

# Medical Office & Clinic-Based Cases

Data Insight

2023



# Introduction

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

**This publication contains an analysis of aggregated data from clinically coded cases opened between 2012-2021 arising in a medical office or clinic.**

## **Keep in mind...**

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.

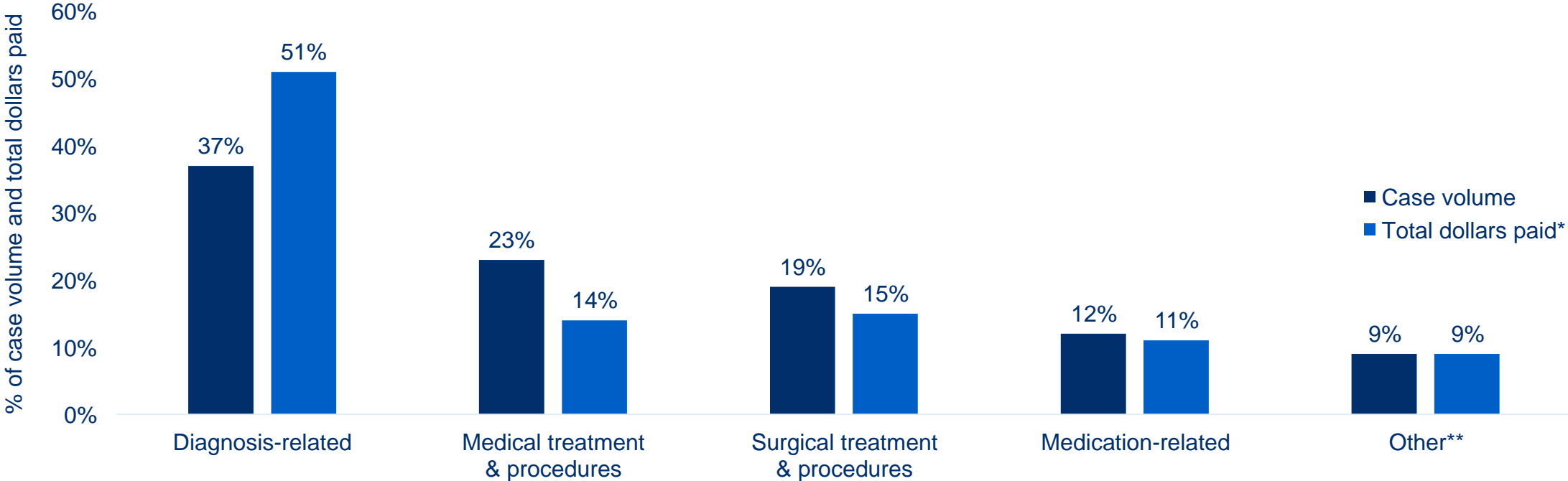
# Key Points - Clinically Coded Data

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- **As would be expected, diagnosis-related allegations account for more than one-third of medical office/clinic case volume** (and more than half of total dollars paid\*). Cancers account for 44% of the diagnoses.
  - These allegations encompass wrong diagnoses, failures/delays, and misdiagnoses. **Key opportunities to reduce diagnostic errors along the diagnostic process of care exist**, specifically during the initial diagnostic and follow-up/care coordination phases.
- **Medical, surgical and medication-related cases are also noted.**
  - **Medical cases are distributed evenly between performance and management-related.** Procedural performance cases (i.e. injections and skin excisions/biopsies) 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.
  - **Cases involving the management and follow-up of surgical patients within an office setting** are often related to the provider's recognition of and response to developing complications.
  - **Medication cases most often involve management of narcotic, anticoagulant, and antibiotic regimens;** ordering errors are also noted.
- **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.**
  - **Several factors**, including inadequate staff training and supervision, insufficient documentation, and inadequate patient assessments and diagnostic decision-making, **are key drivers of both clinical and financial medical office/clinic case severity.**

# 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.



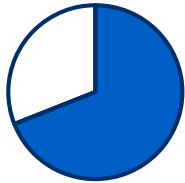
MedPro Group + MLMIC cases opened 2012-2021, medical office/clinic (N=6020); \*Total dollars paid = expense + indemnity; \*\*Other includes allegations for which no significant case volume exists

# Clinical Severity\*

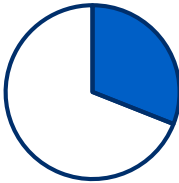
Clinical Severity Categories	Sub-categories	% of case volume
<b>LOW</b>	Emotional Injury Only	<b>9%</b>
	Temporary Insignificant Injury	
<b>MEDIUM</b>	Temporary Minor Injury	<b>43%</b>
	Temporary Major Injury	
	Permanent Minor Injury	
<b>HIGH</b>	Significant Permanent Injury	<b>48%</b>
	Major Permanent Injury	
	Grave Injury	
	Death	

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

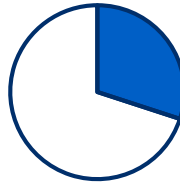
**Focus on high severity cases for the top four allegations**  
(percentage of each allegation category's high severity cases)



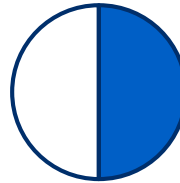
**Diagnostic cases**  
69%



**Medical cases**  
31%



**Surgical cases**  
30%

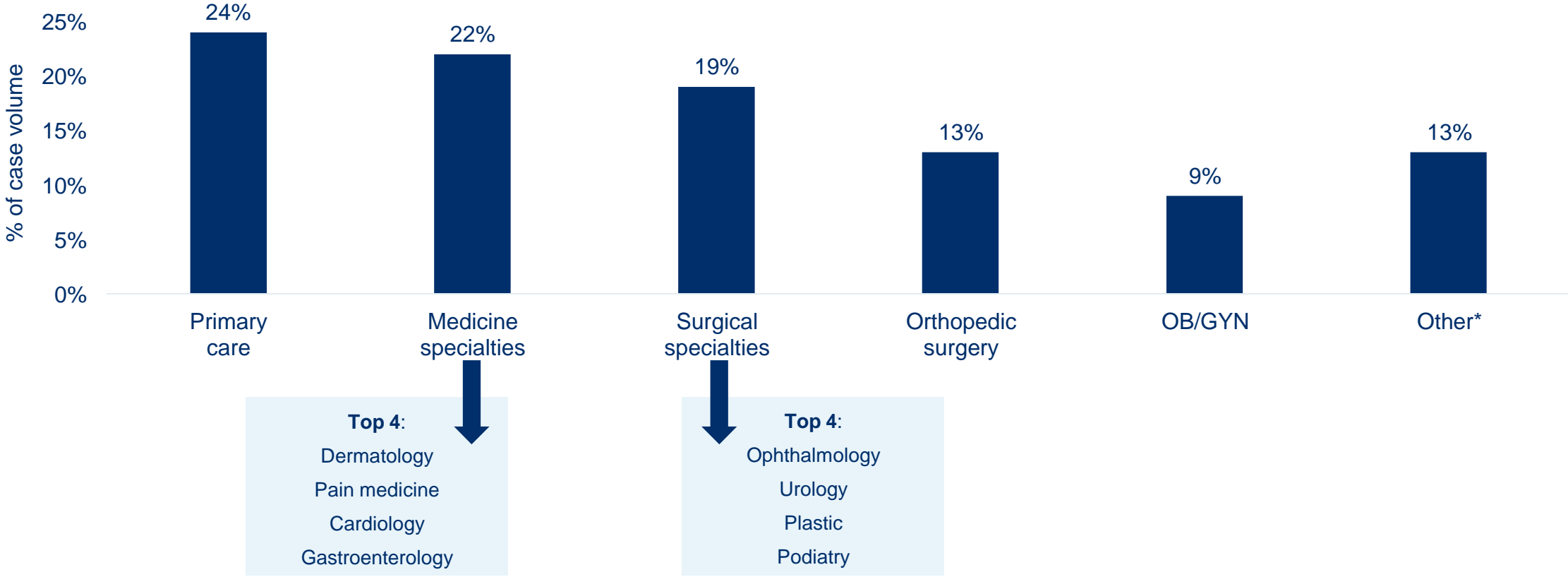


**Medication cases**  
50%

MedPro Group + MLMIC cases opened 2012-2021, medical office/clinic (N=6020); \*Severity codes reflect National Association of Insurance Commissioners (NAIC) injury severity scale

# Most Common Primary Responsible Services

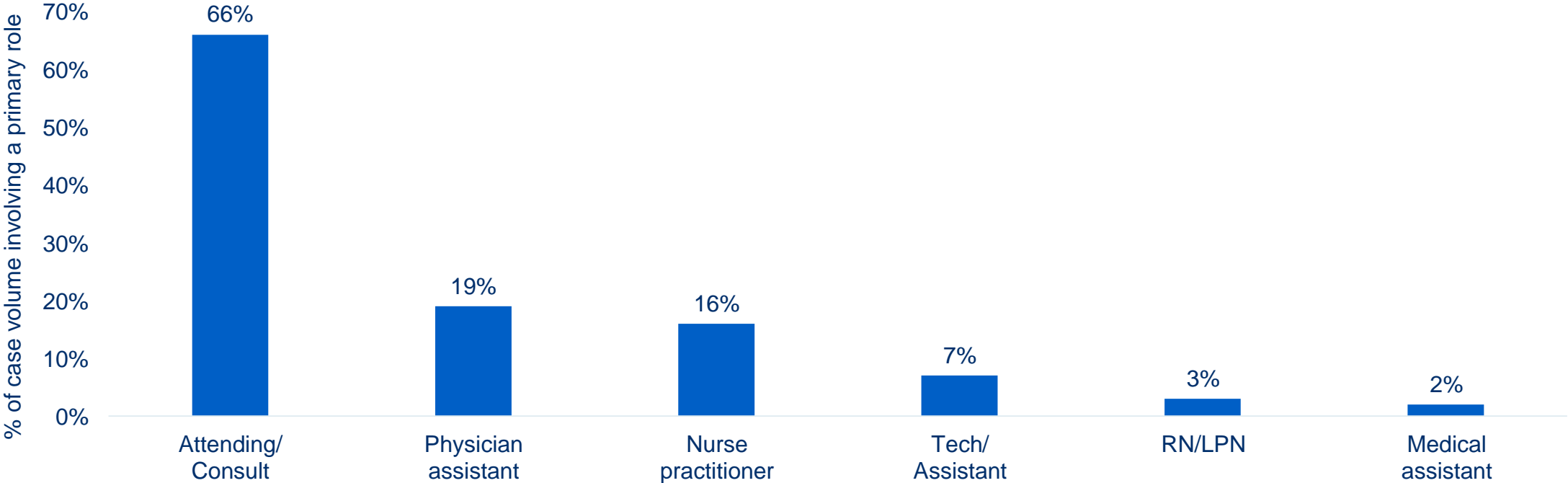
Each case reflects one primary responsible service. This is the specialty that is deemed to be most responsible for the resulting patient outcome. Cases can also reflect one or more 'secondary' responsible services. In the medical office setting, radiology, emergency medicine and nursing staff are among the three most common services noted as secondarily responsible.



MedPro Group + MLMIC cases opened 2012-2021, medical office/clinic (N=6020); \*Other includes services accounting for <=2% of case volume

# Primary Responsible Services: Focus on Primary Roles\*

“Roles” reflect the **specific position within the specialty service team that was involved at the time of the event**. There may be multiple primary roles within the same service team (i.e., an attending/consult and a nurse practitioner – both practicing under the primary care responsible service).



MedPro Group + MLMIC cases opened 2012-2021, medical office/clinic with an identified role (N=2256); \*Role codes have been evolving for several years. The role code portion of the taxonomy was enhanced and made mandatory in July 2021, therefore not all cases coded prior to that date have a role indicated.

# 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.

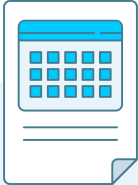
**Multiple factors are identified in each case** because generally, there is not just one issue that leads to these cases, but rather a combination of issues.



Administrative



Behavior-related



Clinical environment



Clinical judgment



Clinical systems



Communication



Documentation



Supervision



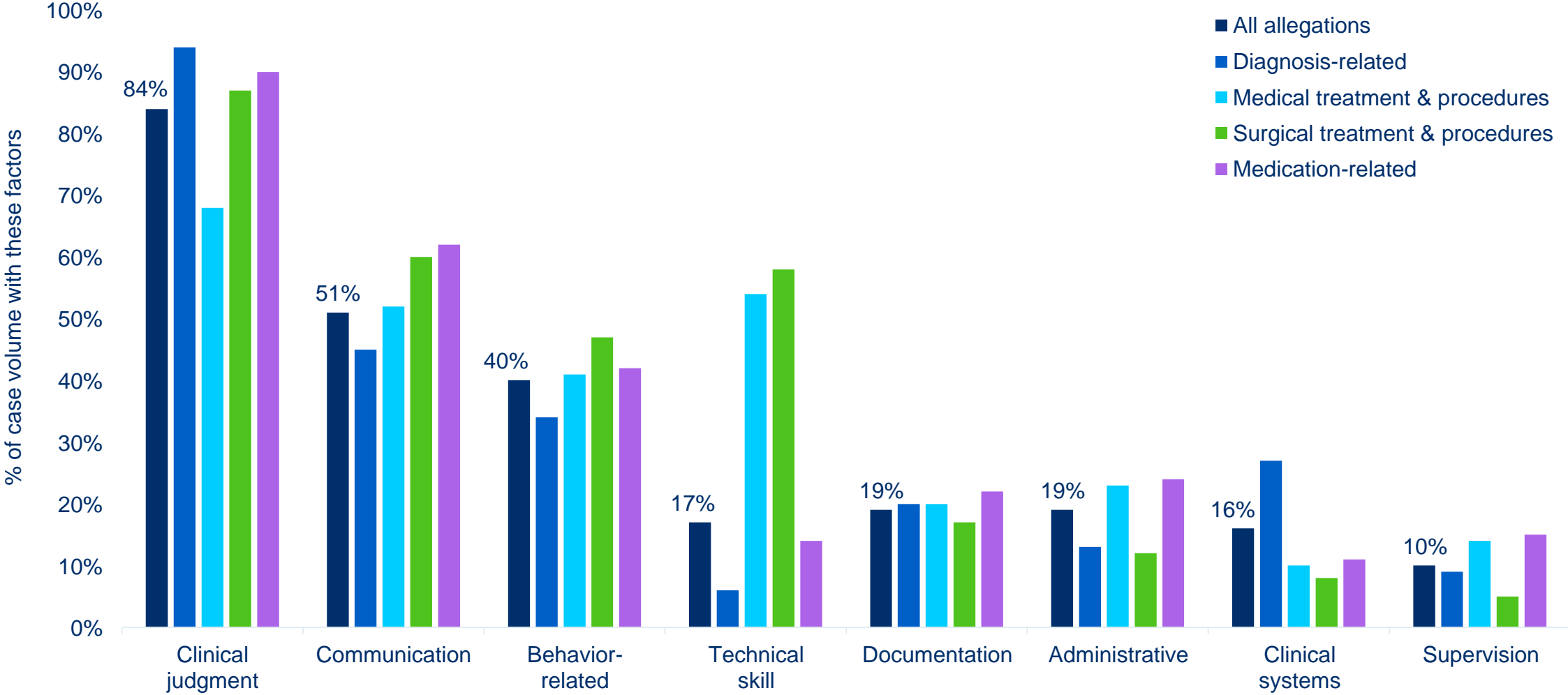
Technical skill

# Contributing Factor Category Definitions

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Administrative	Factors related to medical records (other than documentation), reporting, staff education/training, ethics, policy/protocols, regulatory issues
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
Equipment	Factors related to malfunction and failures to maintain/inspect equipment/materials
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, medical office/clinic (N=6020); More than one factor per case, therefore totals >100%

# Contributing Factors: Focus on Drivers of Clinical & Financial Severity

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These factors are commonly noted in cases with clinically severe patient outcomes and indemnity payments.

**Administrative** Inadequate staff training/education

**Behavior-related** Patient non-adherence with treatment regimen and/or follow-up call/appointment

**Clinical judgment**

- Selection of most appropriate treatment/procedure
- Failure to appreciate/reconcile relevant signs/symptoms/test results
- Failure to establish differential diagnosis
- Misinterpretation of diagnostic results
- Inadequate history/physical
- Delay in ordering diagnostic testing
- Failure/delay in obtaining consult/referral
- Inadequate assessment resulting in premature discharge from care
- Narrow diagnostic focus – failure to establish differential diagnosis

**Communication** Suboptimal communication among providers about patient condition

Failure to read medical record

**Documentation** Insufficient or lack of documentation regarding clinical findings (impacts team communication and makes subsequent defense of malpractice cases more difficult)

# 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.

**Cancers  
(44%)**

Primarily lung, prostate, breast, colorectal, urinary tract and colorectal

**Circulatory system  
(13%)**

Primarily cardiac and cerebrovascular diseases

**Injuries  
(10%)**

Primarily fractures, wounds, sprain/strains, and management of procedural complications

# 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

<b>Initial diagnostic assessment</b>  <b>88%</b> of cases	Patient notes problem & seeks care
	History & physical
	Patient assessed, symptoms evaluated
	Differential diagnosis established
	Diagnostic testing ordered

## Phase 2

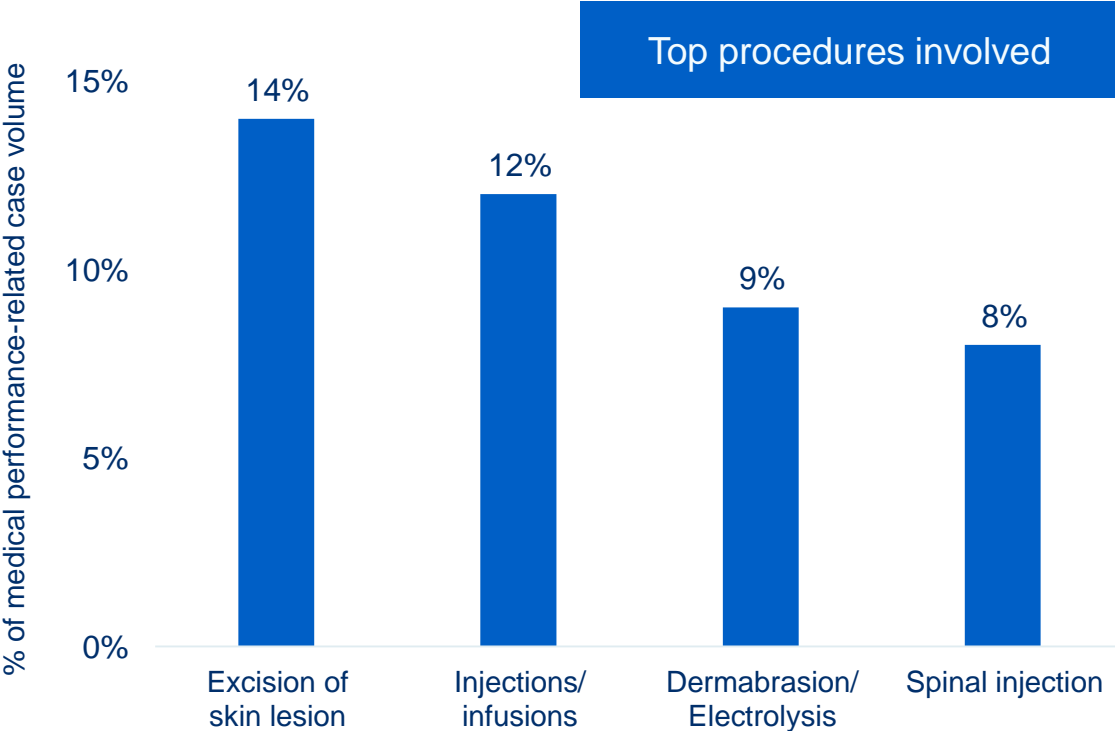
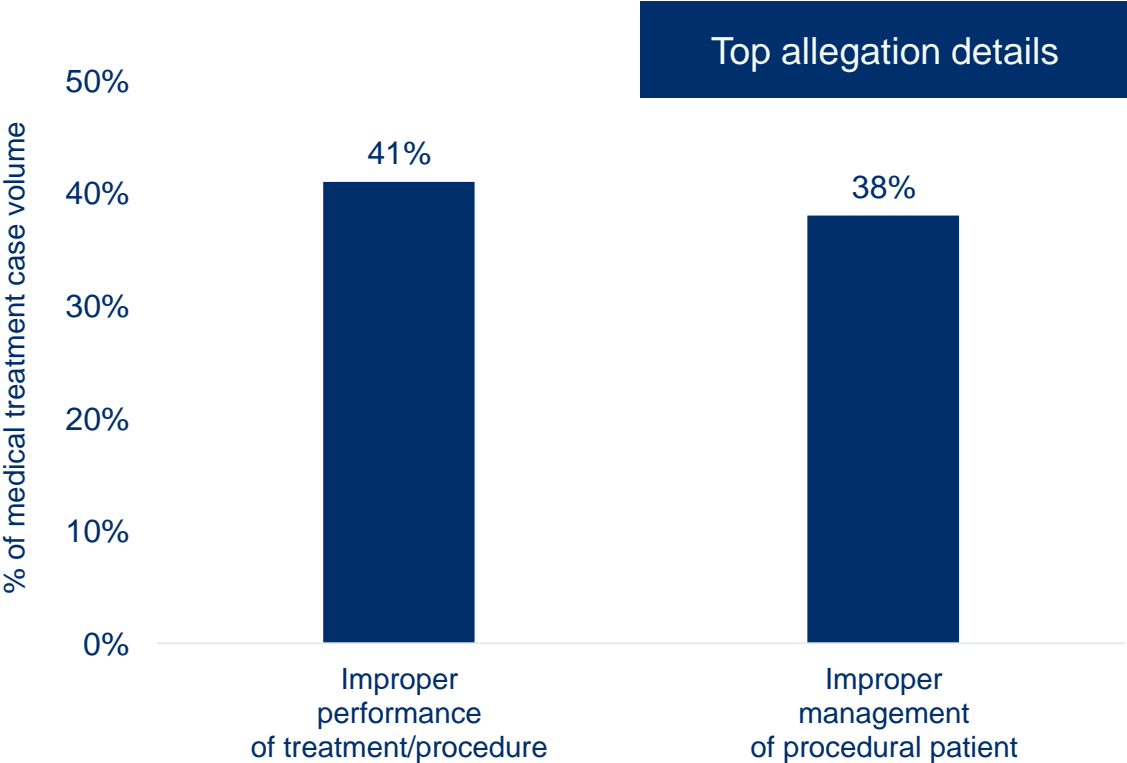
<b>Testing and results processing</b>  <b>24%</b> of cases	Performance of diagnostic tests
	Interpretation of diagnostic test results
	Test results transmitted to/received by ordering provider

## Phase 3

<b>Follow-up and coordination</b>  <b>68%</b> of cases	Physician follows-up with patient
	Referrals/Consults
	Patient information communicated among care team
	Patient compliance with follow-up plan

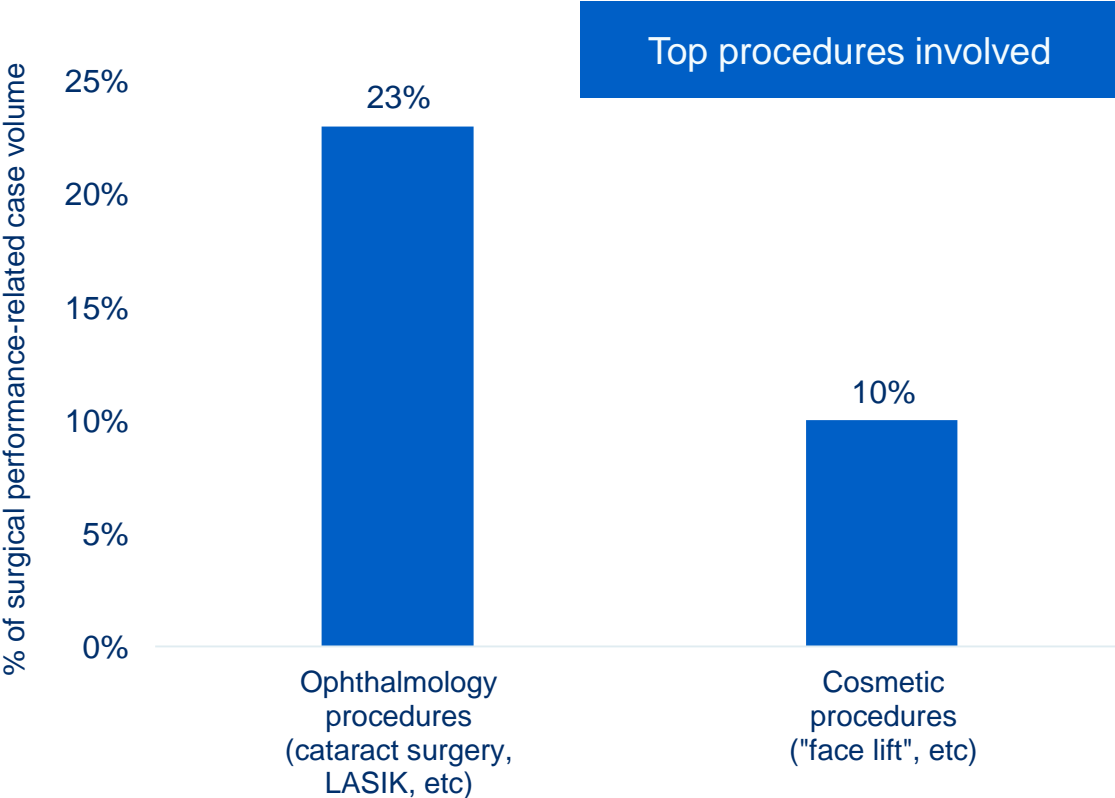
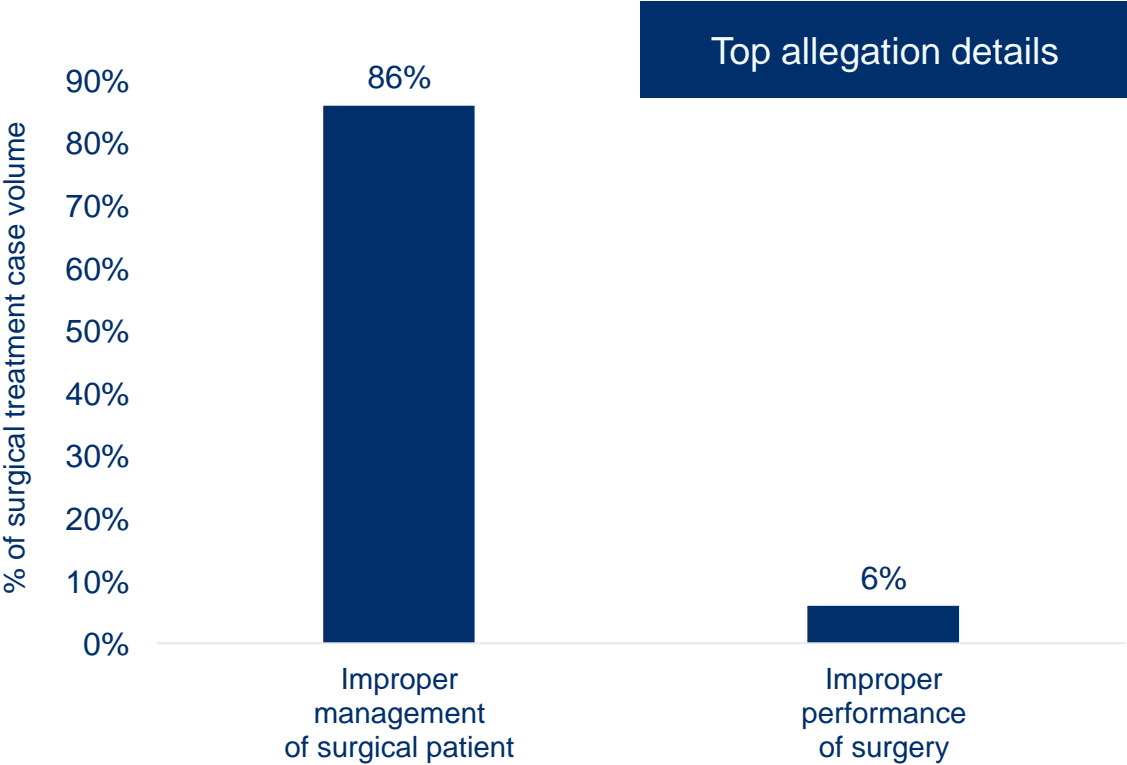
MedPro Group + MLMIC cases opened 2012-2021, medical office/clinic, diagnosis-related allegations(N=2240); \*each step reflects a combination of contributing factors; diagnostic process of care algorithm courtesy of Candello, a division of CRICO Strategies

# Focus on Medical Treatment Allegations



**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 Surgical Treatment Allegations

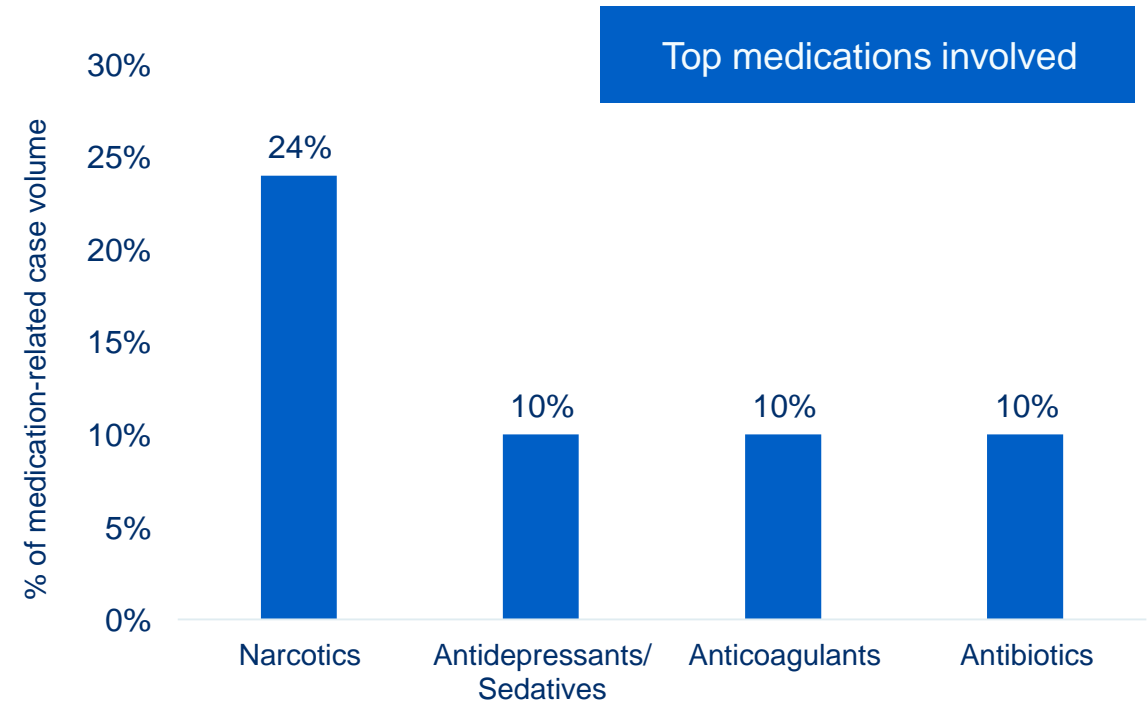
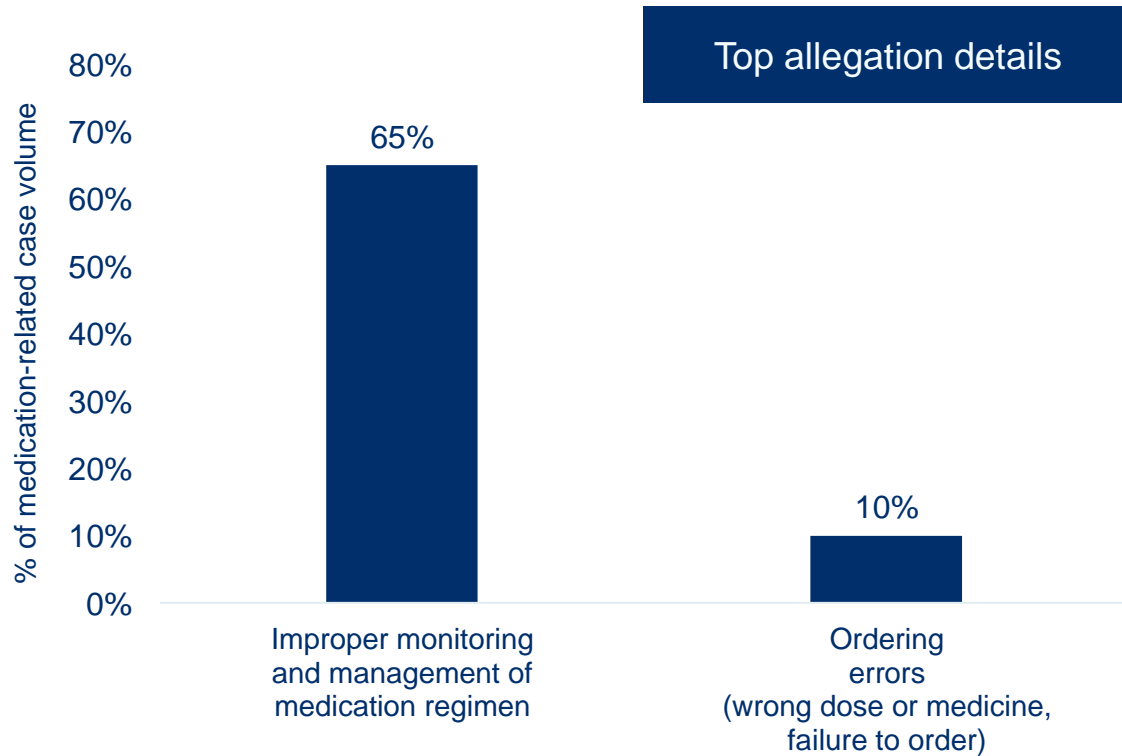


Cases involving the **management and follow-up of patients within an office setting** are often related to the provider's **recognition of and response to developing complications**. While complications of procedures occurring in a clinic may have been the result of procedural error, the **failure to timely recognize and/or monitor/manage the issue prevents the opportunity for early mitigation of the risk of serious adverse outcome**.

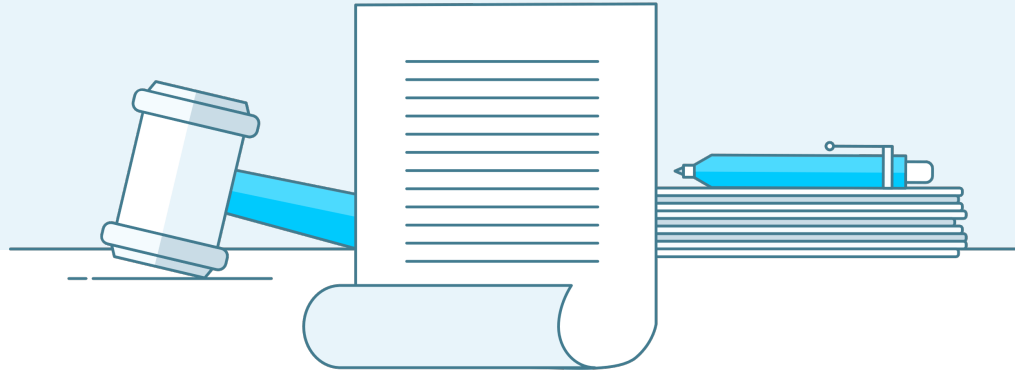


# Focus on Medication-Related Allegations

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**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).



**The following stories are reflective of the allegations and contributing risk factors which drive cases arising in a medical office or clinic.**

**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

**\$900K**

CONTRIBUTING FACTORS

## Administrative

Office record unavailable at the appointment due to electronic health record conversion

## Clinical judgment

Narrow diagnostic focus with an atypical presentation (young female)

Failure to appreciate/reconcile relevant signs/symptoms

Failure/delay in ordering diagnostic test (colonoscopy)

FAILURE TO DIAGNOSE COLON CANCER IN YOUNG WOMAN RESULTING IN METASTASIS AND DEATH

**A female patient in her mid-20's** presented to a colorectal surgery office with **complaints of rectal bleeding and a strong family history of colon cancer** (grandfather with cancer, and father with colon polyps). She was examined, found to have hemorrhoids, and was encouraged to have a colonoscopy, which she refused. **She did not return to the office for another six years.**

**At that time, she presented to the same office with complaints of hemorrhoids and rectal bleeding.** She reported no family history of colon cancer or inflammatory bowel disease. In the intervening years, the patient's last name had changed, and her **prior office records were unavailable to review.** An in-office scope revealed **internal hemorrhoids with mild prolapse. No additional examination was done, and due to her age, no colonoscopy was recommended.**

**Two years later, the patient presented again,** this time with rectal bleeding, urgency with bowel movements, and abdominal cramping. A colonoscopy identified a mass loss in the colon; biopsy revealed a malignancy. The surgeon met with the patient and her father, who related the family history of colon cancer and polyps. **Post-operative testing revealed metastases to the liver.** The patient succumbed to her disease three years later.

Pathology review experts opined that the cancer would have been at Stage II-III if found in when the patient presented to the office for the second time (six years after the first time). **Experts were not supportive that of the colorectal surgeon's failure to seek out and read the patient's prior office record or offer a colonoscopy at that second visit.**

# Case Examples

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

SETTLED

**\$200K**

CONTRIBUTING FACTORS

## Clinical judgment

Intended selection of non-prescribed treatment (soothing oil)

Selection of inappropriate medication (antibiotic ointment)

## Clinical environment

Failure to ensure a safe environment (chemicals kept in unlocked cabinet in patient care room)

## Supervision

Supervision of advanced practice providers

## Technical skill

Administration of incorrect "treatment" (chemical vs oil)

IMPROPER PERFORMANCE OF CERUMEN REMOVAL RESULTING IN BURNS TO EAR CANAL, FACE AND HANDS AND HEARING LOSS

A female patient in her mid-80's was an established patient at an ear, nose and throat clinic (ENT), **presenting routinely for removal of cerumen (earwax)**. At this visit, she complained of additional hearing loss in her right ear (she wore bilateral hearing aids). Rather than the impaction being removed by the ENT physician, **the procedure was performed by a physician assistant (PA), with no supervising physician on site.**

After cleaning out her ears, the **PA wanted to apply soothing oil from her "private stash."** However, rather than selecting the oil, the **PA inadvertently picked up a caustic solution intended for chemical peels. The PA placed an entire dropper of the caustic solution into the patient's ear, causing a burn in the ear canal.** It also spilled on the patient's hand as she reacted. The PA then compounded the situation by administering an antibiotic ointment to the burns despite the patient being allergic to that particular ointment.

**The patient was diagnosed with second-degree burns, a perforated tympanic membrane and right-sided tinnitus.** She also required two new hearing aids, because while hearing aids can be adjusted for slight changes, when one ear suffers such a drastic change, both hearing aids must be replaced to readjust the communication between them.

Experts were critical of the PA for not reading the label on the bottle of solution before administering it. In addition, personal products should not have been kept in the same room/cabinet with caustic chemicals, and those should have been stored in a locked cabinet (was unlocked within the room where patients are seen). The patient's burns were likely made worse by the administration of an antibiotic ointment to which the patient was allergic.

# Case Examples

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SETTLED

**\$175K**

## CONTRIBUTING FACTORS

### Behavior-related

Patient dissatisfaction/sought different provider

### Clinical environment

Saturday ED visit/phone call potentially impacting diagnostic testing decision

### Clinical judgment

Failure to order diagnostic test  
Failure to appreciate/recognize relevant signs/symptoms

### Documentation

Lack of clinic documentation of patient's first two visits

## IMPROPER MANAGEMENT OF KNEE REPLACEMENT PATIENT RESULTING IN INFECTION AND ADDITIONAL SURGERIES

A male patient in his early 60's presented for a **total right knee replacement surgery** following failed conservative treatment for degenerative joint disease and osteoarthritis. **Two months later, on a Saturday, the patient presented to the Emergency Department (ED) complaining of a red, hot, and swollen right knee.** Labs revealed an elevated white blood cell count. The ED physician contacted the patient's orthopedic surgeon and sent pictures of the patient's knee. **The orthopedic surgeon opined that the patient had a superficial wound infection. He was given IV antibiotics while in the ED and discharged with oral antibiotics. No aspiration/cultures of the infection were obtained while in the ED.**

On Monday, the patient saw the surgeon in the outpatient clinic for a knee aspiration, and again on Tuesday to discuss ongoing care (no documentation in the patient's chart was found for either visit). The patient was seen four more times in the clinic, did not complain of significant symptoms, and was participating in physical therapy.

One week prior to the last clinic visit with the orthopedic surgeon who had performed the surgery and who had been seeing the patient in clinic visits, **the patient presented to a second orthopedic surgeon with complaints of knee pain** (and did not tell the first surgeon of this visit). **The second surgeon ordered labs which revealed active inflammation. A knee aspiration showed bacterial growth. Two weeks later, the second surgeon performed a revisional knee surgery with removal of hardware.** An antibiotic 'spacer' was placed, and a **large defect/infection of the patient's quad tendon was noted.** New knee hardware was placed four weeks later, with removal of a hematoma. The hematoma recurred, requiring a second evacuation.

**The patient never regained full movement of his knee and required subsequent surgeries for loosening hardware and repeat infections.** Experts opined the first surgeon should have ordered aspiration of the knee prior to administration of antibiotics in the ED, followed by incision and drainage with removal and replacement of the hardware. **The untreated infection caused the quad tendon defect to persist and progress, ultimately inhibiting rehabilitation.**

# Case Examples

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SETTLED

**\$195K**

CONTRIBUTING FACTORS

Clinical judgment

Failure to order medication

Management of pregnancy

Communication

Language barrier

FAILURE TO ORDER MEDICATION DURING PREGNANCY RESULTING IN INFANT WITH HEMOLYTIC DISEASE AND NEUROLOGICAL DELAYS

**An Arabic-speaking female in her early 30's presented began care with her obstetrician when she was nine weeks pregnant. Her husband served as her translator during all visits. Previous history revealed that she was Rh-negative (a protein found on the surface of red blood cells) with two prior pregnancies, and had been given RhoGAM during each of those pregnancies to prevent complications with maternal/fetal Rh incompatibility.**

Antibody screening was performed at this **initial visit, which revealed a low Rh-antibody titer (Rh-negative). The obstetrician did not document any discussion of prescribing RhoGAM. The patient continued to be seen by the obstetrician for four additional visits through the 29<sup>th</sup> week of pregnancy, but there was still no documentation discussing RhoGAM prescription with the patient.** At 31 weeks, the patient saw a second obstetrician who noted that she had not yet received the medication, and referred her to a maternal-fetal medicine specialist. Testing showed she was already Rh sensitized and therefore could not now receive the RhoGAM injection, however, the fetus' biophysical profile testing was normal. The fetus was at risk for hemolytic disease if antibodies attempt to destroy the fetus' red blood cells, including fetal anemia, jaundice, heart failure or brain damage.

**At 35 weeks, the fetus' biophysical profile was concerning for anemia and a decision was made to perform a caesarean section** due to non-reassuring fetal heart tracings. A 5 pound 11 ounce boy was delivered; he was severely anemic and was transferred to NICU. The placenta had two intra-parenchymal hemorrhages. The baby was transfused and suffered a small brain bleed with the potential risk of developmental delays.

**By age two and a half, the boy required speech, behavioral and occupational therapy, and the mom was now at high risk of complicated future pregnancies.** Experts were critical of the first obstetrician for failing to prescribe/administer RhoGAM between 26-28 weeks of pregnancy. Chart was silent as to any discussions with the mom regarding the necessity of RhoGAM (standard of care). **It is unknown, but possible, that the language barrier made a difference in the patient's care and whether she (and her husband) understood the significance of missing the medication.**

# Risk Mitigation Strategies

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



# 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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