

Pediatrics

Claims Data Snapshot

2023



This publication begins with insight into frequency and financial severity profiles by specialty. Then follows an analysis of aggregated data from clinically coded cases opened between 2012-2021 in which Pediatrics is identified as the primary responsible service.

Keep in mind...

A clinically coded malpractice case can have more than one responsible service, but the “primary responsible service” is the specialty that is deemed to be most responsible for the resulting patient outcome.

Our data system, and analysis, rolls all claims/suits related to an individual patient event into one case for coding purposes. Therefore, a case may be made up of one or more individual claims/suits and multiple defendant types such as hospital, physician, and other healthcare professionals.

Cases that involve attorney representations at depositions, State Board actions, and general liability cases are not included.

This analysis is designed to provide insured doctors, healthcare professionals, hospitals, health systems, and associated risk management staff with detailed case data to assist them in purposefully focusing their risk management and patient safety efforts.

Specialty Benchmarking

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

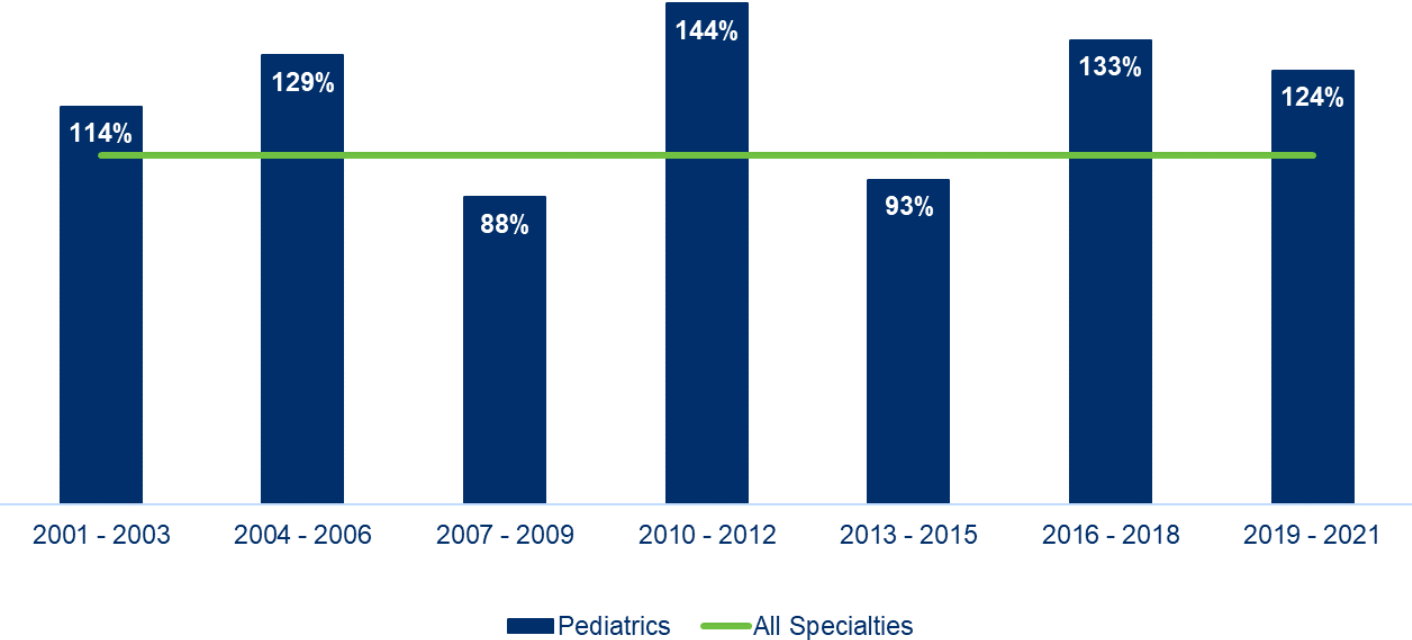
Financial Severity Tier	High	Hematology/Oncology, Pathology, Pediatrics	Anesthesiology, Neurology	Emergency Medicine, Neurosurgery, OB/GYN
	Medium	Family Medicine, Nephrology, Physiatry, Urgent Care	Cardiology, ENT, Gastroenterology, Internal Medicine	Cardiovascular Surgery, General Surgery, Orthopedic 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

Specialty Trends – Pediatrics

Pediatrics has higher financial severity per case and lower claim frequency compared to all specialties.

Average Severity - Pediatrics Relative to All Specialties



Frequency Tier
High
Medium
Low

Source: MedPro Group Physician & Surgeon Claim Experience & Analysis

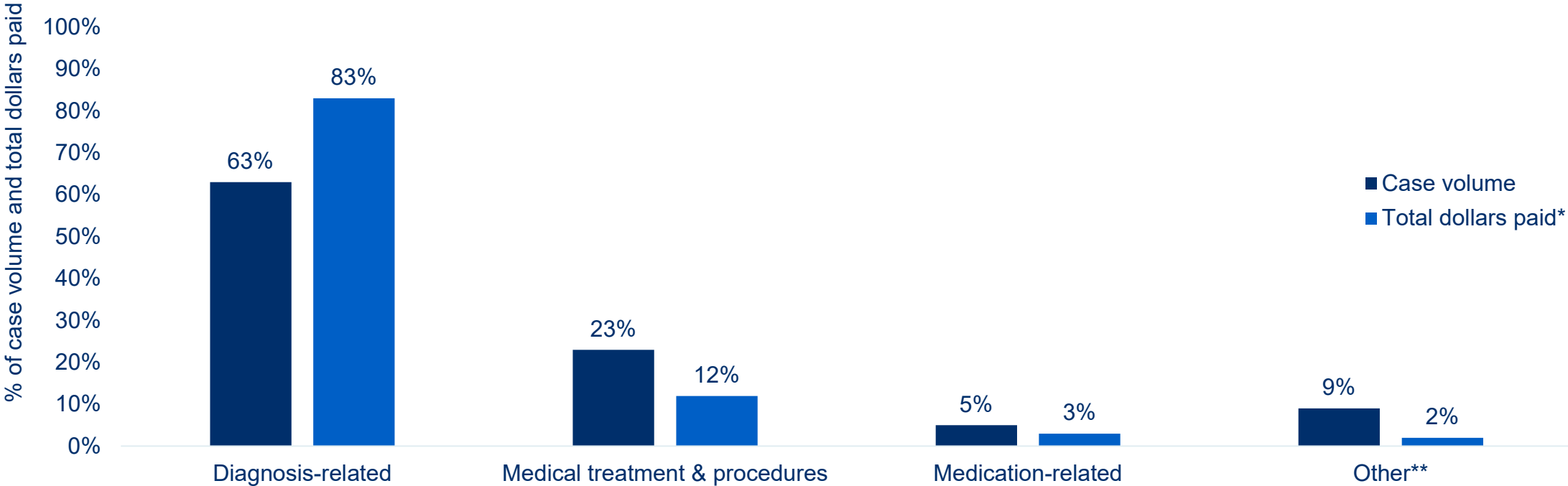
Key Points - Clinically Coded Data

INTRODUCTION | **KEY POINTS** | GENERAL DATA ANALYSIS | CONTRIBUTING FACTORS | FOCUSED DATA ANALYSIS | CASE EXAMPLES | RISK MITIGATION

- **Diagnosis-related and medical treatment allegations** account for the majority (86%) of pediatric case volume and dollars paid*.
- **Diagnosis-related cases encompass wrong, missed and delayed diagnoses.** Most commonly noted are congenital anomalies, gastrointestinal disorders, perinatal conditions and central nervous system infections.
- **Medical treatment allegations reflect an even distribution between procedural performance and medical management.** Procedural performance cases, which most commonly involve circumcisions, can be impacted by delayed recognition of complications, while management cases most often reflect issues with selection of the most appropriate procedure or course of treatment for the patient, and appreciating and reconciling symptoms and test results.
- **Medication-related cases, the third most common case type for pediatrics,** are centered around management of medication regimens, and most often involve central nervous system medications and antibiotics.
- **Contributing factors, which 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, provide valuable insight into risk mitigation opportunities.** Clinical judgment factors, specifically inadequate patient assessment processes, are key drivers of both clinical and financial pediatric case severity. Included are issues with appreciating/reconciling signs/symptoms/test results, delays in ordering diagnostic tests, delays in obtaining referrals, and failures to establish differential diagnoses.

Major Allegations & 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.



MedPro Group + MLMIC cases opened 2012-2021, Pediatrics as responsible service (N=198); *Total dollars paid = expense + indemnity; **Other includes allegations for which no significant case volume exists

Clinical Severity*

Clinical Severity Categories	Sub-categories	% of case volume	<p>Typically, the higher the clinical severity, the higher the indemnity payments are, and the more frequently payment occurs.</p>
LOW	Emotional Injury Only	8%	
	Temporary Insignificant Injury		
MEDIUM	Temporary Minor Injury	35%	
	Temporary Major Injury		
	Permanent Minor Injury		
HIGH	Significant Permanent Injury	57%	
	Major Permanent Injury		
	Grave Injury		
	Death		

MedPro Group + MLMIC cases opened 2012-2021, Pediatrics as responsible service (N=198); *Severity codes reflect National Association of Insurance Commissioners (NAIC) injury severity scale

Claimant Type & Location



Ambulatory
70%



Inpatient
25%



Emergency
5%

Top Locations	% of case volume
Office/clinic	65%
Patient room/ICU	18%
Nursery	7%
Emergency department	5%

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.”

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.

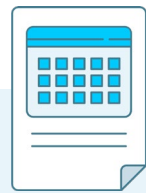
Multiple factors are identified in each case because generally, there is not just one issue that leads to these cases, but rather a combination of issues.



Administrative



Behavior-related



Clinical environment



Clinical judgment



Clinical systems



Communication



Documentation



Supervision



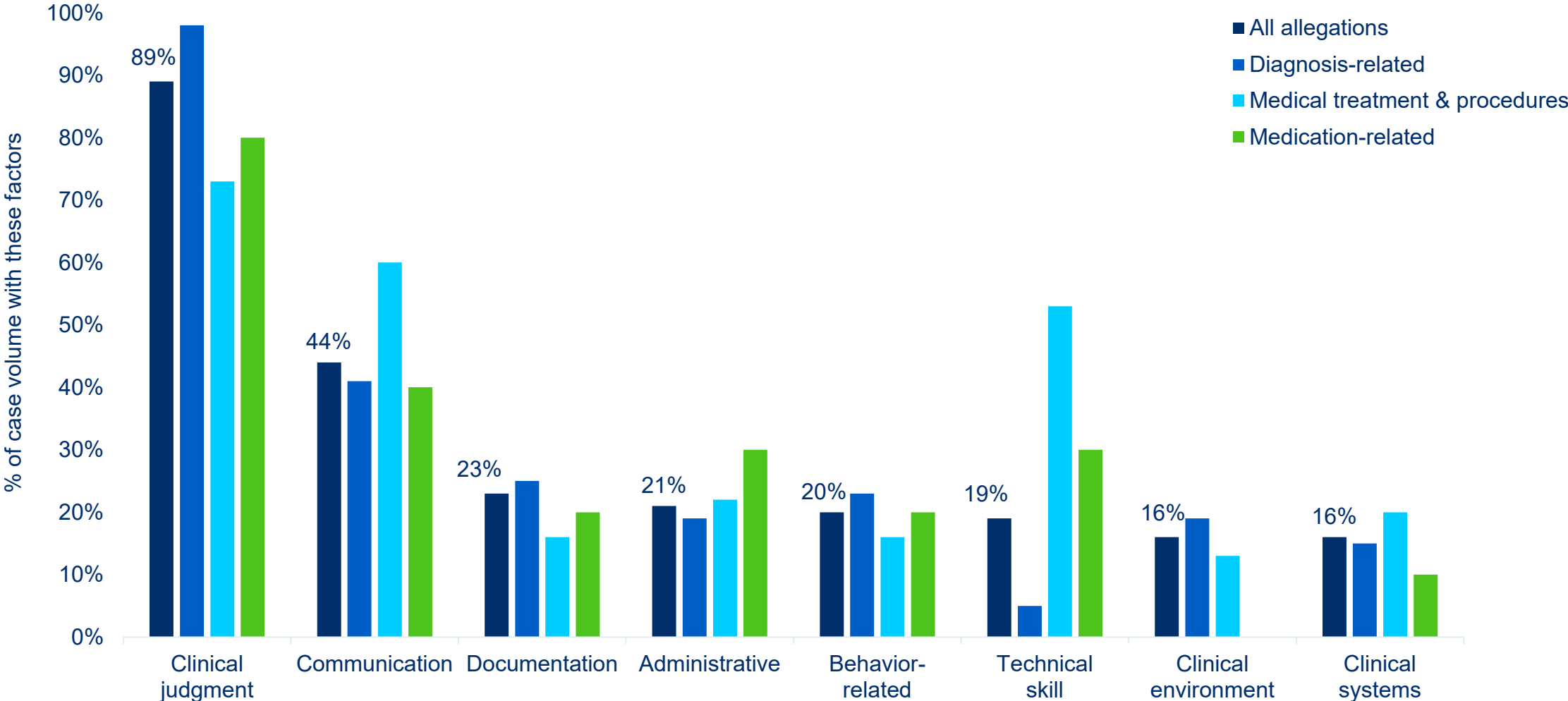
Technical skill

Contributing Factor Category Definitions

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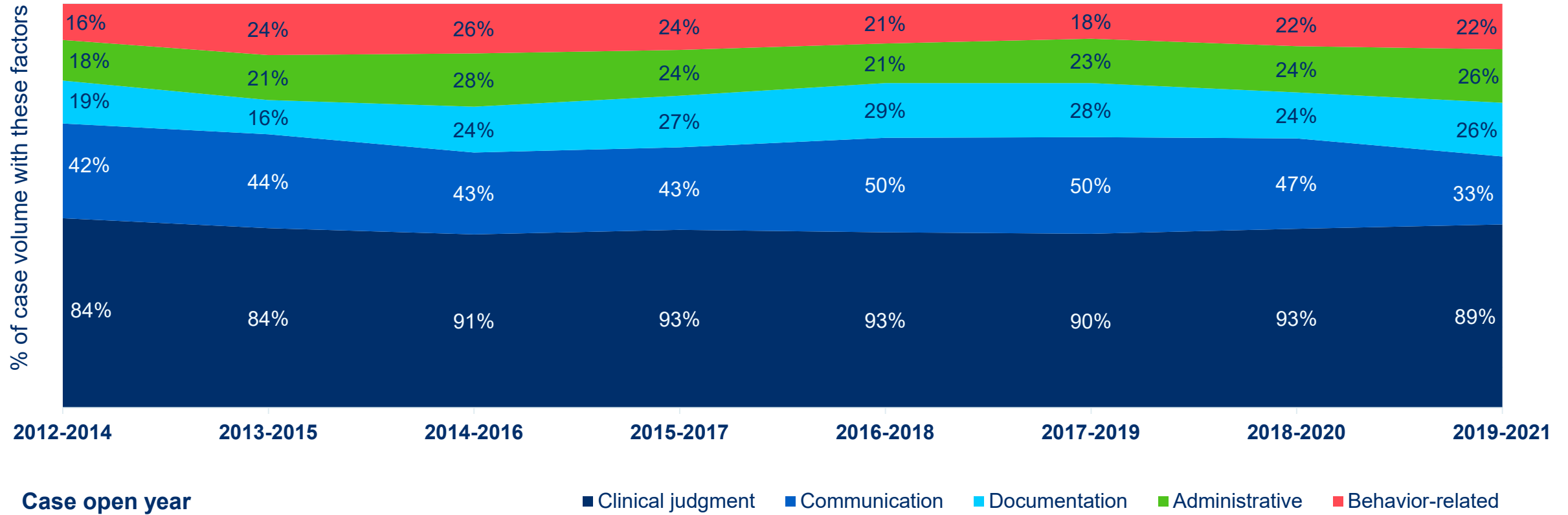
Administrative	Factors related to medical records (other than documentation), reporting, staff, ethics, policy/protocols, regulatory
Behavior-related	Factors related to patient nonadherence to treatment or behavior that offsets care; also provider behavior including breach of confidentiality or sexual 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

Most Common Contributing Factor Categories by Allegation



MedPro Group + MLMIC cases opened 2012-2021, Pediatrics as responsible service (N=198); More than one factor per case, therefore totals >100%

Distribution of Top Five Factor Categories Over Time



While the distribution of these top (most common) factors across rolling three-year timeframes is relatively consistent, take note of even slight increases over time as indicators of emerging risk issues.

Focus on Most Common Drivers of Clinical and Financial Severity

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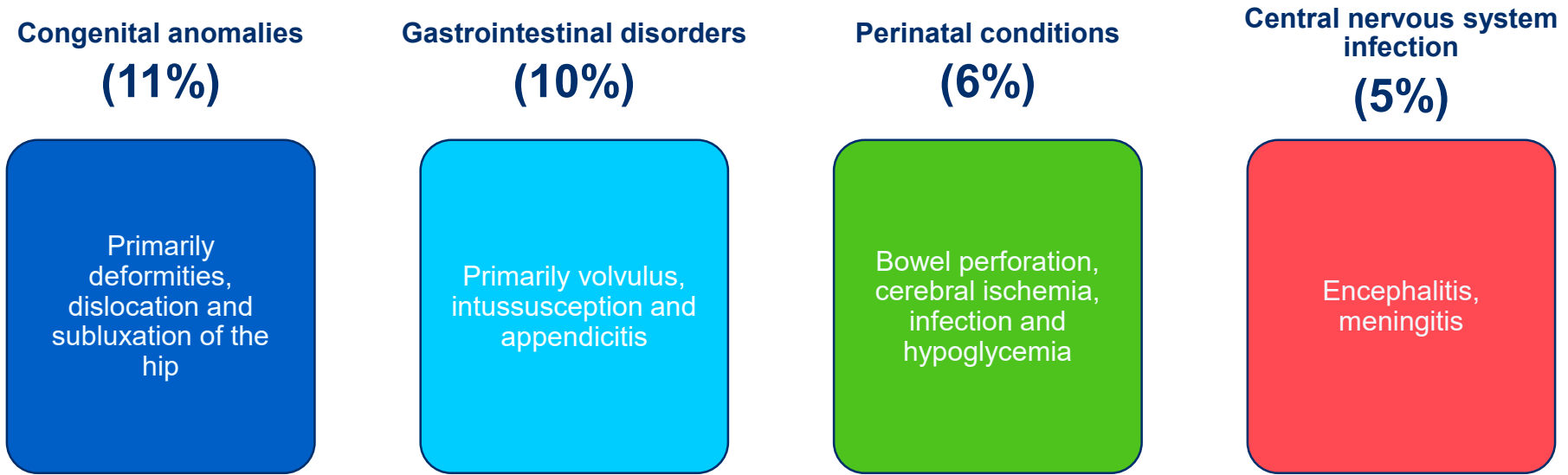
Factors associated with high clinical severity outcomes	(CJ) failure to appreciate/reconcile signs/symptoms/test results (55%)	% of high severity case volume
	(CJ) failure/delay in ordering diagnostic test (40%)	
	(CJ) failure/delay in obtaining consult/referral (38%)	
	(CJ) failure to establish differential diagnosis (31%)	
	(CJ) patient monitoring of physiological status (21%)	
Factors associated with the costliest indemnity payments	(CJ) patient monitoring of physiological status (74%)	% more expensive than the average indemnity payment*
	(CE) weekend/holiday (70%)	
	(CJ) failure/delay in ordering diagnostic test (54%)	
	(CJ) failure to establish differential diagnosis (33%)	
	(CJ) failure to appreciate/reconcile signs/symptoms/test results (19%)	

Clinical judgment factors, specifically inadequate patient assessment processes, are key drivers of both clinical and financial pediatric case severity. Of note, cases involving end stage renal disease, hypoxic-ischemic encephalopathy and malnutrition are frequently associated with indemnity payments.

Focus on Diagnosis-Related Allegations

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Diagnosis-related allegations encompass wrong diagnoses, failures/delays, and misdiagnoses. See below for the top diagnoses* noted in these cases.

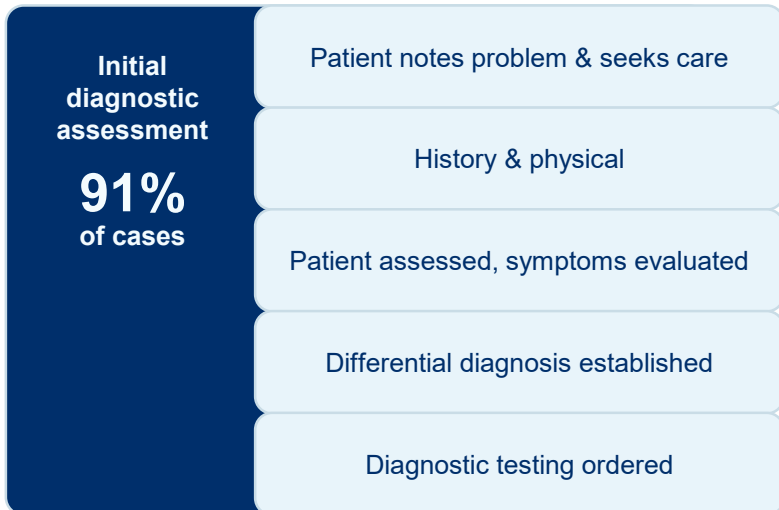


Focus on Diagnosis-Related Allegations

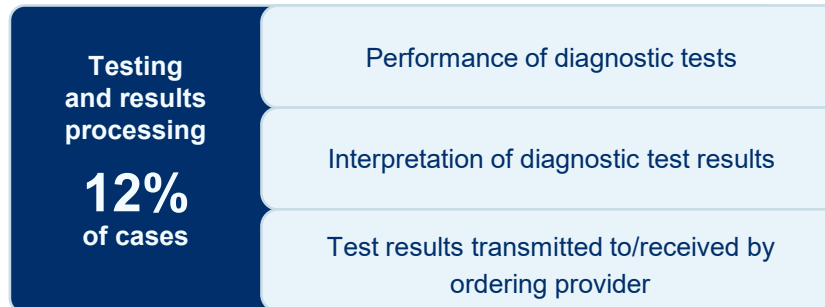
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Diagnosis-related allegations encompass wrong diagnoses, failures/delays, and misdiagnoses. Note the key opportunities to reduce diagnostic errors along the diagnostic process of care* below.

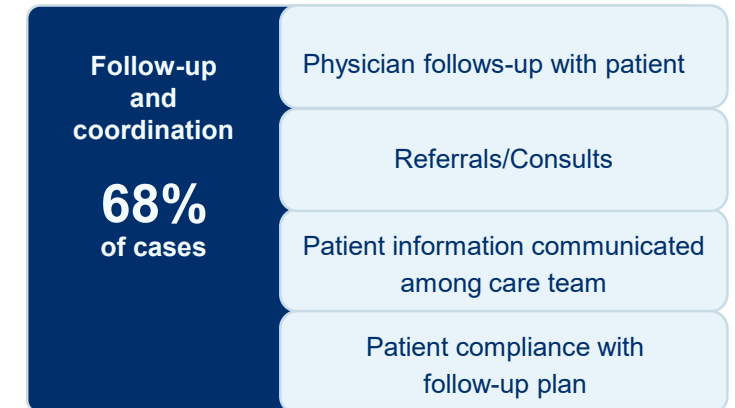
Phase 1



Phase 2

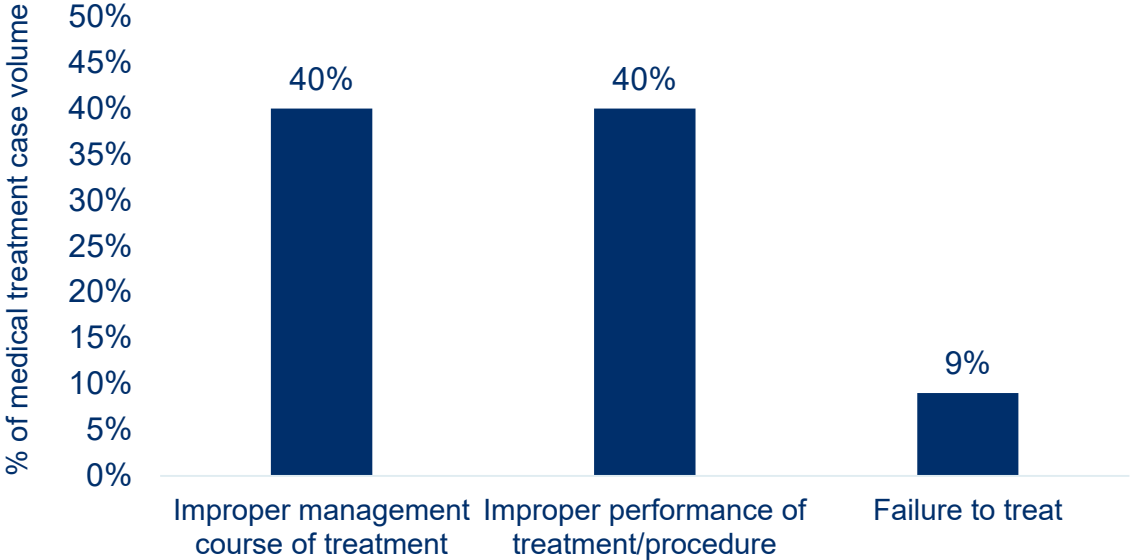


Phase 3

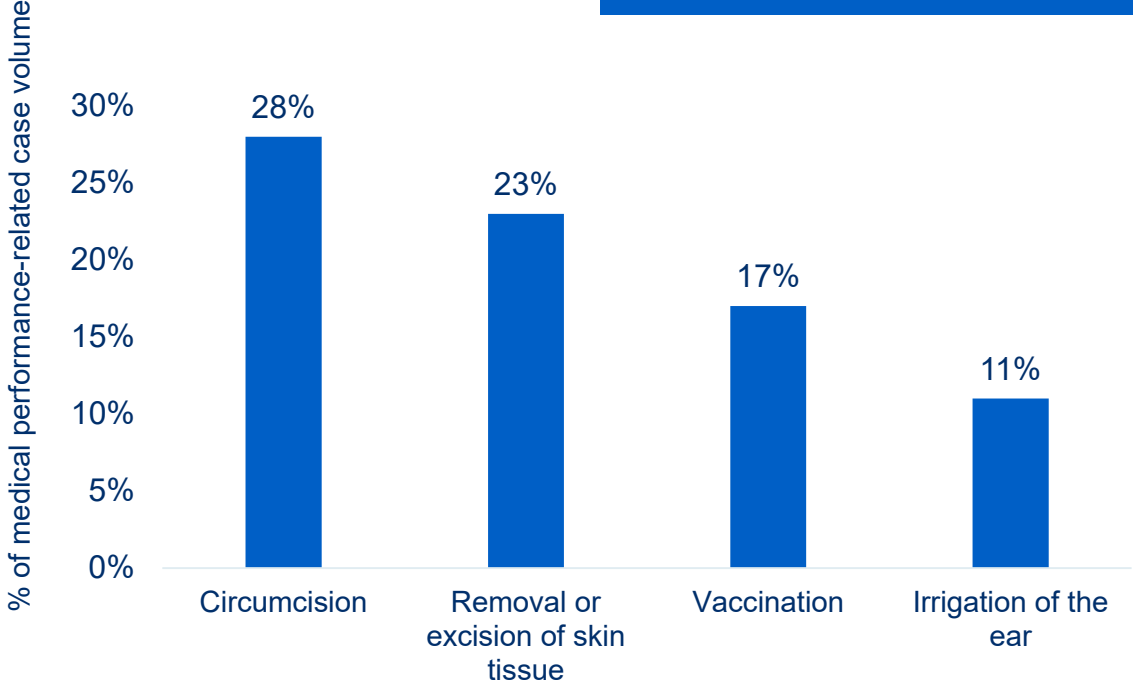


Focus on Medical Treatment Allegations

Top allegation details

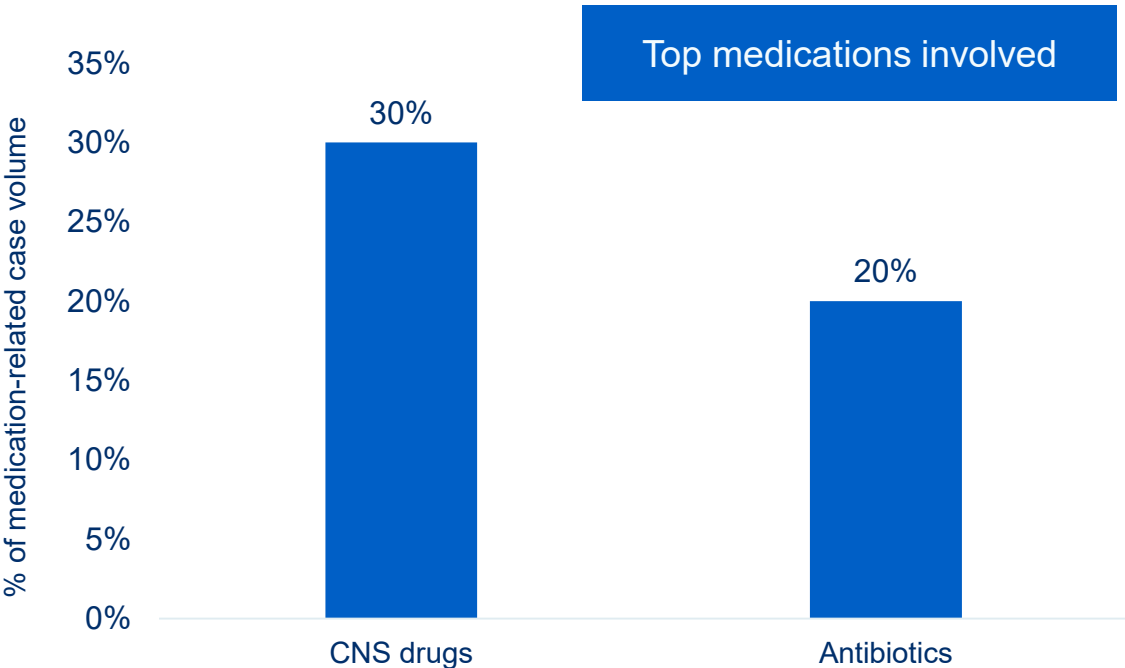
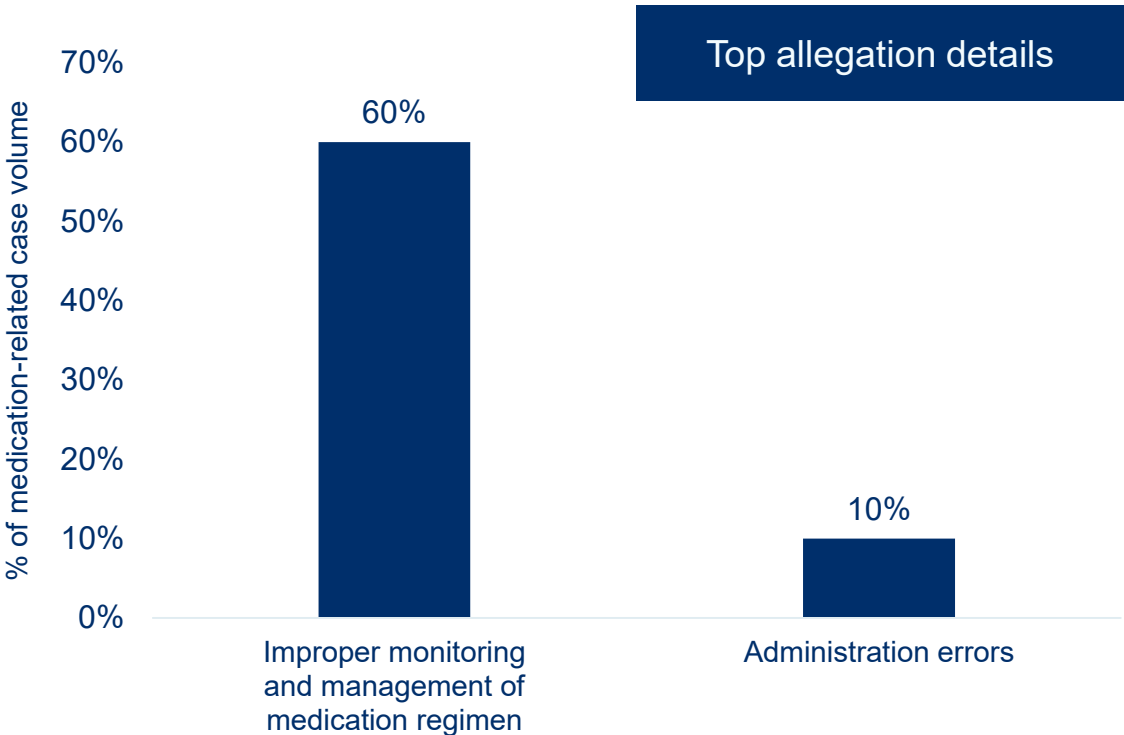


Top procedures involved



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.

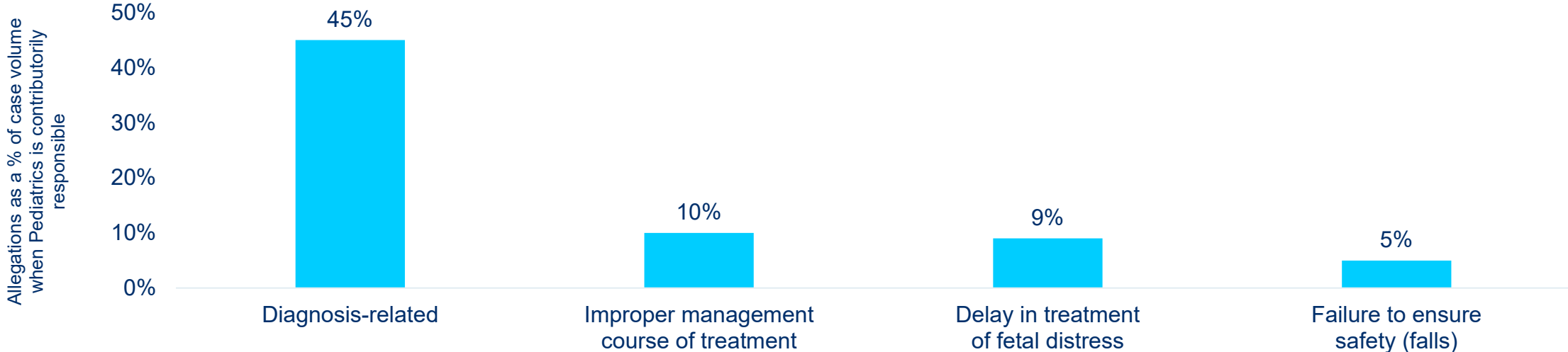
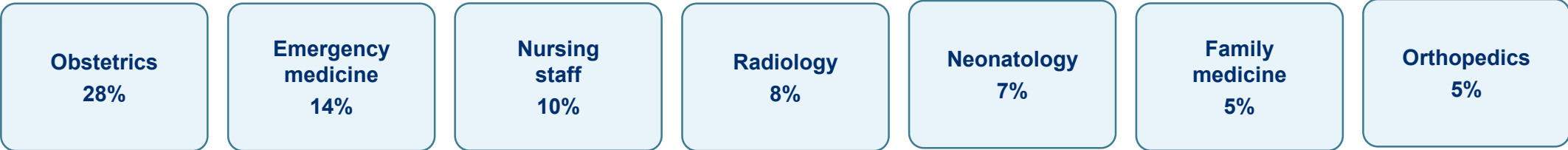
Focus on Medication-Related Allegations



Failures to select the correct medication and management of medication regimen are noted as specific risk issues in CNS drug cases. Among the other most common contributing factors in the medication cases are sub-optimal communication between patient/family regarding medication risks, medication administration errors, and failures to recognize evolving signs/symptoms.

Contributorily Responsible

Although this analysis is focused on cases reflecting Pediatrics as the primarily responsible service, another 102 cases identify Pediatrics as contributorily responsible. The primary services in these cases are varied, reflecting the myriad of providers who care for patients along the healthcare continuum. The most common primary services, and a comparison of top allegation categories, are shown below.





The following stories are reflective of the allegations and contributing risk factors which drive cases brought against Pediatricians.

We're relaying these true stories as lessons to build understanding of the challenges that you face in day-to-day practice. Learning from these events, we trust that you will take the necessary steps to either reinforce or implement best practices, as outlined in the section focused on risk mitigation strategies.

Case Examples

INTRODUCTION | KEY POINTS | GENERAL DATA ANALYSIS | CONTRIBUTING FACTORS | FOCUSED DATA ANALYSIS | **CASE EXAMPLES** | RISK MITIGATION

SETTLED

\$550,000

CONTRIBUTING FACTORS

Clinical environment

Weekend/holiday

Clinical judgment

Narrow diagnostic focus –
failure to establish differential
diagnosis and failure to order
diagnostic testing

Communication

Suboptimal communication
among providers about
patient's condition

Inadequate family education –
lack of clear follow-up
instructions

FAILURE TO DIAGNOSE AND TREAT INTESTINAL OBSTRUCTION RESULTING IN SEPTIC SHOCK AND DEATH

A mother brought her 8-month-old male infant to the pediatrician with complaints of crying all night, not eating and bloody stool. Nurse practitioner (NP) found abdominal exam to be normal with blood confirmed to be in stool. The infant was diagnosed with sensitivity to milk. No other differential diagnosis was noted for sudden onset of abdominal pain and abnormal stool. Soy formula and anti-spasmodic were ordered. Imaging was not ordered.

Next day, on a Saturday, the NP called to check on patient. Mother reported that the infant was more comfortable but spitting up. Plan was to continue to monitor and to consider a different formula. Later that day, the mother called the office to report low grade fever and fussiness with fair appetite. An appointment was made for the next day (she did not speak to the NP).

That night, infant was brought to the ED in septic shock with “currant jelly” stools for 36 hrs. Pediatric surgery was consulted for suspected intussusception (intestinal obstruction) which was confirmed by ultrasound and patient was admitted to the ICU. The bowel obstruction was reduced by way of air enema. However, the patient continued to have abdominal distension and persistent tachypnea, and an exploratory laparotomy was done. Bowel was dilated but no bowel ischemia or intussusception was seen. The patient went on to have a stormy post-operative course with additional rescue bowel surgery, during which the bowel was placed outside abdominal cavity to avoid compartment syndrome.

The infant's condition did not improve. He developed hypotension, bradycardia, then asystole and arrested. Due to poor prognosis, his parents decided to withdraw care. Death was listed as complications of intussusception. No autopsy was performed.

Experts indicated earlier intervention would have prevented sepsis and death and could not support NP not ruling out intussusception.

Case Examples

INTRODUCTION | KEY POINTS | GENERAL DATA ANALYSIS | CONTRIBUTING FACTORS | FOCUSED DATA ANALYSIS | **CASE EXAMPLES** | RISK MITIGATION

SETTLED

\$500,000

CONTRIBUTING FACTORS

Administrative

Need for policy/protocol

Clinical judgment

Narrow diagnostic focus –
failure to establish a differential
diagnosis

Inadequate awareness of
medication alternatives

IMPROPER MANAGEMENT/PRESCRIPTION OF MEDICATION RESULTING IN ANAPHYLAXIS

The teenage male patient with sickle cell anemia had been treated by his pediatrician since birth until age two. During that time, he had multiple episodes of sickle cell crisis and was treated with Rocephin without complication. After 2 years of age, the patient was only seen sporadically.

At age 16, the patient presented in a sickle cell crisis to his pediatrician. He was prescribed IV Toradol every 6 hours which continued for three days. On day two, IV Rocephin was added; the patient began vomiting and became hypotensive within 45 mins. The patient's blood pressure responded to fluids. Hypotension was attributed to hyperemesis. Patient improved and was discharged five days later.

A month later, the patient was again admitted with sickle cell crisis. **IV Rocephin and Toradol were ordered. The patient developed anaphylaxis and coded.** Rocephin was stopped initially but restarted without subsequent complications after the patient's blood pressure responded to fluids. Patient was ultimately revived, **and the pediatrician assumed this had been a reaction to Toradol.**

Six months later, the patient was again hospitalized for sickle cell crisis, and was treated with Rocephin, ordered by his pediatrician. **During administration, the patient suffered another anaphylactic reaction and did not survive.**

Expert review noted this was a "clear cut" missed call with respect to which drug was causing the reaction, as it is well-known that Rocephin can cause hemolysis and anaphylaxis. Research indicates Rocephin can be associated with catastrophic immune hemolysis in pediatric patients, particularly those with underlying diseases such as sickle cell and HIV. In fact, expert suggested a change to hospital policy and procedures regarding the use of the drug in pediatric patients.

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.
 - 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.
- **Document.**
 - Describe the rationale for inclusion/exclusion of differential diagnoses.
 - 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.**
- **Engage patients/families as active participants in their care.**
 - Consider patient/family health literacy and other comprehension barriers.

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.



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