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GAO

Report to Congressional Requesters

April 1987

MEDICAL MALPRACTICE

Characteristics of Claims Closed in 1984

GAO/HRD-87-55

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GAO

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General Accounting Office
Washington, D.C. 20548

Human Resources Division

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April 22, 1987

The Honorable John Heinz
Ranking Minority Member
Special Committee on Aging
United States Senate

The Honorable John Edward Porter
House of Representatives

In response to your requests and later discussions with your offices, we have undertaken a major effort to review the medical malpractice situation in the United States This report, the fourth of a series we plan to issue on medical malpractice, contains information on the characteristics of a sample of malpractice claims closed during 1984

The first report, Medical Malpractice: No Agreement on the Problems or Solutions (GAO/HRD-86-50, Feb 24, 1986), provided the views of major interest groups on the nature of malpractice problems and alternative approaches for resolving claims The second report, Medical Malpractice: Insurance Costs Increased but Varied Among Physicians and Hospitals (GAO/HRD-86-112, Sept. 15, 1986), contained information on the cost of malpractice insurance for physicians and hospitals. The third report, Medical Malpractice: Six State Case Studies Show Claims and Insurance Costs Still Rise Despite Reforms (GAO/HRD-87-21, Dec. 31, 1986), contained information on the medical malpractice insurance situation, problems, and reforms in six states (Arkansas, California, Florida, Indiana, New York, and North Carolina) Separate documents prepared as supplements to that report discussed our work in each state Our fifth report, and last in the series, will provide our recommendations concerning the medical malpractice situation.

As arranged with your offices, unless you publicly announce its contents earlier, we plan no further distribution of this report until 30 days from its issue date At that time, we will send copies to interested parties and make copies available to others upon request.

Richard L. Fogel
Assistant Comptroller General

Executive Summary

Purpose

How many malpractice claims were closed? How many health care providers were involved? What were the allega is of negligence leading to the claims? How much was paid to those who filed claims? What were insurers' costs to investigate and defend the claims? National data on malpractice claims had not been collected since 1978.

At the request of Representative John Edward Porter and Senator John Heinz, Ranking Minority Member of the Senate Special Committee on Aging, GAO undertook a review to obtain information that would assist the Congress in addressing public policy issues regarding (1) the effect of medical malpractice on the quality, availability, and affordability of health care; (2) the equity of compensation for malpractice injuries, and (3) who should be responsible for taking corrective actions The purpose of this report, the fourth in a series of five, is to present nationally representative information on malpractice claims closed in 1984

Background

To do this review, GAO analyzed data from a random sample of malpractice claim files closed in 1984 by 25 insurers. The insurers were randomly selected from a universe of 102 insurers that wrote a total of $2 3 billion in direct premiums in 1983 for medical malpractice insurance. Malpractice insurance costs for physicians and hospitals totaled an estimated $2.5 billion in 1983. Although some insurers limit their markets to a single state, the universe included at least one insurer writing medical malpractice insurance in each of the 50 states and the District of Columbia.

Results in Brief

In 1984 the 102 insurers closed an estimated 73,500 medical malpractice claims involving about 103,300 health care providers. About 43 percent of the claims were closed with an indemnity payment These payments totaled $2.6 billion and ranged from $1 to $2.5 million. The median and average payments were $18,000 and $80,741, respectively Claims closed with indemnities of $250,000 or more (about 9 percent of the paic claims) accounted for 61 percent of the total indemnity. (See pp 18 to 20.)

In addition, insurers paid $807 million to investigate and defend all of the claims closed in 1984. These costs ranged from $0 to $983,810 The median and average costs were $2,390 and $10,985, respectively (See pp. 20 and 21)

Eighty percent of the claims resulted from injuries that occurred in a hospital Three-quarters of the claims involved surgical, diagnostic, treatment, and obstetrics errors (See pp 22 to 25)

For the approximately 31,800 claims closed with payment, insurers often did not know the portion of paid claims that related to economic losses, noneconomic losses, and attorney's fees, however,

- for about 18,300 claims for which economic losses could be estimated, injured patients recovered equal to or more than their economic losses in 70 percent of these claims,
- for about 15,000 claims for which the expected value of the noneconomic losses could be estimated, (1) about 62 percent of the total compensation paid for noneconomic losses was for amounts more than $200,000, but this money went to only about 2 percent of these claims and (2) compensation for noneconomic losses was between $1 and $50,000 for 67 percent of these claims that included compensation for such losses, and
- for about 16,300 claims for which plaintiff attorney's fees could be estimated, such attorney's fees equaled from 31 to 40 percent of the expected value of the indemnity in about 52 percent of these claims (See pp. 44 to 50.)

GAO's Analysis

Awards/Settlements

Indemnity varied for the 31,800 claims closed with payment. About 9 percent of the paid claims were for less than $1,000, while less than 1 percent were for $1 million or more. (See pp. 18 to 20.) The payments varied by type and severity of the injury By type, about 27 percent of the total indemnity was paid for obstetrics errors (about 10 percent of paid claims). Obstetrics errors had the highest median and average payments. By severity, about 52 percent of the indemnity was for "permanent total disabilities" (10 percent of paid claims). (See pp. 39 to 42)

Patient Injuries

About 30 percent of the patients suffered "minor temporary disabilities," about 6 percent of the injuries were "emotional," and about 15 percent of the patients died. (See p 24.)

Claim Processing and Resolution

The length of time from the injury to the claim ranged from less than 1 month to 219 months The median and average were 13 and 16 4 months, respectively About 6 percent of the claims were filed in the same month as the injury, and 6 percent were filed more than 3 years after the injury (See p 32)

For claims closed with an indemnity payment, the median time from filing to closing was 23 months The median for those claims closed without payment was 17 months. Only 0.3 percent of the claims were resolved in the same month in which they were filed Three and one-half percent ranged from 73 to 132 months from filing to closure Generally, the more severe injuries and those resulting in the largest indemnity payments took longer to resolve (See pp. 33 to 36)

Health Care Providers Involved in Claims

Of health care providers involved in malpractice claims, about 71 percent were physicians and about 21 percent were hospitals Obstetricians/gynecologists and general surgeons were the physicians most often named in claims (See pp. 52 to 55.)

Insurers often were not able to provide data related to the training, board certification, and malpractice claims history of the physicians involved in the claims closed in 1984. However, the limited data for which estimates could be made suggest that at least

- 42 percent had claims filed against them previously,
- 52 percent may have been in practice from 11 to 30 years,
- 23 percent were foreign medical graduates (about the same as their percentage representation in the physician population), and
- 51 percent were board certified in the medical specialty in which the injury occurred (about the same as the percentage of board certified physicians in the population) (See pp 56 to 58.)

Recommendations

Recommendations on the malpractice problem will be provided in the overall report to be issued shortly.

Agency Comments

GAO did not obtain comments on this report

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Abbreviations

GAO General Accounting Office
HMO Health Maintenance Organization

Introduction

Medical malpractice involves "bad, wrong, or injudicious treatment of a patient, professionally and in respect to the particular disease or injury, resulting in injury, unnecessary suffering, or death to the patient, and proceeding from ignorance, carelessness, want of proper professional skill, disregard of established rules or principles, neglect, or a malicious or criminal intent."[1]

When a patient is injured in the course of medical treatment and believes the injury resulted from negligent care by a health care provider, the patient can bring an action against the provider seeking financial compensation for the economic (special damages) and noneconomic losses (general damages)[2] resulting from the injury. According to A. Russell Localio, Director of Research, Risk Management Foundation of the Harvard Medical Institutions, the health care provider's insurer may open a claim file related to the incident for one of several reasons, such as:

- The insurer has been notified by the health care provider that an incident has occurred that may lead to a claim being filed.
- A suit for damages has been filed by the injured person (plaintiff).
- The injured person or family member has made either an oral or a written claim for damages, or a statement charging an insured with malpractice and demanding an investigation or explanation.
- An attorney has sent a letter of representation (other than a request only for medical records) to an insured or to the insurer's claims department.
- As a result of a loss arising out of clear negligence, the insurer has decided to approach a patient or family for purposes of exploring the possibility of a settlement and avoiding a likely formal claim or suit.

Once the file has been opened, the insurer may begin an investigation to gather preliminary information on the incident by having the hospital or a consultant review the patient's medical records and interviewing those involved in providing the medical care that led to the incident. From this the insurer forms an initial perception of what has happened and makes a judgment on the allocated expenses for investigation and defense and the amount of damages if the insured is liable. This amount becomes the

[1]Henry Campbell Black, Black's Law Dictionary, Revised Fourth Edition, West Publishing Co. St. Paul, MN, 1968, p. 1111.

[2]Economic losses include medical expenses, lost income, and rehabilitation expenses. Noneconomic losses include pain and suffering, marital losses, and anguish.

"reserve" associated with the case and may be adjusted as the investigation continues and the insurer's estimate of the ultimate cost of the case changes

Insurers' costs for investigation and defense consist of allocated and unallocated loss expenses The unallocated loss expenses include costs to operate the company's claims department and to pay its staff, which may include claims managers, supervisors, and adjusters These costs are not apportioned to individual cases Allocated loss expenses are those incurred in relation to specific cases and may include defense attorneys, medical experts, private investigators, public stenographers for depositions; special photography to document broken equipment, etc.; and other experts, such as engineers, pharmacists, and economists

Factors that could affect payment for economic losses include the patient's age at the time of the injury, earning capacity, medical expenses, and extent of rehabilitation services needed In addition, the award may include compensation of noneconomic losses, the value of which is a very subjective determination

When the resolution of the claim results in a payment to the plaintiff, the payment may be made in a lump sum; as a structured settlement (periodic payments) usually implemented through the purchase of an annuity; as free services; or some combination of these Ordinarily, the structured settlement is part of a package designed to cover up-front costs, such as prior medical expenses, court costs, lost income, attorney's fees, and other immediate needs as well as to provide a lifetime income with the total package tailored to meet the requirements of each specific case.[3]

Newspaper headlines about millions of dollars due to be paid over a claimant's lifetime may have no relationship to the actual dollars currently set aside by an insurance company to fund or structure a stream of benefits that will be paid periodically.[4]

Lawyers handling malpractice cases for plaintiffs usually do so on a contingency fee basis, i e., the lawyer is compensated only if an award or

[3]Donald E Danner and William J Robinson, "Structured Settlements Controlling Calamity Best's Review, November 1985, p 83

[4]James R Posner, "Trends in Medical Malpractice Insurance, 1970-1985," Law and Contemporary Problems, Spring 1986, pp 47-48

settlement results in payment to the plaintiff Generally the attorney will get a percentage of the award

A claim file is closed when (1) a claim for damages is not made, (2) the plaintiff drops the claim, (3) the insurer and plaintiff agree to a financial settlement, (4) a court renders a verdict, or (5) a settlement is reached through arbitration

Objective, Scope, and Methodology

Our work in the medical malpractice area was undertaken to obtain information that would assist the Congress in addressing public policy issues regarding (1) the effect of medical malpractice on the quality, availability, and affordability of health care, (2) the equity of compensation for medical malpractice injuries; and (3) who should be responsible for taking corrective actions. The objective of our closed claims study was to provide nationally representative data relating to cost and equity issues, such as the economic losses of injured patients in relation to awards/settlements, cost to insurers to resolve the claims, length of time it takes to resolve claims, and similarity of awards/settlements for injuries of similar severity. National data on the characteristics of malpractice claims had not been collected since 1978.

To establish a data base of claims, we collected data on a sample of claims closed in 1984 by a sample of insurers writing malpractice insurance in 1983.[5] We identified a universe of 102 insurers, which wrote malpractice insurance in the United States, consisting of 25 commercial companies, 39 physician-owned companies, 28 hospital-owned companies, and 10 joint underwriting associations. Direct premiums written by these insurers totaled $2.3 billion in 1983.[6] Included was at least one insurer writing medical malpractice insurance in each of the 50 states and the District of Columbia.

These insurers were first stratified by type of insurer and then rank-ordered by premium volume. Selection within insurer-type was random, but proportionate-to-size with larger companies having a greater

[5]Insurers define and count claims differently For this study we defined a "claim" as the incident, regardless of how many providers may have been involved or how many claim files may have been opened A claim was considered closed only if all claim files associated with the incident had been closed and all appeals were final

[6]1983 malpractice insurance costs for physicians and hospitals (including $256 million for hospital self-insurance and $31 million for hospital losses paid from general revenues and reserves) totaled an estimated $2 5 billion See Medical Malpractice Insurance Costs Increased but Varied Among Physicians and Hospitals, GAO/HRD-86-112 Sept 15, 1986, pp 2 and 39

probability of selection Twenty-five companies were selected to participate in the closed claims study—six commercial companies, seven physician-owned companies, seven hospital-owned companies, and five joint underwriting associations Ten of the original 25 companies selected declined to participate These companies were replaced in the study in a random manner by companies of the same type and, as nearly as possible, of the same premium volume using the method of selection with probability proportional to size The reasons cited for nonparticipation included the lack of staff and time constraints Based on these reasons, we believe the replacement companies would not be much different in terms of the characteristics of claims closed than the originally selected insurance companies

Each of the 25 companies was requested to provide a listing of claim numbers and indemnity amounts for all claims closed in 1984 The insurers reported a total of 31,395 claims

The claim numbers were stratified for each company into 10 groups by indemnity amount For example, all claims closed without an indemnity payment were put into stratum 0, while stratum 9 included all claims closed with an indemnity payment of $1 million or more Within each stratum we randomly selected the claims to be reviewed

A claim was considered ineligible for this study if

- it was closed without an actual demand for compensation being made by or on behalf of the patient,
- it involved a malpractice incident for which other files were still open,
- it involved general liability rather than professional liability,
- the company's involvement in the claim was only as a reinsurer,[7]
- it was inaccessible (i.e., claim file that was either permanently lost or would not be available during the entire data collection period), or
- it did not meet study criteria for other reasons (e g , the claim was closed in a year other than 1984)

When developing our data collection instrument and instruction manual, we considered those used in previous studies (See app I for a brief description of several previous closed claims studies.) We pretested drafts of our data collection instrument and instruction manual at three of the four types of insurance companies represented in our sample The

[7]Insurance companies buy reinsurance from other insurers to cover potential losses that may be too large for the individual company to absorb

information obtained was used to refine the questions and terminology used in the final data collection instrument and instruction manual (app II contains a copy of the data collection instrument) Appendix III provides the "allegations of negligence" used to categorize the type of error alleged to have caused injury Appendix IV provides the categories of severity used to classify the seriousness of patient injuries

The data collection instrument consisted of two forms One collected data on the incident The other collected data on each health care provider associated with the claim who was insured by the participating insurer One of each form was completed for each eligible claim, however, more than one provider form was completed when the claim involved multiple defendants

The companies reviewed 2,781 claims and completed 1,706 data collection instruments. The companies judged the remaining 1,075 claims to be ineligible for our study

A GAO representative met with each insurer to provide instructions for completing the data collection instruments; however, we did not independently validate the accuracy of the data they provided. The insurers sent the completed data collection instruments to GAO

We began visiting the insurers in June 1985 and completed the visits in December 1985 We received the first completed questionnaires in August 1985 and the last in May 1986

As the completed data collection instruments were received, we reviewed the data question by question for completeness and consistency before coding the responses for entry into a data file Where data items appeared incomplete or inconsistent, the companies were asked to complete the item or to resolve the inconsistency. After the data file was completed for the 25 companies, the data were projected to the 102 companies in the universe.

For our analyses, we concentrated on frequencies and cross-tabulations of the data elements that would answer selected questions regarding medical malpractice incidents, the resulting claims, and health care providers involved. Primarily, we analyzed the allegations of negligence leading to claims and where they occurred, the extent to which patients received compensation and the variance by severity of injury, how long claims were in process, at what stage they were resolved, the companies' costs associated with defending the claims, and what types of health

care providers were involved in the claims Chapters 2, 3, and 4 present this information in a question and answer format Supplementary data developed during our analysis are presented in appendix V Unless otherwise indicated, all data presented in this report are estimates

Our estimates are based on weighting procedures applied to the 25 participating insurance companies' data In instances where data were missing on a claim, the estimated values will be for less than the total number of claims Estimates in chapter 3 of this report which are based on about half of the claims where data were provided are noted These estimates are representative of about one-half of the claims We do not know anything about the other half Therefore, it should not be assumed that the characteristics of the unknown half are the same or not the same as those of the known half We randomly verified the accuracy of data entry tasks and reviewed the computer programs to ensure the reliability of our analysis

Because our estimates are based upon a sample of claims, each estimate has a certain amount of sampling error The sampling errors associated with several key estimates are presented in appendix VI. These sampling errors are stated at the 95-percent confidence level This means that the chances are 19 out of 20 that the true universe characteristic being estimated falls within the range defined by our estimate minus the sampling error and our estimate plus the sampling error

General Questions and Answers Regarding Medical Malpractice Incidents and the Resulting Claims

An estimated[1] 73,472 medical malpractice claims were closed in 1984 Fifty-seven percent were closed with no indemnity, however, payments for claims closed with indemnity totaled $2 6 billion and ranged from $1 to $2 5 million. The median was $18,000 and the average was $80,741 Claims closed with an indemnity of $250,000 or more (about 9 percent of the claims) accounted for 61 percent of the total payments

In addition to the indemnity payments, the insurers spent $807 million to investigate and defend all of the claims closed in 1984 These costs ranged from $0 to $983,810, with a median of $2,390 and an average of $10,985. Insurers incurred costs to investigate and defend the claims whether or not payment was made. The median and average costs were $4,866 and $14,413 for claims closed with indemnity and $1,500 and $8,372 for claims closed without indemnity

Injuries most frequently occurred in hospitals Three-quarters involved four allegations of negligence—surgical, diagnostic, treatment, or obstetrics errors. About 30 percent of all injuries resulted in "minor temporary disabilities."

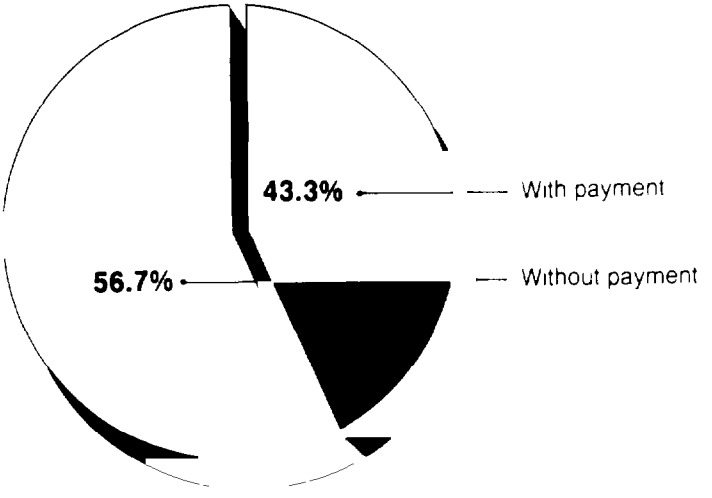
There was a wide variance in the length of time both from the injury to the claim and from the claim to its disposition The average times were 16 months and 25 months, respectively About half of the claims were closed after suit but before trial, while 5 percent were resolved by court verdict. Generally, the more severe injuries and those receiving the largest indemnity payments took longer to resolve Claims with indemnity payments of $1 million or more had the highest median and average time from claim to disposition, 76 months and 65 months, respectively

How Many Claims Were Closed and How Much Were the Total Indemnity Payments?

We estimated that 73,472 medical malpractice claims were closed by the 102 insurance companies in 1984 Figure 2 1 shows that about 43 percent (31,786 claims) were closed with an indemnity payment

[1]Unless otherwise indicated, all data presented in this chapter are estimated Key estimated values used in this chapter are presented with their related sampling errors in tables VI 1 through VI 6

Figure 2.1: Outcome of Claims Closed in 1984



The companies' indemnity payments (present value at the time of closure) for these awards/settlements totaled about $2.6 billion [2] Indemnity payments ranged from $1 to about $2 5 million, with a median of $18,000 and an average of $80,741[3] As shown in table 2 1, about 9 percent of the paid claims were for less than $1,000, while less than 1 percent were for $1 million or more About 69 percent of the paid claims were for less than $50,000 Claims closed with an indemnity payment of $250,000 or more (about 9 percent of paid claims) accounted for about 61 percent of the total indemnity paid

[2]Closed claims represent only a part of an insurer's medical malpractice experience These data should not be considered as a reflection of profitability According to the National Association of Insurance Commissioners profit measures should be based on comparable earned premium and incurred loss data Neither of these measures is included in this study

[3]All the indemnity payments cited in this report are stated as present value at the time of closure unless otherwise noted

Table 2.1: Number of Paid Claims and Total Indemnity Payments by Payment Ranges

Total indemnity payments in millions

	Paid claims		Indemnity payments	
Payment ranges	**Number**	**Percent**	**Total**	**Percent**
$1 to $999	2 950	9 3	$1 4	0 1
$1,000 to $4,999	5 281	16 6	13 1	5
$5,000 to $9,999	4,103	12 9	26 7	1 0
$10 000 to $24,999	4 565	14 4	67 6	2 6
$25,000 to $49,999	5,078	16 0	161 5	6 3
$50,000 to $99 999	3,968	12 5	264 2	10 3
$100 000 to $249,999	2,998	9 4	474 1	18 5
$250,000 to $999,999	2 585	8 1	1,229 4	47 9
$1 million or more	258	8	328 4[a]	12 8
Total	**31,786**	**100.0**	**$2,566.4**	**100 0**

[a]Estimate subject to a large sampling error and should be used with caution

What Costs Did Insurers Incur to Investigate and Defend Claims (Allocated Loss Expenses)?

In addition to the indemnity payments, insurers incurred about $807 million in costs to investigate and defend all of the claims closed in 1984 The median and average costs were $2,390 and $10,985, respectively As shown in table 2 2, the allocated loss expenses ranged from $0 to $983,810.

Table 2.2: Number of Claims and Amount of Allocated Loss Expenses by Size of Allocated Loss Expenses

Amount of allocated expenses in millions

	Claims		Allocated expenses	
Expense ranges	**Number**	**Percent[a]**	**Amount**	**Percent[a]**
Unknown	110	0 1	$ •	•
$0	17,092	23 3	0 0	0 0
$1 to $999	10,676	14 5	5 0	0 6
$1 000 to $4,999	19,943	27 1	54 0	6 7
$5,000 to $9,999	8,519	11 6	60 0	7 4
$10,000 to $24,999	10,020	13 6	161 0	20 0
$25,000 to $99,999	5,921	8 1	241 0	29 9
$100,000 to $249,999	1,060	1 4	195 0[b]	24 2
$250,000 to $983,810	131	0 2	91 0[b]	11 3
Total	**73,472**	**100.0**	**$807.0**	**100.0**

[a]Detail does not add to total due to rounding

[b]Estimate subject to a large sampling error and should be used with caution

About $668 million, or almost 83 percent, of the total allocated loss expenses was for defense counsel Defense counsel expenses ranged from $0 to $702,780 and had an average and median of $9,107 and $1,973, respectively Expert witness expenses and other allocated expenses were about $69 million and $70 million with averages of $942 and $961, respectively

How Did Companies' Allocated Loss Expenses Vary Between Claims Closed With and Without Indemnity Payments?

Insurance companies spent more money to investigate and defend claims closed with payment even though more claims were closed without a payment. Of the estimated $807 million in expenses incurred by companies to investigate and defend the claims closed in 1984, about $458 million, or about 57 percent, was spent on claims closed with payment The average allocated loss expense per paid claim was $14,413 and included 6,443 paid claims where the companies incurred no allocated loss expenses. About 80 percent of this was for defense counsel, which averaged $11,485 per claim. Table 2 3 shows how much companies spent on the claims closed with payment

Table 2.3: Costs to Investigate and Defend Claims Closed With Indemnity Payments

Total costs in millions

	Costs				
				Range	
Categories	Total[a]	Median	Average	Lowest	Highest
All claims	**$458.1**	$4 866	$14 413	$0	$983 810
Defense counsel	**365.0**	3 907	11,485	0	702 780
Expert witness	**49.9**	100	1,573	0	400 000
Other expenses	**43.1**	167	1,365	0	598 969

[a]Detail does not add to total due to rounding

Table 2 4 shows the allocated loss expenses incurred for the 41,686 claims closed without an indemnity payment For about a quarter of these claims (10,649), the companies incurred no allocated loss expense Total expenses ranged from $0 to $247,100 and averaged $8,372 Costs for defense counsel comprised about 87 percent of the total and averaged $7,288

Table 2.4: Costs to Investigate and Defend Claims Closed Without Indemnity Payments

Total costs in millions

	Costs				
				Range	
Categories	**Total**	**Median**	**Average**	**Lowest**	**Highest**
All claims	**$349.0**	$1,500	$8,372	$0	$247 100
Defense counsel	**302.8**	1,293	7 288	0	246 952
Expert witness	**19.0**	0	459	0	26 875
Other expenses	**27.2**	4	655	0	16 495

For each paid claim, we compared the company's defense counsel expense and total allocated expenses to the indemnity payment made to the injured patient. For about 14 percent of these claims, the companies' total defense and investigation expenses were greater than the payment to the injured patient Further, as shown in table 2.5, defense counsel expenses alone exceeded the payment in about 12 percent of these claims.

Table 2.5: Comparison of Defense Counsel and Total Allocated Loss Expenses to Indemnity Payments

	Defense counsel		Total expenses[a]	
Comparison	**Paid claims**	**Percent[a]**	**Paid claims**	**Percent**
Expense less than payment	26,978	84 9	25 940	81 6
Expense equal to payment[b]	846	2 7	1 286	4 0
Expense greater than payment	3,960	12 5	4,557	14 3
Total	**31,784**	**100.0**	**31,784**	**100.0**

[a]Detail does not add to total due to rounding

[b]For purposes of this comparison, we considered expense to equal payment if expense was within 10 percent (less or greater) of the payment

Note The total number of claims is based on the number of claims for which the relevant data were provided

What Were the Principal Allegations of Negligence Leading to Claims?

GAO divided the allegations of negligence leading to injuries for which the claims were filed into 12 general categories. These were further divided into 77 specific categories that described the allegations in more detail [4] (See app III.) As shown in table 2.6, three quarters of the claims closed in 1984 involved allegations[5] of surgical, diagnostic, treatment, or obstetrics errors.

[4]The allegations of negligence used in this study were developed by the Risk Management Foundation of the Harvard Medical Institutions and are used with their permission

[5]Only the principal allegation was used in those cases where a secondary allegation was also provided by the insurer

Table 2.6: Number of Claims by Principal Allegations of Negligence Leading to the Injuries Involved

	Claims		
Type of error	**Number[a]**	**Percent[a]**	**Cumulative percent**
Surgery	18,697	25 4	25 4
Diagnosis	17 372	23 6	49 0
Treatment	14 635	19 9	68 9
Obstetrics	5 517	7 5	76 4
Medication	3,019	4 1	80 5
Medication administration	2,735	3 7	84 2
Anesthesia	2 720	3 7	87 9
Physiology/behavior monitoring, biomedical equipment, intravenous, and blood products[b]	3 284	4 5	92 4
Other[b]	5,491	7 5	99 9
Total	**73,468**	**100.0**	

[a]Detail does not add to total due to rounding

[b]Combined estimates shown with sampling errors in table VI 2 differ due to rounding

Note The total number of claims is based on the number of claims for which the relevant data were provided

As shown in table 2.6, surgical errors were cited in about 25 percent of the closed claims. Of these, about 75 percent involved improper performance of a surgical procedure, and about 6 percent involved foreign bodies[6] left in patients. Diagnostic errors, cited in about 24 percent of the claims, involved failure to diagnose (about 37 percent) or a misdiagnosis (about 33 percent). Treatment-related errors were often associated with improper performance (about 45 percent) and improper choice (about 22 percent) The estimated number of claims for these three types of errors by specific category of allegation is shown in tables V 1 through V 3.

Obstetrics-related errors were listed as the principal allegation of negligence in about 8 percent of the claims, of which about 24 percent were for failure to identify fetal distress. Reliable estimates for the other specific categories of obstetrics errors could not be determined because of limited data in the sample. Also, about 8 percent of the claims had errors that were grouped in the "other" category Reliable estimates show that patient falls (about 39 percent) and failure to insure patient safety (about 22 percent) occurred most often.

[6]Foreign bodies can include objects such as a surgical sponge or clamp

How Severe Were the Injuries for Which Claims Were Filed?

The severity of injury range included nine severity classifications and extended from "emotional" injuries to "death " (See app IV for examples used to classify the seriousness of patient injuries) As shown in table 2 7, the patients involved in about 30 percent of the closed claims experienced "minor temporary disabilities " "Minor permanent partial disabilities" (about 16 percent) and "death" (about 15 percent) accounted for another 31 percent of the claims About 6 percent of the injuries were "emotional," and the fewest number of claims (about 2 percent) involved "grave permanent total disabilities"

Table 2.7: Number of Claims by Severity of Injury Categories

	Claims		
Severity of injury	**Number**	**Percent[a]**	**Cumulative percent**
Emotional	4,660	6 4	6 4
Insignificant	6,823	9 3	15 7
Temporary disability—minor	21,969	30 0	45 7
Temporary disability—major	8 101	11 1	56 8
Permanent partial disability—minor	11,551	15 8	72 6
Permanent partial disability—major	4,225	5 8	78 4
Permanent total disability—major	2 788	3 8	82 2
Permanent total disability—grave	1,794	2 4	84 6
Death	11,179	15 3	99 9[a]
Total	**73,090**	**100.0**	

[a]Detail does not add to total due to rounding

Note The total number of claims is based on the number of claims for which the relevant data were provided

Where Did Injuries Occur?

As shown in table 2 8, about 80 percent of the claims closed involved an injury that occurred in a hospital, and about 13 percent in a physician's office. The remaining injuries occurred in nursing homes, patients' homes, health maintenance organizations (HMOs), emergency care centers, and other types of facilities

Specifically, about 58 percent of the injuries took place in nonteaching community[7] hospitals, 18 percent in teaching community hospitals, and about 4 percent in other types of hospitals. About 30 percent of the errors that occurred in both teaching and nonteaching hospitals were surgery related. Treatment-related errors accounted for about 37 percent of the errors that occurred in physicians' offices. Patients experienced "minor temporary disabilities" in about 24, 29, and 33 percent of the claims where the injuries occurred in teaching hospitals, nonteaching hospitals, and physicians' offices, respectively.

Table 2.8: Number of Claims by Type of Facility Where Injury Occurred

	Claims		
Type of facility	**Number[a]**	**Percent**	**Cumulative percent**
Community hospital—nonteaching	42,666	58.1	58.1
Community hospital—teaching	13,229	18.0	76.1
Other hospital	3,240	4.4	80.5
Physician's office	9,274	12.6	93.1
Nursing home	1,503	2.0	95.1
Emergency care center	1,160	1.6	96.7
HMO, patient's home, other, and unknown	2,399	3.3	100.0
Total	**73,472**	**100.0**	

[a]Detail does not add to total due to rounding.

For the claims closed involving injuries that occurred in nonteaching hospitals, about 38 percent received an indemnity payment and 62 percent did not. About 44 percent of the injuries that took place in teaching hospitals and about 55 percent that occurred in physicians' offices resulted in payment. (See table V.4.) Higher median and average indemnity payments were made for injuries occurring in teaching hospitals than in nonteaching hospitals and physicians' offices. (See table V.5.)

[7]The American Hospital Association defines a community hospital as a nonfederal, short-term general and other special hospital, excluding hospital units of institutions, whose facilities and services are available to the public. There were a total of 5,736 community hospitals in the United States in 1984. Of these, 903 (15.7 percent) were teaching hospitals and 4,833 (84.3 percent) were nonteaching hospitals. Although there were fewer teaching hospitals, in general, they tended to be larger in terms of the number of beds than the nonteaching community hospitals. Of the teaching hospitals, 800 (88.6 percent) consisted of 200 or more beds each, whereas 957 of the nonteaching hospitals (19.8 percent) had 200 or more beds.

How Many Health Care Providers Were Involved in Claims?

The number of health care providers involved in the 73,472 closed claims that were insured by the 102 companies totaled 103,255, or an average of 1 4 providers per claim The number ranged from 1 to 13, however, as shown in table 2.9, about 77 percent of the claims involved only one provider Also, at least 70 percent of all the health care providers were physicians.

Table 2.9: Number of Health Care Providers Involved in Claims

Number of providers involved	Claims			Total number of providers
	Number	Percent[a]	Cumulative percent	
1	56,376	76 7	76 7	56,376
2	9,855	13 4	90 1	19 710
3	3,822	5 2	95 3	11,466
4	2,069	2 8	98 1	8,276
5 to 13	1 350	1 8	99 9[a]	7 427
Total	**73,472**	**100.0**		**103,255**

[a]Detail does not add to total due to rounding

How Were the Patients Compensated?

Indemnity payments for most patients—about 90 percent—were made as lump sum (only) payments, while about 2 percent consisted of free services alone or a combination of free services with another payment form. As shown in table 2.10, the balance of cases involved structured payments alone or in combination with a lump sum payment. Indemnity paid through these forms totaled $951.4 million. Because some of the claims closed in 1984 involve structured payments that will be made over time, the payments received by patients for all the claims closed in 1984 may ultimately total about $5.4 billion. For example, the largest indemnity payment of about $2.5 million had an expected value of about $7.8 million for the patient These expected payments ranged from $1 to $27.2 million, with a median of $18,000 and an average of $169,786 The $951.4 million in payments made through structured payments alone or in combination with a lump sum may have an expected yield of $3.8 billion

Table 2.10: Number of Paid Claims and Indemnity Payments by Payment Form

Dollars in millions

	Paid claims		Indemnity payments	
Payment form	**Number[a]**	**Percent**	**Total**	**Percent[a]**
Lump sum	28,763	90.5	$1,601.6	62.4
Lump sum and structured	1,264	4.0	490.7	19.1
Structured	1,121	3.5	460.7	18.0
Free services only and combinations with lump sum or lump sum and structured	628	2.0	11.4[b]	0.4
Total	**31,775**	**100.0**	**$2,564.4**	**100.0**

[a]Detail does not add to total due to rounding

[b]Estimate is subject to a large sampling error and should be used with caution

Note The total number of claims is based on the number of claims for which the relevant data were provided

What Were the Characteristics of Patients Involved in Malpractice Claims?

People of all ages were involved in medical malpractice claims. Table 2.11 shows the distribution of patients' ages at the time of the injury As shown in the table, about 9 percent of the patients were injured at birth About 14 percent were 65 years or older. The age range most often represented was 18 to 29 years. The average and median ages of the patients were 37 and 35 years, respectively.

Table 2.11: Number of Claims by Ranges of Patients' Ages at the Time of the Injury

	Claims		
Age ranges (years)	**Number**	**Percent**	**Cumulative percent**
At birth	6,209	8.8	8.8
Less than 1	933	1.3	10.1
1 to 17	5,879	8.3	18.4
18 to 29	14,607	20.7	39.1
30 to 39	11,013	15.6	54.7
40 to 49	10,097	14.3	69.0
50 to 59	8,886	12.6	81.6
60 to 64	3,401	4.8	86.4
65 and over	9,616	13.6	100.0
Total	**70,641**	**100.0**	

Note The total number of claims is based on the number of claims for which the relevant data were provided

As might be expected, about 62 percent of the patients injured at birth experienced obstetrics-related errors. Patients 18 to 29 years old often

suffered surgical (about 30 percent) and treatment (about 25 percent) errors, and the oldest patients (65 years and over) experienced other types of errors, such as falls and diagnostic and surgical errors The most severe injuries were experienced most often by the youngest patients About 28 percent of the patients injured at birth died, while about 26 percent of the 65 years or older patients died Patients 18 to 29 years old and those who were 65 years and older experienced "minor temporary disabilities" in about 34 and 30 percent of the claims, respectively

Indemnity payments were made for almost half of the claims that involved injuries occurring at birth These patients received higher median and average payments ($200,000 and $300,500) when compared to patients of all other age ranges. Patients 18 to 29 years old had the lowest percentage of paid claims (about 37 percent), whereas the oldest patients' claims were paid in about 43 percent of the cases (See tables V.6 and V 7)

Table 2 12 shows the distribution of claims by patients' sex As shown, about 57 percent of the patients were female, and 43 percent were male

Table 2.12: Number of Claims by Patients' Sex

	Claims	
Sex	**Number**	**Percent**
Male	31,630	43 1
Female	41 747	56 9
Total	**73,377**	**100.0**

Note The total number of claims is based on the number of claims for which the relevant data were provided

The injuries experienced by male and female patients were generally similar. Both sexes suffered surgical and diagnostic errors most often Males suffered more diagnostic than surgical errors (about 28 percent and 23 percent), whereas females experienced more surgical than diagnostic errors (about 27 and 21 percent). For both sexes the most frequently indicated severity of injury category was "minor temporary disabilities" (about 30 percent). Females experienced slightly more "emotional" and "insignificant" injuries, whereas males had more serious injuries—"major permanent partial disabilities," "grave permanent total disabilities," and "deaths."

Although females were involved in more claims, males had a slightly higher percentage of paid claims (about 45 percent for males and 42 percent for females) Both sexes received the same median payment ($18,000), but males had a higher average payment (See tables V 8 and V 9)

As shown in table 2 13, about one-third of the patients involved in medical malpractice claims were either employed or self-employed, while about 9 percent were unemployed The remainder of the patients were homemakers, retired persons, dependent children/students, and independent students The occupational status of about 12 percent of the patients was unknown.

Table 2.13: Number of Claims by Patients' Occupational Status at the Time of the Injury

	Claims		
Occupational status	**Number[a]**	**Percent[a]**	**Cumulative percent**
Employed	23,921	32 6	32 6
Self-employed	3,462	4 7	37 3
Homemaker	9,311	12 7	50 0
Retired	8,492	11 6	61 6
Unemployed	6,713	9 1	70 7
Dependent child/student	12,532	17 1	87 8
Independent student and other	447	0 6	88 4
Unknown	8 596	11 7	100 1[a]
Total	**73,472**	**100.0**	

[a]Detail does not add to total due to rounding

About 32 percent of both the employed and unemployed patients experienced surgical errors. Homemakers had diagnostic (about 28 percent) and surgical (about 26 percent) errors most often. For dependent children/students, diagnostic and obstetrics errors each accounted for about 32 percent For about 30, 43, and 28 percent of the claims closed for employed and unemployed patients and dependent children/students, respectively, "minor temporary disabilities" were reported. About 19 percent of the homemakers experienced "major temporary disabilities "

Dependent children/students' claims were paid more than half of the time. Employed and unemployed patients and homemakers' claims received payment in about 41, 44, and 42 percent of the cases, respectively. Although the payment percentage was slightly lower for employed patients than the other three patient occupations discussed, they received higher median and average payments than unemployed

patients and homemakers Dependent children/students' median and average payments were the highest of these four categories (See tables V 10 and V 11)

What Were the Annual Earnings of the Patients Involved in Malpractice Claims?

Patients' annual earnings at the time of the injury could be estimated for 55,235 of the 73,472 claims closed (about 75 percent) Table 2 14 provides the distribution for claims where data were available. The earnings ranged from $0 to $1 million The average annual patient earnings for these claims was $7,166 and the median was $0

Table 2.14: Number of Claims by Ranges of Patients' Annual Earnings

	Claims		
Ranges of patients' annual earnings[a]	Number[b]	Percent	Cumulative percent
$0	33,282	60 3	60 3
$1,000 to $4 000	1,293	2 3	62 6
$5,000 to $9,000	2,607	4 7	67 3
$10,000 to $19,000	11 613	21 0	88 3
$20,000 to $29,000	4,197	7 6	95 9
$30,000 to $39,000	1,311	2 4	98 3
$40,000 to $49,000	526	1 0	99 3
$50,000 or more	405	0 7	100 0
Total	**55,235**	**100.0**	

[a]Earnings data were provided to us rounded up to the next $1 000 Earnings do not reflect total family income

[b]Detail does not add to total due to rounding

Note The total number of claims is based on the number of claims for which the relevant data were provided

Considering only the claims where the earnings were greater than $0, the distribution shows that about 18 percent had earnings less than $10,000; about 53 percent were from $10,000 to $19,000; and about 29 percent were $20,000 or more. The average and median patient earning at the time of the patient's injury for these claims were $18,030 and $15,000, respectively. The patients' occupational status for the 33,282 claims (about 60 percent) with $0 annual earnings are shown in table 2 15.

Table 2.15: Number of Claims With No Annual Earnings[a] by Patients' Occupational Status

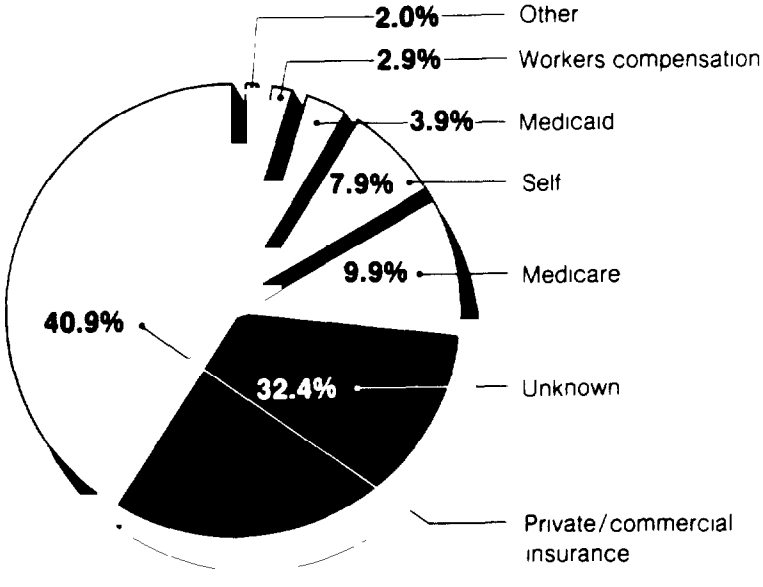
	Claims		
Occupational status	**Number**	**Percent**	**Cumulative percent**
Dependent child/student	11,144	33 5	33 5
Homemaker	8 451	25 4	58 9
Retired	6 756	20 3	79 2
Unemployed	6 391	19 2	98 4
Independent student other, and unknown	540	1 6	100 0
Total	**33,282**	**100.0**	

[a]Although annual earnings were not reported for these patients some may have had an income

What Were the Sources of Payment of Patients' Health Care Costs?

As shown in figure 2 2, health care costs for about 41 percent of the patients involved in medical malpractice claims were paid by private/commercial insurance before the liability injury A small percentage of malpractice claims involved medicare and medicaid recipients, about 10 percent and about 4 percent, respectively However, the source of payment of the patients' health care costs was unknown for a large number of claims—23,803, or about 32 percent.

Figure 2.2: Percent of Claims by Source of Payment of Patients' Health Care Costs



Note Detail does not add to total due to rounding

How Much Time Elapsed Between the Malpractice Injury and Claim Filing?

The length of time from injury occurrence to the claim filing ranged from 0 (less than 1 month) to 219 months (18 25 years) The median and average periods were 13 months and 16 4 months, respectively About 6 percent of the claims were filed within the same month as the injury occurred, and 6 percent took more than 3 years (37 to 219 months) to be filed, as shown in table 2 16.[8]

Table 2.16: Number of Claims by the Length of Time From the Injury Occurrence to the Claim Filing

	Claims		
Time (months)	Number	Percent	Cumulative percent
0 (less than 1)	4,141	5 6	5 6
1 to 3	10,408	14 2	19 8
4 to 8	9,348	12 8	32 6
9 to 12	11,906	16 2	48 8
13 to 18	10,625	14 5	63 3
19 to 24	13,253	18 1	81 4
25 to 36	8,956	12 2	93 6
37 to 219	4,667	6 4	100 0
Total	**73,304**	**100.0**	

Note The total number of claims is based on the number of claims for which the relevant data were provided

Claims filed in the same month as the injury occurred primarily involved surgical (about 19 percent), diagnostic (about 18 percent), and treatment (about 18 percent) related errors The two most frequently cited severities of injury were "minor temporary disabilities" (about 39 percent) and "major temporary disabilities" (about 24 percent)

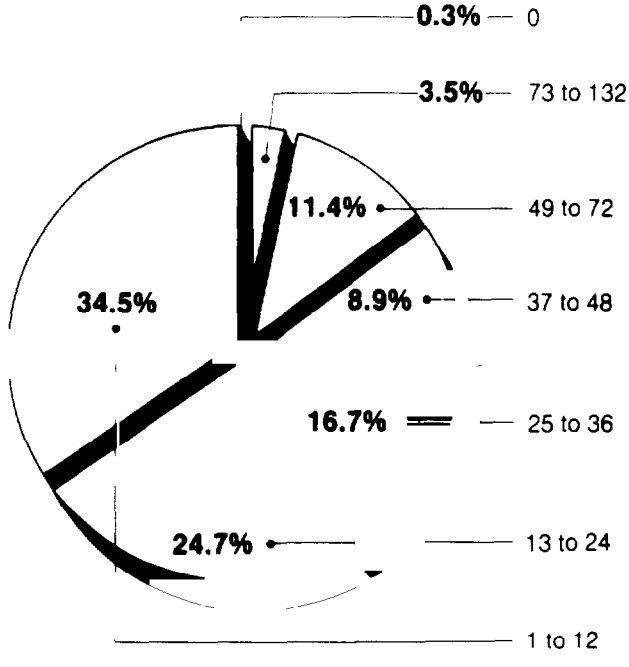
The claims filed more than 3 years after the injury involved obstetrics (about 25 percent) and medication administration (about 22 percent) related errors. Injuries resulting in "minor and major temporary disabilities" accounted for about 36 percent of the claims, and "minor and major permanent partial disabilities" accounted for 32 percent of the claims.

[8]Claims closed during a period of time, such as those in this study, may not fairly represent the patterns arising from occurrences in any period Incidents in this report occurred during several prio time periods, and claims for incidents now occurring will be resolved in several different future year the difference in sets of economic and social factors may alter the patterns of time duration and indemnity amounts Patterns may also be distorted by the different state statutes of limitations

How Long Did It Take to Resolve Claims?

For the 73,204 claims in our universe where data were provided, the length of time from claim filing to complete disposition against all providers involved ranged from 0 (less than 1 month) to 132 months (11 years), with a median of 19 months and an average of 25 months Figure 2 3 shows the percentage of claims for each range of time periods for resolution Paid claims had a median of 23 months for resolution, while those without payment had a median of 17 months. The distribution of time to resolve claims by payment status is shown in table V 12

Figure 2.3: Percent of Claims by Resolution Time (Months)



How Did the Severity of Injury and Amount of Indemnity Relate to the Disposition Time for Claims?

Generally, the more severe and costly cases took longer to resolve For all claims, the highest medians for time between filing and disposition were for "major permanent partial disabilities" and "major permanent total disabilities"—33 and 32 months, respectively. "Major permanent partial disabilities" also had the highest average (34.5 months) and the widest range (0 to 132 months). "Emotional" injuries had the lowest values for all of these measures (See table V.13 for the disposition times for all claims by severity of injury)

For the claims closed with payment, the highest median for time between filing and disposition was for "major permanent total disabilities"—45 months—while the lowest was 12 months for "emotional" injuries As shown in table 2 17, the highest average was 38 8 months for "grave permanent total disabilities "

Table 2.17: Number of Paid Claims and Disposition Time by Severity of Injury Categories

Disposition time in months

	Paid claims		Disposition time			
					Range	
Severity of injury	Number	Percent of total[a]	Median	Average	Lowest	Highest
All claims[b]	31 642	43 3	23 0	28 0	0 0[c]	132 0
Emotional	1,194	25 6	12 0	14 9	0 0	55 0
Insignificant	3 258	48 7	14 0	21 8	0 0	110 0
Temporary disability—minor	8,021	36 6	19 0	25 7	0 0	108 0
Temporary disability—major	2,989	37 2	18 0	22 4	0 0	81 0
Permanent partial disability—minor	6,288	54 4	23 0	28 9	0 0	114 0
Permanent partial disability—major	1,678	40 6	31 0	31 7	0 0	132 0
Permanent total disability—major	1,928	69 2	45 0	37 2	2 0	90 0
Permanent total disability—grave	1,302	72 6	34 0	38 8	1 0	115 0
Death	4,976	44 6	28 0	33 2	1 0	109 0

[a]Shows paid claims as a percentage of total claims within each of the severity of injury categories For example, an estimated 4 654 claims involved emotional injuries Of these, 1 194 (about 25 6 percent) were closed with payment

[b]Detail does not add to total because not all paid claims were classified by the severity of injury categories

[c]A 0 0 in this column indicates that the claim was filed and resolved within the same month

Note The total number of claims is based on the number of claims for which the relevant data were provided

Claims closed with an indemnity payment of $1 million or more had the highest median and average time between filing and disposition (76 0 and 64.9 months). Table 2.18 shows that those claims for which no payment was made had a median disposition time of 17.0 months, and the claims that received the smallest indemnity payments ($1 to $999) had the lowest median and average disposition times of 6.0 and 11 9 months

Table 2.18: Number of Claims and Disposition Time by Indemnity Payment Ranges

Disposition time in months

	Claims[a]		Disposition time			
					Range	
Payment ranges	Number	Percent	Median	Average	Lowest	Highest
All claims	73 204	100	19 0	25 1	0 0[b]	132 0
$0	41 562	56 8	17 0	22 9	0 0	92 0
$1 to $999	2 812	3 8	6 0	11 9	0 0	62 0
$1 000 to $4 999	5 276	7 2	16 0	22 4	1 0	97 0
$5,000 to $9,999	4 103	5 6	22 0	28 7	0 0	108 0
$10,000 to $24,999	4 565	6 2	19 0	22 7	0 0	92 0
$25,000 to $49 999	5 078	6 9	28 0	32 0	1 0	114 0
$50 000 to $99 999	3 968	5 4	29 0	31 6	1 0	110 0
$100,000 to $249,999	2 998	4 1	29 0	33 0	0 0	132 0
$250,000 to $999,999	2 585	3 5	46 0	41 8	0 0	115 0
$1 million or more	258	0 4	76 0	64 9[c]	6 0	84 0

[a]Detail does not add to total due to rounding

[b]A 0 0 in this column indicates that the claim was filed and resolved within the same month

[c]Estimate subject to a large sampling error and should be used with caution

Note The total number of claims is based on the number of claims for which the relevant data were provided

Table 2.19: Number of Paid Claims and Indemnity Payments by Disposition Time

	Paid claims		Indemnity payments			
					Range	
Time (months)	Number	Percent of total[a]	Median	Average	Lowest	Highest
All claims	31 642	43 2	$18 000	$81 105	$1	$2 472 020
0 (less than 1)	158	62 7	515	16 814[b]	100	266 800
1 to 12	8 899	35 2	7 500	31 411	1	1 000 000
13 to 24	8 062	44 6	15 000	69 793	18	2 472 020
25 to 36	5 300	43 4	25 000	73 125	90	1 625 000
37 to 48	3,988	61 4	60 000	134 354	25	1 800 000
49 to 72	3 731	44 8	30 000	109 212	200	2 000 000
73 to 132	1,504	58 0	45 000	259 656[b]	1,000	2 059 388

[a]Shows paid claims as a percentage of total claims within each of the time periods For example an estimated 6 490 claims took 37 to 48 months between filing and disposition Of these 3 988 (about 61 4 percent) were closed with payment

[b]Estimate subject to a large sampling error and should be used with caution

Note The total number of claims is based on the number of claims for which the relevant data were provided

As shown in table 2 19, the median indemnity payments were the highest ($60,000) for claims that took 37 to 48 months between filing and disposition Those paid claims that were filed and resolved in the same month had a median payment of $515

How Frequently Did the Health Care Providers' Insurers Initiate Contact With the Patients?

Files for 5,323 claims (about 7 percent) were initially opened because the practitioner or the hospital notified the insurance companies of a malpractice incident In other cases, insurance companies opened the files because (1) the patient's attorney notified the insured of a claim—about 30 percent, (2) suit papers were served on the insured—about 38 percent, or (3) the patient, or the patient's relative, guardian, or friend complained to the insured—about 18 percent.

In the cases where the claims were opened when the practitioner or the hospital notified the insurance company of a malpractice incident, the company initiated contact with the patient or the patient's representative about 13 percent of the time (707 cases) For these cases, payment was almost always made to the patient—about 99 percent The median indemnity payment was $5,500; the average was $155,019; and the range was $100 to $1 8 million

At What Stage in the Claims Settlement Process Was the Claim Resolved?

Settlement stage data were collected for each health care provider associated with the claim. Since a number of claims involved two or more providers and, thus, two or more potential stages of settlement, we can only relate these data to individual claims where only one provider was involved and the settlement stage was provided. For those 56,355 claims—about 77 percent of the total, about 51 percent settled after the suit was initiated but before the trial. Of these, about 53 percent resulted in payment to the patient.

As shown in table 2 20, the second most frequent settlement stage was after the claim was filed but before the suit was initiated—about 38 percent. Of these, about 36 percent resulted in payment to the patient See table V 14 for details on the claims' payment status by settlement stage

Table 2.20: Number of Claims Involving One Provider by Stage of Settlement

	Claims		
Settlement stage	**Number**	**Percent**	**Cumulative percent**
Claim filed before suit	21,106	37 5	37 5
Suit, before trial	28,541	50 6	88 1
During trial, before verdict	838	1 5	89 6
After verdict by jury	1,642	2 9	92 5
After verdict without jury	114	0 2	92 7
After appeal	1,010	1 8	94 5
Suit, before arbitration	1,713	3 0	97 5
After arbitration	113	0 2	97 7
Other	1,278	2 3	100 0
Total	**56,355**	**100.0**	

Note The total number of claims is based on the number of claims for which the relevant data were provided

Questions and Answers Regarding Medical Malpractice Claims Closed With an Indemnity Payment

The estimated[1] awards and settlements related to claims closed in 1984 varied by the type of error and the severity of the resultant injury Anesthesia errors had the lowest median payment, however, these errors resulted in the largest payment, the greatest range of payments, and the highest percentage of claims paid Obstetrics errors had the highest median and average payments Further, although only 10 percent of the paid claims were for obstetrics errors, they accounted for 27 percent of the total payments.

By severity of injury, except for claims involving "emotional" injuries and "death," the average payment increased as the injury became more severe Generally, the variances in awards and settlements were also larger for the more severe injuries. Errors that resulted in "permanent total disabilities" accounted for about half of the total payments made for claims closed in 1984

Insurers did not know the full extent of patients' economic losses for a large percentage of the claims; however, based on estimates for 54 percent[2] of the 73,472 claims closed in 1984, patients' economic losses totaled $4 5 billion. Eighty-eight percent of this was for future economic losses, such as medical expenses, wage loss, and rehabilitation services

For the 31,786 claims closed with payment, insurers often did not know the portion of the claims that related to economic losses, noneconomic losses, and plaintiff attorney's fees; however,

- for 18,279 claims for which economic losses could be estimated, injured patients recovered equal to or more than their economic losses in 70 percent of these claims,
- for 14,995 claims for which the expected value of noneconomic losses could be estimated, (1) about 62 percent of the total compensation for noneconomic losses was for amounts more than $200,000, but this money went to only about 2 percent of these claims and (2) compensation for noneconomic losses was between $1 and $50,000 for 67 percent of these claims that included compensation for such losses, and

[1]Unless otherwise indicated, all data presented in this chapter are estimated Key estimated values used in this chapter are presented with their related sampling errors in tables VI 7 through VI 12

[2]As stated in the Objective, Scope, and Methodology section we do not know anything about the other 46 percent of the claims, and the reader is cautioned that those claims may or may not exhibit the same characteristics as the 54 percent

- for 16,348 claims for which plaintiff attorney's fees could be estimated, such fees equaled from 31 to 40 percent of the expected value of the indemnity in about 52 percent of these claims.[3]

How Much Were Patients Compensated for the Errors?

The indemnity payments (awards/settlements) in 1984 totaled $2.6 billion. Table 3.1 shows the distribution of the total indemnity payments by type of error. As shown, although only about 10 percent of the total paid claims were for obstetrics errors, they accounted for the second largest amount (about 27 percent) of the total indemnity paid. Diagnostic errors, which accounted for about 24 percent of the paid claims, accounted for about 28 percent of the indemnity. Surgical errors accounted for about 22 percent of the total.

Table 3.1: Distribution of Total Indemnity Payments by Principal Allegations of Negligence

Dollars in millions

	Claims			Indemnity payments	
		Paid			
Type of error	**Total[a]**	**Number[a]**	**Percent**	**Total[a]**	**Percent**
Surgery	18,697	7,235	22.8	$551.7	21.5
Diagnosis	17,372	7,647	24.1	732.1	28.5
Treatment	14,635	5,291	16.6	223.9	8.7
Obstetrics	5,517	3,186	10.0	689.6	26.9
Medication	3,019	1,448	4.6	74.2	2.9
Medication administration	2,735	1,231	3.9	41.1	1.6
Anesthesia	2,720	1,699	5.3	143.5	5.6
Physiology/behavior monitoring, biomedical equipment, intravenous, blood products, and other	8,774	4,046	12.7	109.7	4.3
Total	**73,468**	**31,782**	**100.0**	**$2,565.9**	**100.0**

[a]Detail does not add to total due to rounding.

Note: The total number of claims is based on the number of claims for which the relevant data were provided.

Indemnity payments varied by allegation of negligence. Median payments ranged from $1,500 to $65,000. As shown in table 3.2, the highest median and average payments were made for obstetrics-related errors. These payments were higher than those for diagnostic errors, which had

[3]As stated in the Objective, Scope, and Methodology section, we do not know anything about the 13,507, 16,791, and 15,438 claims where economic losses, noneconomic losses, and plaintiff attorney's fees, respectively, could not be estimated. The reader is cautioned that those claims may or may not exhibit the same characteristics as those for which data were estimated.

the next highest median and average The lowest median was for anesthesia errors, however, these errors also received the largest payment of about $2 5 million, had the greatest range of payments, and had the highest percentage of paid claims

Table 3.2: Number of Paid Claims and Indemnity Payments by Principal Allegations of Negligence

	Paid claims		Indemnity payments			
					Range	
Type of error	Number	Percent of total[a]	Median	Average	Lowest	Highest
All claims[b]	31,786	43 3	$18,000	$80,741	$1	$2,472 020
Surgery	7,235	38 7	25,000	76,255	108	1,616 185
Diagnosis	7,647	44 0	30,000	95,747	28	1 315 996
Treatment	5,291	36 2	12,500	42,316	1	1,000 000
Obstetrics	3,186	57 8	65,000	216,464	187	2,000,000
Medication	1,448	47 9	13,500	51,263	100	709,000
Medication administration	1,231	45 0	6,000	33,379	18	1,000,000
Anesthesia	1,699	62 5	1,500	84,451	20	2,472,020
Physiology/behavior monitoring, biomedical equipment, intravenous, blood products, and other	4,046	46 1	8,000	27,122	9	800 000

[a]Shows paid claims as a percentage of total claims within each of the types of error For example an estimated 2,720 claims involved anesthesia errors Of these, 1,699 (about 62 5 percent) were closed with payment

[b]Detail does not add to total because some paid claims were not classified by their allegation of negligence

How Much Were Patients Compensated by Severity of Injury Categories?

Patients received the highest compensation for the more severe injuries and lower amounts for the less severe injuries. As shown in table 3 3, awards/settlements for "permanent total disabilities (major and grave)" and "insignificant" injuries had the highest and lowest median and average payments, respectively. Median payments ranged from $3,000 to $398,362, whereas averages went from $12,024 to $488,375 The median and average awards/settlements for the claims involving "death" ($35,000 and $75,242) were lower than those involving "major and grave permanent total disabilities."

Table 3.3: Number of Paid Claims and Indemnity Payments by Severity of Injury Categories

	Paid claims		Indemnity payments			
					Range	
Type of error	Number	Percent of total[a]	Median	Average	Lowest	Highest
All claims[b]	31,786	43.3	$18,000	$80,741	$1	$2,472,020
Emotional	1,200	25.8	7,500	21,694	18	560,000
Insignificant	3,396	49.8	3,000	12,024	25	163,000
Temporary disability—minor	8,021	36.5	5,800	13,978	1	589,300
Temporary disability—major	2,989	36.9	15,000	34,670	200	638,097
Permanent partial disability—minor	6,288	54.4	25,000	52,356	325	900,000
Permanent partial disability—major	1,678	39.7	95,000	144,049	750	1,315,996
Permanent total disability—major	1,928	69.2	398,362	364,384	2,500	1,000,000
Permanent total disability—grave	1,302	72.6	250,000	488,375	10,000	2,472,020
Death	4,976	44.5	35,000	75,242	600	1,109,937

[a]Shows paid claims as a percentage of total claims within each of the severity of injury categories. For example, an estimated 6,823 claims involved "insignificant" injuries. Of these, 3,396 (about 49.8 percent) were closed with payment.

[b]Detail does not add to total because some paid claims could not be classified by any of the severity of injury categories.

As shown in table 3.4, about 52 percent of the total indemnity payments made in 1984 were for "major and grave permanent total disabilities," which accounted for about 10 percent of all the paid claims. Only about 4 percent of the total was for "minor temporary disabilities" even though they made up about a quarter of the paid claims.

Table 3.4. Distribution of Total Indemnity Payments by Severity of Injury Categories

Dollars in millions

	Claims			Indemnity payments	
		Paid			
Severity of injury	**Total**	**Number[a]**	**Percent**	**Total[a]**	**Percent**
Emotional	4 660	1 200	3 8	$26 0	1 0
Insignificant	6 823	3 396	10 7	40 8	1 6
Temporary disability—minor	21 969	8 021	25 2	112 1	4 4
Temporary disability—major	8 101	2 989	9 4	103 6	4 0
Permanent partial disability—minor	1[illegible] 551	6 288	19 8	329 2	12 8
Permanent partial disability—major	4 225	1 678	5 3	241 7	9 4
Permanent total disability—major	2 [illegible]88	1 928	6 1	702 4	27 4
Permanent total disability—grave	1 [illegible]94	1 302	4 1	636 0	24 8
Death	11 179	4 976	15 6	374 4	14 6
Total	**73,090**	**31,786**	**100.0**	**$2,566.4**	**100.0**

[a]Detail does not add to total because some paid claims could not be classified by any of the severity of injury categories

Note The total number of claims is based on the number of claims for which the relevant data were provided

How Much Were Patients Compensated for Injuries of the Same Severity?

Medical malpractice awards/settlements varied for injuries of the same severity As shown in table 3 3, the smallest variance occurred for "insignificant" injuries, for which payments ranged from $25 to $163,000 and the largest was for "grave permanent total disabilities" ($10,000 to $2,472,020) Generally, the payment ranges were larger for the more severe injuries

The data did not yield reliable estimates in all cases of the payments made in each severity category by type of error Estimates could not be presented where the related sampling errors were unreasonably high However, where available, the estimates show that indemnity payments varied within severity of injury categories by type of error For example, the payments made for "insignificant" injuries ranged from $25 to $163,000 Anesthesia-related errors had the smallest payment and range of payments ($25 to $2,000), with an average of $815 and a median of $750 Surgical errors had the highest payment and range of payments ($300 to $163,000) The average and median payments for surgery-related "insignificant" injuries were $41,983 and $20,000, higher than anesthesia errors

Paid claims with "minor temporary disabilities" accounted for the largest number of the claims with indemnity Payments for these claims ranged from $1 to $589,300 with an overall median of $5,800 and a $13,978 average The highest payment ($589,300) was made for a diagnostic error while the lowest ($1) was for a treatment-related error The median payments for surgical, diagnostic, and treatment-related errors resulting in "minor temporary disabilities" were relatively similar at $5,750, $7,500, and $6,000, respectively The average payments were $18,242, $13,763, and $16,806

"Grave permanent total disabilities" accounted for the widest range of payments Indemnity payments for "grave permanent total disabilities" ranged from $10,000 for a diagnostic error to $2,472,020 for an anesthesia error The median payment for all the claims in this severity category was $250,000, and the average was $488,375 Obstetrics-related errors, which accounted for almost half of the "grave permanent total disabilities," resulted in a median payment of $350,000. These payments ranged from $15,000 to $2,000,000 and averaged $425,413. The range of payments was the greatest for anesthesia-related errors—from $25,000 to $2,472,020 These errors had the lowest median ($85,000) and averaged $516,410.

What Economic Losses Were Incurred by Injured Patients?

Economic loss amounts were not always known by insurance companies Some reports included only past medical expenses and wage loss without allowance for future costs. We analyzed patients' economic losses only for those claims for which all of the information was provided. For 40,020 of the 73,472 claims (about 54 percent), the total incurred and future anticipated patient economic losses were about $4 5 billion This includes 3,230 claims for which the total economic losses were $0 [4]

Table 3.5 shows how the total was distributed among six economic loss categories About 88 percent of this was for anticipated future economic losses

[4]Because data were not available for about half of the claims, the estimates provided are for about half of the universe of claims We are unable to provide estimates for the balance of the claims

Table 3.5: Total and Average Amount of Patient Economic Losses by Categories

"Amount" in millions

Categories	Economic losses[a] Amount	Percent	Average	Highest
All claims	$4,531 3	100 0	$113 227	$10 463 000
Medical expenses				
Incurred as of claim closing	282 3	6 2	7 055	560 000
Anticipated future	919 2	20 3	22,968	4 000 000
Wage loss				
Incurred as of claim closing	163 6	3 6	4,087	1 000 000
Anticipated future	1,526 2	33 7	38 137	3 000 000
Other[b]				
Incurred as of claim closing	87 4	1 9	2,184	1 400 000
Anticipated future	1,552 6	34 3	38,796	9 999 999

[a]Only represents claims for which data were provided and, therefore are representative of about half of the universe of claims

[b]Other expenses include such items as housekeeping services, vocational rehabilitation travel and home renovation

To What Extent Were Patients' Economic Losses Resulting From Malpractice Injuries Compensated?

Of the 40,020 claims for which patient economic losses could be estimated, 18,279[5] —about 46 percent, were closed with an indemnity payment. Patients' economic losses associated with the 18,279 paid claims totaled about $4.0 billion and averaged $219,370. The median indemnity payment for these claims was $15,000, and the average was $71,530 The remaining 54 percent (21,741 claims) were closed without indemnity, and for these claims, patients had expenses of about $0 5 billion, with an average of about $24,000 As shown in table 3.6, the median payments for patients with economic losses of $100,000 or more were less than the economic losses. The median payments for patients with economic losses that ranged from $0 to $49,999 were larger than the economic losses.

[5]Because data were not available for about half of the paid claims, the estimates provided are for about half of the universe of paid claims We are unable to provide estimates for the balance of the paid claims

Table 3.6: Number of Paid Claims and Indemnity Payments by Size of Patients' Economic Losses

	Paid claims		Indemnity payments			
					Range	
Patients' economic loss ranges	Number[a]	Percent of total[b]	Median	Average	Lowest	Highest
All claims	18,279[c]	45 7	$15 000	$71,530	$1	$1 616 185
$0	1,392	43 1	1,500	16,025[d]	100	560,000
$1 to $999	3,538	51 4	1,500	3 881	9	507 447
$1,000 to $4,999	4,164	35 4	7,500	17,809	108	225 000
$5,000 to $9 999	1,936	37 0	15,000	33,755	500	550 000
$10,000 to $24 999	2,463	43 8	25,000	42,327	1	358,000
$25,000 to $49 999	906	48 8	50,000	65,052	1,500	357 500
$50,000 to $99 999	949	67 5	68,750	80,642	2,500	638 097
$100 000 to $249,999	682	50 4	29,999	138,835	5,000	1 000 000
$250,000 to $999,999	1,037	71 6	200,000	255,234	5,000	1 616,185
$1 million or more	1,213	99 5	398,362	439,397	25,000	1 315 996

[a]Detail does not add to total due to rounding

[b]Shows paid claims as a percentage of total claims within each of the loss ranges For example an estimated 11,778 claims involved patients economic losses ranging from $1,000 to $4,999 Of these 4,164 (about 35 4 percent) were closed with payment

[c]Only represents paid claims for which data were provided and therefore, are representative of about half of all paid claims

[d]Estimate subject to a large sampling error and should be used with caution

As shown in table 3.7, about 73 percent of the patients experiencing "major permanent total disabilities" received payments for their injuries. These patients had the highest percentage of paid claims, however, they also sustained the highest average economic losses—about $1 8 million per incident.

Table 3.7: Number of Paid Claims and Patients' Economic Losses by Severity of Injury Categories

	Paid claims		Patients' economic losses			
					Range	
Severity of injury	Number	Percent of total[a]	Median	Average	Lowest	Highest
All claims	18,279[b]	45 7	$5 000	$219,370	$0	$10 462 999
Emotional	881	24 1	457	6 599[c]	0	117 636
Insignificant	2,352	56 1	379	2 373	0	42 451
Temporary disability—minor	5,404	38 6	2 500	12,012	0	885 781
Temporary disability—major	1,758	50 4	9 191	29,916	0	300 000
Permanent partial disability—minor	3,744	61 7	5,000	64,380	0	1 360 000
Permanent partial disability—major	861	47 0	74,200	196,447[c]	0	2 005 000
Permanent total disability—major	1,325	73 2	1,644,244	1,814,942[c]	1 000	10 462 999
Permanent total disability—grave	495	68 6	1,113 485	1,688,029	5,000	4 840,000
Death	1,459	37 5	11,500	158,173	0	1 675 100

[a]Shows paid claims as a percentage of total claims within each of the severity of injury categories For example, an estimated 1,810 claims involved "major permanent total disabilities Of these 1 325 (about 73 2 percent) were closed with payment

[b]Only represents paid claims for which data were provided and therefore are representative of about half of all paid claims

[c]Estimate subject to a large sampling error and should be used with caution

Although almost three quarters of the claims where patients experienced "major permanent total disabilities" were paid, table 3.8 shows that the median and average compensation ($398,362 and $373,602) were lower than the median and average economic losses ($1 6 million and $1.8 million). It appears that the median indemnity payments for injuries ranging from "emotional" through "minor permanent partial disabilities" and for "death" were greater than the median economic losses.

Table 3.8: Number of Paid Claims and Indemnity Payments by Severity of Injury Categories

	Paid claims		Indemnity payments			
					Range	
Severity of injury	Number	Percent of total[a]	Median	Average	Lowest	Highest
All claims	18,279[b]	45 7	$15 000	$71 530	$1	$1 616 185
Emotional	881	24 1	7,500	24 783	18	560 000
Insignificant	2 352	56 1	3,000	8,162	25	75 000
Temporary disability—minor	5,404	38 6	6,000	13,753	1	212 500
Temporary disability—major	1,758	50 4	20,000	33,253	250	638 097
Permanent partial disability—minor	3,744	61 7	25,000	43,306	500	900 000
Permanent partial disability—major	861	47 0	68,750	130 420	750	1 315 996
Permanent total disability—major	1 325	73 2	398 362	373 602	2 500	996 000
Permanent total disability—grave	495	68 6	350,000	417,513	25 000	1,616,185
Death	1,459	37 5	30,000	108,021	1,000	1 109 937

[a]Shows paid claims as a percentage of total claims within each of the severity of injury categories For example, an estimated 1,810 claims involved major permanent total disabilities Of these 1 325 (about 73 2 percent) were closed with payment

[b]Only represents paid claims for which data were provided and, therefore, are representative of about half of all paid claims

To analyze the extent to which economic losses were covered by the awards/settlements, we compared each patient's total economic loss to the indemnity payment. As shown in table 3.9, the patients' economic losses exceeded the indemnity payment in about 30 percent of these claims.

Table 3.9: Comparison of Patients' Economic Losses to Indemnity Payments

	Paid claims		
Comparison	Number[a]	Percent	Cumulative percent
Loss less than payment	11,299	61 8	61 8
Loss equal to payment[b]	1,495	8 2	70 0
Loss greater than payment	5 486	30 0	100 0
Total	**18,279[c]**	**100.0**	

[a]Detail does not add to total due to rounding

[b]For purposes of this comparison we considered loss to equal payment if loss was within 10 percent (less or greater) of the payment

[c]Only represents paid claims for which data were provided and, therefore, are representative of about half of all paid claims

As shown in table 3.9, economic losses for 11,299 patients were less than their indemnity payments. For about 5 percent of these claims, economic losses were from 75 to 89 percent of the payment, while for about

55 percent, the losses were less than 25 percent of the payment (See table V.15.) "Minor temporary disabilities" (about 32 percent) and "minor permanent partial disabilities" (about 25 percent) were most often associated with these 11,299 claims (See table V 17)

Of the 5,486 claims where the patients' economic losses were greater than the payment, about 8 percent had losses exceeding the payment by 11 to 25 percent. However, for 68 percent, the losses exceeded the payment by more than 100 percent (See table V.16) For the claims where the patients' loss was greater than the payment, about 22 percent involved "minor temporary disabilities." About 18 percent involved "major permanent total disabilities," and 17 percent were "minor permanent partial disabilities " (See table V.17.)

What Percent of Indemnity Payments Are Plaintiff Attorney's Fees?

Our analysis of plaintiff attorney's fees shows the fees as a percentage of the expected values of the indemnity payments to the patients [6] We initially analyzed 20,671 paid claims where the total indemnity payment was made by one of the companies participating in the study (about 65 percent of all paid claims). The expected values of the indemnity payments for these 20,671 claims accounted for a total of about $3 5 billion. However, for 4,323 of these claims, the amount of the attorney's fees was unknown. Of the remaining 16,348 claims, 5,257 claims had reported fees of $0 and the balance had fees totaling $307 4 million [7]

As shown in table 3 10, for about 52 percent of the claims, the plaintiff attorney's fees represented from 31 to 40 percent of the expected value of the indemnity payments. The fees represented 40 percent or less of the indemnity payment in about 96 percent of the claims.

[6]Because some of the claims closed in 1984 involve structured payments that will be made over time, the payments received by patients for the 31,786 paid claims may total about $5 4 billion

[7]Because data were not available for about half of the paid claims, the estimates provided are for about half of the universe of paid claims We are unable to provide estimates for the balance of the paid claims

Table 3.10. Analysis of Plaintiff Attorney's Fees as a Percent of Indemnity Payments

Attorney's fees as a percent of indemnity payments	Paid claims		
	Number	Percent[a]	Cumulative percent
0	5,257	32.2	32.2
1 to 10	554	3.4	35.6
11 to 20	538	3.3	38.9
21 to 30	871	5.3	44.2
31 to 40	8,518	52.1	96.3
41 to 50	503	3.1	99.4
51 to 100	107	0.7	100.1
Total	**16,348[b]**	**100.0**	

[a]Detail does not add to total due to rounding

[b]Only represents paid claims for which data were provided and therefore, are representative of about half of all paid claims

How Did Compensation for Noneconomic Losses Relate to Indemnity Payments?

To determine this relationship, we compared patients' compensation for noneconomic losses to the expected value of the indemnity payments.[8] Of the 20,671 paid claims where the total indemnity payment was made by one of the companies participating in the study, compensation for noneconomic losses for 5,676 of these claims was unknown. Of the remaining 14,995 claims, 3,603 had noneconomic losses of $0, and the balance of the claims included $555.3 million as compensation for noneconomic losses.[9] For 759 of these 14,995 paid claims (about 5 percent), compensation for noneconomic losses was for amounts greater than $100,000 and totaled $403.8 million. This compensation represented about 42 percent of the total expected value of the indemnity payments made for these 759 claims. As shown in table 3.11, about $342.4 million (about 62 percent) of the compensation was included in the claims where losses were greater than $200,000.

[8]Because some of the claims closed in 1984 involve structured payments that will be made over time, the payments received by patients for the 31,786 paid claims may total about $5.4 billion.

[9]Because data were not available for about half of the paid claims, the estimates provided are for about half of the universe of paid claims. We are unable to provide estimates for the balance of the paid claims.

Table 3.11: Number of Claims and Compensation for Noneconomic Losses by Size of Noneconomic Losses

Dollars in millions

Noneconomic loss compensation ranges	Paid claims[a]		Aggregate compensation for noneconomic loss[a]
	Number	Percent	
$0	3,603	24.0	$0.0
$1 to $50,000	10,023	66.8	105.4
$50,001 to $200,000	1,049	7.0	107.6
More than $200,000	321	2.1	342.4
Total	**14,995**	**100.0**	**$555.3**

[a]Detail does not add to total due to rounding

Note: Claims classified by noneconomic loss compensation ranges only represent paid claims for which data were provided and, therefore, are representative of about half of all paid claims.

As shown in table 3.12, compensation for noneconomic losses represented from 51 to 60 percent of the expected value of the indemnity payments in about 18 percent of the claims. However, noneconomic losses accounted for 0 percent of the indemnity payments in 24 percent of the claims.

Table 3.12: Analysis of Compensation for Noneconomic Losses as a Percent of Indemnity Payments

Noneconomic losses as a percent of indemnity payments	Claims		
	Number	Percent	Cumulative percent
0	3,603	24.0	24.0
1 to 10	875	5.8	29.8
11 to 20	590	3.9	33.7
21 to 30	520	3.5	37.2
31 to 40	1,352	9.0	46.2
41 to 50	1,613	10.8	57.0
51 to 60	2,692	18.0	75.0
61 to 70	1,712	11.4	86.4
71 to 80	369	2.5	88.9
81 to 90	597	4.0	92.9
91 to 100	1,072	7.1	100.0
Total	**14,995[a]**	**100.0**	

[a]Only represents paid claims for which data were provided and, therefore, are representative of about half of all paid claims.

How Much Were Medicare/Medicaid Patients Compensated for Their Injuries Compared to Others?

Table 3 13 shows that when payment was made, the median and average indemnity for medicare and medicaid patients were lower than those for patients with other sources of payment for their health care costs

Table 3.13: Number of Paid Claims and Indemnity Payments by Source of Payment for Health Care Costs

	Paid claims		Indemnity payments			
					Range	
Source of health care payments	Number	Percent of total[a]	Median	Average	Lowest	Highest
Self	2,741	47 1	$16,000	$61 394	$9	$589 300
Private/ commercial insurance	15,188	50 5	23,500	105 250	1	1 800 000
Medicare	3 129	42 9	11,667	28,352	25	1 000 000
Medicaid	1 467	51 9	7,500	43,267	222	825 604
Workers compensation	766	35 7	30,000	69,503[b]	108	800 000

[a]Shows paid claims as a percentage of total claims for each of the sources of payment for health care costs For example an estimated 7,293 claims involved medicare patients Of these 3 129 (about 42 9 percent) were closed with payment

[b]Estimate subject to a large sampling error and should be used with caution

Medicare and medicaid beneficiaries experienced all types and severities of injuries; however, medicare beneficiaries most often suffered "minor temporary disabilities" (about 28 percent) or they died (about 26 percent) as a result of malpractice incidents. Medicaid recipients experienced "insignificant" injuries (24 percent) and "minor temporary disabilities" (about 23 percent) most often Injuries most frequently resulted from "other" and diagnostic errors for medicare beneficiaries and from surgical and treatment errors for medicaid beneficiaries

Questions and Answers Regarding Health Care Providers Involved in Medical Malpractice Claims

The claims closed in 1984 involved an estimated[1] 101,890 health care providers Of these, about 71 percent were physicians and about 21 percent were hospitals. The physician specialties most frequently involved in claims were obstetrics/gynecology and general surgery Insurers often were not able to provide data related to the training, board certification, and malpractice claims history of the physicians involved in the claims closed in 1984 However, the limited data for which estimates could be made suggest that at least 51 percent were board certified in the specialty in which the injury occurred and at least 52 percent may have been in practice from 11 to 30 years (estimated based on graduation from medical school between 1950 and 1969 followed by 4 years of postgraduate training) Despite this, at least 42 percent had previous malpractice claims filed against them

Against Whom Were Claims Filed and Payments Made?

A variety of health care providers, including individual practitioners and facilities, were named in medical malpractice claims. However, as shown in figure 4 1, the providers most frequently named in claims were physicians and hospitals, physicians accounted for about 71 percent and hospitals for about 21 percent. The remaining 8 percent included nurses, dentists, technicians, and other facilities, such as HMOs and nursing homes.

[1]Unless otherwise indicated, all data presented in this chapter are estimated The estimates are based on the number of providers for which the companies provided data There were additional providers involved for which the companies provided no information, which accounts for the difference between the 101,890 used in this chapter and the 103,255 providers estimated and discussed in chapter 2 Sampling errors were not computed for the health care provider data estimates since the providers were not randomly selected, thus, the precision of these data is unknown

Figure 4.1: Distribution of Providers Against Whom Claims Were Filed

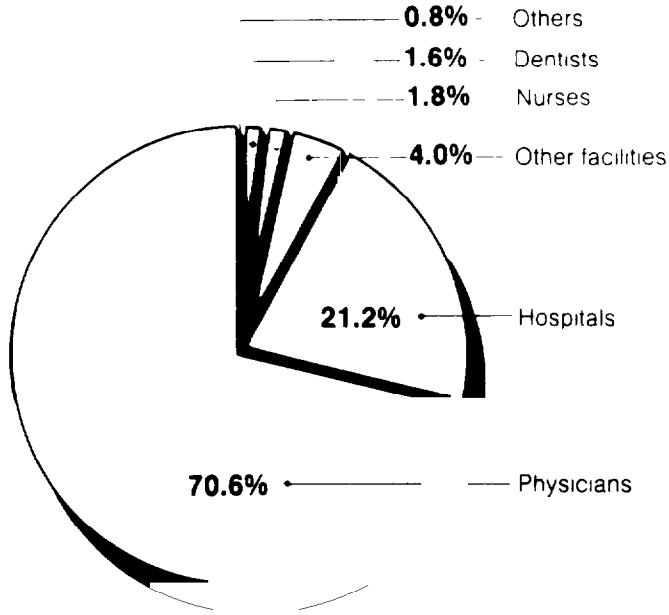


Table 4.1 shows that for all the providers involved in malpractice claims, payment was made for about 34 percent. Claims filed against hospitals had a higher payment percentage (about 39 percent) than those filed against physicians (about 32 percent). Over half of the claims filed against dentists resulted in payments.

Table 4.1: Number of Providers Involved in Claims and Their Payment Status by Type of Provider

	Providers				
		With payment		Without payment	
Provider type	Total[a]	Number[a]	Percent	Number[a]	Percent
All providers	101,890	34,979	34 3	66,470	65 2
Physicians	71,930	22,864	31 8	48 705	67 7
Hospitals	21 558	8,473	39 3	13,023	60 4
Facilities (other than hospitals)	4,032	1,483	36 8	2,544	63 1
Nurses	1,851	646	34 9	1 205	65 1
Dentists	1,650	911	55 2	739	44 8
Other	871	603	69 2	255	29 3

[a]Detail does not add to total due to rounding

Note Detail by payment status does not add to total or 100 percent because payment action was unknown for some providers

What Were the Physician Specialties Most Often Named in Claims?

Malpractice claims were filed against physicians practicing in more than 43 specialty areas However, about half of the physicians named in claims practiced in six areas, and about 86 percent practiced in 17 For all the physicians in the United States, about 40 percent practiced in these six areas, and about 68 percent practiced in the 17 specialties As shown in table 4.2, obstetricians/gynecologists and general surgeons were most often named in malpractice claims About 24 percent of the physicians practiced in these two specialties Orthopedic surgeons and internists accounted for about 16 percent of physicians named in claims Nationally, about 12 percent of all practicing physicians were internists General surgeons and obstetricians/gynecologists accounted for about 6 percent and 5 percent, respectively

Table 4.2: Number of Physicians Involved in Claims Compared to All Physicians by Physician Specialty

	Physicians			
	All[a]		Involved in claims[b]	
Specialty	**Number**	**Percent[b]**	**Number**	**Percent**
Obstetrics/gynecology	25,234	5 2	8,927	12 4
General surgery	31,308	6 4	8 733	12 1
Orthopedic surgery	14 572	3 0	6 064	8 4
Internal medicine	60,118	12 4	5 397	7 5
General practice	29,399	6 1	4 555	6 3
Family practice	31,195	6 4	4 505	6 3
Radiology[c]	19,893	4 1	3,973	5 5
Emergency medicine	7,811	1 6	3,325	4 6
Anesthesiology	16,845	3 5	3,073	4 3
Plastic surgery	3,193	0 6	2,307	3 2
Urology	7,889	1 6	2,156	3 0
Pediatrics	28,027	5 8	2,147	3 0
Ophthalmology	13,281	2 7	2,027	2 8
Neurosurgery	3,498	0 7	1,850	2 6
Otolaryngology	[d]	[d]	1 304	1 8
Psychiatry	27 303	5 6	1,298	1 8
Pathology	12 502	2 6	426	0 6
Other	153,055	31 5	9,862	13 7
Total	**485,123**	**100.0**	**71,930**	**100.0**

[a]Data are as of December 31, 1981, the year most patient injuries occurred for the malpractice claims closed in 1984 and are from Physician Characteristics and Distribution in the U S., 1982 Edition Department of Data Release Services, Division of Survey and Data Resources, American Medical Association 1983, pp 37 and 38

[b]Detail does not add to total due to rounding

[c]Includes radiology diagnostic radiology and therapeutic radiology

[d]Data not provided for this specialty

Although obstetricians/gynecologists and general surgeons each made up about 12 percent of the physicians named in malpractice claims, payments were made on behalf of about 46 percent of the obstetricians/gynecologists, while 26 percent of the general surgeons had payments made against them, as shown in table 4.3. Payments were made for about 21 percent of the radiologists and internists.

Table 4.3: Payment Status for Physicians Involved in Claims by Physician Specialty

	With payment		Without payment	
Specialty	**Number[a]**	**Percent**	**Number[a]**	**Percent**
Obstetrics/gynecology	4,070	45.6	4,857	54.4
General surgery	2,267	26.0	6,466	74.0
Orthopedic surgery	2,058	33.9	4,006	66.1
Internal medicine[b]	1,148	21.3	4,206	77.9
General practice	1,724	37.9	2,831	62.1
Family practice[b]	1,169	25.9	3,330	73.9
Radiology[c]	824	20.7	3,148	79.2
Emergency medicine	814	24.5	2,511	75.5
Anesthesiology[b]	1,273	41.4	1,794	58.4
Plastic surgery	689	29.9	1,618	70.1
Urology	1,179	54.7	977	45.3
Pediatrics	713	33.2	1,434	66.8
Ophthalmology	670	33.1	1,357	66.9
Neurosurgery	440	23.8	1,410	76.2
Otolaryngology	710	54.5	594	45.5
Psychiatry	655	50.5	643	49.5
Pathology	324	76.0	102	24.0
Other[b]	2,139	21.7	7,418	75.2
Total[b]	**22,864**	**31.8**	**48,705**	**67.7**

[a]Detail does not add to total due to rounding.

[b]Detail does not add to number of physicians involved in claims as shown in table 4.2 because payment action was unknown for some physicians.

[c]Includes radiology, diagnostic radiology, and therapeutic radiology. Also, detail does not add to number of radiologists involved in claims as shown in table 4.2 because of rounding.

How Did Companies' Indemnity Payments Differ by Physician Specialty?

We analyzed this question for 14,749 paid malpractice claims in which only one provider was named and that provider was a physician. For these cases, as shown in table 4.4, companies' indemnity payments ranged from $20 for an anesthesiologist to $1,616,185 for a general surgeon. The median payment for physicians was $25,000 and the average was $85,179.

Table 4.4: Number of Paid Claims Involving Only One Physician Provider and Indemnity Payments by Physician Specialty

	Claims with one physician[a]		Indemnity payments			
					Range	
Physician specialty	Total	Paid	Median	Average	Lowest	Highest
All claims	33,068	14,749	$25,000	$85 179	$20	$1 616 185
Obstetrics/gynecology	5,165	2,711	75,000	177 509	90	1 000 000
General surgery	3,952	1,173	49,000	120 889	250	1 616 185
Orthopedic surgery	3,283	1,493	25,000	80 059	108	750 000
Internal medicine	1,288	629	10 000	42,757	40	592 000
General practice	2 076	1,071	45,000	50,264	40	800 000
Family practice	2,400	717	15,000	40,339	442	700 000
Radiology[b]	520	231	19,500	53,101	100	1,000 000
Emergency medicine	826	364	7,000	22,640	250	197 500
Anesthesiology	1,851	884	3,000	42,680	20	632,043
Plastic surgery	1,998	618	22,500	70,172	200	850,000
Urology	912	771	625	14,896	116	137 500
Pediatrics	1,640	492	195,000	198,644	120	521 902
Ophthalmology	1,260	578	10,000	55,593	28	290 000
Neurosurgery	828	247	10,000	65,226	2,500	1 000 000
Otolaryngology	632	419	23,500	23,264	424	543 000
Psychiatry	957	637	25,000	34,914	600	560 000
Pathology	195	195	250,000	197,652	2,500	250 000

[a]Total and paid claims data are provided for 17 specialties and, therefore, do not add to totals for all claims

[b]Includes radiology diagnostic radiology and therapeutic radiology

Did the Physicians Have Previous Claims Made Against Them?

As shown in table 4.5, about 42 percent of the physicians had previous claims made against them; however, the information was unknown for about 28 percent.

Table 4.5: Number of Physicians Who Had Previous Claims Filed Against Them

	Physicians	
Previous claims	Number[a]	Percent
Yes	30,156	41 9
No	21,298	29 6
Unknown	20,477	28 5
Total	**71,930**	**100.0**

[a]Detail does not add to total due to rounding

When Did the Physicians Graduate From Medical School?

As shown in table 4.6, the largest percentage of physicians involved in claims—about 34 percent—graduated from medical school during the years 1960-69. Nationally, about 24 percent of all physicians graduated during that time. For all the physicians practicing in the United States, about 37 percent graduated from medical school in more recent years (1970-81) compared to those named in medical malpractice claims (about 17 percent). However, the year of medical school graduation was unknown for about 20 percent of the physicians against whom claims were made.

Table 4.6: Number of Physicians Involved in Claims Compared to All Physicians by Years of Graduation

	Physicians			
	All[a]		Involved in claims	
Years of graduation	Number	Percent[b]	Number	Percent[b]
1920-29	13,768[c]	2.8[c]	214	0.3
1930-39	34,530	7.1	1,543	2.1
1940-49	57,852	11.9	6,445	9.0
1950-59	83,484	17.2	13,225	18.4
1960-69	115,239	23.8	24,073	33.5
1970-79	148,923	30.7	11,373	15.8
1980-81	31,327	6.4	729	1.0
Unknown	•	•	14,168	19.7
Total	**485,123**	**100.0**	**71,770[d]**	**100.0**

[a]Data are as of December 31, 1981, and are from Physician Characteristics and Distribution in the U.S., 1982 Edition, Department of Data Release Services, Division of Survey and Data Resources, American Medical Association, 1983, p. 44. (The figures shown on the source document have been discussed with the American Medical Association and have been corrected.)

[b]Detail does not add to total due to rounding.

[c]Before 1930.

[d]Does not include 160 physicians who graduated in 1982 and 1983.

To What Extent Were Foreign-Trained Physicians Involved in Malpractice Claims?

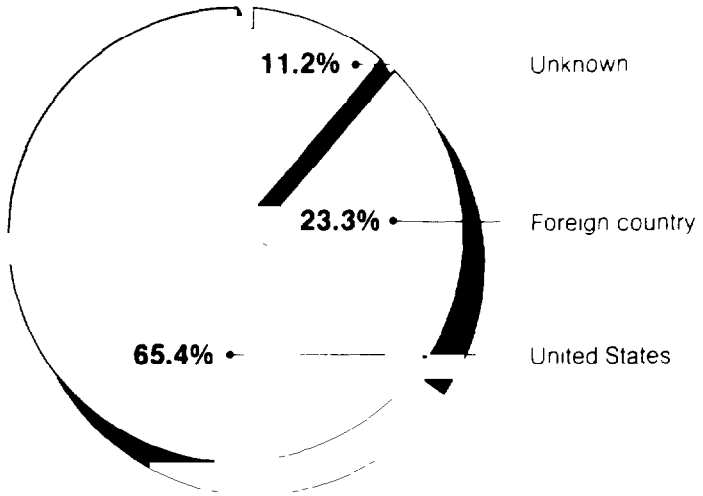
Nationally, in 1981, 110,542[2] (about 23 percent) of the physicians practicing in the United States were educated in foreign medical schools.[3] Figure 4.2 shows that, of the 71,930 physicians in our closed claim universe, about 23 percent (16,780)[4] were foreign trained.

[2]Includes 7,780 physicians educated in Canadian schools.

[3]Physician Characteristics and Distribution in the U.S., 1982 Edition, Department of Data Release Services, Division of Survey and Data Resources, American Medical Association, 1983, pp. 44 and 46.

[4]Includes 885 physicians educated in Canadian schools.

Figure 4.2: Distribution of Physicians by Location of Medical Education



Note Detail does not add to total due to rounding

To What Extent Were Board Certified Physicians Involved in Patient Injuries?

About 52 percent of all physicians practicing in this country in 1981 were board certified [5] As shown in table 4.7, about 51 percent of the physicians involved in claims closed in 1984 were board certified in the medical specialty in which the liability injury occurred However, this information was unknown for about 35 percent

Table 4.7: Board Certification Status for Physicians Involved in Claims Closed in 1984

	Physicians	
Board certification	**Number**	**Percent[a]**
Yes	36 495	50 7
No	10 537	14 6
Unknown	24 898	34 6
Total	**71,930**	**100.0**

[a]Detail does not add to total due to rounding

In What Type of Practice Were the Physicians?

Table 4.8 provides the frequency of insured physicians' involvement in the closed claims by type of practice As the table shows, about 70 percent were in either individual or group practice

[5]Physician Characteristics and Distribution in the U S , 1982 Edition, p 41

Table 4.8: Number of Physicians by Type of Practice

Type of practice	Physicians	
	Number	Percent[a]
Physician in individual practice	27,192	37.8
Physician in group practice	23,210	32.3
Hospital-based salaried physician	6,427	8.9
HMO-based salaried physician	817	1.1
Emergency care center salaried physician	966	1.3
Other	912	1.3
Unknown	12,406	17.2
Total	**71,930**	**100.0**

[a]Detail does not add to total due to rounding

Previous Closed Claims Studies

Closed claim studies have been undertaken to collect data for such purposes as developing programs aimed at preventing medical injuries, evaluating legislation already enacted, providing a basis for enacting legislation, and reviewing aspects of insurance rating and classification Among previous closed claims studies are the following.

- The Secretary of Health, Education, and Welfare (now Health and Human Services) established a commission on medical malpractice The commission issued a report in 1973 based on about 3,000 claims closed in 1970 by 26 insurance companies These companies were among the largest insurers of medical malpractice Analysis of the data focused on the characteristics of claims and the relationship between legal procedures concerning medical malpractice and the occurrence of claims
- The Department of Health, Education, and Welfare sponsored another study, issued in 1978, based on all claims closed between July 1, 1976, and October 31, 1976, by nine of the largest malpractice insurers. The study developed a file of closed claims data for use in analyzing injuries and compensation
- A report issued in 1976 by the Insurance Services Office for the American Insurance Association was based on a sample of claims closed in 1974 by 11 companies The report provided quantitative information about the closed claims in its sample
- The National Association of Insurance Commissioners published four books entitled NAIC Malpractice Claims, which were issued between December 1975 and May 1977 These publications were based on 25,000 claims closed between July 1, 1975, and June 30, 1976, by 54 insurers writing $1 million or more of malpractice business in any single year between 1970 and 1975. The analysis focused on (1) developing programs aimed at preventing medical injuries, (2) evaluating legislation already enacted and providing a basis for legislation to be enacted, and (3) reviewing aspects of pricing methodology. In October 1977 the National Association of Insurance Commissioners resumed data collection on all claims closed since July 1, 1976. At that time, the data collection instrument was modified to provide more detail for professional and hospital loss prevention programs. Cooperation was received from the many new limited purpose companies formed since 1975 (i e , physician-owned and hospital-owned companies). A final compilation of data encompassed 71,782 closed claims and was issued in September 1980

U.S. GENERAL ACCOUNTING OFFICE
MEDICAL PROFESSIONAL LIABILITY INSURANCE CLOSED CLAIMS REPORT

FORM A

Directions: Complete each question with an entry, specified code, or check mark in the appropriate box or space, unless directed to skip that question. Do not write in shaded spaces. Place all numbers as far to the right in the field as possible. When the answer is zero or none, indicate with an "0". If unknown, enter "-" in each space.

Preparer's initials _____ Report No. /__/__/ - /__/-/__/__/ (1-5)

I. BASIC IDENTIFYING DATA CARD 01 (6-7)

1. Claim file identification number:

/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/

2. During what month and year did this medical liability injury occur? /__/__/-/__/__/ mo. yr. (8-11)

3. In what type of facility did the injury occur? (CHECK ONE.) (12-13)

01. [ ] Community hospital, non-teaching
02. [ ] Community hospital, teaching
03. [ ] Other hospital
04. [ ] Nursing home
05. [ ] Physician's office
06. [ ] Patient's home
07. [ ] Health maintenance organization
08. [ ] Walk-in emergency care center
09. [ ] Other (PLEASE SPECIFY.) _____
10. [ ] Unknown

4. What caused your company to open this claim file? (CHECK ONE.) (14)

1. [ ] Patient complained to insured
2. [ ] Patient's relative, guardian or friend complained to insured
3. [ ] Patient's attorney requested records from insured (GO TO QUESTION 6.)
4. [ ] Patient's attorney notified insured of a claim
5. [ ] Suit papers served on insured
6. [ ] Practitioner or hospital notified company of malpractice incident (GO TO QUESTION 5.)
7. [ ] Other (PLEASE SPECIFY.) _____
8. [ ] Unknown

5. Did the company initiate contact with the patient or the patient's representative? (CHECK ONE.) (15)

1. [ ] Yes
2. [ ] No
3. [ ] Unknown

6. During what month and year did the patient or patient's representative make a claim? /__/__/ - /__/__/ (mo. / yr.) (16-19)

7. In what state was the claim filed? /__/__/ (20-21)

_____

8. How many medical providers were involved when this claim was first made? /__/__/ (22-23)

9. How many medical providers were insured by this company? /__/__/ (24-25)

II. PATIENT DATA

10. What was the patient's age at the time of the liability injury? (CHECK ONE AND FILL IN THE BLANK.)

    1. [ ] At birth (before or during delivery) /___/___/___/ (26-28)

    2. [ ] Less than 1 year--in months _____

    3. [ ] 1 year or more--in years _____

11. What is the patient's sex? (CHECK ONE.) (29)

    1. [ ] Male

    2. [ ] Female

12. What was the patient's occupational status at the time of the liability injury? (CHECK ONE.) (30)

    1. [ ] Employed

    2. [ ] Self-employed

    3. [ ] Homemaker

    4. [ ] Retired

    5. [ ] Unemployed

    6. [ ] Dependent child/student

    7. [ ] Independent student

    8. [ ] Other (PLEASE SPECIFY.) _____

       _____

    9. [ ] Unknown

13. What were the patient's annual earnings at the time of the liability injury? Estimate if necessary. (ROUND UP TO NEXT $1,000.00.) $/___/,/___/___/___/,/0/0/0/ (31-34)

14. What was the major source of payment of the patient's health care costs prior to the liability injury? (CHECK ONE.) (35)

1. [ ] Self
2. [ ] Private/commercial insurance (including HMO's)
3. [ ] Medicare
4. [ ] Medicaid
5. [ ] Worker's compensation
6. [ ] Other (PLEASE SPECIFY.) _____

_____

7. [ ] Unknown

QUESTIONS 15-20 BELOW REFER TO EXPENSES AND LOSSES RESULTING FROM LIABILITY INJURY, REGARDLESS OF WHETHER COMPENSATION WAS MADE ON THE CLAIM. IF THE DOLLAR AMOUNTS REQUESTED ARE NOT READILY AVAILABLE IN THE FILE, PLEASE ESTIMATE THEM BASED ON OTHER DATA IN THE FILE AND YOUR OWN EXPERIENCE.

What was the . . .

15. Patient's incurred medical expense as of date claim was closed? $/___/,/___/___/___/,/___/___/___/ (36-42)

16. Patient's anticipated future medical expenses? (ESTIMATE FROM DATE CLAIM WAS CLOSED EXPRESSED IN TODAY'S DOLLARS.) $/___/,/___/___/___/,/___/___/___/ (43-49)

17. Patient's incurred wage loss as of date claim was closed? $/___/,/___/___/___/,/___/___/___/ (50-56)

18. Patient's anticipated future wage loss? (ESTIMATE FROM DATE CLAIM WAS CLOSED EXPRESSED IN TODAY'S DOLLARS.) $/___/,/___/___/___/,/___/___/___/ (57-63)

19. Patient's other anticipated expenses incurred as of date claim was closed? $/___/,/___/___/___/,/___/___/___/ (64-70)

20. Patient's anticipated other expenses for the future? (ESTIMATED FROM DATE CLAIM WAS CLOSED EXPRESSED IN TODAY'S DOLLARS.) $/___/,/___/___/___/,/___/___/___/ (71-77)

A-4

III. INJURY DATA

21. What was the principal allegation(s) of negligence/error leading to injury or complication for which the claim was made? (ENTER UP TO 2 CODES FROM THE LIST ON PAGES 17-18 OF THE INSTRUCTION BOOKLET. IF UNABLE TO FIND THE APPROPRIATE CODE, DESCRIBE THE ALLEGATION(S) OF NEGLIGENCE.)

/___/___/
*02 (8-9)

_____ /___/___/
(10-11)

22. How severe was the injury? (CHECK SEVERITY OF ULTIMATE INJURY ON SCALE PROVIDED BELOW.) (12-13)

01. [ ] Emotional only. For example, fright, pain and suffering; no physical damage.

02. [ ] Insignificant. For example, lacerations, contusions, minor scars, rash. No delay in recovery.

TEMPORARY DISABILITY

03. [ ] Minor. For example, infections, misset fracture, fall in hospital. Recovery delayed.

04. [ ] Major. For example, burns, surgical material left, drug side-effect, brain dysfunction. Recovery delayed.

PERMANENT PARTIAL DISABILITY

05. [ ] Minor. For example, loss of fingers, loss or damage to organs. Include non-disabling injuries.

06. [ ] Major. For example, deafness, loss of limb, loss of eye, loss of one kidney or lung.

PERMANENT TOTAL DISABILITY

07. [ ] Major. For example, paraplegia, blindness, loss of two limbs, brain damage.

08. [ ] Grave. For example, quadriplegia, severe brain damage, life long care or fatal prognosis.

09. [ ] Death.

OTHER

10. [ ] Other (PLEASE SPECIFY.) _____

_____

IV. COST DATA

23. Was payment made? (CHECK ONE.) (14)

1. [ ] Yes (GO TO QUESTION 24.)
2. [ ] No (GO TO QUESTION 31.)

24. What was the form of the payment? (CHECK ALL THAT APPLY.) (15-18)

1. [ ] Lump sum
2. [ ] Structured settlement (periodic payments)
3. [ ] Free services
4. [ ] Unknown

25. During what month and year was any payment first made to the claimant? /__/__/ - /__/__/ (mo. / yr.) (19-22)

26. What was the total value (the expected yield) of the indemnity settlement or award to the claimant on behalf of all defendants by all sources? (I.e., what is the total the claimant would get over time including structured payments and the value of free services, if any.) (IF UNKNOWN, INDICATE WITH "-"'s AND GO TO QUESTION 27.)

$/__/__/,/__/__/__/,/__/__/__/ (23-30)

27. What was the total value (the expected yield) of the indemnity settlement or award to the claimant by this company? $/__/__/,/__/__/__/,/__/__/__/ (31-38)

28. What was the total cost to this company for settlement to the claimant? (This includes the amount of any lump-sum payment and/or the cost of any annuity purchased for future structured payments. Include indemnity only; do not include expenses.) $/__/__/,/__/__/__/,/__/__/__/ (39-46)

29. Did the settlement or award indicated in question 26 cover each of the following items? (FOR EACH THAT WAS COVERED, INDICATE THE AMOUNT. ESTIMATE IF NECESSARY.)

		AMOUNT
1. Medical expenses	Yes [ ] No [ ] (47)	$/___/___/,/___/___/___/,/___/___/___/ (48-55)
2. Lost wages/salary	Yes [ ] No [ ] (56)	$/___/___/,/___/___/___/,/___/___/___/ (57-64)
3. Other economic losses	Yes [ ] No [ ] (65)	$/___/___/,/___/___/___/,/___/___/___/ (66-73)
4. Non-economic loss (such as pain and suffering, loss of consortium, loss of companionship, etc.)	Yes [ ] No [ ] *03 (8)	$/___/___/,/___/___/___/,/___/___/___/ (9-16)

30. Did the settlement or award indicated in question 26 cover each of the following items?. (FOR EACH THAT WAS COVERED, INDICATE THE AMOUNT. ESTIMATE IF NECESSARY.)

		AMOUNT
1. Plaintiff's attorney's fees	Yes [ ] No [ ] (17)	$/___/___/,/___/___/___/,/___/___/___/ (18-25)
2. Punitive damages	Yes [ ] No [ ] (26)	$/___/___/,/___/___/___/,/___/___/___/ (27-34)
3. Pre-judgment interest	Yes [ ] No [ ] (35)	$/___/___/,/___/___/___/,/___/___/___/ (36-43)

31. Were allocated expenses incurred by this company for each of the following items? (FOR EACH THAT WAS INCURRED, INDICATE THE AMOUNT. ESTIMATE IF NECESSARY.)

1. Defense counsel — AMOUNT

Yes [ ] No [ ] (44) $/__/__/,/__/__/__/,/__/__/__/ (45-52)

2. Expert witness(es)

Yes [ ] No [ ] (53) $/__/__/,/__/__/__/,/__/__/__/ (54-61)

3. All other allocated expenses

Yes [ ] No [ ] (62) $/__/__/,/__/__/__/,/__/__/__/ (63-70)

U.S. GENERAL ACCOUNTING OFFICE
MEDICAL PROFESSIONAL LIABILITY INSURANCE CLOSED CLAIMS REPORT

FORM B

Instructions: Submit one FORM B for each person named in claim who was insured by your company

Report No. /__/__/ - /__/-/__/__/ (1-5)

I. INSURED AND DISPOSITION DATA Insured No. _____ /__/__/ (6-7)

1. Claim ID Number

/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/

2. Type of insured at time of liability injury (ENTER A CODE FROM THE LIST ON PAGE 31 OF THE INSTRUCTION BOOKLET. IF UNABLE TO FIND THE APPROPRIATE CODE, DESCRIBE THE TYPE OF INSURED.) /__/__/ (8-9)

_____

3. Did the insured have each of the following types of liability coverage with this company? (FOR EACH THAT SHE/HE HAD INDICATE THE COVERAGE PER OCCURENCE.)

AMOUNT

1. Primary policy

[ ] Yes (10) $/__/__/,/__/__/__/,/__/__/__/ (11-18)

[ ] No

2. Excess

[ ] Yes (19) $/__/__/,/__/__/__/,/__/__/__/ (20-27)

[ ] No

3. Umbrella

[ ] Yes (28) $/__/__/,/__/__/__/,/__/__/__/ (29-36)

[ ] Yes, but no separate limits stated for this individual

[ ] No

B-1

4. Does this insured carry any other excess/umbrella policies? (CHECK ONE.) (37)

   1. [ ] Yes
   2. [ ] No
   3. [ ] Unknown

5. Was payment made on behalf of this insured? (CHECK ONE.) (38)

   1. [ ] Yes
   2. [ ] No
   3. [ ] Unknown

6. What was the month and year of the final disposition of this claim for this insured? (Date claim file was closed for indemnity purposes; all appeals were final.) /__/__/ - /__/__/ mo. yr. (39-42)

7. At what stage of this claim proceeding was the claim closed for this insured? (CHECK ONE.) (43-44)

   01. [ ] Claim filed, but before suit
   02. [ ] Suit, but before trial
   03. [ ] Suit, but before arbitration
   04. [ ] During trial but before verdict
   05. [ ] During binding arbitration, but before decision
   06. [ ] After trial verdict by jury
   07. [ ] After trial verdict without jury
   08. [ ] After appeal
   09. [ ] After binding arbitration
   10. [ ] Other (PLEASE SPECIFY.) _____

8. During its pendency, did this claim undergo a review by a pre-trial screening panel? (CHECK ONE.) (45)

   1. [ ] Yes (GO TO QUESTION 9.)
   2. [ ] No (GO TO QUESTION 10.)
   3. [ ] Unknown (GO TO QUESTION 10.)

9. Was the recommendation of the pre-trial review panel for the claimant or the insured? (CHECK ONE.) (46)

   1. [ ] Claimant
   2. [ ] Insured
   3. [ ] No finding
   4. [ ] Unknown

10. During its pendency, did the claim undergo arbitration? (CHECK ONE.) (47)

   1. [ ] Yes (GO TO QUETION 11.)
   2. [ ] No (GO TO SECTION II.)
   3. [ ] Unknown (GO TO SECTION II.)

11. Was the arbitration finding for the claimant or the insured? (CHECK ONE.) (48)

   1. [ ] Claimant (GO TO QUESTION 12.)
   2. [ ] Insured (GO TO QUESTION 12.)
   3. [ ] No finding (GO TO SECTION II.)
   4. [ ] Unknown (GO TO SECTION II.)

12. Was the arbitration binding or non-binding? (CHECK ONE.) (49)

   1. [ ] Binding
   2. [ ] Non-binding
   3. [ ] Unknown

II. PRACTITIONER DATA

ANSWER THIS SECTION ONLY IF THE TYPE OF INSURED INDICATED IN QUESTION 2 WAS A PHYSICIAN. IF NOT A PHYSICIAN, FORM B IS COMPLETE.

13. At the time of the liability injury how was the insured physician practicing? (CHECK ONE.) (50)

1. [ ] Physician in individual practice
2. [ ] Physician in group practice
3. [ ] Hospital based salaried physician
4. [ ] HMO based salaried physician
5. [ ] Emergency-care center, salaried physician
6. [ ] Other (PLEASE SPECIFY.) _____

_____

7. [ ] Unknown

14. What was the insured's status at the time of the liability injury? (CHECK ONE.) (51)

1. [ ] Medical student
2. [ ] Resident
3. [ ] Fellow
4. [ ] Physician
5. [ ] Unknown
6. [ ] Other (PLEASE SPECIFY.) _____

_____

15. Was the insured physician board certified in the medical speciality area in which the liability injury occurred? (CHECK ONE.) (52)

1. [ ] Yes
2. [ ] No
3. [ ] Unknown

16. In what country did the insured physician receive primary medical education?

_____ /__/__/ (53-54)
(COUNTRY)

[ ] Unknown

17. In what year did the insured graduate from medical school? /__/__/ (55-56)

18. Have previous claims been made against the insured? (CHECK ONE.) (57)

1. [ ] Yes
2. [ ] No
3. [ ] Unknown

Principal Allegations of Negligence[1] That Led to Injury or Complication for Which Claim Was Made

Diagnosis Related	Delay in diagnosis Failure to diagnose (no diagnosis made) Misdiagnosis (original diagnosis incorrect) Failure to obtain consent for diagnostic procedure Unnecessary diagnostic test Improper performance of diagnostic test Other diagnosis-related error
Anesthesia Related	Failure to complete patient assessment Failure to monitor Failure to test equipment Improper choice of anesthesia Improper administration of anesthesia Improper use of equipment Improper intubation Improper positioning Other anesthesia-related error
Surgery Related	Failure to obtain consent for surgery Improper performance Improper positioning Retained foreign bodies Unnecessary surgery Wrong body part Other surgery-related error
Medication Related	Wrong medication ordered Wrong dosage ordered Other drug-related error
Medication Administration Related	Wrong drug given Wrong dosage given Wrong patient Improper route of administration Improper method of administration Other medication administration-related error

[1]The allegations of negligence were developed by the Risk Management Foundation of the Harvard Medical Institutions and are used with their permission

Intravenous Related	Failure to monitor Improper performance Other intravenous-related error
Obstetrics Related	Failure to obtain consent Improper management of pregnancy Failure to properly manage labor Improper choice of delivery method Improperly performed vaginal delivery Delay in C-section Improperly performed C-section Failure to identify fetal distress Failure to treat fetal distress Delay in treating fetal distress Wrongful life/birth Abandonment Other obstetrics-related error
Treatment Related	Failure to obtain consent for treatment Delay in treatment Failure to render treatment Improper choice of treatment Improper performance Premature end of treatment Failure to instruct Other treatment-related error
Physiology/Behavior Monitoring Related	Failure to monitor Failure to report Failure to respond Other monitoring-related error
Biomedical Equipment Related	Failure to inspect Inadequate maintenance/repair Improper use Malfunction/failure Failure to respond to product warnings Other equipment-related error

Blood Products Related	Contamination from blood product Wrong type of blood product Other blood products-related error
Other	Failure to follow consent policies Failure to follow policy/procedure Failure to review provider performance Failure to insure patient safety Transportation Failure to protect third parties Falls Other

Categories Used to Classify Injuries by Severity

Emotional. For example, fright, pain and suffering, no physical damage

Insignificant For example, lacerations, contusions, minor scars, rash No delay in recovery

Temporary Disability

- Minor For example, infections, misset fracture, fall in hospital Recovery delayed.
- Major For example, burns, surgical material left, drug side-effect, brain dysfunction Recovery delayed.

Permanent Partial Disability:

- Minor For example, loss of fingers, loss or damage to organs. Include nondisabling injuries
- Major. For example, deafness, loss of limb, loss of eye, loss of one kidney or lung.

Permanent Total Disability.

- Major. For example, paraplegia, blindness, loss of two limbs, brain damage.
- Grave. For example, quadriplegia, severe brain damage, life long care or fatal prognosis.

Death

Other

Supplemental Estimated Closed Claims Data

Table V.1: Number of Claims for Surgical Errors by Specific Allegations

Allegations	Surgical error claims Number	Percent
All claims	18,697	100.0
Improper performance	13,966	74.7
Other surgery-related error	1,690	9.0
Retained foreign bodies	1,051	5.6
Unnecessary surgery	811	4.3
Failure to obtain consent for surgery	780	4.2
Improper positioning	[a]	
Wrong body part	[a]	

[a]Limited occurrence in sample precludes calculation of reliable estimate

Table V.2: Number of Claims for Diagnostic Errors by Specific Allegations

Allegations	Diagnostic error claims Number	Percent
All claims	17,372	100.0
Failure to diagnose (no diagnosis made)	6,495	37.4
Misdiagnosis (original diagnosis incorrect)	5,794	33.4
Delay in diagnosis	3,891	22.4
Improper performance of diagnostic test	871	5.0
Failure to obtain consent for diagnostic procedure	186	1.1
Unnecessary diagnostic test	[a]	
Other diagnosis-related error	[a]	

[a]Limited occurrence in sample precludes calculation of reliable estimate

Table V.3: Number of Claims for Treatment Errors by Specific Allegations

Allegations	Treatment error claims Number	Percent
All claims	14,635	100.0
Improper performance	6,602	45.1
Improper choice of treatment	3,179	21.7
Failure to render treatment	2,073	14.2
Other treatment-related error	1,192	8.1
Delay in treatment	1,047	7.2
Failure to obtain consent for treatment	[a]	[a]
Premature end of treatment	[a]	[a]
Failure to instruct	[a]	[a]

[a]Limited occurrence in sample precludes calculation of reliable estimate

Table V.4: Number of Claims According to Payment Status by Type of Facility Where Injury Occurred

Type of facility	With payment		Without payment	
	Number	Percent	Number[a]	Percent
All claims	31 786	43 3	41 686	56 7
Community hospital—nonteaching	16 269	38 1	26 397	61 9
Community hospital—teaching	5 797	43 8	7 432	56 2
Other hospital	1 928	59 5	1 312	40 5
Physician s office	5,106	55 1	4 169	44 9
Nursing home emergency care center, HMO patient s home other, and unknown	2 686	53 1	2 377	46 9

[a]Detail does not add to total due to rounding

Table V.5: Number of Paid Claims and Indemnity Payments by Type of Facility Where Injury Occurred

Type of facility	Paid claims		Indemnity payments			
					Range	
	Number	Percent of total[a]	Median	Average	Lowest	Highest
All claims	31 786	43 3	$18,000	$80,741	$1	$2,472,020
Community hospital— nonteaching	16,269	38 1	17 500	92 375	9	2 472,020
Community hospital— teaching	5,797	43 8	25,000	113,083	1	1 800 000
Other hospital	1,928	59 5	25,000	72 172	20	1 616 185
Physician's office	5,106	55 1	15 000	30 559	28	500 000
Nursing home, emergency care center, HMO, patient's home, other, and unknown	2,686	53 1	18 000	42,009	93	1 109 937

[a]Shows paid claims as a percentage of total claims for each of the types of facilities For example an estimated 13 229 claims involved injuries that occurred in teaching hospitals Of these 5 797 (about 43 8 percent) were closed with payment

Table V.6: Number of Claims According to Payment Status by Patients' Age Ranges

Age ranges (years)	With payment		Without payment	
	Number	Percent	Number	Percent
All claims	30 911	43 8	39 730	56 2
At birth	3 049	49 1	3 160	50 9
Less than 1	[a]	[a]	[a]	[a]
1 to 17	3,482	59 2	2,398	40 8
18 to 29	5,441	37 3	9 165	62 7
30 to 39	5,023	45 6	5 990	54 4
40 to 49	3,950	39 1	6 148	60 9
50 to 59	3,512	39 5	5 375	60 5
60 to 64	1,771	52 1	1 630	47 9
65 and over	4 099	42 6	5 517	57 4

[a]Limited occurrence in sample precludes calculation of reliable estimate

Note The total number of claims is based on the number of claims for which the relevant data were provided

Table V.7: Number of Paid Claims and Indemnity Payments by Patients' Age Ranges

	Paid claims		Indemnity payments			
					Range	
Age ranges (years)	Number	Percent of total[a]	Median	Average	Lowest	Highest
All claims	30,911	43 8	$20,000	$81,895	$1	$2,472,020
At birth	3,049	49 1	200,000	300,500	480	2,000,000
Less than 1	[b]	[b]	[b]	[b]	[b]	
1 to 17	3,482	59 2	15,000	40,071	9	700,000
18 to 29	5,441	37 3	13,750	60,389	93	2,059,388
30 to 39	5,023	45 6	15,000	64,078	90	1,616,185
40 to 49	3,950	39 1	35,000	83,858	18	2,472,020
50 to 59	3,512	39 5	20,000	75,222	1	850,000
60 to 64	1,771	52 1	15,000	37,639	25	1,000,000
65 and over	4,099	42 6	7,500	31,627	38	632,043

[a]Shows paid claims as a percentage of total claims within each of the age ranges For example an estimated 6,209 claims involved injuries occurring at birth Of these 3,049 (about 49 1 percent) were closed with payment

[b]Limited occurrence in sample precludes calculation of reliable estimate

Note The total number of claims is based on the number of claims for which the relevant data were provided

Table V.8: Number of Claims According to Payment Status by Patients' Sex

	With payment		Without payment	
Sex	Number	Percent	Number	Percent
All claims	31,786	43 3	41,591	56 7
Male	14,131	44 7	17,499	55 3
Female	17,655	42 3	24,092	57 7

Note The total number of claims is based on the number of claims for which the relevant data were provided

Table V.9: Number of Paid Claims and Indemnity Payments by Patients' Sex

	Paid claims		Indemnity payments			
					Range	
Sex	Number	Percent of total[a]	Median	Average	Lowest	Highest
All claims	31,786	43 3	$18,000	$80,741	$1	$2,472,020
Male	14,131	44 7	18,000	86,420	18	2,000,000
Female	17,655	42 3	18,000	76,196	1	2,472,020

[a]Shows paid claims as a percentage of total claims for each sex For example, an estimated 31,630 claims involved males Of these, 14,131 (about 44 7 percent) were closed with payment

Table V.10: Number of Claims According to Payment Status by Patients' Occupational Status

Patients' occupational status	With payment		Without payment	
	Number	Percent	Number	Percent
All claims	31 786	43 3	41 686	56 7
Employed	9 847	41 2	14 074	58 8
Self-employed	1 723	49 8	1 739	50 2
Homemaker	3 921	42 1	5 389	57 9
Retired	3 111	36 6	5 380	63 4
Unemployed	2,952	44 0	3 761	56 0
Dependent child/student	6,972	55 6	5 560	44 4
Independent student other, and unknown	3,260	36 1	5,783	63 9

Table V.11: Number of Paid Claims and Indemnity Payments by Patients' Occupational Status

Patients' occupational status	Paid claims		Indemnity payments			
	Number	Percent of total[a]	Median	Average	Range Lowest	Range Highest
All claims	31,786	43 3	$18,000	$80,741	$1	$2 472 020
Employed	9,847	41 2	25,000	69,659	18	1 800 000
Self-employed	1,723	49 8	15,000	81,598	41	1 616 185
Homemaker	3,921	42 1	19,500	57,310	1	2 059 388
Retired	3,111	36 6	8,500	31,979	25	1 000 000
Unemployed	2,952	44 0	9,300	55,703	187	949 991
Dependent child/student	6,972	55 6	30,000	156,089	9	2 000 000
Independent student, other, and unknown	3,260	36 1	7,500	50,019	20	2 472 020

[a]Shows paid claims as a percentage of total claims within each of the occupational status categories For example, an estimated 23,921 claims involved employed patients Of these 9 847 (about 41 2 per cent) were closed with payment

Table V.12: Number of Claims According to Payment Status by Claim Resolution Period

Time (months)	With payment		Without payment	
	Number	Percent	Number	Percent
All claims	31,642	43 2	41 562	56 8
0 (less than 1)	158	62 7	94	37 3
1 to 12	8,899	35 2	16 367	64 8
13 to 24	8,062	44 6	10 006	55 4
25 to 36	5,300	43 4	6 914	56 6
37 to 48	3,988	61 4	2 503	38 6
49 to 72	3,731	44 8	4 591	55 2
73 to 132	1,504	58 1	1 087	41 9

Note The total number of claims is based on the number of claims for which the relevant data were provided

Table V.13: Number of Claims and Disposition Time by Severity of Injury Categories

Disposition time in months

Severity of injury	Number of claims	Disposition time			
		Median	Average	Range Lowest	Range Highest
All claims[a]	73,058	19.0	25.0	0.0[b]	132.0
Emotional	4,654	11.0	12.2	0.0	55.0
Insignificant	6,685	14.0	20.8	0.0	110.0
Temporary disability— minor	21,887	20.0	24.4	0.0	108.0
Temporary disability— major	8,028	16.0	22.5	0.0	82.0
Permanent partial disability—minor	11,551	18.0	26.8	0.0	114.0
Permanent partial disability—major	4,130	33.0	34.5	0.0	132.0
Permanent total disability—major	2,788	32.0	33.7	2.0	90.0
Permanent total disability—grave	1,794	23.0	31.4	1.0	115.0
Death	11,159	23.0	27.7	1.0	109.0

[a]Detail does not add to total because not all claims were classified by the severity of injury categories

[b]A 0.0 in this column indicates that the claim was filed and resolved within the same month

Note The total number of claims is based on the number of claims for which the relevant data were provided

Table V.14: Number of Claims Involving One Provider According to Payment Status by Stage of Settlement

Settlement stage	With payment		Without payment	
	Number	Percent	Number[a]	Percent
All claims	24,630	43.7	31,726	56.3
Claim filed, before suit	7,562	35.8	13,544	64.2
Suit, before trial	15,252	53.4	13,288	46.6
During trial, before verdict	585	69.8	253	30.2
After verdict by jury and without jury	331	18.8	1,425	81.2
After appeal	277	27.4	733	72.6
Suit, before arbitration and after arbitration	370	20.3	1,456	79.7
Other	253	19.8	1,025	80.2

[a]Detail does not add to total due to rounding

Note The total number of claims is based on the number of claims for which the relevant data were provided

Table V.15: Economic Losses Compared to Indemnity Payments for Claims Where Losses Were Less Than Payment

	Paid claims		
Loss as a percent of payment	Number[a]	Percent	Cumulative percent
1 to 24	6 253	55 3	55 3
25 to 49	2 629	23 3	78 6
50 to 74	1 813	16 0	94 6
75 to 89	605	5 4	100 0
Total	**11,299**	**100.0**	

[a]Detail does not add to total due to rounding

Table V.16: Economic Losses Compared to Indemnity Payments for Claims Where Losses Were Greater Than Payment

	Paid claims		
Percent by which loss exceeds payment	Number	Percent[a]	Cumulative percent
11 to 25	432	7 9	7 9
26 to 50	556	10 1	18 0
51 to 75	326	5 9	23 9
76 to 100	462	8 4	32 3
Over 100	3,710	67 6	99 9
Total	**5,486**	**100.0**	

[a]Detail does not add to total due to rounding

Table V.17: Number of Claims With Economic Losses Less or Greater Than Indemnity Payments by Severity of Injury Categories

	Economic losses			
	Less than		Greater than	
Severity of injury	Number	Percent	Number	Percent
All claims	11,299	100 0	5 486	100 0
Emotional	684	6 1	[a]	
Insignificant	1,538	13 6	355	6 5
Temporary disability—minor	3,572	31 6	1 191	21 7
Temporary disability—major	1,022	9 0	646	11 8
Permanent partial disability—minor	2,789	24 7	932	17 0
Permanent partial disability—major	455	4 0	315	5 7
Permanent total disability—major	338	3 0	979	17 8
Permanent total disability—grave	[a]	[a]	437	8 0
Death	847	7 5	543	9 9

[a]Limited occurrence in sample precludes calculation of reliable estimate

Key Estimated Closed Claims Data and Related Sampling Errors

Table VI.1: Total Indemnity Payments and Related Sampling Error by Indemnity Payment Ranges

Indemnity payments in millions

	Indemnity payments	
Payment ranges	Estimate	Sampling error[a]
All claims	$2,566 4	$17 3
$1 to $999	1 4	0 2
$1,000 to $4,999	13 1	1 5
$5,000 to $9,999	26 7	3 8
$10,000 to $24,999	67 6	7 5
$25 000 to $49,999	161 5	13 8
$50,000 to $99,999	264 2	23 5
$100,000 to $249,999	474 1	37 4
$250,000 to $999,999	1,229 4	92 1
$1 million or more[b]	328 4	272 6

[a]Sampling errors are stated at the 95-percent confidence level

[b]Estimate subject to a large sampling error and should be used with caution

Note The universe of claims was 31 786

Table VI.2: Number of Claims and Related Sampling Error by Principal Allegations of Negligence Leading to the Injuries Involved

	Number		Percent	
Type of error	Estimate	Sampling error[a]	Estimate	Sampling error[a]
Surgery	18,697	130	25 4	0 2
Diagnosis	17 372	351	23 6	0 5
Treatment	14,635	1,215	19 9	1 7
Obstetrics	5,517	1,320	7 5	1 8
Medication	3,019	289	4 1	0 4
Medication administration	2,735	291	3 7	0 4
Anesthesia	2,720	306	3 7	0 4
Physiology/behavior monitoring, biomedical equipment, intravenous, blood products, and other	8,774	1,116	11 9	1 5

[a]Sampling errors are stated at the 95-percent confidence level

Note The universe of claims was 73 468

Table VI.3: Number of Claims and Related Sampling Error by Severity of Injury Categories

	Number		Percent	
Severity of injury	Estimate	Sampling error[a]	Estimate	Sampling error[a]
Emotional	4,660	579	6 4	0 8
Insignificant	6,823	603	9 3	0 8
Temporary disability—minor	21 969	802	30 0	1 1
Temporary disability—major	8 101	865	11 1	1 2
Permanent partial disability—minor	11,551	464	15 8	0 6
Permanent partial disability—major	4,225	341	5 8	0 5
Permanent total disability—major	2,788	219	3 8	0 3
Permanent total disability—grave	1,794	97	2 4	0 1
Death	11,179	168	15 3	0 2

[a]Sampling errors are stated at the 95-percent confidence level

Note The universe of claims was 73,090

Table VI.4: Average Disposition Time and Related Sampling Error by Severity of Injury Categories

Disposition time in months

	Disposition time	
Severity of injury	Estimate	Sampling error[a]
All claims	28 0	0 1
Emotional	14 9	2 6
Insignificant	21 8	2 0
Temporary disability—minor	25 7	1 1
Temporary disability—major	22 4	1 8
Permanent partial disability—minor	28 9	1 3
Permanent partial disability—major	31 7	3 2
Permanent total disability—major	37 2	7 1
Permanent total disability—grave	38 8	7 2
Death	33 2	1 2

[a]Sampling errors are stated at the 95-percent confidence level

Note The universe of claims was 31 642

Table VI.5: Average Disposition Time and Related Sampling Error by Indemnity Payment Ranges

Disposition time in months

Payment ranges	Disposition time	
	Estimate	Sampling error[a]
All claims	25 1	0 1
$0	22 9	1 0
$1 to $999	11 9	1 5
$1,000 to $4,999	22 4	2 2
$5 000 to $9,999	28 7	4 7
$10 000 to $24,999	22 7	2 2
$25 000 to $49,999	32 0	2 3
$50 000 to $99,999	31 6	2 7
$100,000 to $249,999	33 0	2 9
$250,000 to $999,999	41 8	3 4
$1 million or more[b]	64 9	64 2

[a]Sampling errors are stated at the 95-percent confidence level

[b]Estimate subject to a large sampling error and should be used with caution

Note The universe of claims was 73 204

Table VI.6: Average Indemnity Payments and Related Sampling Error by Disposition Time

Time (months)	Average payments	
	Estimate	Sampling error[a]
All claims	$81 105	$549
0 (less than 1)[b]	16 814	21 878
1 to 12	31 411	813
13 to 24	69 793	3 092
25 to 36	73 125	2 593
37 to 48	134 354	15 475
49 to 72	109 212	7 310
73 to 132[b]	259 656	110 575

[a]Sampling errors are stated at the 95-percent confidence level

[b]Estimate subject to a large sampling error and should be used with caution

Note The universe of claims was 31 642

Table VI.7: Average Indemnity Payments and Related Sampling Error by Principal Allegations of Negligence

Type of error	Average payments	
	Estimate	Sampling error[a]
All claims	$80 741	$545
Surgery	76 255	2 052
Diagnosis	95 747	4 400
Treatment	42 316	2 431
Obstetrics	216 464	21 008
Medication	51 263	13 123
Medication administration	33 379	9 338
Anesthesia	84 451	10 662
Physiology/behavior monitoring, biomedical equipment, intravenous, blood products, and other	27 122	2 815

[a]Sampling errors are stated at the 95-percent confidence level

Note The universe of claims was 31 786

Table VI.8: Average Indemnity Payments and Related Sampling Error by Severity of Injury Categories

Severity of injury	Average payments	
	Estimate	Sampling error[a]
All claims	$80 741	$545
Emotional	21 694	4 894
Insignificant	12,024	1 411
Temporary disability—minor	13,978	533
Temporary disability—major	34 670	3 214
Permanent partial disability—minor	52,356	2 337
Permanent partial disability—major	144 049	19 089
Permanent total disability—major	364,384	72 836
Permanent total disability—grave	488,375	103 496
Death	75,242	2 329

[a]Sampling errors are stated at the 95-percent confidence level

Note The universe of claims was 31 786

Table VI.9: Average Indemnity Payments and Related Sampling Error by Size of Patients' Economic Losses

Patients' economic loss ranges	Average payments	
	Estimate	Sampling error[a]
All claims	$71 530	$1 056
$0[b]	16 025	7 060
$1 to $999	3 881	396
$1,000 to $4,999	17 809	1 474
$5,000 to $9,999	33 755	5 215
$10,000 to $24,999	42,327	4 850
$25,000 to $49,999	65,052	16 166
$50,000 to $99,999	80,642	29,078
$100,000 to $249,999	138,835	45 815
$250,000 to $999,999	255,234	47 125
$1 million or more[b]	439,397	184 546

[a]Sampling errors are stated at the 95-percent confidence level

[b]Estimate subject to a large sampling error and should be used with caution

Note The universe of claims was 18 279

Table VI.10: Average Patient Economic Losses and Related Sampling Error by Severity of Injury Categories

Severity of injury	Average economic losses	
	Estimate	Sampling error[a]
All claims	$219 370	$5 588
Emotional[b]	6 599	5,636
Insignificant	2 373	428
Temporary disability—minor	12 012	1 327
Temporary disability—major	29 916	6,290
Permanent partial disability—minor	64 380	11 639
Permanent partial disability—major[b]	196 447	129 220
Permanent total disability—major[b]	1,814 942	761 866
Permanent total disability—grave	1 688 029	621 577
Death	158 173	22 417

[a]Sampling errors are stated at the 95-percent confidence level

[b]Estimate subject to a large sampling error and should be used with caution

Note The universe of claims was 18 279

Table VI.11: Compensation for Noneconomic Losses and Related Sampling Error by Size of Noneconomic Losses

Compensation in millions

Noneconomic loss compensation ranges	Compensation	
	Estimate	Sampling error[a]
All claims	$555 3	$11 0
$0	0 0	0 0
$1 to $50,000	105 4	3 7
$50 001 to $200,000	107 6	27 6
More than $200,000	342 4	122 0

[a]Sampling errors are stated at the 95-percent confidence level

Note The universe of claims was 14 995

Table VI.12: Average Indemnity Payments and Related Sampling Error by Source of Payment for Health Care Costs

Source of health care cost payments	Average payments	
	Estimate	Sampling error[a]
All claims	$80,741	$545
Self	61,394	6 397
Private/commercial insurance	105 250	1 639
Medicare	28 352	3 307
Medicaid	43 267	11 252
Workers compensation[b]	69 503	50 147

[a]Sampling errors are stated at the 95-percent confidence level

[b]Estimate subject to a large sampling error and should be used with caution

Note The universe of claims was 31 786