

# Dermatology

## 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 Dermatology 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.

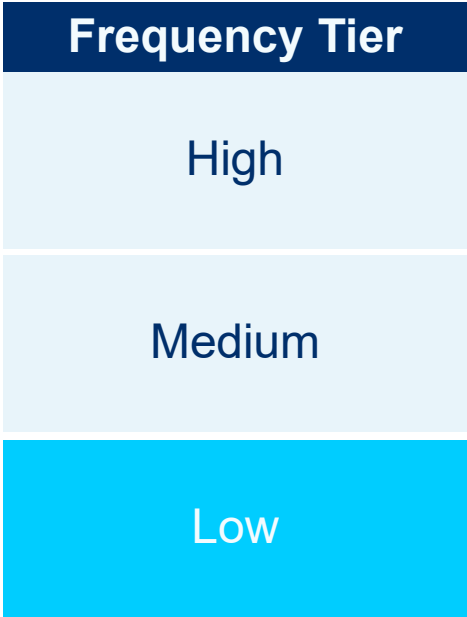
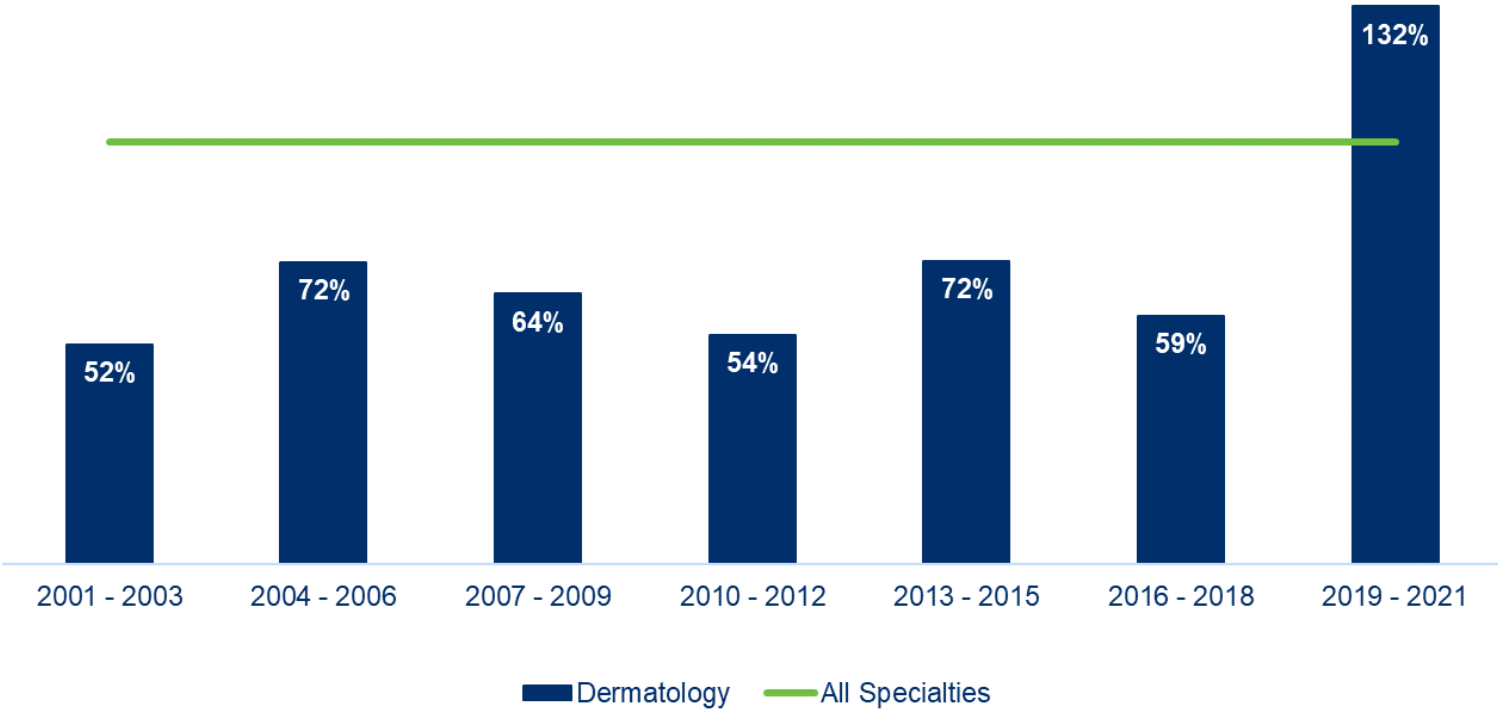
<b>Severity Tier</b>	<b>High</b>	Hematology/Oncology, Pathology, Pediatrics	Anesthesiology, Neurology	Emergency Medicine, Neurosurgery, OB/GYN
	<b>Medium</b>	Family Medicine, Nephrology, Physiatry, Urgent Care	Cardiology, ENT, Gastroenterology, Internal Medicine	Cardiovascular Surgery, General Surgery,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

Source: MedPro Group Physician & Surgeon Claim Experience & Analysis

# Specialty trends – Dermatology

Dermatology has a lower financial severity per case and a lower claim frequency compared to all specialties.

Average Severity - Dermatology Relative to All Specialties



Source: MedPro Group Physician & Surgeon Claim Experience & Analysis

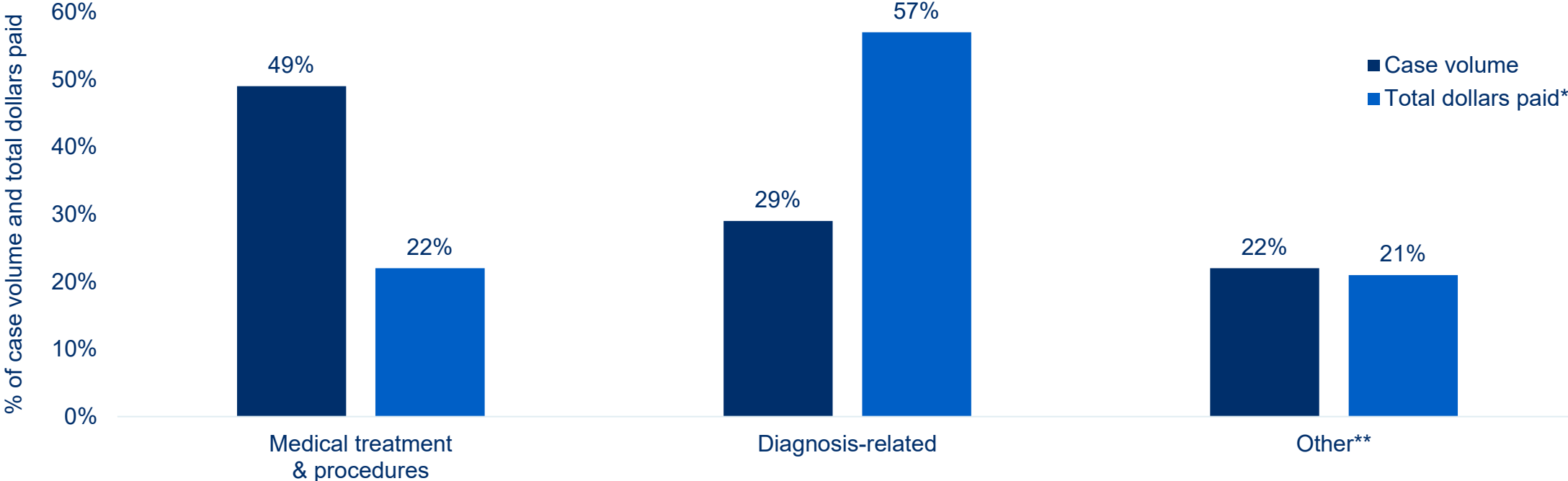
# Key Points - Clinically Coded Data

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

- **Medical treatment allegations account for 49% of Dermatology case volume and 22% of total dollars paid\***. Procedural performance cases, most often reflective of the excision of skin lesions and electrolysis, 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.
- **Diagnosis-related allegations** account for 29% of Dermatology case volume, but more than half of total dollars paid. These most commonly reflect missed/delayed diagnoses of skin cancers – primarily melanomas, and infections. **These cases commonly reflect breaks in the diagnostic process of care**, most often in the initial diagnostic phase, including inadequate assessment and evaluation of patient symptoms, a narrow diagnostic focus, delays or failures in ordering diagnostic testing, and with patient follow-up, including delays in obtaining consults or referrals, and sub-optimal communication among providers on the patient’s care team.
- **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 related to diagnostic decision-making and insufficient documentation, which can lead to a more difficult defense of subsequent medical malpractice actions, are key drivers of both clinical and financial Dermatology 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.



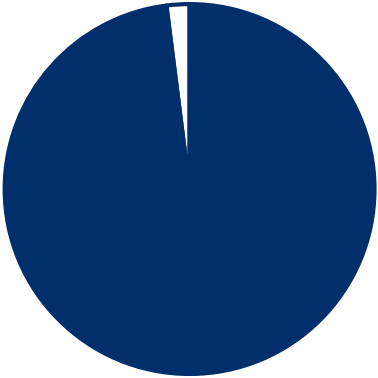
MedPro Group + MLMIC cases opened 2012-2021, Dermatology as responsible service (N=366); \*Total dollars paid = expense + indemnity; \*\*Other includes allegations for which no significant case volume exists

# Clinical Severity\*

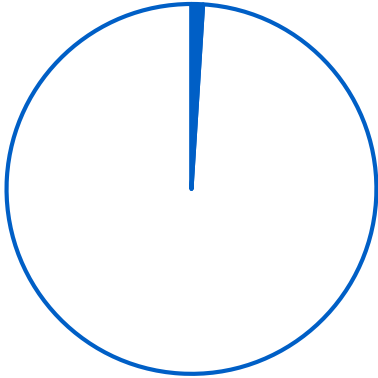
Clinical Severity Categories	Sub-categories	% of case volume	<p><b>Typically, the higher the clinical severity, the higher the indemnity payments are, and the more frequently payment occurs.</b></p>
<b>LOW</b>	Emotional Injury Only	<b>12%</b>	
	Temporary Insignificant Injury		
<b>MEDIUM</b>	Temporary Minor Injury	<b>63%</b>	
	Temporary Major Injury		
	Permanent Minor Injury		
<b>HIGH</b>	Significant Permanent Injury	<b>25%</b>	
	Major Permanent Injury		
	Grave Injury		
	Death		

MedPro Group + MLMIC cases opened 2012-2021, Dermatology as responsible service (N=366); \*Severity codes reflect National Association of Insurance Commissioners (NAIC) injury severity scale

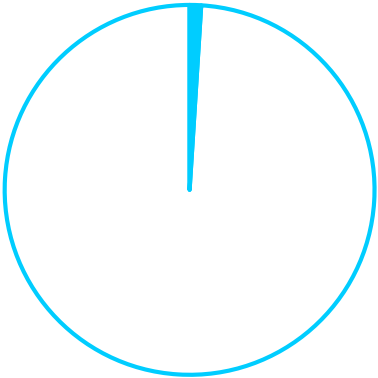
# Claimant Type & Location



**Ambulatory**  
**98%**



**Inpatient**  
**1%**



**Emergency**  
**1%**

Top Locations	% of case volume
Office/clinic	93%
Ambulatory surgery	4%



# 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.

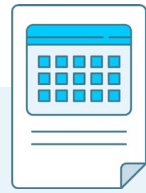
**Multiple factors are identified in each case** because generally, there is not just one issue that leads to these cases, but rather a combination of issues.



Administrative



Behavior-related



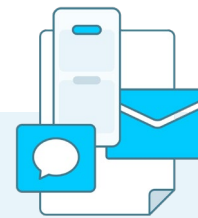
Clinical environment



Clinical judgment



Clinical systems



Communication



Documentation



Supervision



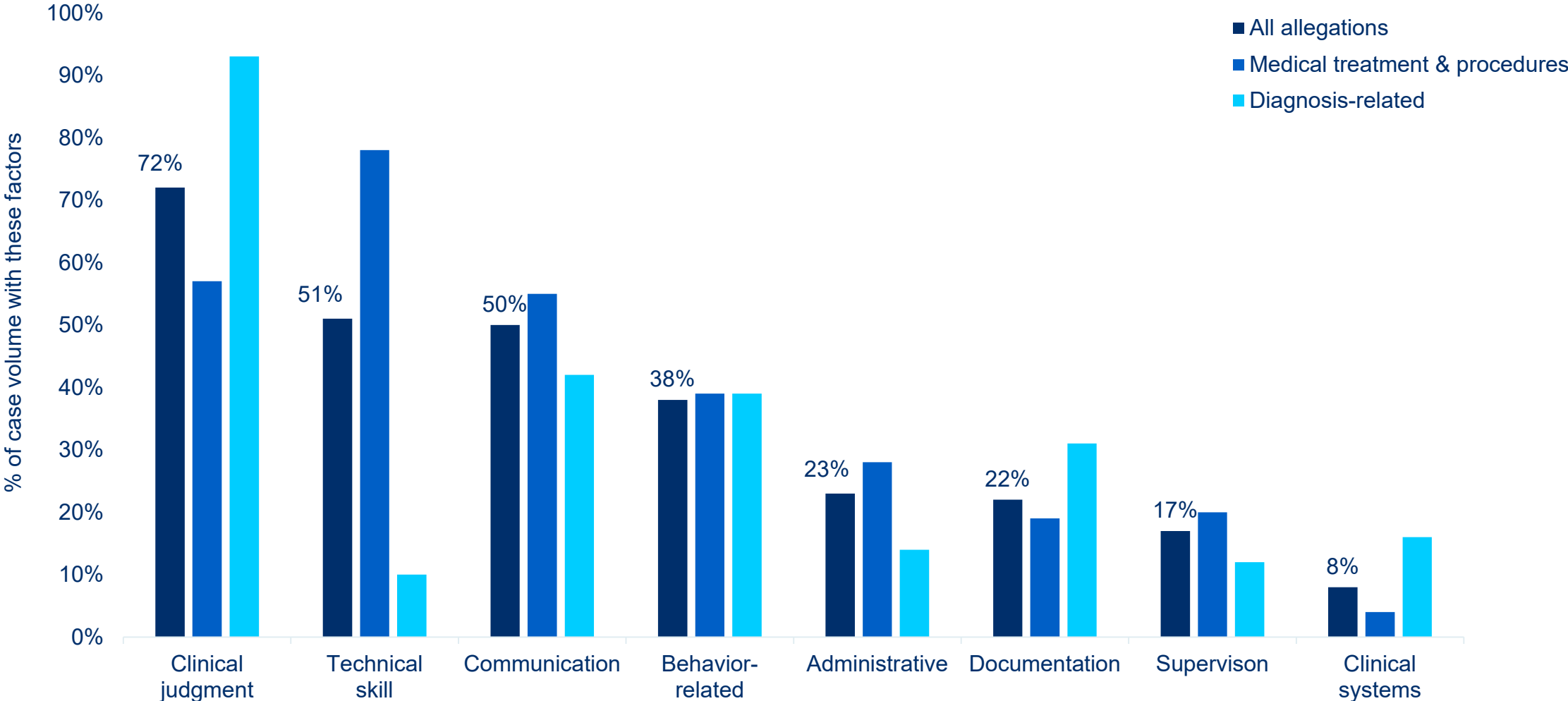
Technical skill

# Contributing Factor Category Definitions

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

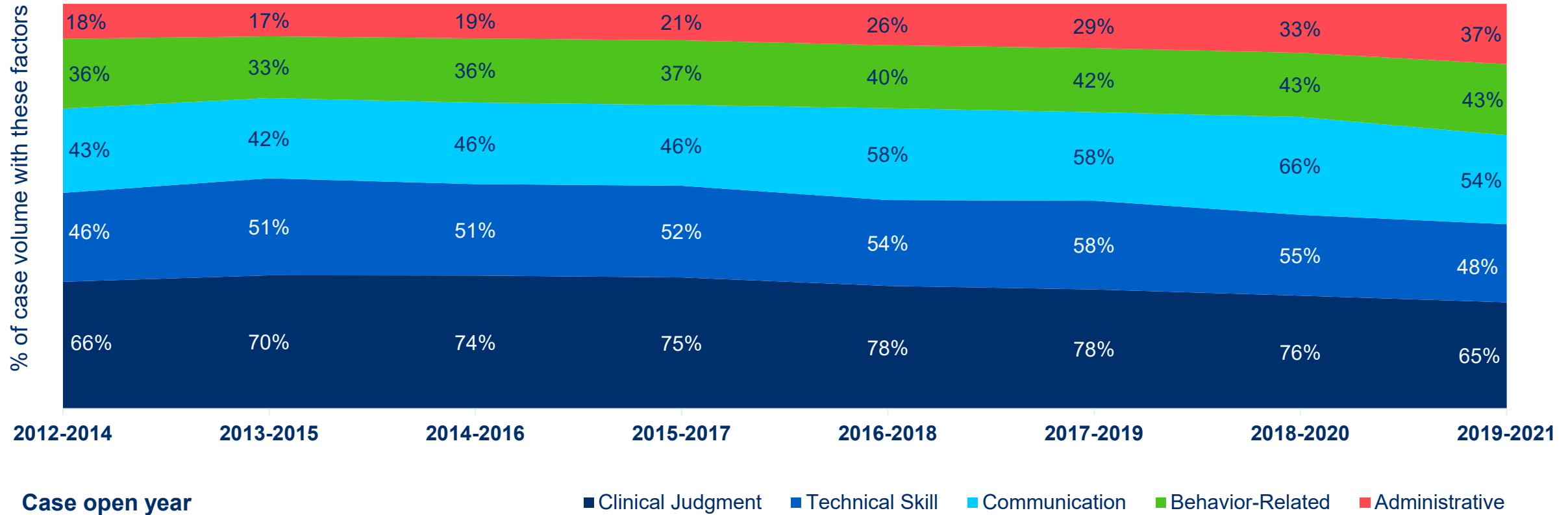
Administrative	Factors related to medical records (other than documentation), reporting, staff, ethics, policy/protocols, regulatory
Behavior-related	Factors related to patient nonadherence to treatment or behavior that offsets care; also provider behavior including breach of confidentiality or sexual 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, Dermatology as responsible service (N=366); 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

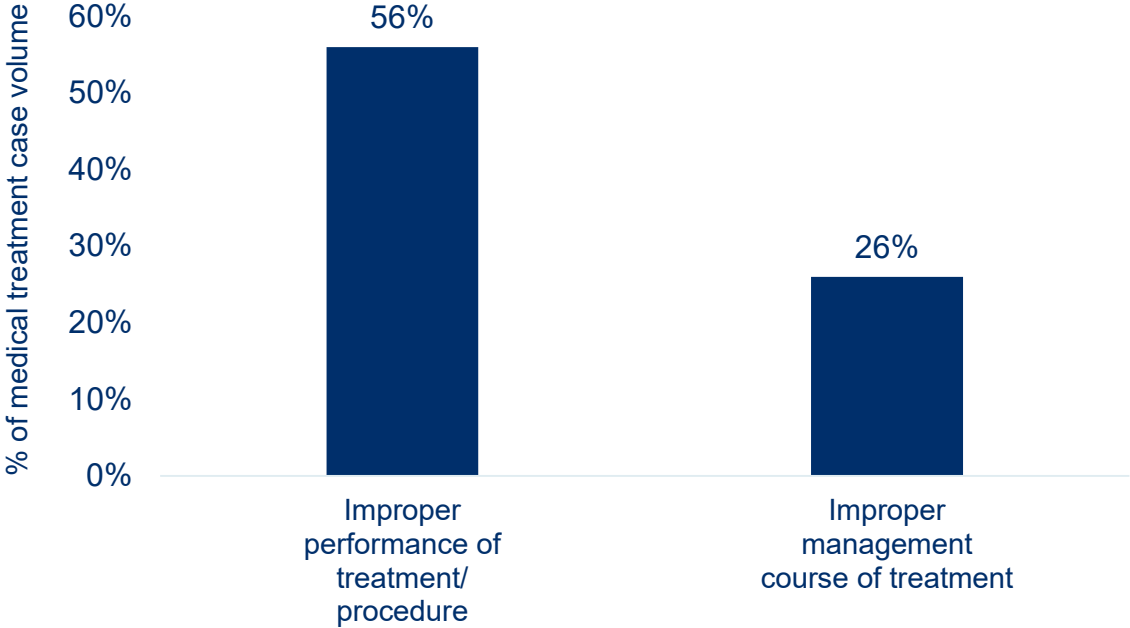
INTRODUCTION | KEY POINTS | GENERAL DATA ANALYSIS | CONTRIBUTING FACTORS | FOCUSED DATA ANALYSIS | CASE EXAMPLES | RISK MITIGATION

Factors associated with high clinical severity outcomes	(CJ) failure/delay in ordering diagnostic test (40%)	% of high severity case volume
	(CJ) failure to appreciate/reconcile signs/symptoms/test results (29%)	
	(CJ) selection/management most appropriate procedure (27%)	
	(CJ) failure/delay in obtaining consult/referral (21%)	
	(CJ) narrow diagnostic focus – failure to establish differential diagnosis (21%)	
Factors associated with the costliest indemnity payments	(CJ) failure/delay in ordering diagnostic test (62%)	% more expensive than the average indemnity payment*
	(DO) insufficient/lack of documentation related to clinical findings (46%)	
	(CJ) failure to appreciate/reconcile signs/symptoms/test results (26%)	
	(CJ) narrow diagnostic focus – failure to establish differential diagnosis (24%)	

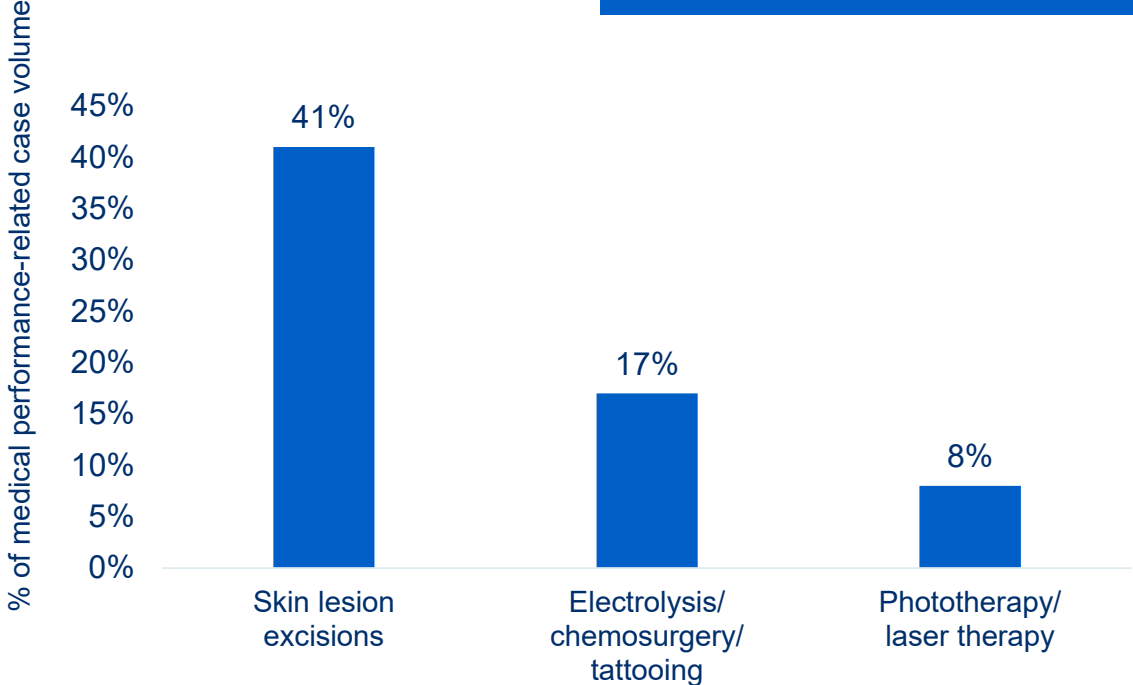
Clinical judgment factors related to diagnostic decision-making and insufficient documentation, which can lead to a more difficult defense of subsequent medical malpractice actions, are key drivers of both clinical and financial Dermatology case severity.

# Focus on Medical Treatment Allegations

Top allegation details



Top procedures involved

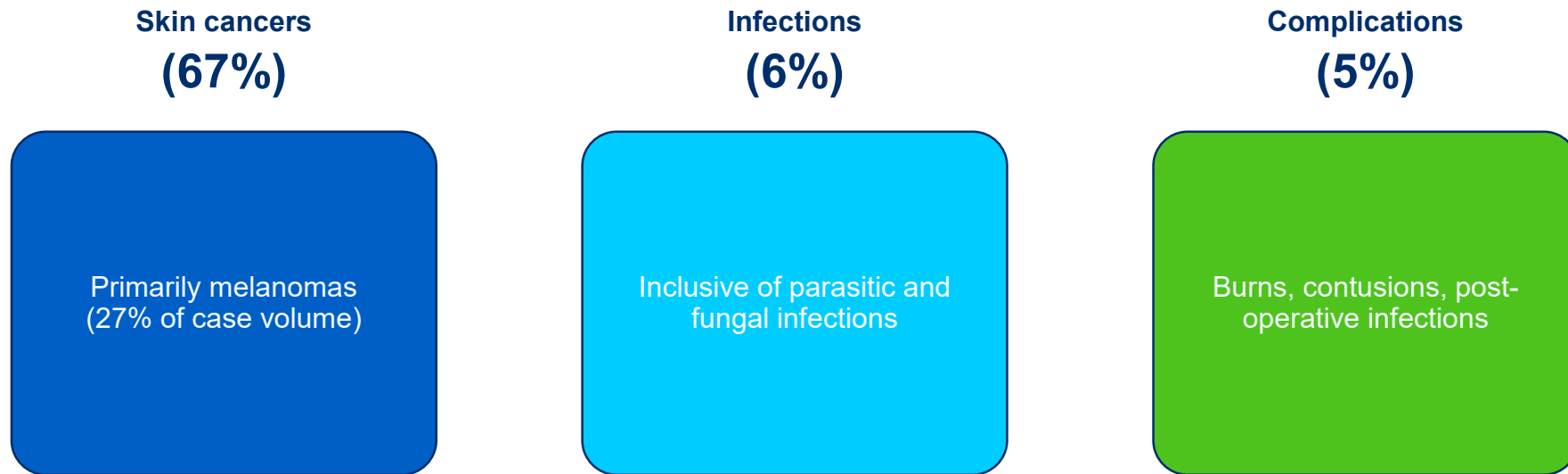


Procedural performance cases can be impacted by delayed recognition of complications, while management cases most often reflect issues with selection of the most appropriate course of treatment for the patient, and appreciating and reconciling symptoms and test results.

# 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.





# 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

<b>Initial diagnostic assessment</b>  <b>84%</b> of cases	Patient notes problem & seeks care
	History & physical
	Patient assessed, symptoms evaluated
	Differential diagnosis established
	Diagnostic testing ordered

## Phase 2

<b>Testing and results processing</b>  <b>21%</b> of cases	Performance of diagnostic tests
	Interpretation of diagnostic test results
	Test results transmitted to/received by ordering provider

## Phase 3

<b>Follow-up and coordination</b>  <b>59%</b> 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, Dermatology as responsible service (N=366); \*each step reflects a combination of contributing factors; diagnostic process of care algorithm courtesy of Candello, a division of CRICO Strategies



**The following stories are reflective of the allegations and contributing risk factors which drive cases brought against Dermatologists.**

**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

**\$250,000**

## CONTRIBUTING FACTORS

### Clinical environment

Chaos in the room

### Clinical judgment

Selection/Management of the most appropriate procedures

### Communication

Inadequate informed consent for procedure

Communication with patient regarding expectations

### Technical skill

Occurrence of known complication

IMPROPER PERFORMANCE OF LASER HAIR REMOVAL RESULTING IN BURN, NEED FOR PLASTIC SURGERY AND SCARRING

15-year-old female with a history of eczema, glabella (unibrow) and tachycardia presented to a Dermatologist (Derm) with complaints of facial rash and unwanted facial hair. **Derm records note patient was advised of the risks and benefits of laser hair removal**, including but not limited to, lightening or darkening of surrounding skin, crusting, scabbing, scarring, reactivation of cold sores, infection, need for multiple treatments, paradoxical hair regrowth and bruising (**patient denies being told of risks of burns or scarring**). Derm claims the patient understood the risks, benefits and alternatives and opted to proceed with treatment. On 2/5, the patient (with her mother) presented for the procedure which used an Alma Soprano Pulse Type SHR Laser placed directly over the treatment area (between eyebrows). During the procedure, **Derm claimed he was distracted by patient's mother having a "seizure."** The procedure lasted approximately 10 seconds and **resulted in the patient receiving an excessive dose of energy.** After Derm removed the device, it was apparent the patient had an injury; area was white and blistering, indicating damage. Derm had his assistant put ice on the affected area.

Although the patient wasn't seen until four days later, she claimed that on the day after the procedure, her eyes were swollen shut and her eyes, nose, cheeks, and forehead were badly bruised. On 2/9, at an office visit with Derm, **the patient was diagnosed with erosion of glabella skin.** The patient was advised to treat affected area with saline soaks, Bacitracin and Tefla. After this visit, Derm called the patient's home 2/12, 2/19 and 2/26, at which times **he noted that the patient report persistent skin erosion.**

On 2/26, the patient had an office visit with a Plastic Surgeon who diagnosed the patient with a 2-3cm 3rd degree burn over the affected area. On 3/5, **the surgeon performed debridement of the burn wound and reconstruction with a full-thickness skin graft** from patient's left post-auricular area. Despite the graft taking, the patient experienced complications with the grafted area, resulting in **hypertrophic scar tissue developing at the edges of the grafting** which were injected with steroids. **Tissue atrophy developed underneath the graft resulting in graft being depressed. Graft remained depressed with scar visible.**

# Case Examples

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

SETTLED

**\$1.5M**

CONTRIBUTING FACTORS

## Clinical judgment

Narrow diagnostic focus – atypical presentation & chronic/previous diagnosis assumed

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

## Documentation

Insufficient/lack of documentation – clinical findings

FAILURE TO DIAGNOSE MELANOMA RESULTING IN METASTASIS, WORSENING OF DISEASE AND PROGNOSIS

A 32-year-old male presented to his Dermatologist (Derm) for an **evaluation of a “changing” mole on the right midback** (electronic health record template defaulted to this as the chief complaint). Patient reported mole was present for years and had not changed. **Derm diagnosed asymmetric intradermal nevus** and recommended follow up in 2 to 3 months for monitoring.

The patient returned four months later, and Derm noted the lesion unchanged (**no pictures taken for comparison**). She felt that it was a benign intradermal nevus and possibly a combined nevus (2 moles that grew together). Derm recommended follow up in six months later for a full body skin exam. Patient did not return.

One year later, the patient went to another provider with complaints of a swollen gland in his right axilla and was found to have metastatic melanoma. **The primary site was determined to be the right paraspinal lesion that had been previously evaluated by Derm.** Patient had surgery followed by chemotherapy, which affected his pituitary gland. He will require lifelong hormone replacement therapy and lifelong monitoring for recurrence of cancer.

**The patient claimed Derm failed to biopsy the lesion, resulting in a failure to diagnose melanoma and resulting in metastasis,** need for more extensive treatment, worsening of prognosis and complications. Experts were not supportive of Derm’s lack of photos (which is the standard of care) and decision to not biopsy.

# Risk Mitigation Strategies

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

- **Ongoing evaluation of procedural skills and competency with equipment is critically important.**
- **Conduct a thorough assessment.**
  - Understand patient complaints and concerns.
  - Update and review medical and family history at every visit to ensure the best decision-making.
  - Be alert to high-risk diagnoses such as cancer, and maintain problem lists.
- **Communicate with each other.**
  - Focus on care coordination if other specialties are involved, including next steps and determining who is responsible for the patient.
  - Talk also to the patient/family, elicit a comprehensive patient history, conduct a thorough informed consent discussion, and provide thorough and clear patient instructions.
- **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.**
  - Discrepancies or gaps in the details/timing make it much more difficult to build a supportive framework for defense against potential malpractice cases.
  - Verify that documentation supports the clinical rationale for the method of treatment and describe the rationale for inclusion/exclusion of differential diagnoses.
- **Know (and adhere to) your supervision responsibility for advanced practice providers.**

# 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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