Residents & Fellows

Claims Data Snapshot

2025

MedPro Group

MLMIC

MLMIC Insurance Company

CELEBRATING 50 FIFTY YEARS

Introduction

This publication contains an analysis of aggregated data from clinically coded cases opened between 2014-2023 in which Residents & Fellows are identified in a primary responsible service role (across all specialties).

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.

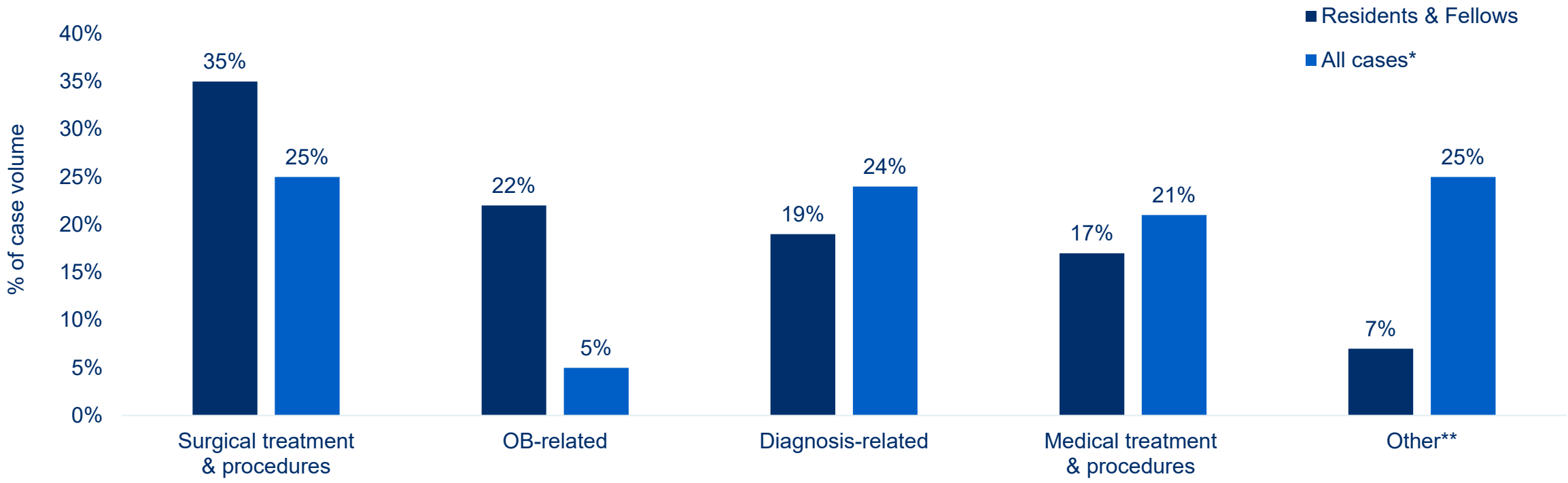
Key Points - Clinically Coded Data

- Three-fourths of cases involving residents and/or fellows across all specialties reflect surgical, obstetrical and diagnostic case types.
- In general, when compared to all other cases, resident/fellow-involved cases result in a slightly higher level of patient severity, more often involve obstetrics-related allegations, and not unexpectedly, reflect a higher volume of supervision-related issues.
- Surgical cases are evenly distributed between procedural and patient management-related issues.
- Obstetrical cases most commonly involve recognition and management of fetal distress and issues arising out of the management of vaginal deliveries.
- Diagnosis-related allegations most commonly reflect missed/delayed diagnoses of circulatory system diseases. These cases reflect breaks in the diagnostic process of care, most often during the initial diagnostic phase.
- 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.
  - With a couple of exceptions, the distribution of contributing factors stemming from cases involving residents and fellows is relatively similar to all other cases.
  - Noticeable distinctions across the clinically severe cases when compared with all other cases include the volume of cases reflecting events arising during nights/weekends/holidays, those involving suboptimal communication (i.e. failure to close the loop), and labor/delivery decision-making.

MedPro Group + MLMIC cases opened 2014-2023, Residents & Fellows in a primary responsible service role (N=489); *All cases with any role identified (N=>13K); *Total dollars paid = expense + indemnity

Most Common Major Allegations

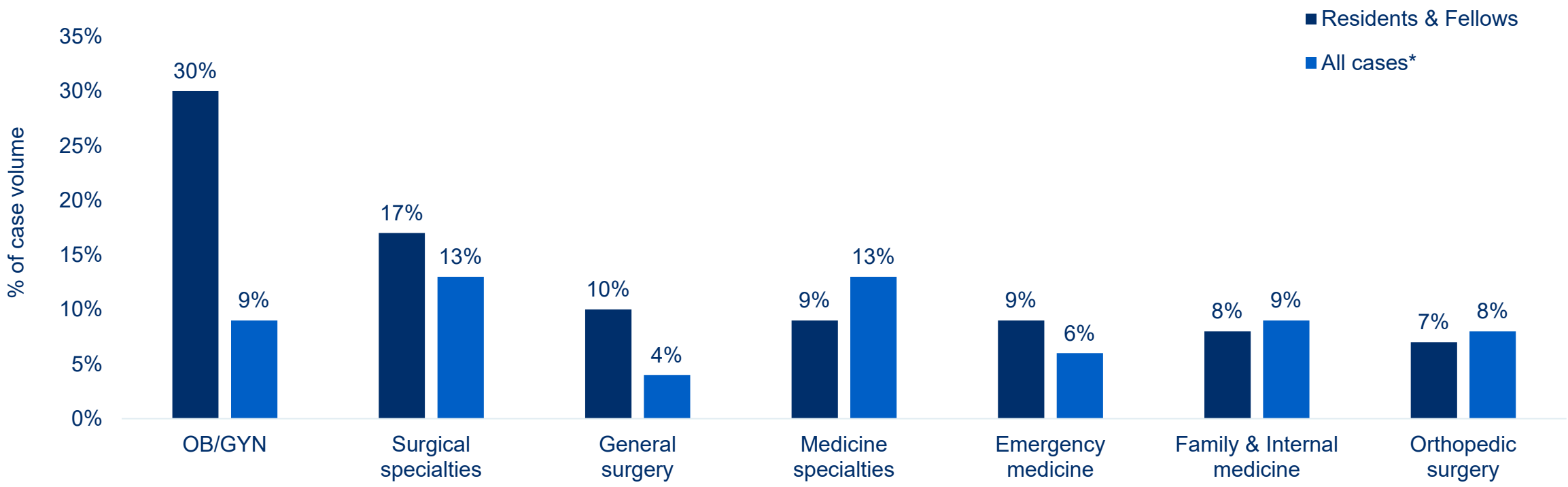
Each case reflects one major allegation category. Categories are designed to enable the grouping and analysis of similar cases and to drive focused risk mitigation efforts. The coding taxonomy includes detailed allegation sub-categories; insight into these is noted later in this report. With the exception of OB cases, the distribution of allegations stemming from cases involving residents and fellows is relatively similar to all other cases.



MedPro Group + MLMIC cases opened 2014-2023, Residents & Fellows in a primary responsible service role (N=489); *All cases with any role identified (N=>13K); **Other includes allegations for which no significant case volume exists

Most Common Primary Responsible Services

A 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.
With the exception of OB/GYN cases, and to a lesser extent general surgery, the distribution of primary responsible services stemming from cases involving residents and fellows is relatively similar to all other cases.



MedPro Group + MLMIC cases opened 2014-2023, Residents & Fellows in a primary responsible service role (N=489); *All cases with any role identified (N=>13K)

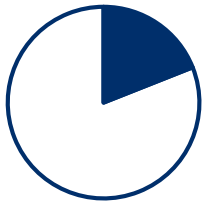
Clinical Severity**

Clinical severity* categories	Sub-categories	% of Resident & Fellow case volume	% of all case volume*	Definitions
LOW	Emotional Injury Only	**2%**	**5%**	Mental distress or suffering that is generally temporary; includes HIPAA violations, discrimination, involuntary stay
	Temporary Insignificant Injury			Lacerations, contusions, minor scars, rash; no delay in recovery
MEDIUM	Temporary Minor Injury	**36%**	**39%**	Infection, fracture set improperly or a fall in the facility, where recovery is complete but delayed
	Temporary Major Injury			Burns, drug side effect; recovery delayed
	Permanent Minor Injury			Loss of fingers or loss or damage to organs; includes non-disabling injuries
HIGH	Significant Permanent Injury	**61%**	**56%**	Deafness, loss of limb, loss of eye or loss of one kidney or lung
	Major Permanent Injury			Paraplegia, blindness, loss of two limbs or brain damage
	Grave Injury			Quadriplegia, severe brain damage, life-long care or fatal prognosis
	Death			Death
		28%	**26%**	**% of cases resulting in patient death**

MedPro Group + MLMIC cases opened 2014-2023, Residents & Fellows in a primary responsible service role (N=489); *All cases with any role identified (N=>13K); **Severity codes reflect National Association of Insurance Commissioners (NAIC) injury severity scale

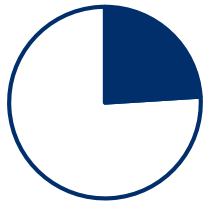
Most Common Locations

Residents & Fellows



- Labor & delivery 19%
- Inpatient surgery 19%
- Patient room 17%
- Emergency 15%

All cases*



- Office/Clinic 24%
- Patient room 21%
- Inpatient surgery 14%
- Emergency 8%

MedPro Group + MLMIC cases opened 2014-2023, Residents & Fellows in a primary responsible service role (N=489); *All cases with any role identified (N=>13K); *Severity codes reflect National Association of Insurance Commissioners (NAIC) injury severity scale

Contributing Factors

Despite best intentions, processes designed for safe patient outcomes can, and do, fail.

Contributing factors are multi-layered issues or failures in the process of care that appear to have contributed to the patient's outcome, and/or to the initiation of the case, or had a significant impact on case resolution.

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

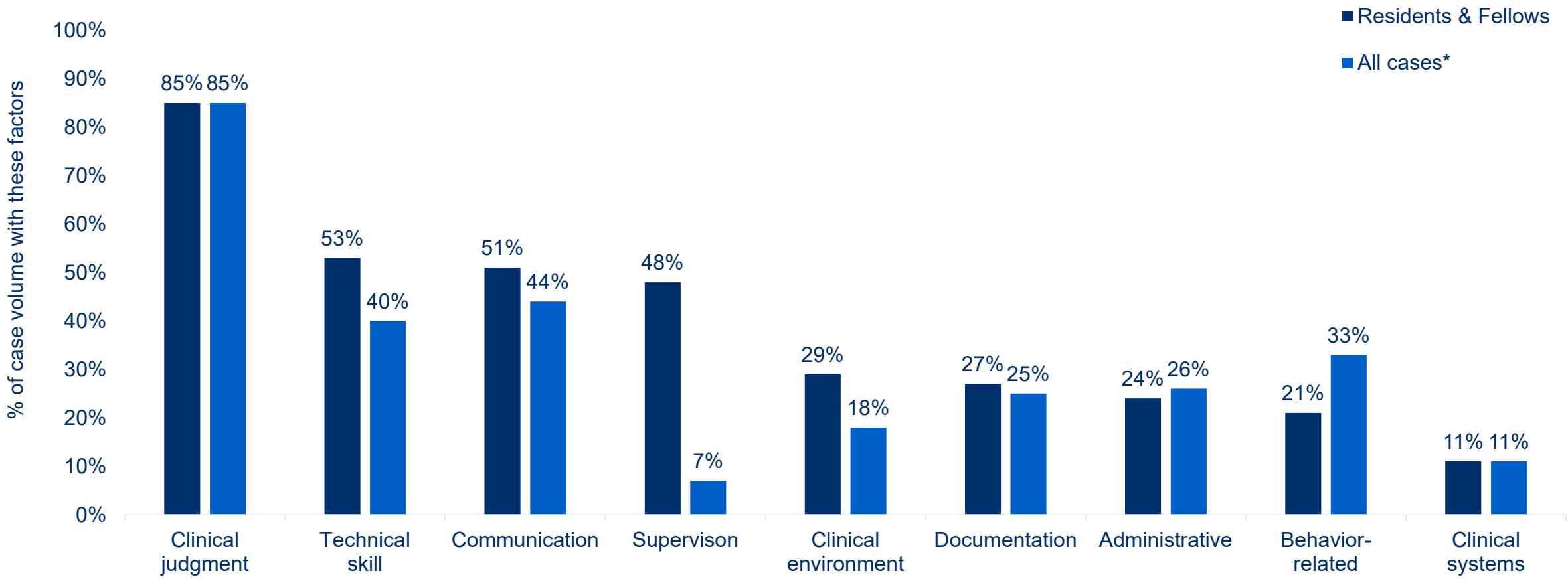
Administrative | Behavior-related | Clinical environment | Clinical judgment | Clinical systems | Communication | Documentation | Supervision | Technical skill

Contributing Factor Category Definitions

Administrative	Factors related to reporting of adverse events, adequacy of staffing, staff education/training, ethics, failure to follow and/or need for policy/protocols
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, diagnostic decision-making, 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

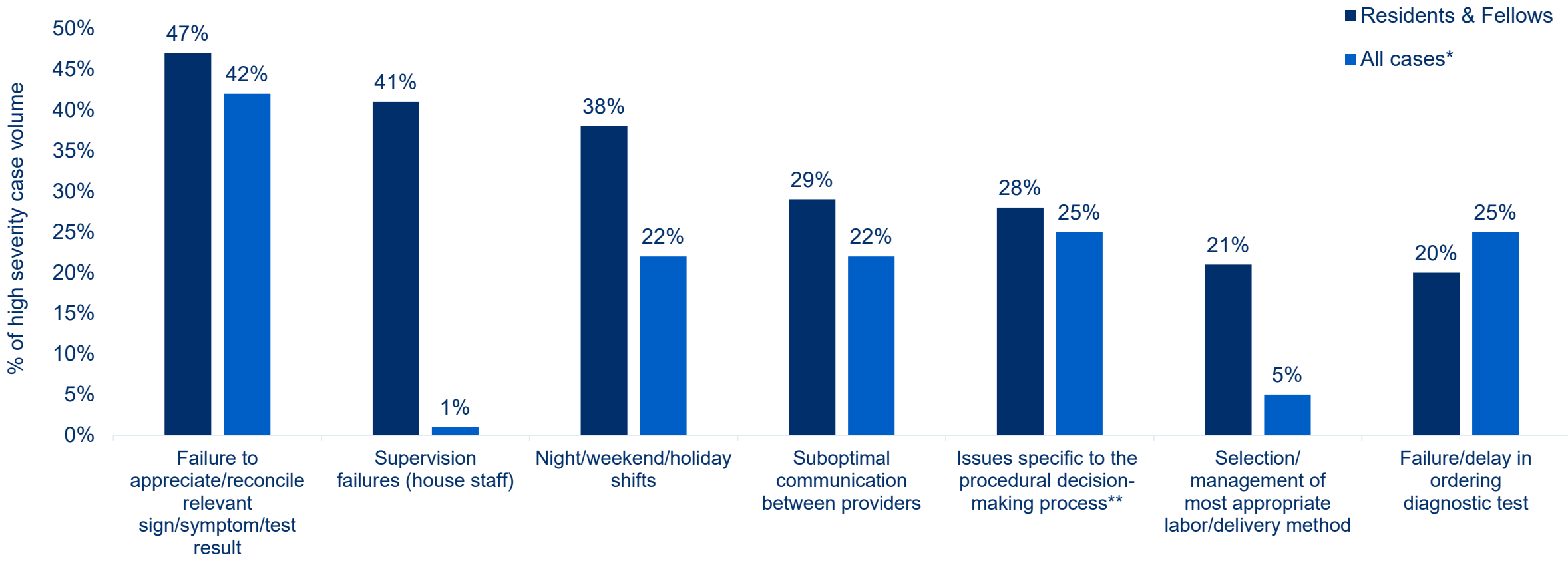
With the notable – and expected - exception of supervision-related factors, and to a lesser extent clinical environment factors, the distribution of contributing factors stemming from cases involving residents and fellows is relatively similar to all other cases.



MedPro Group + MLMIC cases opened 2014-2023, Residents & Fellows in a primary responsible service role (N=489); *All cases with any role identified (N=>13K); More than one factor per case, therefore totals >100%

Focus on Most Common Drivers of Clinical Severity

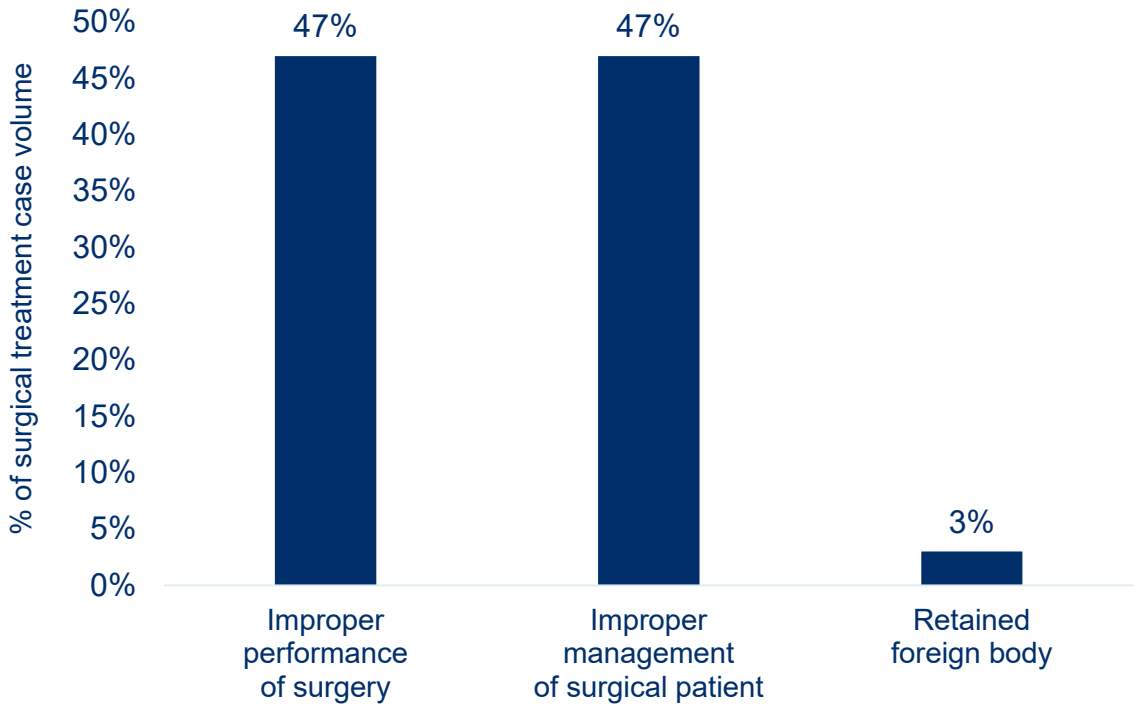
The seven most common drivers of clinically severe patient outcomes for cases involving residents & fellows are noted below, with a comparison to all other cases. As expected, supervision issues continue to be a distinction. Other notable issues include the volume of cases reflecting events arising during nights/weekends/holidays, those involving suboptimal communication (i.e. failure to close the loop), and labor/delivery decision-making.



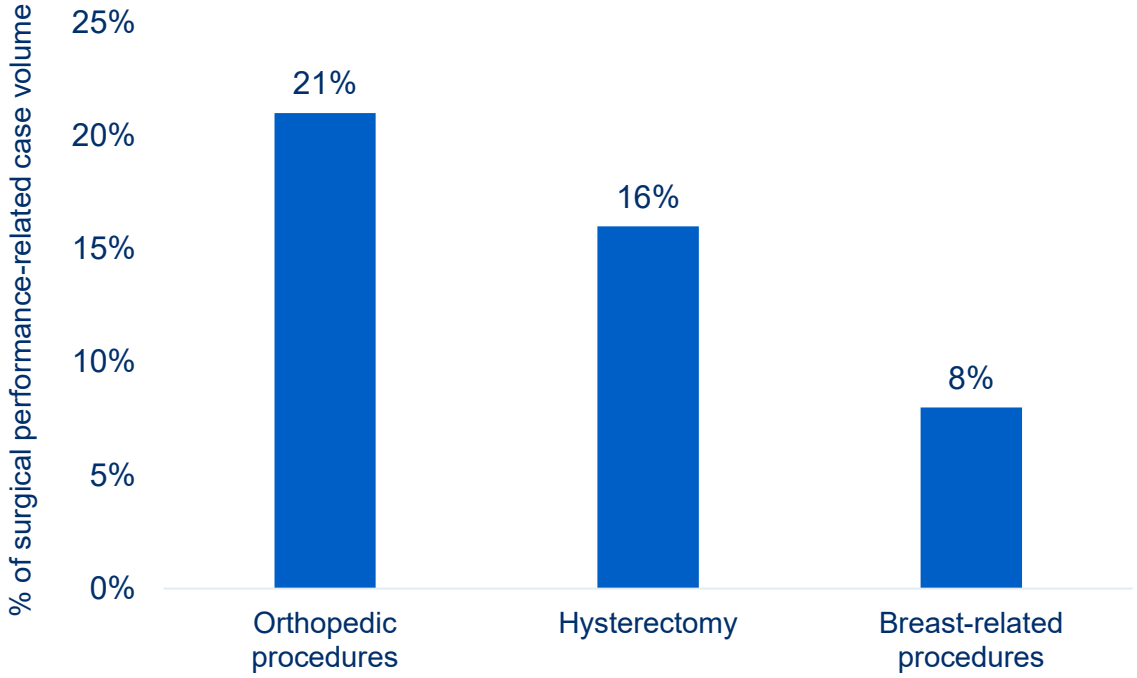
MedPro Group + MLMIC cases opened 2014-2023, Residents & Fellows in a primary responsible service role (N=489); *All cases with any role identified (N=>13K); More than one factor per case, therefore totals >100%; **Before, during, and after surgeries/procedures, including appropriateness of the patient for the procedure

Focus on Surgical Treatment Allegations

Top allegation details



Top procedures involved

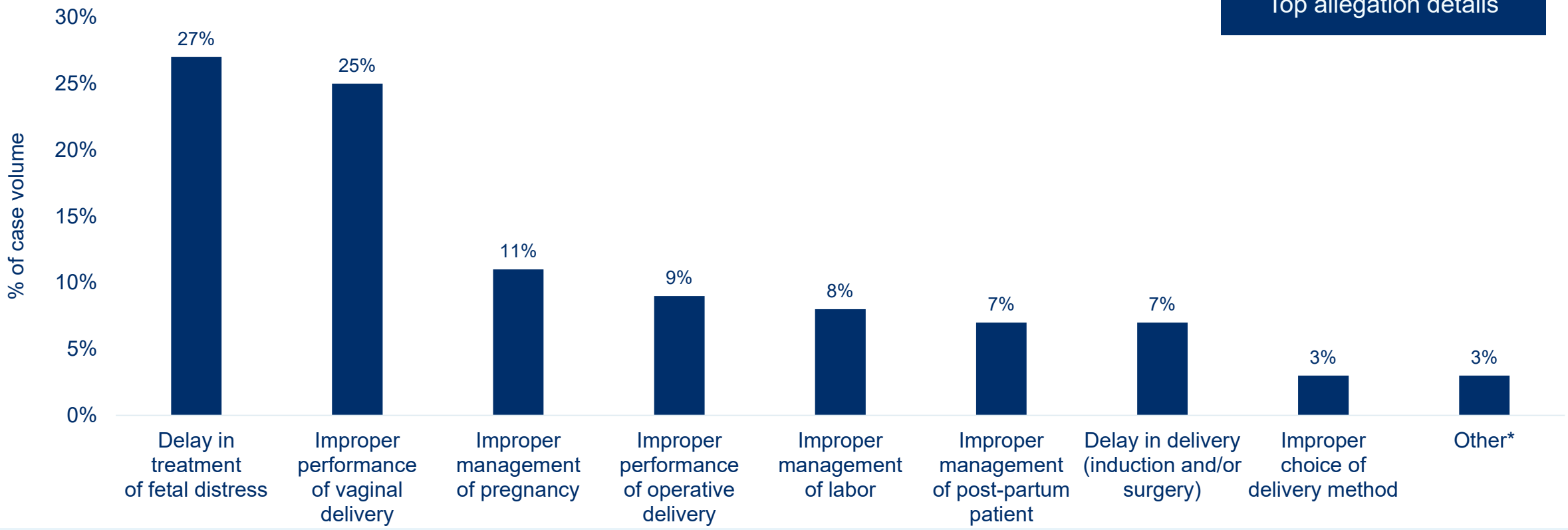


Cases involving the management of surgical patients, including pre-, intra-, and post-operatively, are often related to the surgeon's response to developing complications. While complications of procedures may have been the result of procedural error, the failure to timely recognize and/or monitor/manage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

MedPro Group + MLMIC cases opened 2014-2023, Residents & Fellows in a primary responsible service role (N=489)

Focus on OB-Related Allegations

Top allegation details



More than half of OB cases involving residents and fellows involve recognizing and responding to evidence of fetal distress, and performance of deliveries.

MedPro Group + MLMIC cases opened 2014-2023, Residents & Fellows in a primary responsible service role (N=489); *Other includes allegations for which no significant case volume exists

Focus on Diagnosis-Related Allegations

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

Circulatory system (31%)

Primarily cardiac and cerebrovascular diseases

Injuries (16%)

Primarily procedural complications, fractures, wounds and sprain/strains

Central nervous system (14%)

Primarily infections (spinal abscess, meningitis)

Digestive system (9%)

Primarily appendicitis and infections

MedPro Group + MLMIC cases opened 2014-2023, Residents & Fellows in a primary responsible service role (N=489); *as a percentage of all diagnosis-related allegations

Focus on Diagnosis-Related Allegations

Diagnosis-related allegations encompass wrong diagnoses, failures to diagnose, and delays in diagnosis. Note the key opportunities to reduce diagnostic errors along the diagnostic process of care* below.

Phase 1

Initial diagnostic assessment

90%
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

27%
of cases

- Performance of diagnostic tests
- Interpretation of diagnostic test results
- Test results transmitted to/received by ordering provider

Phase 3

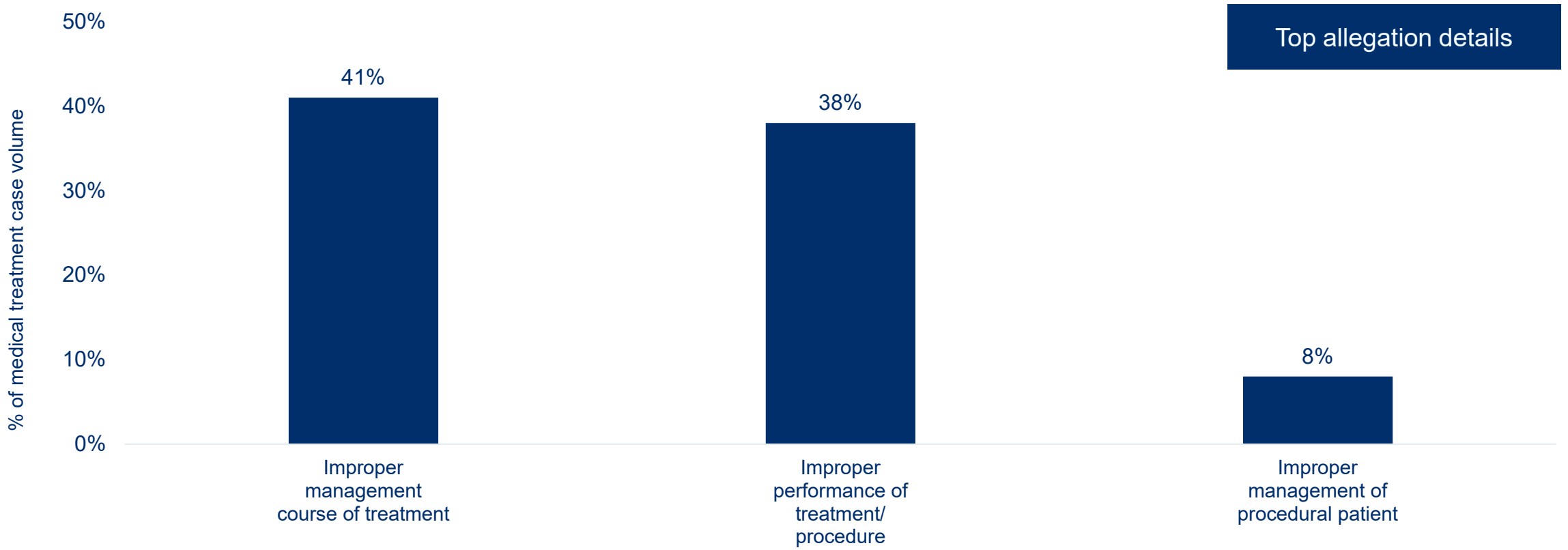
Follow-up and coordination

59%
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 2014-2023, Residents & Fellows in a primary responsible service role (N=489); *each step reflects a combination of contributing factors; diagnostic process of care algorithm courtesy of Candello, a division of CRICO Strategies

Focus on Medical Treatment Allegations



Procedural performance cases can be impacted by delayed recognition of complications, while management cases most often reflect issues with selection of the most appropriate course of treatment for the patient, and appreciating and reconciling symptoms and test results.

MedPro Group + MLMIC cases opened 2014-2023, Residents & Fellows in a primary responsible service role (N=489)

Risk Mitigation Strategies

- **Insufficient communication with other providers regarding the relevant facts about the patient's care is a concern.**
  - Ensure that residents/fellows are comfortable communicating their concerns without fear of appearing weak or non-confident.
  - Ensure that residents and fellows understand that they are an essential part of a care team and that they must share pertinent patient information, which, when combined with other provider observations, could indicate a much more severe issue.
  - Ensure hand-off communication is effective and unrushed.

- **Residents/fellows may not be aware of all policies/procedures in place at an institution or office/clinic.**
  - Failure to adhere to these policy and procedures can result in patient harm and significantly impact successful defense of malpractice cases.
  - Establish a safety culture that allows for the following:
    - Verify all staff awareness of important policies and procedures.
    - Authorize and invoke the "stop the line" concept by anyone who identifies a risk to a patient.
    - Encourage escalation of concerns up the chain of command.

- **Multiple providers involved with one patient's care can result in potentially varied documentation styles.**
  - Inconsistent documentation of patient symptoms and a provider's clinical rationale for treatment can result in patient care errors and create malpractice case defensibility issues.
  - Ensure consistent documentation among providers, with explanations where there is any inconsistency.
  - Do not sign off on charted information without thoroughly reading it.

Risk Mitigation Strategies

- **Insufficient supervision/oversight/training is a frequently noted risk issue in resident/fellow- involved cases.**
  - Ensure that required supervision is a regular, on-going activity.
  - Establish that all staff who will working on your behalf fully understand each facility/office norms/policies/procedures.
  - Be able to effectively communicate how you are able to determine/assess the competency of residents/fellows to perform their assigned tasks.
  - Use supervisory time to ensure that the resident/fellow is comfortable relating doubts or questions.

- **Ongoing evaluation of procedural skills and competency with equipment is critically important.**

- **OB-specific strategies:**
  - Focus on team training, which encourages clear communication across all providers, even during shift changes and evenings/weekends during lesser-staffed hours.
  - Recognize that inexperience with high-severity situations can be mitigated with situation-specific drills and team training.
  - Be aware of the potential impact to patient care during ‘off-shift’ times including evenings/nights, weekends and holidays.
  - Be aware that lack of access to outpatient prenatal records, containing documentation of maternal risk factors such as pre-eclampsia, as well test results for congenital fetal conditions, can significantly impact the decision-making of the inpatient team during labor and delivery.
  - Enable a culture where ‘chain of command’ policies are routinely followed in both the labor and delivery unit and in the OR, and acted upon in the event of delayed response from the managing physician/surgeon.
  - Focus on repetitive drills for managing fetal distress so that next steps in the escalation of care are well-established.

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.