
MEDICAL MALPRACTICE LITIGATION

The Number Beneath the Verdict

Why Damages Rise or Fall on the Clinical Record

BY MICHELLE CARROLL · FOUNDER & CEO, LEXCURA SUMMIT

Ten-million-dollar verdicts used to make headlines. Now there are enough of them that someone has to count.

Marathon Strategies does the counting. Its latest report found nearly 200 verdicts of \$10 million or more against corporate defendants in 2025, up 40.7 percent from 2024 and the most it has recorded since it started tracking in 2009. Forty topped \$100 million. Four topped \$1 billion. Malpractice is part of that picture: TransRe data reported by Medscape show malpractice verdicts over \$10 million rising from 34 in 2013 to 57 in 2023.

People argue about why. Distrust of big institutions, erosion of damages caps, lawyer advertising, a public that has stopped flinching at nine-figure numbers. Venue plays a part too. Pennsylvania dropped its medical malpractice venue restriction at the start of 2023, and a defense-side analysis published this month counted Philadelphia as the source of 11 of the state's 17 nuclear malpractice verdicts between mid-2021 and mid-2026.

I'm not going to settle that debate here. What I want to talk about is something that holds no matter which side you're on: a damages number is only as strong as the clinical facts underneath it. When those facts are fuzzy, juries fill the gap with sympathy, anchoring, or whichever expert they liked better. When the facts are pinned down, the number has something to stand on, and something to be tested against.

A FICTIONAL CASE TO WORK WITH

A 52-year-old man comes into an emergency department dizzy, slurring his words, and unsteady on his feet. He's told it's an inner ear problem and sent home. The next day he's back with a large stroke in the back of the brain. He survives, but he can't work, needs help with daily care, and has trouble swallowing.

There are real liability questions in that case. Should the presentation have raised concern for a posterior circulation stroke? What exam and imaging were called for? Would earlier treatment probably have changed anything? Set those aside for now. The question here is what the injury is worth, and why.

START WITH WHO HE WAS BEFORE

Every damages model compares life after the injury to life before it. The “before” part is usually thinner than it should be.

Our patient had high blood pressure and diabetes. How well controlled were they? Any kidney disease, heart disease, earlier TIAs? What did he do for work, and how physical was it? Was he independent, active, coaching his kid’s team, or was he already slowing down?

This cuts two ways. Baseline defines the loss: you can’t measure the gap without knowing where he started. It also shapes every projection, because pre-existing disease can shorten life expectancy or bring on disability regardless of the stroke. The defense will dig into that. Plaintiff’s counsel is better off digging first and building a model that holds up when they do.

Primary care notes, pharmacy fills, specialist visits, and employment records usually tell you far more than the hospital chart. That’s why Baseline Profiling sits as its own pillar in the Lexcura Clinical Intelligence Model.

LIFE EXPECTANCY IS WHERE THE MONEY MOVES

Almost every economic element gets multiplied by life expectancy, so a few years either way changes the value of a case enormously.

Population life tables are a starting point, nothing more. A man who can’t swallow safely is at risk for aspiration pneumonia. Someone who’s immobile is at risk for clots, pressure injuries, and infections. The research on survival after stroke, brain injury, and spinal cord injury tends to sort people by function: can they walk, feed themselves, communicate? Diagnosis alone doesn’t tell you much.

So when you’re looking at a life expectancy opinion, ask which functional findings it relies on and where those are documented. Ask what complications have already happened and how they were counted. Three aspiration pneumonias in the first year is significant. So is a stable year with none. Ask whether the opinion accounts for the quality of care he’s getting and for the disease he already had.

EVERY LINE OF A LIFE CARE PLAN NEEDS A REASON

A life care plan turns clinical needs into dollars. Each item is only as good as its support. For each one, I'd want to know: Did a treating clinician recommend it, or did the planner project it? Does the record show he needs it? Does the level of care match his actual function? Is he using it now, and if not, why not?

Plans go wrong in both directions. Twenty-four-hour skilled nursing for someone whose records show he needs supervision and help with some tasks invites a challenge that can drag down the whole plan. On the other side, a plan that leaves out the speech therapy and swallowing follow-up his chart plainly documents leaves real losses on the table. You find both problems the same way: by reading the record.

EARNING CAPACITY

Lost earnings rest on clinical facts too: cognition, stamina, fine motor skills, communication. Neuropsychological testing, therapy notes, and any functional capacity evaluation should agree with each other before a vocational expert relies on them. If they don't, someone needs to figure out why.

PAIN AND SUFFERING ARE DOCUMENTED MORE THAN PEOPLE THINK

Non-economic damages drive most nuclear verdicts, and they're often described as impossible to measure. Hard to put a price on, yes. Disconnected from evidence, no.

Nursing and therapy notes record pain scores and pain behaviors. Psychology and psychiatry notes record depression, frustration, and grief. Family visits, how he responds to his kids, whether he participates in anything: it's usually in there, often in more detail than attorneys expect.

Be careful with awareness. Some records show a man who knows exactly what he's lost. Others leave it genuinely unclear. Describe what the chart supports and stop there. Overstating it is easy to expose, and once a jury catches it, they discount everything else.

DAMAGES FROM THE DELAY, NOT FROM THE DISEASE

You can't separate damages from causation. What's compensable is the difference between the outcome he had and the outcome he probably would have had with proper care.

Say that even with a prompt diagnosis he'd probably still have had a stroke, just a smaller one with a better recovery. Then the damages model has to describe that better recovery concretely. Would he have gone back to work? Needed any ongoing care? Getting there takes a neurologist's view of the treatment options and likely outcomes. Whether the jurisdiction allows recovery for a

lost chance, and how it apportions damages, is counsel's call. But a model built on that comparison will hold up far better than one that charges every consequence of the stroke to the delay.

WHAT THIS MEANS DEPENDING ON WHERE YOU SIT

If you represent the plaintiff, precision is what keeps a large verdict alive through post-trial motions and appeal. Tie every major number to records, recommendations, and a documented baseline.

If you represent the defendant or the carrier, the same work tells you which parts of the demand are soft and which aren't. Attacking something the record clearly supports costs credibility you'll need later. An honest early read on exposure makes for better decisions about settlement, trial, and reserves.

If you run a healthcare organization, remember that the notes written after an adverse event, describing function, complications, and care needs, will be read very closely by people deciding what that event cost.

And for everyone: do this early. A damages review at intake shapes which records you request, which experts you hire, and what you ask at deposition. A review the week before mediation can only describe what's already there.

RECORDS WORTH REQUESTING

- Five or more years of pre-injury primary care, specialist, and pharmacy records
- Employment and earnings history, job descriptions, and physical demands
- Acute care, inpatient rehab, and skilled nursing records
- PT, OT, and speech therapy evaluations and progress notes
- Neuropsychological testing and any functional capacity evaluation
- Current treating clinicians' recommendations for future care
- Records of every complication and readmission since the injury
- Imaging and neurological assessments documenting the extent of injury

SOURCES

- Marathon Strategies, *Corporate Verdicts Go Thermonuclear*; Insurance Journal, "Nuclear Verdicts Go Boom, Increase 40.7% in 2025" (Aug. 25, 2026)
- Becker's ASC Review, "Malpractice mega-verdicts skyrocketing: 5 numbers to know" (citing TransRe data reported by Medscape)
- Pennsylvania Coalition for Civil Justice Reform, "Pennsylvania's Medical Malpractice Climate Leading to More Nuclear Verdicts" (Sept. 18, 2026), summarizing an analysis by Marshall

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- Pa. R.C.P. 1006(a.1) (rescinded effective Jan. 1, 2023)

This newsletter is for education only and isn't medical or legal advice. The case is fictional.

ABOUT LEXCURA CLINICAL INTELLIGENCE

Lexcura Clinical Intelligence provides integrated clinical and regulatory analysis for attorneys handling healthcare litigation. If you have a catastrophic injury case and want each piece of the damages model tied to the record, from baseline to life expectancy to future care, we'd welcome the conversation.

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