

FEBRUARY

CLAIMS Rx

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Decoding Medical Professional Liability:

Emerging Trends and Risk Reduction Strategies
in Three Key Medical Specialties

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Decoding Medical Professional Liability:

Emerging Trends and Risk Reduction Strategies in Three Key Medical Specialties

INTRODUCTION

Medical professional liability remains a challenge for healthcare providers in the United States, intricately linked to clinical practice and legal landscapes. As physicians and healthcare providers navigate their roles in patient care, they are met with a unique set of liability risks that require specialized attention. A nuanced understanding of these risks not only helps reduce claim frequency but also elevates the standard of patient care, thereby contributing to the broader goals of healthcare excellence.

Advancements in data analytics have enabled a more rigorous examination of medical professional liability claims, offering valuable insights into patterns, risk factors, and risk reduction strategies. Informed by extensive data spanning multiple years, this analysis ventures into the specifics of claim trends and risk management strategies, focusing on three unique specialties: family medicine, orthopedic surgery, and radiology.

As healthcare settings evolve and become increasingly complex, the need for a data-driven approach to medical liability becomes ever more critical. Guided by evidence-based analysis, this discussion aims to be a cornerstone resource for healthcare providers and risk managers. It outlines key findings relevant to each specialty and offers practical, actionable advice to mitigate risks and improve patient outcomes.

The takeaway is clear: The healthcare industry is changing, necessitating individualized approaches to risk management. Care quality, the likelihood of medical professional liability lawsuits, and the financial and public standing of healthcare providers and organizations can all be improved with the help of this data-driven strategy. The healthcare business can welcome a safer and more reliable future for all parties involved by turning insights into proactive measures.

METHODOLOGY

The basis of this study is a dual-source analytical approach to achieve a unique and nuanced understanding of medical professional liability claims. We examined data from two pivotal nationwide repositories: the National Practitioner Data Bank (NPDB) and the Medical Professional Liability (MPL) Association Data Sharing Project. Each offers unique yet complementary insights into the landscape of healthcare claims. For a reasonable sample size, we focused only on data with claims closing within a 10-year period (2012-2021).

National Practitioner Data Bank (NPDB)

The NPDB is a primary source for analyzing overarching trends in healthcare claims. This federal database consolidates a wide array of reports concerning disciplinary actions and medical malpractice payments, offering a robust platform for a nationwide analysis. We leveraged NPDB data to conduct our longitudinal assessment of key trends such as claim frequency and severity. One of the limitations of the NPDB is that it does not offer specialty-specific insights or granular data related to allegations and patient injuries, necessitating the incorporation of supplementary data from other sources.

Medical Professional Liability (MPL) Association Data Sharing Project

To delve into specialty-specific claims, we analyzed data within the MPL Association Data Sharing Project. This repository is esteemed for its exhaustive aggregation of medical professional liability data, offering nearly case-level granularity across various medical specialties. To ensure relevance and adequate sample size, we focused on claims data with unique aspects pertinent to three large medical specialties.

Overview of Medical Liability Claims Trends

Analyzing healthcare claims over the past decade reveals noteworthy trends in an environment where every metric and statistical fluctuation can have far-reaching implications. Using data from the NPDB, this section focuses on three main aspects: the frequency of healthcare claims, the average severity of these claims, and the percentage with indemnity payments exceeding one million dollars.

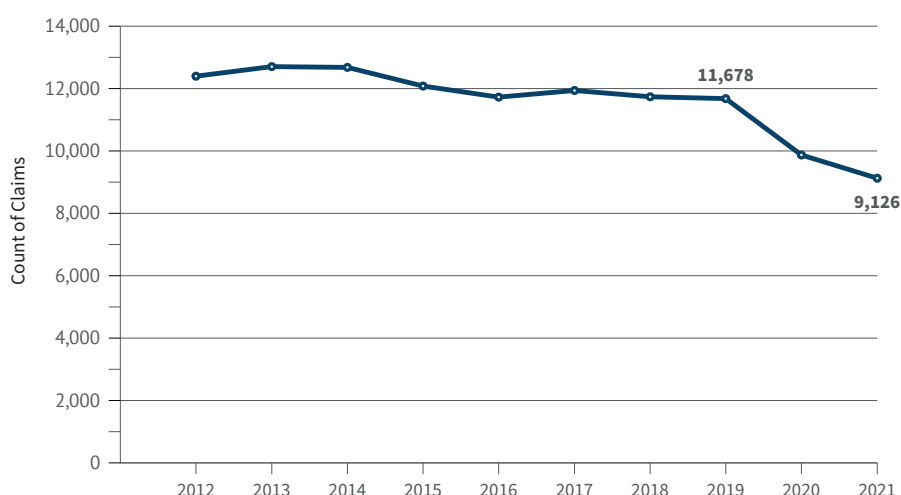
THE FREQUENCY OF CLAIMS HAS DECREASED

Fewer professional liability claims alleging medical malpractice have been filed since the early 2000s. In 2018 a CRICO Strategies benchmarking report identified a 27% drop in claims overall. This decline was observed broadly “across the many segments of health care delivery.”¹

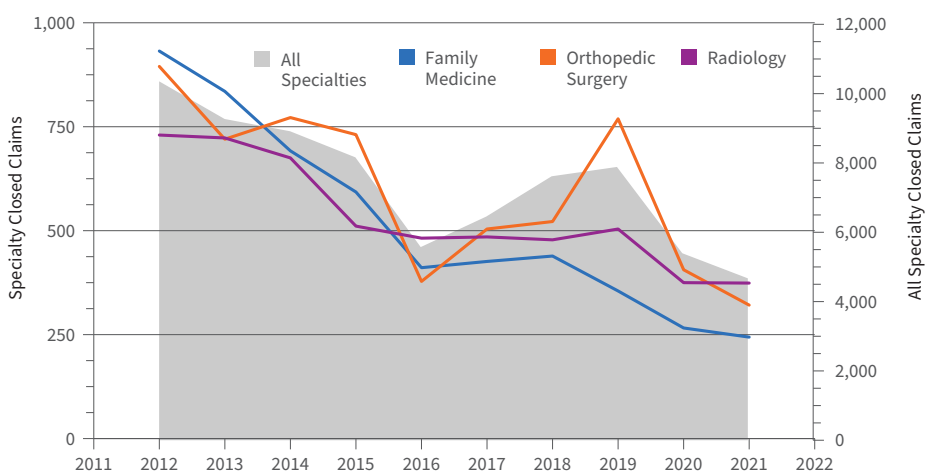
For our review period, healthcare witnessed a gradual but consistent decline in paid claims. These are professional liability claims against healthcare providers that resulted in an indemnity payment or money being paid to a plaintiff on behalf of a defendant. According to the analysis of the NPDB, in 2012 the number of paid claims stood slightly above 12,000; by 2021 this figure had decreased to just over 9,000.²

In our analysis, the MPL Association data for the three selected specialties—family medicine, orthopedic surgery, and radiology—corroborate these broader trends observed in the NPDB. Specifically, the MPL Association data reinforced the overarching trend of declining frequency of claims across these specialties, aligning closely with the national statistics.³ It is worth noting that each specialty presented unique nuances in the MPL data, providing a deeper, more granular view that underlines the importance of targeted, specialty-specific risk management and risk mitigation strategies.

Paid Claim Frequency Trends



Closed Claim Frequency Trends



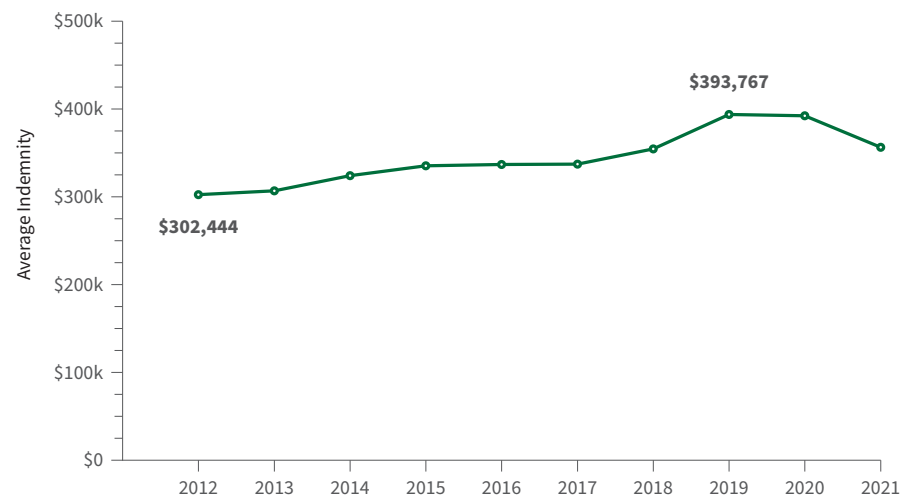
AVERAGE INDEMNITY OF CLAIMS HAS INCREASED

While the frequency of claims shows a decline, the landscape changes significantly when we examine the financial severity of these claims. Indemnity in medical professional liability insurance is money paid to a claimant or plaintiff for adjudicated damages. Indemnity in medical professional liability claims can serve as a useful barometer for evaluating risk in the healthcare sector. Analyzing the average indemnity payments year over year reveals patterns that can be invaluable for risk assessment. Fluctuations in these payments manifest from many different influences, many of which are difficult or impossible to discern. These influences could include advancements in medical technology, evolving patient expectations, and changing legal environments.

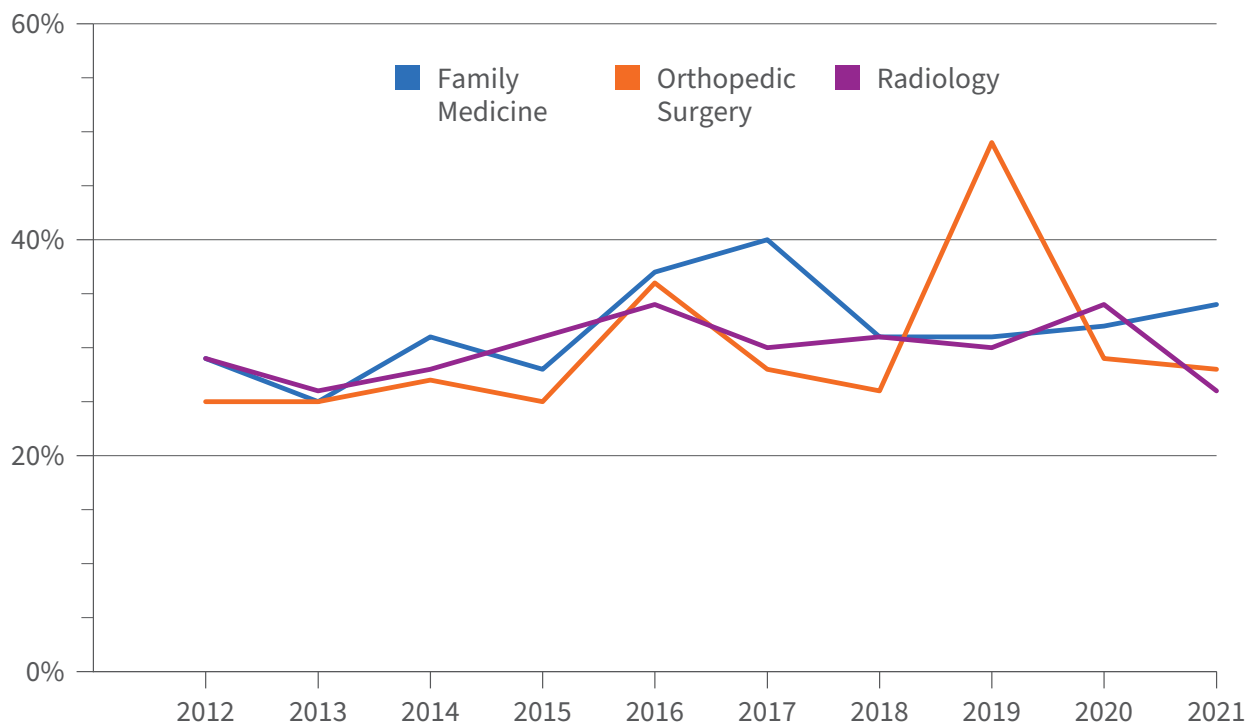
Contrary to the decline in frequency, the severity of claims—measured in monetary terms—has generally escalated. According to NPDB data, in 2012 the average payout for a healthcare claim was just above \$300,000. By 2019 this average had surged to nearly \$400,000.² This escalation shows that while there may be fewer claims, the cases that arise are increasingly costly in terms of indemnity payments.

This is also reflected in MPL Association data with a slight increase in the paid-to-close category.³ The paid-to-close ratio is the overall number of claims filed divided by the number of claims with indemnity paid.

Paid Claims Average Severity Trends



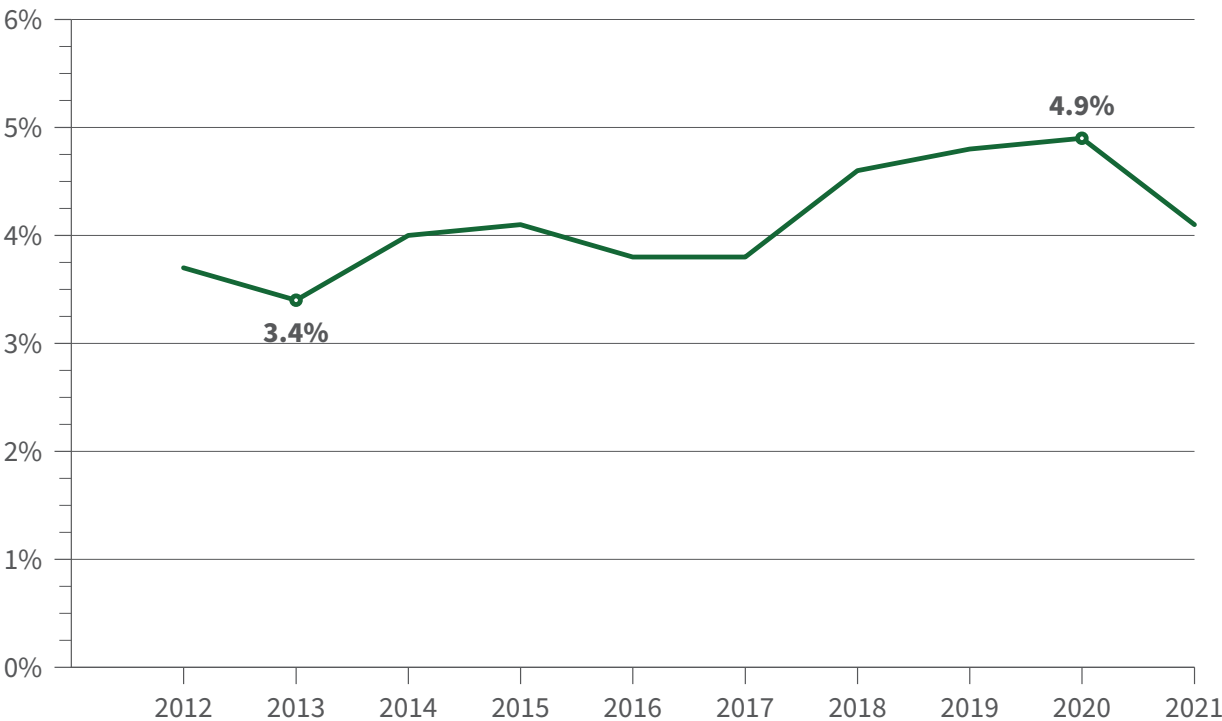
Paid-to-Close Ratio Trends



HIGH-VALUE INDEMNITY CLAIMS

Another trend that has manifested over the years is the growth in high-value indemnity claims, specifically those exceeding one million dollars. According to NPDB data, in 2012 these constituted about 3.4% of all paid claims. This percentage peaked at almost 5% in 2020 before slightly retracting to a little over 4% in 2021.² Other reports such as the Aon/ASHRM annual survey also note a continual increase in large claim frequency of claims greater than \$5M.⁴ The increase in high-value indemnity payments warrants attention as an important signal in litigation trends.

Percent of Indemnities Over \$1M



The trends highlighted here provide a nuanced picture of the evolving landscape of healthcare claims. While the frequency of claims appears to be on a downswing, both the average severity and the proportion of high-value claims have followed an upward trajectory. These developments underscore the need for healthcare providers to continuously refine their risk management strategies, keeping abreast of the quantitative and qualitative shifts in healthcare claims.



Comparisons Across Medical Specialties:

Common Threads, But Unique Risks

Examining overall trends is an important first step in understanding the claims environment. But in the diverse world of healthcare specialties, a one-size-fits-all approach to evaluating professional liability claims provides only limited insights. Specialties vary significantly in their procedures, patient interactions, and inherent risks, making dissecting claims data on a specialty-specific basis imperative. Digging deeper, though, reveals that while some specialties may experience a higher frequency of claims, the financial and clinical severity of these claims can vary widely. For example, while we would naturally expect family medicine to have fewer surgical error claims than orthopedic surgery, the claims in family medicine are more diverse, ranging from misdiagnosis to medication errors. These comparative insights are crucial for healthcare providers and risk managers to understand their place within the broader healthcare ecosystem and to develop specialty-specific risk mitigation strategies.

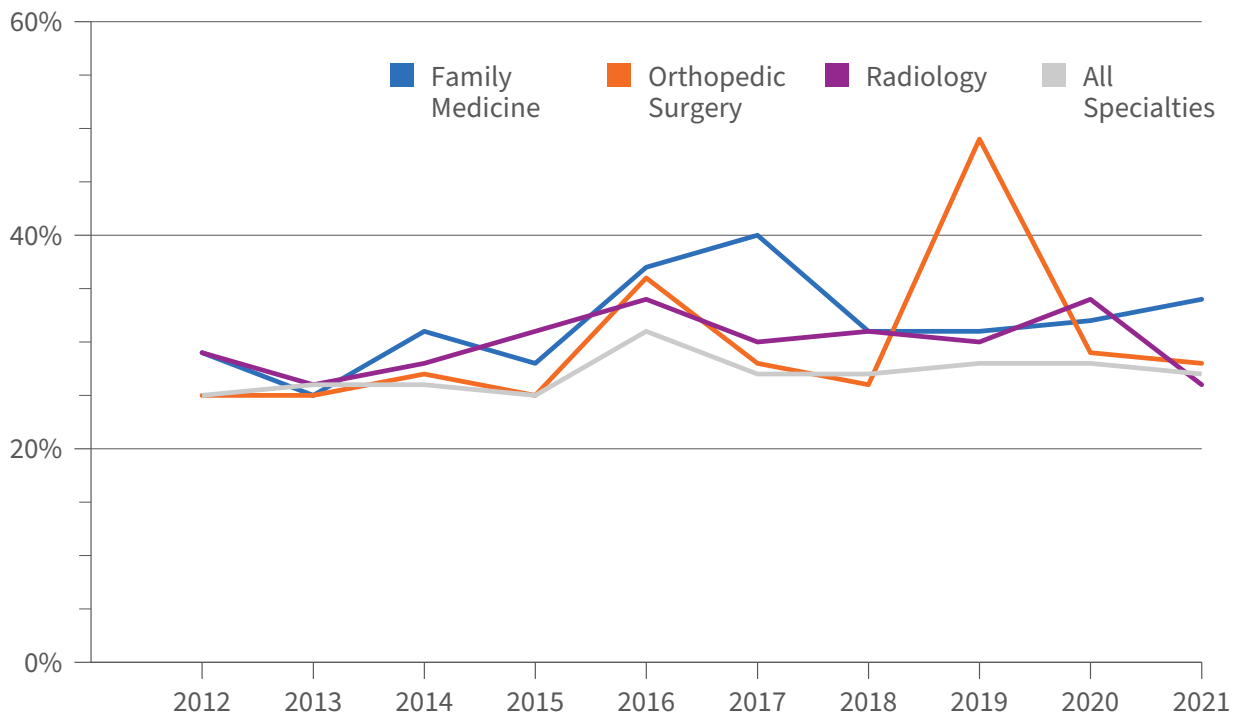
Understanding the nuances of liability claims within a specific specialty can directly inform patient safety measures. Whether recognizing a recurring issue in postoperative care in orthopedics or identifying a pattern of misdiagnosis in family medicine, specialty-specific data provides the granular detail necessary to implement targeted interventions.



Family Medicine Claims: Above Average Paid-to-Close Ratio

Family medicine claims exhibit unique characteristics that differentiate them from the overall attributes of medical specialty liability claims. This specialty faces a significant and challenging claims profile in part because of the breadth of services provided, including cardiovascular and obstetric care.⁵ One of the most striking features of this study is the paid-to-close ratio for family medicine claims, which averaged a higher ratio compared to other specialties in this period.

Paid-to-Close Ratio Trends



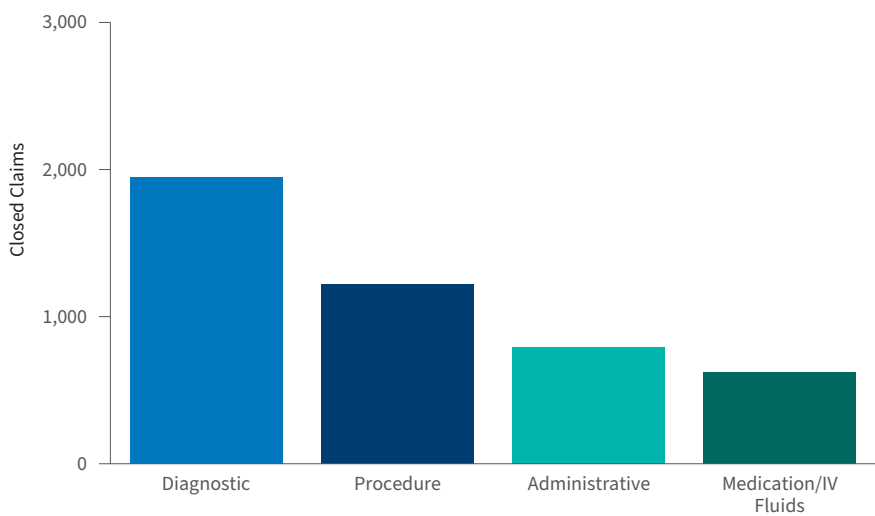
Claims in family medicine often center around issues related to diagnostic errors, delayed treatments, and issues with medication prescriptions. Analysis of MPL Association data shows a breakdown of some of the most frequent main allegations against family medicine physicians and providers.³

A study of medical liability claims involving a large academic family medicine department provides similar results: 61.8% of claims involved diagnosis-related allegations, and 16.4% involved treatment-related allegations.⁵

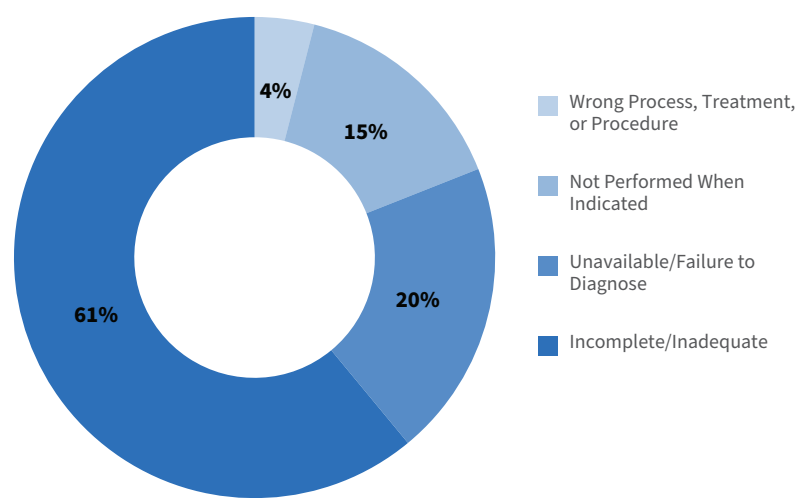
Digging further into the diagnostic claims, our analysis shows the breakdown of the chief medical factors associated with diagnostic error allegations. The major factor, encompassing more than 60% of claims, was allegations of incomplete or inadequate diagnostic process.³ One study in this area found that out of more than 2,000 primary care claims, the main reason for the claims was delays in screening or testing.⁶

Regarding alleged injury, family medicine claims tend to have a below-average severity compared to specialties overall. While this is a positive aspect, the elevated frequency of such claims suggests that the lower severity should not cause complacency. The types of allegations often relate to critical parts of medical practice, diagnosis, and testing. Even if the financial payouts are below average, the human cost and the reputational risk remain significant concerns.

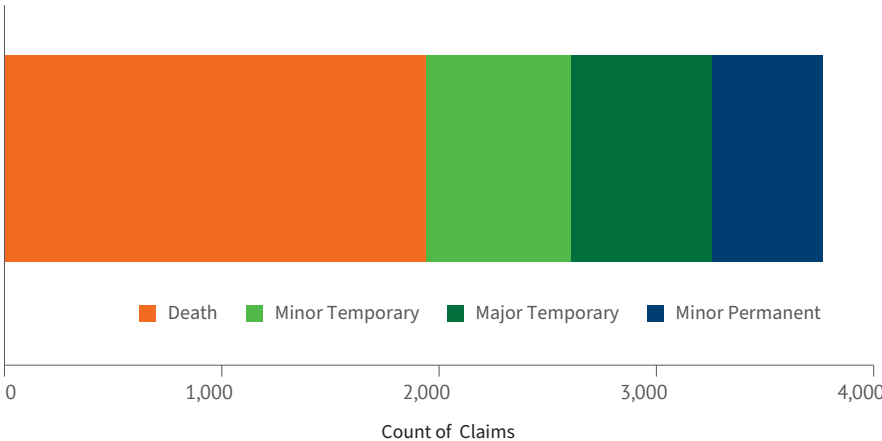
Top Primary Allegations: Family Medicine



Diagnostic Chief Medical Factors: Family Medicine



Top Severity of Alleged Injury For Family Medicine Claims





CASE ONE:

Misdiagnosis

The patient presented to the physician with complaints of a lump in his groin and over a week of coughs, shortness of breath, chills, and night sweats. Lab results were normal. A chest x-ray, read by a radiologist, revealed minimal infiltrate of the left middle lung consistent with pneumonia. Based on the x-ray and patient complaints, the doctor prescribed an antibiotic.

Over a month later the doctor called the patient to follow up. The patient reported feeling well, and the doctor instructed him to obtain a follow-up x-ray. The patient later denied he was told this, and the doctor failed to document it.

About 10 months later the patient left a message for the doctor complaining of an upper respiratory infection with bronchial cough. The doctor prescribed azithromycin and promethazine with codeine. About three months after that the patient saw the doctor for an upper respiratory infection for one week and congestion, phlegm, fever, chills, and sweats. Temperature was normal and lungs were noted as clear. Azithromycin was prescribed.

A few months after that the patient presented to the local hospital with a cough and shortness of breath for one week. A chest CT scan indicated a 4 cm x 6 cm x 6 cm mass in the left lower lobe that abutted the major fissure. It indicated some scattered subcentimeter nodules in the left lower lobe. The patient was referred to a pulmonologist and oncologist for follow-up.

One month later and following an endobronchial ultrasound with needle aspiration of four lymph nodes, the patient was diagnosed with stage IV non-small cell squamous lung cancer. He had two Gamma Knife procedures for brain tumors but passed away less than a year later.

A lawsuit was filed against the physician. It alleged, among other things, failure to perform further testing after the initial visit and follow-up to ensure the pneumonia had cleared and that the infiltrate was caused by pneumonia.



DISCUSSION

Plaintiff and defense experts disagreed on whether the standard of care necessitated a follow-up x-ray or additional tests. The plaintiff alleged that a follow-up x-ray should have been ordered. Further, the plaintiff asserted that if the finding was the same it would have necessitated a CT scan, needle biopsy, and referral to a thoracic surgeon for resection.



RISK REDUCTION STRATEGIES

To mitigate risks identified in the claims data, family medicine practitioners can:

- Engage in professional development programs focusing on the common reasons for professional liability.
- Adhere to established clinical guidelines and best practices for diagnosis and management of respiratory conditions.
- Consider consultation or referrals. Consult with a specialist, such as a pulmonologist, if the patient's condition is complex or if there is an uncertainty about the diagnosis.
- Ensure that patients receive timely follow-up care.
- Make sure that patients are well informed about their conditions and treatment plans and that they have the opportunity to ask questions and express concerns.
- Clearly document the rationale for performing diagnostic testing. Include any clinical rationale based on the patient's condition.
- Document all actions related to patient communication and education, including telephone encounters.

ADDITIONAL RESOURCE

ProAssurance *Claims Rx*: “[Delayed Diagnosis of Lung Cancer: Risk Reduction Communication Strategies for the Healthcare Team](#)”⁸

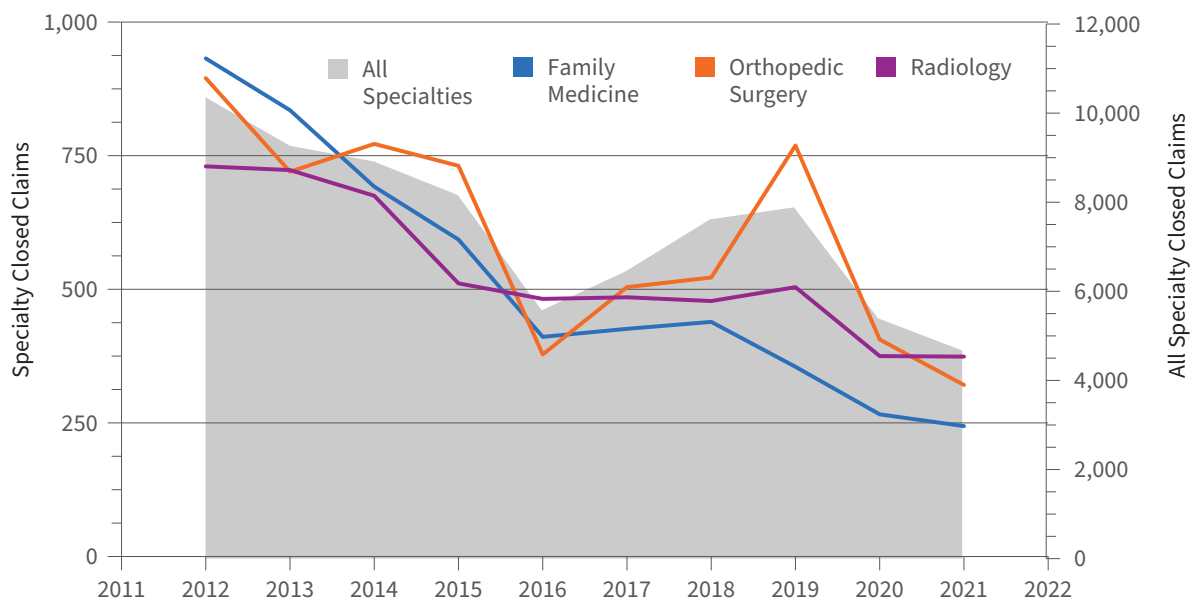


Orthopedic Surgery Claims: Procedural Complication Allegations Dominate

Orthopedic surgery data shows discernible fluctuations in average indemnity payments over the years, impacted by various factors such as advances in surgical techniques, legal changes, and patient expectations. For instance, the introduction of new surgical technologies can lead to a transient increase in claims as surgeons adapt to the latest techniques.⁹ Understanding indemnity trends such as these can offer orthopedic surgeons valuable risk assessment and strategic planning perspectives.

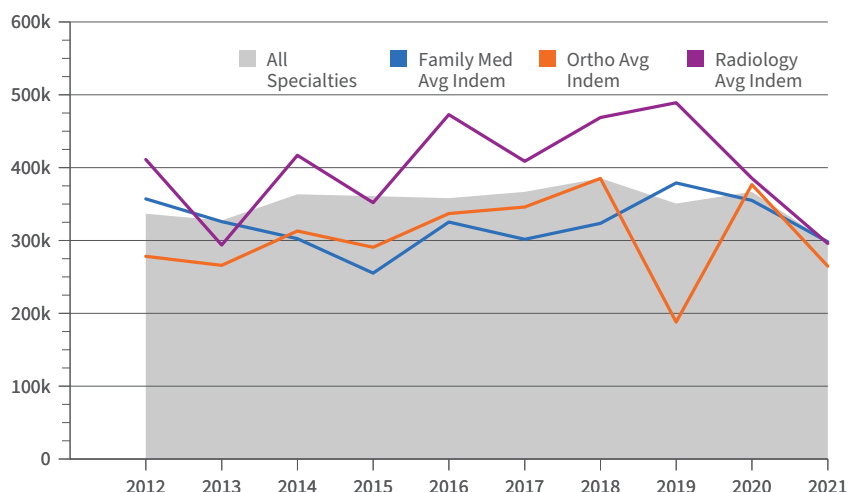
Orthopedic surgery stands out for its relatively paradoxical pattern of claims. On the one hand it exhibits an average frequency of closed and paid claims when compared to other specialties. On the other, based on analysis of MPL Association data, the severity of these claims often falls slightly below the average.³

Closed Claim Frequency Trends



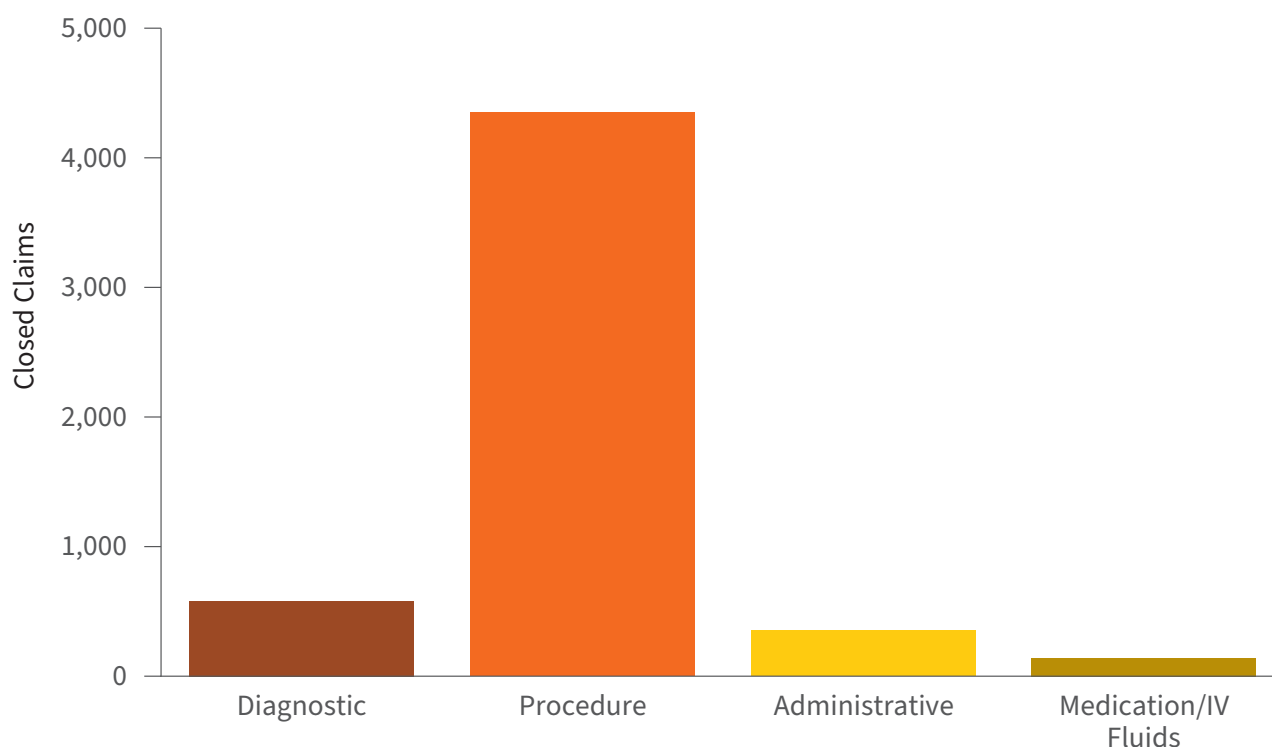
In orthopedic surgery, procedural complications emerge as the dominant medical factor regarding claims frequency.³ These factors often involve issues such as incomplete or inadequate procedures and failure to recognize problems during the surgical process. One study classified surgical specialties as high risk for professional liability claims. This is because the allegations center around actions and performance issues, or as the study authors referred to it, issues of commission vs. omission.¹⁰

Average Indemnities: Specialty Comparison



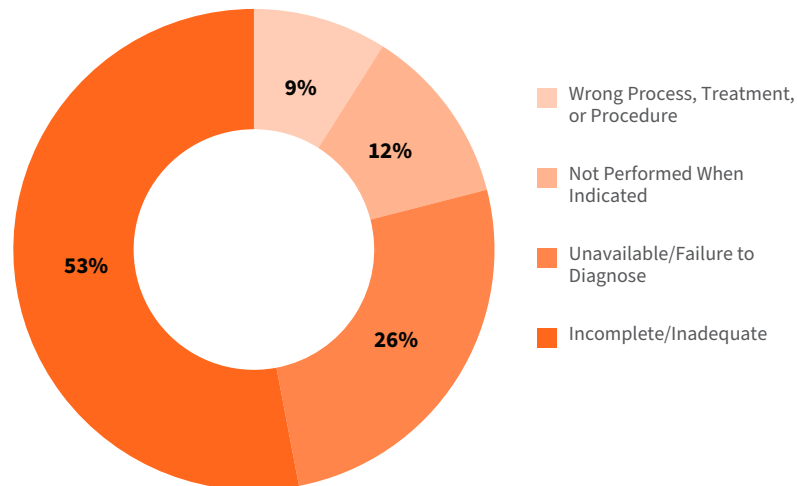
Procedural complications account for a staggering 72% of allegations made in orthopedic surgery claims. This contrasts with the broader landscape of medical professional liability claims, where procedural allegations make up only 26%.³ This disparity emphasizes the heightened risk associated with surgical procedures in orthopedic practice and underscores the need for rigorous standards and protocols to mitigate these risks.

Top Primary Allegations: Orthopedic Surgery



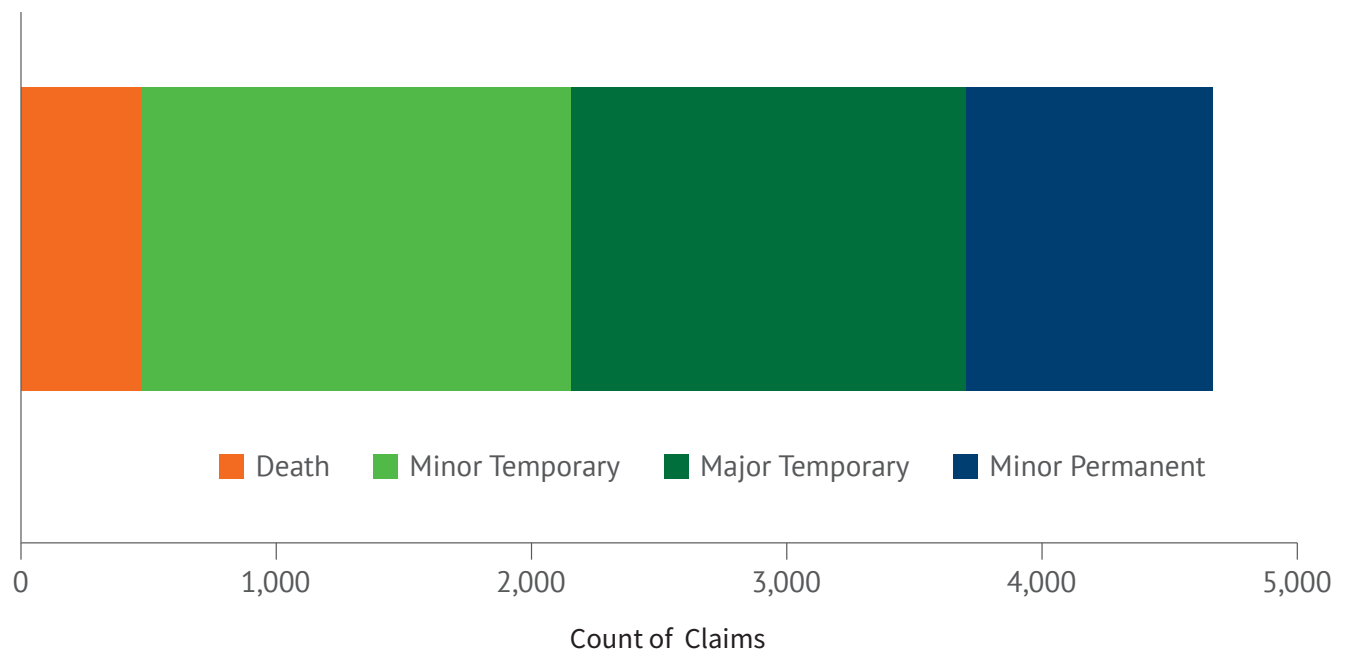
Digging deeper into the chief medical issues commonly implicated in orthopedic claims, we also find that alleged inadequacies in surgical technique, and failure to recognize postoperative complications, are prevalent. Unique to orthopedic surgery among the specialties in this study is the role of diagnostic or assessment errors concerning surgical procedures. This highlights the intricate relationship between preoperative evaluation and surgical outcomes, pointing to a critical area for targeted risk management.

Diagnostic Chief Medical Factors: Orthopedic Surgery



In terms of severity, orthopedic surgery claims tend to result in less severe outcomes when compared to the broader spectrum of medical specialty claims. The most common categories of severity include temporary minor and major injuries, often related to surgical complications or postoperative care. One study of orthopedic claims found the most frequent injury alleged by plaintiffs was “residual pain after treatment due to a mechanical etiology, followed by complaints of nerve damage.”¹¹ Interestingly, the incidence of death in orthopedic surgery claims is significantly low, constituting only 8% of claims as opposed to the general rate of 26% across all specialties.³

Top Severity of Alleged Injury For Orthopedic Surgery Claims





CASE TWO: Inadequate Technique

A 48-year-old patient presented to an orthopedic surgeon to evaluate and treat a sports-related injury to the right knee. The patient reported that he had injured his knee practicing martial arts more than a month earlier. He reported pain of 8/10 with decreased range of motion (ROM), reduced strength, and difficulty ambulating. The surgeon reviewed a previous MRI study which revealed a right anterior cruciate ligament (ACL) rupture and a right medial collateral ligament (MCL) tear, grade 2.

After a month of unsuccessful conservative treatment, ACL reconstructive surgery was scheduled. During the procedure the Coring Reamer broke while drilling the tibial tunnel, and the positioning of the hardware caused a 50% tear and avulsion of the autograft tendon. The surgeon missed a small fragment of the reamer underneath the skin at the incision site. Because of the damaged tendon, the surgeon drilled a second tunnel and supplemented it with allograft tissue to complete the procedure.

A little over two months later the surgeon performed a right knee arthroscopy. An extensive release of adhesions was performed, which improved the ROM significantly. The surgeon also removed the remaining metallic fragment.

Over the next three months the patient followed up with the surgeon for limited ROM, mild to moderate effusion of the knee, and muscle atrophy. The surgeon performed multiple needle aspirations and directed the patient to continue with PT and refrain from exercise/impact activities.

Following this, the patient began receiving treatment with several other orthopedic surgeons and underwent multiple surgical procedures, attempting to regain full ROM. About five years after the original surgery, the patient underwent plastic surgery to prepare the leg for reconstruction. Postop, he developed MRSA requiring an extensive stay in the ICU. Soon after that he underwent an above-the-knee amputation.

The patient brought a lawsuit against the orthopedic surgeon alleging, among other things, improper performance of an ACL repair of the right knee. It stated failure to remove retained metal fragments and tearing of the ACL graft during surgery caused severe arthrofibrosis of the right leg and subsequent amputation above the knee. The patient further alleged that the orthopedic surgeon failed to obtain informed consent because he never discussed the risks of surgery or the chance of developing arthrofibrosis.



DISCUSSION

Expert support was mixed. Criticisms centered on the orthopedic surgeon not removing the avulsed graft and proceeding with an allograft or another autograft from the patient's hamstring. Further, when the second set of tunnels was placed in the "supplemental allograft," the femoral tunnel was too anteriorly placed, and the second graft was tensioned with the patient's leg in 15-20 degrees of flexion. The second graft then caused pain upon flexion.



RISK REDUCTION STRATEGIES

To mitigate risks identified in the claims data, orthopedic surgeons can:

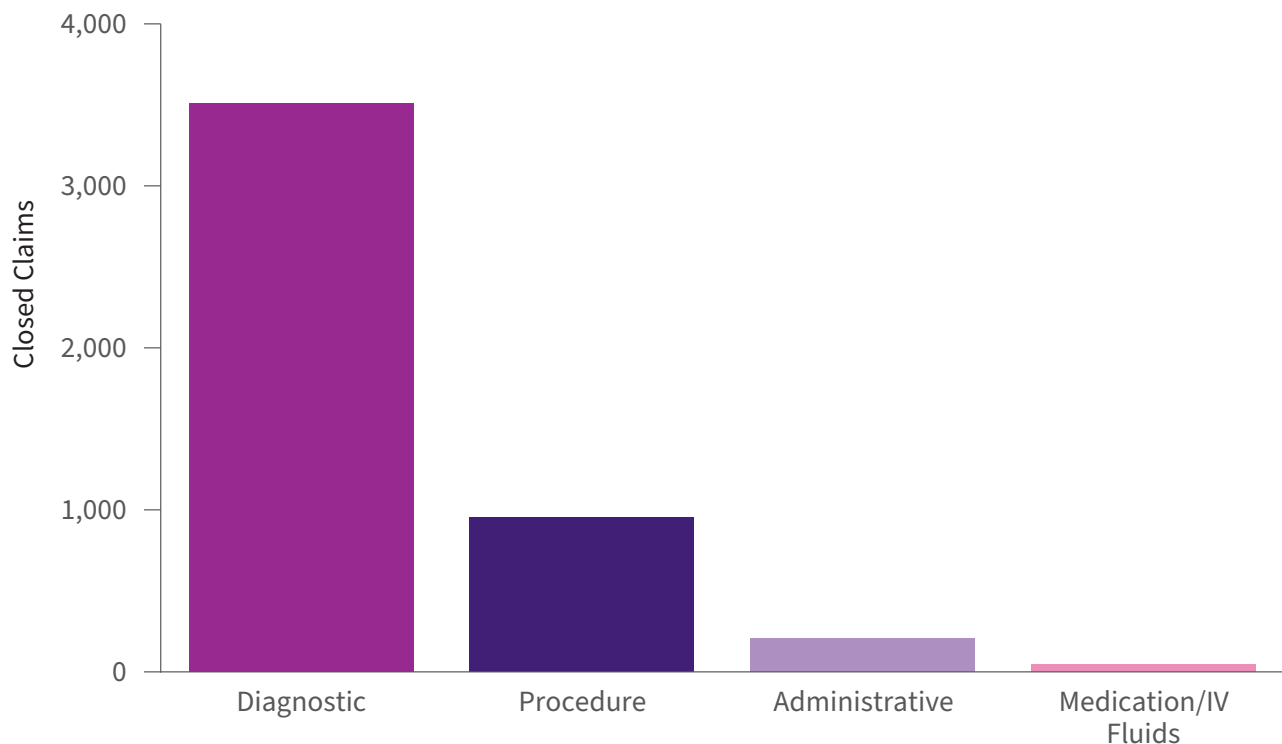
- Prior to performing any surgical procedure, obtain informed consent from the patient.
 - ▶ Discuss the risks, benefits, and alternatives, including potential complications, with the patient in a clear and understandable manner.
 - ▶ Document clearly the informed consent process in the patient's medical record, including the discussion of the potential risks, benefits, complications, and alternatives to the surgery.
 - ▶ Use standardized consent forms that outline the procedure, potential complications, and risks and have the patient sign and date the form.
- Maintain open and transparent communication with the patient throughout the entire treatment process, addressing any concerns or questions.
- Ensure that surgical protocols are followed, including surgical checklists and verification procedures, to minimize the risk of retained foreign objects and surgical errors.
- Promote effective teamwork in the operating room and communicate clearly with surgical staff to help prevent errors and complications during surgery. Document the surgical procedure thoroughly, including any unexpected events or complications, and follow standardized reporting protocols.
- Implement quality assurance programs and regular case reviews to identify potential areas for improvement and help reduce the risk of complications.
- If a complication does occur, conduct a thorough root cause analysis to understand the factors that contributed to the incident and implement corrective measures.



Radiology Claims: Elevated Misdiagnosis Allegation Frequency

Radiology has its own set of medical liability challenges. Data analysis reveals fluctuating trends in average indemnity payments over the period included in this study. Radiology claims exhibit a pattern of primary allegations that closely corresponds to the overall medical liability claims trends. There is one distinctive feature, however: a significantly higher frequency of diagnostic allegations.³ Unlike specialties where procedural errors may dominate, radiology is particularly vulnerable to allegations stemming from missed or delayed diagnoses.

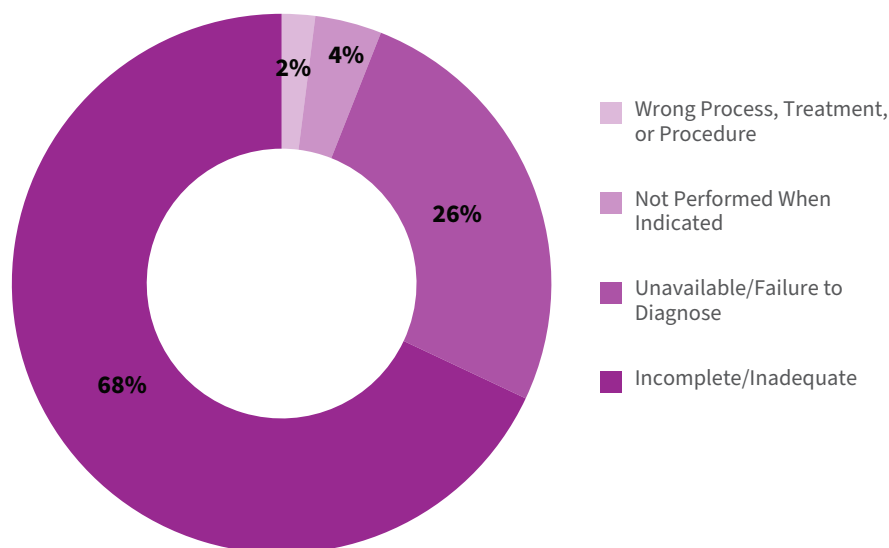
Top Primary Allegations: Radiology



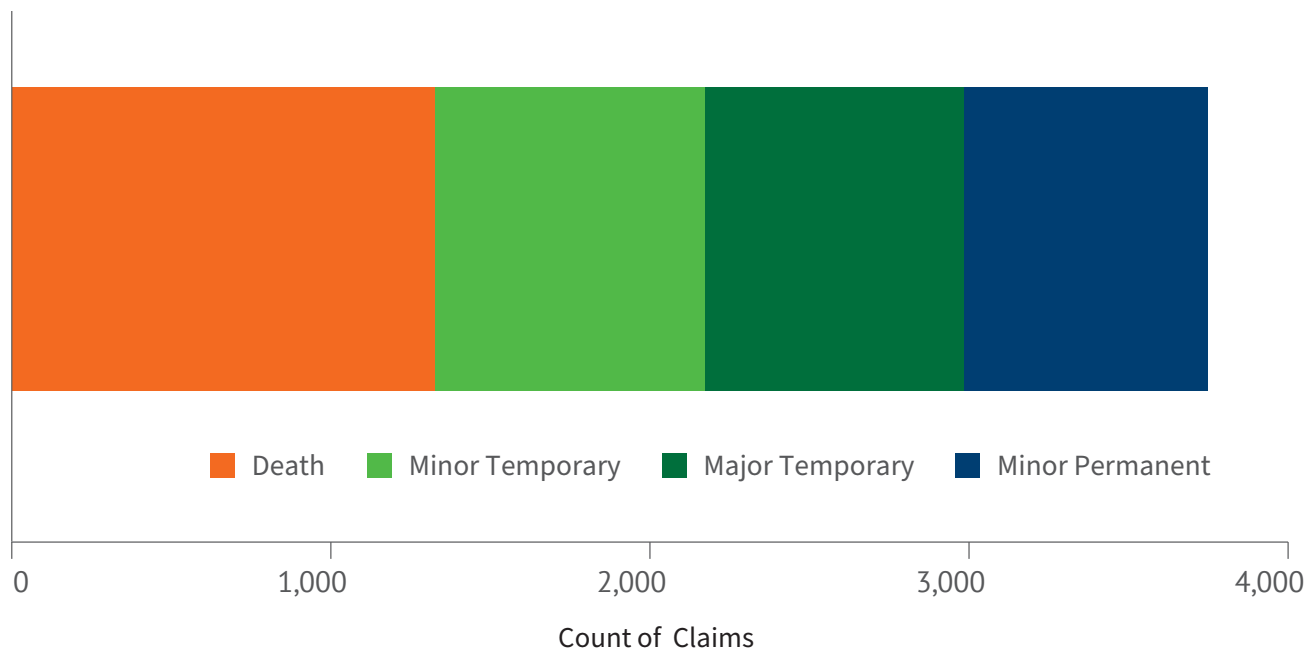
A further breakdown of the diagnostic allegations shows they range from failure to identify a visible condition during imaging to misinterpretation leading to incorrect or delayed treatment. The nature of these allegations underscores the complexity and responsibility associated with radiological diagnostics and elevates the need for advanced training and continuous education in interpreting imaging results.

When examining severity of injuries associated with radiology claims, it becomes evident that significant permanent injuries and, in some instances, death are more frequent outcomes in radiology claims than with most other specialties. This elevated severity is often a consequence of diagnostic challenges, where an incorrect or delayed diagnosis can lead to inappropriate treatment or exacerbation of an existing condition. Such outcomes highlight the critical role of timely and accurate diagnoses in mitigating the severity of claims in radiology. In this specialty there is an urgent need for targeted interventions aimed at enhancing diagnostic accuracy and interpretation skills. These could range from specialized training programs to implementing advanced diagnostic technologies.

Diagnostic Chief Medical Factors: Radiology



Top Severity of Alleged Injury For Radiology Claims





CASE THREE:

Missed Incidental Finding

The radiologist read a CT scan ordered to rule out aortic dissection following the patient's laparoscopic cholecystectomy. The radiologist also noted an abnormal right anterior rib that "may represent a fracture but does have a focal lucency w/in so other rib abnormality is also possible." He recommended that a bone scan correlation may be helpful, but it was never performed. Ten months later the patient suffered a burst fracture of T10 due to multiple myeloma, which left him paralyzed. The patient filed a lawsuit against the radiologist alleging he breached the standard of care by failing to note the incidental finding of a lytic lesion on the vertebra at T10.



DISCUSSION

In hindsight the defendant radiologist and experts identified the lytic lesion on the CT scan. The radiologist testified that the lesion was not in the report because, at the time of the initial interpretation, it resembled a disk and he did not perceive it. Experts believed the radiologist's interpretation was defensible because the lesion would probably have been missed in most circumstances. Further, the fact that the radiologist was reading the CT to rule out an aortic dissection should be considered when evaluating the standard of care.



RISK REDUCTION STRATEGIES

To reduce the risk of diagnostic errors, consider the following strategies:

- Implement double-read protocols.
- Regularly engage in image interpretation continuing education.
- Be open to asking for help or referring to a colleague if there are doubts while performing a diagnostic or interventional procedure.
- Do not assume an ordering physician will discover a potentially malignant lung finding in a report sent through an EHR.
- Err on the side of caution when determining whether an incidental finding should be directly reported to the ordering physician.
- Follow up direct communication with the final written report of findings.
- Review patient visit documentation before signing off on the note to ensure it accurately reflects what occurred during the visit.
- Develop dependable steps for managing study results and adhere to these steps for all results that are received.
- Do a gap analysis of your follow-up system to detect any ways a study result could fall through the cracks. Develop additional procedures to eliminate any gaps you discover.
- Analyze EHR programs for possible weaknesses in study result delivery, communication, auto population, and follow-up.
- Ensure the EHR system has the capability to create an inclusive list of outstanding results and generate a flag or notation for an unresolved test/consult in an individual patient's electronic record.
- Understand the common causes of liability claims against radiologists.

ADDITIONAL RESOURCES

ACR Incidental Finding Committee: [Incidental Findings Publications](#)¹²

ProAssurance Claims Rx: "[When Radiologists Fail to Communicate Findings and Recommendations](#)"¹³

ProAssurance Claims Rx: "[Diagnostic Error in Radiology](#)"¹⁴



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CONCLUSION

The landscape of medical professional liability is intricate and constantly evolving, influenced by many factors including technological advancements, legislative changes, and shifts in patient expectations. Navigating this complex terrain requires more than just understanding the legal aspects; it demands a comprehensive, data-driven analysis of the unique challenges and opportunities within each medical specialty. This article has endeavored to provide such an in-depth perspective, focusing on the specialties of family medicine, orthopedic surgery, and radiology.

Medical specialties, while diverse in their scope and challenges, share the common thread of being susceptible to allegations in professional liability claims. While these common threads exist, each specialty presents unique liability risks. For example, orthopedic surgery sees a higher prevalence of claims related to surgical errors and postoperative complications. In contrast, family medicine often faces claims alleging diagnostic errors or delayed treatments. Radiology presents its own unique set of challenges, primarily related to the interpretation of imaging studies. Understanding the similarities and differences in claim trends across these specialties is imperative for targeted risk reduction strategies.

Another notable commonality is the impact of communication in patient care. Inadequate or unclear communication can lead to misunderstandings and, ultimately, to professional liability claims. This aspect underscores the need for standardized communication protocols across all specialties.¹⁵

While healthcare continues to change, the imperative for proactive risk management remains a constant. By leveraging the insights and strategies outlined in this discussion, healthcare providers can take significant strides toward mitigating risks, improving patient outcomes, and elevating the overall standard of clinical care.

ENDNOTES

The documents referenced in this article, along with many other risk management resource documents and past editions of *Claims Rx*, are available by calling Risk Management at 844-223-9648 or by email at RiskAdvisor@ProAssurance.com.

1. "Medical Malpractice in America: A 10-Year Assessment with Insights," Candello, accessed November 1, 2023, <https://www.candello.com/Insights/Candello-Reports/MedMal-in-America>.
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