



# Million Dollar Claims

A Closer Look

Claims Review and Loss Analysis Report



## Million Dollar Claims

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# 29,063

professional liability claims processed  
by MLMIC between 2013 and 2017

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# 459

professional liability claims analyzed for the purpose  
of this report where the indemnity payment  
totaled one million dollars or more

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# \$1,332,040

average indemnity payment among the claims  
reviewed in this report. The highest indemnity payment  
was \$2.35 million

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MLMIC Insurance Company prepared this analysis of claims that closed during 2013 through 2017 and resulted in payments of one million dollars or more. Our goal was to determine the issues and commonalities of those losses in order to proactively mitigate high-exposure risks for our insureds.

## Million Dollar Claims

Each closed claim reviewed in this report is derived from MLMIC's database of losses within the State of New York. As the leading liability carrier for healthcare professionals and facilities in New York, only MLMIC has the experience, knowledge and expertise to provide such a detailed overview of New York's medical professional liability environment.

Below is a preview of the findings we will discuss within this report. We will also present case studies that demonstrate some of the chief medical factors identified in these claims. Additionally, we will offer resources and strategies to lessen the risks of high-exposure professional liability claims in the future.



### Chief Medical Factor

The most common chief medical factor was improper performance.

# 42%



### Severity

The severity of the injury was death in 30 percent of all reviewed files.

# 30%



### Specialty

The highest number of claims was for Obstetrics/Gynecology.

# 24%

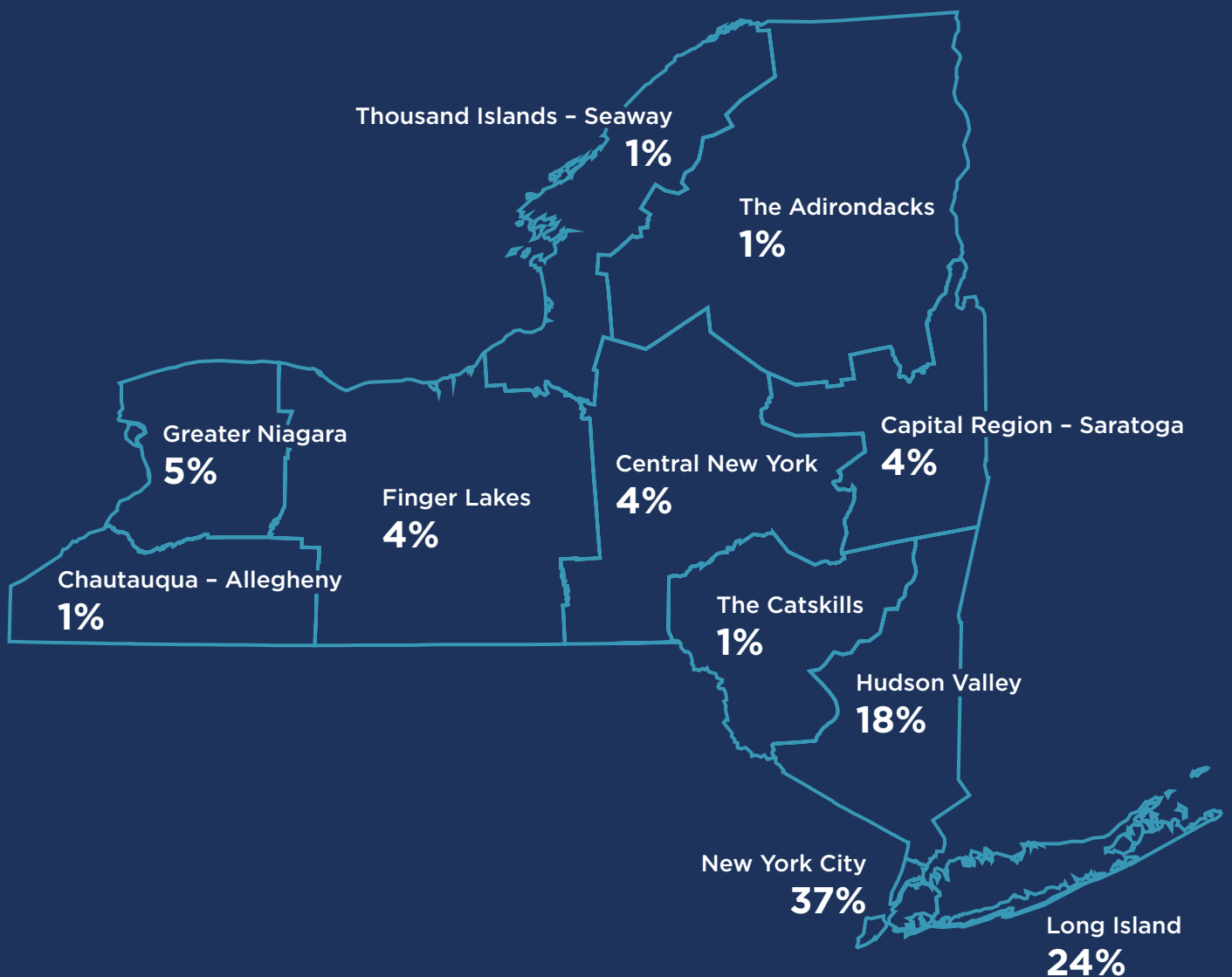


## Million Dollar Claims

### Reviewed Cases by Region

The graphic below illustrates the geographic distribution of claims that resulted in a payout of one million dollars or more.

More than 1 in 3 of these claims originated in the southern part of New York State.

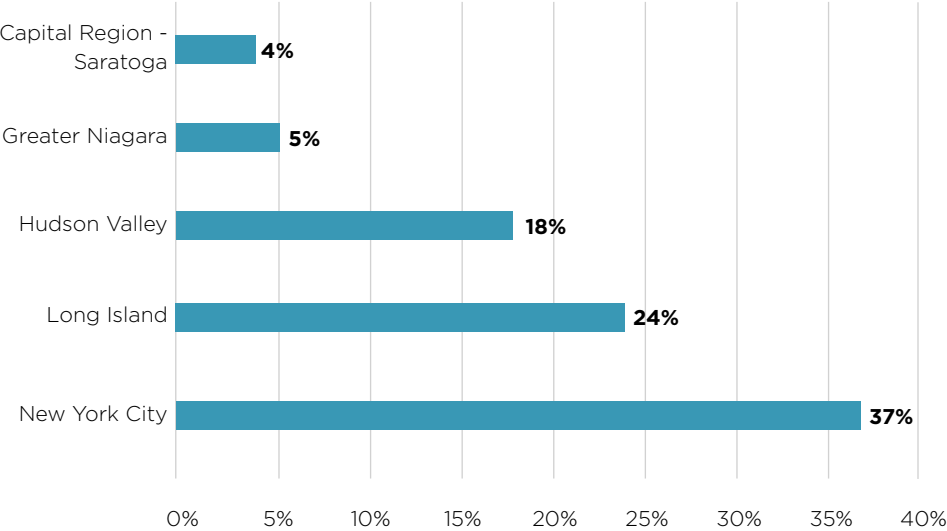


# Million Dollar Claims

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When comparing the U.S. Census Bureau’s data to MLMIC’s claims experience, 57% of New York’s population resides in New York City and on Long Island. This area accounts for 61% of MLMIC’s million dollar claims. This directly correlates with our findings shown in the bar graph below, which illustrates where the reviewed cases were venued. More than half of our large loss claims were filed where the majority of the population resides.

## Top Five Regions: All Reviewed Cases



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**37%** of MLMIC’s million dollar claims occurred in New York City.

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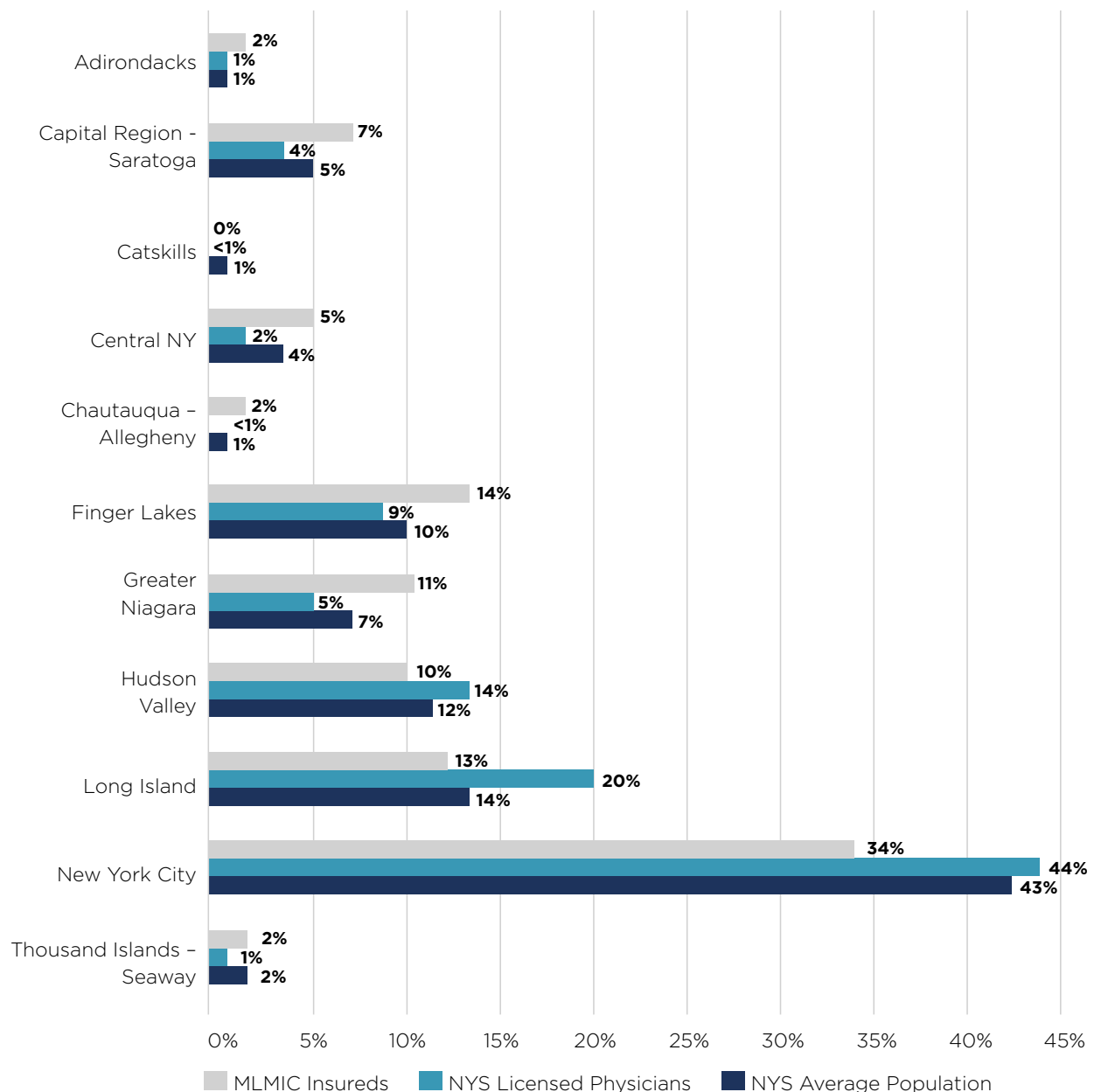
**43%** of the state’s total population resides in Manhattan, Queens, Kings and Richmond counties, and the Bronx.

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## Million Dollar Claims

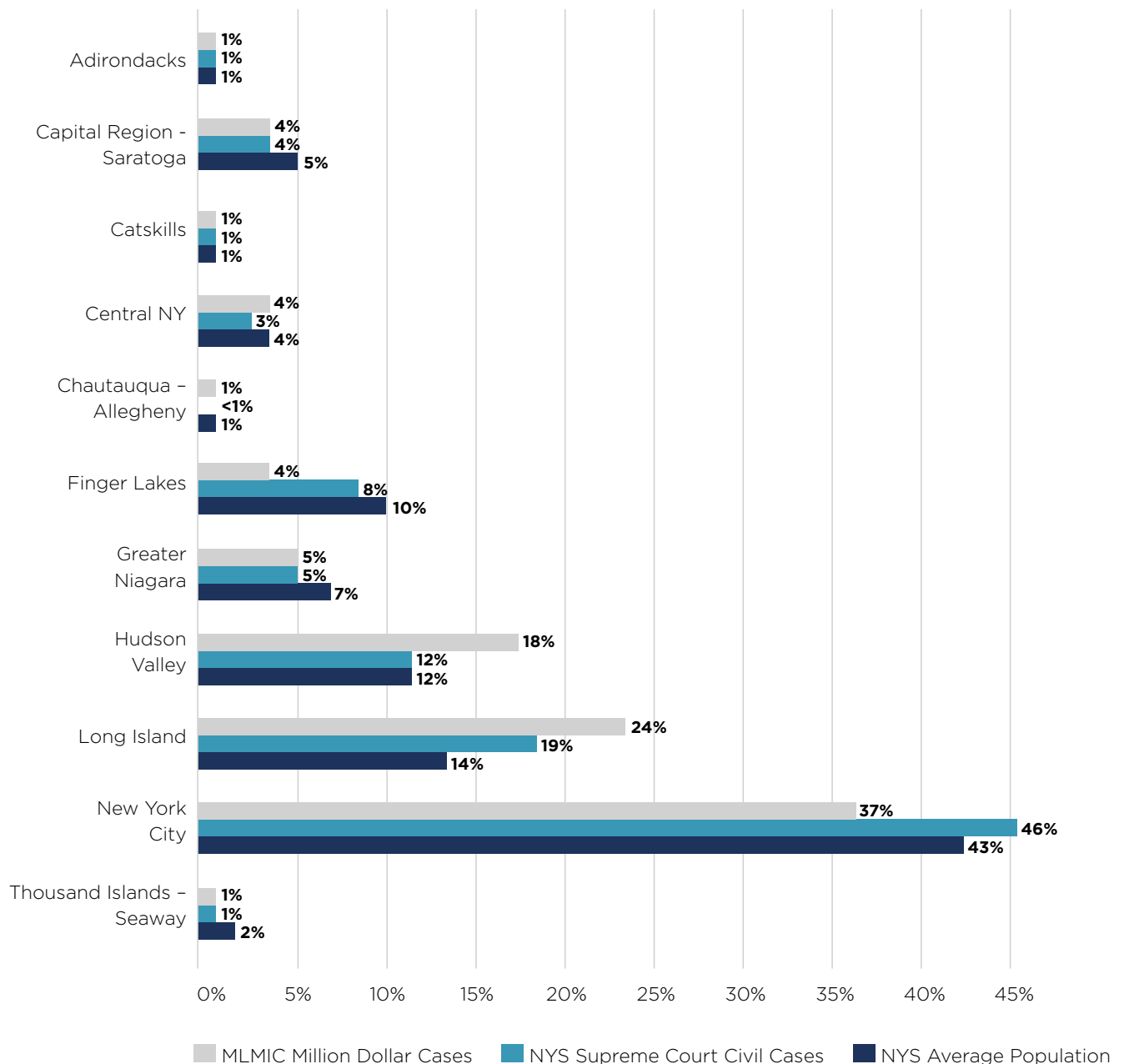
The chart below compares the most recent snapshot of physicians insured by MLMIC, the most recent total of New York State licensed physicians, and the average population of New York State.

This geographic dispersal of people corresponds with our findings of claims distribution. The more people you have requiring services in an area, the more interactions with physicians and healthcare providers. In terms of liability, each patient encounter is an opportunity for an event to occur. In other areas of the state, the population is less concentrated. Hence, the impact of volume on interactions is less dense, resulting in a more widespread distribution of million dollar lawsuits.



## Million Dollar Claims

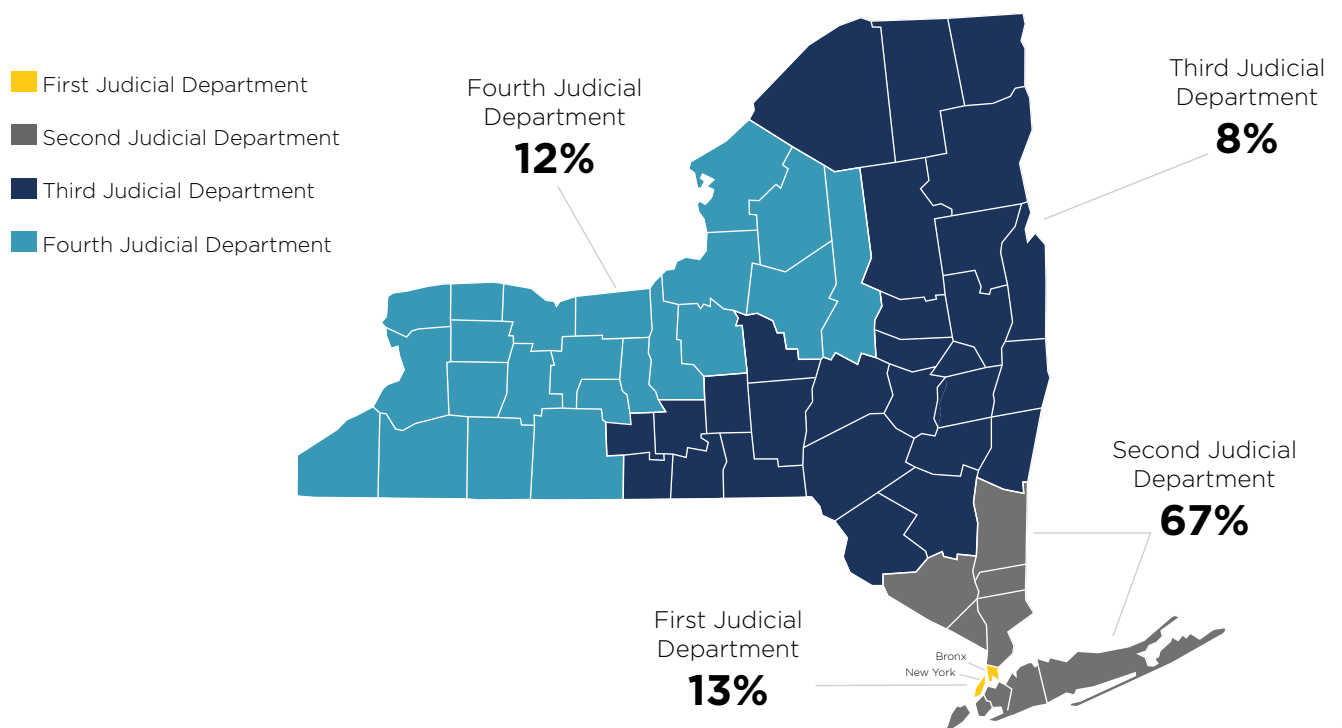
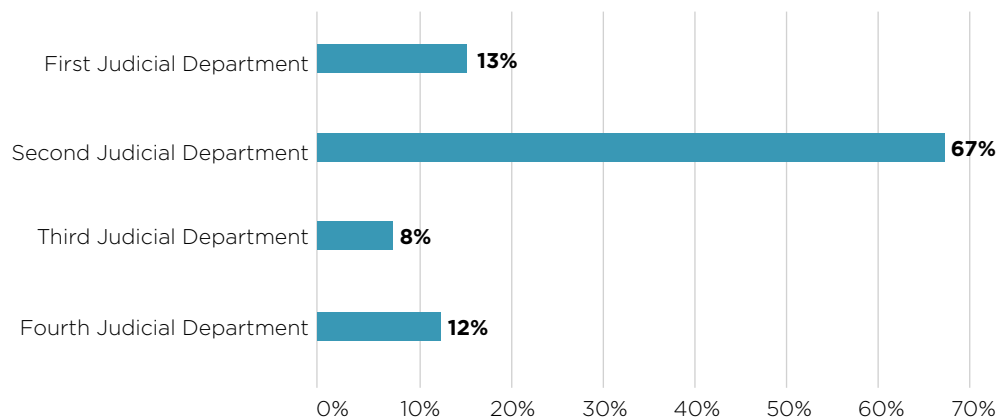
As expected, physicians in New York City and the surrounding communities have the highest incidence of claims resulting in payments of one million dollars or greater. However, when you overlay the data – population, number of physicians in the area, volume of court filings and MLMIC cases resulting in million dollar payments – you can see that all physicians in New York State have a chance of experiencing a substantial professional liability claim over the course of their careers.



## Million Dollar Claims

Most medical malpractice lawsuits are litigated in one of the New York State Supreme Courts, which are in each county of the state. These courts are known as trial courts. If there is a challenge being made to a determination at the trial court level, such as a verdict, the case will proceed to the Appellate Division of the New York State Supreme Court. There are four Appellate Divisions across the state, one in each of the four Judicial Departments. One of the functions of an appellate court is to determine whether there is a legal basis to substantiate a verdict rendered in the trial court. This appellate review can have an impact on the value of the case, resulting in a lower verdict or fostering settlement negotiations to bring the case to final resolution.

### Reviewed Cases by Judicial Department





# Million Dollar Claims

## The Five Ds of a PCE

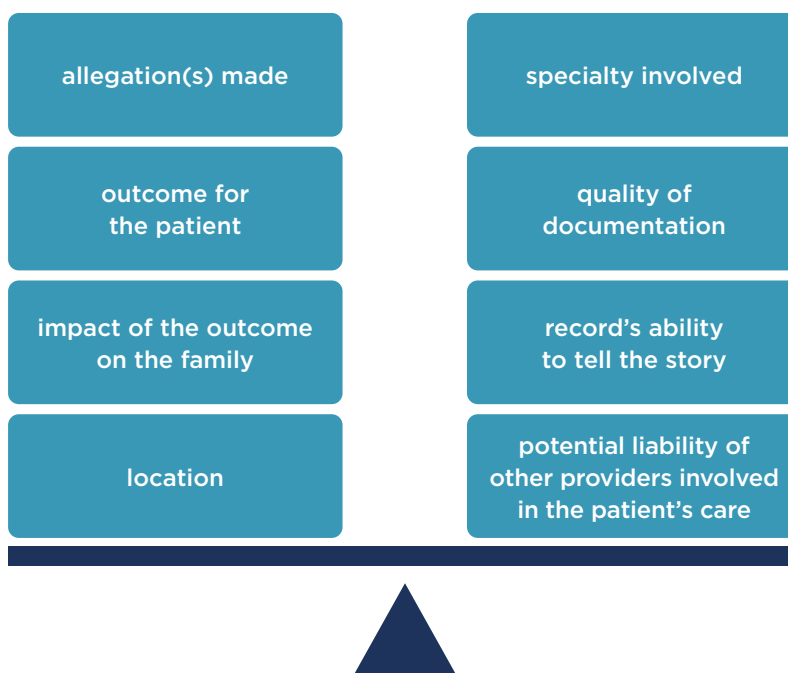
A potentially compensatory event (PCE) can arise from treatment that results in an adverse outcome. However, this does not always equate to malpractice. MLMIC Insurance Company has a high rate of success in defending our insured healthcare professionals at trial.

MLMIC has developed and mastered a rigorous procedure for managing a PCE. The process begins when a call comes in from an insured related to a PCE. Our claims examiners use their expertise and experience to determine whether a claim has merit, and identify the appropriate direction for the file.

**This is summarized in The Five Ds of a PCE:**



The above graphic highlights the broad categories and questions that need to be answered for each claim. While the responses help to formulate the defense strategy, they are not the only points considered. Other factors that are measured when determining the merit and value of claims in terms of liability include, but are not limited to, the following:



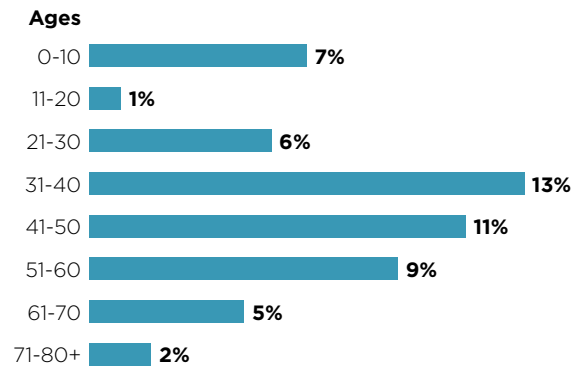
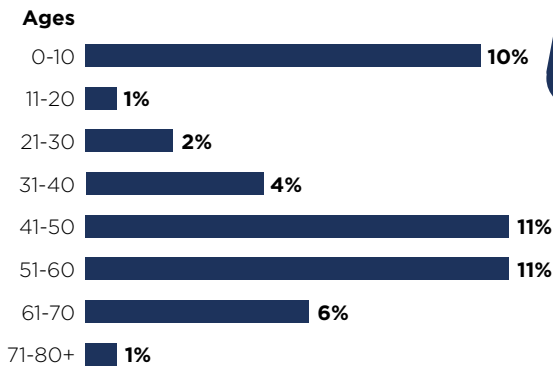
# Million Dollar Claims

## The Claimant Profile

**46%**  
of all claimants  
reviewed are male



**54%**  
of all claimants  
reviewed are female



**88%**

of male claimants noted to be in the 0-10 age range involved birth-related claims.

**34%**

of claims involving women ages 21-45 related to care provided before, during or immediately after labor and delivery.

As part of our analysis, we reviewed the demographics collected from those involved in our data set in order to portray a detailed claimant profile. We discovered that claimants were found to be female at a higher rate of frequency than male. We also found that female claimants were younger in age at the time of loss. This is the result of the large percentage of claims involving breast cancer and Obstetrics, both of which impact younger, female claimants.

**When considering the severity of death, 48% of those cases involved a male claimant, and 52% involved a female claimant.**

**1 in 5**

claims with the chief medical factor of diagnostic error involved a cancer diagnosis.

**3 in 5**

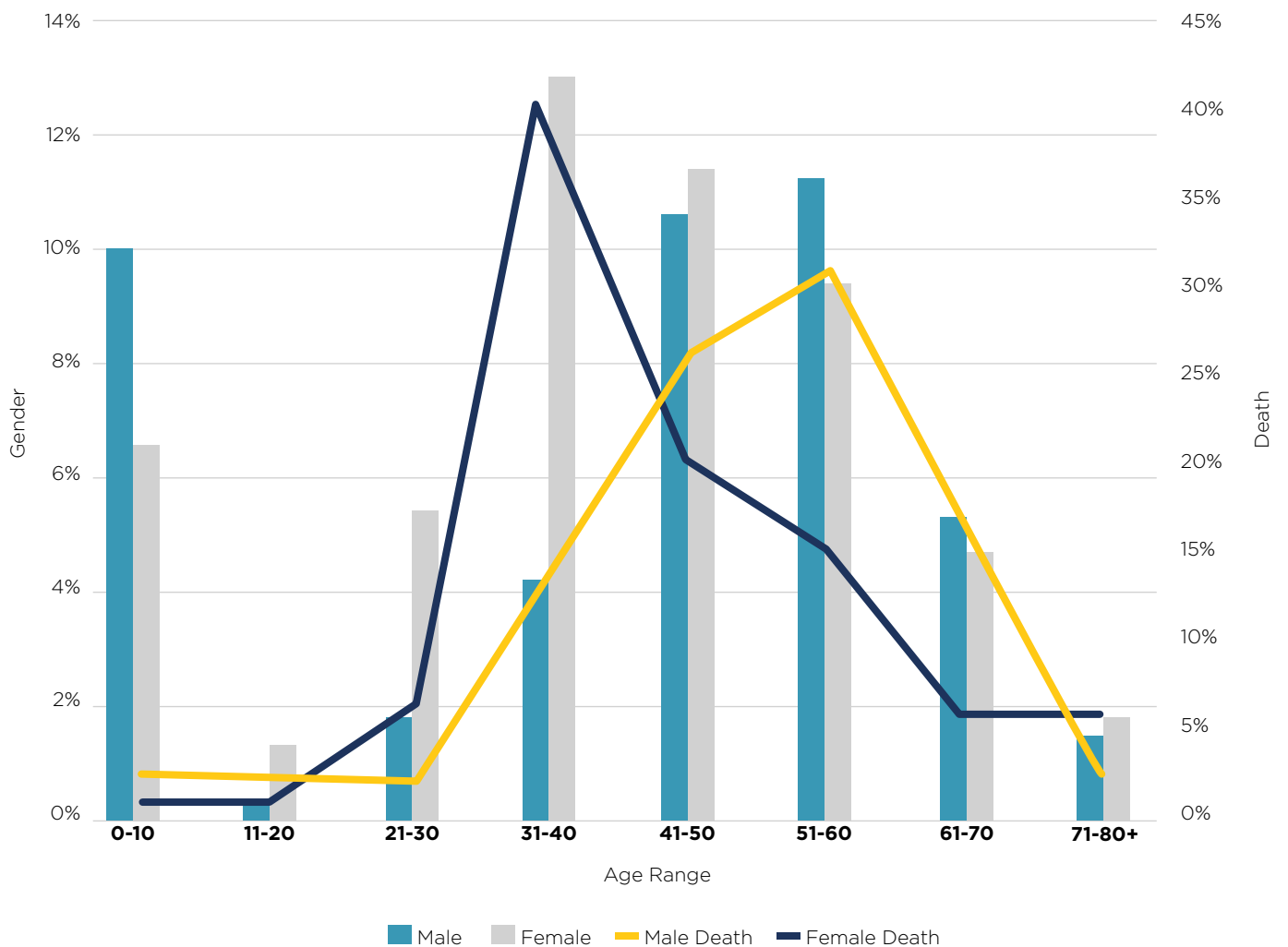
claims with the chief medical factor of diagnostic error involved a cancer diagnosis.

# Million Dollar Claims

## Age, Gender and Death

Our analysis of professional liability claims resulting in death revealed female claimants died more frequently and at a younger age than male claimants. When comparing women of childbearing age (defined as 21-45 years of age) with men of the same age, the data shows females are almost twice as likely to be identified as a claimant, at 30% and 17%, respectively. Likewise, in a review of the same age range, the incidence of death for women was 59% as compared to men at 23%.

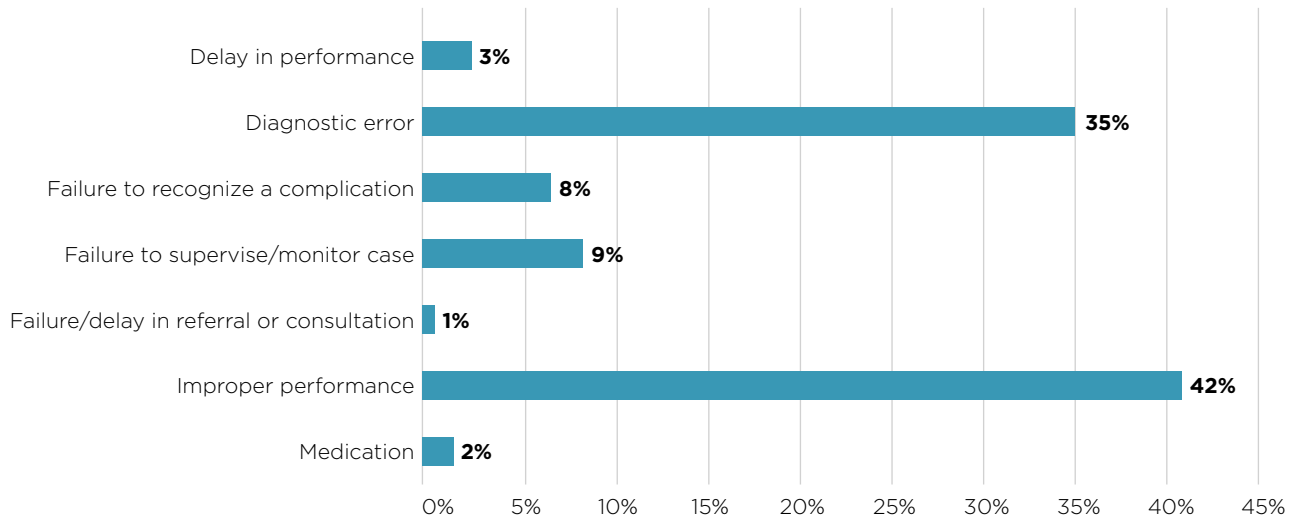
## Reviewed Cases by Age, Gender and Death



## Million Dollar Claims

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### Reviewed Cases by Chief Medical Factor



**Improper performance** is an allegation made any time the anticipated outcome does not meet the expectations defined by the patient. Our analysis indicates that over 2 of every 5 (42%) claims brought against an insured alleged improper performance. This is seen most frequently in Surgery and in Obstetrics, for example, when complications arise during labor and delivery.

**Diagnostic error** is an allegation made any time a diagnosis is delayed, missed or incorrectly identified. Our data indicates that diagnostic error was alleged in more than 1 in 3 (35%) claims. It has been cited as one of the top five allegations made in the medical liability industry by the Medical Professional Liability Association (MPL Association). Diagnostic Error is one of the top concerns of patient safety experts as identified by the ECRI, having first been named as a healthcare issue in the groundbreaking report *To Err Is Human* in 1999.

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**42%** of our reviewed files allege improper performance on the part of the physician or member of the healthcare team.

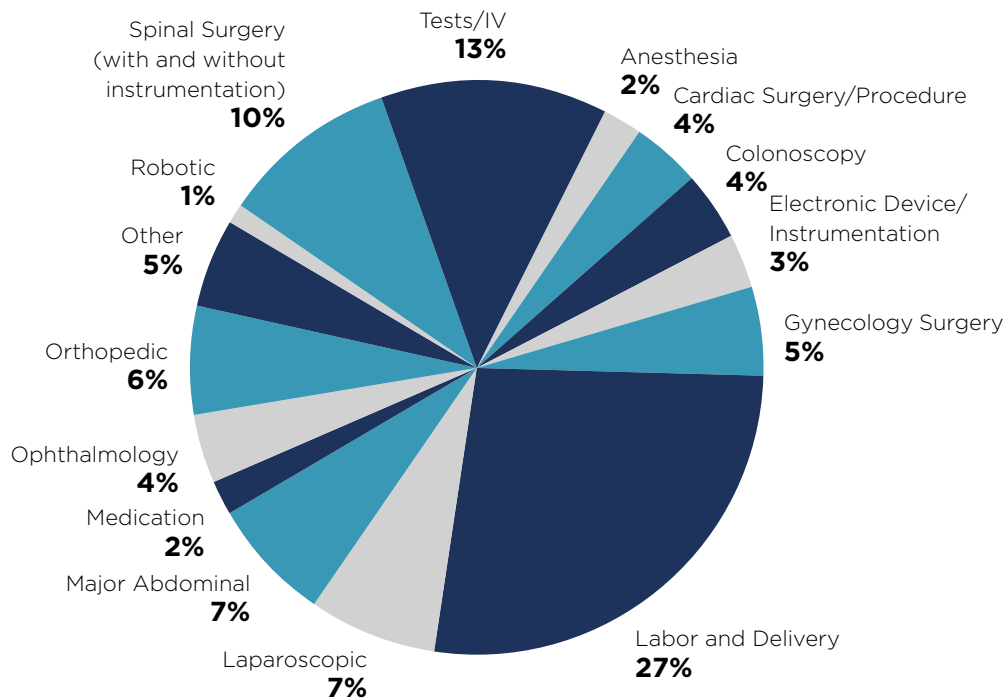


# Million Dollar Claims

## Improper Performance: A Breakdown by Procedure/Service

A closer look at the chief medical factor of improper performance shows that multiple specialties are involved, and different types of procedures are triggering lawsuits. For example, in a surgical specialty, improper performance may be alleged during the operative consultation, the operative procedure itself, the management of a patient in the Post Anesthesia Care Unit (PACU) immediately after surgery, or during the care rendered prior to discharge from the floor or ambulatory surgical center. Nearly 4 in 10 (39%) of our files reviewed involved a surgical procedure. Examples include:

- a laparoscopic procedure that required conversion to an open procedure (e.g., to repair a bowel perforation);
- a spinal fusion performed with or without instrumentation (e.g., resulting in nerve damage); and
- an orthopedic procedure (e.g., a total knee replacement with postoperative sepsis, requiring joint removal and subsequent amputation above the knee).



## Million Dollar Claims

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In our review of closed claims, the specialty most often associated with improper performance was Obstetrics/Gynecology, which was cited in almost one-third (27%) of all files reviewed. The most common associated factor was labor and delivery. For example, an allegation of improper performance was made when a physician had to use maneuvers during a vaginal delivery for which the patient was not prepared; or when complications arose during the performance of a Cesarean section, exposing both mother and baby to a higher level of risk for injury.

At 13%, tests and intravenous therapy was the second largest category of claims in improper performance. These tests and therapies include instances such as the insertion of a central venous line for monitoring in an intensive care unit; or the insertion of a Broviac catheter for the administration of long-term therapies, such as chemotherapy; or a diagnostic bronchoscopy. In these cases, there was an expectation for each test or intravenous placement, which was not met, leading to allegations involving the informed consent process and lack of documentation in the medical record.

### Informed Consent

When filing a claim or suit, a plaintiff attorney may also allege a lack of informed consent. In certain instances, such as during a routine physical examination or in a medical emergency where the delay in lifesaving care will cause harm, consent between the doctor and the patient is implied. However, for invasive tests and surgical procedures, informed consent must be obtained.

While there is a specific form to be completed and signed after an informed consent discussion between the doctor and the patient, there must also be reasonable documentation in the medical record that provides an accounting of the discussion. Informed consent is a non-delegable duty that rests with the physician who will be performing the test or procedure.

The discussion must include:

- Risks and benefits of the test/procedure
- Alternatives to the proposed treatment/procedure
- Risk of the alternative options
- Option of no treatment
- Time for questions and answers
- Consent to proceed with the proposed therapy

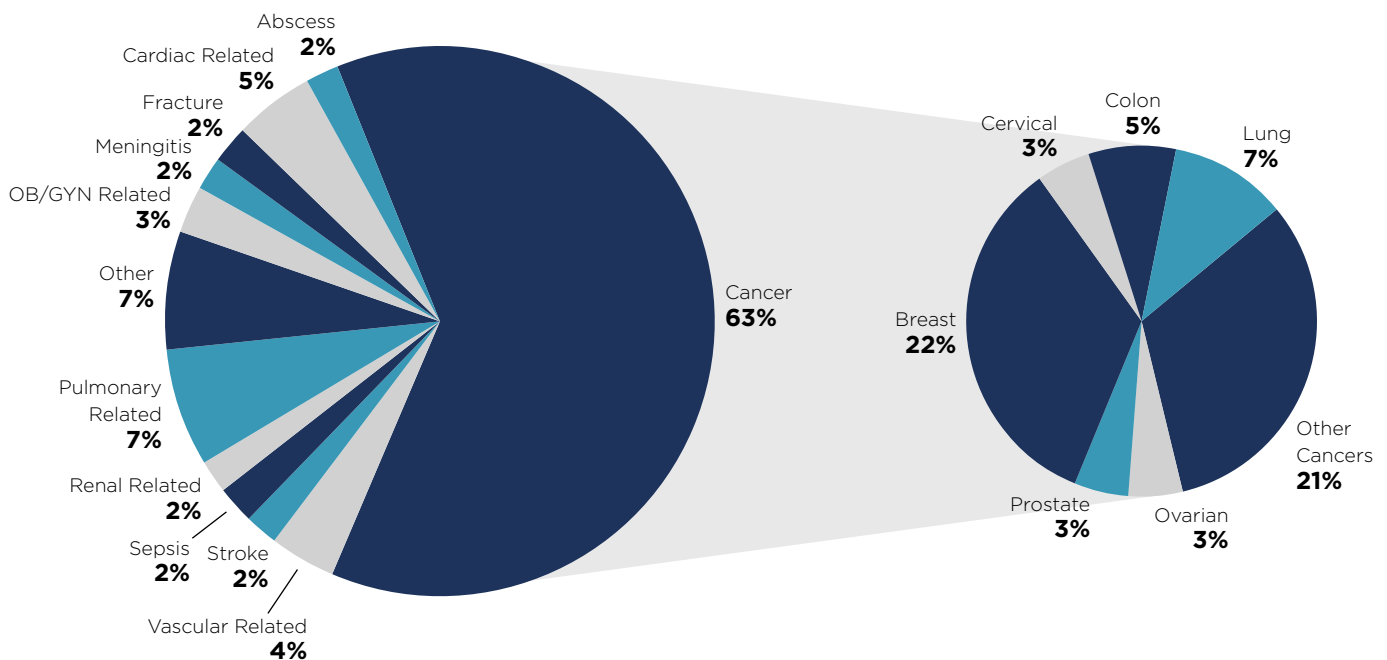
# Million Dollar Claims

## Diagnostic Error: A Breakdown by Type

The allegation of diagnostic error can occur in any medical specialty. According to studies and claims analyses performed by ECRI, diagnostic errors are common and can have serious consequences. A study by the MPL Association performed over a five-year period noted that among the top five medical factors that trigger medical malpractice claims, diagnostic error ranked second and resulted in the highest average indemnity payments. The MPL Association data also identified Radiology as the specialty ranked highest in the frequency of diagnostic error claims, most often citing the condition of a missed or delayed (lung, breast or colorectal) cancer diagnosis. Our review of claims supports this finding, as a cancer diagnosis was missed, delayed or misidentified in more than 6 in 10 (63%) files. Diagnostic errors were also noted, to a lesser extent, at a combined 33% in other body systems.

For example:

- pulmonary system: pulmonary emboli or pneumonia;
- cardiac system: endocarditis or cardiomyopathy;
- vascular system: thoracic dissecting aneurysm or arterial thrombosis; and
- gastrointestinal system: intra-abdominal hemorrhage.



Percentages in the above chart do not equal 100% due to rounding.

# Million Dollar Claims

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## Case Study - A Missed Abscess

A 56-year-old, married woman presented to her primary care physician (PCP), who specialized in Internal Medicine, with a three-month history of neck pain. She was treated with non-steroidal anti-inflammatories (NSAIDs) and a course of physical therapy (PT) without relief. Blood work and a urine test revealed an elevated sedimentation (SED) rate and a slight elevation in the C-reactive proteins. An MRI was ordered that showed a bulging disc at C5-C6 with central disc herniation. Nerve root compression at C3-C4 and C4-C5 was also noted, along with the suggestion of the possibility of an infection. The patient was referred for a Rheumatology consult within the group practice due to concerns of possible vasculitis. The patient advised the rheumatologist of headaches, fever and neck pain radiating to the left shoulder, which was described as occasional pins and needles. The examination, however, failed to identify any rheumatological basis for her neck pain. She was then referred to Orthopedics for further assessment of her neck pain, along with the consideration that her pain might possibly be attributable to an infection. Six days later, an orthopedist examined the patient, reviewed the MRI, and advised the patient that her complaints were consistent with inflammatory osteoarthritis. He further felt that the possibility of an infection was remote. Medications were ordered, along with a bone scan and another course of PT. The patient was instructed to return if there was no improvement.

The bone scan was performed several days later. The final reading included a statement that infection “must be ruled out” as one of the causes of the patient’s complaints. Based on this report, the PCP ordered a CT for the following week. However, the day before the scan was to be performed, the patient was seen in a local emergency department (ED) due to complaints of severe neck pain, numbness and tingling in her right arm. A CT was performed that showed evidence of erosion at the C3-C4 level involving the facet joints on the left side. There was no mention of an infection. During her stay in the ED, there was no neurologic examination despite her neurologic complaints. She was discharged before being evaluated by a doctor and was instructed to follow up with her PCP.

Two days later, she presented to the ED of a major metropolitan hospital. She was ambulatory upon arrival, and her complaints included difficulty raising her right arm along with significant neck pain. Although she was monitored by ED staff, she was not seen by Neurosurgery until six hours after presentation. An MRI was ordered, and the Neurosurgical team determined the patient had a surgical emergency with cord compression. She was admitted to the hospital and scheduled for surgery the next morning. As the evening progressed, the nurses noted worsening in her neurological status, including significant weakness in her right arm, loss of bladder control and weakness in her legs. She was again seen by a neurosurgeon later that evening who noted the nurses’ observations but took no immediate action to have the patient rushed to surgery. By the time the patient presented to the operating room (OR), almost 17 hours had passed since she had been declared a surgical emergency.

An anterior cervical corpectomy and fusion at C5-C6 was performed, and purulent material was drained. Culture results grew methicillin-sensitive *Staphylococcus aureus* (MSSA), which was treated with antibiotics. Several days later, a posterior fusion from C3 to C7 was performed. The patient subsequently required a tracheostomy and a percutaneous endoscopic gastrostomy tube (PEG). She is now triplegic with total paralysis below the umbilicus.

A lawsuit was commenced that eventually named nine defendants.

Discovery was undertaken, and expert opinions were secured from various specialties, including Internal Medicine, Orthopedics, Neurosurgery and Infectious Disease. A multimillion-dollar demand was made by the plaintiff’s attorney, and settlement discussions ensued. Based on the expert opinions provided in this case, the matter was eventually settled on behalf of eight of the nine defendants.



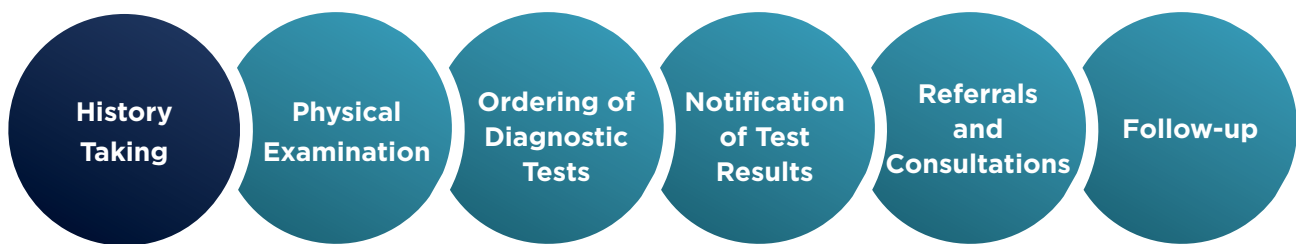
## Million Dollar Claims

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### Diagnostic Error

Despite being underreported, diagnostic error is common, occurring in 5%-20% of emergency department, inpatient and ambulatory visits. While there are many contributing factors, such as faulty detection of symptoms, a failure to act on a voiced concern and poor communication – absent, ineffective or content-poor – are frequently associated with cases of diagnostic error. Our review identified a diagnostic error resulted in death 34% of the time, followed by significant permanent injury 32% of the time. Regardless of settlement amounts, an allegation of a diagnostic error is costly to defend (PS Net/AHRQ article posted 2.5.19).

According to the MPL Association, “the PIAA Data Sharing Project tells us diagnostic error is a leading cause of claims for many specialties, making it a key issue in risk management and patient safety” ([www.mplassociation.org/docs/OnlineExtra/Online\\_Extra\\_Ryan.pdf](http://www.mplassociation.org/docs/OnlineExtra/Online_Extra_Ryan.pdf)). Many studies have been conducted to determine the causes of diagnostic error. They are usually the result of process breakdowns during the physician-patient encounter, involving individual and system-related factors. Diagnostic errors are commonly associated with the following actions:



While cognitive bias on the part of a physician plays a role in many diagnostic errors, system-related factors also contribute to missed and delayed diagnoses. Some of the leading issues include poor communication, inefficient coordination of care, ineffective follow-up systems and faulty diagnostic equipment. A number of human factors, such as distractions and excessive workloads, can also influence a physician’s ability to properly and correctly diagnose.

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**34%** of files reviewed for this study indicated a death due to a diagnostic error.

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## Million Dollar Claims

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Research has shown that flaws in cognitive thinking arise in the diagnostic process and contribute to errors. Clinicians frequently use heuristics (mental shortcuts or “rules of thumb”) when making a provisional diagnosis, especially when a patient presents with symptoms that commonly fit a particular diagnosis. For experienced physicians, heuristics are fast and effective and generally lead to accurate decision-making. However, they can have a negative influence on a clinician’s decisions by introducing bias, which can contribute to diagnostic error.

**Listed below are other cognitive influences that have been known to play a role in diagnostic errors:**

<b>Bias</b>	<b>Definition</b>
<b>Affective</b>	Also called visceral bias; emotional influences can induce thinking errors, including the feelings physicians have about their patients, both positive and negative.
<b>Anchoring</b>	Narrow focus on a single feature in a patient’s presentation to support a diagnostic hypothesis, even if other concurrent features or subsequent information refutes the hypothesis.
<b>Availability</b>	The tendency to think that things that come to mind immediately are more likely or more common.
<b>Blind Obedience</b>	Inappropriate deference to the recommendations of authority, either by direct superiors or by expert consultants, even in the absence of a sound rationale.
<b>Confirmation</b>	The tendency to search for evidence to support an initial diagnostic impression, and the tendency not to search for, or even to ignore, evidence that refutes it.
<b>Diagnostic Momentum</b>	The tendency of a diagnostic label to become propagated by multiple intermediaries (patients, physicians, nurses, other team members) over time; what might have begun as a possible “working diagnosis” becomes “definite.”
<b>Framing Effect</b>	The susceptibility of diagnosticians to be disproportionately influenced by how a problem is described, by whom it is described or even by the environment where an encounter takes place.
<b>Hindsight Bias</b>	Knowing the outcome of an event influences the perception and memory of what actually occurred; in analyzing diagnostic errors, this can compromise learning by creating illusions of the participants’ cognitive abilities, with potential for both underestimation and overestimation of what the participants knew (or could have known).
<b>Overconfidence</b>	The tendency to think one knows more than one does, especially in physicians who might place faith in opinions without gathering the necessary supporting evidence.
<b>Premature Closure</b>	Making a diagnosis before it has been fully verified.

# Million Dollar Claims

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## Case Study – Treating Friends and Family

A 58-year-old male smoker was seen for primary care by his PCP who specialized in Internal Medicine. The two men had also shared a long-standing friendship prior to the initiation of a professional relationship. Over the years, the patient was seen and treated at the office for various complaints and was monitored for insulin-dependent diabetes. During his 2004 annual physical examination, a prostate-specific antigen (PSA) was ordered and resulted in an elevated value. However, the patient was never advised of the result, nor was he referred to a urologist. In 2005, a physical exam was noted to be normal. However, a rectal exam was not performed at that time. It was later learned this was deferred at the patient's request. Unfortunately, this was not documented in the chart. He continued to receive care and treatment by the practice over the course of the next six years. His treatment at those times centered on his diabetes therapy and blood sugar testing, and he was being seen by the PA on staff.

A few days after the 2005 physical, the patient returned to review his blood sugar test results with the PA. He reported abdominal issues and was referred to a gastroenterologist. The patient was seen by a GI physician within six weeks. He had an endoscopy and colonoscopy that showed gastritis and internal hemorrhoids. The patient returned to the GI office within two months with continued complaints of abdominal discomfort. CT scans of the abdomen and pelvis were ordered to rule out diverticulitis. The pelvic scan revealed a thickening of the bladder wall. Further evaluation of the bladder was recommended to rule out a possible mass. He was seen again by the gastroenterologist within several weeks of the scans being performed. The GI physician noted the abdominal discomfort was resolved, and the plan was for the patient to continue with his current medications. All test results were provided to the patient's PCP. He was discharged with no further diagnostic follow-up recommended at that time.

Although the patient continued to be treated by his primary care physician's practice, the majority of his visits were with the PA. Another PSA test was not ordered until 3½ years later. That test reflected a significant increase in the patient's PSA levels. A physical exam at that time noted a hard nodule in the interior prostate. The patient was referred to a Urologist, who subsequently diagnosed advanced prostate cancer with metastasis to the bones.

Subsequently, a lawsuit was initiated against the patient's PCP. While the patient denied ever refusing a rectal exam or any other treatment, that claim could not be refuted absent the proper documentation, due in part to the personal relationship between the patient and physician. Expert reviewers opined that the treatment provided by our insured physician deviated from the standard of care, as there was no follow-up on either the test results or the recommendation for further evaluation of the bladder to rule out a possible mass. In addition, our physician was criticized for the failure to discuss all test results with the patient and consider a urological consultation upon receipt of the first elevated PSA. As a result, the case was settled in excess of one million dollars.

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**Physicians are often asked by close friends, relatives or colleagues for medical advice, treatment or prescriptions both inside and outside of the office.** At times, these individuals may be seen as a courtesy and/or at no charge. Although the American Medical Association advises physicians not to treat immediate family members except in cases of emergency or when no one else is available, this practice continues to occur. We have seen several lawsuits filed against physicians by close friends, as in the above case study, by colleagues and even by their own family members because of care provided. The defense of these suits is frequently hampered by the fact that there are often sparse or entirely nonexistent medical records for the patient.

## Million Dollar Claims

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### The Risk Management Trifecta

Throughout our 40+ years of experience of working with, examining and closing claims, MLMIC has seen a significant number of claims that occurred due to lack of documentation and communication, as well as various issues regarding follow-up, as illustrated by the case studies within this report. To mitigate these three potential threats, we have included universal risk management strategies that can, and should, be employed by all healthcare providers.

Case reviews and data analytics are performed on closed medical malpractice claims with the intent to identify areas of weakness and opportunities for improvement. The goal is to identify risks and develop and execute strategies to mitigate those potential risks in future patient encounters. An individualized MLMIC Analytics® report can target and evaluate vulnerabilities within an insured's practice or daily procedures to help reduce these liabilities and enhance a positive doctor-patient relationship.



**“It’s a good idea to review past mistakes before committing new ones.”**

-Warren E. Buffett

# Million Dollar Claims

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## Communication

Physicians communicate on many levels: with patients, families, pharmacists, therapists, other healthcare providers and insurance agents. At each level of interaction, effective communication is essential to developing and executing the best plan possible for optimum patient outcomes.

Below are strategies when communicating with the following:

### **Patients and family members:**

- Acknowledge that the perception of physician communication skills may impact the potential for allegations of malpractice.
- Promote open communication with patients to enhance their ability to reach an accurate diagnosis and develop an appropriate plan of care.

### **Physicians and other healthcare providers:**

- Recognize poor communication among providers can result in poor care coordination and increased liability risks for all involved parties.
- Develop systems to address and document calls from other provider offices.
- When consulting with another specialist, physicians must do the following:
  - Define the roles and responsibilities of all involved parties, including the patient.
  - Delineate the steps to take when a patient fails to keep a follow-up appointment.
  - Implement a system for providing office notes and updates on care.
  - Coordinate provider responsibilities for treatment and the follow-up of tests.
  - Manage the transition of care back to the PCP when the consulting physician's treatment plan is complete.
- Provide prescription clarification from patients and pharmacists:
  - E-prescribing, while dramatically reducing legibility issues, does generate telephone calls to address parts of the prescribing process, such as dosage, interactions or availability issues.

### **Advanced practice providers:**

- Encourage clear and concise communication among healthcare professionals to promote safe and more effective patient care.
  - Establish parameters for supervision, including but not limited to patient care oversight, coordination of care and availability of a supervising physician for consultation.

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## Documentation

The medical record is a legal document and the primary means of communication among members of the healthcare team. The information contained should tell the patient's story, capture the care that was rendered and reflect the patient's response to treatment. The failure to maintain proper medical record documentation can be seen as both malpractice and professional misconduct.

The following elements should be considered when documenting patient care:

### **Plan of care:**

- Comprise a descriptive, clear and concise treatment plan for the patient, inclusive of the critical-thinking process used to determine the current direction of care.

### **Care developed:**

- Confirm there is a detailed written account of the care provided to the patient, including his/her responses and treatment outcomes.

### **Communication:**

- Incorporate notes regarding the patient, including but not limited to ordered tests and results, consultations, all telephone calls, notes from covering physicians, changes in the patient's condition and the provided family history.

Documentation at the time of care will always be more accurate and reliable than any recollection of events. In litigation, the medical record will be reviewed by both the plaintiff and defense counsel, as well as experts, to determine the merits of a case and prove or disprove liability. Clear, timely and complete documentation can stop a plaintiff's attorney from proceeding with a claim or a suit.

## Million Dollar Claims

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### Follow-up

Follow-up is an integral part of healthcare. Medical appointments may be missed or forgotten, tests may not be completed, or results may be lost, overlooked or not received. Any one of these acts can contribute to a potential delay in diagnosis or misdiagnosis and subsequent liability exposure. The following steps should be taken to ensure a seamless patient care plan:

- Educate patients/families on the importance of complying with the plan of care.
- Use a system to track tests and consultations.
- Document all measures taken to contact the patient.
- Determine if the physician/patient relationship can continue if/when a plan of care is not followed/disrupted.

#### **For tests and consultations:**

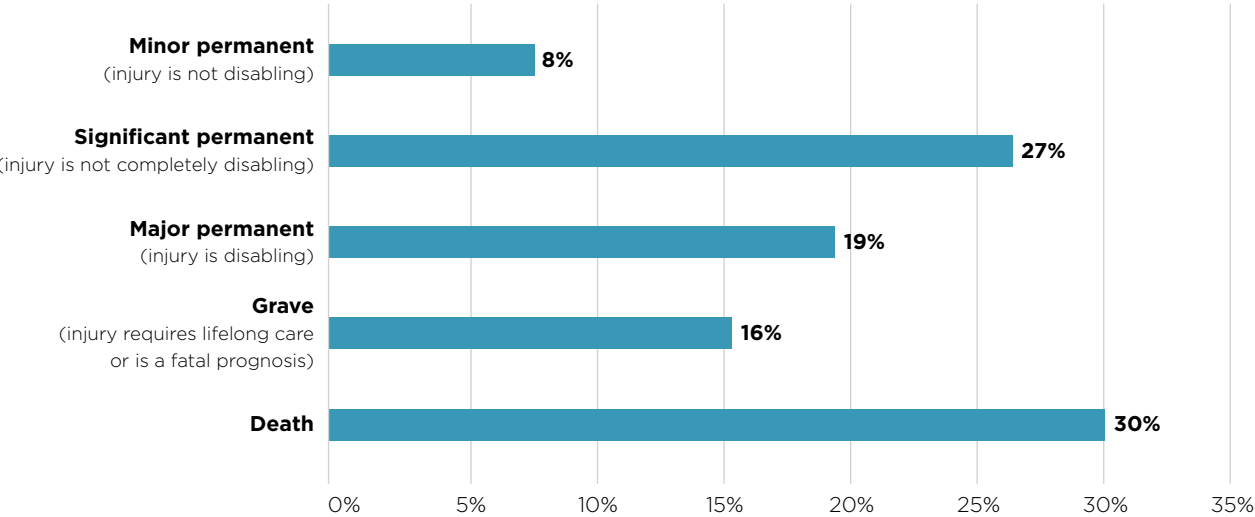
- Document and track the dates when:
  - the test and/or referral was performed;
  - the results and/or recommendations were received and reviewed; and
  - the discussion of study results with the patient and any advice given.

#### **For missed appointments:**

- Advise the provider of all missed appointments.
- Adjust the care plan as needed.
- Explore the reasons for the missed appointment.
- Re-educate the patient on the rationale for keeping appointments.

# Million Dollar Claims

## Reviewed Cases by Severity



The category of severity reflects the patient’s outcome. These range from no apparent medical injury, to significant permanent injury, to death. Given that this analysis is a five-year look-back of claims in which one million or more dollars were paid out, the severity of injuries was noted to be at the more devastating end of the severity scale.

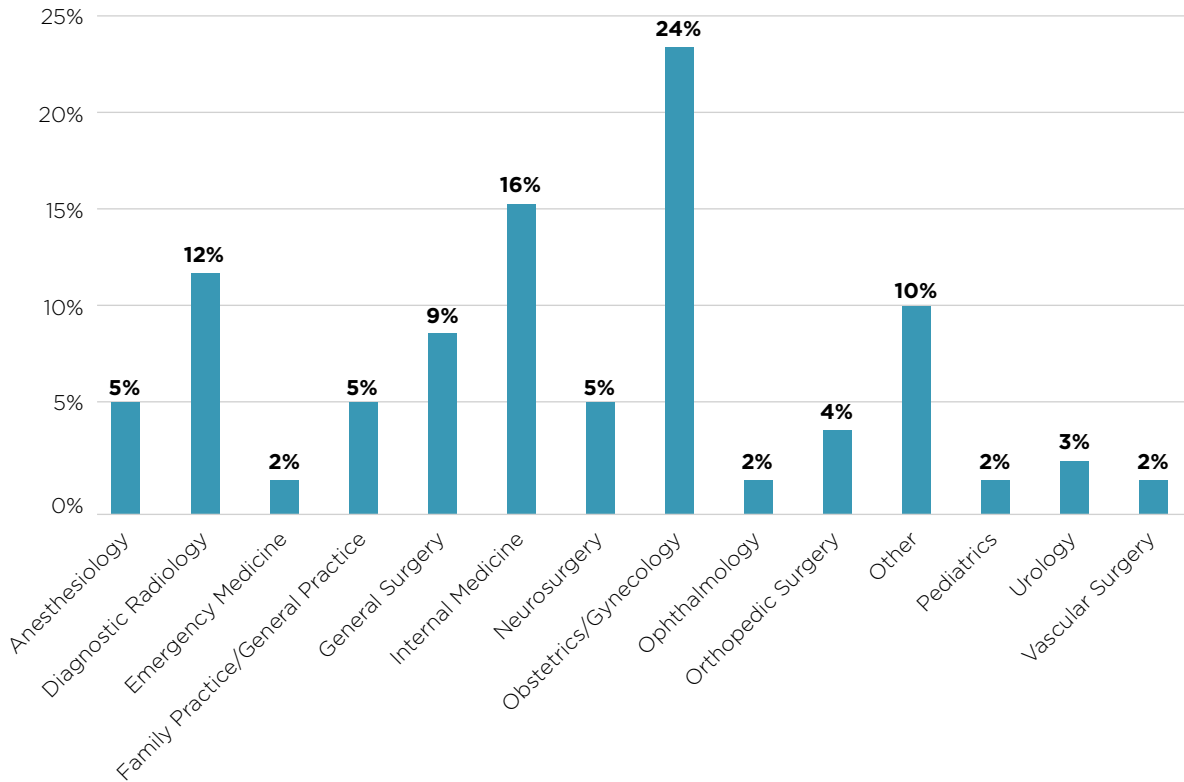
Our analysis revealed that while death occurred in 30% of all claims reviewed, a significant permanent injury, which would include a loss of a limb or one kidney or lung, was the outcome in a little over 1 in 4 (27%) claims. When considering an associated chief medical factor of an error in a diagnosis of cancer, nearly 1 in 3 (30%) of these claims resulted in a significant permanent injury. Additionally, an improper performance allegation resulting in a significant permanent injury was identified in 1 in 4 Obstetrics/Gynecology claims at 25%.

It should be noted that of the claims reviewed with a grave severity of injury that include the claimant requiring lifelong care or having suffered a severe brain insult, 44% of those claims also involved Obstetrics/Gynecology.



# Million Dollar Claims

## Reviewed Cases by Specialty



Our findings revealed that Obstetrics/Gynecology was the specialty most frequently associated with claims that resulted in payouts totaling one million or more dollars, having been identified in almost 1 of 4 (24%) files reviewed. In the field of Obstetrics, physicians are caring for two patients - or more when it comes to multiple births. When the outcome is not as anticipated, damages are compounded by the likelihood of multiple claimants and jurors' sympathy in such cases.

Internal Medicine and Diagnostic Radiology were the specialties noted next in frequency at 16% and 12%, respectively, and most often connected to a diagnostic error. General Surgery rounds out our top four with 9% of total claims, with the most common allegation being an improperly performed procedure.

Given the skill set and expertise required to deliver care in each specialty, it was not unexpected that these four specialties were identified in our study as those claims or suits that generated indemnity payments of one million dollars or more.

# Million Dollar Claims

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## Conclusions

### **Where we have been...**

As New York State's largest medical liability carrier for healthcare professionals, only MLMIC Insurance Company has the experience to provide this in-depth analysis of the New York claims experience. Our experience gives us the perspective to learn as we move forward. Certainly, there are inherent high-exposure specialties and procedures in the field of healthcare, especially those that provide care of an urgent and complex nature. For this reason, our finding of Obstetrics/Gynecology as the most frequent specialty associated with this large loss review was not unexpected. As for chief medical factors, our top findings of improper performance and diagnostic error support the conclusions of similar studies made in the medical liability industry, including those published by the MPL Association and ECRI. Collectively, we have used these findings to develop our risk management programs and activities.

### **What we have learned...**

All of medicine can be viewed through the prism of risks and benefits that are weighed against evidence-based practice, expertise and experience. Even with ideal circumstances, there are times when unanticipated outcomes occur. While not every untoward occurrence becomes a claim or suit, New York State has a long-standing reputation of being a very litigious environment for professional liability claims. This report demonstrates that there is a correlation with the distribution of both population and physician licenses, together with the incidence of court filings and MLMIC's claims experience, confirming that there is no true geographic boundary as to where a large loss claim may occur. Every event will have unique circumstances that will be investigated and analyzed by experts, in turn determining the direction and merit of the event. While there are no guarantees in medicine – or, for that matter, medical liability – efforts to enhance communication with patients, families and members of the healthcare team; provide documentation that tells the story of the care delivered; and perform adequate follow-up on tests, reports and appointments will mitigate the risk of an event becoming a significant malpractice claim.

### **Where we are going...**

Our review of cases that generated payments of one million dollars or more determined the specialties of Obstetrics/Gynecology, Internal Medicine, Diagnostic Radiology and General Surgery as those most frequently associated with large payments. In subsequent reports, we will take a closer look at select specialties, chief medical factors, severity of injuries and medical conditions that have contributed to the loss experience, with a focus on identifying trends and providing strategies to mitigate future risk.

# Million Dollar Claims

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For additional tips and risk management resources, **please visit MLMIC.com**.

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