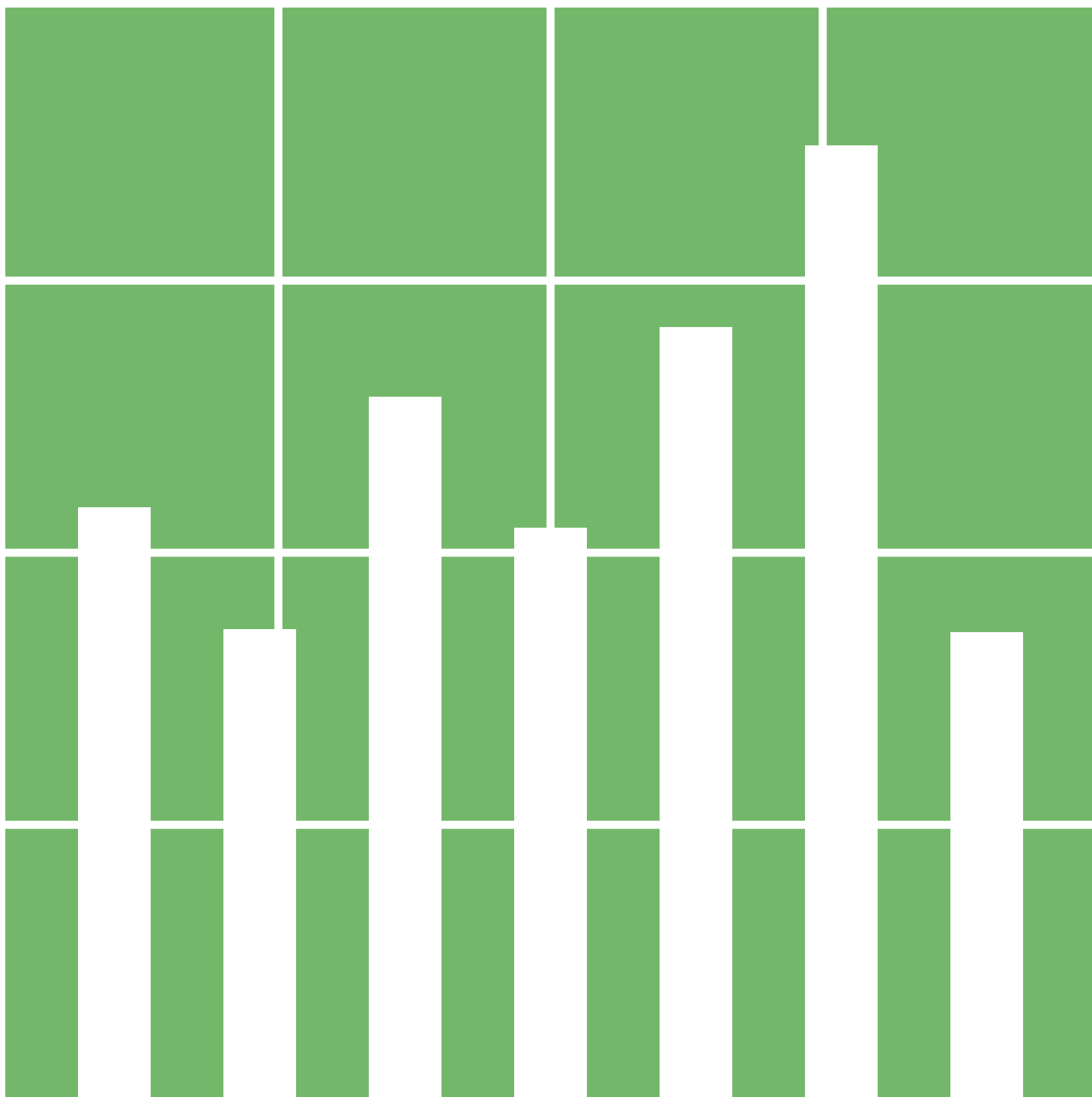


# Family Medicine

Specialty  
Report



December 2014

MedPro Group Patient Safety & Risk Solutions

 **MedPro Group**  
*Berkshire Hathaway's dedicated healthcare liability solution*

MedPro Group is a member of the Berkshire Hathaway group of businesses. The Medical Protective Company and Princeton Insurance Company clinical risk management consultants provide risk management services on behalf of MedPro Group members, including The Medical Protective Company, Princeton Insurance Company, and MedPro RRG Risk Retention Group.

# Contents

<b>Introduction</b>	<b>1</b>
A Note About MedPro Group Data	1
<b>Family Medicine Claims — Overview</b>	<b>2</b>
<b>Family Medicine Claims — Frequency</b>	<b>3</b>
<b>Family Medicine Claims — Severity</b>	<b>4</b>
<b>Family Medicine Claims — Practice Setting</b>	<b>4</b>
<b>Family Medicine Claims — Patient Factors</b>	<b>5</b>
<b>Family Medicine Claims — Contributing Factors</b>	<b>6</b>
Clinical Judgment	8
Communication	10
Documentation	10
Behavioral, Clinical System, and Administrative Factors	11
<b>Diagnosis-Related Claims</b>	<b>11</b>
Focus on Diagnosis-Related Claims Involving Cancer	12
Top Contributing Factors for Diagnosis-Related Claims Involving Cancer	13
<b>Treatment-Related Claims</b>	<b>15</b>
<b>Medication-Related Claims</b>	<b>17</b>
<b>Obstetrics-Related Claims</b>	<b>19</b>
<b>Key Points</b>	<b>21</b>
<b>Family Medicine Risk Strategies</b>	<b>21</b>

---



# Introduction

---

This report is an analysis of the aggregated data from MedPro Group's family medicine claims opened between 2003 and 2012. The report is designed to provide our insureds with detailed claims data to assist them in purposefully focusing their risk management and patient safety efforts.

Data are based on claim counts, not on dollars paid (unless otherwise noted). The type of claims and the details associated with them should not be interpreted as an actuarial study or financial statement of dollars paid; however, the information may be referenced for issues of relativity.

## A Note About MedPro Group Data

---

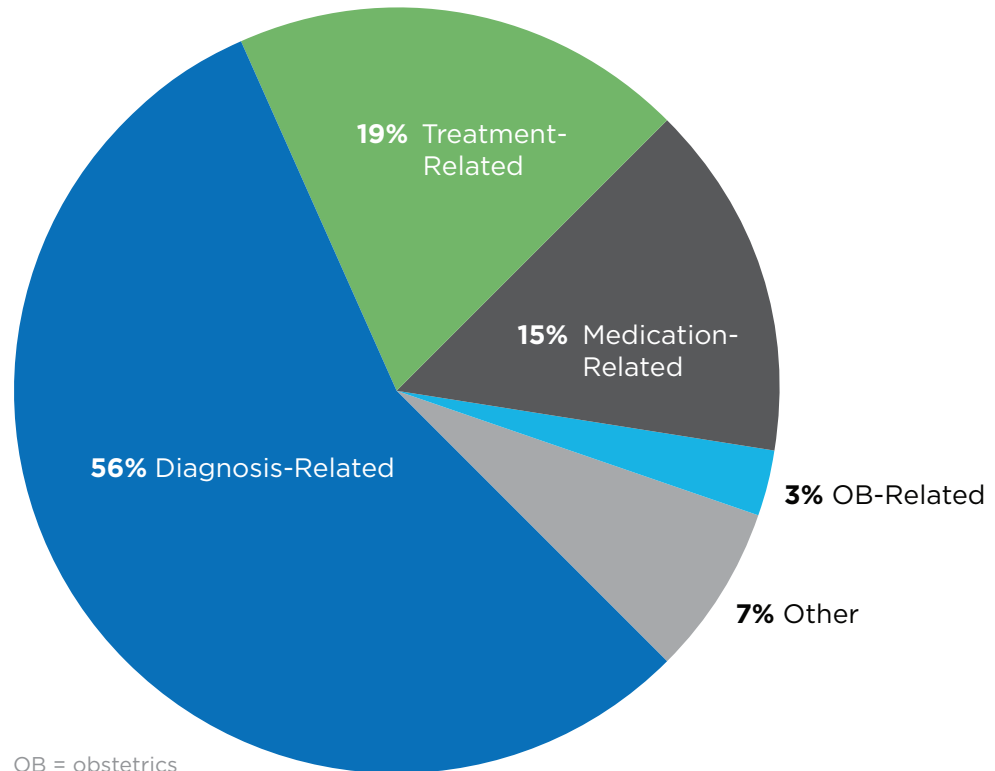
MedPro Group has entered into a partnership with CRICO Strategies, a division of the Risk Management Foundation of the Harvard Medical Institutions. Using CRICO's sophisticated coding taxonomy to code claims data, MedPro Group is better able to identify clinical areas of risk vulnerability.

All data in this report represent a snapshot of MedPro Group's experience with family medicine claims, including a deep dive into risk factors that drive these claims.

# Family Medicine Claims — Overview

Most family medicine claims opened between 2003 and 2012 are associated with care provided in outpatient settings. Figure 1 shows the volume of family medicine claims by allegation category.

**Figure 1.**  
Claim Volume by Allegation  
Category, 2003–2012



Diagnosis-related claims make up the majority of claim volume for family medicine providers. These claims involve allegations of failure to diagnose or delay in diagnosis.

Treatment-related claims primarily involve allegations of improper management of a course of treatment or improper performance of a treatment/procedure. These claims do not include OB-related allegations.

Medication-related claims primarily involve allegations of improper management of a patient's medication regimen. Less-common allegations involve issues with ordering and dispensing medications.

The OB-related allegation category is based on family medicine practitioners providing OB treatment. Only 3 percent of all allegations against family medicine providers fall into the OB-related category; however, the injury and financial severity associated with these claims make them a topic worth further discussion.

Interestingly, data analysis of financial severity reveals that both diagnosis-related and OB-related claims account for higher percentages of total incurred dollars than claim volume. (NOTE: Financial severity is determined by total incurred dollars. Total incurred dollars = indemnity plus expense dollars reserved on open claims and paid on closed claims.)

The “other” category captures low-volume allegations, including those related to communication issues among providers and between providers and patients, breach of confidentiality, and medical management of surgical patients.

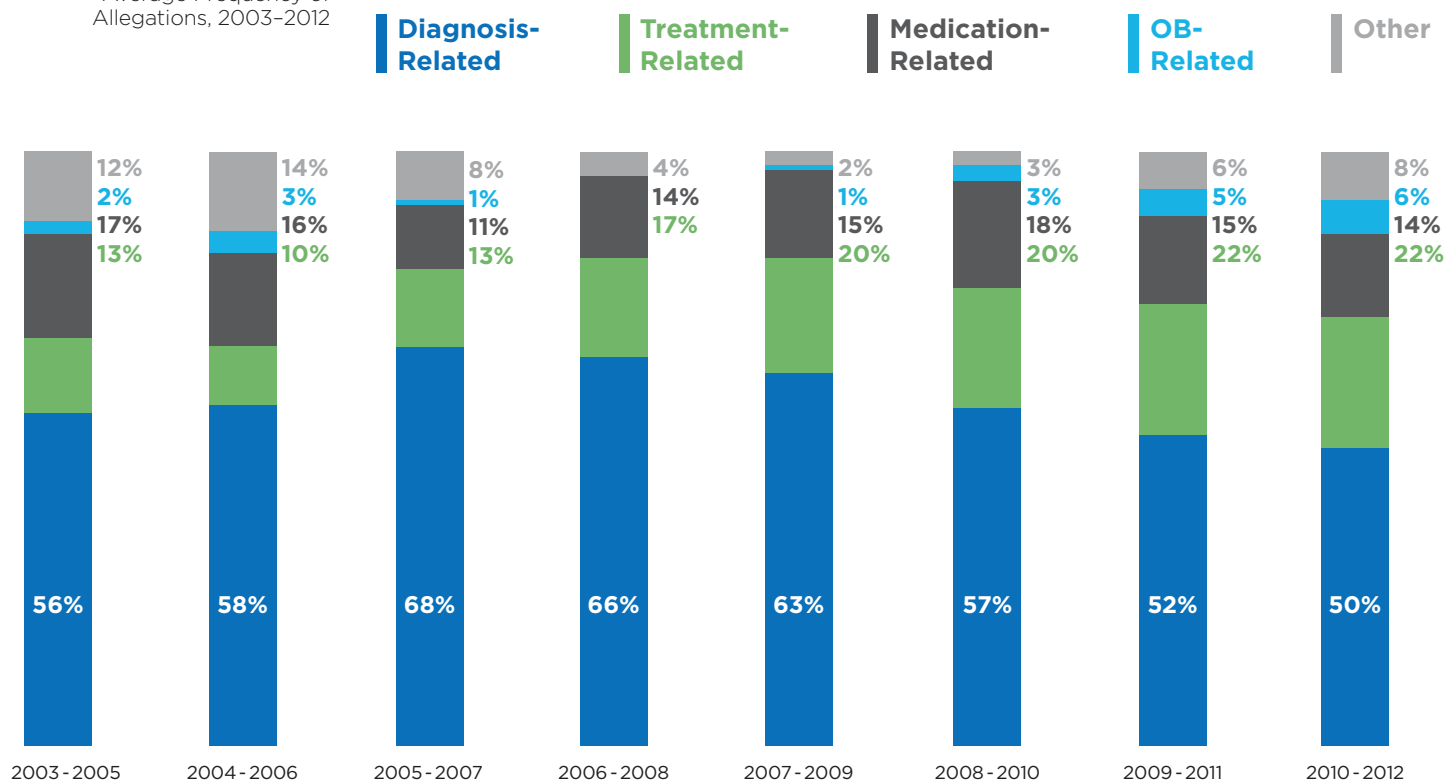
## Family Medicine Claims — Frequency

Figure 2 shows the average frequency of family medicine allegations over a 10-year period, grouped in overlapping 3-year increments.

Although diagnosis-related allegations are the most frequent, the percentage of diagnosis-related claims has decreased slightly over the last few years — while the percentage of treatment-related claims has increased.

Whether these trends will continue is difficult to assess due to the cyclical nature of medical malpractice claims.

**Figure 2.**  
Average Frequency of  
Allegations, 2003-2012

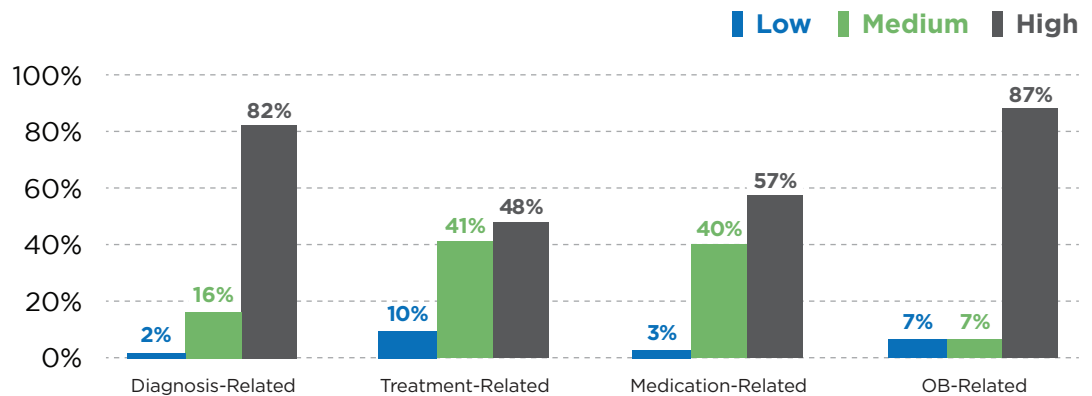


*NOTE: Any totals not equal to 100 percent are the result of rounding.*

## Family Medicine Claims — Severity

When analyzing family medicine claims for clinical severity, data show that high-severity claims dominate across all categories (see Figure 3). High-severity claims include those involving death or permanent injury. In family medicine, these claims most often are associated with diagnosis-related allegations. Although OB-related allegations represent only 3 percent of the overall claim volume, almost 90 percent of these allegations fall into the high-severity category.

**Figure 3.**  
Clinical Severity of Claims by  
Allegation Category,  
2003–2012

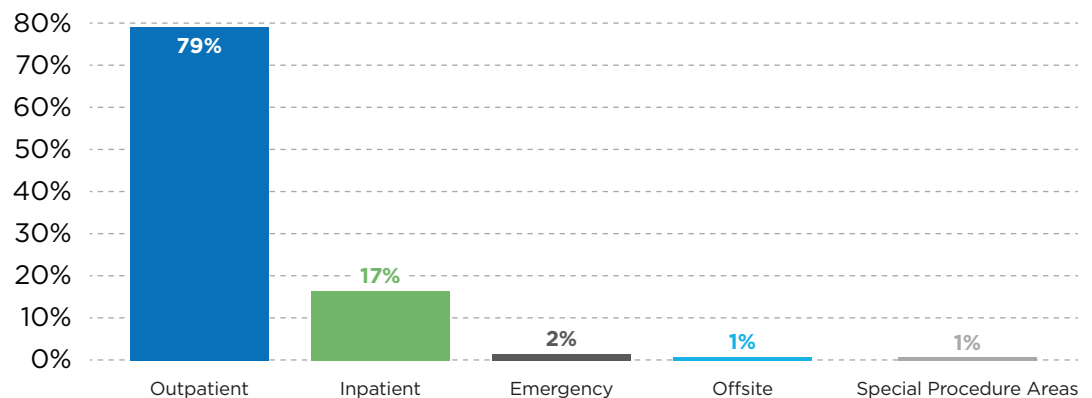


*NOTE: Figure 3 intentionally omits the “other” allegation category. Any totals not equal to 100 percent are the result of rounding.*

## Family Medicine Claims — Practice Setting

As noted earlier, most family medicine claims are associated with outpatient settings, primarily physician offices and clinics (see Figure 4). A different perspective shows the practice setting distribution by allegation category (see Figure 5). Of note, average total incurred dollars per claim is much higher in the inpatient setting than in outpatient or emergency department settings.

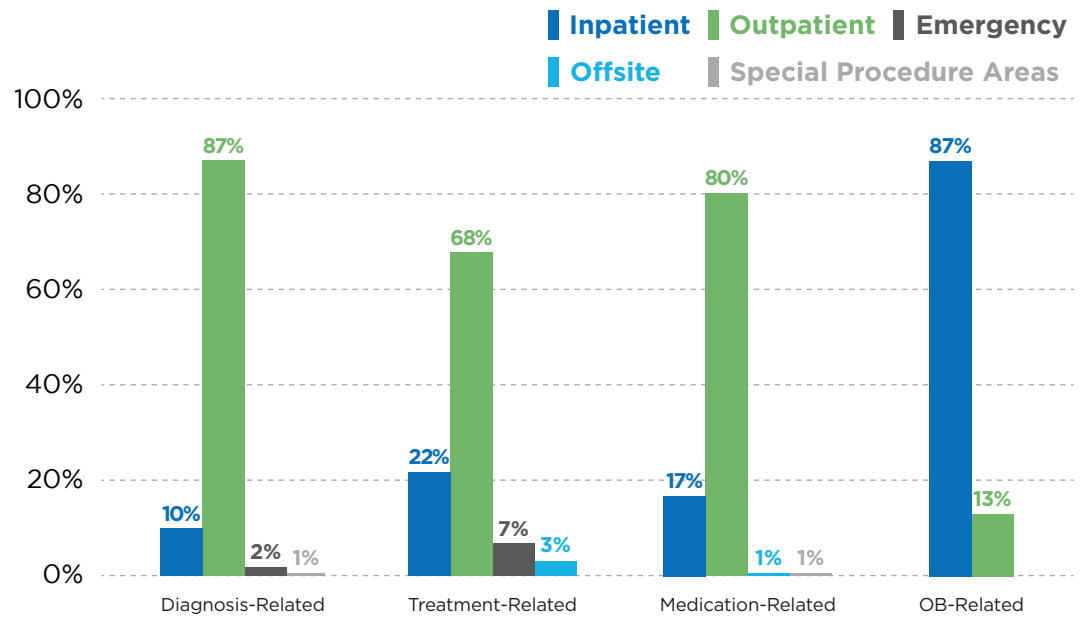
**Figure 4.**  
Claim Volume by Practice  
Setting, 2003–2012



*NOTE: The offsite category reflects allegations originating in a patient’s home (e.g., reflective of phone consultations) or in a prison setting.*



**Figure 5.**  
Allegation Category by  
Practice Setting, 2003–2012



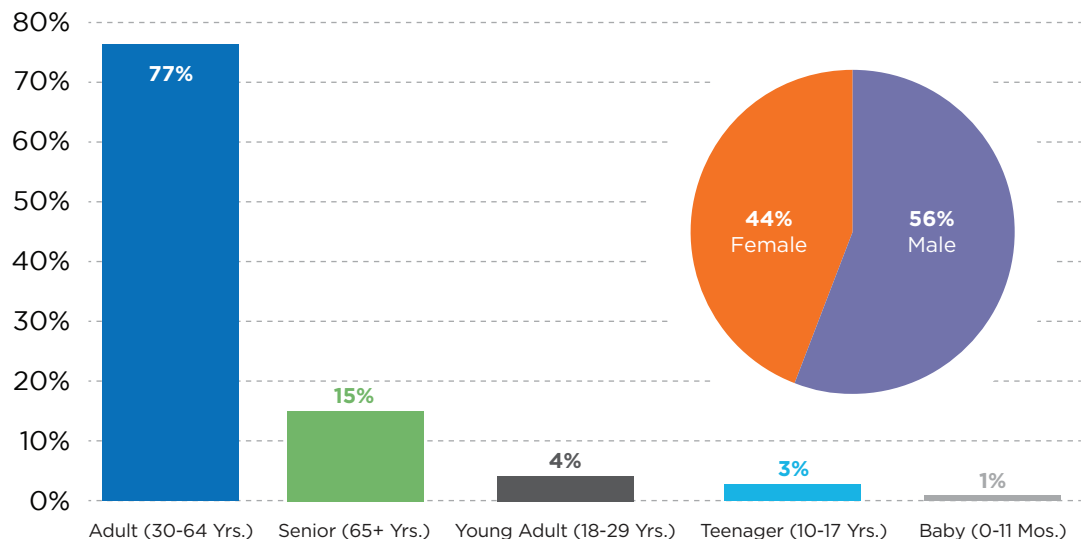
*NOTE: Figure 5 intentionally omits the “other” allegation category. Any totals not equal to 100 percent are the result of rounding.*

Not surprisingly, OB-related claims are mostly associated with inpatient settings, while diagnosis-related, treatment-related, and medication-related claims are primarily linked to outpatient offices and clinics.

## Family Medicine Claims — Patient Factors

Data analysis shows that the majority of family medicine claims opened between 2003 and 2012 involve middle-aged adults, with a fairly even distribution by gender (see Figure 6).

**Figure 6.**  
Claim Volume by  
Patient Age & Gender,  
2003–2012



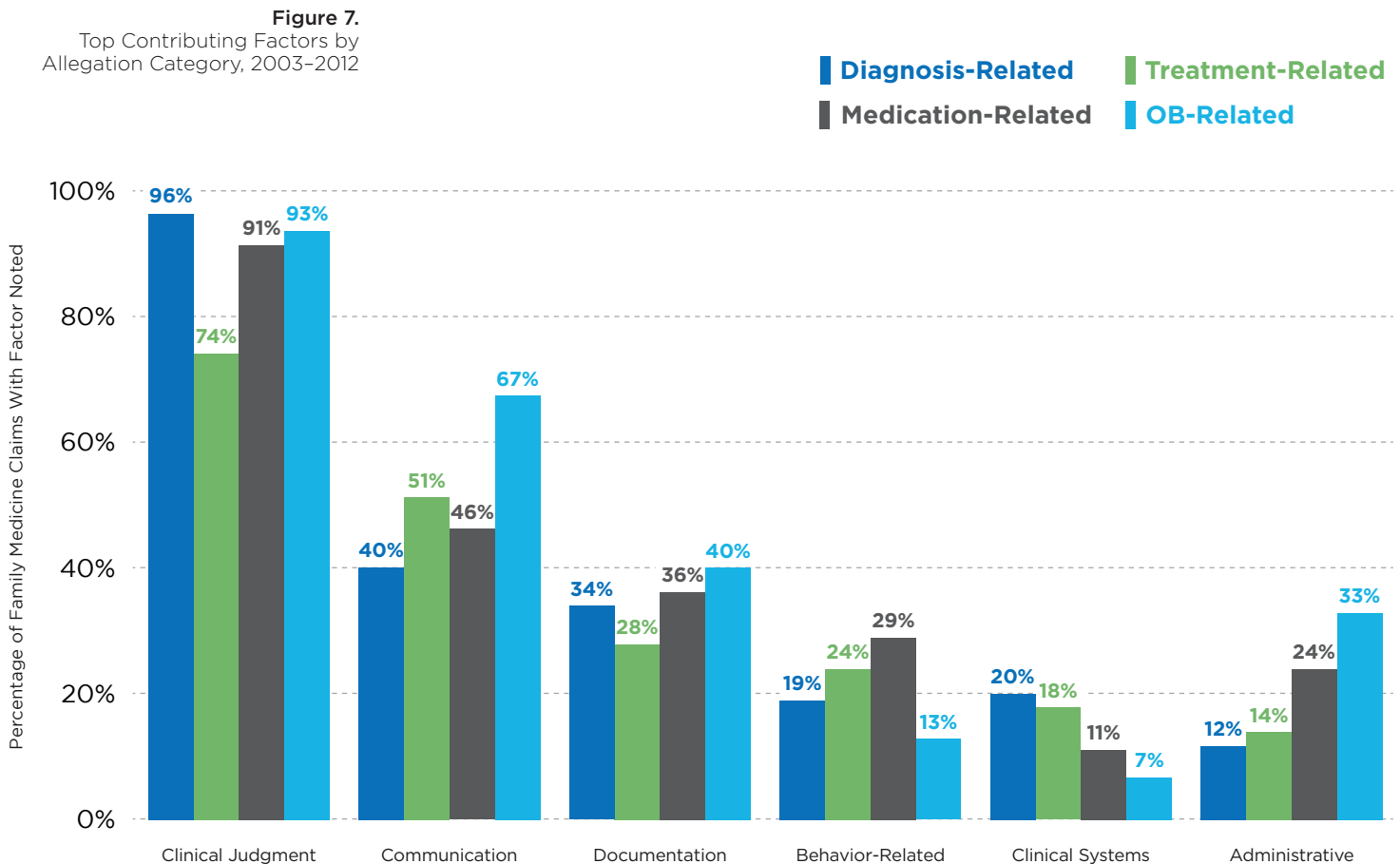
*NOTE: No claims were noted in this set for patients aged 1–9 years old.*

## Family Medicine Claims — Contributing Factors

This section focuses on factors that contribute to the following family medicine allegation categories: diagnosis-related, treatment-related, medication-related, and OB-related. The “other” allegation category is intentionally omitted from the data in this section.

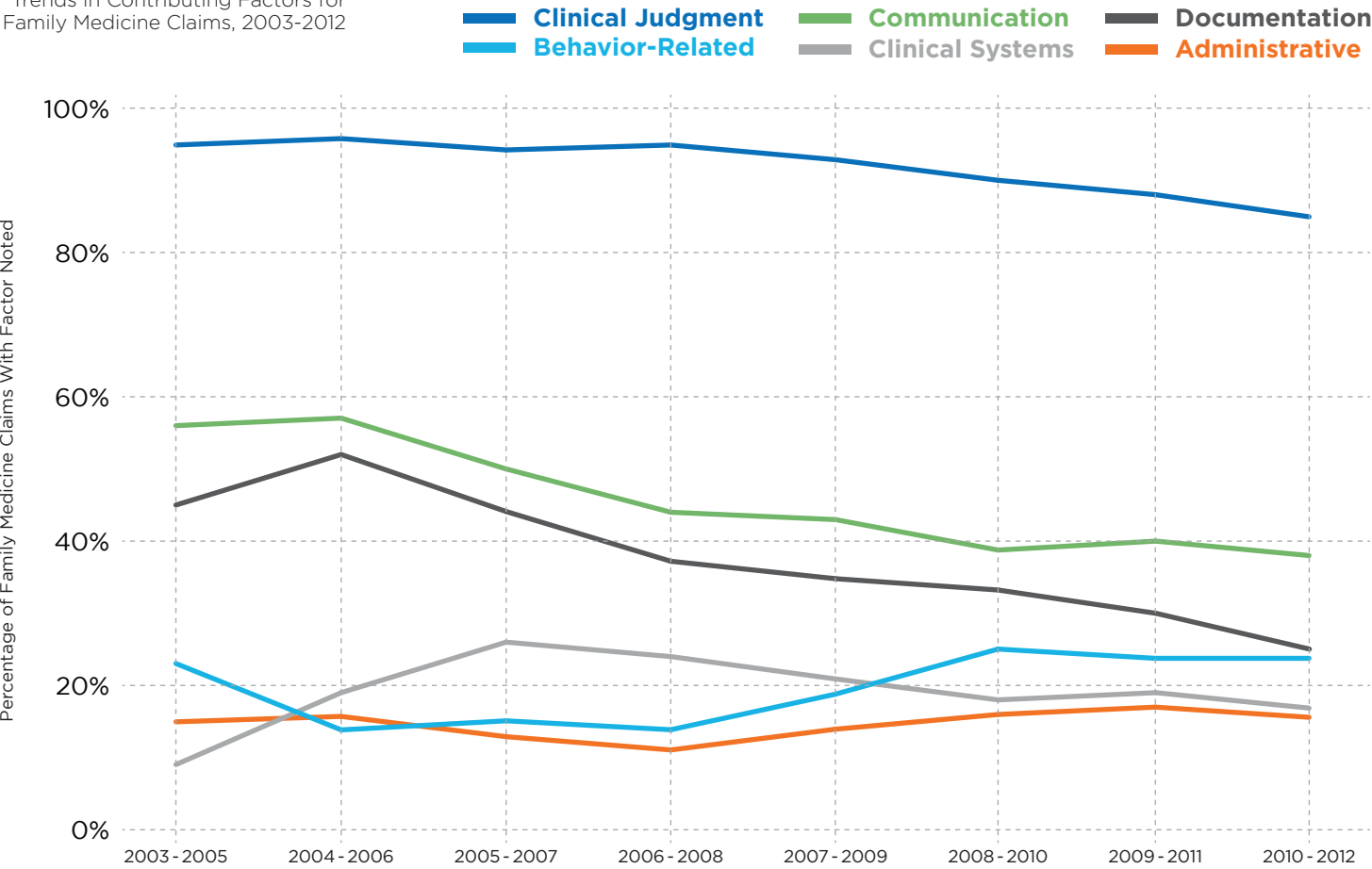
Contributing factors are broad areas of concern that may have contributed to allegations, injuries, or initiation of claims. These risk factors reflect issues that might be amenable to loss-prevention strategies. A claim may have one or more contributing factors.

Figure 7 shows the top risk factors that contribute to family medicine claims, separated by allegation category. Clinical judgment issues are pervasive across all allegation categories. Communication and documentation issues are common as well.



When analyzed across overlapping 3-year periods, the top contributing factors remain persistent and fairly flat. Despite a slight downward trend in communication and documentation issues, both factors remain among the most frequently occurring critical factors.

**Figure 8.**  
Trends in Contributing Factors for  
Family Medicine Claims, 2003-2012

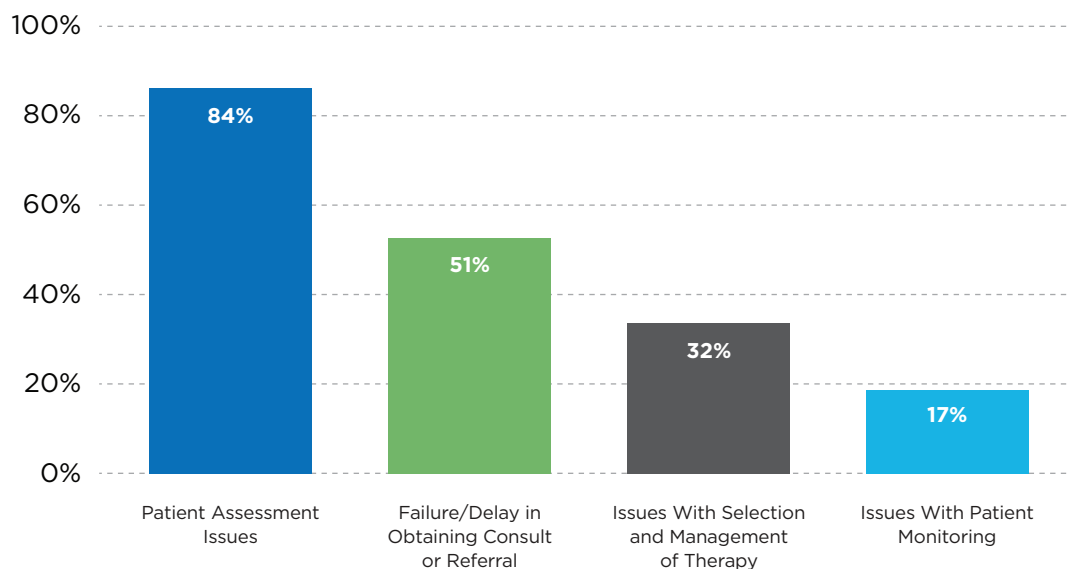


## Clinical Judgment

Clinical judgment is the most persistent and recurring contributing factor across the allegation categories, as shown previously in Figures 7 and 8.

In family medicine claims, clinical judgment is highly concentrated in the areas of patient assessment issues and the failure or delay in seeking consultations or referrals (see Figure 9).

**Figure 9.**  
Factors That Contribute to  
Clinical Judgment Issues,  
2003–2012



Top patient assessment issues in family medicine claims include:

- Failure or delay in ordering diagnostic tests
- Maintaining a narrow diagnostic focus
- Failure to establish a differential diagnosis

As discussed later in this report, diagnosis-related claims are primarily related to cancer. The claims involving cancer repeatedly reveal issues associated with narrow diagnostic focus.

## Claim Analysis

### Inadequate Patient Assessment

A middle-aged male who had a history of insulin-dependent diabetes presented to his family medicine provider with complaints of left arm, shoulder, back, and chest pain. The provider concluded that the pain was due to arthritis, and he prescribed a course of medication. The provider did not include documentation in the chart about the patient's family history or the duration and intensity of the pain.

An order for additional lab work, a chest X-ray, and an ECG was given, but the patient was not advised to have the tests done immediately. Later the same day, the patient collapsed as a result of chest pain. He was rushed to the emergency department and diagnosed with myocardial infarction and congestive heart failure. He underwent emergent coronary artery bypass surgery, but ultimately died.

---

### Risk Management Issues for This Claim

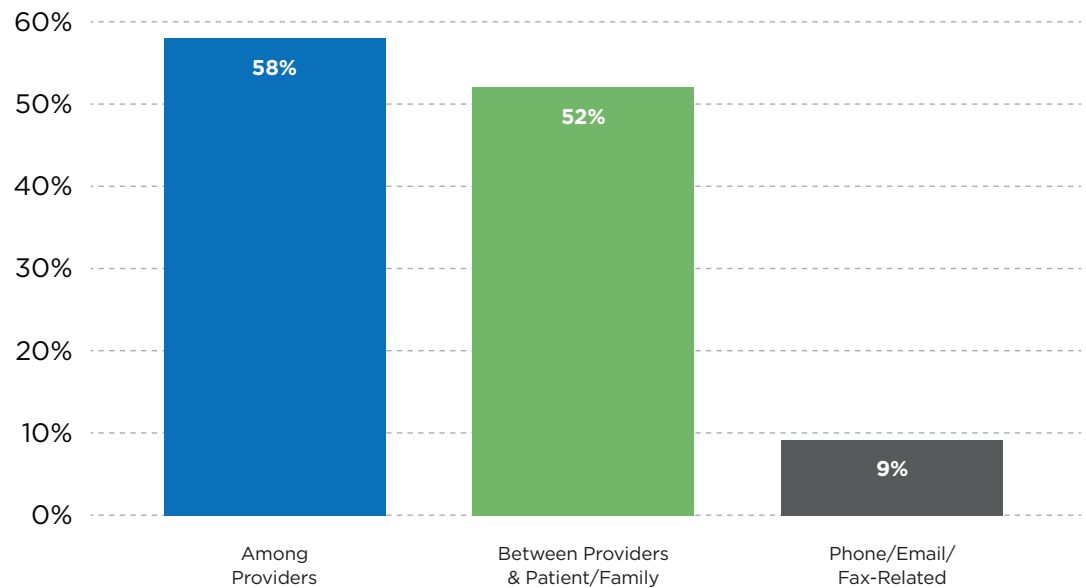
- Inadequate assessment of the patient's new symptoms
  - Failure to order immediate diagnostic tests
  - Failure to obtain a cardiology consult
  - Inadequate patient education related to follow-up instructions
-

## Communication

Communication is the second most common contributing factor in family medicine claims. The majority of communication issues tend to be split fairly evenly into two categories: communication among healthcare providers and communication between healthcare providers and patients. Communication issues related to phone, email, and fax are less common (see Figure 10).

Among providers, communication risks often are associated with handoffs and care transitions. Between providers and patients (and their families), risks tend to relate to follow-up care instructions and patient education.

**Figure 10.**  
Communication Issues by  
Type, 2003–2012



## Documentation

Documentation issues round out the top three contributing factors in family medicine claims. These issues include insufficient and inconsistent documentation within the medical record, as well as content-related concerns.

Allegations involving inconsistent documentation of clinical history and current symptoms in the medical record account for the persistence of documentation as a contributing factor in family medicine claims.

## Behavioral, Clinical System, and Administrative Factors

Although occurring less frequently than other contributing factors, behavior-related issues, clinical system problems, and administrative risk factors still represent persistent risk concerns, and they offer opportunities to improve patient safety and reduce liability.

Behavior-related issues, which have increased in frequency over the past few years, can have a notable impact on overall outcomes. In family medicine, these factors most often are associated with patient compliance, both with follow-up appointments and with medication/treatment regimens.

Clinical system factors, often noted in cancer claims, include delays in patient follow-up, especially in relation to communicating test results to patients.

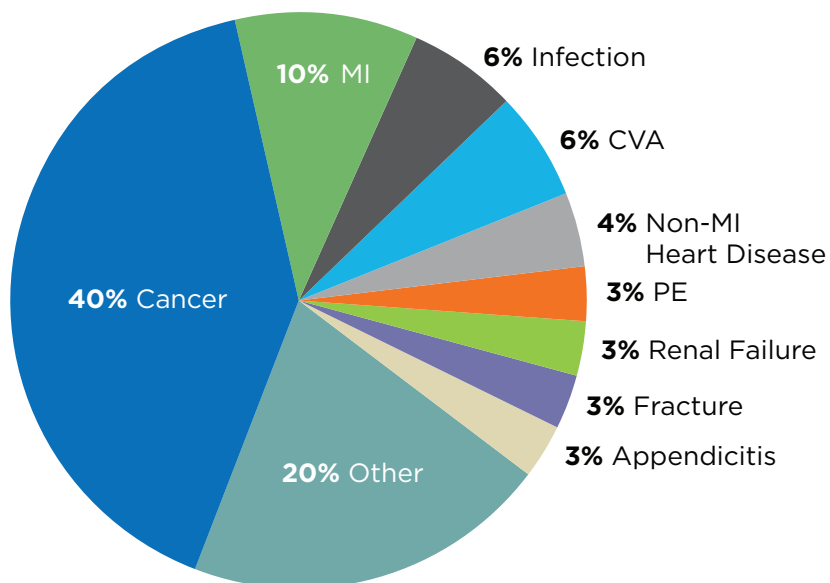
Administrative risks include failure to adhere to practice policies and procedures, missing medical record documentation, and issues related to credentialing and training of healthcare providers.

## Diagnosis-Related Claims

Diagnosis-related allegations represent the largest claim category for family medicine providers — both in frequency (56 percent of all claims) and clinical severity (injury). These claims also account for almost two-thirds of total incurred dollars on family medicine claims. Allegations related to cancer represent nearly half of all of the diagnosis-related claims, as shown in Figure 11.

**Figure 11.**  
Diagnosis-Related  
Allegations by Condition,  
2003-2012

CVA = cerebrovascular accident  
MI = myocardial infarction  
PE = pulmonary embolism

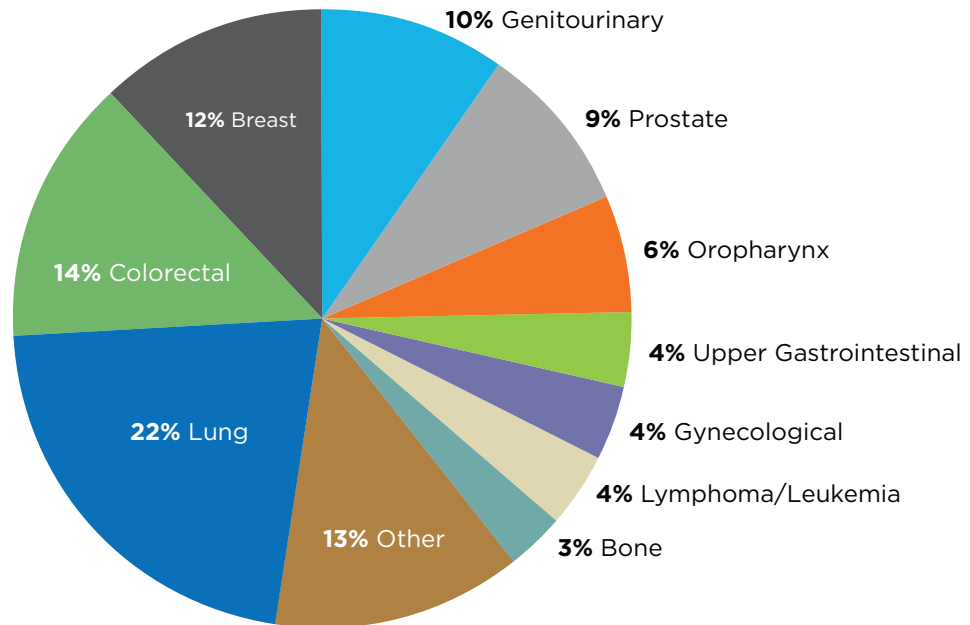


*NOTE: Any totals not equal to 100 percent are the result of rounding.*

## Focus on Diagnosis-Related Claims Involving Cancer

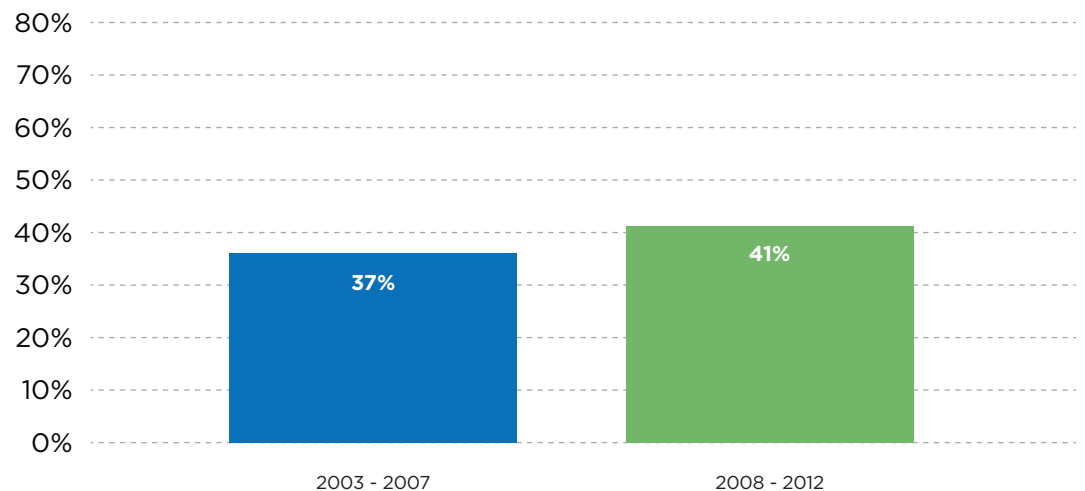
Examination of the diagnosis-related claims involving cancer reveals that the top five cancers implicated in these claims are lung, colorectal, breast, genitourinary, and prostate (see Figure 12). A slight rise in the frequency of cancer allegations within the diagnosis-related claims is seen when comparing 5-year time increments (see Figure 13).

**Figure 12.**  
Diagnosis-Related Claims:  
Cancer Diagnoses,  
2003-2012



*NOTE: Any totals not equal to 100 percent are the result of rounding*

**Figure 13.**  
Diagnosis-Related Claims:  
Frequency of Cancer  
Allegations, 2003-2012

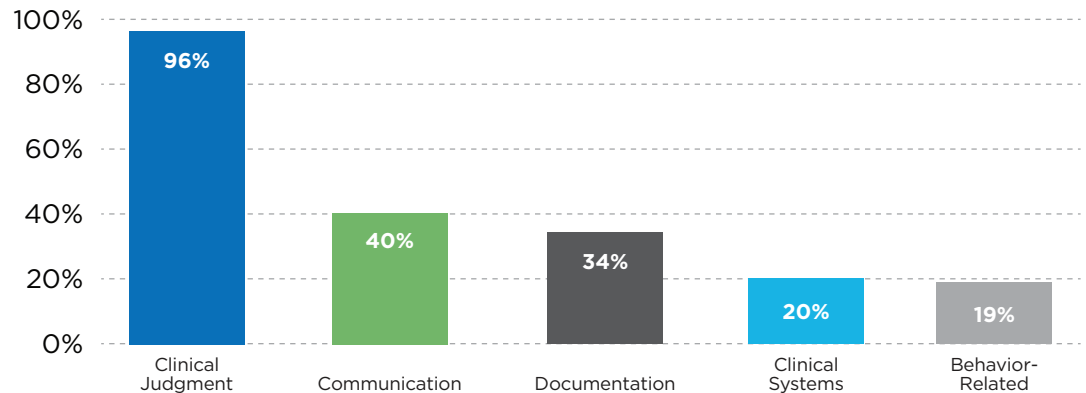




## Top Contributing Factors for Diagnosis-Related Claims Involving Cancer

Clinical judgment and communication top the list of risk factors that contribute to diagnosis-related claims involving cancer (see Figure 14).

**Figure 14.**  
Diagnosis-Related Claims  
Involving Cancer:  
Top Contributing Factors,  
2003–2012

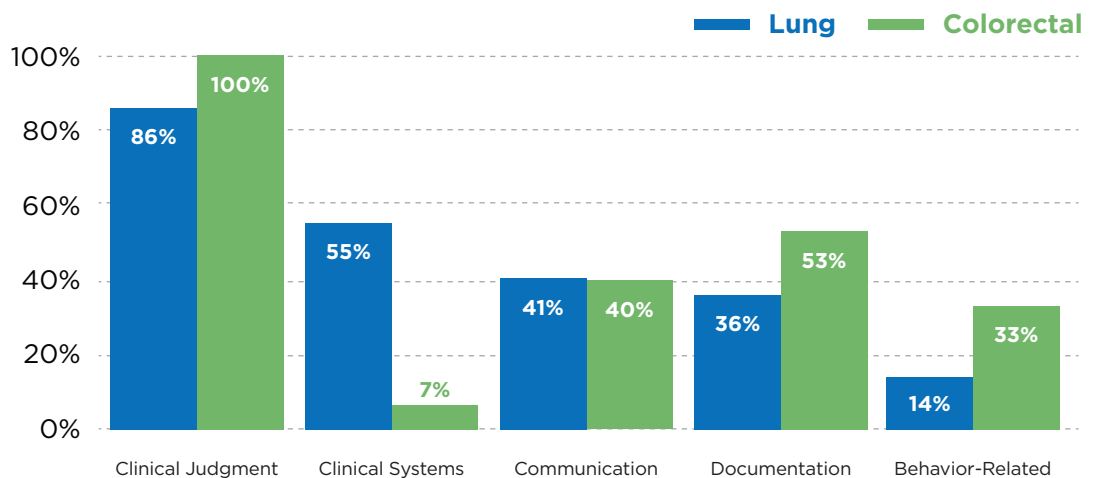


Analysis of the contributing factors for the top two types of cancer involved in diagnosis-related allegations (lung cancer and colorectal cancer) reveals some interesting differences (see Figure 15).

Issues related to clinical systems are much more prevalent in the lung cancer claims than in the colorectal cancer claims. The majority of clinical system issues for the claims related to lung cancer involve failures in communicating test results to patients and failures in following up on new clinical findings.

Conversely, documentation and behavioral issues (specifically, patient noncompliance) are more common in diagnosis-related claims linked to colorectal cancer than in claims associated with lung cancer.

**Figure 15.**  
Diagnosis-Related Claims  
Involving Lung Cancer or  
Colorectal Cancer:  
Top Contributing Factors,  
2003–2012



## Claim Analysis

### Delay in Diagnosis of Lung Cancer

During treatment for thyroid cancer, a male patient who had a history of smoking and hypertension was noted to have a lung nodule. PET scan results suggested that the nodule was benign. The patient underwent a total thyroidectomy and received subsequent radioactive iodine ablation for multiple positive lymph nodes.

Two years later, a repeat PET scan showed that the original lung nodule was now suspicious for malignancy. The scan also identified a suspicious nodule in the neck. The patient's family medicine provider referred the patient, with a copy of the most recent PET scan results, to the general surgeon who had treated the patient's thyroid cancer.

The general surgeon sent a report back to the family medicine provider related to the remission status of the patient's thyroid

cancer, but did not mention the suspicious lung nodule. The general surgeon later stated that he doesn't treat lung cancer, and that the referral for evaluation of the lung nodule was not appropriate. However, he never notified the family medicine provider or made another referral to a specialist.

Almost a year later, the patient contacted the family medicine provider to ask whether he should make another appointment. The patient was told that he should have followed up with the general surgeon months ago.

Six months later, the patient presented to the family medicine provider complaining of shortness of breath, and he was diagnosed with primary lung cancer. Despite aggressive treatment, he developed metastasis to his brain and died.

---

### Risk Management Issues for This Claim

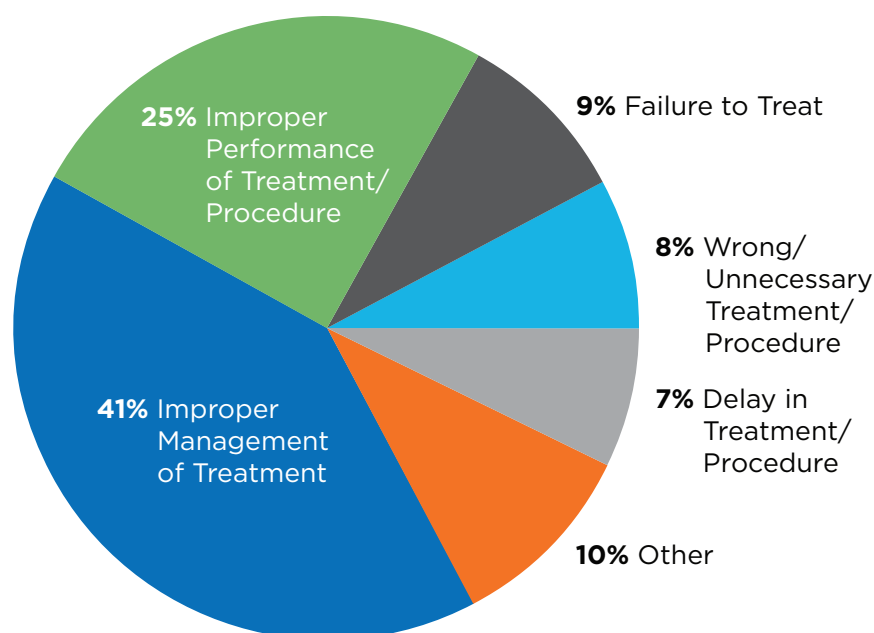
- Failure to obtain a timely consult
  - Significant lack of communication among providers and between the providers and the patient regarding subsequent instructions
  - Lack of a reliable system for patient follow-up regarding new diagnostic test findings
-

## Treatment-Related Claims

Claims related to medical treatment in family medicine are diverse. Approximately two-thirds of these claims fall into the subcategories of improper management of a course of treatment and improper performance of a treatment/procedure (see Figure 16).

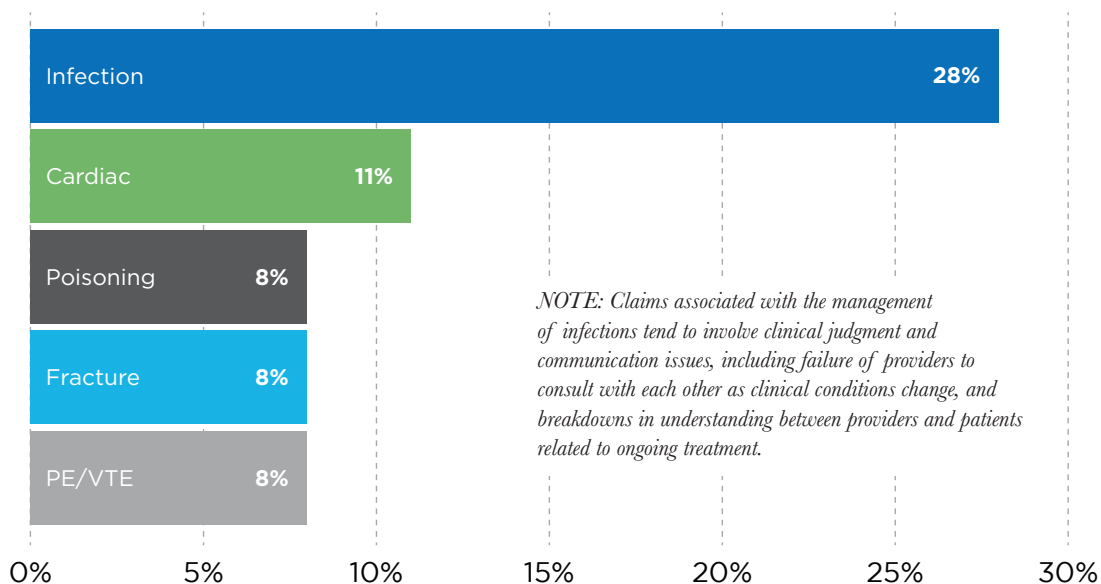
Management of treatment regimens for infections drives more than a quarter of the claims associated with improper management of treatment (see Figure 17).

**Figure 16.**  
Treatment-Related Claims  
by Allegation Subcategory,  
2003–2012



*NOTE: Procedures involved in the improper performance of treatment/procedure category are varied and include incisions and irrigations.*

**Figure 17.**  
Improper Management of  
Treatment: Top Patient  
Conditions, 2003–2012



*NOTE: Claims associated with the management of infections tend to involve clinical judgment and communication issues, including failure of providers to consult with each other as clinical conditions change, and breakdowns in understanding between providers and patients related to ongoing treatment.*

PE/VTE = pulmonary embolism/venous thromboembolism

## Claim Analysis

### Improper Management of Treatment

A female patient in her mid-sixties who had a history of hypertension and noncompliance with recommended routine health screenings presented to her family medicine provider with complaints of weakness and tachycardia. New onset, rapid atrial fibrillation with rapid ventricular response was noted during an ECG.

The family medicine provider performed carotid massage, which reduced the patient's heart rate. He also started the patient on a beta-blocker, noted the need for a cardiology consult, and instructed the patient to return to the office for follow-up in 1 to 2 days. A follow-up call that afternoon to the patient revealed that she was feeling better.

The patient returned to the office the next day with a much improved heart rate, and she was started on an aspirin regimen. Chart notes reflect that the provider had yet to obtain a cardiology consult, and that he had tried to convince the patient to go to the emergency department the previous day, but she refused.

The patient subsequently presented to the emergency department a day after the second office visit, and she was diagnosed with a right middle cerebral artery stroke secondary to cardiac embolism. She sustained permanent injuries, including weakness, aphasia, and a seizure disorder, and she required PEG tube feedings, a wheelchair, and frequent admissions to hospitals and nursing facilities.

---

### Risk Management Issues for This Claim

- Issue with selection and management of an appropriate medication regimen
  - Failure to obtain a consult despite patient's acute symptoms
  - Failure to document informed refusal of treatment
-

## Medication-Related Claims

Although medication-related allegations represent only 15 percent of the family medicine claims opened between 2003 and 2012, more than half of these claims have a high clinical severity rating, as shown in Figure 3 on page 4. An in-depth analysis of this allegation category reveals some interesting perspectives.

Improper management of medications represents more than two-thirds of the medication-related allegations (see Figure 18). This allegation subcategory includes issues related to monitoring the effects of medications on patients, assessing the potential for medications to exacerbate the symptoms of other diseases, and assessing contraindicated use of medications during procedures.

**Figure 18.**  
Medication-Related Claims  
by Allegation Subcategory,  
2003-2012

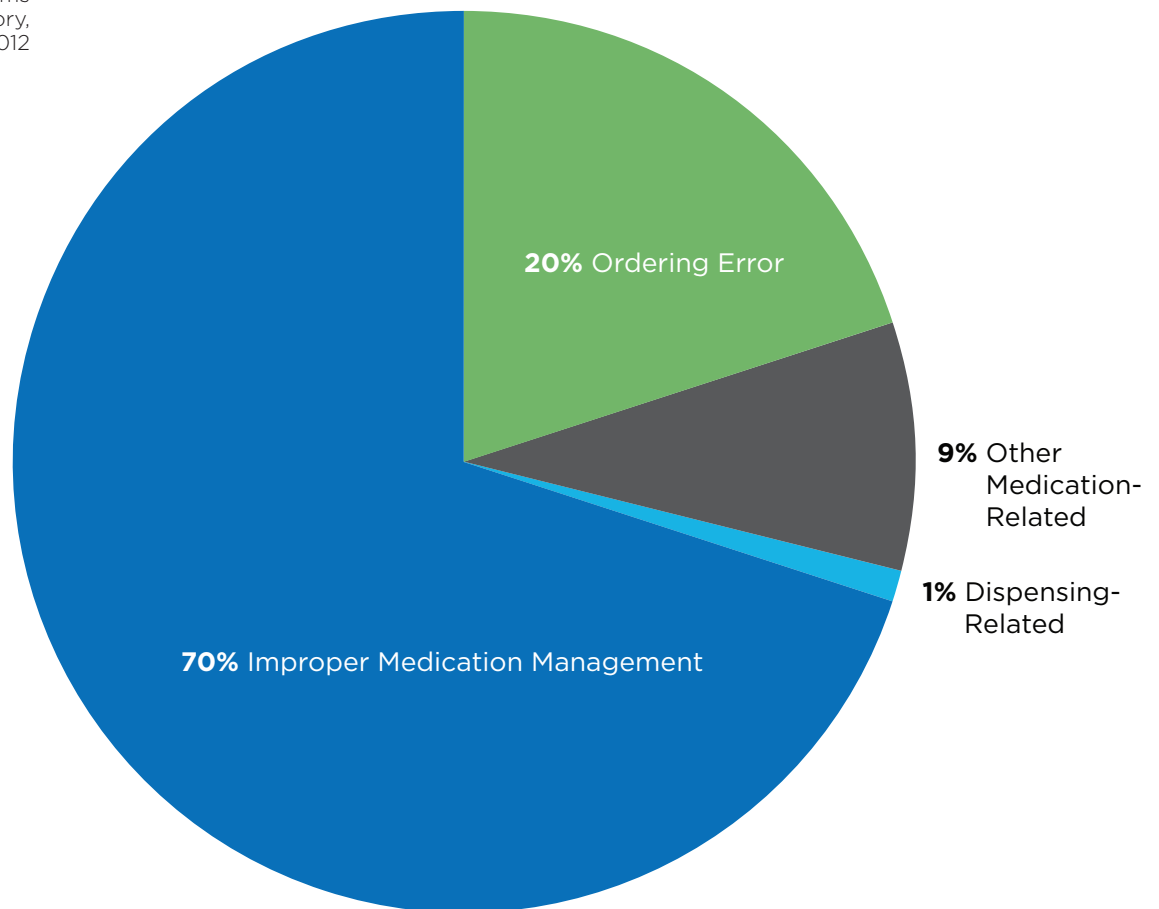
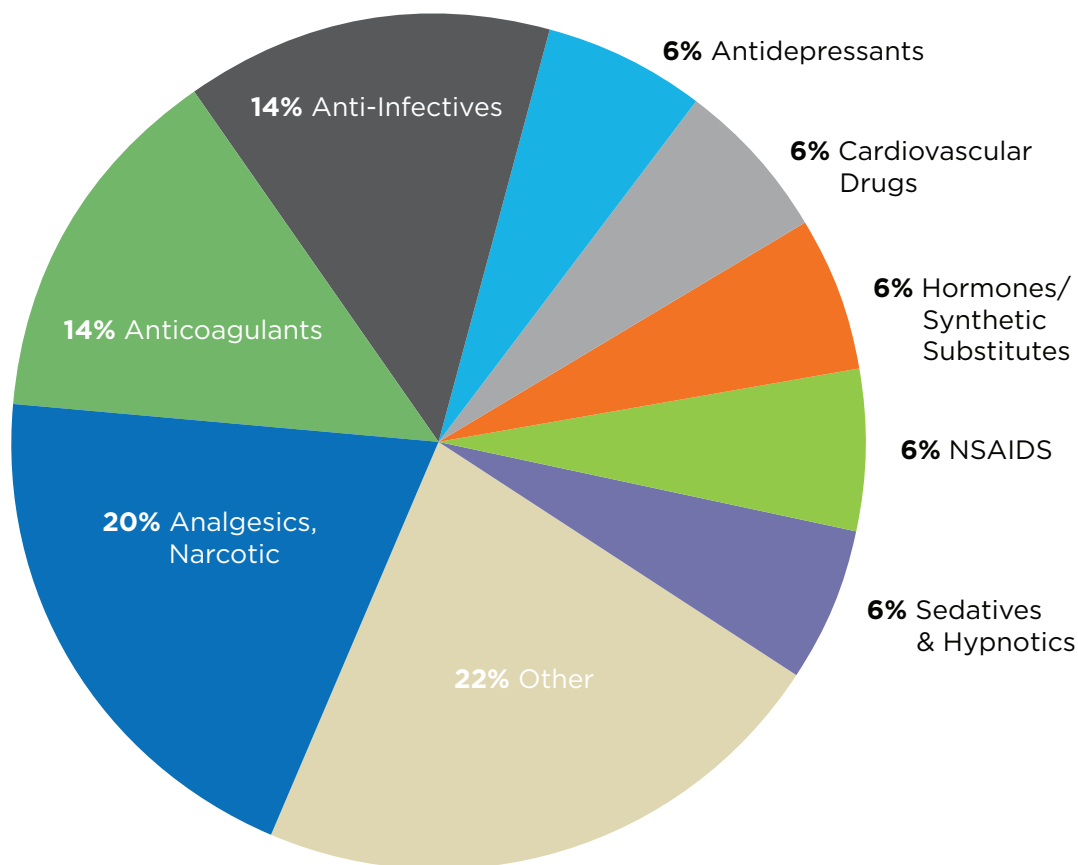


Figure 19 shows the types of medications implicated in family medicine claims. Although claims involving anticoagulants account for only 14 percent of the medication-related allegations, they are the most costly claims, dominating the total incurred dollars with 40 percent of the total.

**Figure 19.**  
Medication-Related  
Claims by Medication  
Type, 2003-2012



NSAIDS = Nonsteroidal anti-inflammatory drugs

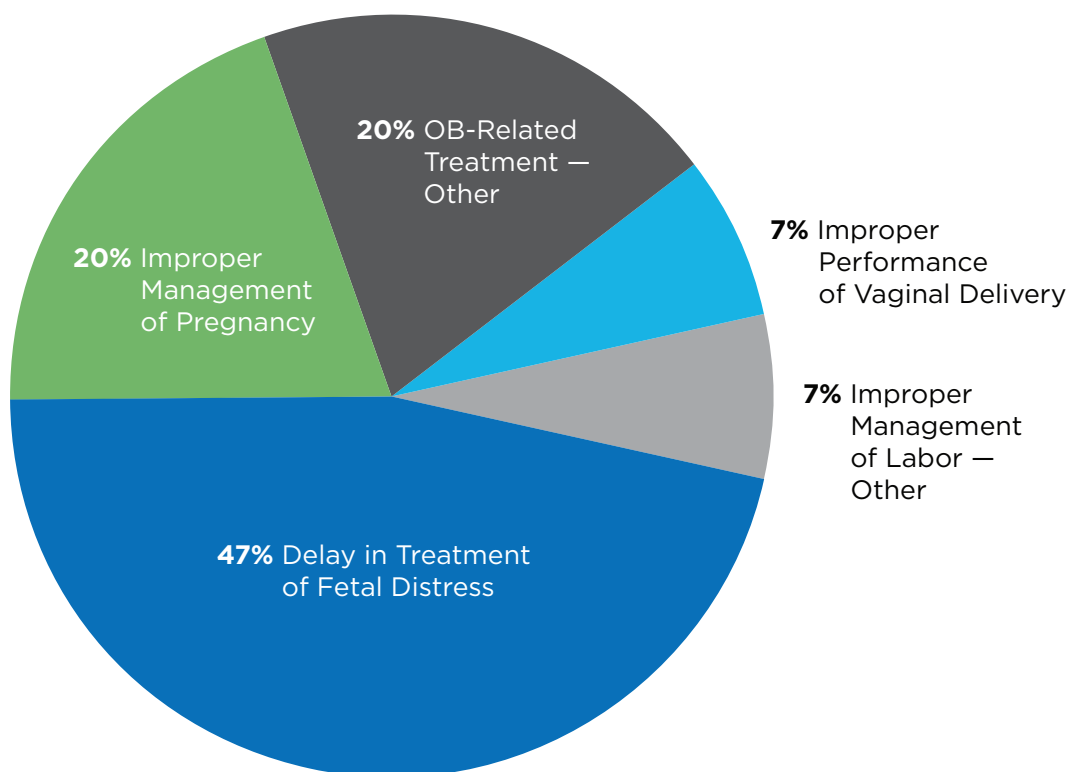
Risk factors associated with medication-related claims mainly include inadequate patient education about medication risks and lack of follow-up instructions. Inadequate assessment of changing clinical scenarios was also noted as a recurring theme.

## Obstetrics-Related Claims

As stated earlier in this report, OB-related allegations make up only 3 percent of all family medicine claims opened between 2003 and 2012. However, because of the nature of these allegations, claims involving OB tend to represent high risk, both clinically and financially. Figure 3 on page 4 shows that almost 90 percent of OB-related claims involve an outcome of permanent injury or death.

The highest concentration of OB-related allegations involves delay in treatment of fetal distress, as shown in Figure 20.

**Figure 20.**  
OB-Related Claims by  
Allegation Subcategory,  
2003-2012



*NOTE: Any totals not equal to 100 percent are the result of rounding.*

Not surprisingly, clinical judgment is a top contributing factor in all of these fetal distress claims, and communication issues among providers are a very close second.

Administrative issues, including lack of adherence to chain-of-command protocols and procedures for notifying a consulting provider of potential fetal distress, were noted. Interestingly, issues with labor/delivery occurring during nights or on weekends or holidays also were noted in more than a few cases.

## Claim Analysis

### Delay in Treatment of Fetal Distress

A low-risk pregnant patient had been receiving prenatal care from a family medicine provider who devoted a significant amount of her practice to obstetrics. Due to a breech position, induction of labor with a planned C-section was initiated at 37 weeks. Upon admission, the breech position had resolved. The family medicine provider proceeded with induction, with a goal of vaginal delivery.

Variable decelerations and variations in fetal heart rate were noted during labor. Nursing staff called for the family medicine provider after the membranes ruptured, thick meconium was noted, and the fetal heart rate declined, with slow recovery.

Upon the provider's arrival, the mother was noted to have tachycardia, and her oxygen saturations had decreased to 80 percent. Pitocin was started, and the patient was instructed to push. Upon pushing, the mother became unresponsive, the fetal heart rate dropped and never recovered, and a "crash" C-section was ordered.

It was determined that the mother suffered an amniotic fluid embolism, which caused collapse of the cardiovascular system. She suffered permanent injury in the form of a seizure disorder, and the baby experienced a severe hypoxic ischemic brain injury.

---

### Risk Management Issues for This Claim

- Improper selection of appropriate delivery method based on the changing clinical scenario
  - Issues with patient monitoring for both the mother and baby
  - Delay in obtaining a consult prior to initiation of the delivery process
-



## Key Points

---

- Diagnosis-related allegations represent the largest claim category for family medicine providers (56 percent of all claims). The events that trigger these claims tend to occur in outpatient settings, such as physician offices and clinics.
- Cancer diagnoses, specifically lung cancer and colorectal cancer, drive diagnosis-related claims for family medicine.
- Issues associated with clinical judgment, communication, and documentation top the list of risk factors that contribute to diagnosis-related claims involving cancer.
- Claims associated with high clinical severity dominate in all family medicine allegation categories, but are most prominent in diagnosis-related claims. Although OB-related allegations represent only 3 percent of the overall claim volume, almost 90 percent of these allegations fall into the high-severity category.
- Approximately two-thirds of treatment-related claims in family medicine involve improper management of a course of treatment or improper performance of a treatment/procedure. Management of treatment regimens for infections drives more than a quarter of the claims associated with improper management of treatment.
- Medication-related claims, although low in volume, tend to result in high-severity injuries. Issues identified in these claims include lack of patient education, assessment, and follow-up.
- Although OB-related claims represent only a small percentage of the family medicine claims opened between 2003 and 2012, these claims tend to be severe — both clinically and financially. In OB-related claims, the top allegation subcategory is delay in treatment of fetal distress.

## Family Medicine Risk Strategies

---

The following strategies may help family medicine providers improve patient safety and address the factors that contribute to liability risks:

- Obtain complete patient history and medical information prior to the patient exam, including cancer and cardiac history and risk factors.
- Implement evidence-based guidelines, including appropriate cancer screening tests and assessments.
- Arrange timely consults for medically complex and/or atypical clinical presentations.
- Implement comprehensive test-tracking and referral-tracking procedures, including patient follow-up and documentation. Routinely run reports to identify overlooked results and communication from referral sources.
- Develop and implement a consistent telephone triage system, utilizing only experienced registered nurses for assessment and triage to the practitioner.
- Communicate with patients and parents. Conduct appropriate informed consent, provide adequate patient/parent education, and encourage patients/parents to participate in their plans of care.
- Document patients' informed refusal of recommended treatment as part of overall patient education efforts.
- Reconcile medications for every patient at every visit, and provide documentation in each patient's medical record.
- Delegate medication administration to qualified staff, and assess and document staff competency on an annual basis.



This document should not be construed as establishing professional practice standards or providing legal advice. Compliance with any of the recommendations contained herein in no way guarantees the fulfillment of your obligations as may be required by any local,

state, or federal laws, regulations, or other requirements. Readers are advised to consult a qualified attorney or other professional regarding the information and issues discussed herein, and for advice pertaining to a specific situation.



5814 Reed Road  
Fort Wayne, IN 46835-3568

[www.medpro.com](http://www.medpro.com)

800-463-3776 | 800-334-0588 (NJ and NY)

---

MedPro Group is a member of the Berkshire Hathaway group of businesses. MedPro Group includes The Medical Protective Company, Princeton Insurance Company, and MedPro RRG; its insurance products are underwritten and provided by these and other Berkshire Hathaway affiliates. Product availability varies based upon business and regulatory approval and differs between companies.

©2014 MedPro Group.® All Rights Reserved.