

Gynecology

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 Gynecology 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.

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		

Specialty trends – Obstetrics-Gynecology

Obstetrics-Gynecology has a higher financial severity per case and a higher claim frequency compared to all specialties.

Average Severity - Obstetrics & Gynecology Relative to All Specialties



Source: MedPro Group Physician & Surgeon Claim Experience & Analysis

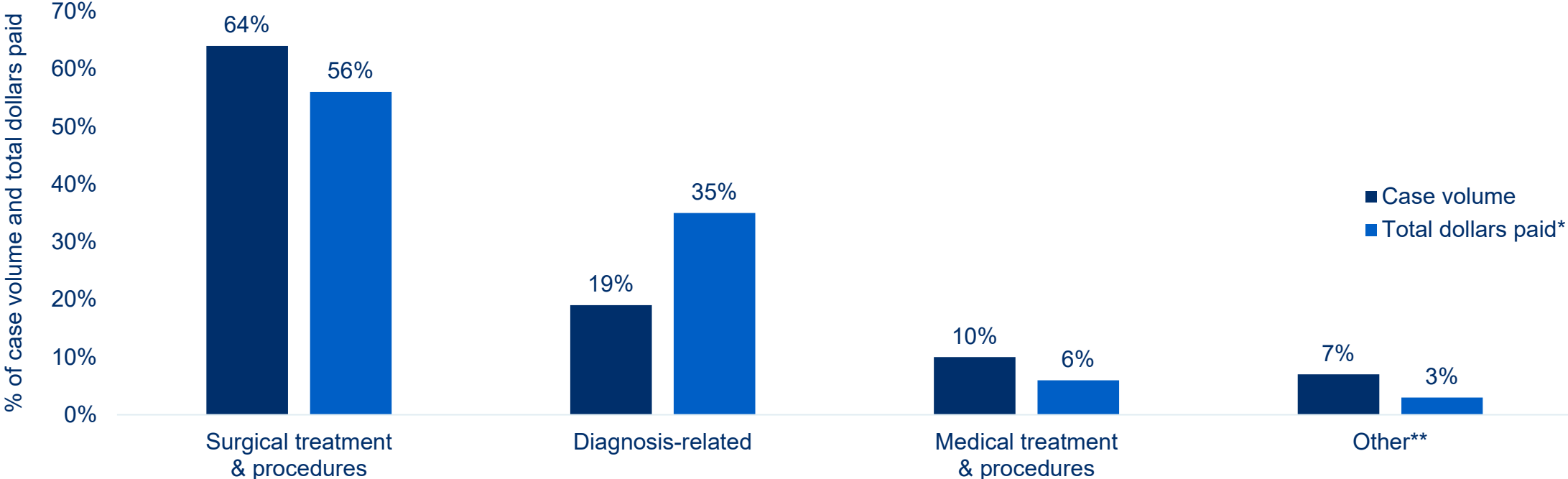
Key Points - Clinically Coded Data

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

- The previous two specialty slides reference combined Obstetrics-Gynecology frequency and severity profiles. However, **the clinically coded data section of this analysis – in all subsequent pages – is reflective only of cases involving Gynecology as the responsible service.**
- **Surgical allegations account for two-thirds of Gynecology case volume and more than half of total dollars paid*.** Performance-related allegations account for 58% of those, with the majority involving hysterectomies. **Cases involving the management of surgical patients, including pre-, intra-, and post-operatively,** are often related to the surgeon'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.
- **Diagnosis-related allegations** account for 19% of Gynecology case volume (and 35% of total dollars paid). These most commonly reflect missed/delayed diagnoses of cancers, post-operative complications and infections. **These cases commonly reflect breaks in the diagnostic process of care,** most often in the initial diagnostic assessment phase - including inadequate assessment and evaluation of patient symptoms, a narrow diagnostic focus, and delays or failures in ordering diagnostic testing, and also breaks in the patient follow-up phase.
- Medical allegations account for 10% of Gynecology case volume. **IUD insertion/removal, hysteroscopies and tubal ligations** account for the majority of the medical procedure-related case volume.
- **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, including the selection of the most appropriate procedure for the patient's condition and those related to diagnostic decision-making, technical skill factors including recognition/management of known complications and poor procedural technique, and suboptimal communication, are key drivers of both clinical and financial Gynecology 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.



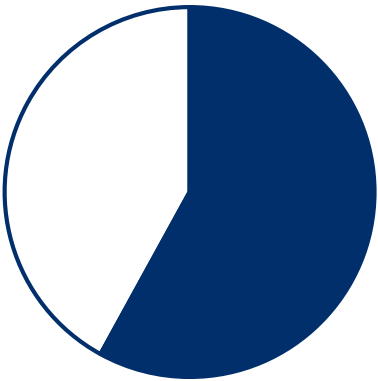
MedPro Group + MLMIC cases opened 2012-2021, Gynecology as responsible service (N=894); *Total dollars paid = expense + indemnity; **Other includes allegations for which no significant case volume exists

Clinical Severity*

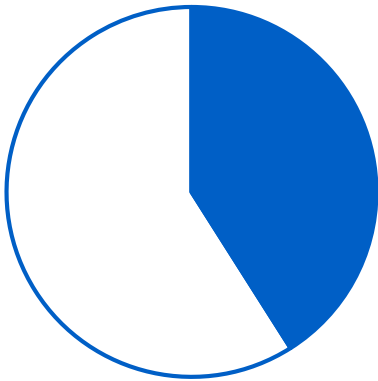
Clinical Severity Categories	Sub-categories	% of case volume	<p>Typically, the higher the clinical severity, the higher the indemnity payments are, and the more frequently payment occurs.</p>
LOW	Emotional Injury Only	7%	
	Temporary Insignificant Injury		
MEDIUM	Temporary Minor Injury	58%	
	Temporary Major Injury		
	Permanent Minor Injury		
HIGH	Significant Permanent Injury	35%	
	Major Permanent Injury		
	Grave Injury		
	Death		

MedPro Group + MLMIC cases opened 2012-2021, Gynecology as responsible service (N=894); *Severity codes reflect National Association of Insurance Commissioners (NAIC) injury severity scale

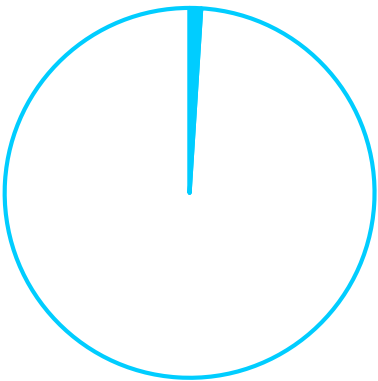
Claimant Type & Location



Ambulatory
58%



Inpatient
41%



Emergency
1%

Top Locations	% of case volume
Inpatient surgery	38%
Office/clinic	35%
Ambulatory surgery	17%
Patient room	6%

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.

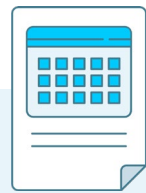
Multiple factors are identified in each case because generally, there is not just one issue that leads to these cases, but rather a combination of issues.



Administrative



Behavior-related



Clinical environment



Clinical judgment



Clinical systems



Communication



Documentation



Supervision



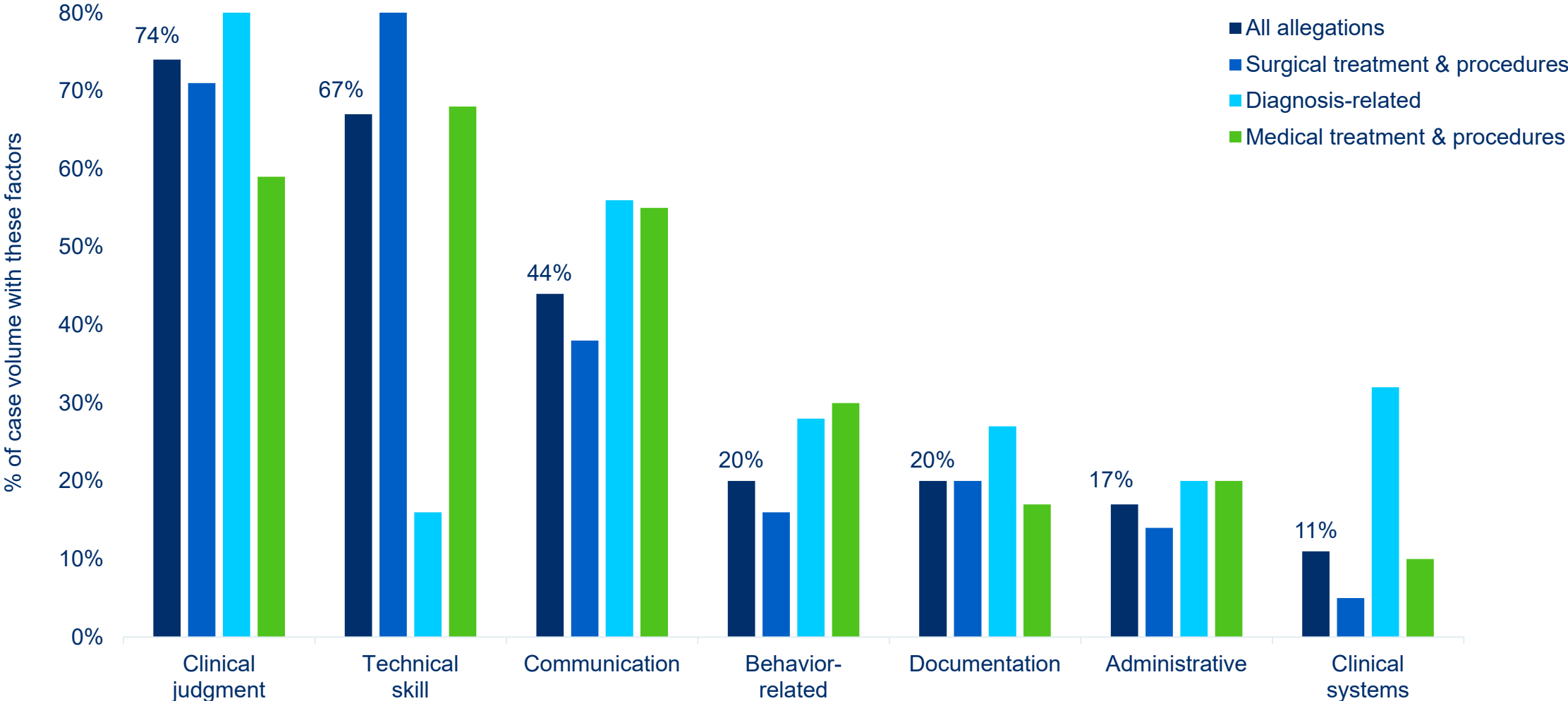
Technical skill

Contributing Factor Category Definitions

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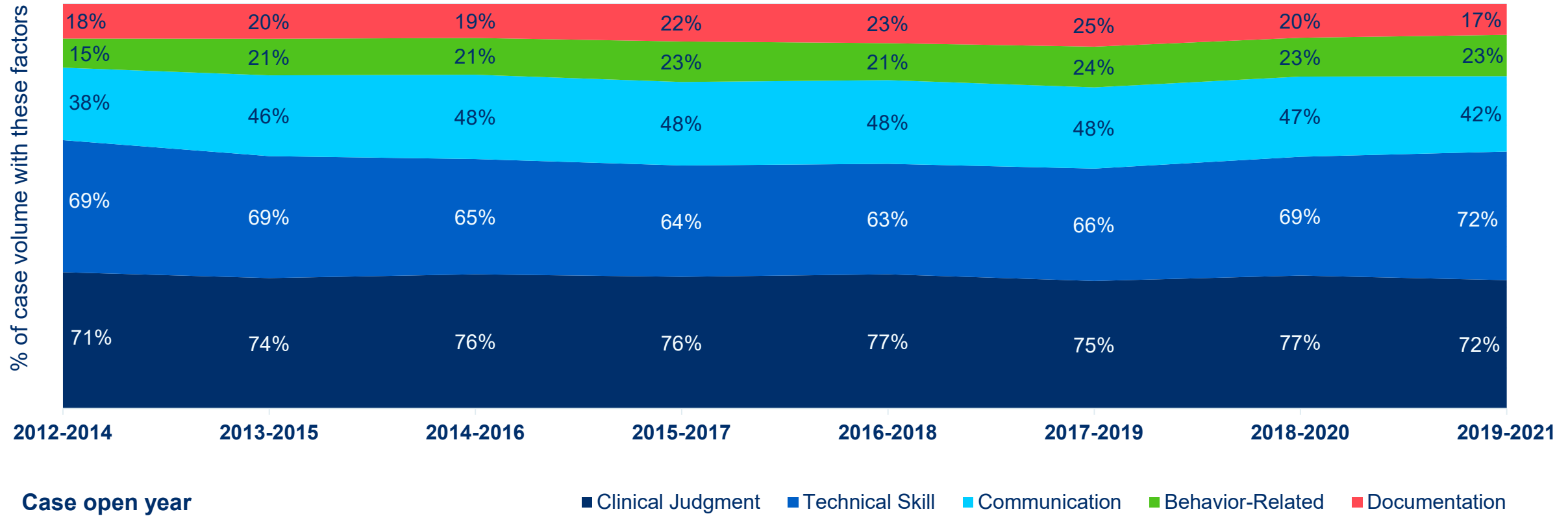
Administrative	Factors related to medical records (other than documentation), reporting, staff, ethics, policy/protocols, regulatory
Behavior-related	Factors related to patient nonadherence to treatment or behavior that offsets care; also provider behavior including breach of confidentiality or sexual 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, Gynecology as responsible service (N=894); 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.

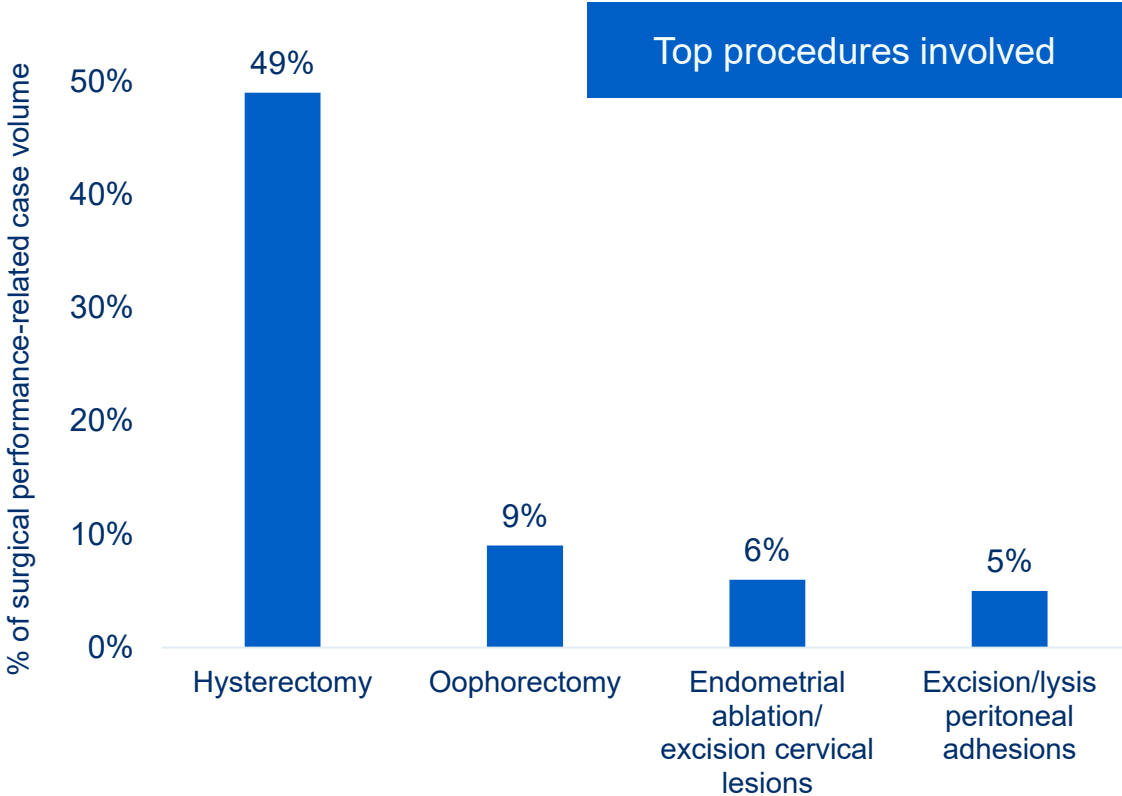
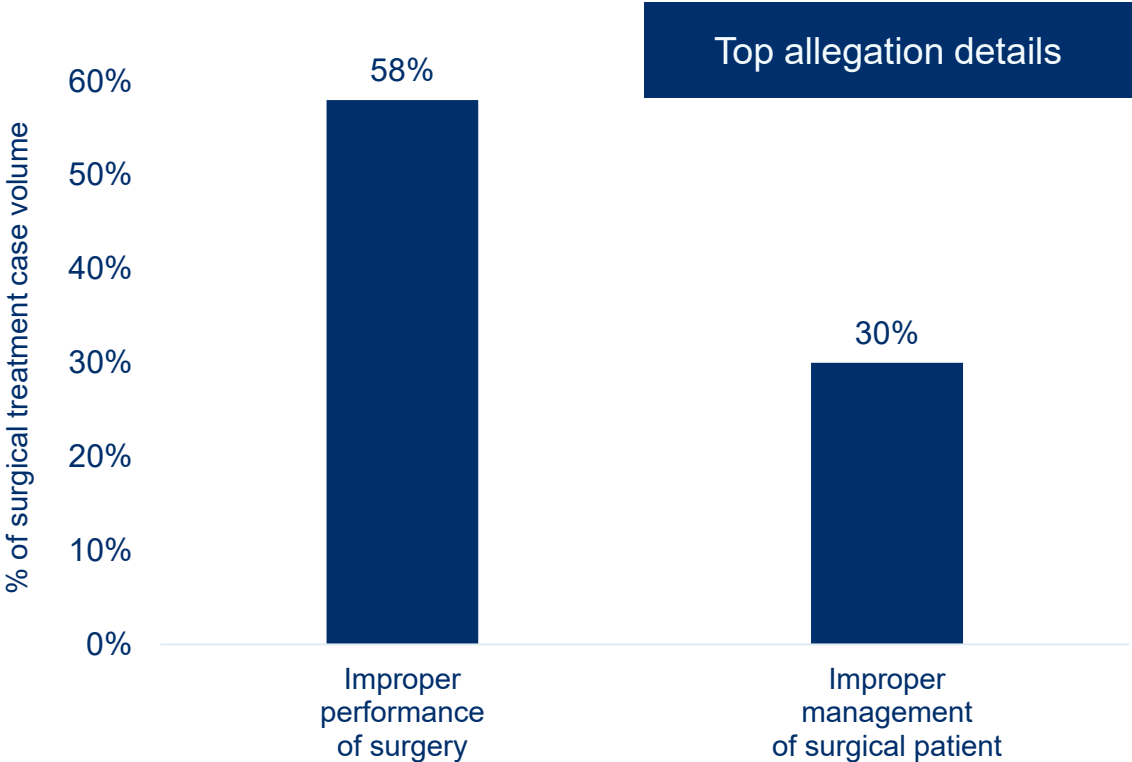
Focus on Most Common Drivers of Clinical and Financial Severity

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Factors associated with high clinical severity outcomes	(CJ) selection/management of most appropriate surgical procedure (46%)	% of high severity case volume
	(CJ) failure to appreciate/reconcile signs/symptoms/test results (39%)	
	(TS) recognition/management of known complications (32%)	
	(CJ) failure/delay in ordering diagnostic test (23%)	
	(CJ) failure to establish differential diagnosis (21%)	
Factors associated with the costliest indemnity payments	(CJ) inadequate patient monitoring (31%)	% more expensive than the average indemnity payment*
	(CJ) failure/delay in obtaining consult/referral (24%)	
	(CJ) failure to establish differential diagnosis (19%)	
	(CO) suboptimal communication between provider and patient/family (15%)	
	(CJ) misinterpretation of diagnostic studies (14%)	

Clinical judgment factors, including the selection of the most appropriate procedure for the patient's condition and those related to diagnostic decision-making, technical skill factors including recognition/management of known complications and poor procedural technique, and suboptimal communication, are key drivers of both clinical and financial Gynecology case severity.

Focus on Surgical Treatment Allegations

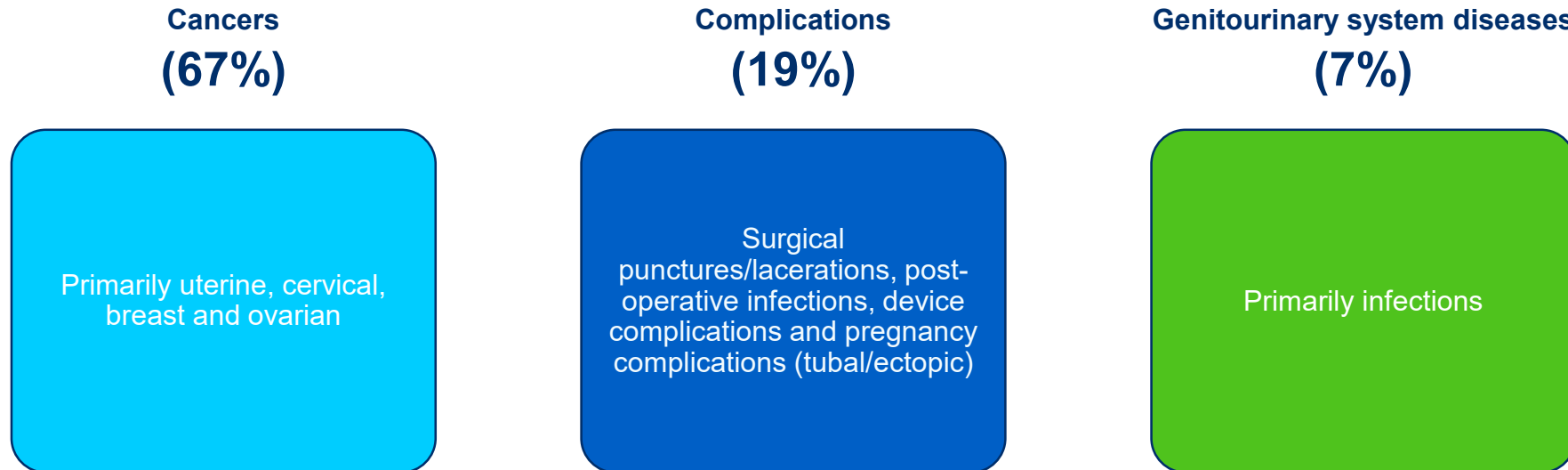


Cases involving the management of surgical patients, including pre-, intra-, and post-operatively, are often related to the surgeon's response to developing complications. While complications of procedures may have been the result of procedural error, the failure to timely recognize and/or monitor/manage the issue prevents the opportunity for early mitigation of the risk of serious adverse outcome.

Focus on Diagnosis-Related Allegations

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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

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 31% of cases	Performance of diagnostic tests
	Interpretation of diagnostic test results
	Test results transmitted to/received by ordering provider

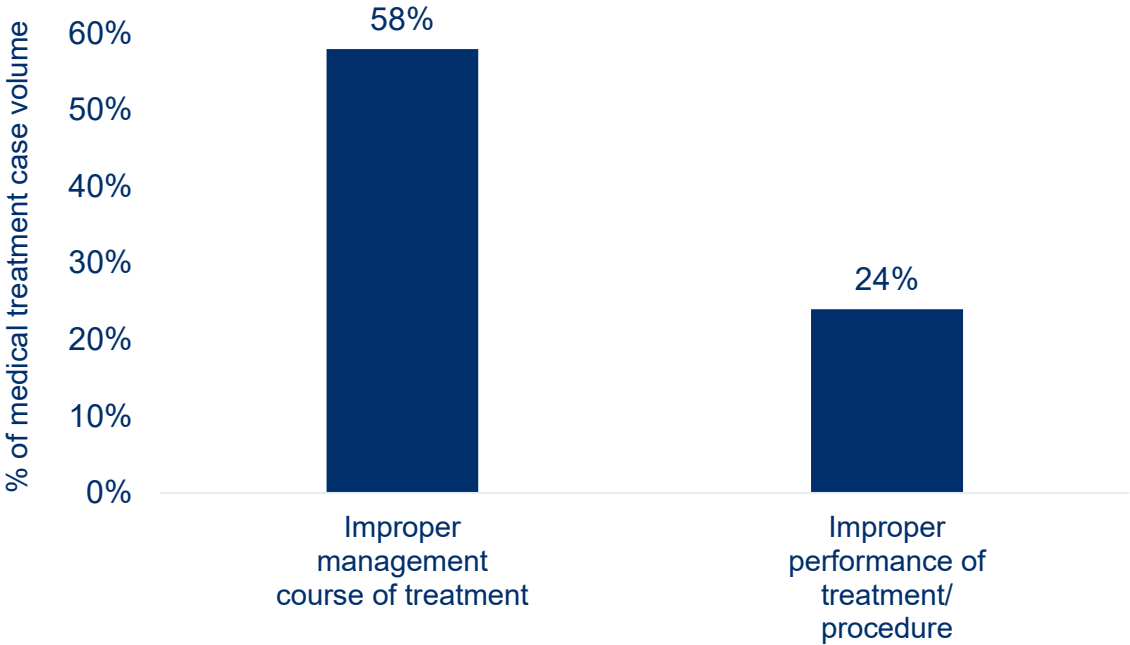
Phase 3

Follow-up and coordination 67% of cases	Physician follows-up with patient
	Referrals/Consults
	Patient information communicated among care team
	Patient compliance with follow-up plan

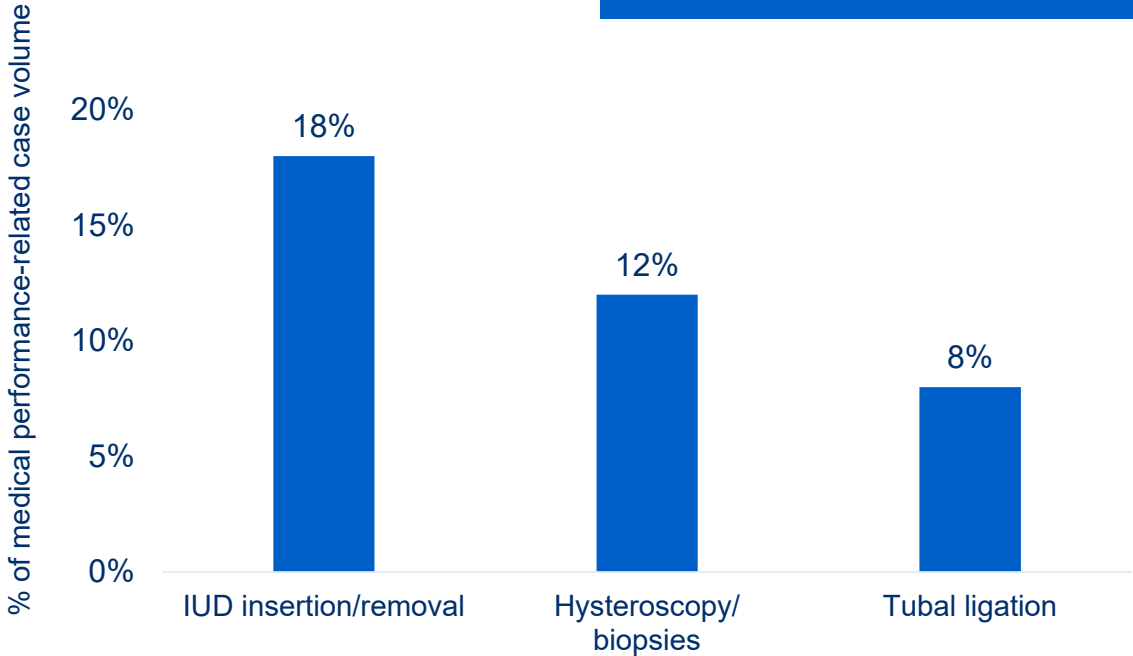
MedPro Group + MLMIC cases opened 2012-2021, Gynecology as responsible service (N=894); *each step reflects a combination of contributing factors; diagnostic process of care algorithm courtesy of Candello, a division of CRICO Strategies

Focus on Medical Treatment Allegations

Top allegation details



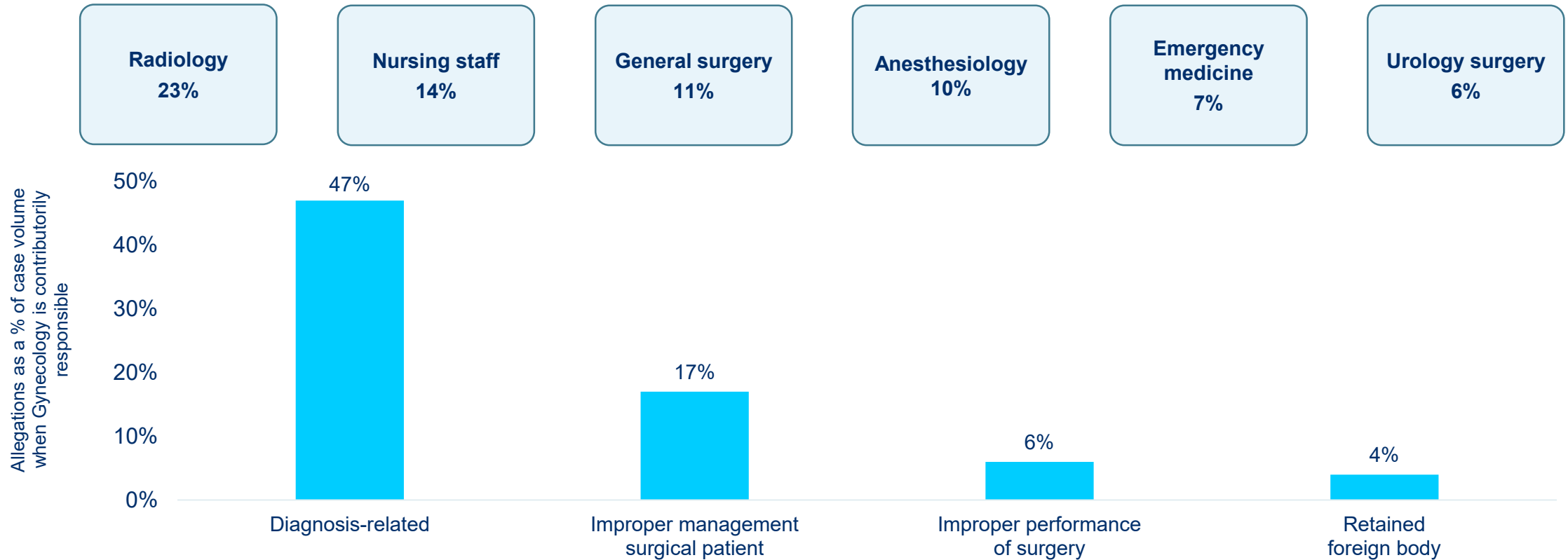
Top procedures involved



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.

Contributorily Responsible

Although this analysis is focused on cases reflecting Gynecology as the primarily responsible service, another 178 cases identify Gynecology 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 Gynecologists.

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

\$1.25M

CONTRIBUTING FACTORS

Clinical judgment

Selection/management of the most appropriate therapy

Failure to appreciate/reconcile signs/symptoms/test results

Failure to rescue

Clinical systems

Failure/delay in reporting critical test results

Technical skill

Occurrence/management of known complication

IMPROPER PERFORMANCE OF SURGERY RESULTING IN PERFORATION OF MESENTERIC ARTERY WITH TROCAR RESULTING IN DEATH

A female in her early 40s was admitted to the hospital for a robotic assisted laparoscopic hysterectomy due to abnormal bleeding and pain. Surgery began at 9am and **the Gynecologist (GYN) noted that when the port was inserted into the peritoneal cavity, there was an apparent laceration in the mesentery resulting in bleeding and hematoma formation.** The hematoma tamponaded itself off, but the GYN applied pressure and called for a General Surgeon. The General Surgeon scrubbed in, noted no active bleeding, and that the hematoma was smaller. **He recommended that the GYN proceed with the hysterectomy, but GYN elected not to continue, noting 150-200cc of blood loss.**

The patient was taken to the post-anesthesia care unit (PACU). Pre-operative hemoglobin was in the normal range at 13.6; **the first post-operative hemoglobin was 0.8 (a delayed response to this critical result was noted).** GYN ordered type and cross match for blood, but **patient requested no transfusions.** GYN spoke with the patient's husband, who gave permission for transfusion and was advised to come to the hospital. At 11:23am, a code was called on the patient as her blood pressure dropped. An Intensivist was called and the General Surgeon was called to return to the hospital. The patient received the transfusion and ultimately received 42 bags of blood, 18-fresh frozen plasma, 18 thawed plasma, 9 platelets, and 4 cryoprecipitates.

At 12:30pm, the patient was returned to the operating room when General Surgeon arrived. The GYN assisted. 500ml blood noted in abdomen and active bleeding was noted at base of mesentery. **The patient developed disseminated intravascular coagulation.** She was returned to PACU where she coded at 2:53pm and died.

Case Examples

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SETTLED

\$500,000

CONTRIBUTING FACTORS

Clinical judgment

Failure to appreciate/reconcile relevant signs/symptoms/test results

Narrow diagnosis focus – failure to establish differential diagnosis

Clinical system

Lack of system for patient care – follow up appointments

CASE IS ABOUT DELAY IN DIAGNOSIS AND TREATMENT OF ENDOMETRIAL CANCER RESULTING IN DISEASE PROGRESSION

The female patient in her mid-50s, with a history significant for breast cancer, treated with lumpectomy, chemotherapy, radiation, and anti-estrogen medication, was referred to a Gynecologist (GYN) for post-menopausal bleeding. An ultrasound (U/S) was done on 1/24, revealing a mild atrophic uterus with normal thickness of the endometrial stripe. The patient then presented to GYN for an exam. She **had never had a gynecological exam, and was anxious and crying so the exam was deferred**, although the need for an endometrial biopsy was discussed. The patient returned on 2/18 for an exam and PAP smear. The GYN recommended the patient undergo a D&C and hysteroscopy; procedures were done on 3/5. GYN noted atrophic changes which she opined was the cause of the intermittent bleeding. Plan was for the patient to call the office if recurrent bleeding was noted. **The patient called the office 5 months later and reported continued bleeding.**

U/S was done on 9/5; it revealed a normal sized uterus, but limited visualization of the endometrial stripe which measured 3mm. Patient was seen again by GYN two weeks later who continued to opine that the bleeding was related to atrophic changes. She also conferred with treating oncologists who advised that the anti-estrogen medication did not cause vaginal bleeding. **The patient then reported left lower quadrant abdominal pain**, so GYN referred her to her primary care provider. **The patient had follow-up appointments scheduled with GYN in January and April, both of which were canceled by the office.**

In April, the patient presented to a Gastroenterologist for continued abdominal pain. A CT scan of the abdomen and pelvis **revealed fluid in the endometrial cavity with nodular components not seen on prior U/S**. Differential diagnoses included endometrial malignancy or fluid containing blood products. **A left adnexal cyst measuring 1.8cm was also noted.** GYN reviewed the CT findings and **focused on the cystic structure as opposed to the endometrial findings**. The patient was instructed to follow-up with GYN in 6 to 8 weeks. A follow-up U/S was done in July in advance of the GYN appointment, and **revealed thickening and heterogeneity of the endometrial stripe concerning for possible mass lesion**. GYN took the patient to surgery for a D&C and hysteroscopy which revealed high – grade endometrial adenocarcinoma. The patient was referred to a gynecological oncologist who assumed care.

Later, the GYN expressed regret that the **two patient appointments were canceled by her office, and that she had a narrow focus when reviewing the CT findings** in April. She stated that she would have done a D&C and hysterectomy at that time.

Risk Mitigation Strategies

- **Ongoing evaluation of procedural skills and competency with equipment is critically important.**
- **Conduct a thorough assessment of the patient pre-operatively.**
 - Ensure that all testing and specialty evaluations are available for review prior to induction; in an ambulatory setting, these details might not always be as readily available as in the inpatient setting.
 - Maintain a consistent post-procedure assessment process.
- **Communicate with each other.**
 - Actively collaborate with other members of the patient's surgical care team – including all operating and recovery room staff. Coordinate the steps of the patient's care, including post-operatively.
 - Talk also to the patient/family, elicit a comprehensive patient history and conduct a thorough informed consent with the patient.
 - Focus on 'closing the loop' with regards to receiving, reporting and acting on test results.
- **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.**
 - The operative record is critically important for detailing the pre-operative patient assessment, intra-operative steps, and post-operative sequence of events. Discrepancies or gaps in the details/timing make it much more difficult to build a supportive framework for defense against potential malpractice cases.

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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