

Understanding Key Factors in Indemnity-Paid Cases

Data Insight

2024



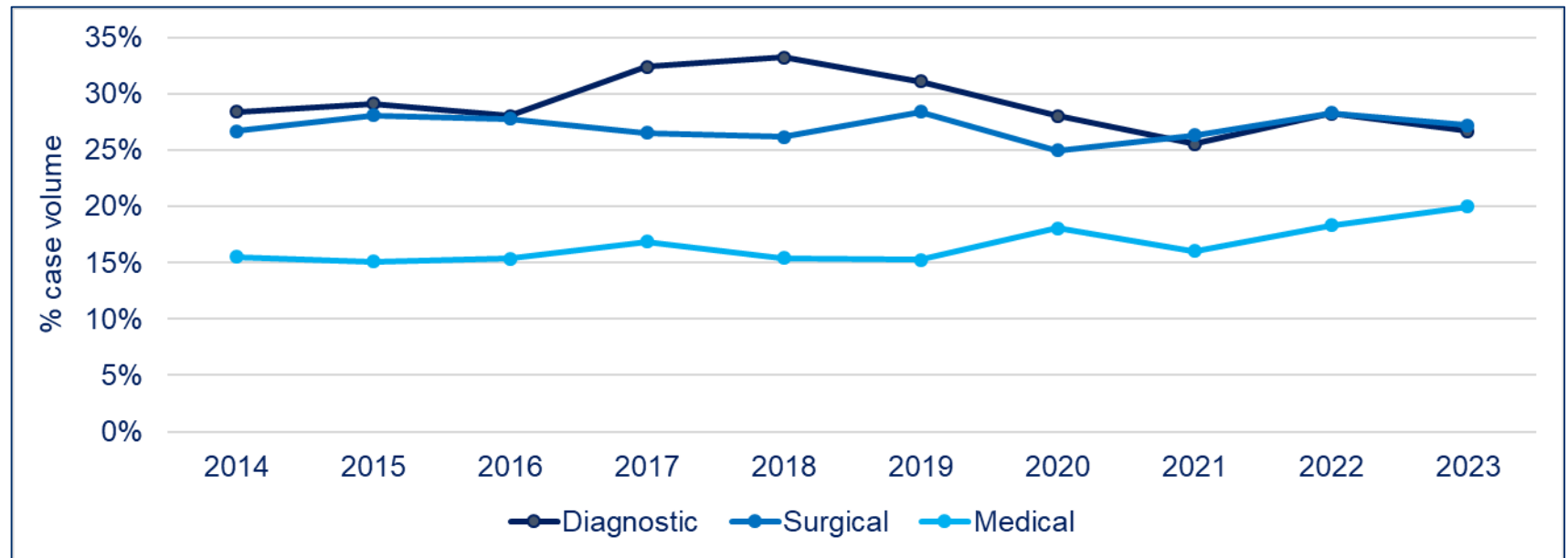
Case Types



Medical malpractice cases closed with indemnity payments reflect a variety of case types. Diagnostic, surgical, and broad-scope medical cases together account for 76% of these cases, followed by obstetric, medication, and anesthesia-related scenarios.*

Across the years, diagnostic cases have been most common, although in more recent years, an increase in surgical and medical cases has been identified, narrowing that gap.

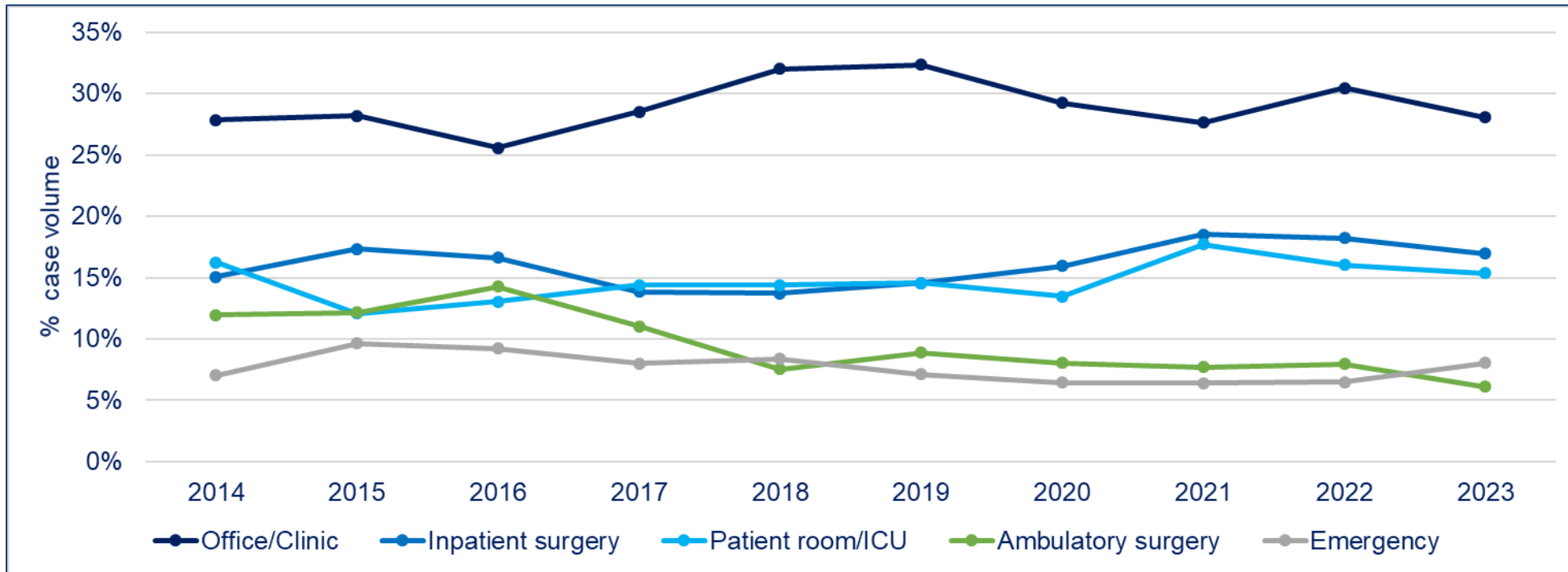
Diagnostic cases continue to be most often associated with cancers. Procedural performance and patient management issues are driving the increase in both surgical and medical case types.



*MedPro Group + MLMIC medical cases closed with indemnity paid 2014-2023 (N=>11K; excludes dental & senior care cases)

By Location

By location, indemnity-paid cases arise most frequently in an office/clinic setting. Related to the rising volume of surgical and medical cases, increasing case volumes are noted in inpatient surgery and patient room/ICU locations.

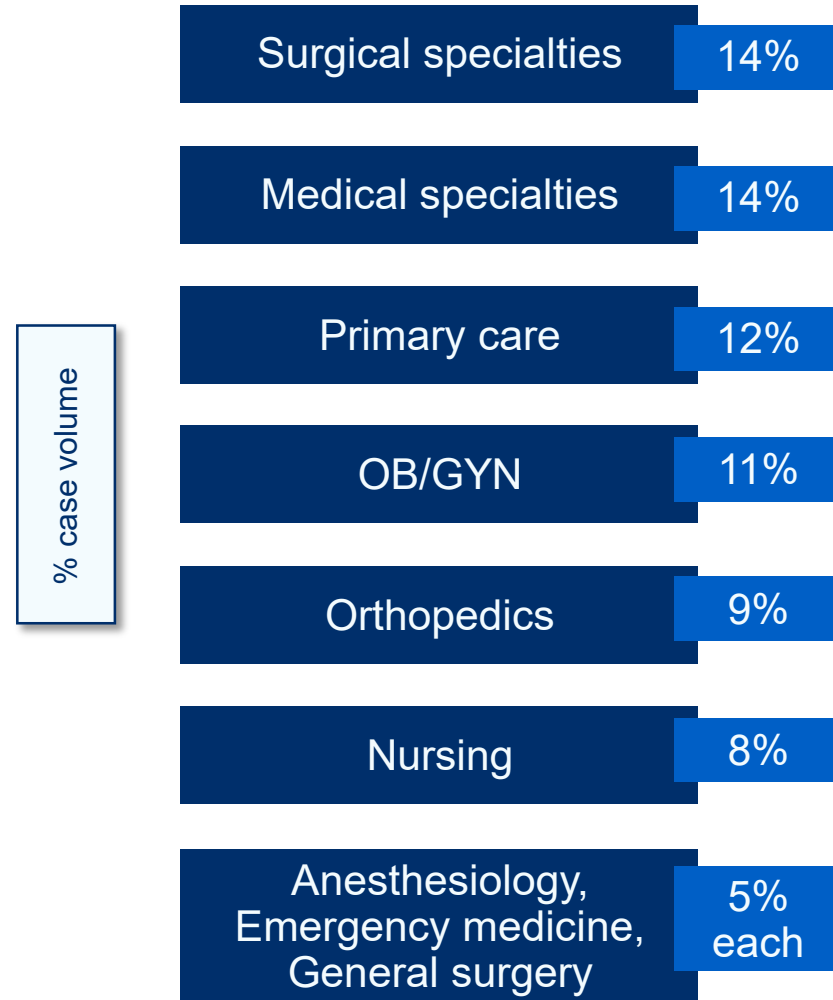


By Service

Each case reflects one service deemed to be primarily responsible for the patient's outcome. Those most commonly identified are noted here.

Each service includes the spectrum of providers delivering healthcare, including attending/consulting physicians, residents/fellows, advanced practice clinicians, nursing staff, and others.

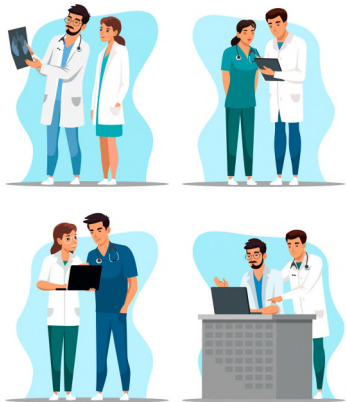
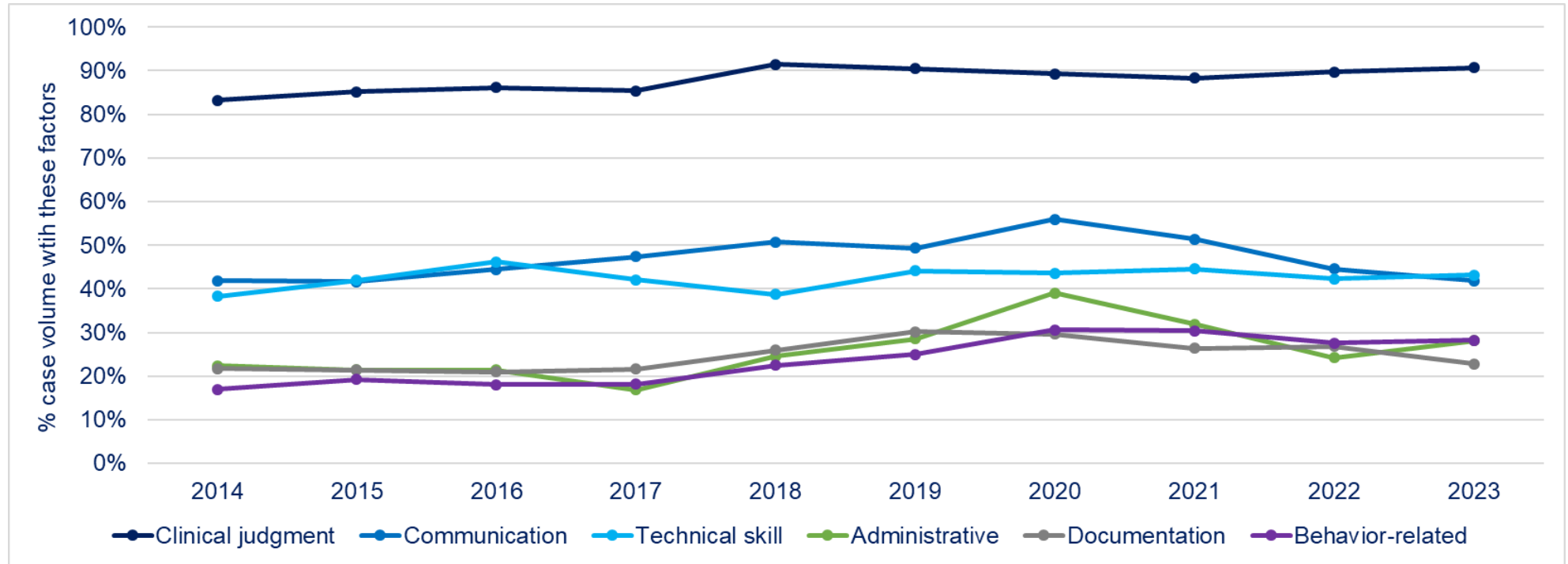
Across the years in this report, no notable trends were observed.



By Key Contributing Risk Factors

Contributing factors identify failures in the process of care which contribute to patient outcomes. These factors may also represent key considerations for initiation of the medical malpractice case, and often have significant impact on case resolution decisions. Multiple factors are identified in each case because generally, there is not just one issue, but rather a combination.

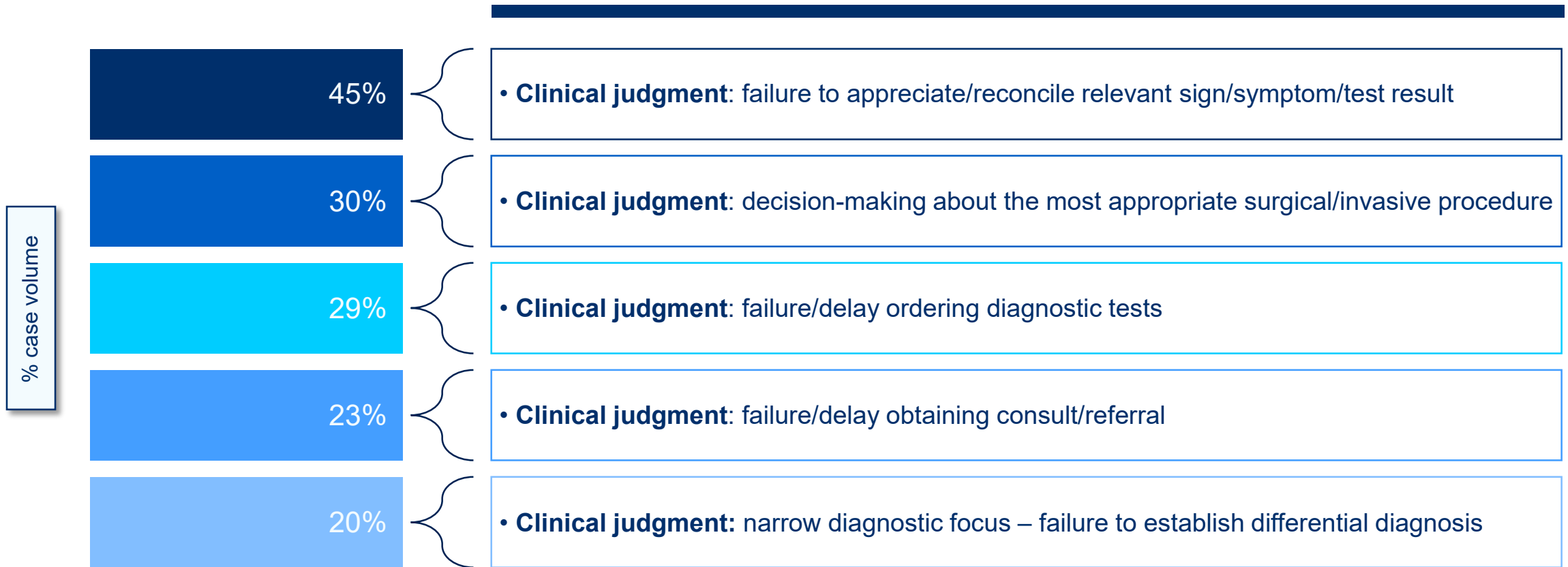
Across the years, the volume of communication, administrative and behavior-related case volumes changed most notably.



Key Contributing Risk Factor Details: Cases Closed \geq \$250K Indemnity Paid

INTRODUCTION | LOCATION | RESPONSIBLE SERVICES | CONTRIBUTING FACTORS | CASE EXAMPLES | RISK MITIGATION

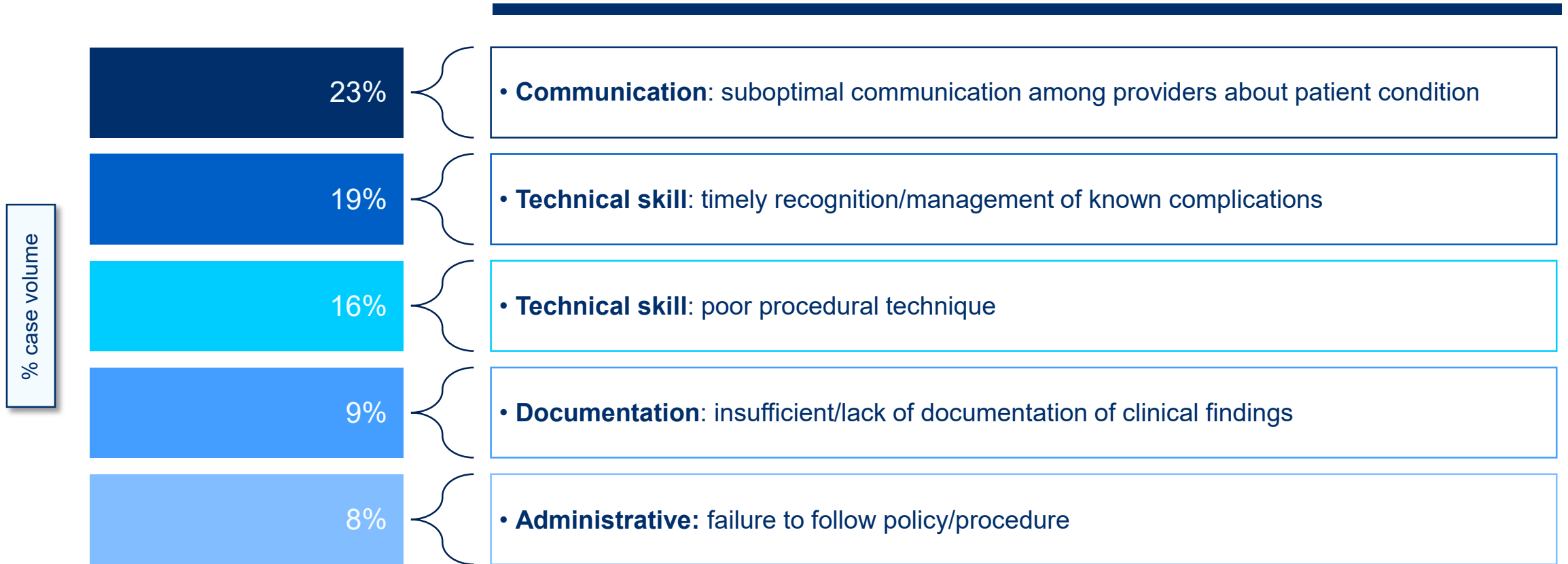
Due to the concentration of diagnostic cases in this dataset, clinical judgment factors, which are inclusive of diagnostic decision-making, heavily influence the case volume.

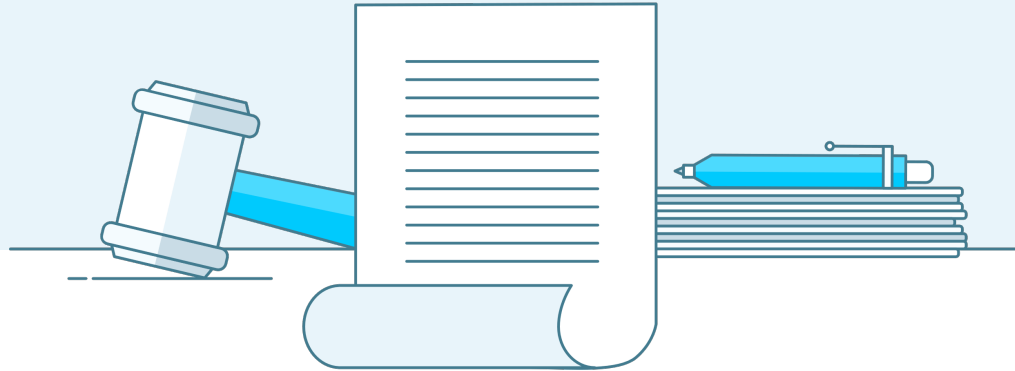


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Non-clinical judgment factors most commonly span communication, technical skill, documentation and administrative-related issues.





The following examples are reflective of the contributing risk factors which drive indemnity-paid cases.

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

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

Pediatrician did not appreciate the significance of the patient's abnormal echocardiogram and existing heart murmur; failed to consider endocarditis as differential diagnosis despite persistent fevers.

\$1.3M

Decision-making about the most appropriate surgical/invasive procedure

Expert reviewers critical of decision to perform a hernia repair at the end of a prostatectomy procedure, which prolonged surgery and anesthesia time for a patient with significant co-morbidities.

\$247K

Failure/delay ordering diagnostic tests

Failure to obtain pre-operative MRI and failure to use intra-operative neuro-monitoring during placement of spinal cord stimulator.

\$700K

Failure/delay obtaining consult/referral

Neurosurgeon failed to obtain infectious disease consult while patient was still in the hospital when a post-operative MRI revealed inflammation in the surgical area and culture was positive for infection.

\$450K

Narrow diagnostic focus – failure to establish differential diagnosis

Chest CT negative for suspected pulmonary embolus. Abdominal ascites and free air were noted in the upper abdomen; findings were attributed to recent surgery. Malignancy was not a differential diagnosis.

\$1.4M

Indemnity payments



Case Examples

Suboptimal communication among providers about patient condition

Patient's primary care physician and urologist never discussed the patient's pre-op and post-op anticoagulation regimen.

\$1.7M

Timely recognition/management of complications

Ophthalmologist's procedure resulted in a retinal tear (known complication); however, it was not immediately recognized and addressed during post-operative follow-up, leading to an eye infection.

\$375K

Poor procedural technique

General surgeon did not convert to open procedure when inflammation was encountered which obstructed the view of the surgical field.

\$400K

Insufficient/lack of documentation of clinical findings

Surgeon's operative notes lacked any mention of steps taken to preserve nerve function within the operative field (post-operative nerve damage sustained).

\$1.0M

Failure to follow policy/procedure

Nursing staff failed to follow policy for vesicant infusion site choice and then, after extravasation occurred, failed to follow the extravasation procedure, including notification of the oncologist.

\$236K

Indemnity payments



These resources were curated from MedPro's publications.

[Clinical Judgment in Diagnostic Errors](#)

[Handoffs and Care Transitions](#)

[Documentation Essentials](#)

Find additional helpful resources online at www.medpro.com/dynamic-risk-tools, and follow us on [LinkedIn](#) and X/Twitter ([@MedProProtector](#)).

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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