the fault.

have created an incentive to sue as many defendants as possible, particularly large institutions such as hospitals, to make sure someone has sufficient assets to pay the damages. These concerns have generated state laws that limit who can be required to pay an award for negligence when there was more than one possible defendant, and laws controlling how much each defendant may be required to pay. Kansas, for example, limits the amount of damages from any defendant to the portion of the injury caused by that defendant.<sup>9</sup> In Pennsylvania, any defendant that is found responsible for 60% or more of an injury is jointly responsible for the entire amount; defendants who are responsible for smaller shares of an injury are only responsible for their own share of the injury.<sup>10</sup> Ohio has another variant on this theme: a defendant determined to have negligently caused more than 50% of an injury is jointly responsible for the entire amount of any economic loss but is responsible only for his share of any non-economic loss.<sup>11</sup>

**Lump Sum or Periodic Payments.** Defendants who are found to have negligently injured a person often must pay all of the damages that are owed in a lump sum at the end of the legal action. Since awards often include estimated future losses, such as lost income or future medical expenses, some argue that it is unfair to require the defendant to pay all the damages immediately. Another issue is whether a defendant should be required to pay for estimated future damages that never materialize. These concerns have led to state laws that permit either party to elect that some damage awards (e.g., damages awards over \$250,000) be paid periodically rather than as a lump sum. Some states, such as Florida, may require security for the future amounts.<sup>12</sup> States also may permit a defendant to cease payments if anticipated losses do not occur (e.g., periodic payments for damages other than lost earnings may cease if the plaintiff dies).<sup>13</sup>

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<sup>9</sup> Kansas Statutes § 60-258a(d).

<sup>10</sup> 42 Pa. Cons. Stat. § 7102(b.1).

<sup>11</sup> Ohio Revised Code § 2307.22.

<sup>12</sup> Florida Statutes § 768.78(2)(b)2.

<sup>13</sup> See, for example, Utah Code § 78-14-9.5(6).

**Recoveries from Collateral Sources.** Fairness concerns have also arisen over the longstanding practice of letting injured persons collect the full amount of judgments in lawsuits even if part of their losses also are paid for by insurance or some other source. These other sources of payment are often referred to as “collateral sources.” The argument for not reducing a plaintiff’s award by amounts received from collateral sources rests in part on the view that a negligent defendant should not benefit from actions that the plaintiff has taken to protect him or herself. A number of state laws, however, address this issue. Some states require that malpractice awards be reduced by amounts received from collateral sources, adjusted by any insurance premiums or other costs that the plaintiff bore.<sup>14</sup> Another approach is to permit defendants to present evidence to the jury about amounts available from collateral sources, permitting the jury to consider whether or not to take the amounts into account in determining the damages owing. In some states, the treatment of collateral source payments varies by the source (e.g., in Tennessee, payments by government programs or employer–sponsored insurance are considered collateral sources and will offset a jury award, but amounts paid by insurance held directly by the plaintiff do not count to reduce a jury award.)<sup>15</sup>

### **How Much Time Should People Have to Bring Lawsuits?**

**Statutes of Limitations.** Another area where states have passed new laws relates to the length of time that patients have to file a malpractice suit after the event that gives rise to the action. This period is called the “statute of limitations.” Most types of legal actions are subject to statutes of limitations. They serve several purposes, such as helping to assure that relevant facts and potential witnesses will be available and current when the dispute is adjudicated, and providing potential defendants with some certainty that they will not be held responsible for actions that occurred long ago. At the same time, some injuries do not manifest themselves immediately, so statutes of limitations often have special provisions that extend the period for bringing a

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<sup>14</sup> See, for example, Florida Statutes § 768.76.

<sup>15</sup> Tennessee Code § 29– 26–119.

lawsuit for some period after the injury should reasonably have been discovered.

Statutes of limitation address the issue of “certainty,” which has been an important consideration for states looking at the affordability of malpractice coverage. Malpractice insurance companies need to have sufficient reserves to cover potential lawsuits, and the longer the period of time for possible cases to arise, the greater the outstanding liability that insurers have to be prepared for. So, prolonged uncertainty about whether or not a patient will sue for malpractice affects the premiums that malpractice insurers charge. Many states have shortened the amount of time someone has to bring a lawsuit. Some of the new laws start the time clock from the moment an injury occurred whether it is apparent at that point or not, while others don’t impose a time limit until people have had a reasonable period to discover their injury. Nebraska, for example, requires that a plaintiff bring an action within two years of the act giving rise to the injury, or within one year after the injury should reasonably have been discovered.<sup>16</sup> A different and more limiting variant is an Illinois state law that requires that an action be brought within two years of the discovery of an injury, but no later than four years after the negligent act.<sup>17</sup> Some states extend the limitation periods in cases of injuries to young children or for injuries involving foreign objects or concealment by the defendant.<sup>18</sup>

### **Newer Proposals for Statutory Reforms of Malpractice Litigation**

In addition to the tort law changes discussed above, several more recent proposals have been made at the state or national level with potential implications for patients and providers. Laws have been enacted in a few states in one of these newer areas, while others have only been discussed in academic journals.

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<sup>16</sup> Nebraska Revised Statutes §25.222.

<sup>17</sup> 735 Ill. Comp. Statutes § 5/13-212(a).

<sup>18</sup> See, for example, 735 Ill. Comp. Statutes § 5/13-215, which extends the time for bringing an action in cases of fraudulent concealment.

**Patient Compensation Funds.** A variation on “caps” on the size of awards has been to limit the liability of individual physicians, while providing for additional payments to injured patients from sources other than the physician or the physician’s malpractice insurance carrier. A number of the states have established Patient Compensation Funds or state–operated malpractice insurance pools. Regardless of the size of an award against them, physicians generally are responsible for only a certain amount of damages. The rest of the award comes from the Patient Compensation Fund. This helps physicians by limiting their individual financial exposure and the amount of liability insurance they have to buy. In South Carolina, for example, the fund will pay amounts over \$200,000 per incident or \$600,000 per year.<sup>19</sup> States have taken different approaches to subsidizing the funds, including surcharges on physicians and general revenues. These funds may co–exist in a given state with caps on the size of awards.

**Aligning Malpractice Law and Patient Safety Concerns.** An emerging issue is the perceived conflict between the medical malpractice system and developing efforts to improve the quality of care and patient safety.<sup>20</sup> A series of major reports from the Institute of Medicine and others have pointed out serious deficiencies in the quality of medical care delivered in this country, with high rates of medical error causing harm or death. These studies and similar ones have generated interest in systematic changes in the way medical care is delivered that would minimize the risks to patients and improve overall quality. Proponents of these changes believe that most injuries to patients and defects in quality are not the fault of individual acts of negligence, but instead result from the failure to have adequate systems in place to prevent inevitable human error from creating harm. They argue that medical malpractice, which is built on the concept that someone was careless and should be held accountable, is a barrier to creating systems of oversight that reward, rather than penalize, open recognition of errors.

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<sup>19</sup> South Carolina Code § 38–79–420.

<sup>20</sup> Mello, Michelle M. *Malpractice Liability and Medical Error Prevention: Strange Bedfellows?* Paper prepared for the Council on Health Economics and Policy conference on Medical Malpractice in Crisis: Health Policy Options, March 2003.

These discussions have led to scholarly reports that suggest reforms that link tort law changes to systematic improvements in quality assurance and patient safety. One idea that has been put forward would link the benefits of tort reforms, such as caps on medical malpractice actions, to physician participation in error reduction efforts, such as adverse event reporting. A more far-reaching approach would eliminate the fault-based system of medical malpractice and replace it with a no-fault system that compensates injured patients for injuries that result from “preventable” errors. Although determining what may have been “preventable” may appear to retain a notion of negligence, the concept is consistent with the principle that most errors are system-based rather than attributable to individuals.

While discussed widely in scholarly journals, the no-fault approach has yet to be adopted by any state. In part, this stems from concerns that systematic approaches to error reduction would be shielded from possible discovery and not available to be used in malpractice cases, thereby curtailing patient rights without actually leading to effective improvements in quality or more effective compensation of injured persons. In addition, tort reform discussions in most states have largely been around competing views from organized medical groups and trial lawyers and have not directly involved proponents of the quality improvement and error reduction position.

**Expanding Risk Pools.** Since medical malpractice has developed on a state-by-state basis, the insurance coverage for malpractice has reflected the differences among the states. In many states, the majority or all of the malpractice insurance is provided through companies owned by the medical association or other physician groups. Many large hospitals and physician groups are self-insured, meaning they pay their own malpractice expenses up to a certain limit and only buy what is known as re-insurance to cover losses above that point. Even when an insurance company sells malpractice insurance in multiple states, premiums are still based on the expected experience of physicians within a single state or an even smaller geographic area. As a result, the differences in medical malpractice law among the states can lead to substantial differences in the cost of malpractice insurance from one state to another, even for the same specialty, and to wide fluctuations from year to year.

No measures that would broaden and thereby stabilize physician risk pools have been identified.

**Prudent Physician Standard of Care.** As noted above, the performance standard physicians are held to has largely moved from a local to a national one. In either case, the standard of care was still based on what other physicians would consider accepted medical practice. Some courts, however, have held physicians to a standard that reflects what was possible, given the state of medical science and technology, even if very few or even no physicians actually practiced at that level. The first notable case to follow this approach was some thirty years ago,<sup>21</sup> but in the intervening years there have been very few other cases that did so. Only a few courts have imposed this approach, which considers that physicians are not being reasonably prudent in delivering care if they simply practice in the accepted way when better care is possible. This potential shift in expectations, and the increased likelihood of being found negligent, has emerged as a serious concern for physicians, but has not taken widespread hold as a statutory reform.

**Enterprise Liability.** The Clinton health reform proposal in 1993 included a number of the malpractice reforms outlined above. The most far-reaching and contested proposal was one that was considered during the planning stages but did not appear in the final legislation. That malpractice reform would have shifted liability from physicians to health plans and other enterprises, an approach known as “enterprise liability.” This approach was consistent with the direction of the Clinton plan, under which physicians and other providers were to be affiliated with only one or a few health plans. It is not as easily applied under the current structure of our health care system, since physicians may have many such affiliations, or they may have no managed care contracts at all. Enterprise liability has received some attention in the academic literature, but has not been enacted as such thus far. Some states have attempted to hold health plans accountable for harm that results when the plan in effect makes “medical decisions,” but those laws do not shift liability away from the physician who acts negligently.

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<sup>21</sup> Helling v. Carey, Supreme Court of Washington, 83 Wn.2d 514; 519 P.2d 981, 1974.

## Trends in Medical Malpractice Claims and Payments

This section presents trend data nationally and for states on the number of malpractice claims and average and total claims costs. Getting comprehensive data on medical malpractice trends in the United States is a challenging task because most claims tracking systems are maintained by individual states or private insurance companies, and confidentiality provisions severely limit access to these data. We rely on two different data sources to provide information on U.S. trends. The first source – the National Practitioner Data Bank (NPDB) – is a national database maintained by the Health Resources and Services Administration (HRSA) in the federal Department of Health and Human Services. The NPDB was mandated in 1986<sup>22</sup> and began collecting data on September 1, 1991. Since its inception, the NPDB has accumulated data on approximately 200,000 medical malpractice payments made on behalf of physicians. The second source – the Physician Insurers Association of America’s (PIAA) Data Sharing Project – is a private database maintained by PIAA for the purpose of tracking industry trends. PIAA data are used primarily by insurance company members of PIAA to examine trends in the medical conditions, procedures, and practices that give rise to medical malpractice claims.<sup>23</sup> This database can provide more detail than NPDB data, but on a more limited set of claims and physicians. While each of these data sources has limitations, analyses of these data provide important insights concerning recent trends in medical malpractice claims and payment rates.<sup>24</sup>

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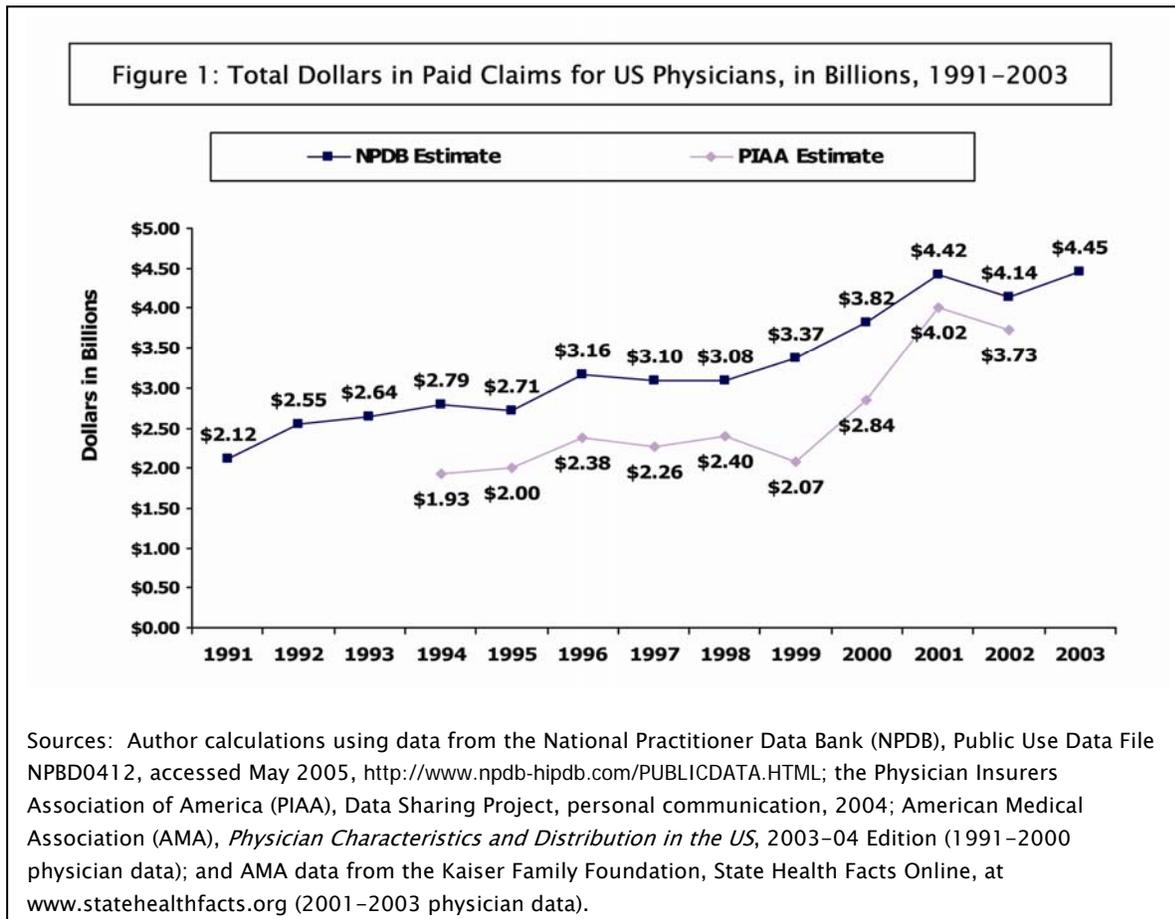
<sup>22</sup> Title IV of P.L. 99-660, the Health Care Quality Improvement Act of 1986, as amended.

<sup>23</sup> Smarr LE. A Comparative Assessment of the PIAA Data Sharing Project and The National Practitioner Data Bank: Policy, Purpose, and Application. *Law and Contemporary Problems* 1997 Vol. 60, No.1:59-79.

<sup>24</sup> Critics of the NPDB data note that multiple reports for the same claims payment are possible and that some data elements are inconsistently coded (see, for example, U.S. General Accounting Office: *National Practitioner Data Bank: Major Improvements Needed to Enhance Data Bank’s Reliability*. Washington, DC: GAO Report GAO-01-130, Nov 2000). Other data support the quality of NPDB data. See, for example, Waters TM, Parsons J, Warnecke R, Almagor O, Budetti PP, “Usefulness of Information Provided by the National Practitioner Data Bank,” *The Joint Commission Journal on Quality Improvement*, 2003, 29(8): 416-424. The limitations of the PIAA data stem primarily from its less than national coverage.

## Total Dollars in Paid Claims

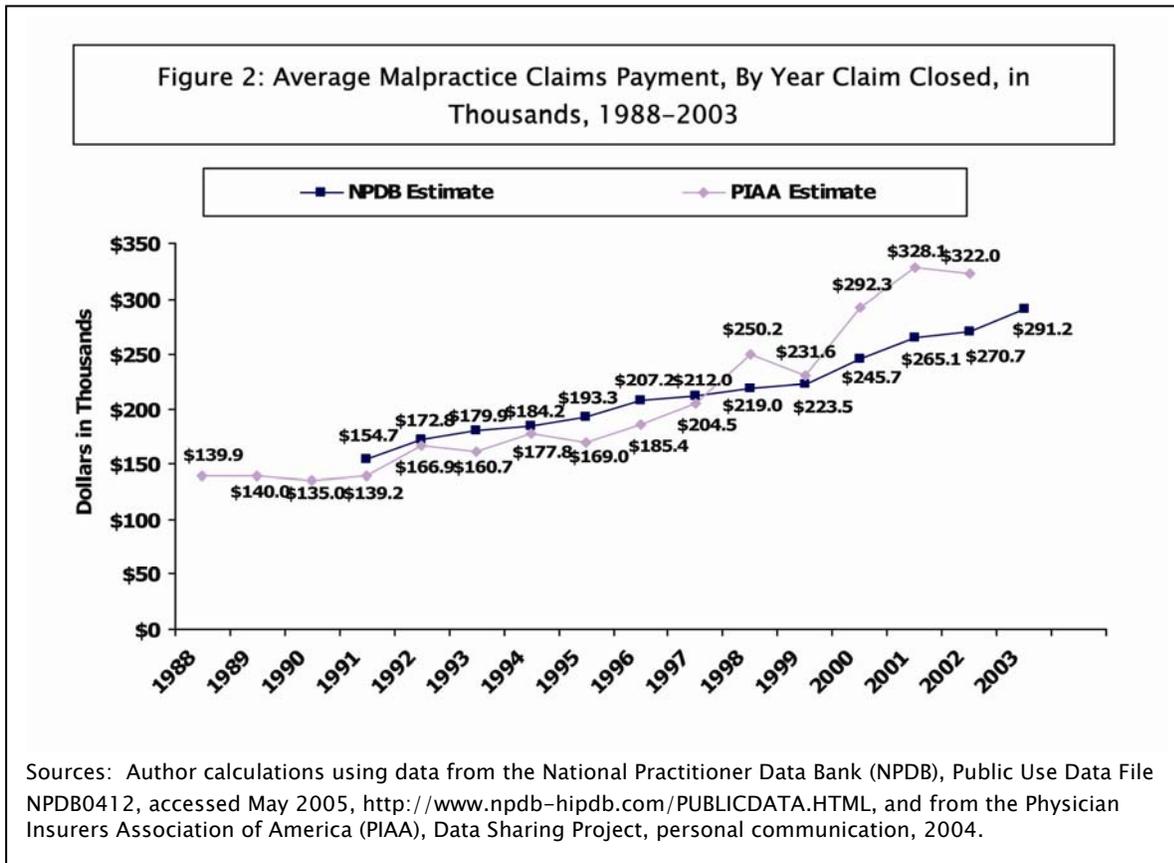
Figure 1 shows the total medical malpractice payments for physicians for the years 1991 through 2003 (the PIAA data begins in 1994 and ends in 2002). Total payments on medical malpractice claims rose substantially during the 1990s and early 2000s. According to the NPDB, total payments for physician medical malpractice claims in the U.S. more than doubled between 1991 and 2003, rising from \$2.12 billion in 1991 to \$4.45 billion in 2003. Extrapolating from PIAA data,<sup>25</sup> a second set of estimates was created for the years 1994–2002. While these estimates are somewhat lower than those derived from NPDB data, they generally parallel the NPDB trend. Together, these data highlight the increase in total claims payment over the last decade.



<sup>25</sup> Extrapolation made by multiplying the ratio of all active US physicians (AMA data) to the number of physicians covered by the PIAA data (PIAA Data Sharing Project).

## Average Claims Payments

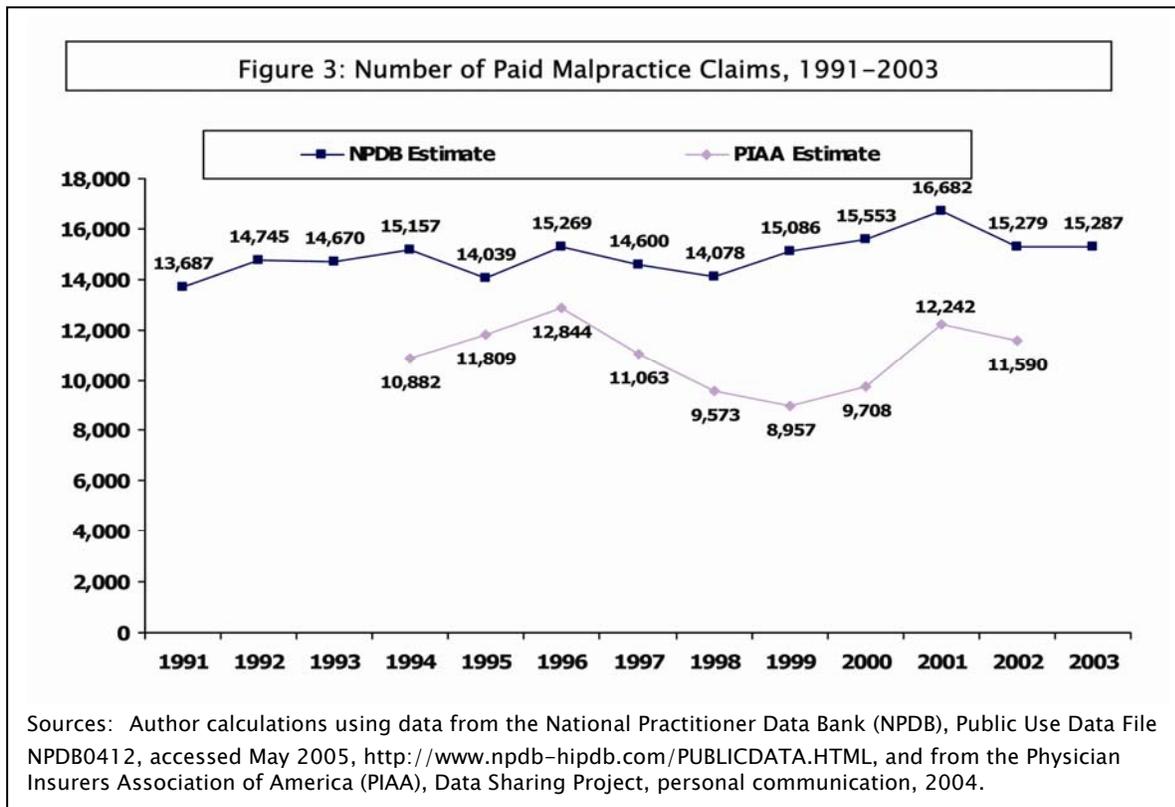
Figure 2 shows the average payment for a physician medical malpractice claim for the years 1991 through 2003 (1988–2002 for PIAA). The average claim rose significantly over the period: between 88% (NPDB estimate, 1991–2003) and 131% (PIAA estimate, 1991–2002).



## Number of Paid Claims

Figure 3 presents the number of paid medical malpractice claims each year from 1991 to 2003 (1994–2002 for PIAA). Both the NPDB data and the PIAA suggest that there has been at most a modest increase in the number of paid claims over the last decade. Considering just the start and end points of the data, NPDB data would indicate a 12% increase in the number of claims,

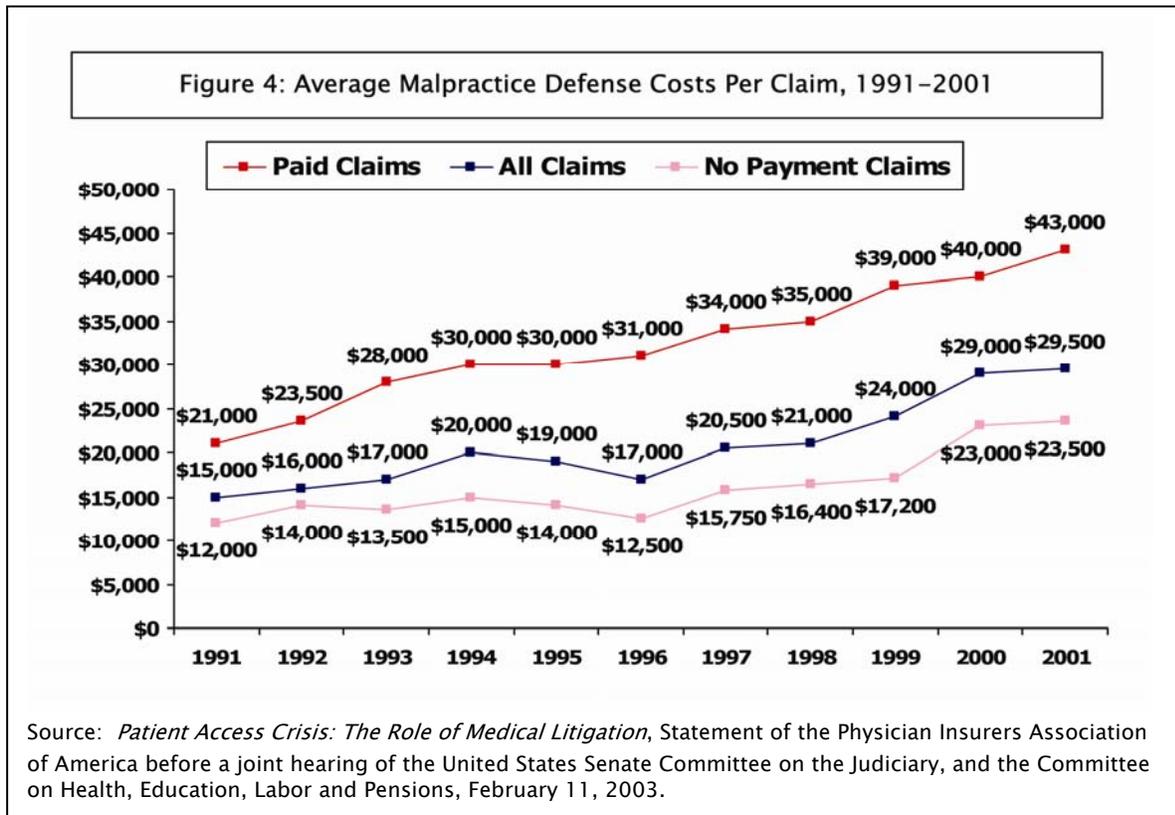
rising from an estimated 13,687 paid physician claims in 1991 to 15,287 in 2003 (see Figure 3), while the PIAA data also show a modest increase, from 10,882 in 1994 to 11,590 in 2002, a 7% increase. Looking at the trend lines over the entire period, however, there does not appear to be consistent growth in the number of paid claims.



### Average Defense Costs Per Claim

Every medical malpractice claim levied against a physician—including those that result in no payment—results in sizeable “defense costs” on the part of the malpractice insurer or defendant (legal fees, expert witness costs, other handling fees). Figure 4 shows PIAA data on the average defense costs per medical malpractice claim for the period 1991 to 2001. These costs parallel the pattern for total and average claim payments, rising rapidly since 1991 (see Figure 4). In 1991, defense costs were approximately \$15,000 per physician claim. In 2001, these costs had risen to approximately \$29,500. Defense costs

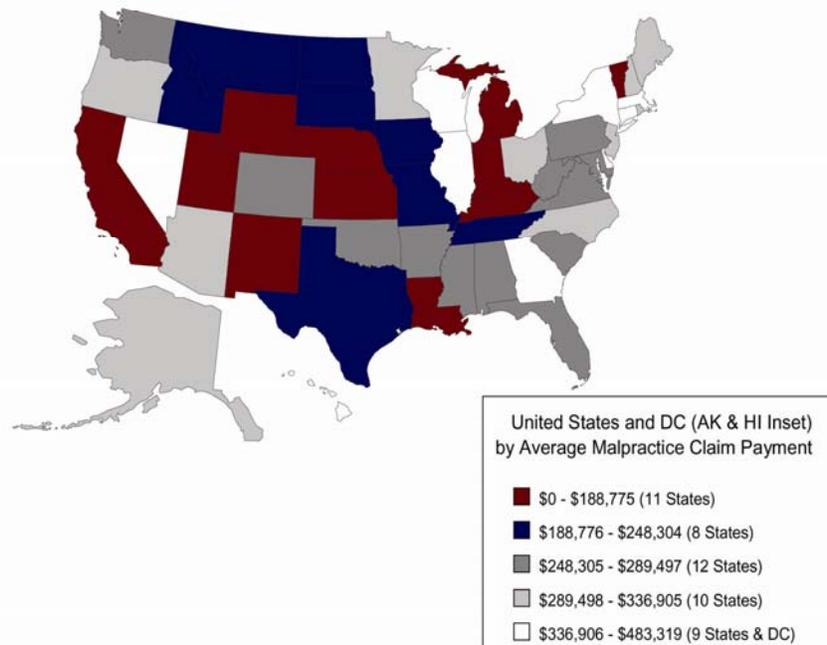
for paid claims more than doubled from \$21,000 in 1991 to almost \$44,000 in 2001, while defense costs for claims with no payment (61% of all claims) almost doubled from \$12,000 to \$23,500.



### Variation Across States

While the general trend in the U.S. has been increasing medical malpractice costs, it is important to note that there is considerable variation across states in the severity of the trend. Figure 5 illustrates the magnitude of the variation in average medical malpractice payment (per physician claim) using NPDB data for the years 2001-2003. For those years, the U.S. average payment was \$276,235 (based on NPDB data), but that payment ranged from a low of \$121,313 for the state of Michigan to a high of \$483,319 for the state of Connecticut.

Figure 5: Average Malpractice Claim Payment, By State, 2001–2003



Source: Author calculations using data from the National Practitioner Data Bank (NPDB), Public Use Data File NPDB0412, accessed May 2005, <http://www.npdb-hipdb.com/PUBLICDATA.HTML>.

Different states have also had significantly different experiences with medical malpractice costs over time. Some states have experienced relatively modest growth, even in recent years, while others have faced rapidly escalating average and total medical malpractice payments. Figures 6 and 7 illustrate the experience of selected states. Figure 6 focuses on the experience of several high (total) expenditure states (California, Florida, Illinois, New Jersey, and Texas) between 1999 and 2003. While all five states saw increases in their malpractice costs, there are striking differences between the experiences of Florida (66% increase between 1999 and 2003 but relatively stable in the early 2000s), New Jersey (47% increase with highly volatile year-to-year changes), and California (11% increase and reasonably stable over the time period).

Figure 7 focuses on the experience of several low (total) expenditure states (Indiana, Kansas, New Mexico, South Carolina, Wisconsin). While several of these states experienced increases in payments (Indiana, 145% increase; South Carolina, 81% increase), others actually saw declines in their total payments (Kansas, 26% decrease; New Mexico, 25% decrease).

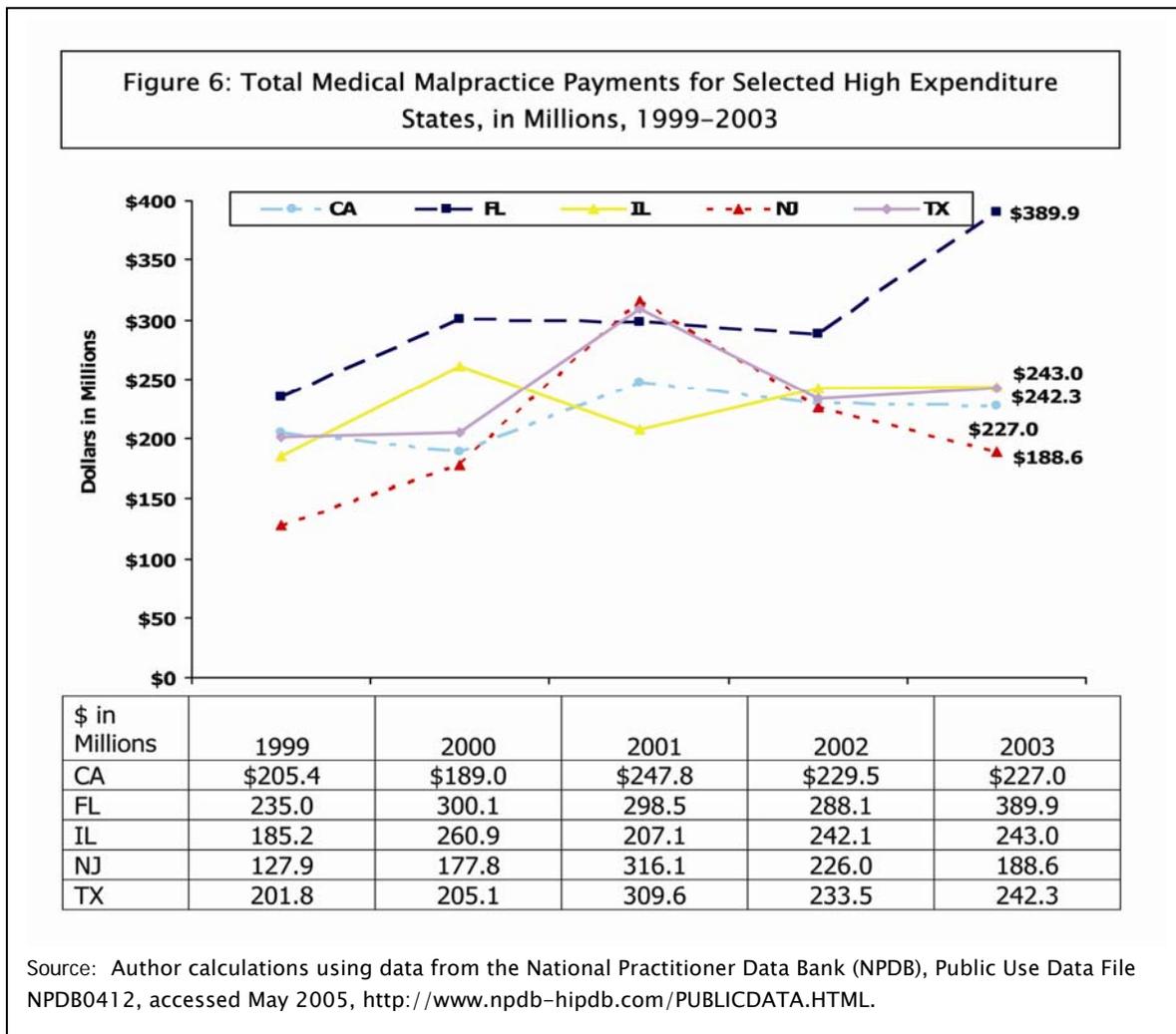
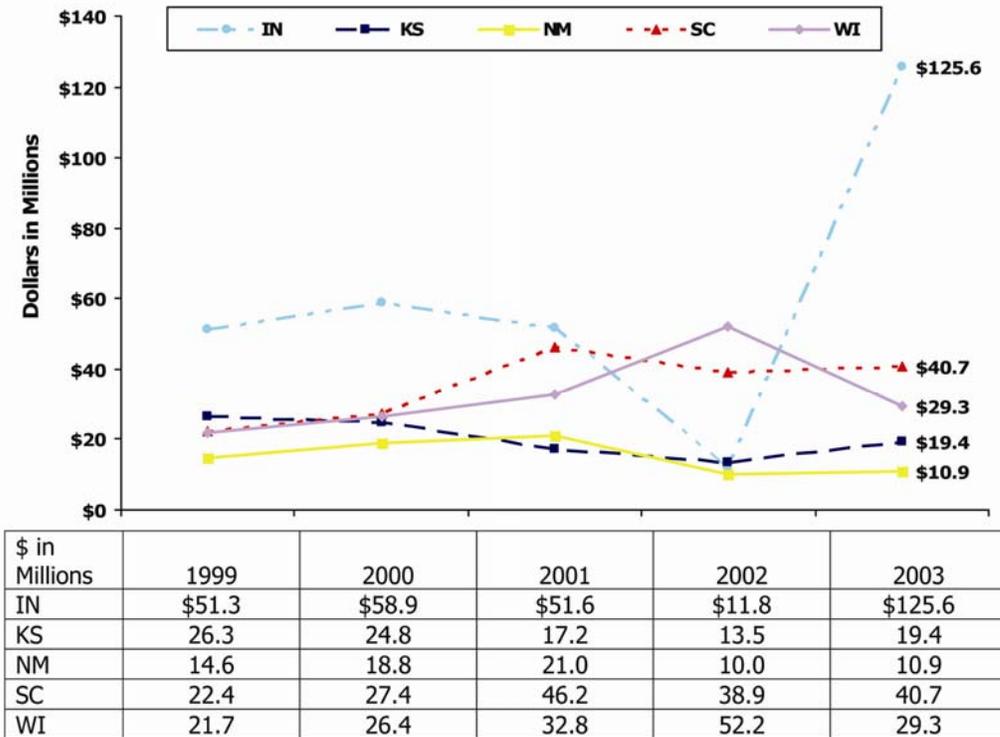


Figure 7: Total Medical Malpractice Payments for Selected Low Expenditure States, in Millions, 1999–2003

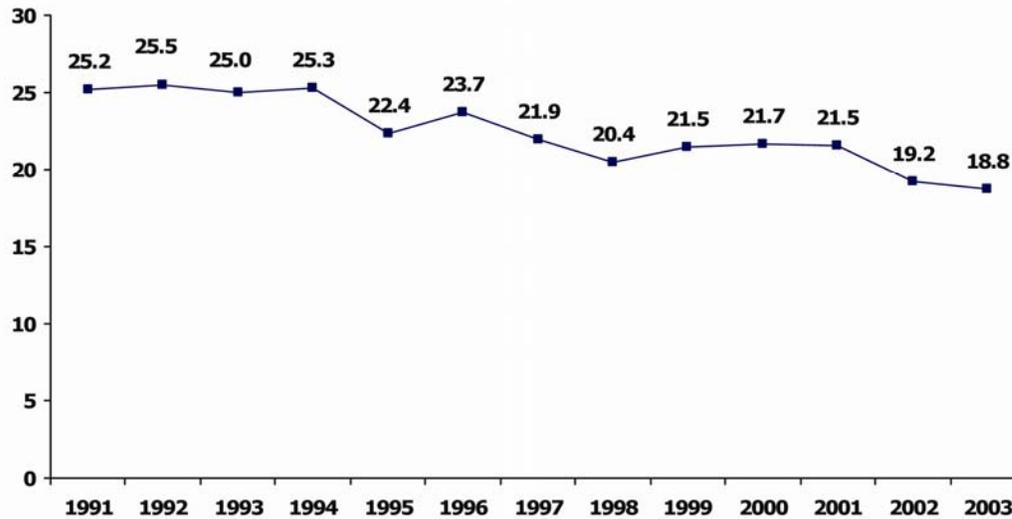


Source: Author calculations using data from the National Practitioner Data Bank (NPDB), Public Use Data File NPDB0412, accessed May 2005, <http://www.npdb-hipdb.com/PUBLICDATA.HTML>.

### Rising Number of Physicians

Between 1992 and 2003, the estimated number of U.S. non-federal physicians rose from 623,378 to 814,909, which is an increase of almost 31% (AMA data). Given that the average number of paid claims rose only modestly over the period (Figure 3), the increase in the number of physicians means that the average number of claims per physician in the U.S. fell relatively steadily over the period (see Figure 8).

Figure 8: Average Number of Paid Medical Malpractice Claims Per 1,000 Active, Non-Federal Physicians, 1991–2003

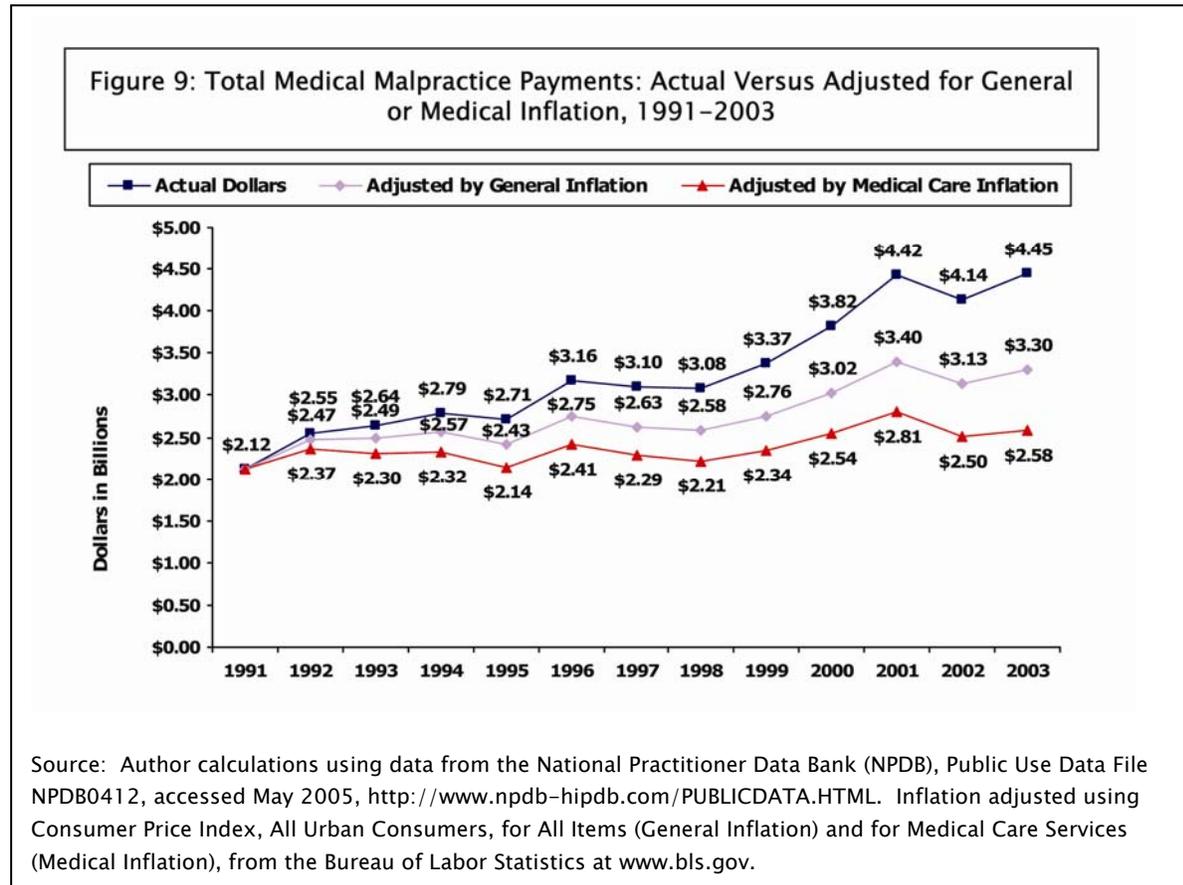


Source: Author calculations using data from the National Practitioner Data Bank (NPDB), Public Use Data File NPDB0412, accessed May 2005, <http://www.npdb-hipdb.com/PUBLICDATA.HTML>; American Medical Association (AMA), *Physician Characteristics and Distribution in the US*, 2003–04 Edition (1991–2000 physician data); and AMA data from the Kaiser Family Foundation, State Health Facts Online, at [www.statehealthfacts.org](http://www.statehealthfacts.org) (2001–2003 physician data).

## General Inflation and Health Care Inflation

Figure 9 shows the impact of adjusting the medical malpractice payment amounts for inflation. Total medical malpractice payments rose 110% between 1991 and 2003 (an average annual increase of 6.4% per year). During that same period, however, overall prices rose 35% (CPI–All Items), while the cost of medical care services rose 73% (CPI–Medical Care Services). If we adjust total

medical malpractice payments for general inflation, the increase between 1991 and 2003 falls to 56% (an average annual increase of 3.8%); adjusting for medical care inflation, the increase falls to 22% (an average annual increase of 1.7%).



## Summary and Conclusion

Medical malpractice law in the United States has undergone numerous changes in the past three decades. Most notably, while medical malpractice law and lawsuits had traditionally been handled under principles of court-made Common Law, state legislatures have enacted a variety of statutes that change or clarify many of those principles.

These statutes were designed to address a series of policy issues that emerged with respect to medical malpractice law. Concerns over who should evaluate the adequacy of care led to controls on the requirements to serve as an expert witness, to the establishment of pre-trial screening panels with some level of medical expertise, and to alternative dispute resolution procedures such as arbitration and mediation to minimize the likelihood of ending up in court.

One of the principal issues that states have sought to address is how much money should be awarded to plaintiffs or paid to lawyers. Many states have now instituted statutory limits on damages and on attorney compensation. Some states have also addressed a related set of issues dealing with how damages should be paid and by whom. In this area, legislatures have enacted changes in the rules governing joint and several liability, whether damages would be made in lump sum or periodic payments, and the extent to which collateral sources of payments would reduce damage awards.

Another substantial area of tort reform has addressed how long people would have to bring lawsuits. Many states enacted changes to their statutes of limitation, usually shortening the period available to bring suit.

In addition to the main areas in which state laws have been modified in recent decades, a number of newer proposals for tort reform have emerged, only one of which has actually been adopted in some states. Patient compensation funds now exist in a few states; these funds serve to subsidize payments from traditional malpractice insurance and thereby reduce pressure on premiums. On the other hand, despite a substantial theoretical literature

supporting the aligning of malpractice law with patient safety reforms, no states have enacted such legislation. Similarly, no movement was found toward expanding malpractice insurance risk pools beyond state lines or replacing individual with enterprise liability.

Analysis of trends in medical malpractice claims and payments reveals that the total dollars in paid physician medical malpractice claims have approximately doubled in the past decade. Average defense costs per claim have increased substantially, also doubling. As expected, there is substantial variation across states in these measures.

Further analysis shows the growth in dollars paid on malpractice claims is mainly due to increases in the average size of claims. The total number of paid claims has been relatively stable, despite a sizeable increase in the number of physicians. The overall increase in total medical malpractice payments was only slightly above the rate of medical care inflation, but somewhat greater than the general rate of inflation.

The impact of medical malpractice law reform on the appropriateness of malpractice awards, rising malpractice premiums, and the availability of coverage is often unclear. And while medical malpractice continues to be a focus of state legislatures, the U.S. Congress, and the Bush Administration, little agreement exists on what approach best addresses the problems of medical malpractice. Whether reform of tort law or changes in the malpractice insurance system provides better solutions is debated. But better understanding of these complex systems and their interaction could lead to the most appropriate proposals for change.



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