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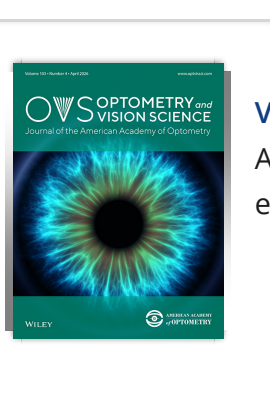

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Malpractice payments by optometrists in the United States: An analysis of the National Practitioner Data Bank from 1996 to 2023

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ABSTRACT

Purpose

To analyze trends in malpractice payments made on behalf of U.S. optometrists from 1996 to 2023 using National Practitioner Data Bank (NPDB) data, and to assess whether state-level scope-of-practice expansions are associated with increased liability risk.

Methods

Publicly available NPDB data were reviewed for malpractice payments involving optometrists between 1996 and 2023. Variables included number and value of payments, provider age, patient demographics, geographic distribution, and allegation category. Nationwide trends were analyzed using the Mann–Kendall test; pre- and post-scope expansion comparisons in 11 states were evaluated using the Mann–Whitney rank-sum test. All monetary values were inflation adjusted to 2023 U.S. dollars.

Results

A total of 1040 malpractice payments were recorded (mean 38.5 cases/year). Mean payment was $220,918 (SD $311,395; range $300–$2.95 million). The average provider age was 43 years; 56% of patients were >50 years old. 'Failure to diagnose' accounted for 40% of primary allegations. Inflation-adjusted total payments demonstrated a significant upward trend ($p = 0.008$) that became nonsignificant after excluding 2021–2023 ($p = 0.15$). No significant change in annual case numbers was observed ($p = 0.28$). Among 11 states with expanded optometric authority, no statistically significant increase in malpractice cases occurred post-expansion except in Indiana ($p = 0.049$). Expanded-scope states mirrored national trends in both payment frequency and amount.

Conclusions

Malpractice payments involving optometrists remain infrequent and financially modest compared with other health professions, with most claims arising from diagnostic rather than procedural issues. There is no evidence that expanding optometric privileges, including lasers, injections, or oral medications, has increased malpractice risk. Advances in education, technology, and interprofessional collaboration likely underpin this stability. Ongoing monitoring of NPDB data will help ensure that optometry's growing clinical role continues to align with patient safety and professional accountability.

Significance

Despite major expansions in optometric scope of practice, including therapeutic drug use, injections, and in-office laser procedures, little is known about how these changes affect malpractice liability. Understanding national malpractice trends can inform legislation, education, and risk-mitigation strategies as optometry continues to assume broader clinical responsibilities.

INTRODUCTION

The scope of practice for optometrists in the United States has expanded significantly over the past four decades, but the impact on medical malpractice liability is unknown. In 1990, optometrists could prescribe therapeutic medications in only half of all states.[1] By 2024, they could prescribe therapeutic and oral medications, including those for glaucoma, in all 50 states, while also administering injectable agents in 44 states, excise eyelid lesions in 20 states, and perform in-office laser procedures in 12 states.[1-3] It is estimated that the United States could save $4.6 billion annually if states modernized optometric practice acts to align with the profession's education and training.[4] As optometrists' clinical responsibilities broaden, understanding malpractice payment trends could help mitigate both personal and patient safety risks, as the perceived risk of liability may influence clinical decision-making.[5, 6]

Established by Congress in 1986, the National Practitioner Data Bank (NPDB) serves as a centralized repository of information on healthcare providers, including adverse actions related to licensure, healthcare facility credentialing, and malpractice claims.[7, 8] Although NPDB data were used to study optometrist malpractice trends from 1991 to 2008, the profession's increased prescriptive and procedural privileges warrant an updated analysis.[9, 10] Herein, we use NPDB data to further study malpractice claims paid on behalf of optometrists from 1996 to 2023. We examined the number of payments per year, payment amounts, geographic distribution, provider age, type of litigation, and category of alleged malpractice.

METHODS

This study used publicly available NPDB data which contain no identifiable health information and therefore are exempt from Institutional Review Board oversight. Data were obtained on January 27, 2025[11] and state population data were obtained from the 2020 U.S. Census Bureau.[12] The analysis included malpractice judgments against optometrists between 1996 and 2023 utilizing NPDB terminology. The study period was intentionally restricted to 1996 onward to reflect a more consistent national scope of optometric practice, as by the mid-1990s nearly all states had authorized diagnostic and therapeutic pharmaceutical prescribing. Inclusion of earlier years would capture a period of markedly heterogeneous practice authority and limit comparability across states and over time. Data from 2024 were excluded because the NPDB was only updated through the third quarter at the time of download.

We extracted data on provider age, state of occurrence, patient demographics, and the most common malpractice allegations. Our primary analysis evaluated nationwide trends in total and mean payments, using the Mann–Kendall trend test to assess changes over time. We also conducted a separate analysis of cases from the post-pandemic years (2021–2023). We considered patient (age and sex) and practitioner (age) demographics for potential influence on payment amounts using linear regression models. It should be noted that these demographic variables were only collected starting in 2004. No other relevant demographic data were available and no data on diagnosis category were available.

For our secondary analysis, we focused on 11 states that had expanded scope of practice before 2023 (Alaska, Arkansas, Colorado, Indiana, Kentucky, Louisiana, Mississippi, Oklahoma, Virginia, Wisconsin, and Wyoming). We compared the number of malpractice payment events per year before and after scope expansion. Because data were not normally distributed, pre- and post-expansion occurrences were compared using the nonparametric Mann–Whitney rank-sum test.

We report our findings using p-value <0.05 as the threshold for statistical significance. All monetary values were adjusted to 2023 dollars using the Bureau of Labor Statistics Consumer Price Index calculator.[13] Analyses were performed in STATA 18.[14]

RESULTS

Between 1996 and 2023, 1040 malpractice payments were made on behalf of optometrists, averaging 38.5 cases annually. The mean payment was $308,548 (SD $424,260), with a range of $351 to $3,280,000. Claims often involved multiple providers (mean 1.1, SD 0.6, range 1–9). The average provider age was 43.1 years (SD = 12.5, range 20–80). More than half of cases (56.1%) involved patients over 50 years of age, whereas only about 8% involved individuals under 20.

Multivariable linear regression models were employed to examine the impact of demographic data on payment amounts. Patients under the age of 20 had higher payments compared with patients 20 and older ($p < 0.001$). Patient sex did not impact the payment amount ($p = 0.42$) nor did practitioner age (no age group rose to the level of statistical significance).

The most frequent primary allegation in paid optometric malpractice claims was 'failure to diagnose' (416 cases, 40%), followed by 'delay in diagnosis' (66 cases, 6.4%). Among cases with a secondary allegation, 'failure/delay in referral or consultation' was most common (37 cases, 20.4%) (Table 1).

TABLE 1. National Practitioner Data Bank (NPDB) reported demographic data for all 1,040 malpractice payments against optometrists from 1996 to 2023.

Practitioner age group	Total N of 1,040 (%)	Mean $ payment (SD)
20–29	53 (5.1%)	$194,419 (254,497)
30–39	245 (23.6%)	$173,101 (233,840)
40–49	306 (29.4%)	$209,754 (338,296)
50–59	249 (23.9%)	$231,295 (305,495)
60–69	140 (13.5%)	$303,205 (375,324)
70–79	42 (4.0%)	$290,179 (326,744)
80+	5 (0.5%)	$125,250 (207,444)
Primary allegation (top 5)	$N = 1040$	
Failure to diagnose	416 (40%)	$269,131 (336,776)
Delay in diagnosis	66 (6.4%)	$226,670 (237,555)
Failure/delay in referral	57 (5.5%)	$288,701 (287,777)
Improper performance	54 (5.2%)	$159,732 (257,001)
Improper management	46 (4.4%)	$210,202 (307,782)
Secondary allegation (top 5)	$N = 181$	
Failure/delay in referral	37 (20.4%)	$272,067 (267,859)

States or territories with the highest claims per million population included Northern Mariana Islands, New Mexico, Oklahoma, Nevada, and Pennsylvania (Table 2), whereas the lowest were South Dakota, Puerto Rico, Wisconsin, Minnesota, and Alabama (Table 3).

TABLE 2. Highest five states/territories for number of cases by population between 1996 and 2023.

State	Number of cases	Cases per million population
Northern Mariana Islands	1	19.6
New Mexico	39	18.4
Oklahoma	34	8.4
Nevada	23	7.2
Pennsylvania	91	7.0

TABLE 3. Lowest five states/territories for number of cases by population between 1996 and 2023.

State	Number of cases	Cases per million population
Alabama	6	1.2
Minnesota	6	1.0
Wisconsin	4	0.7
Puerto Rico	1	0.3
South Dakota	0	0

Inflation-adjusted analysis revealed a statistically significant positive trend between year and total payments ($p = 0.008$). However, when excluding post-pandemic years (2021–2023), this trend was no longer significant ($p = 0.15$). Similarly, we examined the total number of cases nationwide per year and found no statistically significant trend over time ($p = 0.28$) (Figure 1).

FIGURE 1 Open in figure viewer | PowerPoint

Trends in optometry malpractice payments and cases reported to the NPDB, 1996–2023. This figure displays the annual mean inflation-adjusted total malpractice payments and the number of paid malpractice cases involving optometrists in the United States from 1996 through 2023. Payment amounts were adjusted for inflation to constant dollars. Data were obtained from the NPDB public use data file. Malpractice payments represent finalized indemnity payments and do not include dismissed, pending, or unpaid claims. NPDB, National Practitioner Data Bank.

States with expanded scope of practice were analyzed graphically and compared with data from the rest of the United States (Figure S1).

Both the annual number of cases and the total annual payment amounts followed trends similar to those for national data. We applied the Mann–Whitney rank-sum test to the expanded scope states and found no statistically significant difference in the mean number of cases before versus after scope expansion, except Indiana ($p = 0.049$) (Table 4).

TABLE 4. Mann–Whitney rank-sum test comparing mean number of occurrences prior to expanded scope with the mean number of occurrences following expanded scope by state.

State (year expansion)	Mean prior to expansion	Mean following expansion	p-value
Oklahoma (1998)	1	1.2	0.67
Kentucky (2011)	0.6	0.9	0.08
Louisiana (2014)	1.2	0.6	0.14
Alaska (2017)	0.1	0	0.46
Wisconsin (2018)	0.2	0	0.33
Arkansas (2019)	0.5	0.3	0.78
Indiana (2019)	1.2	2.3	0.049
Mississippi (2021)	0.3	0	0.23
Wyoming (2021)	0.2	0	0.63
Colorado (2022)	0.6	0	0.35
Virginia (2022)	0.6	0	0.48

DISCUSSION

Between 1996 and 2023, the total number of malpractice payments made on behalf of optometrists in the United States increased slightly but remained infrequent, indicating individual optometrist risk remains very low. In 2023, with approximately 41,390 optometrists practicing in the United States,[15] there were only 41 malpractice payments—an estimated annual risk of just 0.10% per optometrist. Paid malpractice claims involving optometrists remain rare relative to many other health professions, which experience substantially higher rates of paid claims over time.[6, 16] For example, among 770,850 active osteopathic or allopathic physicians in 2023, there were 8603 malpractice payments (1.12%).[15] Similarly, 138,680 practicing dentists had 1123 malpractice payments (0.81%) and 9470 practicing podiatrists had 224 payments (2.58%).[15]

The mean dollar amount per payment increased from $213,560 in 1996 to $448,720 in 2023, although the post pandemic years of 2021–2023 so far appear to be outliers. Our test for trend indicates a positive upward trend in the mean dollar amount per claim from 1996 to 2023, although after excluding the three post pandemic years, the trend does not reach statistical significance. Additionally, examination of the number of cases per year over time does not show a statistically significant increase from 1996 through 2023. This could indicate a shift in attitudes toward healthcare providers in the current economic climate in which juries are willing to award higher dollar amounts to injured patients.

Despite frequent claims that expanding optometric privileges, particularly for laser procedures, poses safety concerns, our analysis yields no malpractice litigation evidence to suggest such expansions have compromised patient safety.[17-19] This is further supported by our findings that states in which optometrists practice in an expanded capacity did not see statistically significant differences in the number of paid claims following expansion of scope of care compared with prior to expansion in nearly all instances. Of note, examination of the most frequent allegations showed that relatively few cases were procedure related. The most common allegation, by a wide margin, was 'failure to diagnose', which accounted for 40% of all cases. Very few cases ($n = 21$) involved individuals under the age of 10, however, these cases resulted in higher payments compared with individuals age 10 and older.

Education

Several interrelated factors could explain the long-term stability of malpractice payments among optometrists, with education playing a central role. Over the past three decades, optometric education has evolved from a primarily refraction and contact lens focused curriculum to one that emphasizes systemic disease awareness, pharmacologic management, and interdisciplinary care. The expansion of faculty development programs has driven instructors to remain current with best practices, whereas enhanced research capacity has introduced more evidence-based approaches to clinical decision-making.[20, 21] Communication training, once underemphasized, now forms a core part of optometry education, equipping graduates with the skills to engage patients in informed discussions about risks, treatment options, and expectations, all critical elements in minimizing litigation risk.[22-24]

The growth of U.S. optometry schools, from 20 in 2011 to 25 by 2025, has occurred alongside a notable decline in matriculants.[25] This has paradoxically helped preserve standards of selectivity, as applicant pools remain competitive. The Accreditation Council for Optometric Education (ACOE) requirements, including the mandate that 80% of matriculants must complete training and licensure within 6 years, has helped further safeguard program quality.[25] Postgraduate residency programs have also gained traction, with over one-quarter of graduates now pursuing advanced training in areas such as ocular disease, low vision, and surgical comanagement.[2] These residencies improve patient care by preparing optometrists to manage complex, higher-risk cases that might otherwise increase liability exposure. Continuing education has likewise expanded, with the Council on Optometric Practitioner Education (COPE) and interprofessional partnerships fostering a culture of lifelong learning and collaboration.[26] Collectively, these trends indicate that ongoing educational investments are directly tied to the low and stable malpractice profile of the profession.

Technology

The rapid adoption of advanced diagnostic imaging technologies, particularly optical coherence tomography (OCT) and wide-field fundus photography has transformed optometrists' ability to detect and manage ocular disease at earlier stages.[27-29] These tools now allow for earlier intervention and more precise monitoring of diseases such as glaucoma and macular degeneration.[29] This not only improves patient outcomes but may also reduce legal vulnerability by strengthening clinical documentation and objective evidence of disease progression.[30, 31] Importantly, the integration of these technologies into everyday practice reflects a broader trend: optometrists are increasingly functioning as the first line of defense in preventing vision loss. As artificial intelligence and machine learning become even more integrated into imaging interpretation in the coming decade, their impact on future malpractice risk remains to be seen.

In addition to diagnostic imaging advances, the widespread adoption of electronic health records (EHRs) during the 2010s may have influenced malpractice risk through improved documentation, standardized workflows, and enhanced clinical decision support. More complete and contemporaneous documentation may reduce liability exposure by strengthening the medical record in the event of adverse outcomes. However, EHR implementation across optometric practices varied during this period, and the NPDB does not capture information regarding documentation systems in use at the time of an alleged event. As such, although EHR adoption represents a plausible contributor to stable malpractice trends, its impact could not be directly evaluated in the present analysis.

Surgical and laser procedures

Optometrists' participation in pre- and post-operative co-management continues to facilitate safe and efficient care.[32] Allegations most relevant to such cases include 'improper management' (4.4%), 'failure to recognize a complication' (4.2%), and 'failure to obtain informed consent' (0.7%) represent only a small fraction of total cases. Optometrist post-operative management remains an effective way for ophthalmologists to manage workload, particularly after cataract surgery.[33]

Whereas LASIK and PRK were once associated with higher malpractice rates for both optometrists and ophthalmologists,[9, 34] claims related to these procedures have declined sharply since 2000.[33] The recent expansion of laser privileges to optometrists in 11 states has not, with the possible exception of Indiana, been associated with an increase in malpractice rates. This may be due in part to the formalized educational and credentialing programs that accompany these procedural authorities, ensuring optometrists are prepared for laser and injection procedures before practicing independently.[19] However, these findings should be interpreted with caution, as many of these scope-of-practice expansions are recent with more than half of the states achieving expansion within the past 4–5 years. Importantly, Oklahoma, Kentucky, and Louisiana have each permitted optometrists to perform laser procedures for more than a decade, and none show a statistically significant change in malpractice cases compared with the period before expansion.

Importantly, scope of practice expansions are not uniform in risk, and procedural authorities such as injections or laser interventions may differ fundamentally from prescribing expansions. The NPDB does not allow linkage of malpractice claims to specific procedures or scope-related activities, precluding granular risk stratification. Accordingly, our findings should be interpreted as reflecting overall malpractice patterns rather than procedure-specific safety profiles.

Underreporting

Although NPDB data provide the most comprehensive nationwide record of malpractice payments, they likely underestimate the true number of adverse outcomes involving optometrists. Malpractice claims represent an imperfect surrogate for patient safety, as many adverse events do not result in litigation, and malpractice frequency does not consistently correlate with quality-of-care.[35]

Several structural factors further limit the completeness of NPDB reporting. Corporate shielding, in which claims are settled in the name of a clinic or institution rather than an individual provider, can prevent cases from appearing in the database.[36] Similarly, federal liability protections covering optometrists practicing within the Veterans Health Administration effectively remove malpractice cases from NPDB reporting.

The rise of disclosure-and-offer programs may also reduce the number of claims captured in national databases. These programs emphasize early communication, transparency, and proactive compensation following adverse events, often resolving disputes before formal litigation occurs.[6, 37, 38] Whereas beneficial for patients and providers alike, they also reduce the visibility of malpractice events in national data.

And lastly, optometrists often have longstanding trust-based patient relationships, and in cases of adverse outcomes, patients may prefer direct discussions with their optometrist rather than litigation.[39] Thus, the low claim frequency observed in NPDB reports likely underrepresents the full spectrum of optometry-related liability.

Gender

Although NPDB records do not identify provider gender, broader trends in health care suggest that the increasing number of women in the optometry workforce may influence malpractice risk. Female physicians across multiple specialties have been shown to face fewer lawsuits than their male peers, a phenomenon often attributed to longer consultation times, stronger communication, and higher patient satisfaction ratings.[40, 41] Given that nearly half of practicing optometrists are now women and that women make up the majority of current optometry students, it is reasonable to expect similar dynamics in eye care.[42] If these patterns hold true, the profession's shifting gender balance may further contribute to its already low rate of malpractice claims in years to come.

Geography

Although population density has been proposed as a potential contributor to malpractice risk, its influence appears to be independent of scope of practice. In fact, the states we identified with the highest number of claims per million residents (New Mexico, Oklahoma, Nevada, Pennsylvania, and Wyoming), includes both rural and more densely populated states as well as those with varying scope-of-practice laws. This pattern suggests that factors beyond population density and statutory scope, such as local legal climate, patient demographics, or variations in health care delivery systems, may have a stronger influence on malpractice claim rates.

Differences in practice setting may also contribute to the relatively low frequency of malpractice claims observed among optometrists compared with other health professions. Optometrists in the United States predominantly practice in outpatient private or retail settings and are less frequently involved in inpatient or hospital-based care, where patients often present with greater medical complexity and higher acuity. Reduced exposure to medically complex populations and system-driven adverse events may partially explain differences in malpractice patterns across professions. Because practice setting is not captured in NPDB data, its impact could not be directly evaluated in the present analysis.

COVID-19 pandemic

The COVID-19 pandemic substantially disrupted outpatient health care delivery across the United States, including optometric services. Temporary clinic closures, reductions in routine and preventive visits, and shifts toward urgent or deferred care altered patient access patterns during this period. These disruptions have important implications for interpreting malpractice trends, particularly given the low frequency of malpractice events and the lag between clinical encounters, claim initiation, and payment resolution.

In the short term, reduced patient volume and deferred non-urgent care may have temporarily decreased exposure to malpractice risk. Conversely, delays in diagnosis or treatment resulting from postponed visits could contribute to adverse outcomes that may not manifest as malpractice claims until years later. Because the NPDB records payments, and because malpractice claims often involve prolonged resolution timelines, the long-term impact of pandemic-related care disruptions on malpractice payments remains uncertain.

In addition, pandemic-era changes in health care delivery, including increased reliance on telehealth and modified clinical workflows, may have influenced documentation practices and patient expectations in ways that are not captured in administrative datasets. As a result, observed malpractice trends during and immediately following the pandemic should be interpreted cautiously, with recognition that COVID-19–related effects on malpractice risk may be delayed or incompletely reflected in current NPDB data.

Limitations

This study has several important limitations that should be considered when interpreting the findings. Malpractice payments among optometrists are rare events, which limits statistical power, particularly for state-level and post-scope expansion analyses. Several states included in the expanded scope analysis have limited post-expansion follow-up, including two states with only a single year of available data and no reported claims. Given the low frequency of malpractice events, the absence of observed claims in these settings should not be interpreted as definitive evidence of no effect but rather as an early signal requiring continued longitudinal surveillance as additional years of data accrue.

The NPDB does not provide granular clinical detail regarding the nature of alleged malpractice events. Claims are categorized using broad allegation groupings, such as 'failure to diagnose' or 'delay in diagnosis', without information on specific diseases, procedures, medications, or severity of outcomes. As a result, we were unable to evaluate whether malpractice risk differed by disease type or to attribute claims to specific scope-of-practice activities, such as prescribing, injections, or laser procedures. Accordingly, our findings reflect aggregate malpractice trends rather than procedure-specific risk.

State-level comparisons must also be interpreted within the context of substantial variation in legal and insurance environments. Differences in tort laws, damage caps, malpractice insurance requirements, and litigation culture are known to influence malpractice claims across health professions but are not captured in NPDB data. Geographic variation in claim frequency or payment amounts may therefore reflect differences in legal climate or health care delivery systems rather than differences in clinical practice alone.

Changes in health care delivery over the study period may further influence malpractice trends in ways not directly measurable using administrative data. The widespread but heterogeneous adoption of electronic health records during the 2010s may have affected documentation practices, clinical workflows, and patient communication, yet information regarding documentation systems in use at the time of an alleged event is not available in the NPDB. The impact of such technological changes could therefore not be directly assessed.

Practice setting represents another potential modifier of malpractice risk. Optometrists in the United States predominantly practice in outpatient private or retail settings, with less frequent involvement in inpatient or hospital-based care. This practice distribution may reduce exposure to medically complex patients and high-acuity environments associated with increased malpractice risk in other health professions. Because practice setting is not recorded in NPDB data, its impact could not be directly evaluated.

Finally, NPDB data likely underestimate the true incidence of adverse events involving optometrists. Corporate shielding, federal liability protections for Veterans Affairs providers, and the growing use of disclosure-and-offer programs may prevent some cases from being reported as individual malpractice payments. Although these factors may reduce the completeness of NPDB reporting, the database remains the most comprehensive national source for evaluating malpractice payment trends over time.

CONCLUSIONS

Overall, malpractice payments involving optometrists in the United States remain rare, relatively stable, and low in both frequency and severity compared to other health professions. The majority of claims continue to stem from alleged diagnostic errors, rather than from therapeutic mismanagement or surgical complications. As the scope of optometric practice continues to expand, including authority for prescribing oral medications, administering injections, and performing in-office laser procedures, there is no evidence to date that these expansions compromise patient safety or increase malpractice liability. Instead, advances in education, adoption of sophisticated diagnostic technologies, stronger patient-provider communication, and interprofessional collaboration all likely contribute to reducing risk and promoting high-quality care.

Looking ahead, the profession's ability to sustain this favorable liability profile will depend on continued investments in training, technology, and transparency. Ongoing monitoring of NPDB data, combined with more granular analysis of geographic and demographic trends, will be essential in identifying emerging risks. If optometrists remain proactive in adopting high-reliability practices, embracing telehealth safeguards, and fostering strong patient relationships, they will likely be well positioned not only to maintain low malpractice risk but also to serve as a model for other health professions navigating the intersection of expanding clinical authority and patient safety.

AUTHOR CONTRIBUTIONS

Robert S. Duszak: Conceptualization (equal); project administration (lead); writing—original draft preparation (lead); writing—review and editing (equal). **Molly S. Phan**: Conceptualization (equal); data curation (lead); formal analysis (lead); writing—review and editing (equal); visualization (lead). **Richard Duszak**: Conceptualization (equal); writing—review and editing (equal).

CONFLICT OF INTEREST STATEMENT

The authors declare no conflicts of interest.

Supporting Information

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