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Perspective

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FUNDAMENTALS OF HEALTH LAW

Medical Malpractice Law — Doctrine and Dynamics

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When she turns 50, Ms. P. follows Dr. D.'s advice to have her first screening mammogram, which is negative. Dr. D. advises her to return "in a few years" for repeat screening.

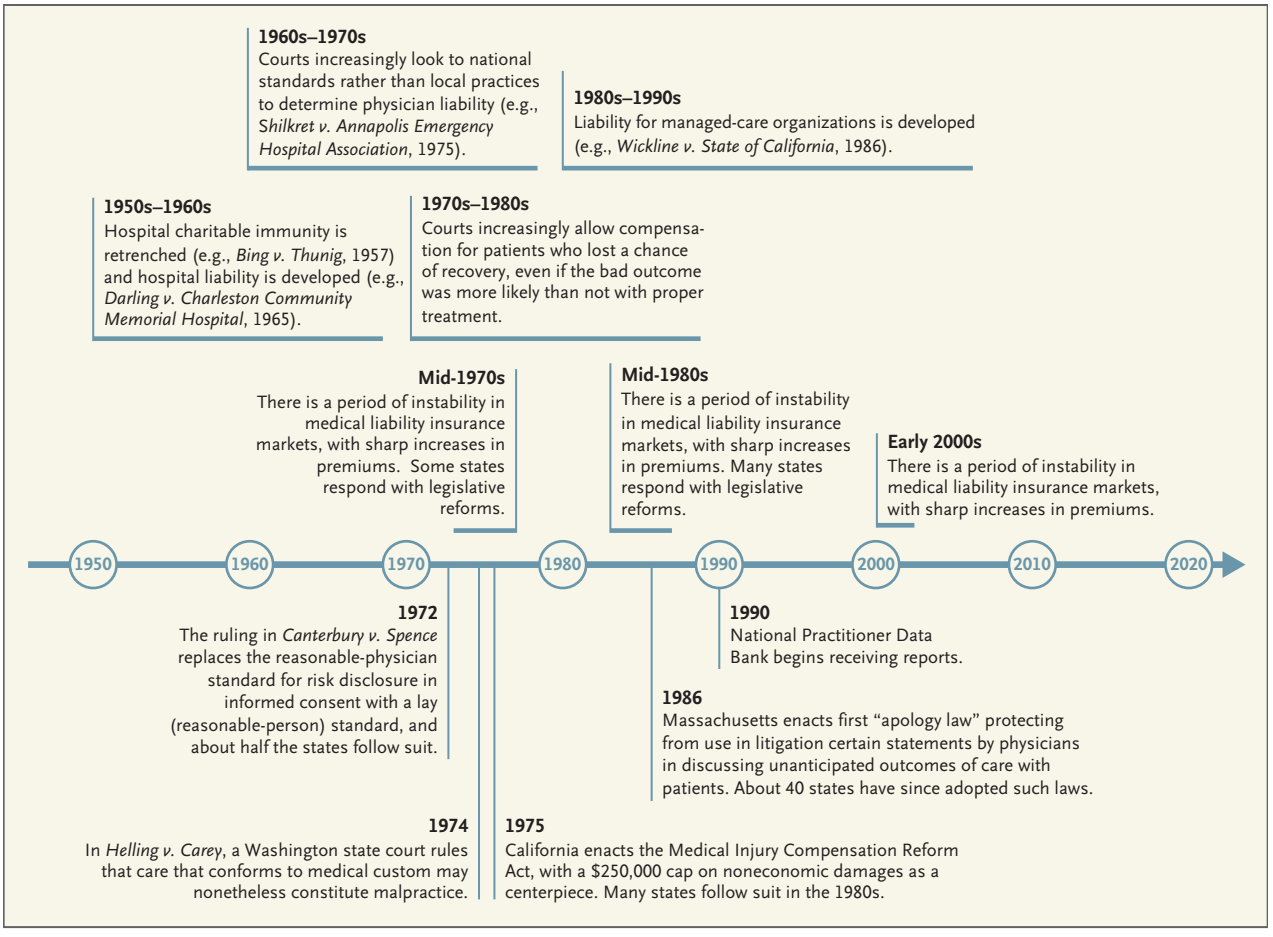
Twenty-seven months later, she is diagnosed with stage 3 breast cancer and sues Dr. D. At trial, an expert testifying for Ms. P. states that many doctors and consensus guidelines recommend mammograms annually or every 2 years for people Ms. P.'s age. Dr. D.'s expert testifies that a range of intervals is acceptable and that the local practice is to advise that, absent symptoms or family history, about every 2 or 3 years is sufficient.

For many physicians, the specter of being sued for malpractice is one of the most distasteful aspects of medicine. Yet patients frequently experience financial loss, pain, and disability as a result of medical error, and it's widely believed that the threat of legal sanctions creates incentives to be more careful and invest in safety. When a lawsuit is filed, these divergent perspectives collide.

Medical malpractice law is a species in the genus torts, part of civil law. Some tort claims address intentional acts (e.g., battery, defamation), but most involve one person suing another person or an institution for a physical injury allegedly caused by negligence. Malpractice claims against professionals take this form. Physicians are sued for negligence more than any other professional group, largely because medical care is intrinsically hazardous and frequently leads to bodily harm, tort law's central concern.

To establish a negligence claim, plaintiffs must prove that the defendant owed them a duty of care, the defendant breached that duty, and the breach resulted in injury to the plaintiff. These elements come chiefly from "common law" — legal precedents from previous cases. To create medical malpractice law, courts have adapted generic tort rules to recognize distinctive features of medicine (see timeline). (In elucidating this body of law, we draw in part on a synthesis under way by the American Law Institute, to which we are contributing.[1])

The core question in negligence claims is whether defendants breached their duty of care. To address it, tort law considers what an ordinary, reasonable person would do in the same or similar circumstances. Physicians are held to the standard of a reasonable practitioner in their field (customary practice), as established by expert testimony from peers in their specialty. In most nonmedical tort cases, customary behavior is use-



Key Developments in U.S. Medical Malpractice Law.

ful for deciding whether a defendant's behavior fell short, but it isn't determinative. In medical malpractice cases, customary practice *is* the standard of care, and establishing conformity with it usually defeats the plaintiff's claim. Courts reserve the right to deem customary medical practice unreasonable, but they rarely do. Thus, in principle, tort law grants the medical profession the privilege of defining the legal standards to which its members are held. However, customary medical practices are rarely self-evident and undisputed.

One challenge is that many clinical situations are too idiosyncratic for a custom to be identified. Another is that many medical malpractice claims involve conflicting expert testimony about both what professional custom demands and whether the defendant has conformed. Lay juries must choose, and they may be influenced more by expert witnesses' credentials and persuasiveness than the technical validity of their testimony. Uncertainty and variability in jury decisions undercut the medical profession's ability to draw clear guidance from case outcomes; tort law thus pushes physicians to practice defensively and adopt approaches to care that are not cost-effective.

Conflicting expert testimony often stems from the coexistence of multiple schools of thought. Courts accommodate this reality in two ways. First, they recognize that reasonable differences of professional opinion can exist, so they may allow juries to excuse physicians like Dr. D. if some of his peers testify that his treatment approach is a respectable choice, even if most of his peers believe a different approach is superior.

Second, to narrow their focus to the "same or similar circumstances," courts frame their search for the relevant standards of care by reference to certain factors; practice location is an important one. Originally, courts looked only to local standards. Attention later shifted to national standards,

though traces of the local frame remain. A physician practicing in a remote clinic, for example, may be held to the standards of physicians with the same training practicing in a similar setting. The same is true for specialists practicing at large, academic medical centers. So in Dr. D.'s case, the norms for recommending screening mammography in his geographic area and practice setting may become relevant.

The legal obligation to adhere to a standard of care applies only when a duty is owed. Generally, there is no duty to aid a stranger in distress, and merely having superior knowledge and skills doesn't create a duty of care to others. But the patient–physician relationship creates a broad range of affirmative legal obligations. For example, physicians are expected to give their patients unsolicited advice, obtain informed consent, and maintain confidentiality.

Finally, plaintiffs must prove both that they've been injured and that their injury was caused by the defendant's negligence. In theory, the injury may be mental or physical, mild or severe. In practice, the economics of litigation dictate that claims usually involve severe physical conditions. Linking such harms to the defendant's negligence may nonetheless be difficult. Whereas a typical tort claim involves a healthy person harmed by an external force, such as an automobile crash, medical malpractice claims tend to involve sick patients for whom there are often plausible, rival causes of adverse outcomes, including the natural processes of disease and unavoidable variation in responses to treatment.

More than one fifth of all claims and one third of paid claims involve missed or delayed diagnoses.[2] Determining causation in these cases involves a vexing counterfactual question: Would an accurate and timely diagnosis have averted the patient's poor outcome? Even if Dr. D. had counseled Ms. P. to return for a mammogram within 2 years, for example, she might still have received a late-stage cancer diagnosis. Recognizing the inherent uncertainty in such inquiries, many courts allow plaintiffs to receive compensation when their chances of recovery or improvement were substantially reduced by a negligent diagnosis, even if causation cannot be proved in the usual way.

Medical malpractice claims are adjudicated in state courts. When they go to trial, the judge decides matters that are clear-cut after both sides have presented their evidence. The jury decides the rest, including whether the defendant is liable and, if so, the amount of damages owed to the plaintiff.

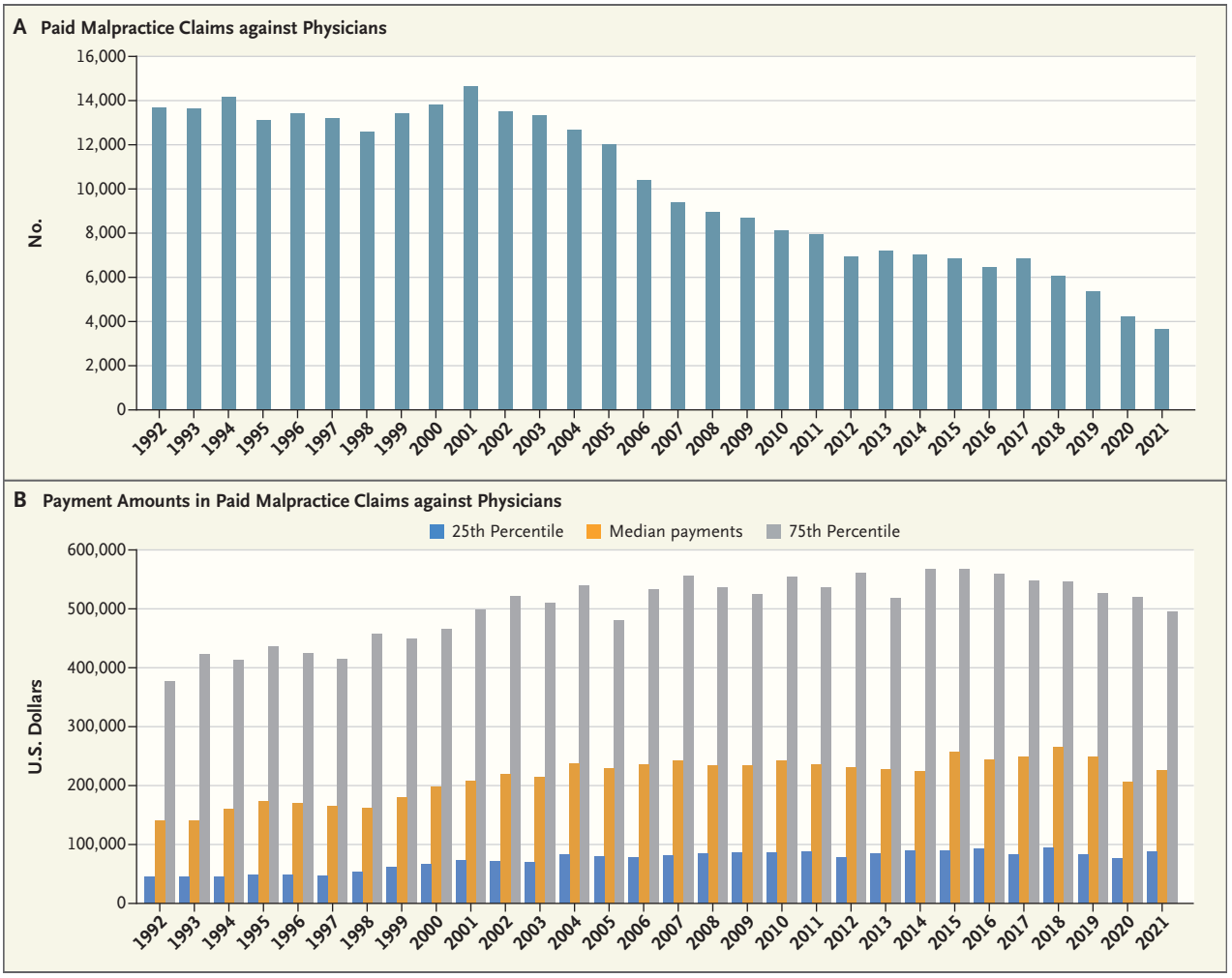
To establish liability, the patient must prove the elements outlined above against a "more likely than not" standard. That can be a steep hill to climb, and patients lose about 80% of medical malpractice trials.[3] However, fewer than 1 in 20 claims end in courtroom verdicts; about one third are settled out of court with a payment to the patient, and the remainder are dropped or dismissed.[3]

Detailed data on the volume and outcomes of medical malpractice litigation are hard to come by. Professional liability insurers and attorneys are tight-lipped about their cases, and settlements are often shrouded by confidentiality agreements — practices that hinder efforts to improve patient safety. The nearest approximation to a national database of closed claims is the National Practitioner Data Bank (NPDB). Anyone who pays a malpractice claim against a health care practitioner is required by federal law to report it to the NPDB.

NPDB data reveal a remarkable phenomenon: the number of paid claims against physicians has decreased by 75% in the past 20 years (see graph). The Covid-19 pandemic recently disrupted court activities, but reasons for the precipitous decline over the longer run are unclear.

One possibility is that successive waves of "tort reform" — state legislative measures aimed at reducing the scale and cost of tort litigation — have steadily gained traction. Caps on damages are associated with reductions in claims volume,[4] probably because they sap the financial incentives for plaintiffs' attorneys to pursue claims that have uncertain merit or involve relatively small economic losses. In 2021, a total of 19 states had caps on noneconomic damages, 5 had caps on total compensatory damages, and 2 had caps on both. For virtually all other types of reform (e.g., pretrial screening panels, attorney fee limits), there is either no clear evidence that they have reduced claims frequency or good evidence that they have not.[4]

Another possibility is that movement in health care systems toward greater openness about medical errors has reduced patients' inclination to sue. A few error-disclosure programs have reported this outcome. But the wider picture is unclear, with respect to both the prevalence of candid disclosure after medical injury and its effect on the likelihood of litigation.



Paid Medical Malpractice Claims against Physicians in the United States, 1992–2021.

Physicians include medical doctors and doctors of osteopathy. Payments have been adjusted to 2021 dollars using the consumer price index for all urban consumers (https://data.bls.gov/PDQWeb/cu).

A more prosaic explanation for plummeting malpractice claims relates to the completeness of NPDB data. Unlike practitioners, health care institutions need not report payments made to resolve negligence claims against them. "Corporate shielding," whereby institutions assume liability and payment responsibility in claims against physicians, thus averting reporting requirements, has been a concern since the NPDB's inception. The trend toward physician employment by corporate entities has expanded opportunities for using this strategy.

The most optimistic possibility is that the quality of care has improved markedly, making the type of harmful events that trigger malpractice litigation far less frequent. Unfortunately, there is no clear evidence that adverse-event rates nationwide have declined substantially. Moreover, the number of serious adverse events attributable to negligence has long been much larger than the number of claims brought,[5] so even if reductions in the prevalence of these injuries occurred, that would be unlikely to independently drive down claims.

Whatever the cause, the sharp decrease in medical malpractice litigation has probably helped avert the kinds of instabilities that roiled medical liability insurance markets in the mid-1970s, mid-1980s, and early 2000s. The past two decades of relative calm could have been an opportunity for trying innovative reforms aimed at making the malpractice system more ac-

curate, fair, and efficient. For the most part, however, such reform hasn't happened, and the system in place for more than 150 years grinds on, largely disconnected from wider efforts to improve the quality and safety of patient care.

An audio interview with Dr. Studdert is available at NEJM.org

Disclosure forms provided by the authors are available at NEJM.org.

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Abortion Access as a Racial Justice Issue

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Restrictions on reproductive bodily autonomy — the freedom to decide whether, when, and how to have a child, with whom, and under what circumstances — have long been leveraged to oppress and control persons and communities that are devalued by racist, classist, or ableist societies.[1] On June 24, 2022, in the landmark *Dobbs v. Jackson Women's Health Organization* decision, the U.S. Supreme Court revoked the right to abortion. Even though abortion is an essential component of comprehensive reproductive health care that has been protected in the United States for nearly 50 years, future access will be severely limited or denied in the 26 states that have banned or are likely to ban abortion care.

Decisions regarding the legal status of abortion and other reproductive health services reflect the status of civil rights for anyone with the capacity for pregnancy, but they have a particular resonance for Black and Indigenous people living in the United States, who have experienced reproductive oppression for centuries. The *Dobbs* decision rolls back fundamental rights for many people, and it is a direct assault on efforts to improve racial equity in health care. Indeed, abortion access is fundamentally a racial justice issue. We believe that clinicians, health care delivery systems, and policymakers should approach it as such.

The United States was built, in part, on racially differentiated policies toward reproduction. During the 256 years when slavery was legal, the country had a substantial economic interest in the fertility of Black people; increased fertility meant a larger labor supply and higher property value. Slaveholders therefore condoned rape of enslaved people, withheld from them knowledge about birth control, allowed gynecologic experimentation on them without anesthesia, and provided "incentives" to coerce them into reproducing.[2] Abortion was an important tool leveraged by enslaved pregnant people to control their fertility and prevent future children from experiencing the horrifying and inhumane conditions of chattel slavery.[2]

After emancipation and during the Jim Crow era, U.S. economic interest in Black bodies shifted. Once Black people were no longer a source of free labor, "eugenic" depopulation policies informed by White supremacist ideology began emerging in both government and clinical care.[1,2] In 1927, the Supreme Court legitimized eugenic sterilization laws in *Buck v. Bell*, a case that has never been explicitly reversed. Forced sterilization, colloquially known as "Mississippi appendectomy," was commonplace in the 20th century, with some estimates suggesting that as many as 70,000 people were involuntarily steril-