

# Internal Medicine

## Claims Data Snapshot

2023



**This publication provides an analysis of aggregated data from clinically coded cases opened between 2012-2021 in which Internal Medicine 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.

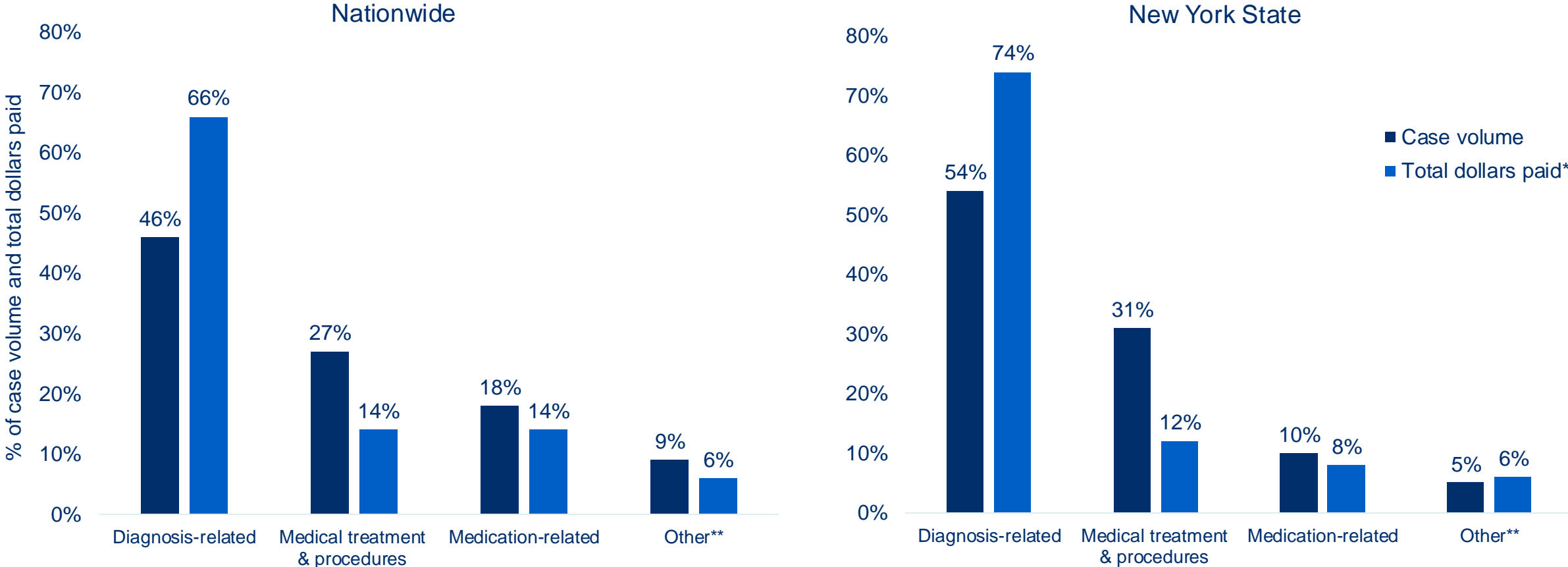
# Key Points - Clinically Coded Data

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

- **Throughout this analysis, nationwide Internal Medicine case volume is reflected, with targeted focus on several New York State-specific data points.**
- **Diagnosis-related allegations** account for almost half of Internal Medicine case volume and two-thirds of total dollars paid\*. These most commonly reflect missed/delayed diagnoses of cancers and circulatory system diseases. **These cases commonly reflect breaks in the diagnostic process of care**, most often including inadequate assessment and evaluation of patient symptoms, a narrow diagnostic focus, delays or failures in ordering diagnostic testing, delays in obtaining consults or referrals, and sub-optimal communication among providers on the patient's care team.
- **Medical treatment allegations, which account for 27% of case volume**, are primarily related to issues with selection of the most appropriate treatment regimen for the patient, and appreciating and reconciling symptoms and test results.
- **Monitoring and managing patients' medication regimens account for two-thirds of all medication-related allegations.** Selection of the most appropriate medication for the patient's condition is one of the most frequently noted risk issues in medication cases. Issues reflecting patient non-adherence to prescriptions are sometimes impacted by inadequate patient/family education of the importance of prescription adherence. Inadequate patient monitoring, and suboptimal communication about medication regimens across the patient's care team are also commonly noted risk issues.
- **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 and communication factors, specifically inadequate patient assessment processes, a narrow diagnostic focus, and team communication failures, inadequate supervision, and failures in systems designed for reporting and acting upon diagnostic test results are key drivers of both clinical and financial Internal Medicine 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.



MLMIC + MedPro Group cases opened 2012-2021, Internal Medicine as responsible service; Nationwide N=1186, New York State N=265; \*Total dollars paid = expense + indemnity; \*\*Other includes allegations for which no significant case volume exists

# Clinical Severity\*

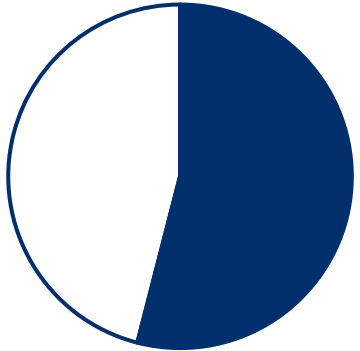
Clinical Severity Categories	Sub-categories	% of Nationwide case volume	% of New York State case volume
<b>LOW</b>	Emotional Injury Only	<b>7%</b>	<b>7%</b>
	Temporary Insignificant Injury		
<b>MEDIUM</b>	Temporary Minor Injury	<b>23%</b>	<b>23%</b>
	Temporary Major Injury		
	Permanent Minor Injury		
<b>HIGH</b>	Significant Permanent Injury	<b>70%</b>	<b>70%</b>
	Major Permanent Injury		
	Grave Injury		
	Death		

**Typically,  
the higher the clinical severity, the higher the indemnity payments are, and the more frequently payment occurs.**

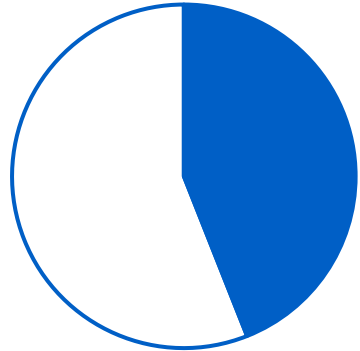
MLMIC + MedPro Group cases opened 2012-2021, Internal Medicine as responsible service; Nationwide N=1186, New York State N=265; \*Severity codes reflect National Association of Insurance Commissioners (NAIC) injury severity scale

# Claimant Type & Location

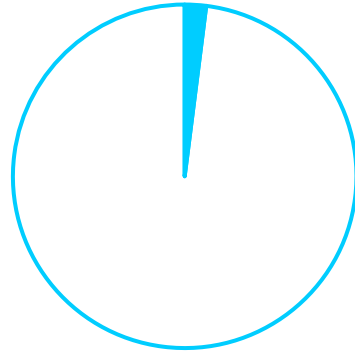
Nationwide



Ambulatory  
**54%**



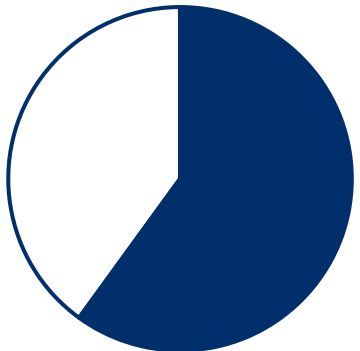
Inpatient  
**44%**



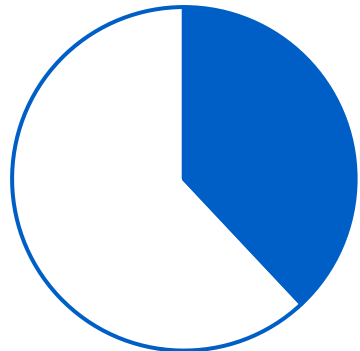
Emergency  
**2%**

Top locations	% of case volume
<b>Office/clinic</b>	<b>44%</b>
<b>Patient room</b> (includes ICU & extended care/skilled nursing)	<b>41%</b>
<b>Emergency/Urgent Care</b>	<b>6%</b>

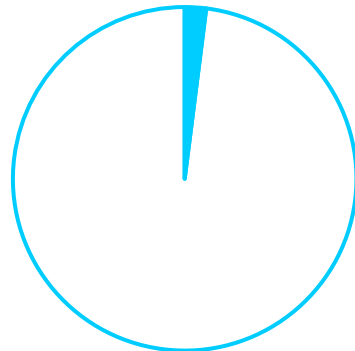
New York State



Ambulatory  
**60%**



Inpatient  
**38%**



Emergency  
**2%**

Top locations	% of case volume
<b>Office/clinic</b>	<b>52%</b>
<b>Patient room</b> (includes ICU & extended care/skilled nursing)	<b>37%</b>
<b>Emergency/Urgent Care</b>	<b>7%</b>

# 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.”

# Contributing Factors

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

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

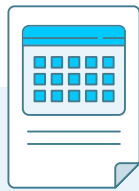
**Multiple factors are identified in each case** because generally, there is not just one issue that leads to these cases, but rather a combination of issues.



Administrative



Behavior-related



Clinical environment



Clinical judgment



Clinical systems



Communication



Documentation



Supervision



Technical skill

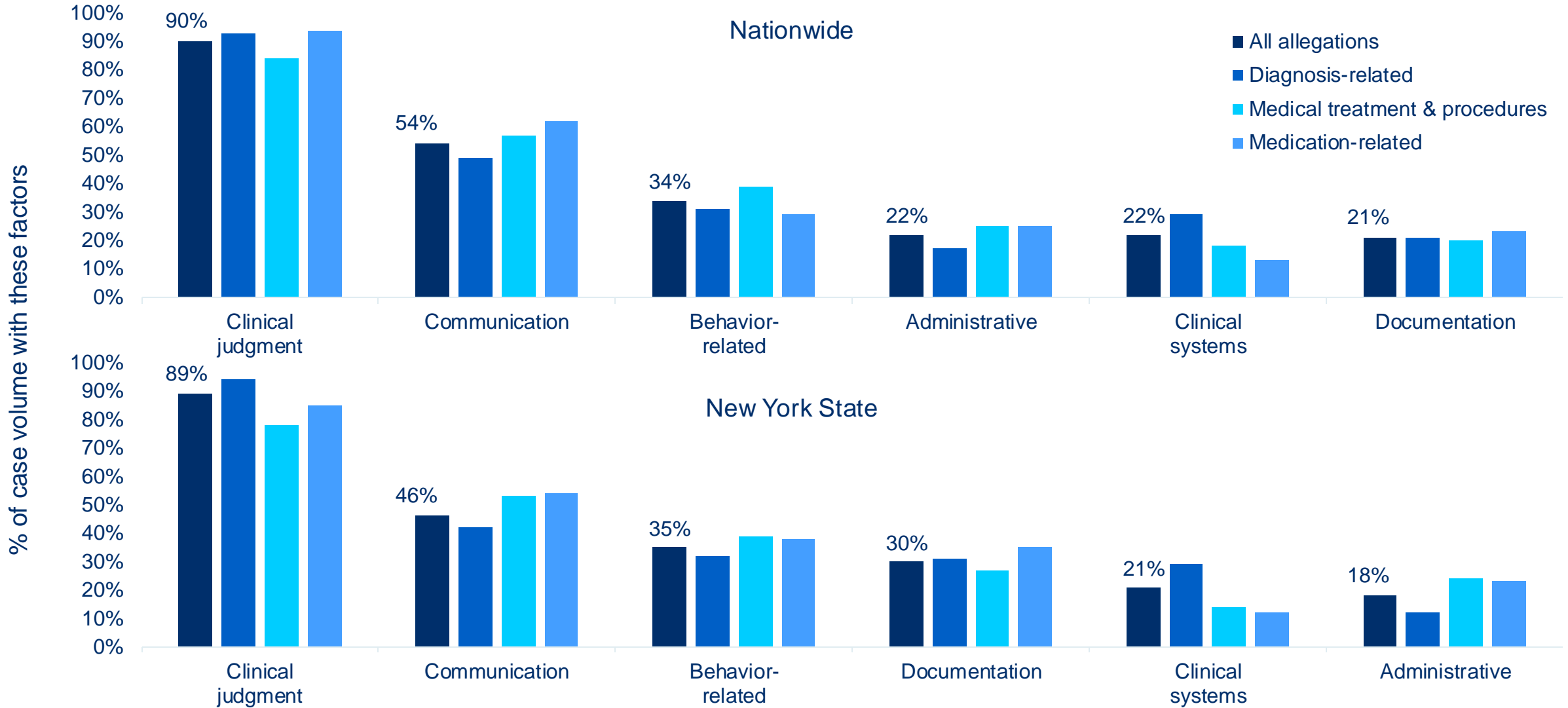


# Contributing Factor Category Definitions

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

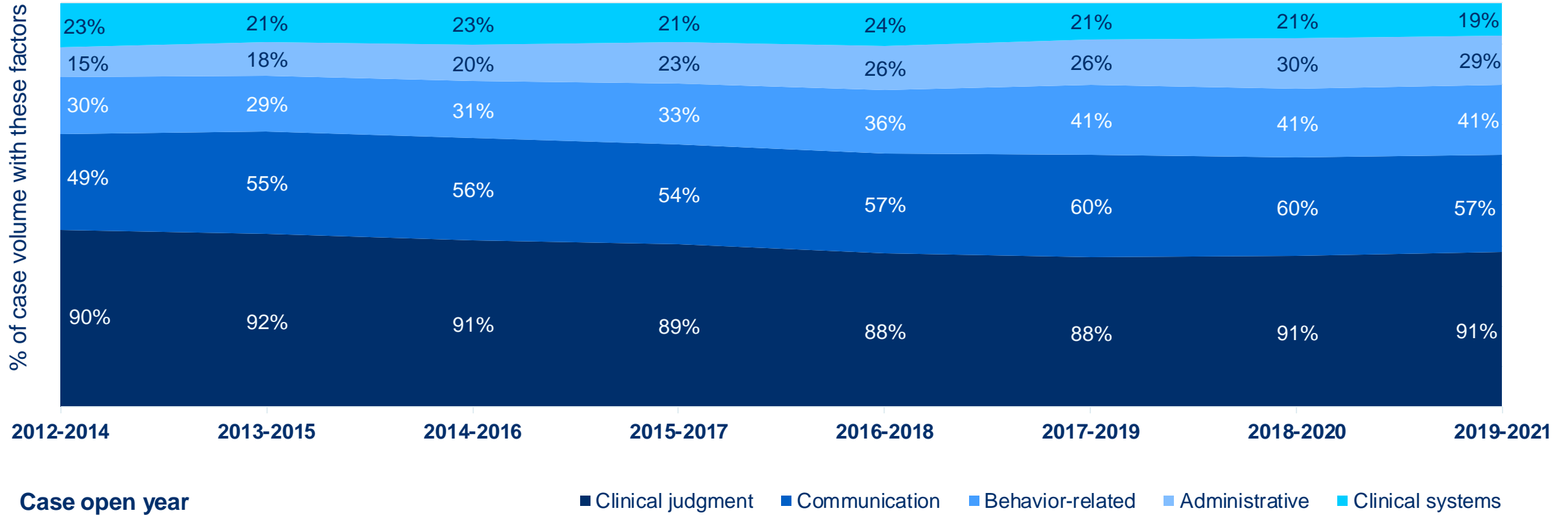
<b>Administrative</b>	Factors related to medical records (other than documentation), reporting, staff education and training, ethics, policy/protocols
<b>Behavior-related</b>	Factors related to patient nonadherence to treatment or behavior that offsets care; also, provider behavior including breach of confidentiality or sexual misconduct
<b>Clinical environment</b>	Factors related to workflow, physical conditions and “off-hours” conditions (weekends/holidays/nights)
<b>Clinical judgment</b>	Factors related to patient assessment, diagnostic decision making, selection and management of therapy, patient monitoring, failure/delay in obtaining a consult, failure to ensure patient safety (falls, burns, etc.), choice of practice setting, failure to question/follow an order, practice beyond scope
<b>Clinical systems</b>	Factors related to coordination of care, failure/delay in ordering test, reporting findings, follow-up systems, patient identification, specimen handling, nosocomial infections
<b>Communication</b>	Factors related to communication among providers, between patient/family and providers, via electronic communication (texting, email, etc.), and telehealth/tele-radiology
<b>Documentation</b>	Factors related to mechanics, insufficiency, content
<b>Supervision</b>	Factors related to supervision of nursing, house staff, advanced practice clinicians
<b>Technical skill</b>	Factors related to improper use of equipment, medication errors, retained foreign bodies, technical performance of procedures

# Most Common Contributing Factor Categories by Allegation



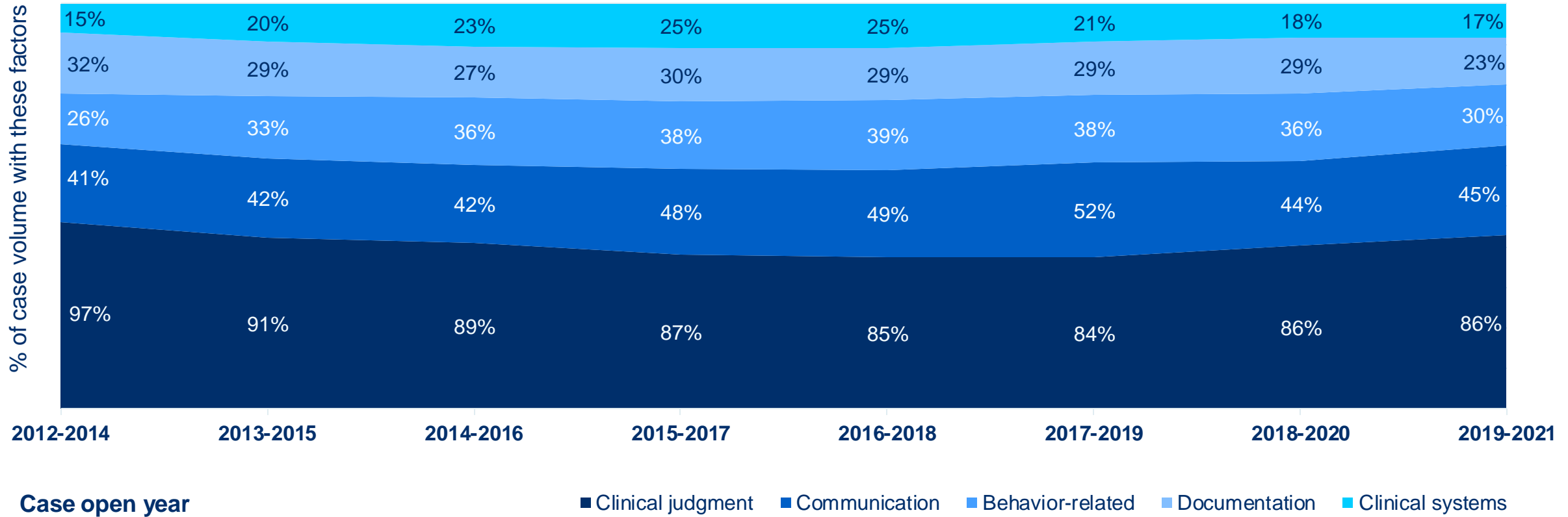
MLMIC + MedPro Group cases opened 2012-2021, Internal Medicine as responsible service; Nationwide N=1186, New York State N=265; More than one factor per case, therefore totals >100%

# Nationwide: 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.

# New York State: 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.

Over time in New York, we see a slight decrease in cases noting clinical judgment and documentation issues.

# Nationwide: Focus on Most Common Drivers of Clinical & Financial Severity

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

<b>Factors associated with high clinical severity outcomes</b>	<b>(CJ) failure to appreciate/reconcile signs/symptoms/test results (43%)</b>	<b>% of high severity case volume</b>
	<b>(CJ) failure/delay in ordering diagnostic test (32%)</b>	
	<b>(CJ) failure/delay in obtaining consult/referral (28%)</b>	
	<b>(CO) suboptimal communication among providers about patient condition (27%)</b>	
	<b>(CJ) narrow diagnostic focus – failure to establish differential diagnosis (25%)</b>	
<b>Factors associated with the costliest indemnity payments</b>	<b>(CJ) misinterpretation of diagnostic studies (85%)</b>	<b>% more expensive than the average indemnity payment*</b>
	<b>(CJ) failure/delay in ordering diagnostic test (36%)</b>	
	<b>(SU) supervision of advanced practice providers (32%)</b>	
	<b>(CO) suboptimal communication among providers – failure to read record (29%)</b>	
	<b>(CS) lack of/failure in patient follow-up system for test result communication (28%)</b>	

Clinical judgment and communication factors, specifically inadequate patient assessment processes, a narrow diagnostic focus, and team communication failures, inadequate supervision, and failures in systems designed for reporting and acting upon diagnostic test results are key drivers of both clinical and financial Internal Medicine case severity.

# New York State: Focus on Most Common Drivers of Clinical & Financial Severity

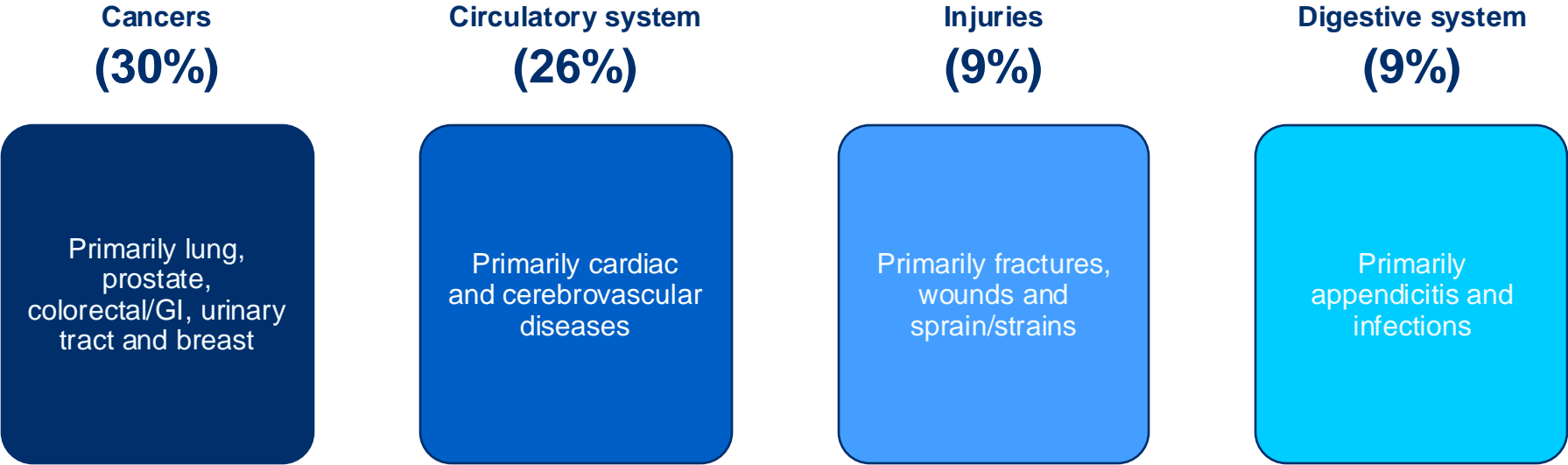
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Factors associated with high clinical severity outcomes	(CJ) failure to appreciate/reconcile signs/symptoms/test results (43%)	% of high severity case volume
	(CJ) failure/delay in ordering diagnostic test (36%)	
	(CJ) failure/delay in obtaining consult/referral (30%)	
	(CJ) narrow diagnostic focus – failure to establish differential diagnosis (25%)	
	(CO) suboptimal communication among providers – about patient condition (18%)	
Factors associated with the costliest indemnity payments	(CJ) failure/delay in ordering diagnostic test (42%)	% more expensive than the average indemnity payment*
	(CJ) failure to appreciate/reconcile signs/symptoms/test results (29%)	
	(CJ) failure/delay in obtaining consult/referral (9%)	

Clinical judgment and communication factors, specifically inadequate patient assessment processes, a narrow diagnostic focus, and team communication failures, are key drivers of both clinical and financial Internal Medicine New York case severity, similar to the nationwide drivers.

# Nationwide: Focus on Diagnosis-Related Allegations

Diagnosis-related allegations encompass wrong diagnoses, failures/delays, and misdiagnoses. See below for the top diagnoses\* noted in these cases.



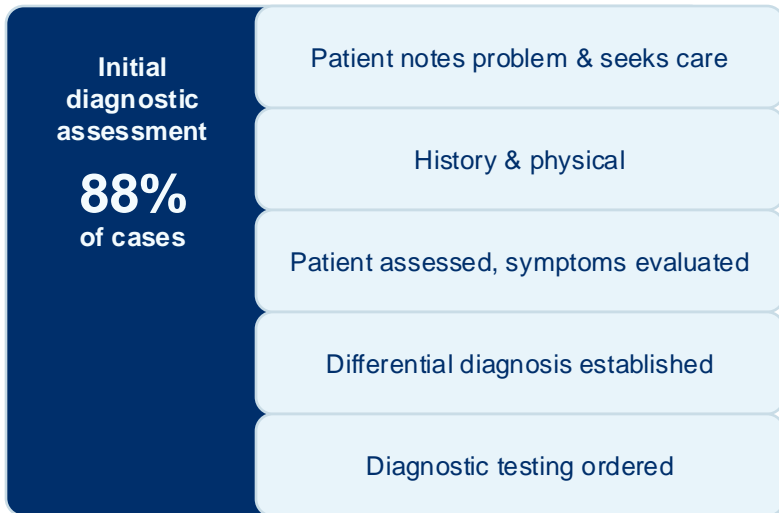
MLMIC + MedPro Group cases opened 2012-2021, Internal Medicine as responsible service; Nationwide N=1186, New York State N=265; \*as a percentage of all diagnosis-related allegations

# Nationwide: Focus on Diagnosis-Related Allegations

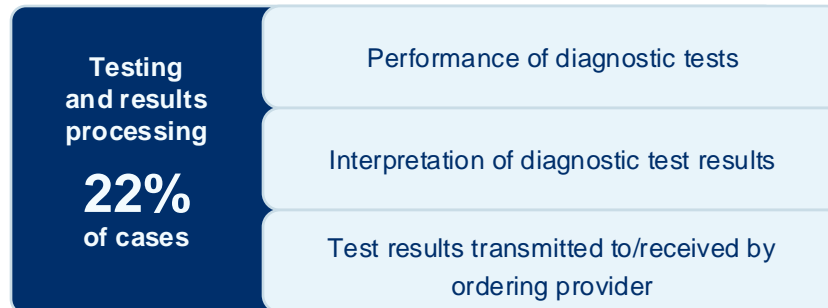
INTRODUCTION | KEY POINTS | GENERAL DATA ANALYSIS | CONTRIBUTING FACTORS | **FOCUSED DATA ANALYSIS** | CASE EXAMPLES | RISK MITIGATION

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

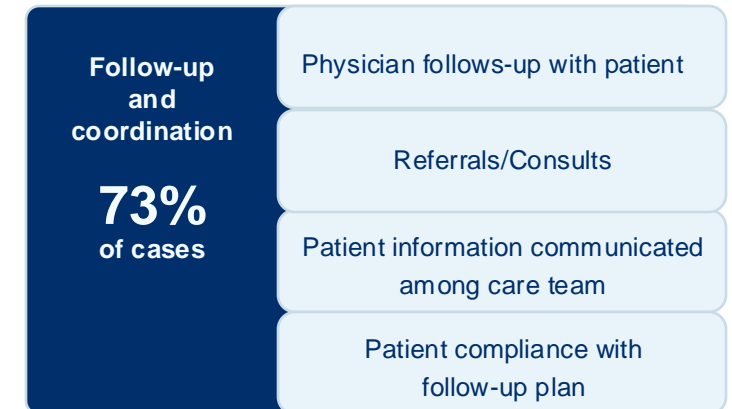
## Phase 1



## Phase 2

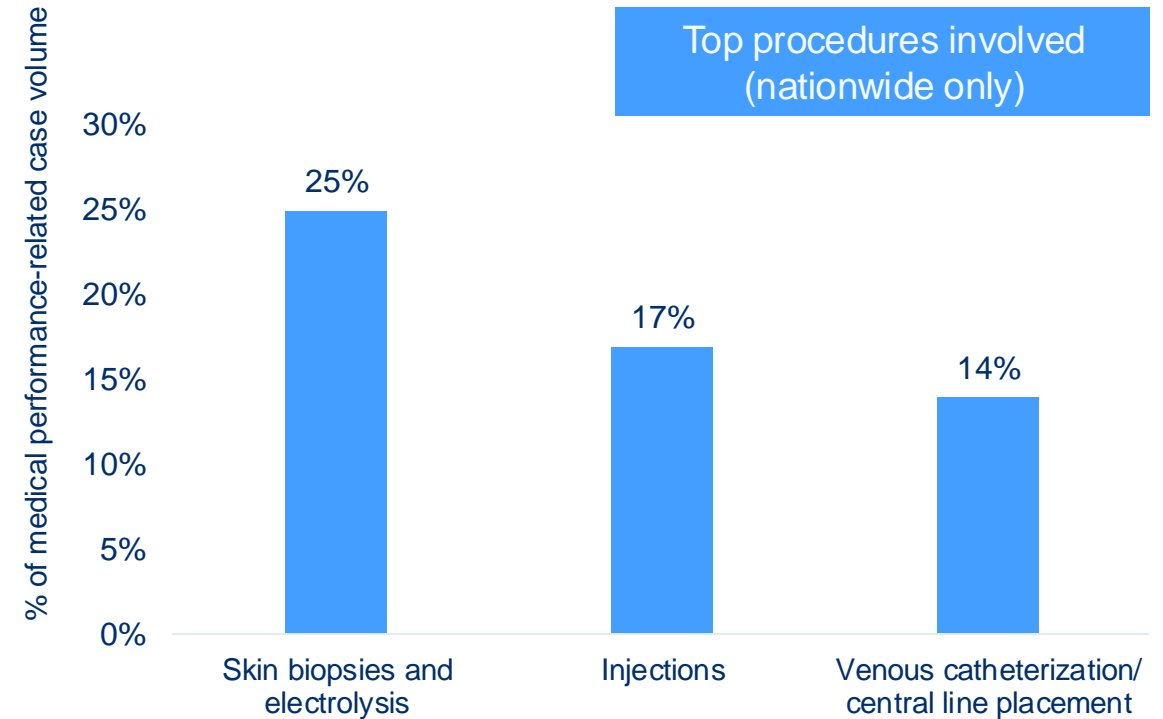
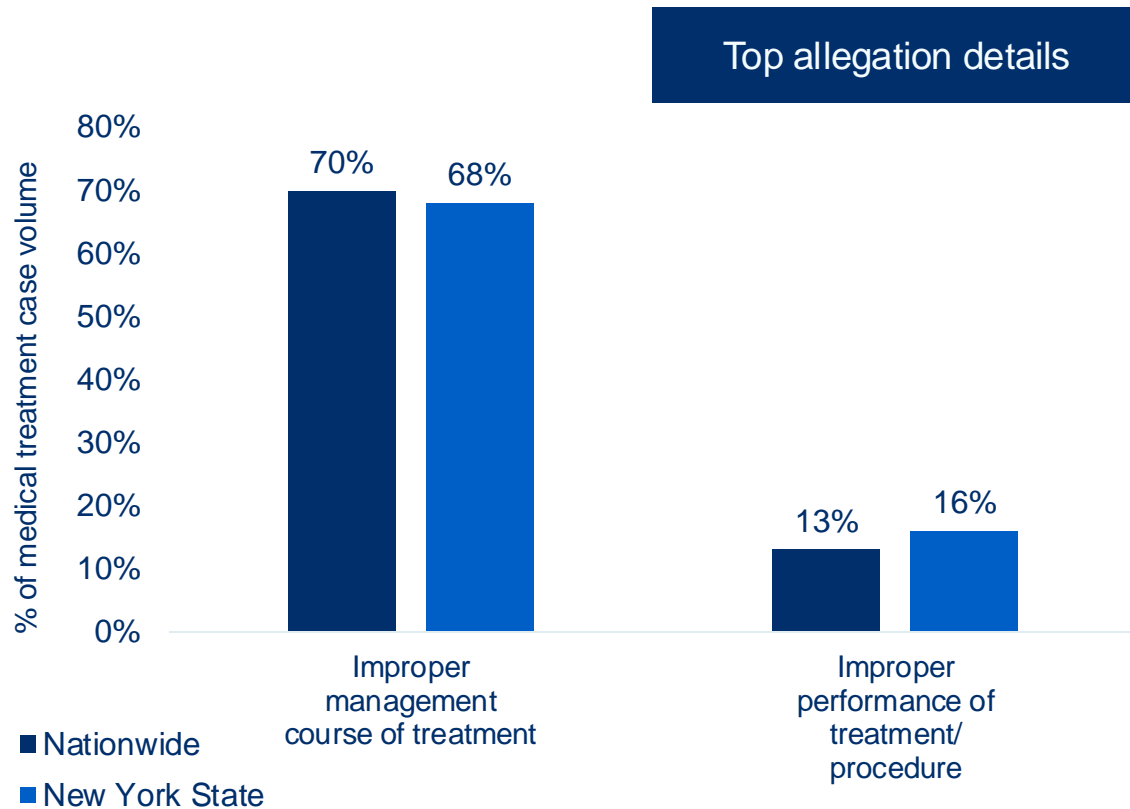


## Phase 3



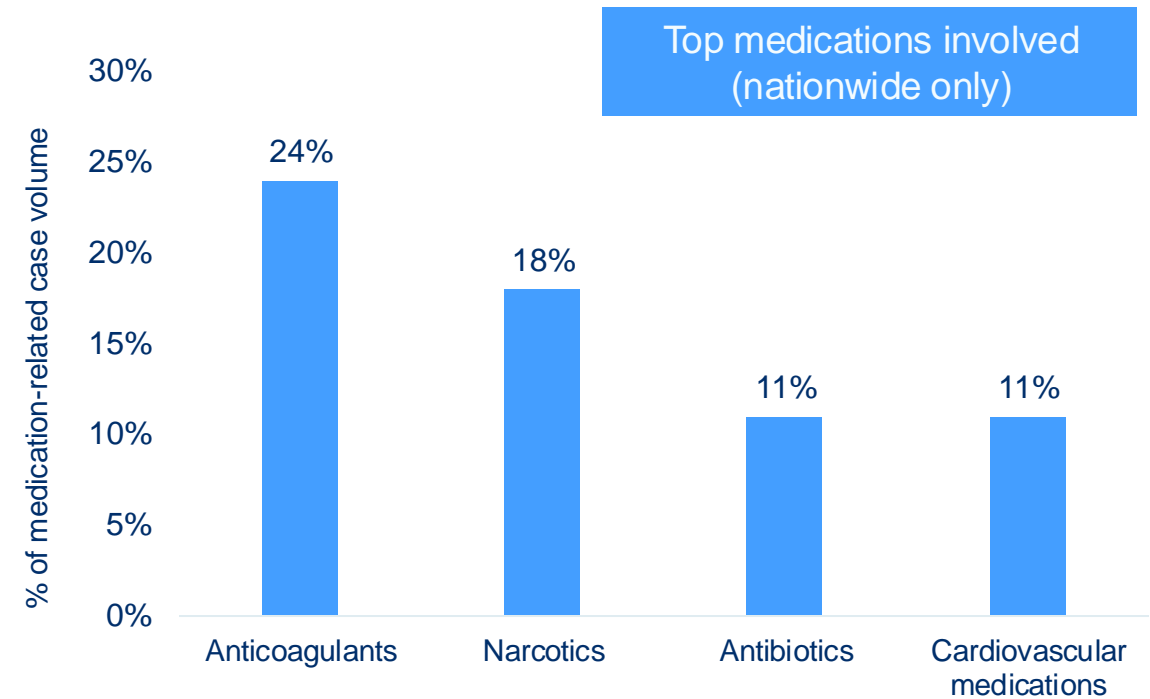
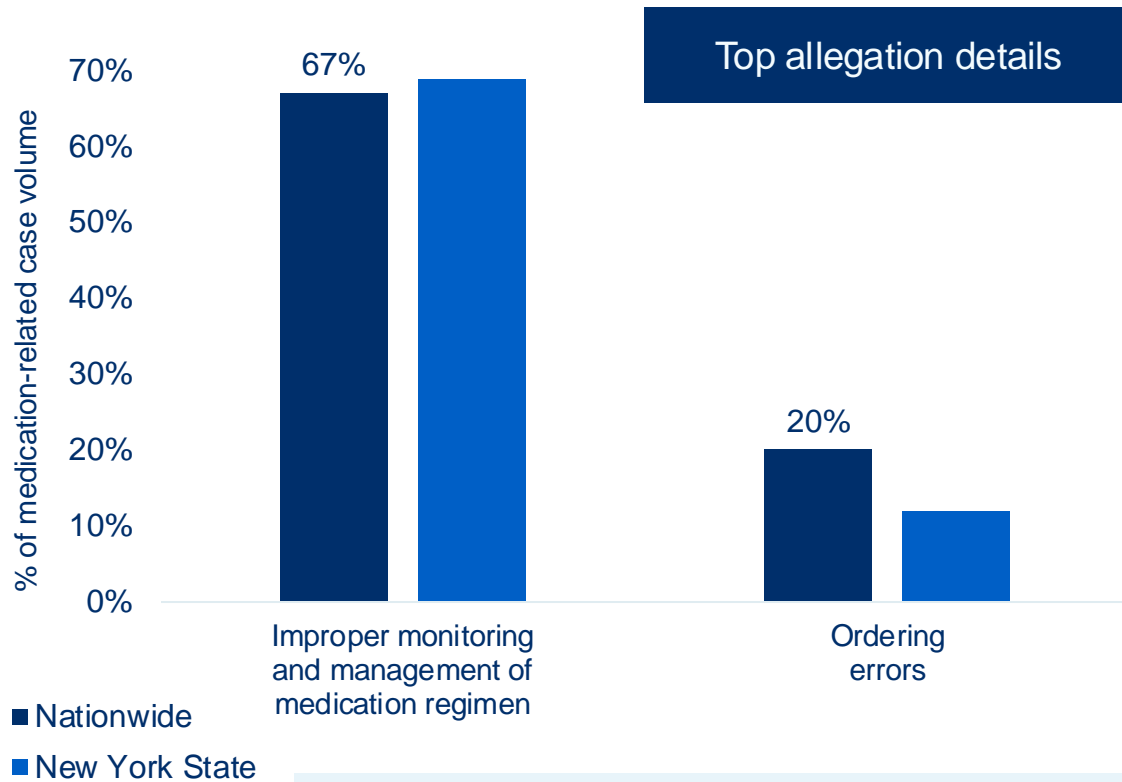


# Focus on Medical Treatment Allegations



For both nationwide and New York State, 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.

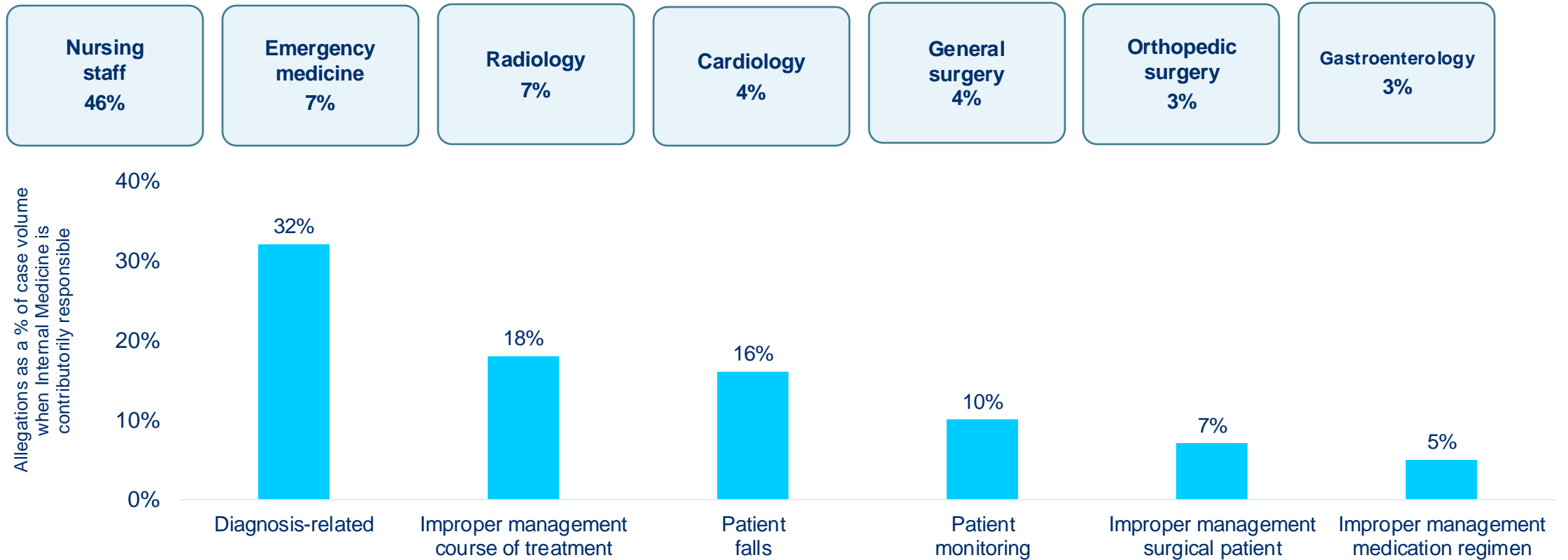
# Focus on Medication-Related Allegations



Selection of the most appropriate medication for the patient's condition is one of the most frequently noted risk issue in medication cases. Issues reflecting patient non-adherence to prescriptions are sometimes impacted by inadequate patient/family education of the importance of prescription adherence. Inadequate patient monitoring, and suboptimal communication about medication regimens across the patient's care team are also commonly noted risk issues.

# Nationwide: Contributorily Responsible

Although this analysis is focused on cases reflecting Internal Medicine as the primarily responsible service, another 1,210 cases identify Internal Medicine as contributorily responsible. The primary services in these cases are varied, reflecting the myriad of providers who care for patients along the healthcare continuum. The most common primary services, and a comparison of top allegation categories, are shown below.





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

**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

SETTLED

**\$1.5M**

## CONTRIBUTING FACTORS

### Clinical judgment

Narrow diagnostic focus, including relying on previous provider's diagnosis, and failure to establish a differential diagnosis

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

Failure/delay in ordering diagnostic testing

Misinterpretation of diagnostic studies

Failure/delay in obtaining consult/referral

## FAILURE TO DIAGNOSE CORONARY ARTERY DISEASE RESULTING IN DEATH

The patient was a 59 year-old male with a **long-standing history of gastroesophageal reflux disease (GERD)**, hypertension, and hypercholesterolemia, **and a family history significant for cardiac disease and his father's death at a young age**. The patient had been treating with the same internal medicine practice for many years. He was switched to a new primary internal medicine provider in the practice who noted the patient's history of GERD which was poorly controlled by medications. He was referred to a general surgeon one year later for potential surgical treatment of GERD, with a **pre-operative EKG ordered by internal medicine. EKG results were abnormal, showing a possible myocardial infarction and left ventricular hypertrophy**. However, internal medicine cleared the patient for surgery **without ordering any additional studies or consults**.

Five months later, the patient complained of "some burning pain substernal". Seven months after that, he reported a "squeezing sensation felt retro-sternally which has steadily worsened since surgery." **No cardiac evaluation or workup was ordered by internal medicine, who attributed patient's symptoms to ongoing reflux problems**. One month later, the patient died suddenly while on a hunting trip. **Cause of death was noted to be an arrhythmia generated by cardiac ischemia from severe atherosclerosis with 75-90% occlusion of vessels and a prior myocardial infarction**.

# Case Examples

SETTLED

**\$37,500**

## CONTRIBUTING FACTORS

### Communication

Failure to read medical record

Inadequate education to patient about risks of ACE inhibitor (prescribed 7/21; medical record silent as to whether education was provided)

### Behavior-related

Patient failure to inform provider of allergy to this class of medication

## MEDICATION ORDERING ERROR RESULTING IN ALLERGIC REACTION AND ADMISSION TO ICU

The 46 year-old female **with multiple co-morbidities but no known allergies**, switched her care to a new practice. Two years later, she was hospitalized for angioedema. **During the admission, she learned that she was allergic to Lisinopril.** She was told that she would **need to advise her providers of her allergy to ACE inhibitors and angiotensin receptor blockers.**

Eleven months later, she was seen at the clinic by her internal medicine nurse practitioner for symptoms related to an infection. Records from a previous hospital admission related to treatment of a similar infection were requested. Upon receipt, **that set of records, with documentation of the patient's allergies to Lisinopril and Cipro, was placed in the back of the patient's clinic chart.** No notation was made in the clinic chart of those allergies. Although the patient was seen several times over the next few months at the clinic, these allergies were neither noted nor discussed.

The patient presented on July 21 **at which time the nurse practitioner prescribed an ACE inhibitor for treatment of hypertension** (BP 138/102). In the subsequent malpractice action, the patient testified that because she had told her physician she was allergic to Lisinopril, she believed she would not be given a script for a drug in the same class. **However, there is no documentation in the record that the patient ever notified the clinic about this allergy.**

On July 28, the patient called the clinic and spoke to the LPN. A subsequent note was placed in the patient's chart to *"discontinue Benzapril-HCTZ per NP due to allergic reaction."* **A new script was called in for another ACE inhibitor.** Later that day, the patient presented to the emergency room with angioedema. She required intubation and admission to ICU for three days **as treatment for an allergic reaction to ACE inhibitors.**

# Risk Mitigation Strategies

## **Conduct an appropriate and thorough assessment of the patient.**

- 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, cardiac disease, stroke and infections.
- 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.
- Give 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.**

- Timely document thorough, objective information about the results of patient assessments, education of the patient/family about treatment plans - including medication regimens, and any instances of patient nonadherence.
- Thorough, consistent documentation in the chart enhances communication between providers and provides a supportive framework for defense of any subsequent malpractice case.

## **Review office processes for test tracking, consults/referrals, appointment setting, and managing patient nonadherence.**

## **Know (and adhere to) your supervision responsibility for advanced practice providers.**

# MLMIC & MedPro Group Data

**MLMIC and MedPro Group 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**, MLMIC and MedPro Group 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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