

Hematology & Medical Oncology

Claims Data Snapshot

2023



Introduction

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

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 Hematology & Medical Oncology 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				

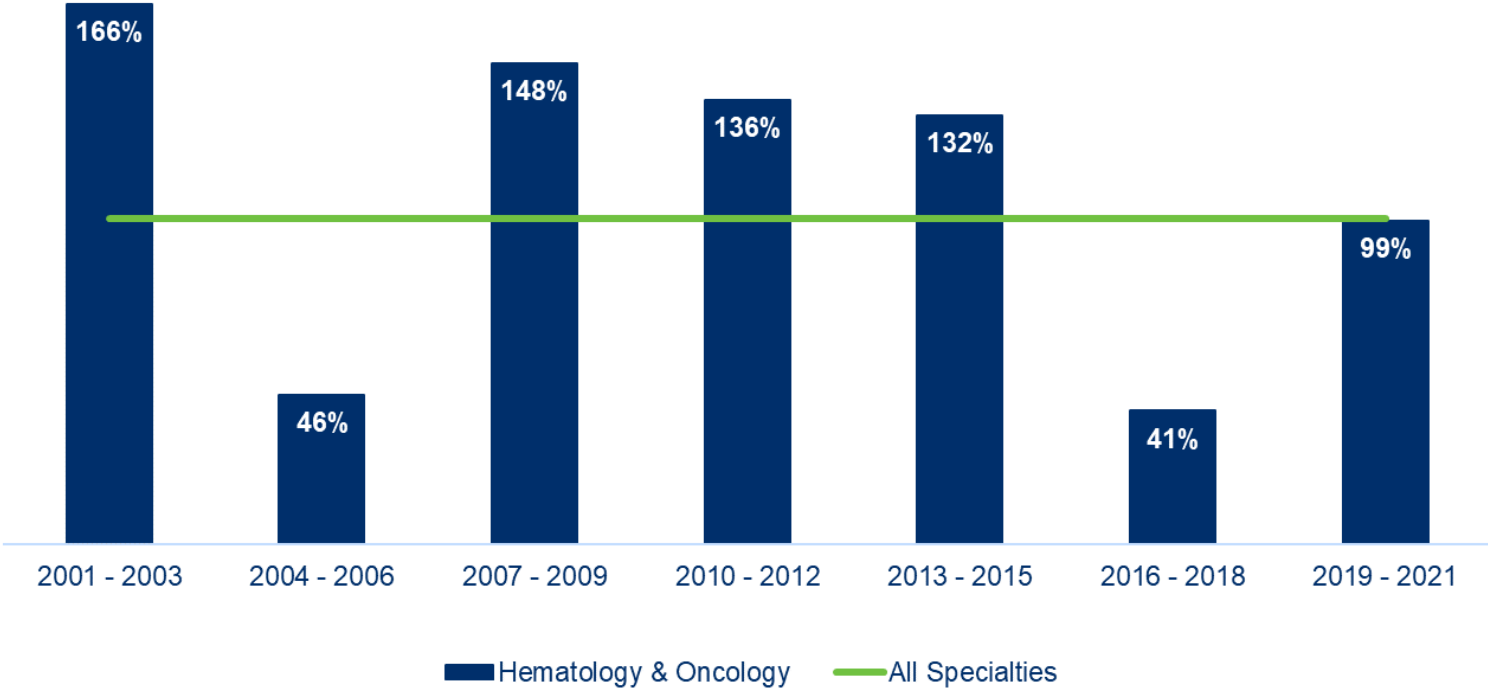
Source: MedPro Group Physician & Surgeon Claim Experience & Analysis

Specialty trends – Hematology & Medical Oncology

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

Hematology & Medical Oncology has a higher financial severity per case and a lower claim frequency compared to all specialties.

Average Severity - Hematology & Oncology Relative to All Specialties



Source: MedPro Group Physician & Surgeon Claim Experience & Analysis

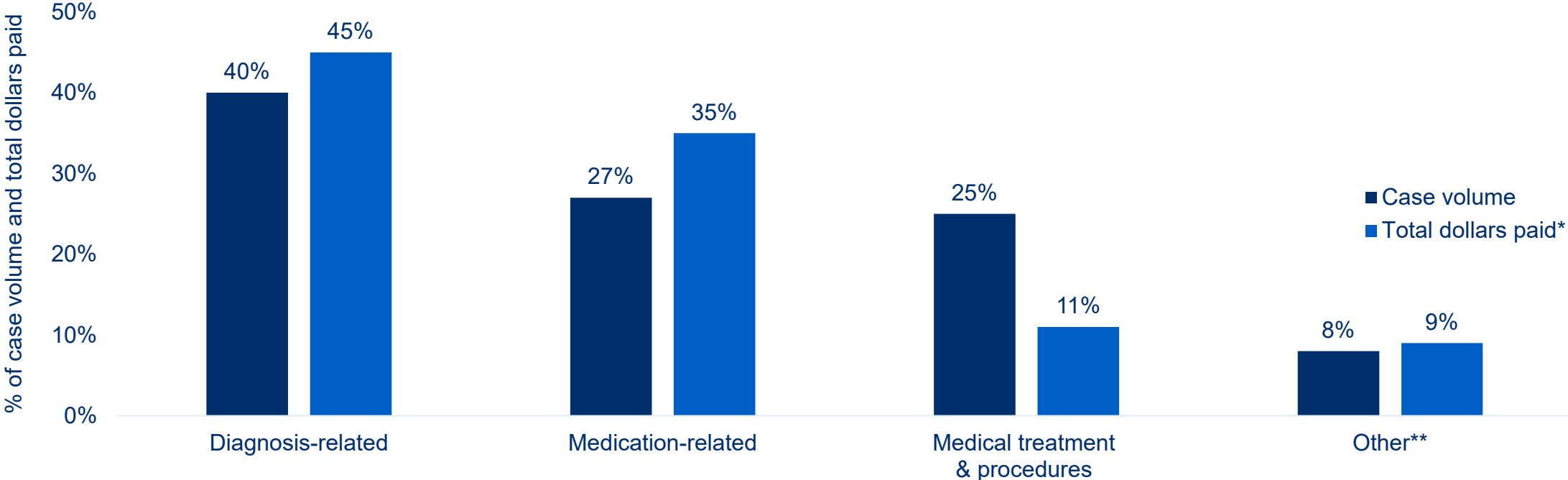
Key Points - Clinically Coded Data

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

- **Diagnosis-related allegations** account for more than one-third (40%) of Hematology & Medical Oncology case volume and 45% of total dollars paid.* These most commonly note missed/delayed diagnoses of cancers. **These cases reflect breaks in the diagnostic process of care**, often during the initial phase of diagnostic assessment, including evaluation of patient symptoms, establishing differential diagnoses and ordering of diagnostic testing. Follow-up, treatment coordination and referrals/consults are also noted risk issues within the process of care.
- **Monitoring and managing patients' medication regimens account for more than half (61%) of all medication-related allegations.** Selection of the most appropriate medication for the patient's condition is one of the most frequently noted risk issues in medication cases. Issues reflecting patient non-adherence to medication regimens are noted, and are sometimes impacted by inadequate patient/family education of the importance of prescription adherence. Inadequate patient monitoring, and suboptimal communication about medication regimens across the patient's care team are also commonly noted risk issues
- **Medical treatment allegations, which account for 25% of case volume**, are primarily related to issues with selection of the most appropriate treatment regimen for the patient, and appreciating and reconciling symptoms and test results.
- **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 and communication factors, specifically inadequate patient assessment and monitoring processes, a narrow diagnostic focus, and team communication failures, are key drivers of both clinical and financial Hematology & Medical Oncology 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.



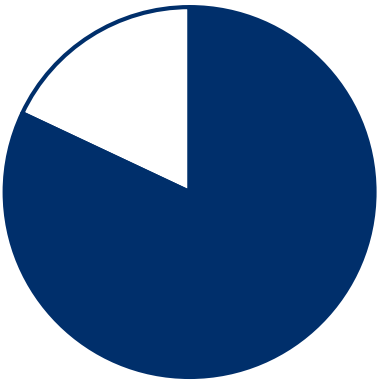
MedPro Group + MLMIC cases opened 2012-2021, Hematology & Medical Oncology as responsible service (N=151); *Total dollars paid = expense + indemnity; **Other includes allegations for which no significant case volume exists

Clinical Severity*

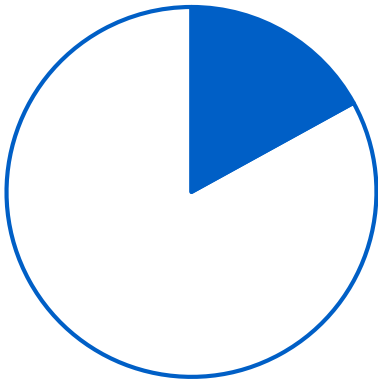
Clinical Severity Categories	Sub-categories	% of case volume	<p>Typically, the higher the clinical severity, the higher the indemnity payments are, and the more frequently payment occurs.</p>
LOW	Emotional Injury Only	4%	
	Temporary Insignificant Injury		
MEDIUM	Temporary Minor Injury	21%	
	Temporary Major Injury		
	Permanent Minor Injury		
HIGH	Significant Permanent Injury	75%	
	Major Permanent Injury		
	Grave Injury		
	Death		

MedPro Group + MLMIC cases opened 2012-2021, Hematology & Medical Oncology as responsible service (N=151); *Severity codes reflect National Association of Insurance Commissioners (NAIC) injury severity scale

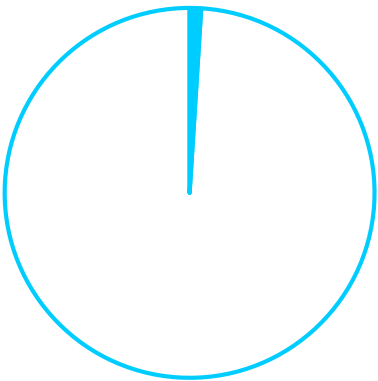
Claimant Type & Location



Ambulatory
82%



Inpatient
17%



Emergency
1%

Top Locations	% of case volume
Office/clinic	78%
Patient room/ICU	16%
Emergency department	1%

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.

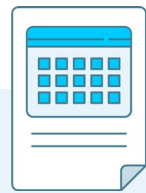
Multiple factors are identified in each case because generally, there is not just one issue that leads to these cases, but rather a combination of issues.



Administrative



Behavior-related



Clinical environment



Clinical judgment



Clinical systems



Communication



Documentation



Supervision



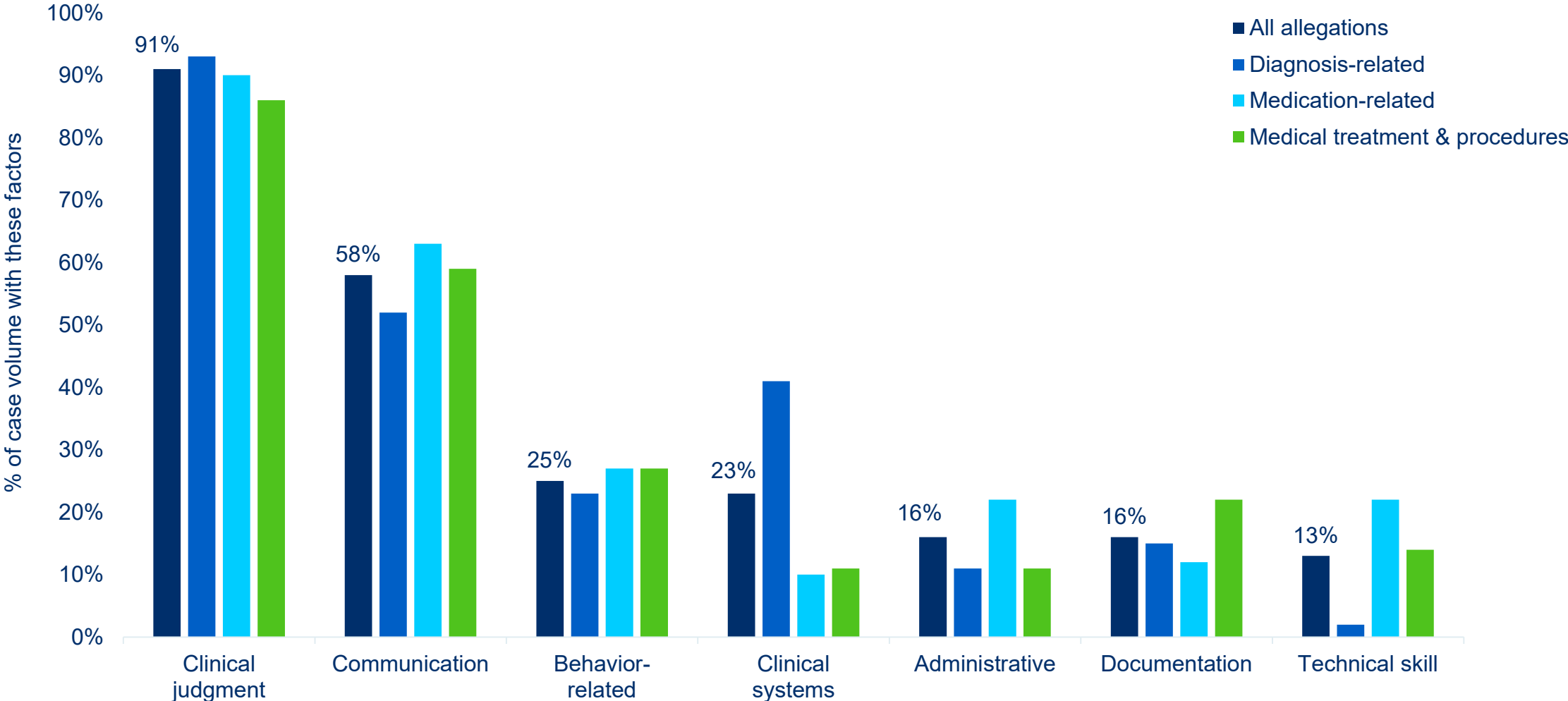
Technical skill

Contributing Factor Category Definitions

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

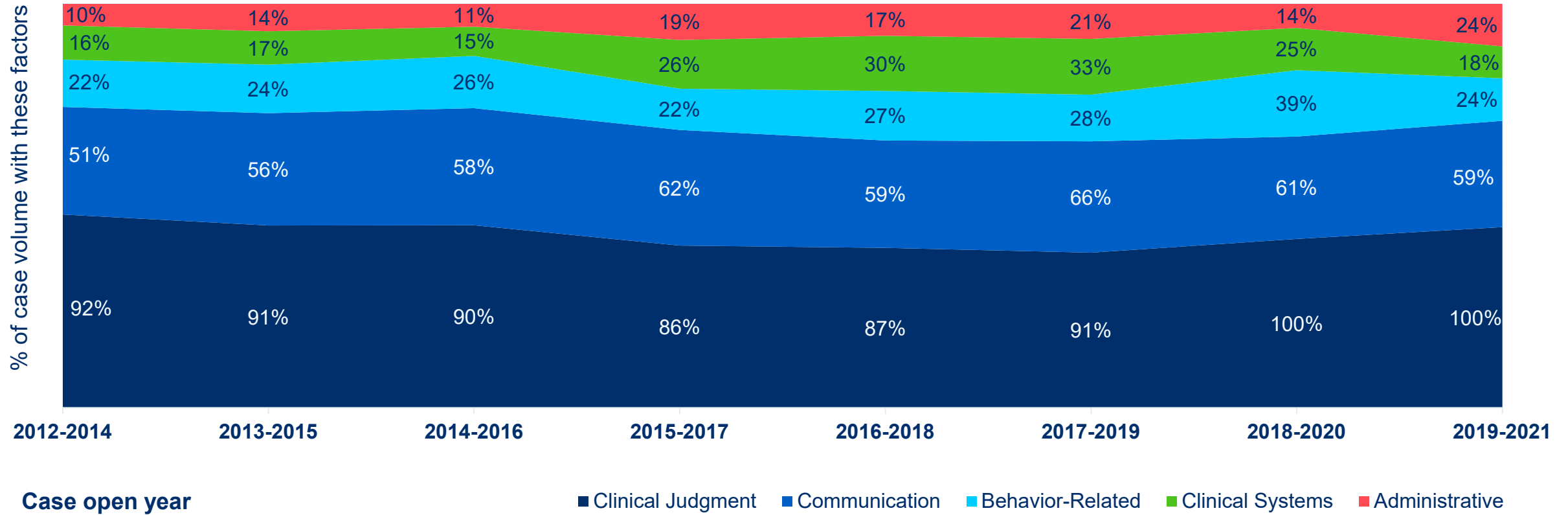
Administrative	Factors related to medical records (other than documentation), reporting, staff, ethics, policy/protocols, regulatory
Behavior-related	Factors related to patient nonadherence to treatment or behavior that offsets care; also provider behavior including breach of confidentiality or sexual 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, Hematology & Medical Oncology as responsible service (N=151); 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

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

Factors associated with high clinical severity outcomes	(CJ) failure to appreciate/reconcile signs/symptoms/test results (45%)	% of high severity case volume
	(CJ) failure/delay in ordering diagnostic test (30%)	
	(CO) suboptimal communication among providers about patient condition (27%)	
	(CJ) inadequate patient monitoring – medication regimen (18%)	
Factors associated with the costliest indemnity payments	(CJ) selection/management of most appropriate medication (18%)	% more expensive than the average indemnity payment*
	(CJ) inadequate patient monitoring – medication regimen (39%)	
	(CJ) failure/delay in obtaining consult/referral (34%)	
	(CO) inadequate education of patient/family – risks of medications (15%)	

Clinical judgment and communication factors, specifically inadequate patient assessment and monitoring processes, a narrow diagnostic focus, and team communication failures, are key drivers of both clinical and financial Hematology & Medical Oncology case severity.

Focus on Diagnosis-Related Allegations

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

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

**Cancers
(64%)**

Primarily lymphoma and leukemia, breast, lung

**Circulatory system
(10%)**

Strokes, thrombotic micro-angiopathy

**Injuries & treatment complications
(10%)**

Medication reactions/poisoning, infections

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 87% of cases	Patient notes problem & seeks care
	History & physical
	Patient assessed, symptoms evaluated
	Differential diagnosis established
	Diagnostic testing ordered

Phase 2

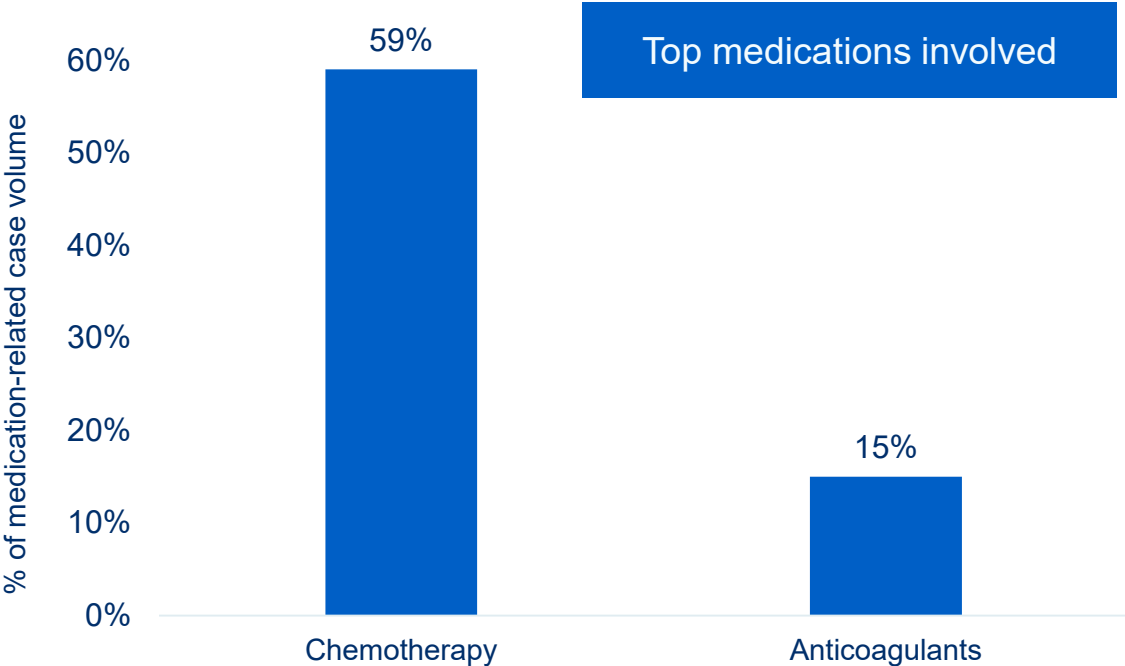
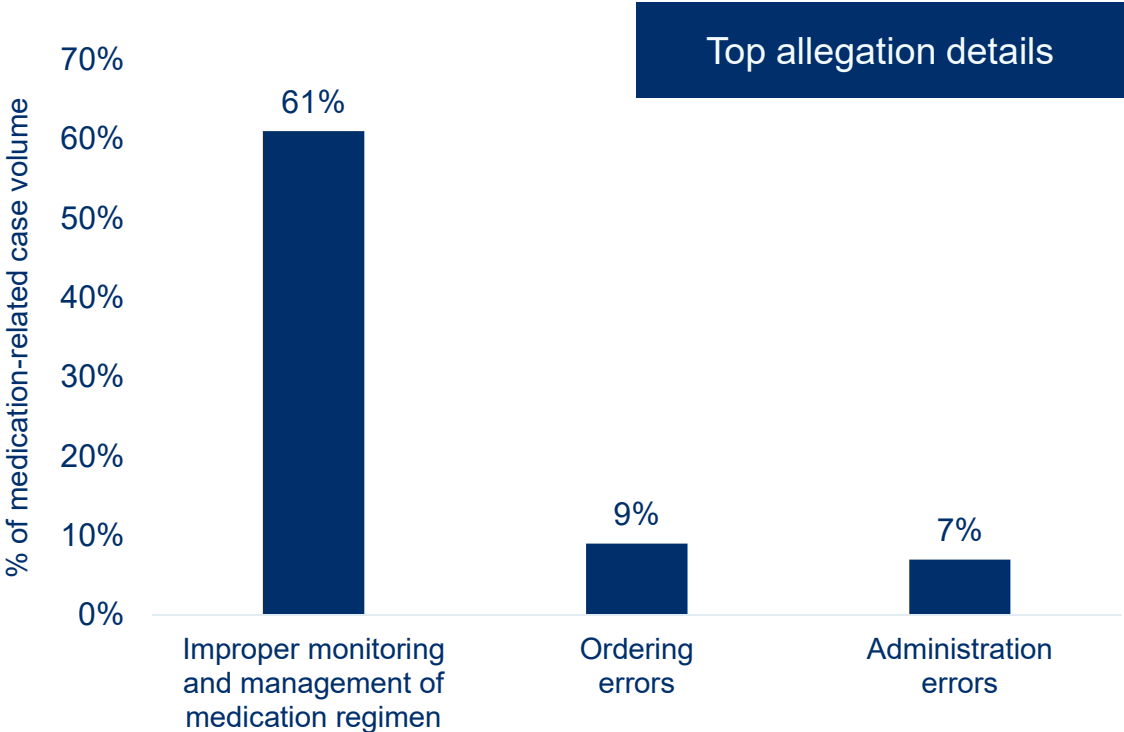
Testing and results processing 33% of cases	Performance of diagnostic tests
	Interpretation of diagnostic test results
	Test results transmitted to/received by ordering provider

Phase 3

Follow-up and coordination 61% 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, Hematology & Medical Oncology as responsible service (N=151); *each step reflects a combination of contributing factors; diagnostic process of care algorithm courtesy of Candello, a division of CRICO Strategies

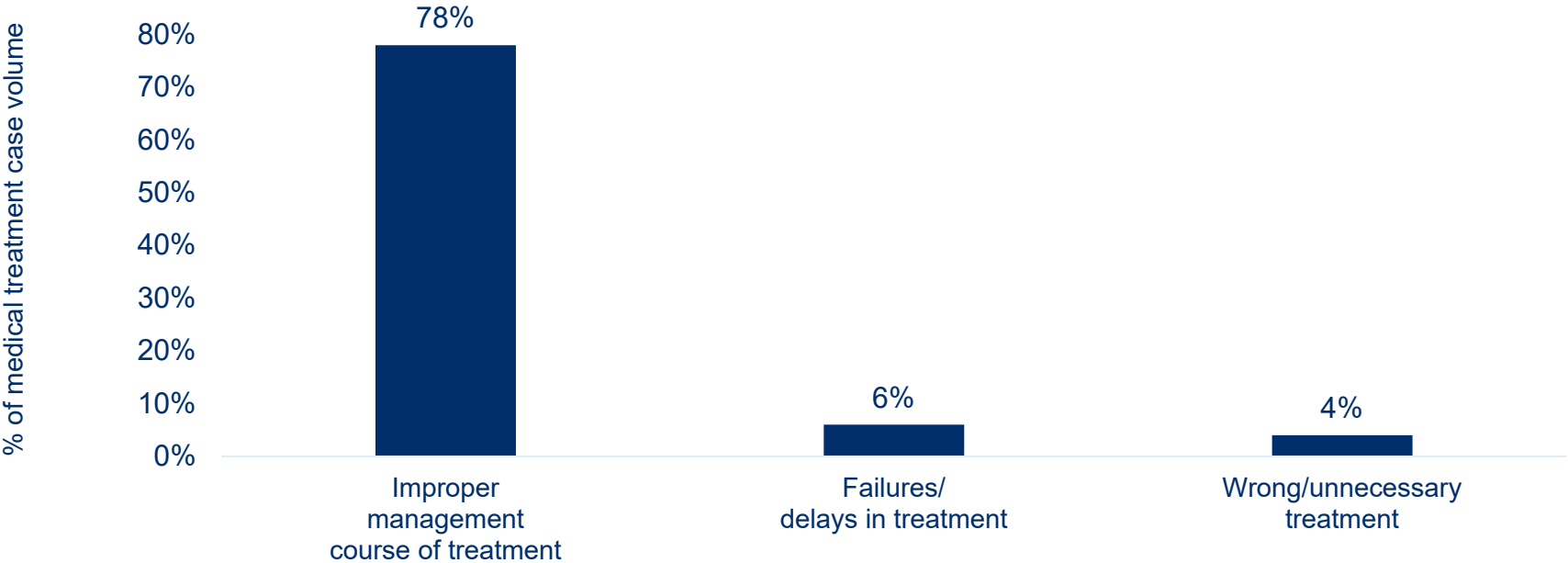
Focus on Medication-Related Allegations



Selection of the most appropriate medication for the patient’s condition is one of the most frequently noted risk issue in medication cases. Issues reflecting patient non-adherence to prescriptions are sometimes impacted by inadequate patient/family education of the importance of prescription adherence. Inadequate patient monitoring, and suboptimal communication about medication regimens across the patient’s care team are also commonly noted risk issues.

Focus on Medical Treatment Allegations

Top allegation details



Medical patient management allegations encompass a variety of conditions, including medication-related complications and infections. These 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.



The following stories are reflective of the allegations and contributing risk factors which drive cases brought against Hematologists & Medical Oncologists.

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

\$1.75M

CONTRIBUTING FACTORS

Clinical judgment

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

Selection/management of most appropriate medication

Failure/delay in obtaining consult/referral (referred patient to surgeon instead of back to the hematologist)

Patient monitoring - medication

Communication

Patient education regarding risks of medication

IMPROPER MANAGEMENT OF ANTICOAGULATION RESULTING IN HEMORRHAGIC STROKE

A female in her late 50s, with a history of hypertension, asthma, GERD, UTIs, and morbid obesity, presented for a panniculectomy to remove excess abdominal skin after significant weight loss. Post-operatively, the patient developed shortness of breath and acute renal failure; she was **found to have a pulmonary embolism, but could not be placed on an anticoagulant regimen due to post-operative bleeding**. An inferior vena cava filter was placed, and a patient was referred to Hematology for follow-up care. The hematologist **placed her on a long term anticoagulation regimen with two medications for almost six years**. Towards the end of the sixth year, the patient presented to her primary care provider (PCP) for a flu shot, and complained of a hematoma on flank/lower abdomen for four days, with no history of trauma. Her PCP ordered an ultrasound of the hematoma as well as blood studies. **The ultrasound showed a subcutaneous hematoma**, and the report was sent to both the PCP and Hematologist. **PCP instructed the patient to follow up with a surgeon to have the hematoma drained** if it did not show improvement. **Patient did not return to the office or contact a surgeon.**

Two weeks later, the patient woke up with a headache, right-side weakness, and slurred speech. Upon presenting to the emergency department, she **was found to have suffered an intracranial hemorrhage** and was admitted to the intensive care unit. She endured a stormy course, including renal failure, acute respiratory failure requiring a ventilator, and ultimately was discharged to a long-term care rehabilitation facility.

The patient has permanent hemiplegia and hemiparesis following her stroke, and claims **permanent brain damage from improper management of anticoagulation**.

Experts were critical of the hematologist for keeping the patient on two anticoagulants for such a significant length of time, and for not monitoring patient closely enough.

Case Examples

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

SETTLED

\$700,000

CONTRIBUTING FACTORS

Clinical judgment

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

Clinical System

Patient did not receive test results

Lack/failure in follow-up system

Communication

Communication among providers – failure with closed loop communication

DELAY IN DIAGNOSIS AND TREATMENT OF RECURRENT BREAST CANCER RESULTING IN DEATH

A female patient in her mid-60s was diagnosed with breast cancer in 2001. She was successfully treated with chemotherapy, radiation, and endocrine therapy.

In 2017 the patient saw her primary care provider (PCP) for complaints of abdominal pain for a few months. **CT imaging revealed a cyst on her ovary and small spot on her lung.** A follow-up PET scan showed increased uptake in regions of the neck, posterior nasopharynx, and from the right chest wall to brachial plexus suspicious for lymphadenopathy.

The patient was referred to an Oncologist (Oncol A) for consultation. Tumor marker studies and biopsy were ordered. **The biopsy revealed metastatic breast cancer.** Oncol A signed the pathology report 22 days after receiving it, however, **did not initiate any follow-up.**

The patient's chart reflects documentation that she called the office (on the day Oncol A signed the report) and requested a call back. Two medical assistants checked the system that day and the day after to find the result. **Despite the contact, no one called the patient or directed follow-up care. The patient thought everything was fine since they never called her back.**

Two years later, in 2019, the patient presented to Oncol B from the same practice with complaints of chest wall burning and right arm numbness. **Oncol B discovered the positive pathology result from 2017 and informed the patient.** PET-CT revealed nodules consistent with malignancy, and the patient was referred back to Oncol A, who apologized, disclosed what had happened and referred the patient for immediate treatment. However, the patient's disease progressed quickly and she transitioned to palliative care.

Expert review was not supportive of Oncol A, and opined that if the patient had begun treatment in 2017, she would have had a 60-70% chance of cure vs a less than 10% chance in 2019.

Risk Mitigation Strategies

- **Ongoing evaluation of procedural skills and competency with equipment is critically important.**
- **Conduct a thorough pre-treatment assessment of the patient.**
 - Conduct a thorough pre-treatment assessment of patients for risk factors related to medication regimens and maintain a consistent post-medication administration assessment process.
 - Update and review medical and family history at every visit to ensure the best decision-making.
- **Communicate with each other.**
 - Maintain open communication across all members of the patient's health care team, and identify the primary provider who will coordinate care.
 - Talk also to the patient/family, elicit a comprehensive patient history and conduct a thorough informed consent with the patient.
- **Engage patients as active participants in their care.**
 - Consider the patient's health literacy and other comprehension barriers. Recognize patterns of patient non-compliance, and focus on documentation of efforts made to encourage compliance and follow up with treatment.
 - 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.
- **Clinical systems**
 - Focus on 'closing the loop' with regards to receiving, reporting and acting on test results, including incidental findings. Educate the patient on the importance of receiving test results, and how to follow up with the provider if results are not received.
- **Administrative**
 - Reinforce the need for ongoing staff training/education related to administrative policies/procedures, including those involving clarification of orders and appropriate medication administration protocols.

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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