

Otolaryngology & Otorhinolaryngology (ENT)

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 Otolaryngology & Otorhinolaryngology (ENT) 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.

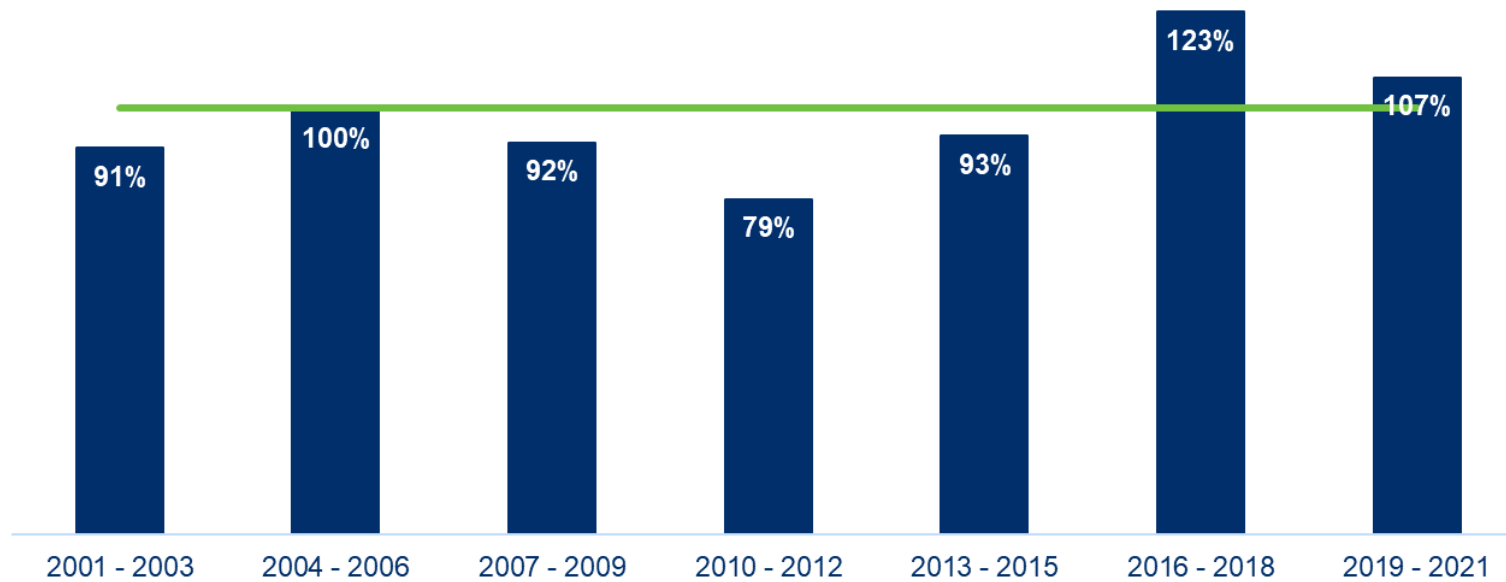
Severity Tier	High	Hematology/Oncology, Pathology, Pediatrics	Anesthesiology, Neurology	Emergency Medicine, Neurosurgery, OB/GYN
	Medium	Family Medicine, Nephrology, Physiatry, Urgent Care	Cardiology, ENT, Gastroenterology, Internal Medicine	Cardiovascular Surgery, General Surgery, Orthopedic Surgery, Radiology, Urology
	Low	Allergy, Dermatology, Occupational Medicine, Psychiatry, Rheumatology	Ophthalmology, Plastic Surgery, Pulmonology	Hospitalists
		Low	Medium	High
		Frequency Tier		

Specialty trends – Otolaryngology (ENT)

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Otolaryngology has an average financial severity per case and an average claim frequency compared to all specialties.

Average Severity - Otolaryngology Relative to All Specialties



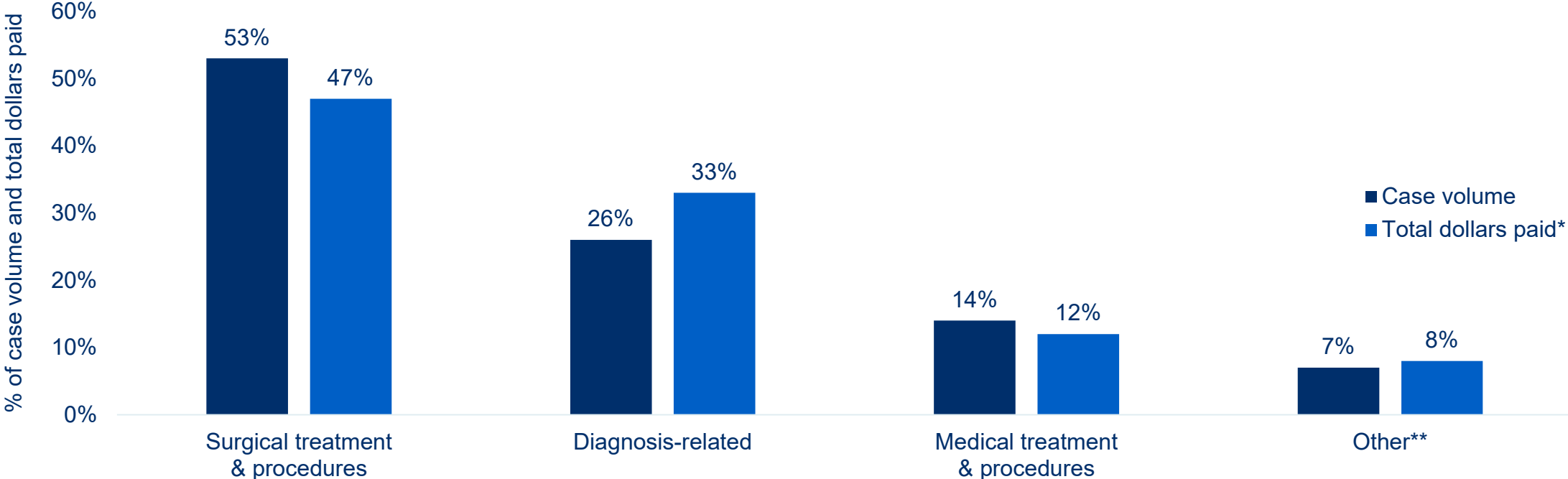
Key Points - Clinically Coded Data

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- **Surgical allegations account for more than half (53%) of Otolaryngology & Otorhinolaryngology (ENT) case volume and almost half of total dollars paid***. Performance-related allegations account for two-thirds of those, with the majority involving septoplasty & rhinoplasty. **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 one-fourth of ENT case volume. These most commonly reflect missed/delayed diagnoses of cancers, ear conditions and post-operative complications and infections. **These cases commonly reflect breaks in the diagnostic process of care**. Almost all of them (93%) involve issues within the first step of the diagnostic process, including assessment and evaluation of patient symptoms, establishing differential diagnoses, and delays or failures in ordering diagnostic testing.
- Medical allegations account for 14% of Otolaryngology & Otorhinolaryngology case volume. **Performance of tracheostomies and injections are most often noted within the medical procedure-related case volume**. 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.
- **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 suboptimal communication are key drivers of both clinical and financial ENT 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.



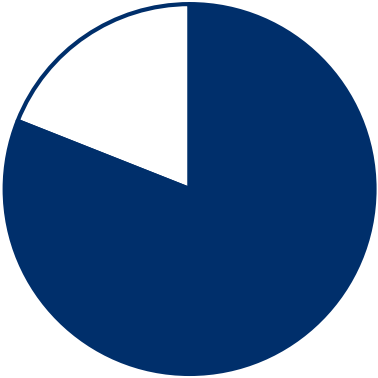
MedPro Group + MLMIC cases opened 2012-2021, Otolaryngology & Otorhinolaryngology as responsible service (N=353); *Total dollars paid = expense + indemnity; **Other includes allegations for which no significant case volume exists

Clinical Severity*

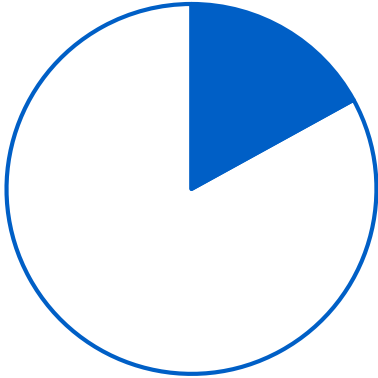
Clinical Severity Categories	Sub-categories	% of case volume	<p>Typically, the higher the clinical severity, the higher the indemnity payments are, and the more frequently payment occurs.</p>
LOW	Emotional Injury Only	5%	
	Temporary Insignificant Injury		
MEDIUM	Temporary Minor Injury	46%	
	Temporary Major Injury		
	Permanent Minor Injury		
HIGH	Significant Permanent Injury	49%	
	Major Permanent Injury		
	Grave Injury		
	Death		

MedPro Group + MLMIC cases opened 2012-2021, Otolaryngology & Otorhinolaryngology as responsible service (N=353); *Severity codes reflect National Association of Insurance Commissioners (NAIC) injury severity scale

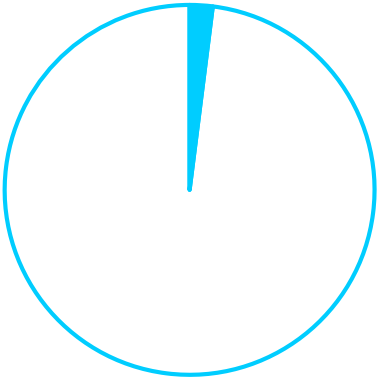
Claimant Type & Location



Ambulatory
81%



Inpatient
17%



Emergency
2%

Top Locations	% of case volume
Office/clinic	38%
Ambulatory surgery	33%
Inpatient surgery	17%
Patient room/ICU	6%
Emergency department	2%

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.

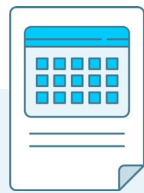
Multiple factors are identified in each case because generally, there is not just one issue that leads to these cases, but rather a combination of issues.



Administrative



Behavior-related



Clinical environment



Clinical judgment



Clinical systems



Communication



Documentation



Supervision



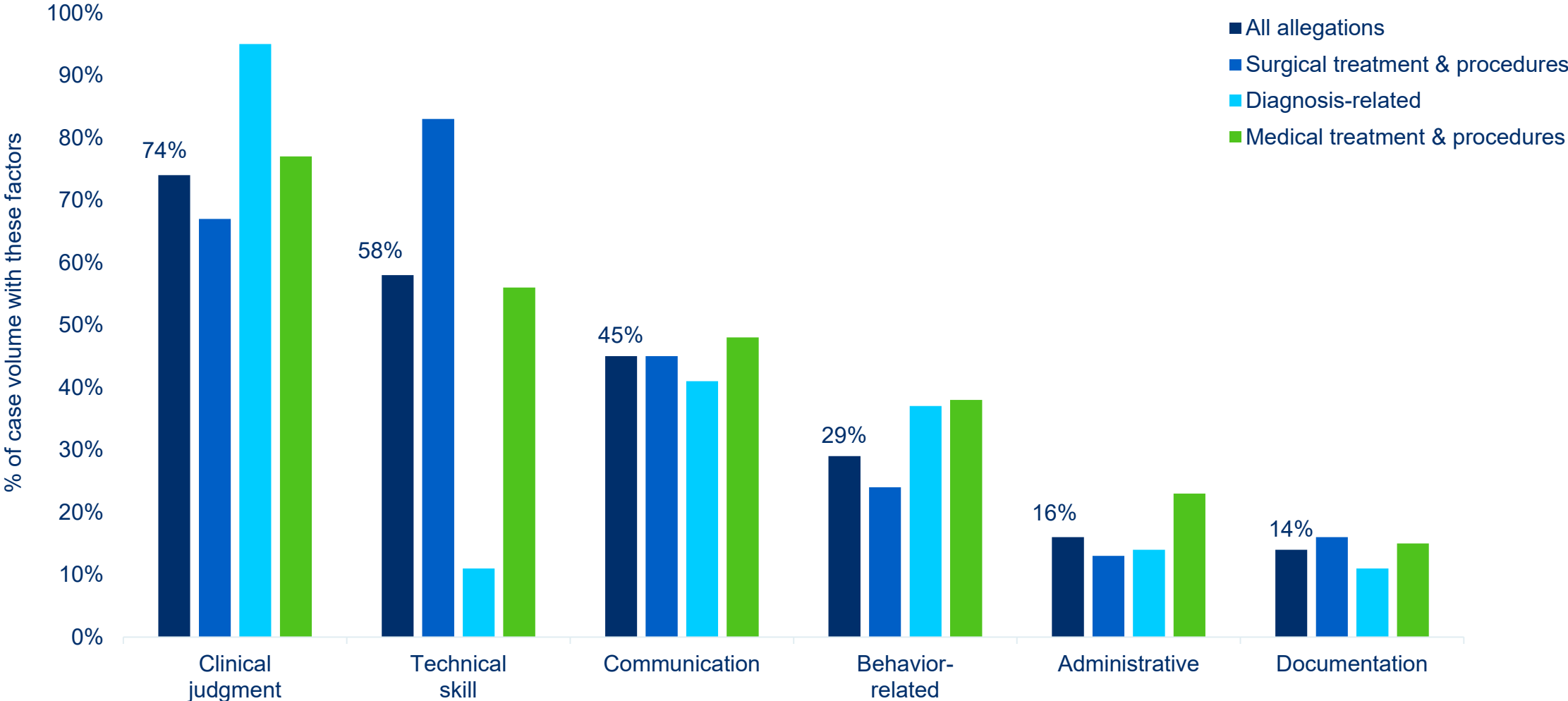
Technical skill

Contributing Factor Category Definitions

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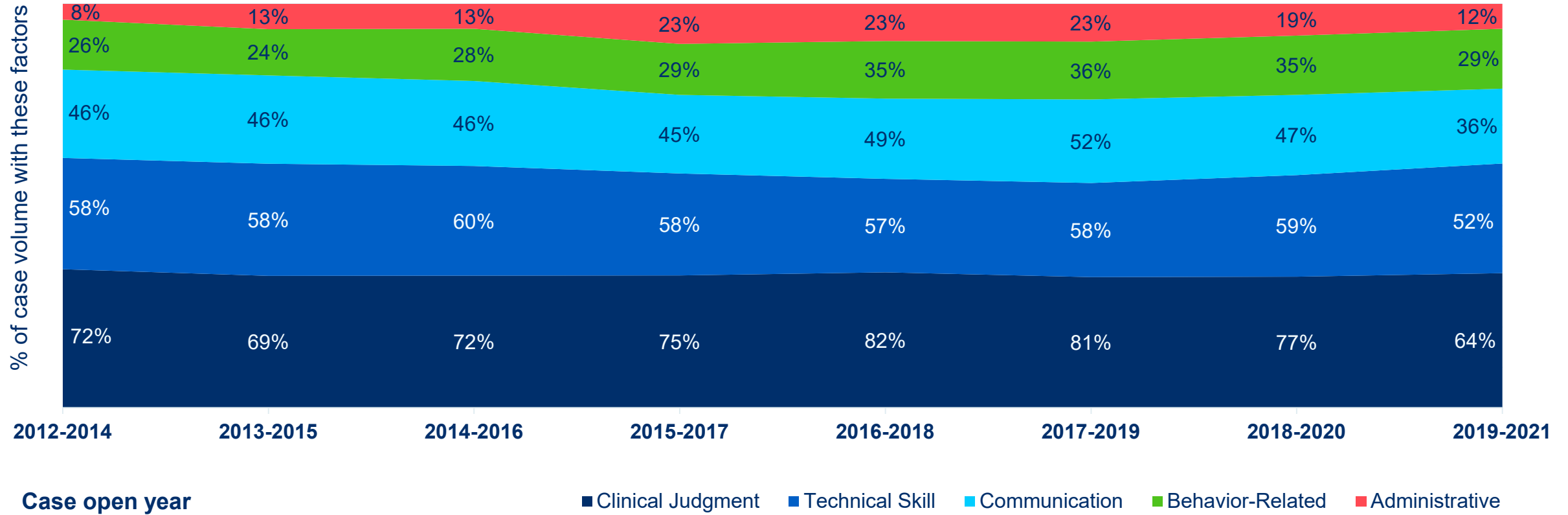
Administrative	Factors related to medical records (other than documentation), reporting, staff, ethics, policy/protocols, regulatory
Behavior-related	Factors related to patient nonadherence to treatment or behavior that offsets care; also provider behavior including breach of confidentiality or sexual 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, Otolaryngology & Otorhinolaryngology as responsible service (N=353); 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.

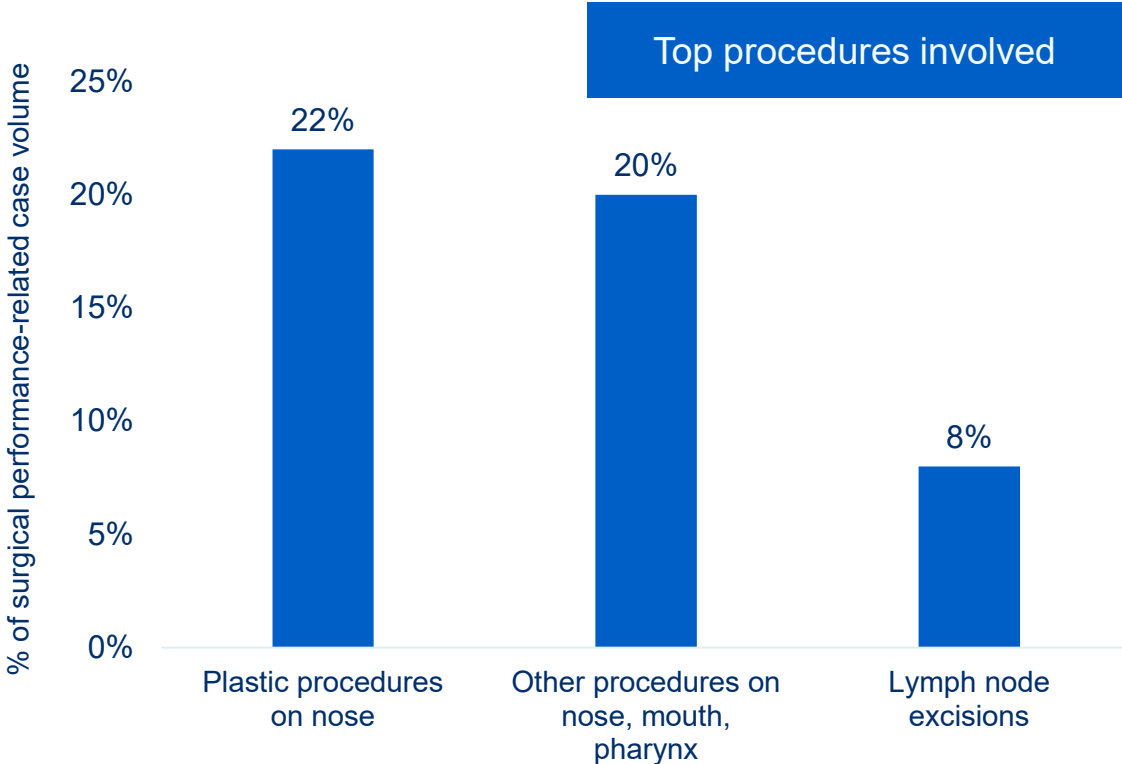
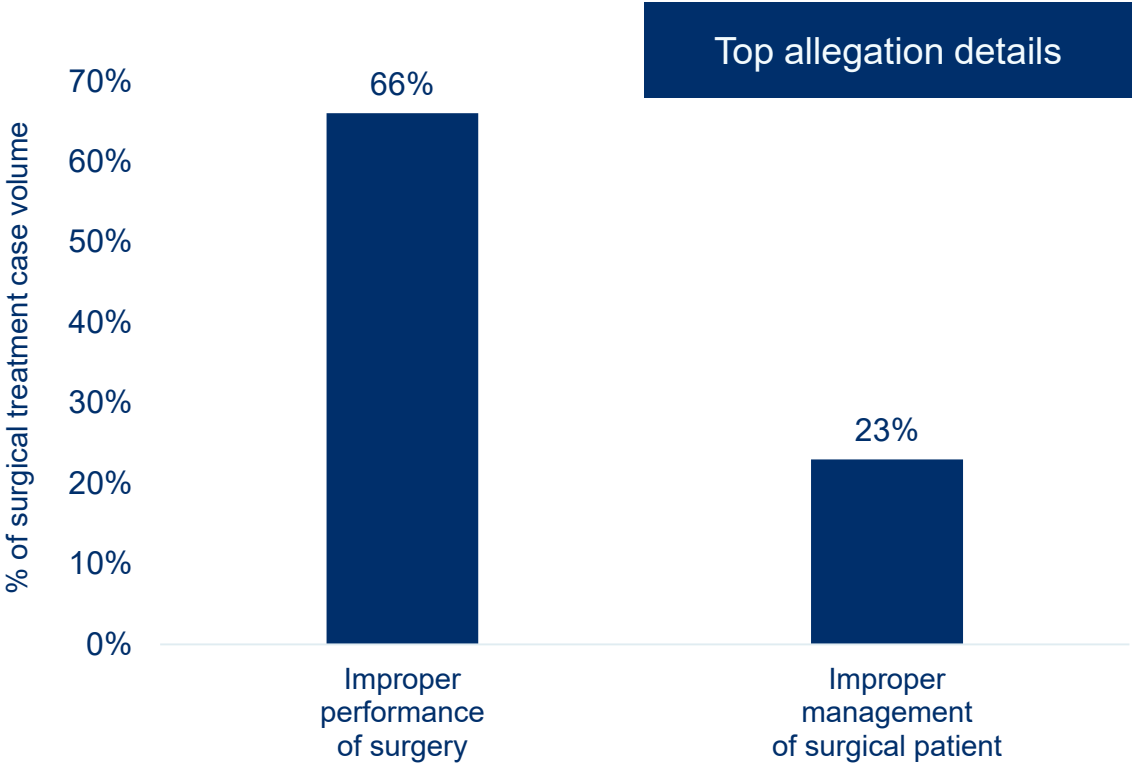
Focus on Most Common Drivers of Clinical and Financial Severity

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Factors associated with high clinical severity outcomes	(CJ) selection/management of most appropriate surgical procedure (39%)	% of high severity case volume
	(CJ) failure to appreciate/reconcile signs/symptoms/test results (31%)	
	(CJ) failure/delay in ordering diagnostic test (31%)	
	(CJ) failure to establish differential diagnosis (25%)	
	(TS) occurrence/management of known complication (23%)	
Factors associated with the costliest indemnity payments	(CO) suboptimal communication between providers about patient condition (58%)	% more expensive than the average indemnity payment*
	(CJ) overreliance on negative findings for patient with continued symptoms (45%)	
	(CJ) failure to appreciate/reconcile signs/symptoms/test results (8%)	

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 suboptimal communication are key drivers of both clinical and financial ENT case severity.

Focus on Surgical Treatment Allegations

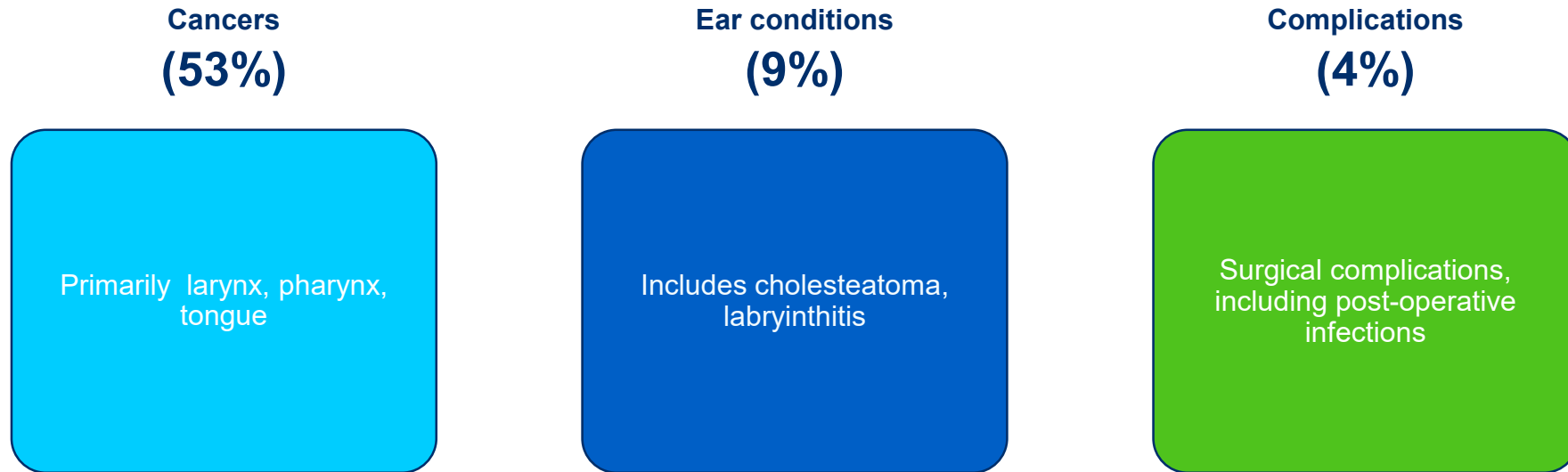


Cases involving the management of surgical patients, including pre-, intra-, and post-operatively, are often related to the surgeon's response to developing complications. While complications of procedures may have been the result of procedural error, the failure to timely recognize and/or monitor/manage 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 93% 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 29% of cases	Performance of diagnostic tests
	Interpretation of diagnostic test results
	Test results transmitted to/received by ordering provider

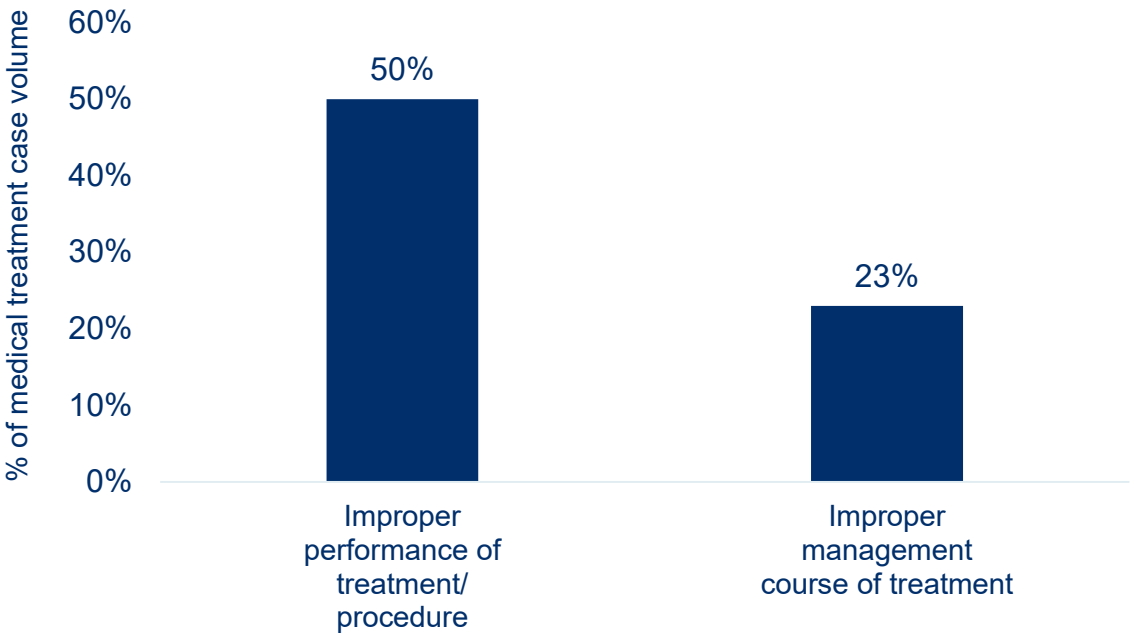
Phase 3

Follow-up and coordination 53% of cases	Physician follows-up with patient
	Referrals/Consults
	Patient information communicated among care team
	Patient compliance with follow-up plan

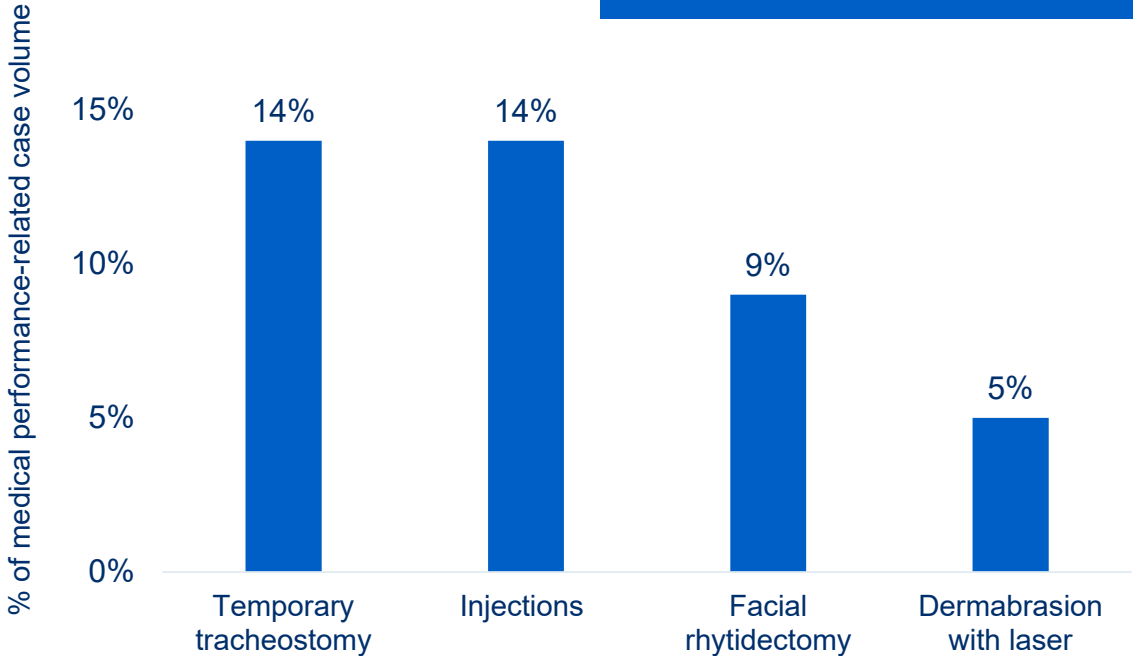
MedPro Group + MLMIC cases opened 2012-2021, Otolaryngology & Otorhinolaryngology as responsible service (N=353); *each step reflects a combination of contributing factors; diagnostic process of care algorithm courtesy of Candello, a division of CRICO Strategies

Focus on Medical Treatment Allegations

Top allegation details



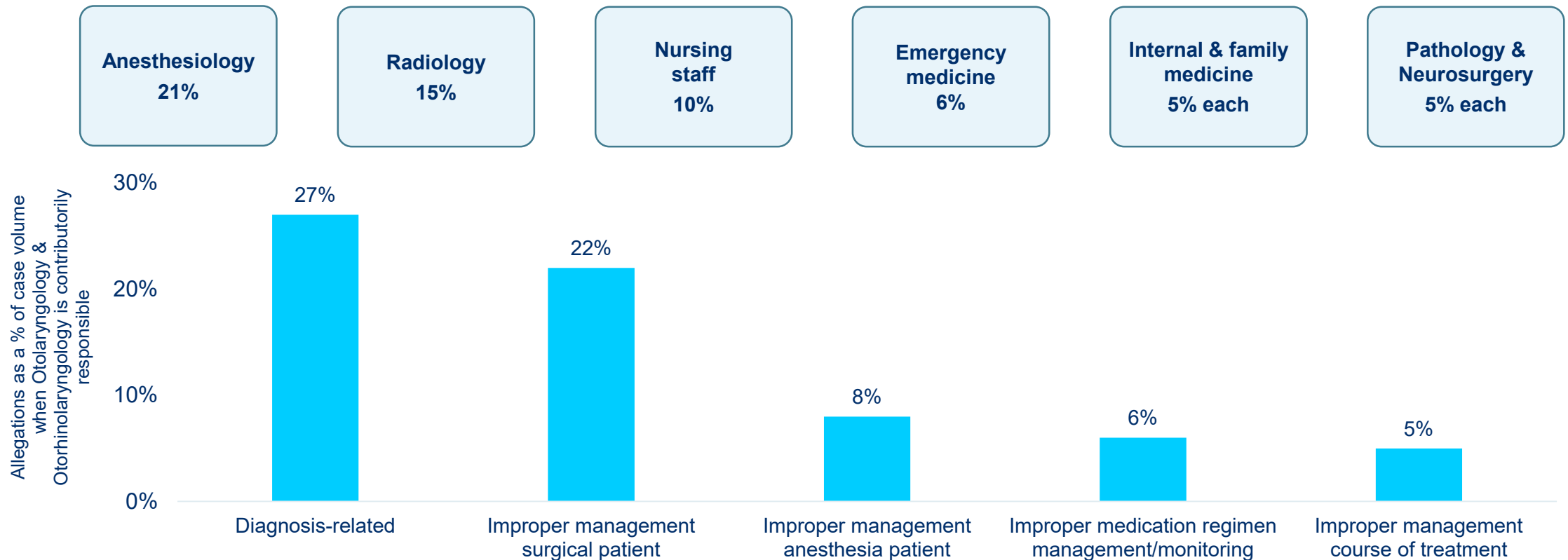
Top procedures involved



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 ENT as the primarily responsible service, another 110 cases identify ENT 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 ENTs.

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

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SETTLED

\$1.85M

CONTRIBUTING FACTORS

Behavior-related

Patient non-adherence with treatment plan

Clinical judgment

Failure to appreciate and reconcile relevant sign/symptom/test result

Patient assessment – ED triage, failure to rescue

Selection of most appropriate medical procedure (trach removal for patient who did not tolerate trach capping)

PREMATURE TRACH DECANNULATION (REMOVAL) RESULTING IN HYPOXIC BRAIN INJURY AND DEATH

Following a scooter accident and an induced coma, an 18-year-old female was intubated for two months. Several attempts were made to wean the patient from the trach (capping), but were unsuccessful. The patient was referred to an Otolaryngologist (ENT) and ordered to start a strict anti-reflux diet. **Additional weaning attempts were made, but the patient could not tolerate due to stenosis of over 90% (and refused to follow the anti-reflux diet).**

Five months later, **the patient underwent a steroid injection and trach removal in the ENT's office.** The patient remained in office at least 30 minutes. She was told to return to office or call EMS if any acute problem(s) occurred. **After eating spicy food and ice cream, the patient complained of having a “hard time breathing.” Her mother suctioned the patient and then took her to a fire station (2 hours after the patient's breathing difficulties began).** An IV was started and supplemental oxygen given over the stoma. Her blood pressure, pulse and respirations were all elevated and she was transferred to the hospital by EMS.

While in the Emergency Department (ED), the patient developed respiratory failure, vomiting and aspirated. **At 6:51pm, a nurse (who later testified) knew the patient was having respiratory difficulty, yet was educating a new nurse, and assumed someone else would respond to the patient. No one intervened for several minutes,** until the Emergency Medicine physician did attempt to place a trach but could not advance it past the subglottic stenosis. A CRNA was able to intubate at 7:50pm. However, by this time the patient was severely obtunded, and was admitted to ICU. **The patient suffered a severe anoxic brain injury and after a week, the family opted for comfort measures only.**

Experts opined the patient's tracheostomy was placed too high originally, that the patient's food choice contributed to her initial difficulties (before seeking care at the fire station), and that while in the ED, the trach should have been placed earlier. Also, prolonged intubation placed the patient at greater risk of developing subglottic stenosis.

Case Examples

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SETTLED

\$250,000

CONTRIBUTING FACTORS

Behavior-related

Patient factors – seeking other providers due to dissatisfaction of care and non-adherence to follow-up appointments

Clinical judgment

Selection/management of most appropriate surgical procedure

Failure to appreciate and reconcile relevant sign/symptom/test result

Communication

Communication between family/provider regarding expectations

Technical skill

Occurrence of known complication

IMPROPER PERFORMANCE OF COCHLEAR IMPLANT PLACEMENT RESULTING IN NERVE DAMAGE

A 3-year-old male patient, with a history of bacterial meningitis at five months, was evaluated by an audiologist who diagnosed severe hearing loss bilaterally with no auditory brainstem responses. The patient was referred for a cochlear implant evaluation. The ENT noted that the **CT showed “completely whited-out cochleae” due to abnormal bone deposition in both cochlea; this decreased chances of successful device implantation. Parents were advised of the risks (of which there were several), and of the ENT's lowered expectations of success; they chose to proceed.**

The ENT implanted a double array electrode into the right ear to improve contact with auditory nerve. **Extensive ossification was encountered, and the ENT had to drill out bone, resulting in a small rent and cerebrospinal fluid leak (known complication; repaired with fibrin glue).** Initially, the patient did well but a follow-up scan showed one lead outside of the cochlea. Nine months later, **CT showed both leads had migrated outside the cochlea.** ENT planned to remove and reimplant the device if it was still functional.

The second procedure was done with assistance from device company and neuromonitoring which showed proper functioning of implant. No complications were noted. One month later, the patient appeared to be healing well. However, **parents did not bring the patient back to ENT or have programming of device done.** The patient was taken for a second opinion two years later, but no treatment was rendered at that time. **Two years after that, a CT revealed the electrodes again outside of the cochlea, extending into the petrous apex (near the carotid artery).** Device was then removed.

Parents claimed the ENT was negligent in performance of implant surgery, drilling out too much bone, placing electrodes too deeply within ear canal, failing to recognize improper placement resulting in permanent damage to auditory nerve, facial pain, headaches, and permanent loss of chance for meaningful hearing. Experts were overall supportive as the procedure had low chances of success due to the original cochlear ossification.

Risk Mitigation Strategies

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- **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.
- **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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