MPL Lessons Learned: 10 Years in Review

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Objectives

After completing this program, the learners will:

- Describe the current trends in both the frequency and severity of malpractice claims
- Understand the root causes of medical malpractice
- Determine proactive strategies to mitigate risks to the most common professional liability exposures

Healthcare Liability Market Update

Challenges facing healthcare

Changing delivery platform

Changing reimbursement

Changing workforce

Continued advances in technology, genetics, etc.

Greater focus on consumerism

Continued consolidation

Healthcare delivery changes

Corporatization of medicine
Including private equity investments

CV19 impact on population health
Deferred care, missed care, etc.

Healthcare consolidation
Larger, more complex healthcare systems

Healthcare staffing
Contract staffing, provider burnout, turnover, violence

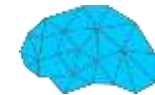## Physician employment
Less private practice, more corporate/hospital

Scope of practice
Expanding for PAs, NPs, CRNAs, etc.

Shifting environment of care
More outpatient, home health, telehealth, etc.

Technology innovations
AI, genetics, etc.

Changes in the litigation environment

- **COVID-19 impact**
  - Judges are pressuring parties to settle by setting unreasonable deadlines and stacking trial dates.
  - Directives from high courts are affecting scheduling.
  - Pressure creates difficulties for attorneys, experts, and insureds.
  - COVID-19 "healthcare halo" not a significant factor in influencing juries.

- **Compromise Verdicts/Splitting the Baby**: Jurors are awarding $$ even when liability not clear.

- **Aging trial bar**: we are focused on identifying and helping to train next-gen "First Chairs."

- **Changing jury pool**: what can we expect from millennial jurors?
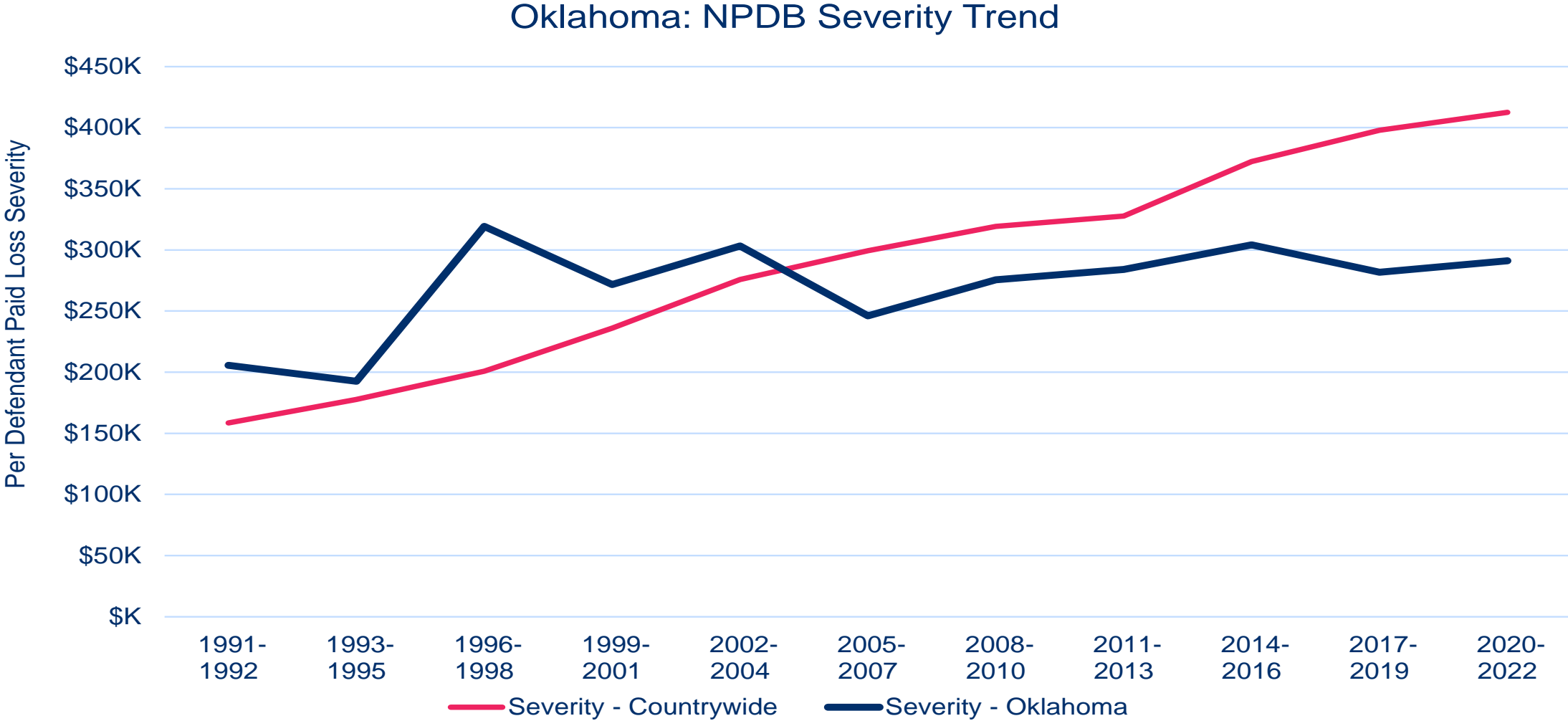
Deteriorating loss environment ...

- Industry trends: frequency flat & severity up
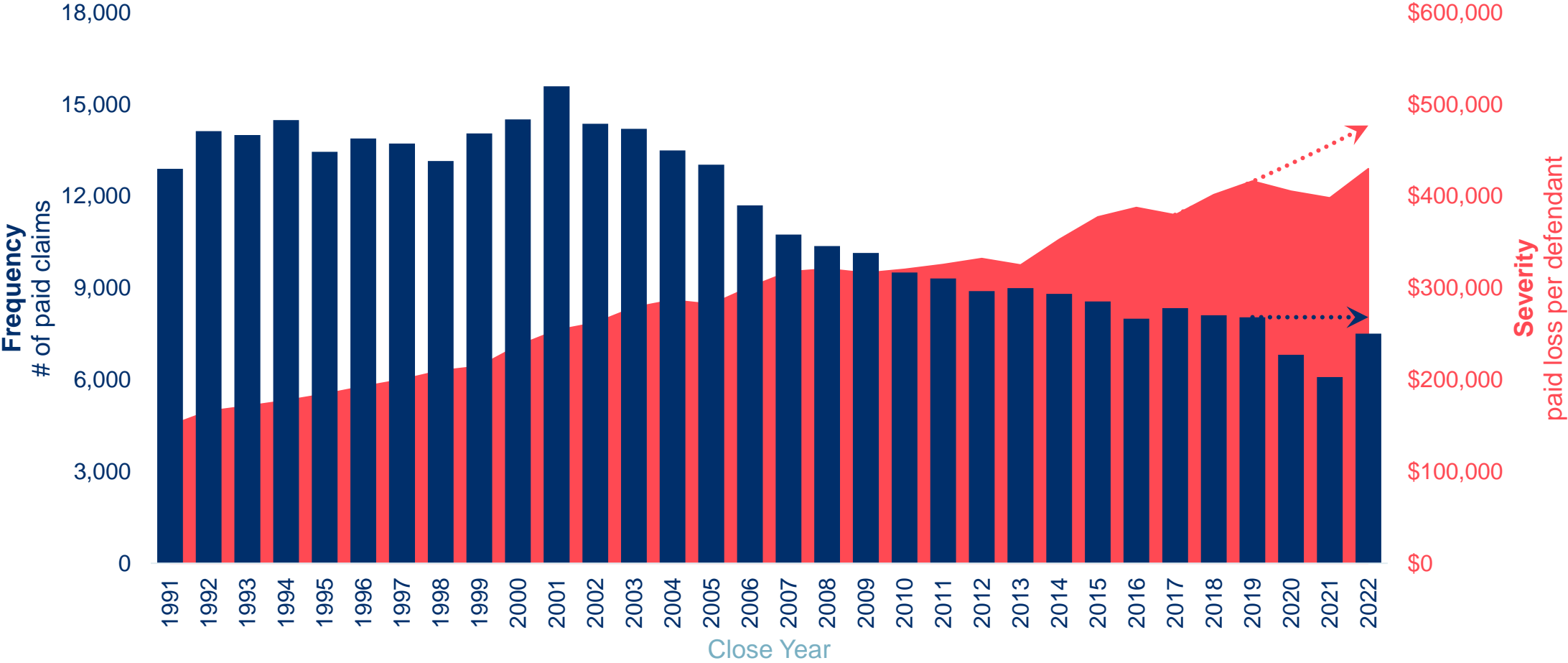
- Source: National Practitioner Data Bank Public Use Data File, December 2022, Physicians & Surgeons Countrywide

Oklahoma loss trends

Oklahoma: NPDB Severity Trend

Per Defendant Paid Loss Severity

Legend: Severity - Countrywide, Severity - Oklahoma

X-axis: 1991-1992, 1993-1995, 1996-1998, 1999-2001, 2002-2004, 2005-2007, 2008-2010, 2011-2013, 2014-2016, 2017-2019, 2020-2022

Y-axis: $K, $50K, $100K, $150K, $200K, $250K, $300K, $350K, $400K, $450K

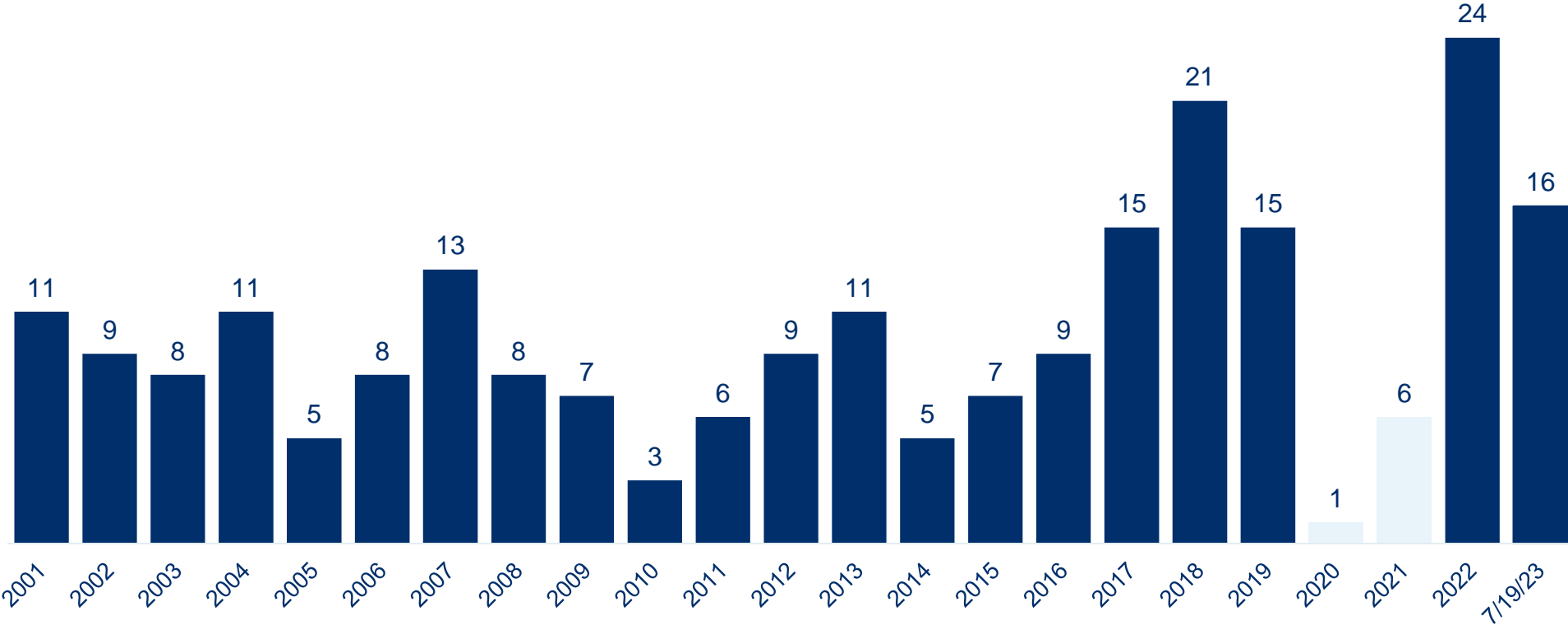- Source: National Practitioner Data Bank Public Use Data File, December, 2022.

... severity & social inflation increasing: $10+ shock verdicts

- As courts reopen, US HCL verdicts $10+ resume … expanding beyond "Judicial Hellholes"

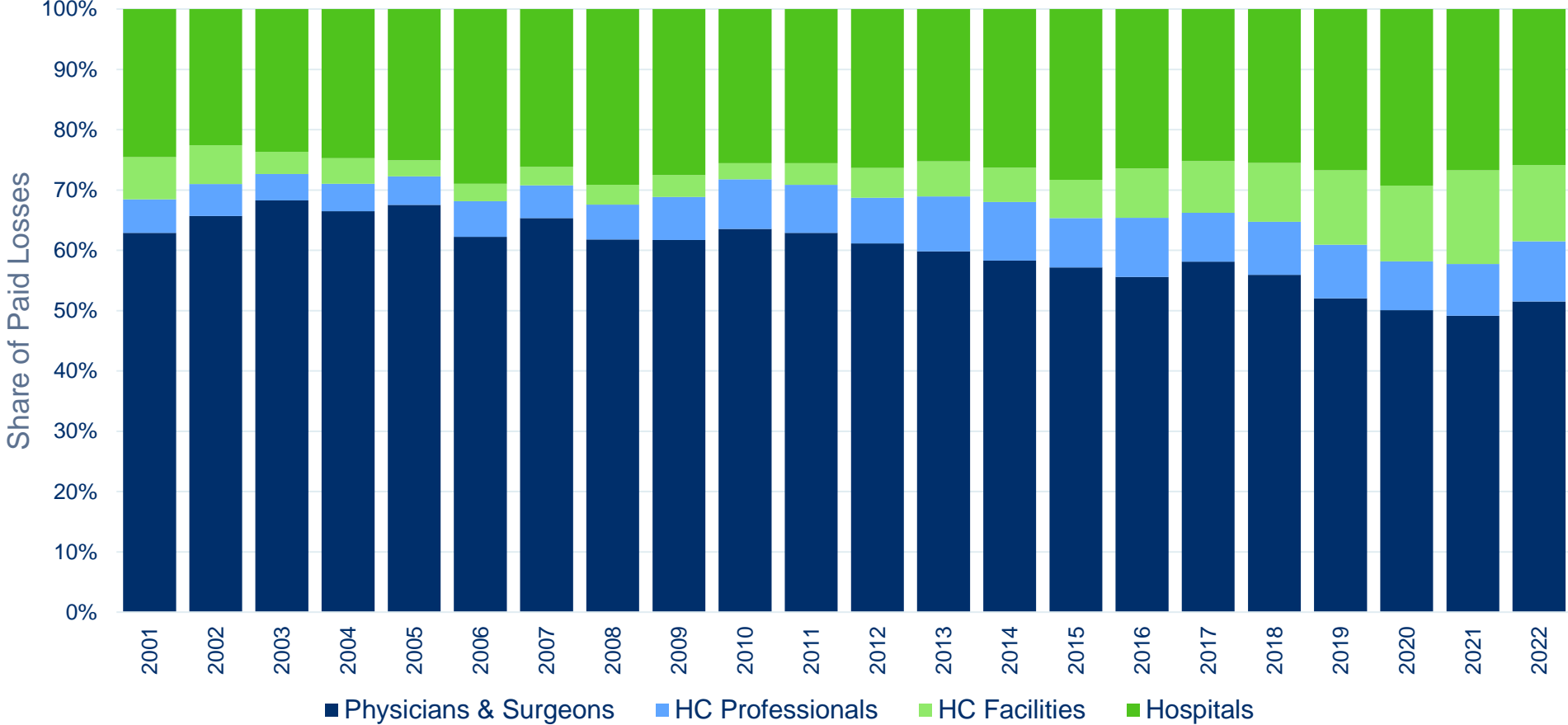■ Hospitals/OB   ■ Other Specialties   ■ Senior Care
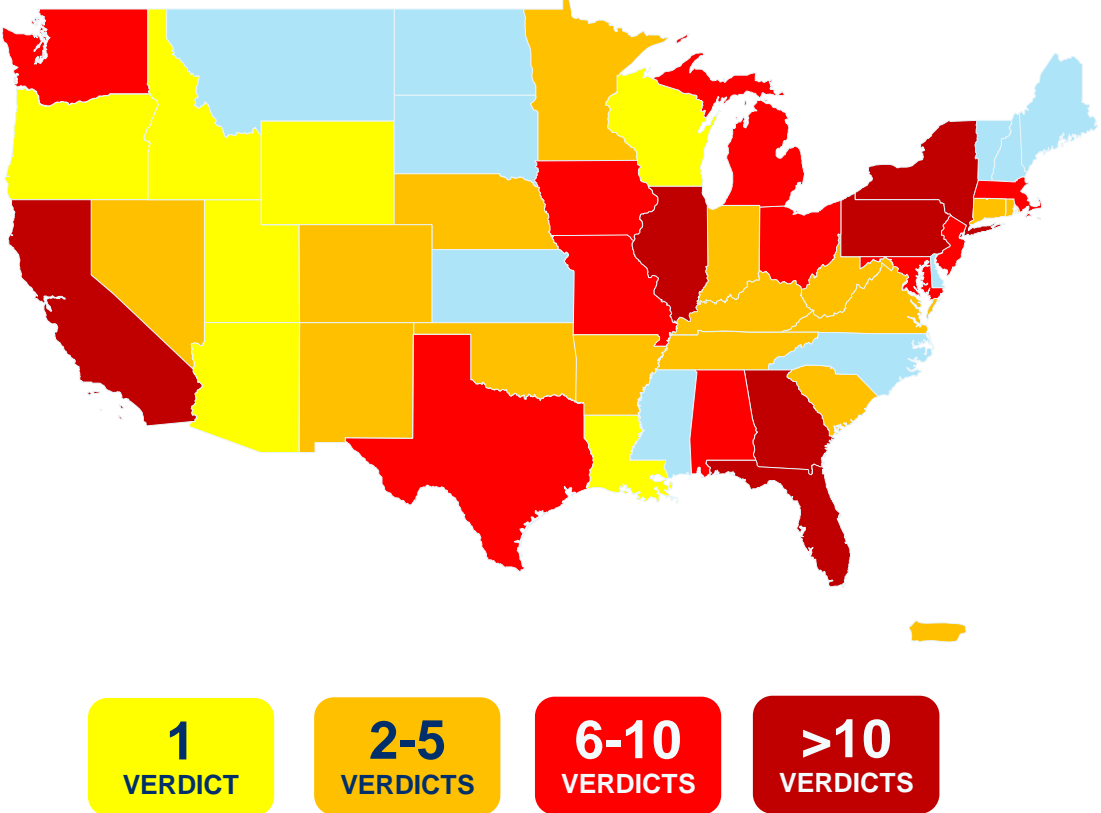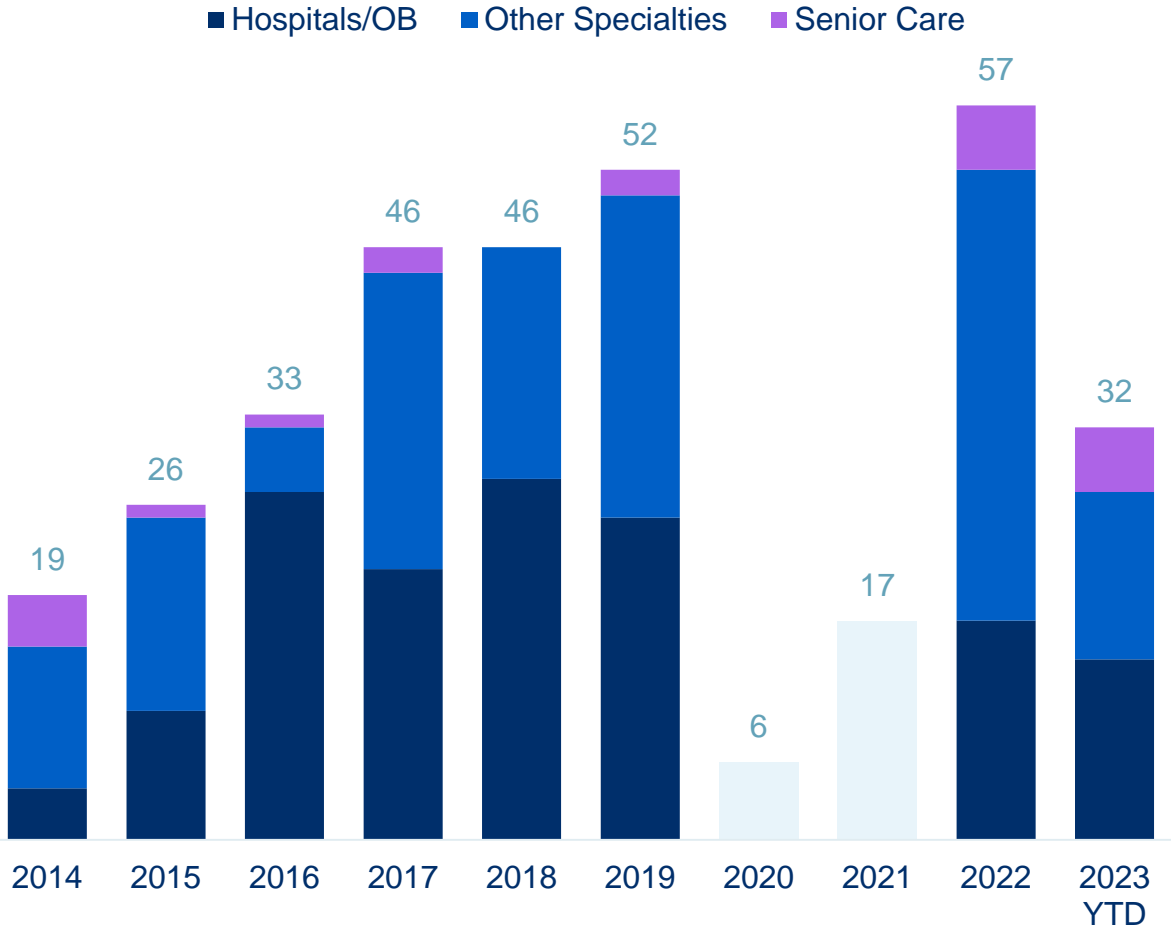
Source: TransRe and various internet articles with publication dates between 01/01/2014 and 07/19/2023.
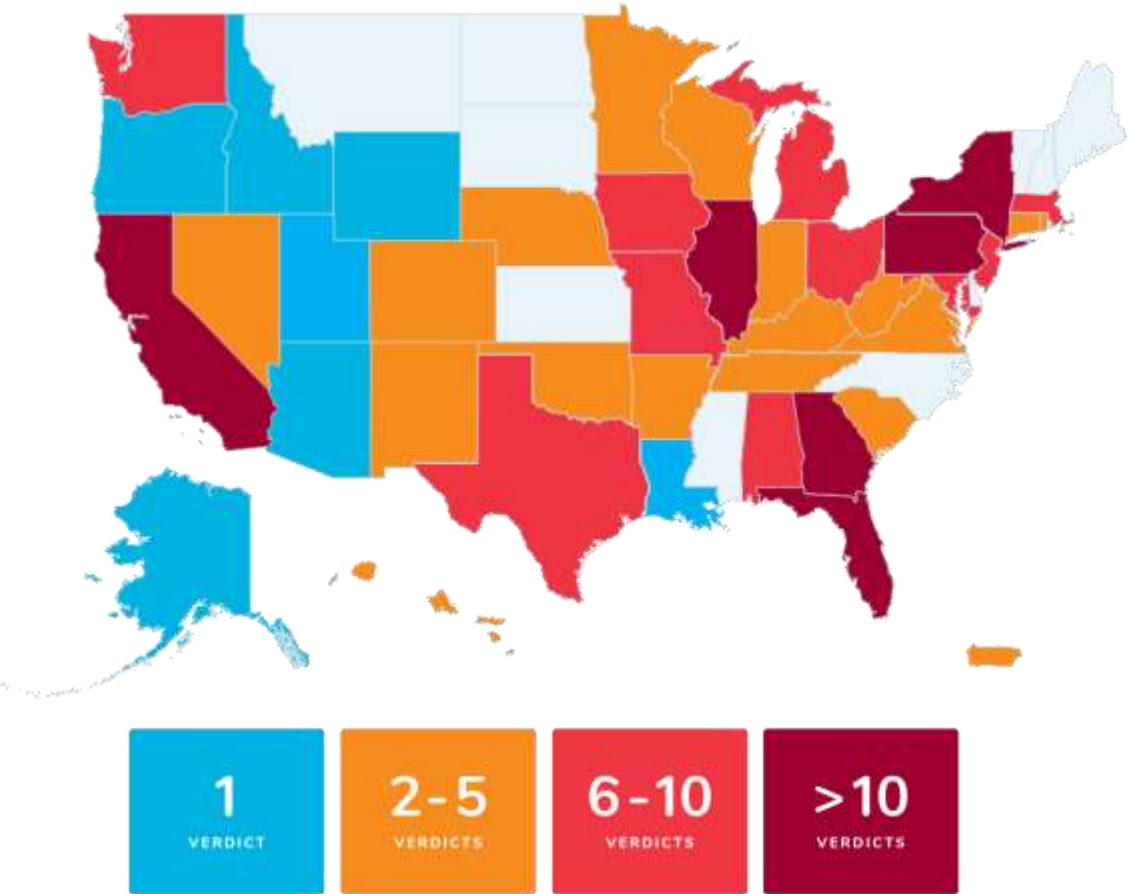
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… including $25M+ aberration verdicts

- Source: Trans Re and various internet articles with publication dates between 1/1/2016 and 7/19/2023

… and losses shifting from HC Providers to HC Entities

Share of Paid Losses by year (2001–2022), categorized by Physicians & Surgeons, HC Professionals, HC Facilities, and Hospitals.

- Source: S&P Global Market Intelligence

# Increasing HCL shock verdicts / social inflation nationwide

Oklahoma > $10M

Nurse, Correctional Health	82
General Surgeon	17.5
Obstetrics, Hospital	15
Correctional Medicine	12.3

Legend:
- 1 VERDICT
- 2 – 5 VERDICTS
- 6 – 10 VERDICTS
- >10 VERDICTS

• Sources: Chart: Trans Re and various internet articles with publication dates between 01/01/2016 and 05/19/2023.

Hyperlinks to verdicts are clickable in slideshow mode   13

Oklahoma loss trends

Oklahoma: NPDB % of Claims over $250,000
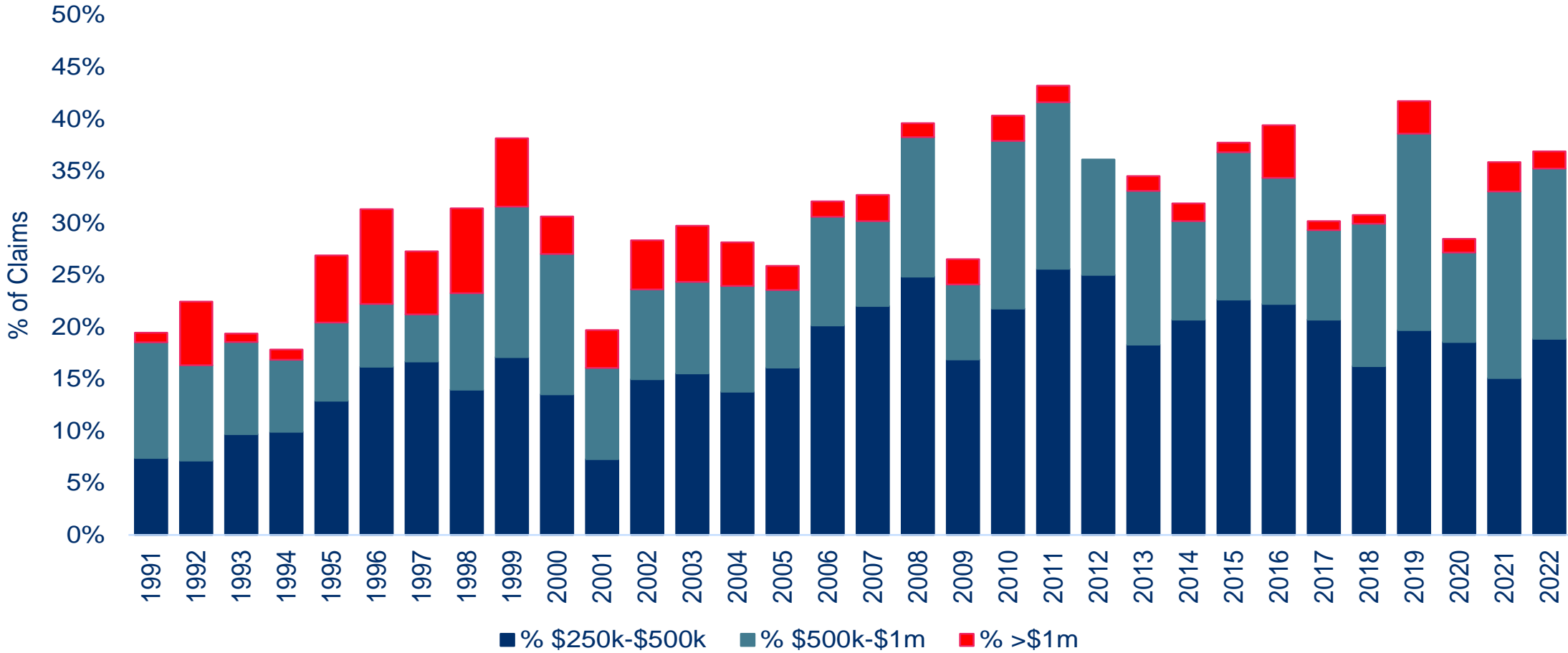
Legend: ■ % $250k-$500k ■ % $500k-$1m ■ % >$1m

- Source: National Practitioner Data Bank Public Use Data File, December, 2022.

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Specialty benchmarking

Specialties have different frequency and financial severity profiles which combine to produce differing risk levels.

Severity Tier				
	High	Hematology/Oncology, Pathology, Pediatrics	Anesthesiology, Neurology	Emergency Medicine, Neurosurgery, OB/GYN
	Medium	Family Medicine, Nephrology, Physiatry, Urgent Care	Cardiology, ENT, Gastroenterology, Internal Medicine	Cardiovascular Surgery, General Surgery, Orthopedic Surgery, Radiology, Urology
	Low	Allergy, Dermatology, Occupational Medicine, Psychiatry, Rheumatology	Ophthalmology, Plastic Surgery, Pulmonology	Hospitalists
		Low	**Medium**	**High**
		Frequency Tier		

Source: MedPro Group Physician & Surgeon Claim Experience & Analysis

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Specialty trends – Family Medicine

Family Medicine has an average financial severity per case and lower claim frequency compared to all specialties.
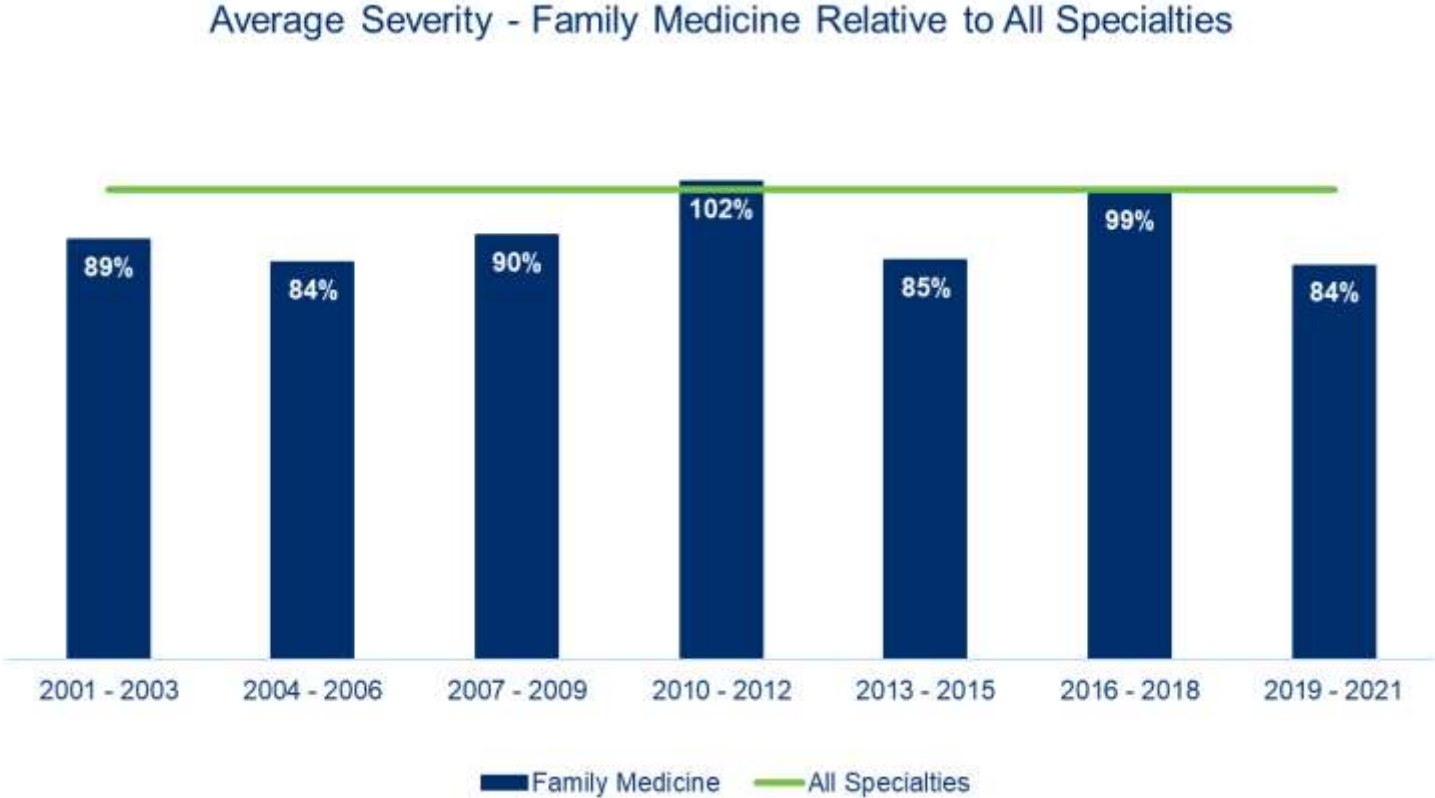
Average Severity - Family Medicine Relative to All Specialties

Frequency Tier
High
Medium
Low

Source: MedPro Group Physician & Surgeon Claim Experience & Analysis

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Specialty trends – General Surgery

General Surgery has an average financial severity per case and a higher claim frequency compared to all specialties.

Average Severity - General Surgery Relative to All Specialties

2001 - 2003	105%
2004 - 2006	94%
2007 - 2009	90%
2010 - 2012	98%
2013 - 2015	110%
2016 - 2018	102%
2019 - 2021	98%

Legend: ■ General Surgery — All Specialties

Frequency Tier

- High
- Medium
- Low

Source: MedPro Group Physician & Surgeon Claim Experience & Analysis

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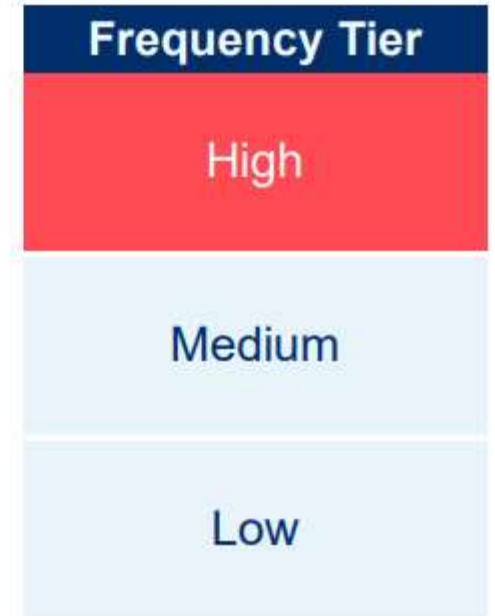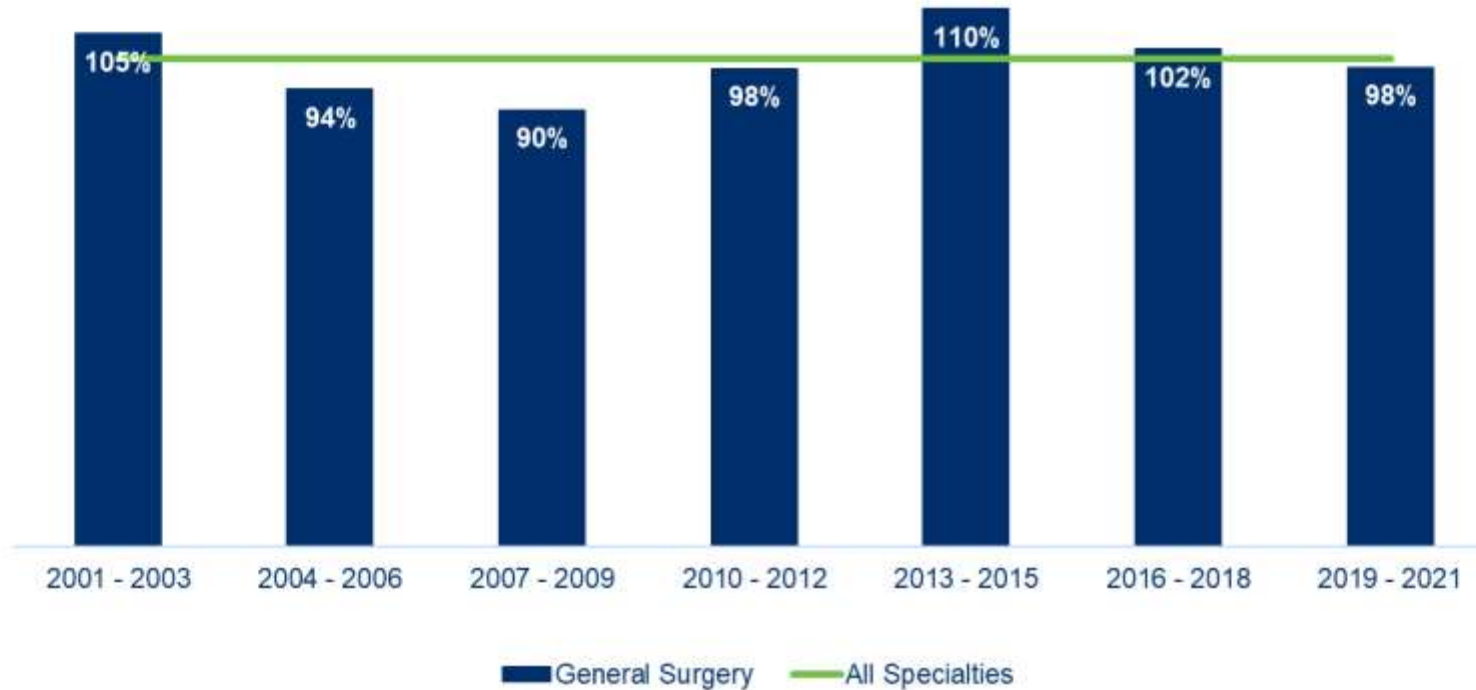
Specialty trends – Internal Medicine

Internal Medicine has an average financial severity per case and an average claim frequency compared to all specialties.

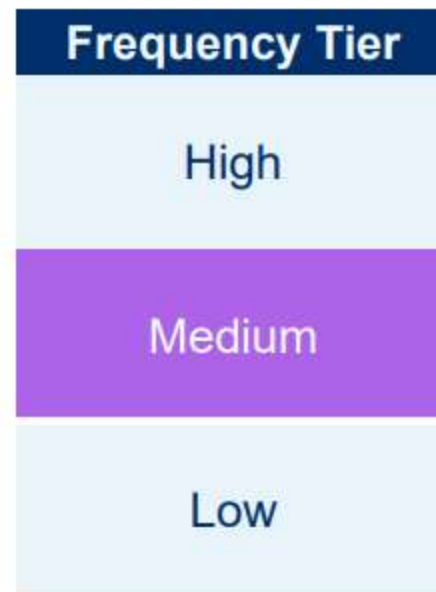Average Severity - Internal Medicine Relative to All Specialties

Frequency Tier
High
Medium
Low

Legend: Internal Medicine / All Specialties

Bar values: 2001-2003: 95%, 2004-2006: 99%, 2007-2009: 85%, 2010-2012: 94%, 2013-2015: 117%, 2016-2018: 96%, 2019-2021: 97%

Specialty trends – Emergency Medicine

Emergency Medicine has a higher financial severity per case and a higher claim frequency compared to all specialties.

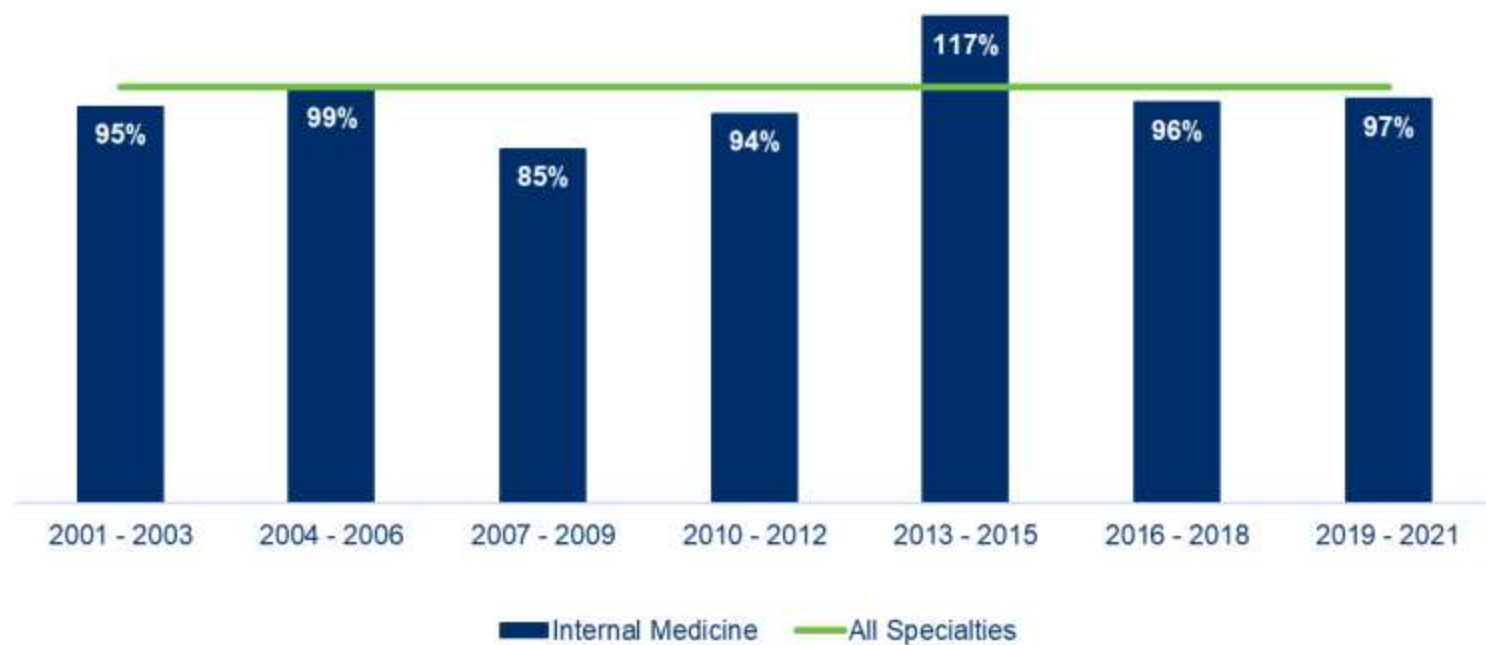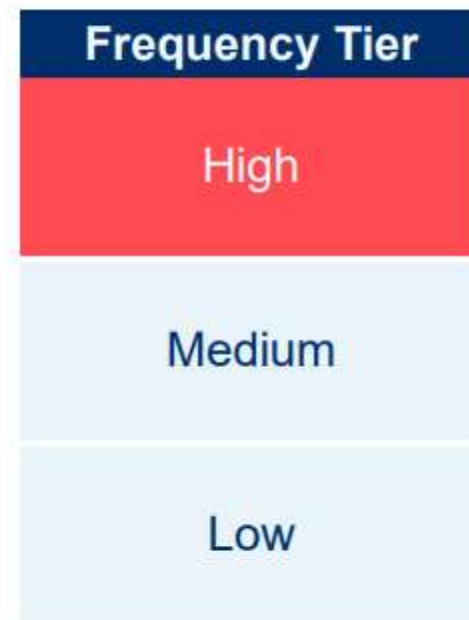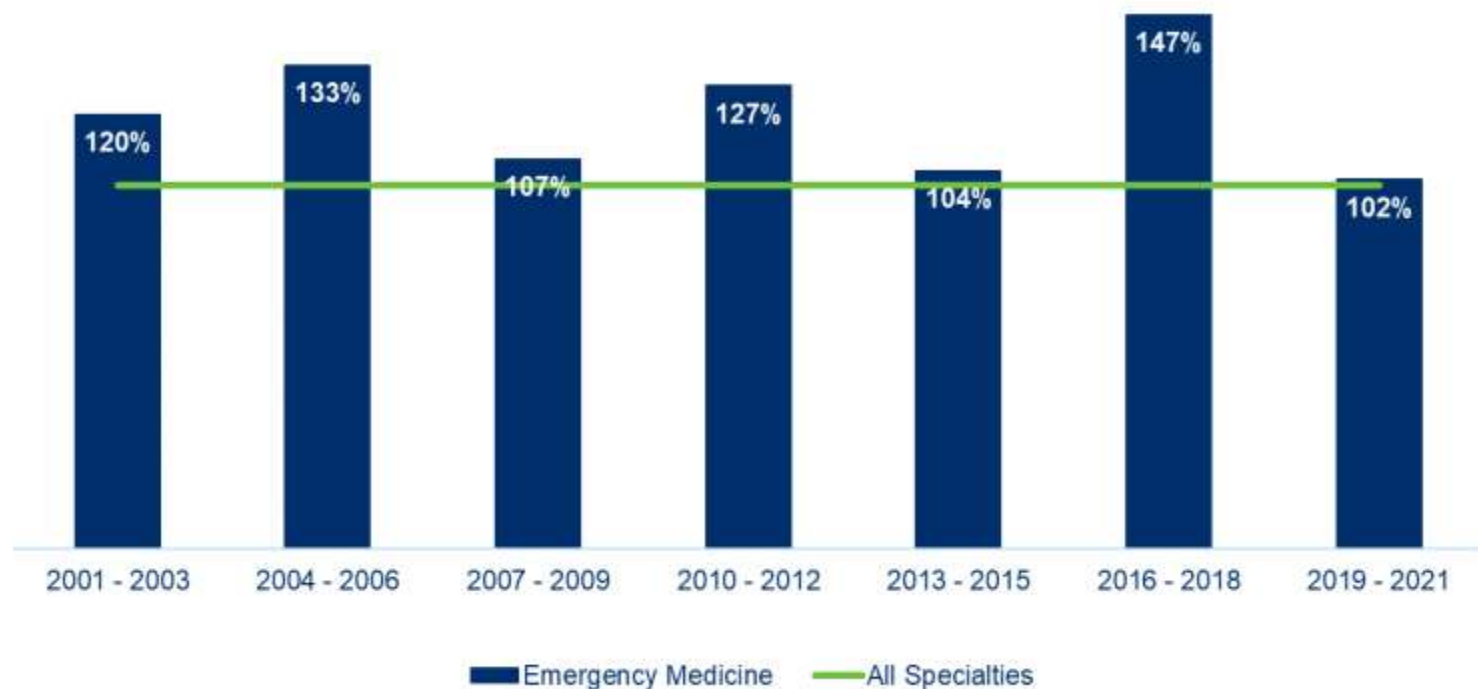Average Severity - Emergency Medicine Relative to All Specialties

Frequency Tier
High
Medium
Low

Chart data (Emergency Medicine bars):
- 2001 - 2003: 120%
- 2004 - 2006: 133%
- 2007 - 2009: 107%
- 2010 - 2012: 127%
- 2013 - 2015: 104%
- 2016 - 2018: 147%
- 2019 - 2021: 102%

Legend: ■ Emergency Medicine — All Specialties

10 Year Lookback

Claimant Type and Location
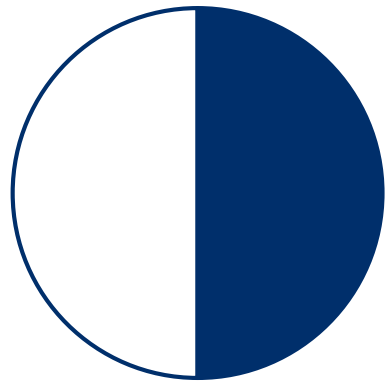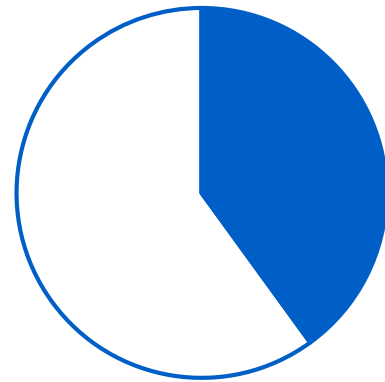
Ambulatory
50%

Inpatient
40%

Emergency
10%

Top Locations	% of case volume
Office/clinic	26%
Patient room/ICU	17%
Inpatient surgery	15%
Ambulatory surgery	11%
Emergency department	10%

MedPro Group + MLMIC cases opened 2012-2021 (N=22,625)

Major Allegation Categories

- Each case reflects one major allegation/case type category. Categories are designed to enable the grouping and analysis of similar cases and to drive focused risk mitigation efforts.

  The distribution of case types across both the nationwide and Oklahoma data sets are similar, with surgical and diagnosis-related cases being most common.
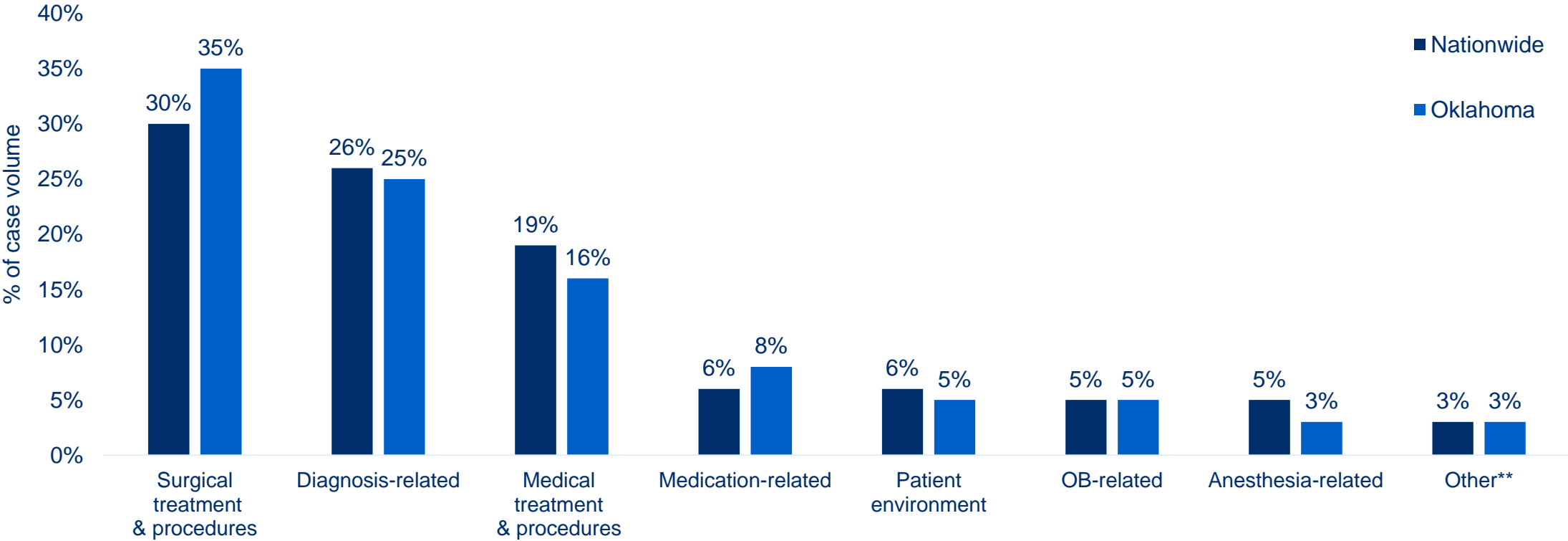
- Nationwide = MedPro Group + MLMIC cases opened 2012-2021 (N=22,625); Oklahoma = MedPro Group cases opened 2012-2021 (N=1052)

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Primary Responsible Services

- The primary responsible service in each case is the specialty that is deemed to be most responsible for the resulting patient outcome. The distribution of service types across both the nationwide and Oklahoma data sets are similar, with orthopedic and primary care specialties being slightly more common in the Oklahoma data.

Chart: % of case volume — Nationwide vs Oklahoma

Service	Nationwide	Oklahoma
Surgical specialties	14%	11%
Medicine specialties	13%	11%
Orthopedic surgery	11%	14%
Primary care	10%	13%
Nursing	10%	9%
OB/GYN	9%	9%
Emergency medicine	7%	8%
Radiology	6%	5%
Anesthesiology	5%	3%
General surgery	5%	7%
Other*	10%	10%

Clinical* & Financial Severity

High clinical severity cases by open year
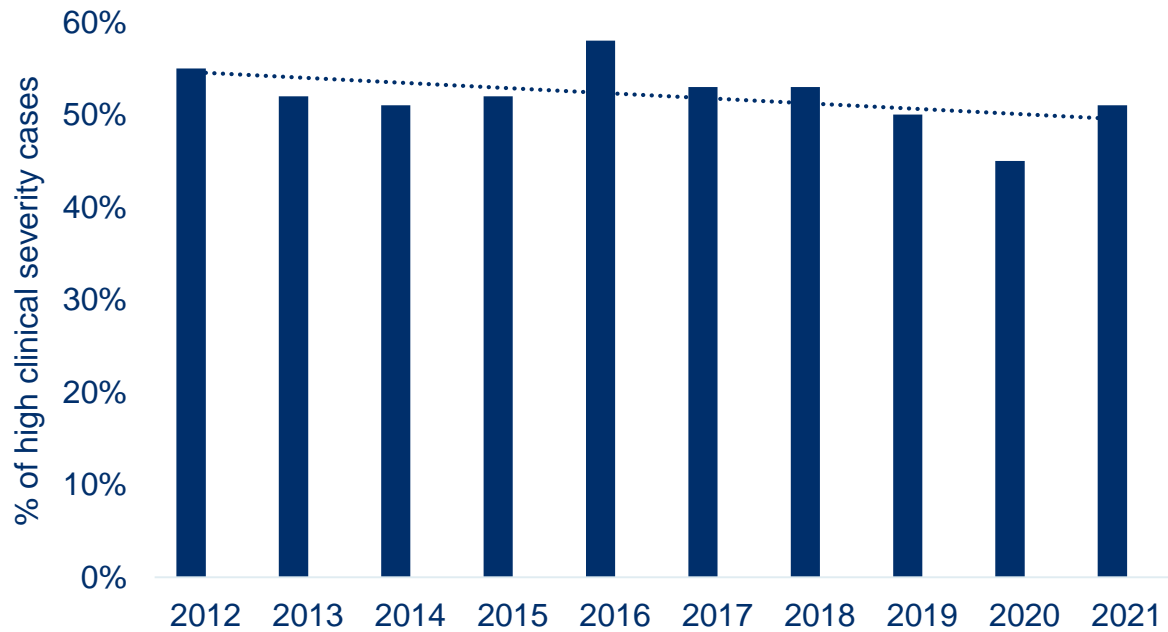
High clinical severity closed cases – average financial severity by closed year**
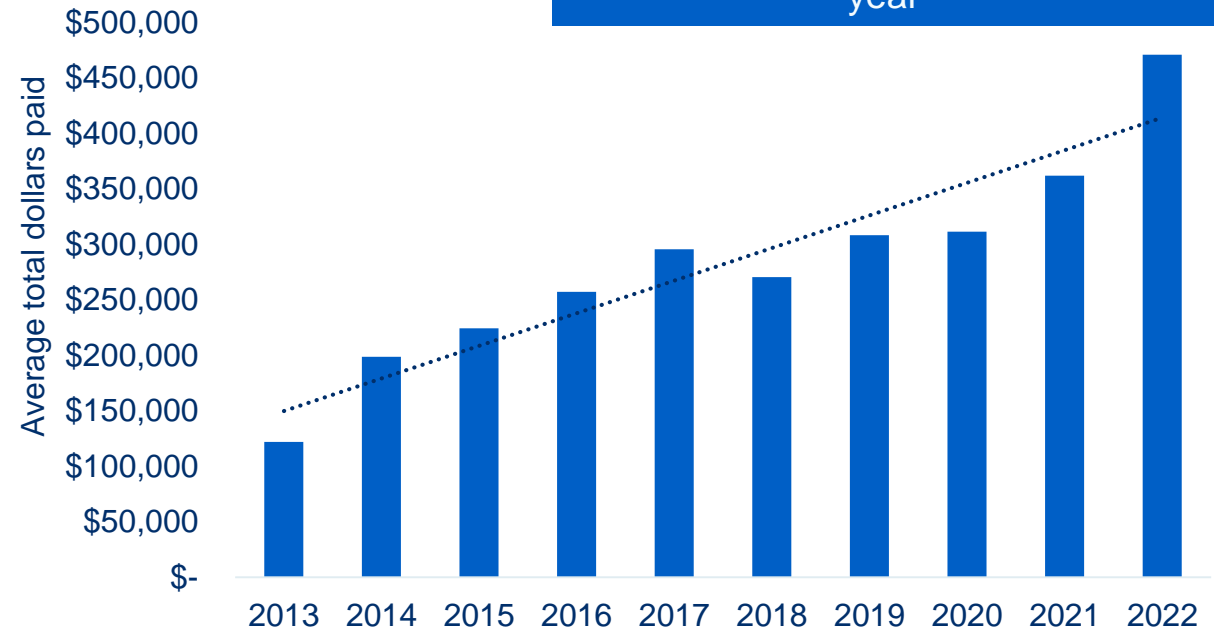
Although across the years the percentage of high clinical severity cases in this data set **opened each year is slightly declining,** the **average cost to resolve** these cases is **rapidly increasing**.

MedPro Group + MLMIC cases opened 2012-2021 (N=22,625); *Severity codes reflect National Association of Insurance Commissioners (NAIC) injury severity scale (high severity N=11.696); **Total dollars paid = expense + indemnity (high severity closed case N=10,195)

Clinical Severity*

Clinical Severity Categories	Sub-categories	% of case volume
LOW	Emotional Injury Only	**6%**
	Temporary Insignificant Injury	
MEDIUM	Temporary Minor Injury	**41%**
	Temporary Major Injury	
	Permanent Minor Injury	
HIGH	Significant Permanent Injury	**53%**
	Major Permanent Injury	
	Grave Injury	
	Death	

Typically, the higher the clinical severity, the higher the indemnity payments are, and the more frequently payment occurs.

Clinical Severity*: Focus on Top Five Major Allegation Categories

The percentage of diagnosis-related cases which reflect a high clinical severity patient outcome far surpasses that of other allegations. The only exception is OB-related cases (74% of those are high severity).

MedPro Group + MLMIC cases opened 2012-2021 (N=22,625); *Severity codes reflect National Association of Insurance Commissioners (NAIC) injury severity scale

Major Allegation Categories and Financial Severity

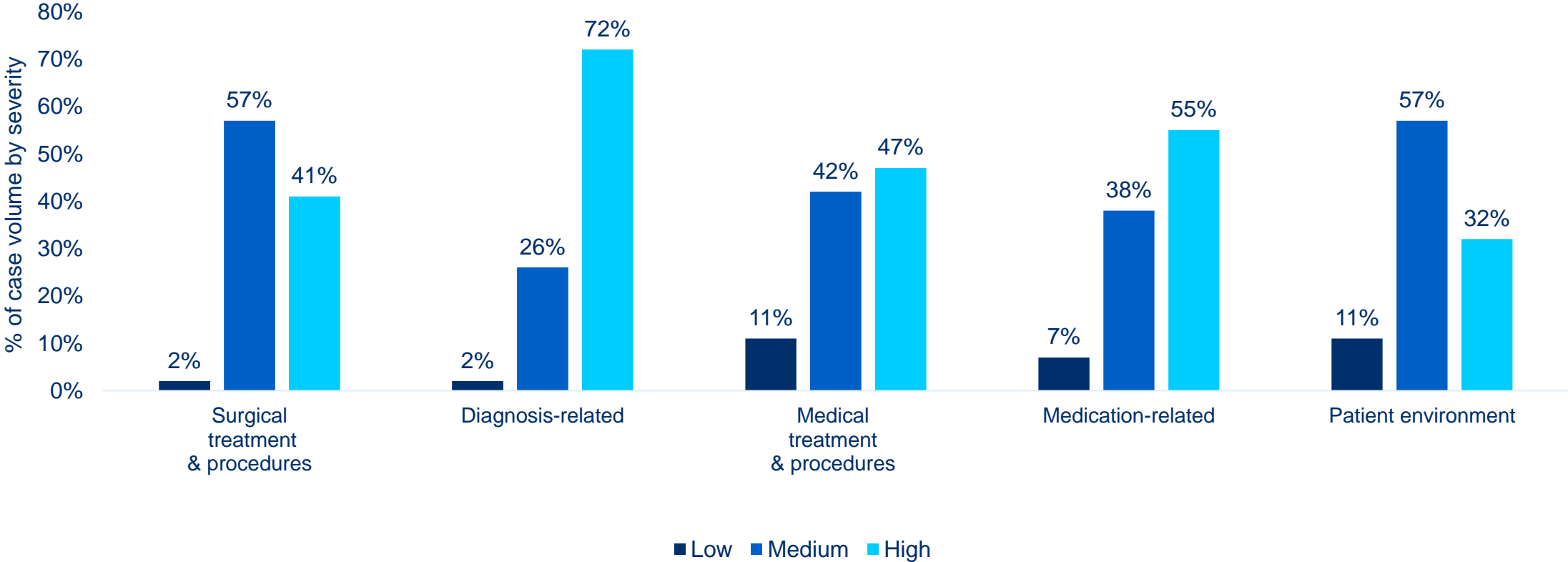**Each case reflects one major allegation category.** Categories are designed to enable the grouping and analysis of similar cases and to drive focused risk mitigation efforts. The coding taxonomy includes **detailed allegation sub-categories; insight into these is noted later in this report.** Surgical and diagnosis-related cases are most common, and although diagnosis-related cases account for one-third of total dollars paid, **OB and anesthesia-related cases are, on average, the most costly to defend**.

MedPro Group + MLMIC cases opened 2012-2021 (N=22,625); *Total dollars paid = expense + indemnity; **Other includes allegations for which no significant case volume exists

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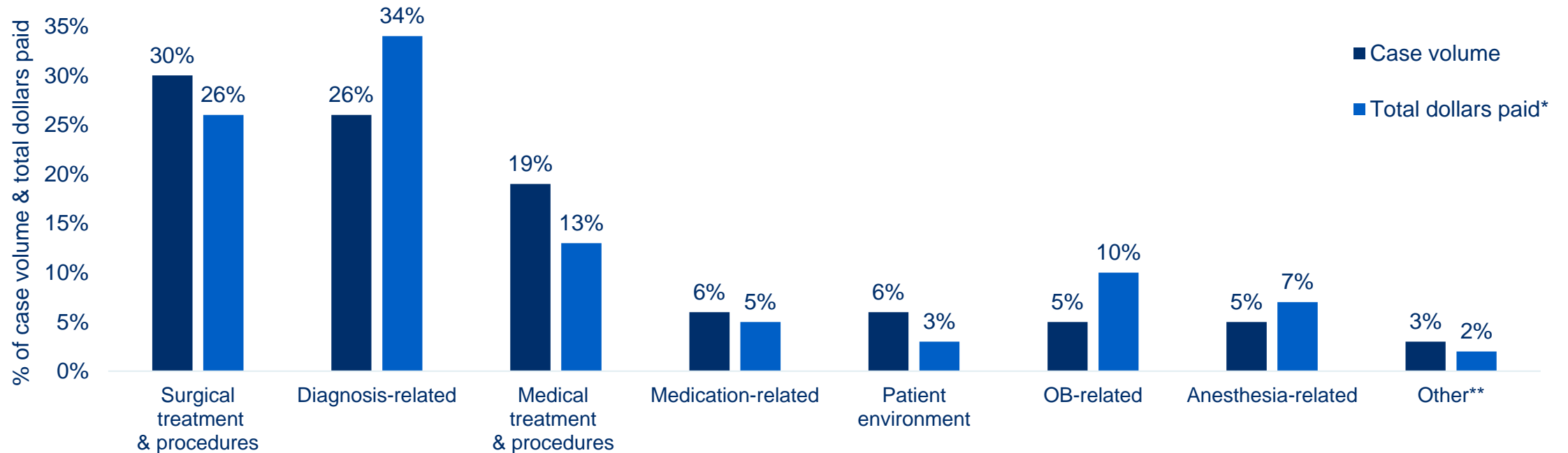
Focus on Surgical Treatment Allegations

Allegation details

Chart — % of surgical treatment case volume:
- Improper performance of surgery: 47%
- Improper management of surgical patient: 42%
- Retained foreign body: 4%
- Other - including unnecesary surgery & delay in surgery: 7%
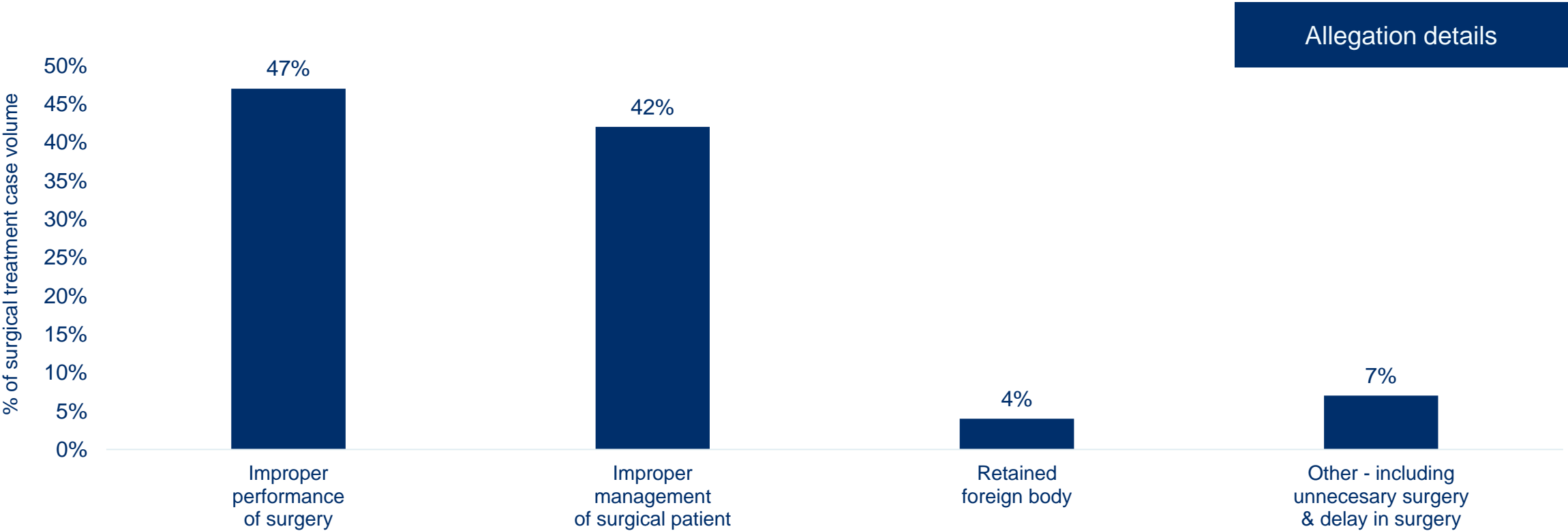
Cases involving the management of surgical patients, including pre-, intra-, and post-operatively, are often related to the surgical team's response to developing complications. While complications of procedures may have been the result of procedural error, the failure to timely recognize and/or monitor/manage the issue prevents the opportunity for early mitigation of the risk of serious adverse outcome.

Focus on Diagnosis-Related Allegations

Diagnosis-related allegations encompass wrong diagnoses, failures/delays, and misdiagnoses. Below are the portions of **each primary responsible service's cases which are diagnosis-related.** Highlighted in red are those services for which diagnostic allegations account for at least one-third of case volume.
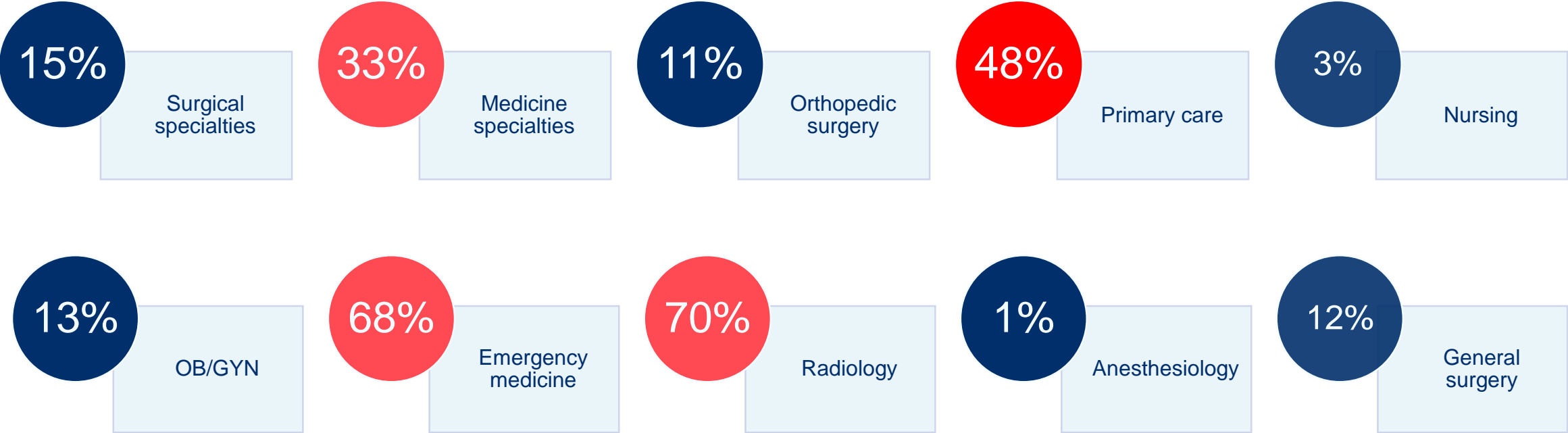
15% Surgical specialties	**33%** Medicine specialties	**11%** Orthopedic surgery
48% Primary care	**3%** Nursing	
13% OB/GYN	**68%** Emergency medicine	**70%** Radiology
1% Anesthesiology	**12%** General surgery	

MedPro Group + MLMIC cases opened 2012-2021 (N=22,625)

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Focus on Diagnosis-Related Allegations

Diagnosis-related allegations encompass wrong diagnoses, failures/delays, and misdiagnoses. Note the key opportunities to reduce diagnostic errors along the diagnostic process of care* below.

Phase 1

Initial diagnostic assessment

84% of cases

- Patient notes problem & seeks care
- History & physical
- Patient assessed, symptoms evaluated
- Differential diagnosis established
- Diagnostic testing ordered

Phase 2

Testing and results processing

35% of cases

- Performance of diagnostic tests
- Interpretation of diagnostic test results
- Test results transmitted to/received by ordering provider

Phase 3

Follow-up and coordination

62% of cases

- Physician follows-up with patient
- Referrals/Consults
- Patient information communicated among care team
- Patient compliance with follow-up plan

Focus on **Medical Treatment** Allegations-Family Medicine

Top allegation details

% of medical treatment case volume

- Improper management course of treatment: 46%
- Improper performance of treatment/procedure: 25%
- Failures/delays in treatment: 13%
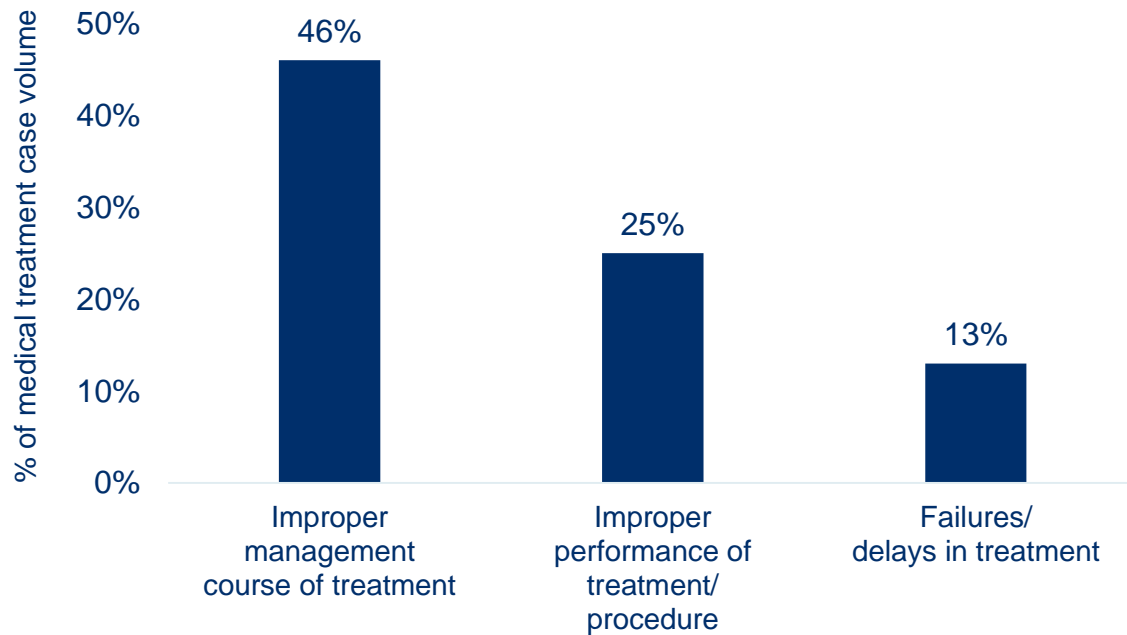
Top procedures involved

% of medical performance-related case volume

- Excision of skin lesion: 22%
- Steroid injections: 11%
- Colonoscopy: 9%
- Other injections: 7%
- Irrigation of ear: 7%
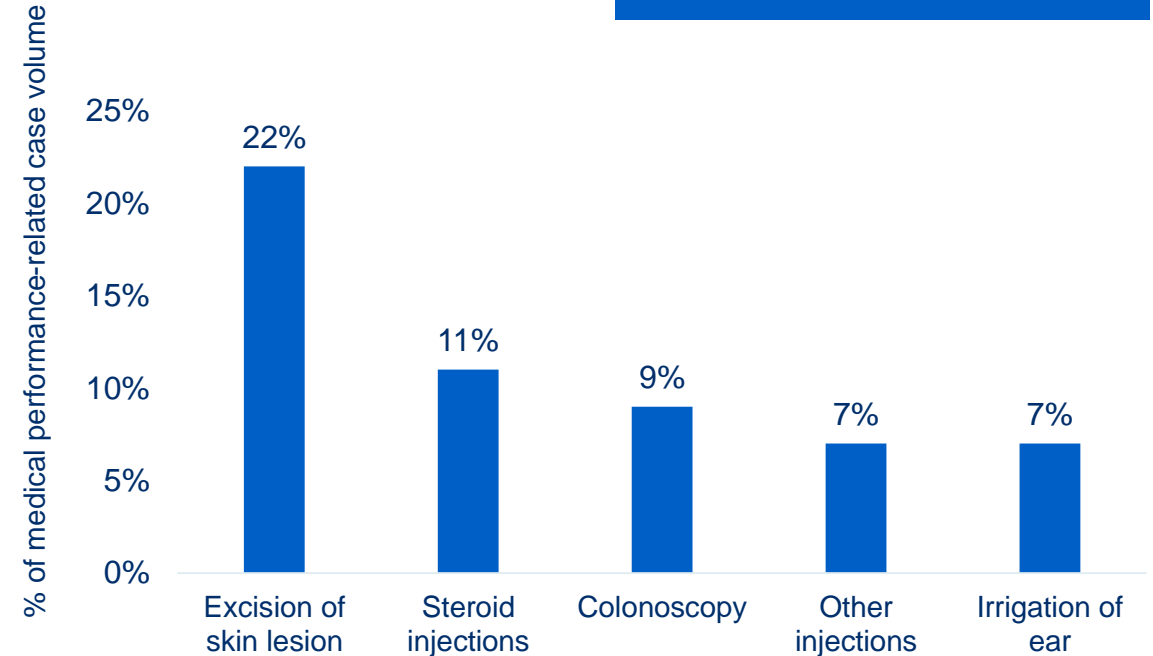
Procedural performance cases can be impacted by delayed recognition of complications, while management cases most often reflect issues with selection of the most appropriate course of treatment for the patient, and appreciating and reconciling symptoms and test results.

Focus on Medication-Related Allegations-Family Medicine

Top allegation details

% of medication-related case volume

- Improper monitoring and management of medication regimen: 78%
- Ordering errors: 13%

Top medications involved

% of medication-related case volume

- Narcotics: 28%
- Antidepressants/Sedatives: 20%
- Anticoagulants: 15%
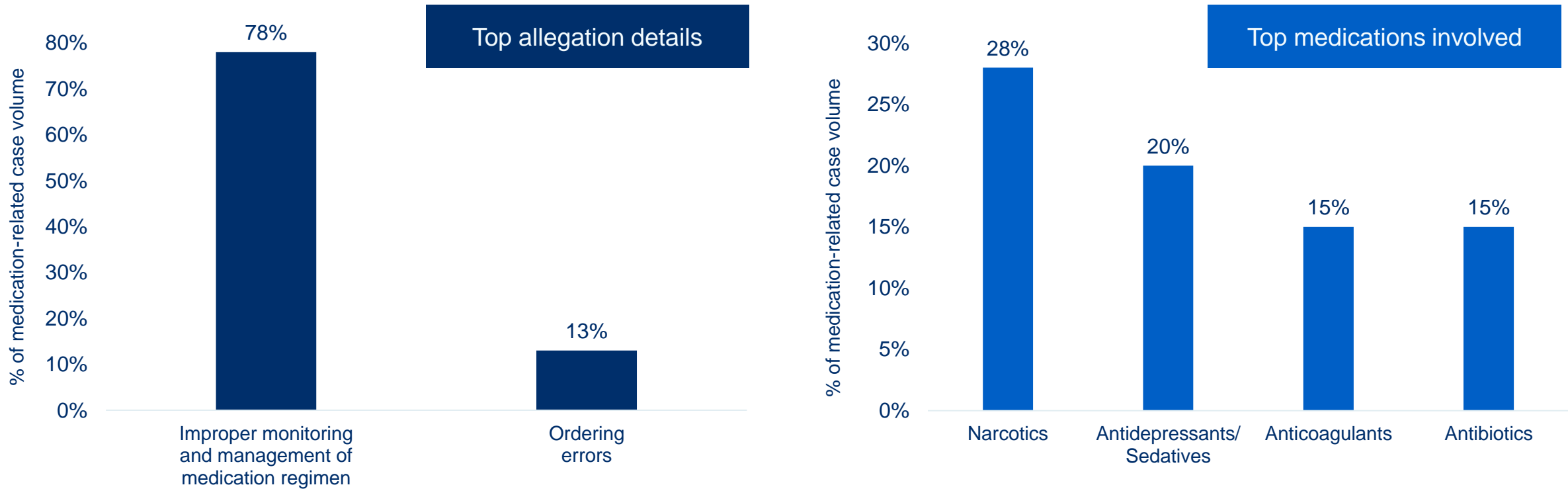- Antibiotics: 15%

Selection of the most appropriate medication for the patient's condition is a noted risk issue in narcotic cases, along with patient non-adherence to prescriptions. Issues with inadequate patient/family education about medication regimens is an often-noted factor across all medication types. Anticoagulant cases reflect a few instances of failures to restart/reorder and failures to identify which provider is coordinating anticoagulant regimens following a period of holding the medication (i.e. for surgery).

MedPro Group + MLMIC cases opened 2012-2021, Family Medicine as responsible service (N=1194)

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Contributing Factors

"Contributing factors reflect both provider and patient issues. They denote breakdowns in technical skill, clinical judgment, communication, behavior, systems, environment, equipment/tools, and teamwork. The majority are relevant across clinical specialties, settings, and disciplines; thus, they identify opportunities for broad remediation."

Contributing Factors

Despite best intentions, processes designed for safe patient outcomes can, and do, fail.

Contributing factors are multi-layered issues or failures in the process of care that appear to have contributed to the patient's outcome, and/or to the initiation of the case, or had a significant impact on case resolution.

Multiple factors are identified in each case because generally, there is not just one issue that leads to these cases, but rather a combination of issues.

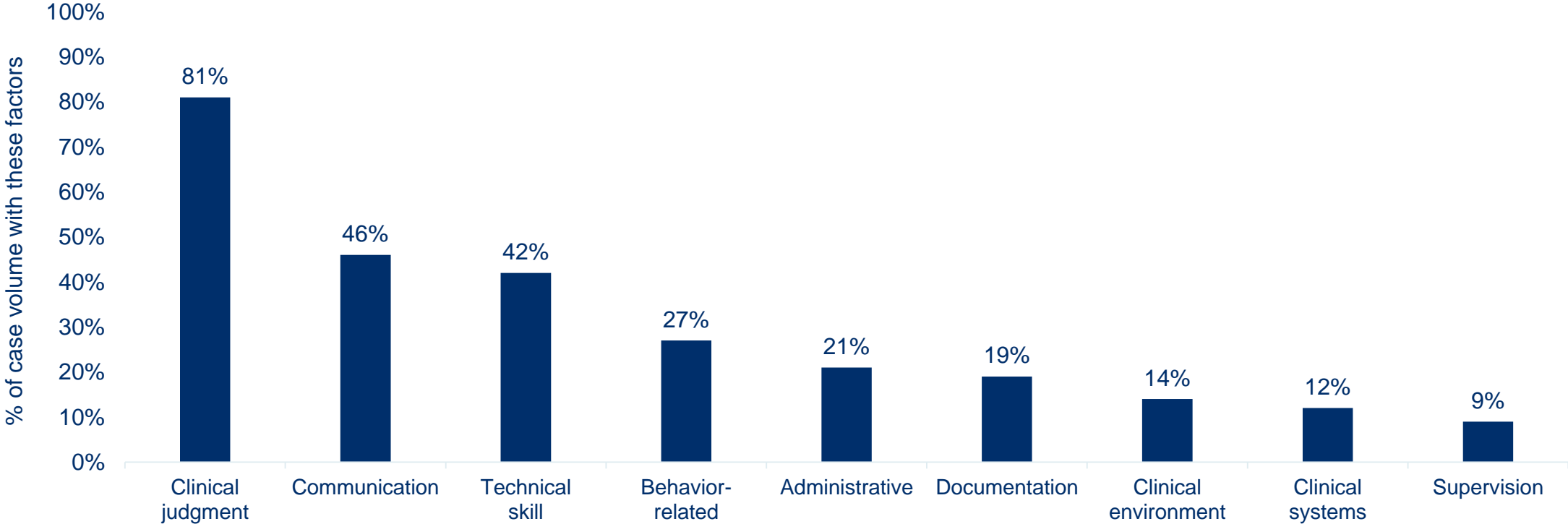| Administrative | Behavior-related | Clinical environment | Clinical judgment | Clinical systems | Communication | Documentation | Supervision | Technical skill |

Most Common Contributing Factor Categories

Bar chart — % of case volume with these factors:

- Clinical judgment: 81%
- Communication: 46%
- Technical skill: 42%
- Behavior-related: 27%
- Administrative: 21%
- Documentation: 19%
- Clinical environment: 14%
- Clinical systems: 12%
- Supervision: 9%

Not unexpectedly, more than **three-fourths of all cases note clinical judgment factors.** These cases are reflective of provider clinical decision-making (patient assessments, obtaining consults, etc.). Also of note, an increasing (but still few) number of cases are **beginning to reflect Covid-related influences***, most often treatment and/or access to care which was impacted/delayed by pandemic conditions.

MedPro Group + MLMIC cases opened 2012-2021 (N=22,625); More than one factor per case, therefore totals >100%; *Environmental contributing factor (overall just 1% of cases reflect an Environmental factor, which also includes building and weather-related safety/security issues)

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Most Common Contributing Factor Categories-Oklahoma

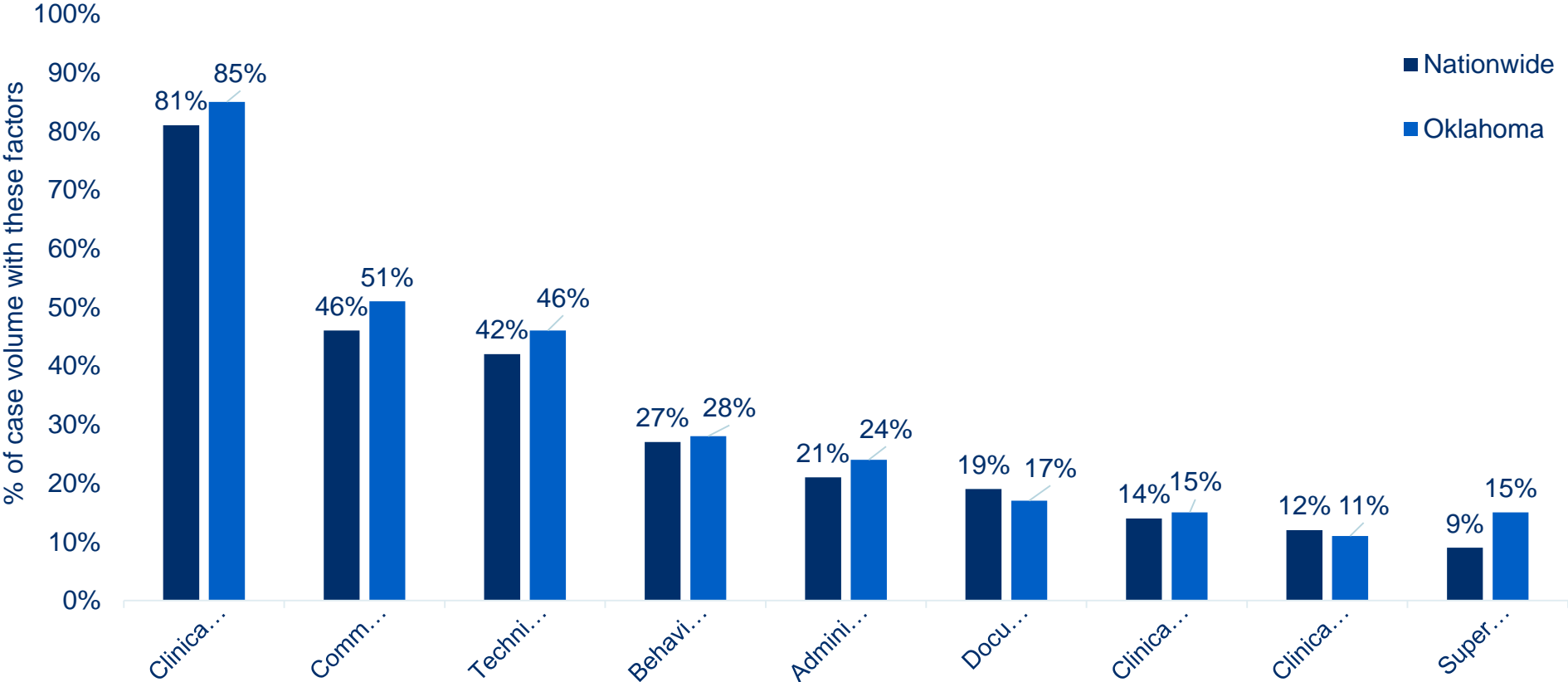- The distribution of contributing factors across both two data sets are similar. Not unexpectedly, more than three-fourths of all cases note clinical judgment factors. These cases are reflective of provider clinical decision-making (patient assessments, obtaining consults, etc.). Also of note, an increasing (but still few) number of cases are beginning to reflect Covid-related influences*, most often treatment and/or access to care which was impacted/delayed by pandemic conditions.

Legend: Nationwide (dark blue), Oklahoma (light blue)

% of case volume with these factors

Category	Nationwide	Oklahoma
Clinica...	81%	85%
Comm...	46%	51%
Techni...	42%	46%
Behavi...	27%	28%
Admini...	21%	24%
Docu...	19%	17%
Clinica...	14%	15%
Clinica...	12%	11%
Super...	9%	15%

Contributing Factors as Primary Drivers: Focus on Clinical Judgment

Contributing factors are **multi-layered issues or failures in the process of care** that appear to have contributed to the patient's outcome, initiation of the case, or had a significant impact on case resolution. Factors can now be identified as the **primary driver (most impactful influence)** and are **linked to responsible services** in each case.* This visual reflects **those cases in which a CLINICAL JUDGMENT factor is the primary driver.**

Most common clinical judgment as primary factor details	% of clinical judgment cases with these details	Top three most common responsible services linked to each factor detail (1st, 2nd, 3rd)		
Failure to appreciate/reconcile relevant sign/symptom/test result	**32%**	Emergency medicine	Orthopedic surgery & Nursing	Obstetrics
Selection/management most appropriate surgical/invasive procedure	**25%**	Orthopedic surgery	General surgery	Gynecology
Failure/delay in ordering diagnostic test	**16%**	Emergency medicine	Primary care	Orthopedic surgery
Failure to establish differential diagnosis	**13%**	Emergency medicine	Primary care	Orthopedic surgery
Misinterpretation of diagnostic studies	**12%**	Radiology	Pathology	Obstetrics, Emergency medicine & Orthopedic surgery

MedPro Group + MLMIC cases opened 2012-2021 (N=22,625); More than one factor per case, therefore totals >100%; *Identification of primary drivers and linking to services available for all cases coded after July 2021 (N=5746)

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Contributing Factors as Primary Drivers: Focus on Communication

Contributing factors are **multi-layered issues or failures in the process of care** that appear to have contributed to the patient's outcome, initiation of the case, or had a significant impact on case resolution. Factors can now be identified as the **primary driver (most impactful influence)** and are **linked to responsible services** in each case.* This visual reflects **those cases in which a COMMUNICATION factor is the primary driver.**

Most common communication as primary factor details	% of communication cases with these details	Top three most common responsible services linked to each factor detail (1st, 2nd, 3rd)		
Suboptimal communication among providers – about patient condition	**30%**	Nursing	Anesthesiology	Radiology
Suboptimal communication with patients/families – about expectations	**13%**	Orthopedic surgery	Ophthalmology	Plastic surgery & Anesthesiology
Failure to read medical record	**10%**	Primary care	Emergency medicine	General surgery
Inadequate informed consent process for surgical/invasive procedures	**8%**	Orthopedic surgery	Gynecology	Ophthalmology
Suboptimal communication among providers – failure to escalate concerns	**5%**	Nursing	Anesthesiology	Emergency, Primary care & obstetrics
Inadequate patient education – about follow-up instructions	**5%**	Primary care	Emergency medicine & Gynecology	Dermatology

Health care communication is defined as

the successful exchange of information needed to diagnose and treat patients.

The Cost of Technology

© 2011 Thomas G. Murphy, MD.

- Toll, E. (2012, June 20). The cost of technology. JAMA, 307(23), 2497-2498.

Contributing Factors as Primary Drivers: Focus on Behavior-Related

Contributing factors are **multi-layered issues or failures in the process of care** that appear to have contributed to the patient's outcome, initiation of the case, or had a significant impact on case resolution. Factors can now be identified as the **primary driver (most impactful influence)** and are **linked to responsible services** in each case.* This visual reflects **those cases in which a BEHAVIOR-RELATED factor is the primary driver.**

Most common behavior-related as primary factor details	% of behavior-related cases with these details	Notes
Patient non-adherence to treatment regimen	20%	These patient-related behavior factors reflect issues which, for the most part, are beyond the control of a healthcare provider. However, consider that those involving patient non-adherence to treatment might be a result of suboptimal communication with and education of patients/families as to the importance of continuing care.
Patient dissatisfaction – seeking other providers	13%	
Patient non-adherence to scheduled follow-up call/appointment	12%	

MedPro Group + MLMIC cases opened 2012-2021 (N=22,625); More than one factor per case, therefore totals >100%; *Identification of primary drivers and linking to services available for all cases coded after July 2021 (N=5746)

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Contributing Factors as Primary Drivers: Focus on **Administrative**

Contributing factors are **multi-layered issues or failures in the process of care** that appear to have contributed to the patient's outcome, initiation of the case, or had a significant impact on case resolution. Factors can now be identified as the **primary driver (most impactful influence)** and are **linked to responsible services** in each case.* This visual reflects **those cases in which an ADMINISTRATIVE factor is the primary driver.**

Most common administrative as primary factor details	% of administrative cases with these details	Top three most common responsible services linked to each factor detail (1st, 2nd, 3rd)		
Policy/protocol not followed	**47%**	Nursing	Emergency medicine, Radiology & Anesthesiology	Obstetrics
Staff training/education	**14%**	Nursing	Radiology	Primary care
Need for policy/protocol	**13%**	Leadership/ Administration	Nursing	Radiology
Credentialing issues	**5%**	Leadership/ Administration	Emergency medicine	Primary care

Contributing Factors as Primary Drivers: Focus on Other Common Factors

Contributing factors are **multi-layered issues or failures in the process of care** that appear to have contributed to the patient's outcome, initiation of the case, or had a significant impact on case resolution. Factors can now be identified as the **primary driver (most impactful influence)** and are **linked to responsible services** in each case.* This visual reflects **those cases in which other factors are primary drivers.**

Other factors	Most common other primary factor details	% of each "other factor" cases with these details	Top three most common responsible services linked to each factor detail (1st, 2nd, 3rd)		
Documentation	Insufficient/lack of documentation – about clinical findings	**70%**	Nursing	Gynecology	Primary care
Clinical environment	Events occurring during nights/weekends/holidays	**85%**	Note: although these factors are beyond the control of individual healthcare providers, risk mitigation efforts should focus on recognizing that ease of access to resources/consultants, etc. might be different than during weekday hours.		
Clinical systems	Lack of/failure in patient follow-up processes related to diagnostic testing	**30%**	Primary care	Gynecology	Urology surgery
	Failure/delay in reporting diagnostic findings	**29%**	Radiology	Emergency medicine	Primary care
Supervision	Inadequate supervision of advanced practice clinicians	**33%**	Anesthesiology	Emergency medicine	Orthopedic surgery

Contributing Factors: Focus on Primary Drivers of **Financial Severity**

Administrative	Policy/protocol not followed
Clinical judgment	Management of labor & delivery
	Misinterpretation of diagnostic studies
	Choice of practice setting (inpatient vs ambulatory)
	Inadequate patient assessment (history & physical)
	Narrow diagnostic focus
	Failure/delay in obtaining consult/referral
	Failure/delay in ordering diagnostic test
	Failure to appreciate/reconcile relevant sign/symptom/test result
Communication	Failure to read medical record
	Suboptimal communication among providers – about patient condition
Technical skill	Misidentification of anatomical structure
	Improperly utilized equipment
	Poor technique

More than half of all cases with any of these primary driver contributing factors closed with indemnity paid.*

MedPro Group + MLMIC cases opened 2012-2021 (N=22,625); *Identification of primary drivers available for all cases coded after July 2021 (N=5746) and only factors with >/=65 cases each are included in this visual; More than one factor per case

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Contributing Factors: Focus on Drivers of Financial Severity-Oklahoma

Factor Category & Sub-Category		Nationwide*	Oklahoma*
Clinical judgment	Failure to appreciate/reconcile relevant signs/symptoms/test results	43%	50%
Clinical judgment	Failure/delay in ordering diagnostic test	27%	26%
Communication	Suboptimal communication among providers about changes in patient condition	23%	31%
Clinical judgment	Failure/delay in obtaining consult/referral	22%	20%
Clinical judgment	Failure to establish differential diagnosis	19%	21%
Technical skill	Poor procedural technique	18%	18%

These are among the most common factors noted in cases closing with indemnity payments >/=$100K.

Case Examples

SETTLED

$1.5M

CONTRIBUTING FACTORS

Clinical judgment
Narrow diagnostic focus, including failure to appreciate/reconcile signs/symptoms/test results; failure/delay in ordering diagnostic testing; failure to obtain consult/referral; and relying on previous provider's diagnosis

FAILURE TO DIAGNOSE BLADDER CANCER RESULTING IN DEATH

A 51 year-old female with a history of frequent urinary tract infections (UTI), pyelonephritis, hypertension, hyperlipidemia and asthma presented to her long-time family medicine physician for a routine office visit. **She was found to have elevated creatinine levels, and renal insufficiency was diagnosed**. An ultrasound of her kidneys and a renal function panel were both within normal limits.

At a follow-up office visit one month later, she complained of discomfort with urination. A small amount of blood was noted in the urinalysis (UA); records are silent as to whether any treatment was provided. Three months later, she reported ongoing pain and burning with urination, along with frequent thirst. UA showed hematuria plus leukocytes and nitrates. She was treated for a UTI. A repeat UA one week later was better, but the urine cultures grew E. coli; antibiotics were continued. Seven months later she presented for an office visit. UA positive for leukocytes, and antibiotics were prescribed. Lab work revealed decreased renal function and a urine culture was again positive for E. coli. Two months later, patient was treated for "overactive bladder." Eight months after that, she complained of urinary burning/frequency for two weeks and was treated with antibiotics.

She was not seen again for one year. At that time, **she was seen by the physician assistant, who noted the patient had a two month history of hematuria, frequent urination, foul smelling urine, lower back/pelvic pain, and passing golf ball sized blood clots when urinating. Antibiotics and analgesics were prescribed**. One month later, she reported the same symptoms to a second physician assistant and was again treated for a UTI.

She requested referral to a urologist. Subsequent CT and MRI results showed a **urinary bladder mass (squamous cell carcinoma) measuring 7.0 x 4.4 x 7.8 cm**. She underwent cystoscopy and tumor resection, but mass was unable to be completely resected due to size. Patient quickly developed metastatic disease and died three months later.

Case Examples

SETTLED

$387,500

CONTRIBUTING FACTORS

Clinical judgment

Inadequate assessment related to history & physical; failure to order medication; selection of invasive procedure (despite incomplete pre-op clearance form); and failure/delay in obtaining consult/referral

Communication

Suboptimal communication among providers

Failure to establish clear lines of responsibility

Documentation

Insufficient related to clinical rationale, and incomplete pre-op form

IMPROPER MONITORING AND MANAEGMENT OF ANTICOAGULANT REGIMEN RESULTING IN STROKE

A 76 year-old male patient with a history of recently diagnosed Parkinson's disease, **chronic atrial fibrillation controlled with Coumadin**, congestive heart failure and multiple other co-morbidities (no hyper-coagulation history provided), moved and established care with a family medicine physician. The patient, who had not been under the care of a cardiologist before moving, **reported taking 81mg of aspirin daily and an unknown dose of Coumadin. The family medicine physician did not obtain the patient's previous medical records**.

One year later, the patient required eyelid surgery to treat uncontrolled ptosis. Pre-surgery, the patient was required to obtain clearance from the family medicine physician, via a pre-op form which included check boxes for yes or no responses **related to stopping Coumadin** seven days prior to surgery. **The physician left the boxes unchecked (abstained from giving opinion), but did sign off on medical clearance for surgery**.

The patient did stop Coumadin seven days prior to surgery; there were no specified directives as to when to resume Coumadin. **On the day after surgery, he developed slurred speech while at home and was diagnosed with occlusion in the left middle cerebral artery**. He was given tPA, which caused bleeding from eye incisions. He did undergo a successful thrombectomy. However, he sustained suffered permanent brain damage resulting in persistent right-sided weakness and aphasia, and is now wheelchair-bound.

Expert review was critical of the family medicine physician for not ordering a Lovenox bridge, for at least a few days pre-operatively. The physician contended that the patient didn't disclose a comprehensive history related to hyper-coagulation and that the CHADS2 score (atrial fibrillation stroke risk) was used as part of the diagnostic clinical decision making process. From that score, the physician determined that the patient wasn't at high risk for perioperative stroke related to his underlying atrial fibrillation. **However the physician did not document the CHADS2 score, and didn't believe that a cardiology referral was warranted**. He deferred Coumadin management to the ophthalmologist.

Risk Mitigation Strategies

- **Conduct an appropriate and thorough assessment of the patient.**

  - Understand patient complaints and concerns.

  - Update and review medical and family history at every visit to ensure the best decision-making.

  - Be alert to high-risk diagnoses, such as cancer, cardiac disease, stroke and infections.

  - Maintain problem lists.

- **Communicate with each other.**

  - Focus on care coordination if other specialties are involved, including next steps and determining who is responsible for the patient.

  - Give thorough and clear patient instructions.

- **Engage patients as active participants in their care.**

  - Consider the patient's health literacy and other comprehension barriers.

  - Recognize that patient satisfaction with treatment outcomes can be influenced by a thorough informed consent and education process.

- **Document.**

  - Timely document thorough, objective information about the results of patient assessments, education of the patient/family about treatment plans - including medication regimens, and any instances of patient nonadherence.

  - Thorough, consistent documentation in the chart enhances communication between providers and provides a supportive framework for defense of any subsequent malpractice case.

- **Review office processes for test tracking, consults/referrals, appointment setting, and managing patient nonadherence.**

- **Know (and adhere to) your supervision responsibility for advanced practice providers.**

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MedPro Group & MLMIC Data

MedPro and MLMIC are partnered with Candello, a national medical malpractice data collaborative and division of CRICO, the medical malpractice insurer for the Harvard-affiliated medical institutions.

Derived from the essence of the word candela, a unit of luminous intensity that emits a clear direction, Candello's best-in-class taxonomy, data, and tools provide unique insights into the clinical and financial risks that lead to harm and loss.

Using Candello's sophisticated coding taxonomy to code claims data, MedPro and MLMIC are better able to highlight the critical intersection between quality and patient safety and provide insights into minimizing losses and improving outcomes.

Leveraging our extensive claims data, we help our insureds stay aware of risk trends by specialty and across a variety of practice settings. Data analyses examine allegations and contributing factors, including human factors and healthcare system flaws that result in patient harm. Insight gained from claims data analyses also allows us to develop targeted programs and tools to help our insureds minimize risk.

Addendum

Key Points - Clinically Coded Data

- **Distribution of the five most common allegation categories across rolling three-year timeframes is relatively consistent**.

  - Surgical allegations are most common, followed closely by those which are diagnosis-related. Medical, patient environment and medication-related allegations round out the top five allegation categories.

  - Medical treatment and patient environment cases do appear to be increasing as a percentage of the overall case volume. Medical treatment is inclusive of broad-scope non-surgical, non-medication and non-OB-related cases. Patient environment primarily reflects patient falls and other safety-related events.

- **Although diagnosis-related cases account for one-third of total dollars paid, OB and anesthesia-related cases are, on average, the most costly to defend**. Diagnosis-related allegations encompass wrong diagnoses, failures/delays, and misdiagnoses. There are key opportunities to reduce errors along the diagnostic process of care, especially during the initial patient assessment phase.

- Although the percentage of high clinical severity cases opened each year is slightly declining, the **average cost to resolve these is rapidly increasing**.

- **The primary responsible service in each case is the specialty that is deemed to be most responsible for the resulting patient outcome.** In keeping with the volume of surgical cases, surgical specialties are most commonly noted, but followed closely by a variety of medical specialties and nursing staff.

- **"Roles" are also identified; they reflect the specific position within the specialty service team that was involved at the time of the event**. As would be expected, attending/consulting roles are by far the most commonly noted.

- **Contributing factors are multi-layered issues or failures in the process of care** that appear to have contributed to the patient's outcome, and/or to the initiation of the case, or had a significant impact on case resolution. The **distribution of the five most common factors across rolling three-year timeframes is relatively consistent**.

  - Clinical judgment factors are, not surprisingly, most often identified, followed by communication, technical skill, behavior-related issues and administrative factors.

Contributing Factor Category Definitions

Administrative	Factors related to medical records (other than documentation), reporting, staffing, ethics, policy/protocols, regulatory
Behavior-related	Factors related to patient non-adherence to treatment or behavior that offsets care; also provider behavior including breach of confidentiality or sexual misconduct
Clinical environment	Factors related to workflow, physical conditions and "off-hours" conditions (weekends/holidays/nights)
Clinical judgment	Factors related to patient assessment, selection and management of therapy, patient monitoring, failure/delay in obtaining a consult, failure to ensure patient safety (falls, burns, etc), choice of practice setting, failure to question/follow an order, practice beyond scope
Clinical systems	Factors related to coordination of care, failure/delay in ordering test, reporting findings, follow-up systems, patient identification, specimen handling, nosocomial infections
Communication	Factors related to communication among providers, between patient/family and providers, via electronic communication (texting, email, etc), and telehealth/tele-radiology
Documentation	Factors related to mechanics, insufficiency, content
Supervision	Factors related to supervision of nursing, house staff, advanced practice clinicians
Technical skill	Factors related to improper use of equipment, medication errors, retained foreign bodies, technical performance of procedures