

Obstetrics

Claims Data Snapshot

2023



This publication provides an analysis of aggregated data from clinically coded cases opened between 2012-2021 in which Obstetrics 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

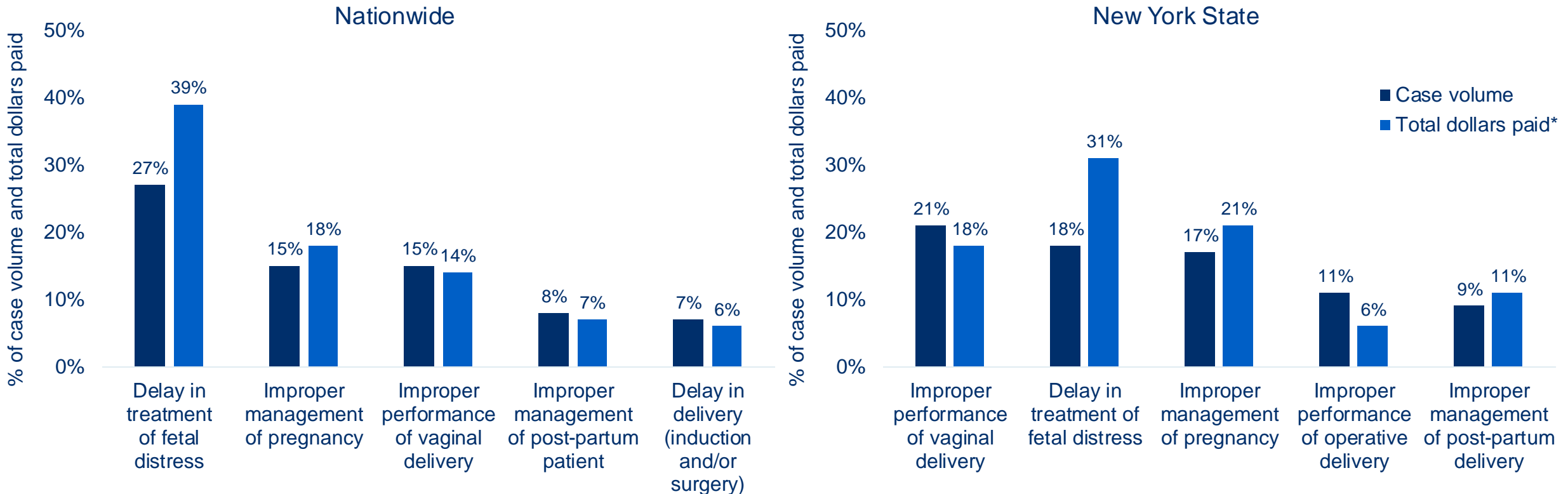
- **Throughout this analysis, nationwide Obstetric-related case volume is reflected, with targeted focus on several New York State-specific data points.**
- The previous two specialty slides reference combined Obstetrics-Gynecology frequency and severity profiles. However, **the clinically coded data section of this analysis – in all subsequent pages – is reflective only of cases involving Obstetrics as the responsible service.**
 - Included in Obstetrics is the OB-Hospitalist specialty. Case volume is very limited (N=25), and therefore there is no separate focus provided for the OB-Hospitalist cases.
 - Midwifery is a separately identified responsible service, and, as with OB Hospitalists, reflects limited case volume (N=61). However, page 17 does include a focus on the Midwifery cases.
- **Obstetrics-related allegations account for 87% of cases;** these allegations are the sole focus of this analysis. Diagnostic and medical treatment/procedure allegations comprise the majority of remaining case types.
- **Delays in the treatment of fetal distress, improper management of pregnancy and improper performance of vaginal deliveries are the three most commonly noted allegations,** accounting for 57% of case volume and 71% of total dollars paid*. Midwifery cases are similar, however they do reflect a higher volume of fetal distress-related cases.
- **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 assessments, narrow diagnostic considerations, and team communication failures, are key drivers of both clinical and financial Obstetrics case severity.

Most Common Major Allegations & Financial Severity

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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.

Nationally, for Obstetrics, 87% of all case volume reflects Obstetrics-related allegations, therefore, the focus of this report will be on those allegations. In addition, a focus on Midwifery cases is included on page 17.



MLMIC + MedPro Group cases opened 2012-2021, Obstetrics as responsible service & OB-related allegations; Nationwide N=907, New York State N = 266; *Total dollars paid = expense + indemnity

Clinical Severity*

Clinical Severity Categories	Sub-categories	% of Nationwide case volume	% of New York State case volume
LOW	Emotional Injury Only	4%	5%
	Temporary Insignificant Injury		
MEDIUM	Temporary Minor Injury	22%	26%
	Temporary Major Injury		
	Permanent Minor Injury		
HIGH	Significant Permanent Injury	74%	69%
	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, Obstetrics as responsible service & OB-related allegations; Nationwide N=907, New York State N = 266; *Severity codes reflect National Association of Insurance Commissioners (NAIC) injury severity scale

Claimant Type & Location

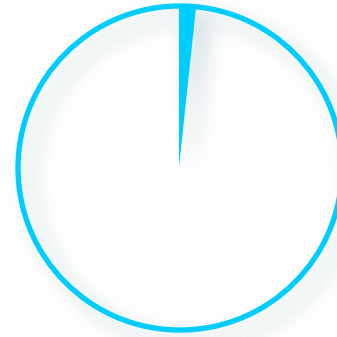
Nationwide



Inpatient
78%



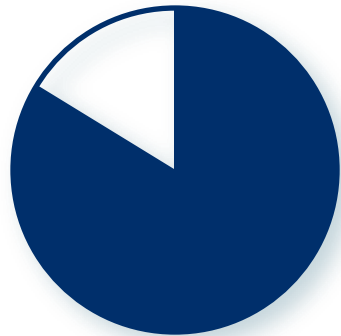
Ambulatory
21%



Emergency
1%

Locations	% of case volume
Labor and delivery	73%
Office/clinic	15%
Patient room/ICU	5%
Inpatient OR/recovery	5%
Emergency department	2%

New York State



Inpatient
80%



Ambulatory
18%



Emergency
2%

Locations	% of case volume
Labor and delivery	76%
Office/clinic	15%
Patient room/ICU	4%
Inpatient OR/recovery	3%
Emergency department	2%

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.

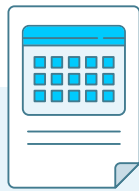
Multiple factors are identified in each case because generally, there is not just one issue that leads to these cases, but rather a combination of issues.



Administrative



Behavior-related



Clinical environment



Clinical judgment



Clinical systems



Communication



Documentation



Supervision



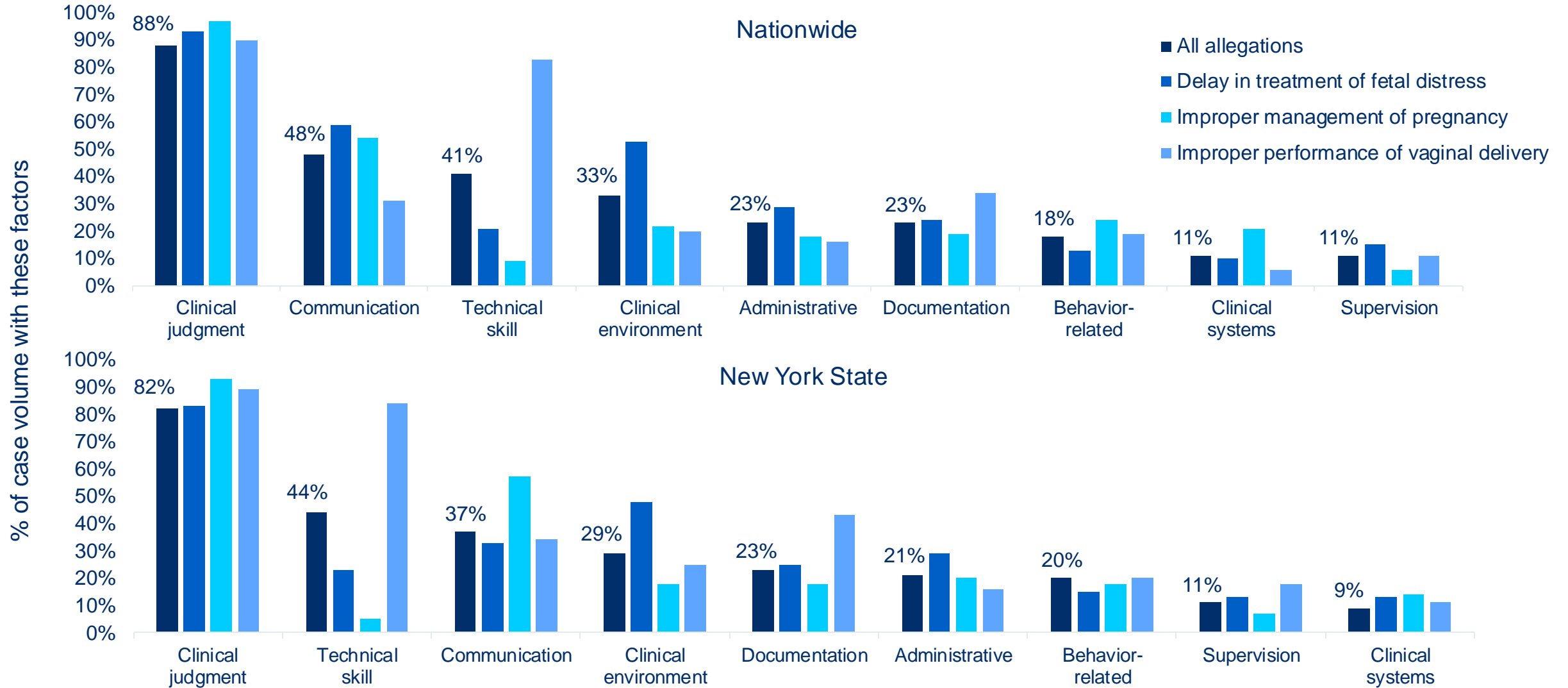
Technical skill

Contributing Factor Category Definitions

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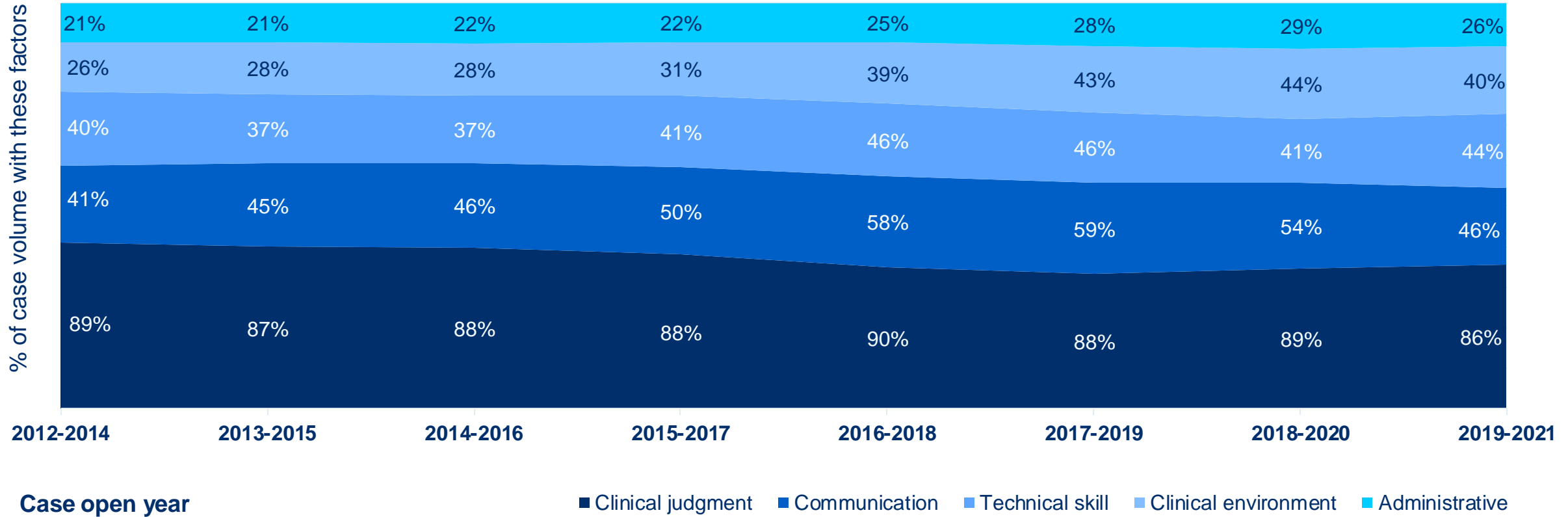
Administrative	Factors related to medical records (other than documentation), reporting, staff education and training, ethics, policy/protocols
Behavior-related	Factors related to patient nonadherence to treatment or behavior that offsets care; also, provider behavior including breach of confidentiality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

Most Common Contributing Factor Categories by Allegation



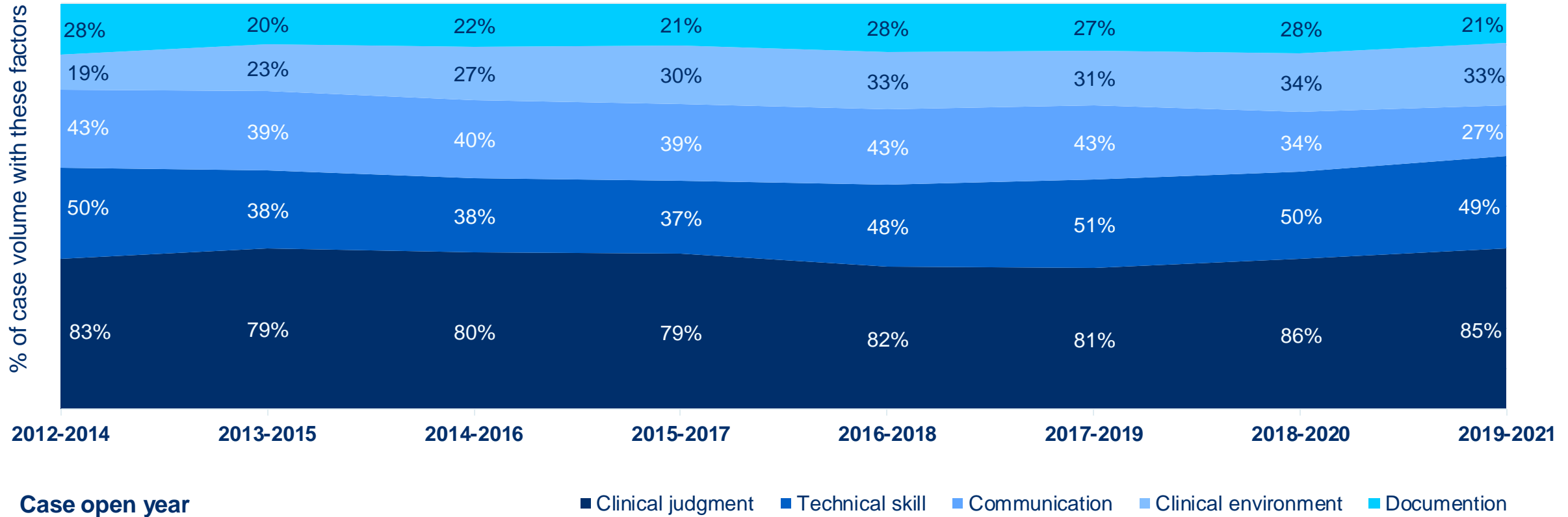
Nationwide: Distribution of Top Five Factor Categories Over Time

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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 increase in cases noting clinical judgment, a sharper decrease in those noting communication, and an increase in those reflecting clinical environment factors.*

MLMIC + MedPro Group cases opened 2012-2021, Obstetrics as responsible service & OB-related allegations; Nationwide N=907, New York State N = 266; More than one factor per case, therefore totals >100%;
 *Overall low case volume in later years directly impacts the volume of contributing factors

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

Factors associated with high clinical severity outcomes	(CJ) selection/management best method for labor/delivery (65%)	% of high severity case volume
	(CJ) failure to appreciate/reconcile relevant sign/symptom/test result (47%)	
	(CO) suboptimal communication among providers about patient condition (29%)	
	(CJ) inadequate monitoring of patient's condition (23%)	
	(CE) night shift (21%)	
Factors associated with the costliest indemnity payments	(CJ) inadequate patient assessment/failure to rescue (34%)	% more expensive than the average indemnity payment*
	(CJ) narrow diagnostic assessment – atypical presentation (32%)	
	(CJ) failure/delay obtaining consult/referral (27%)	
	(CJ) misinterpretation of diagnostic studies (22%)	
	(CO) suboptimal communication – failure to escalate concerns (21%)	

Clinical judgment and communication factors, specifically inadequate patient assessments, narrow diagnostic considerations, and team communication failures, are key drivers of both clinical and financial Obstetrics 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) selection/management best method for labor/delivery (59%)**
- (CJ) failure to appreciate /reconcile relevant sign/symptom/test result (36%)**
- (CE) night shift (21%)**
- (CJ) selection/management of therapy during pregnancy (20%)**
- (TS) recognition/management of known complications (1%)**

% of high severity case volume

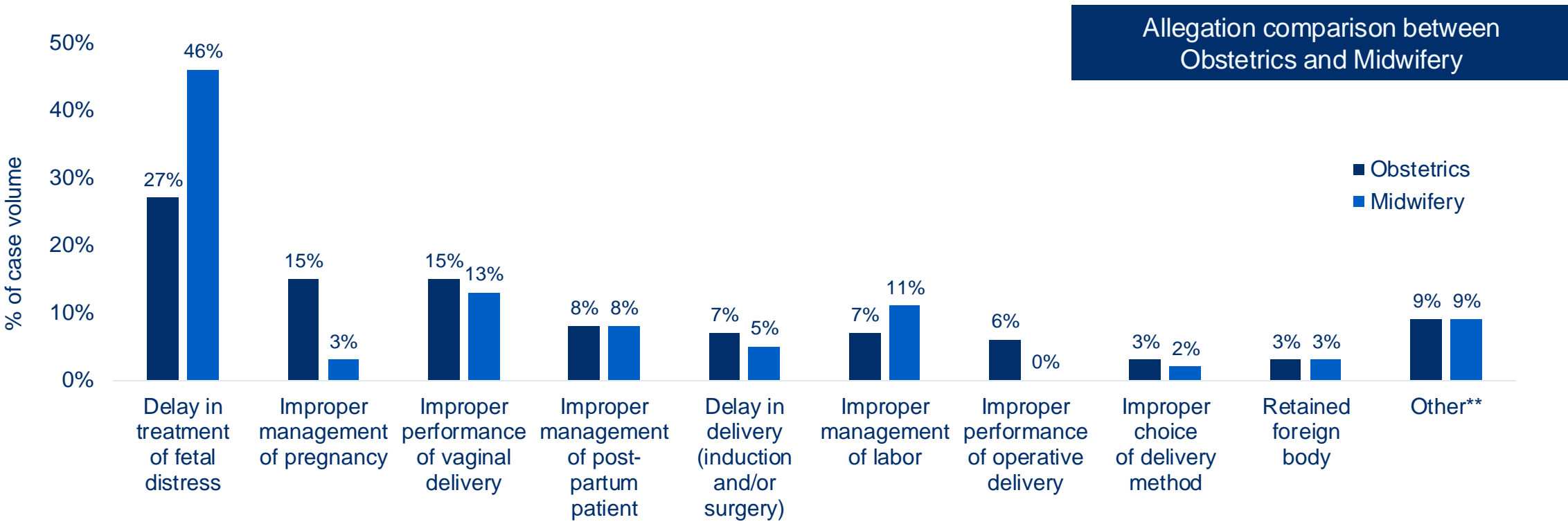
Factors associated with the costliest indemnity payments

Selection/management of best method for labor/delivery and failures to appreciate/reconcile signs/symptoms/test results are the contributing risk factors noted most often in the indemnity-paid cases, but the low overall New York State case volume does not allow for conclusive statements.

Clinical judgment and communication factors, specifically inadequate patient assessments, narrow diagnostic considerations, and team communication failures, are key drivers of both clinical and financial Obstetrics case severity, similar to the nationwide drivers.

Nationwide: Focus on OB-Related Allegations Involving Midwifery

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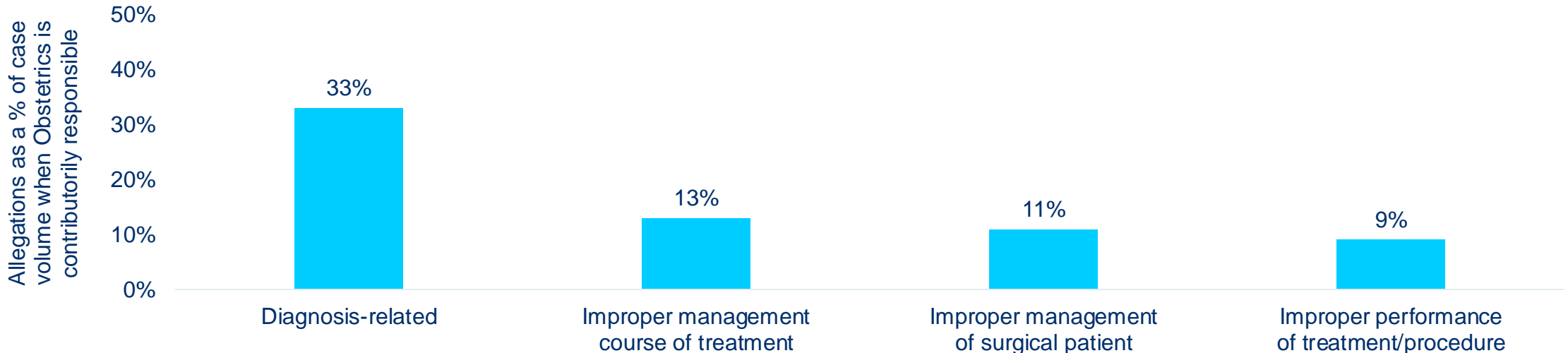
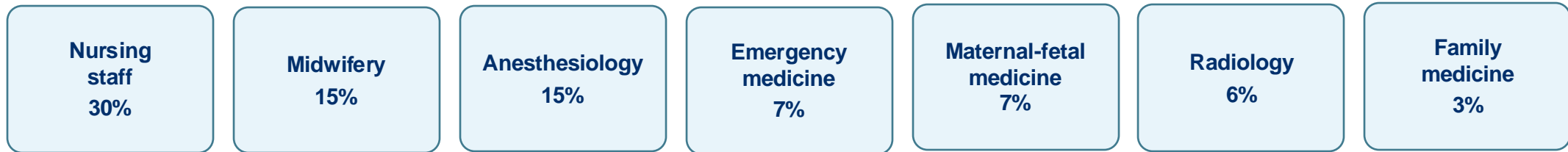


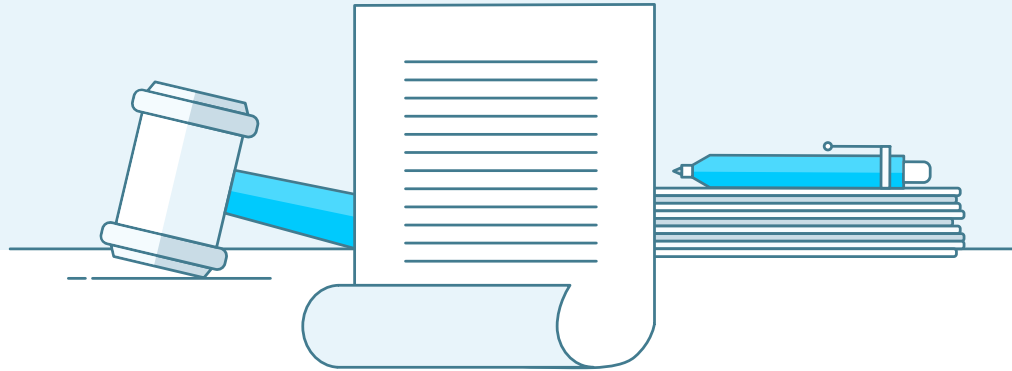
Overall case volume for midwifery is low, however, with the exception of cases involving fetal distress and pregnancy management, the distribution of allegations is similar to that of obstetricians. The distribution of contributing factors is similar also, although midwifery cases reflect a slightly higher volume of cases involving inadequate patient monitoring, suboptimal communication among members of the labor and delivery team, and those impacted by night shift environments.

Nationwide: Contributorily Responsible

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Although this analysis is focused on cases reflecting Obstetrics as the primarily responsible service, another 226 cases identify Obstetrics 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 Obstetricians.

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

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SETTLED

\$70,000

CONTRIBUTING FACTORS

Clinical environment

Weekend

Clinical judgment

Selection/management of the most appropriate course of labor

Inadequate patient monitoring

Communication

Suboptimal communication among providers about patient's condition

Technical skill

Inexperience with procedure

IMPROPER MANAGEMENT OF LABOR RESULTING IN UTERINE RUPTURE AND FETAL DEATH

A 39-year old mother (G6P2) with gestational diabetes requested induction at 38 weeks gestation due to discomforts of late pregnancy and being tired of using an insulin pump. The obstetrician (OB) **scheduled the induction for the following Sunday (at 39+ weeks) due to concerns of the baby being large for gestational age.**

Sunday evening, the certified nurse midwife (CNM) examined the mother and found the cervix long, thick and closed. Cervidil was placed then removed at 10am on Monday per protocol. At this point, the cervix was 1cm dilated, thick and vertex high. Fetal heart rate (FHR) was normal with regular contractions. **CNM ordered Foley balloon with Misoprostol 25mcg** (experts critical of this decision, as patient was already contracting). An OB intern was **unsuccessful at placing the Foley balloon.** Later that afternoon, a resident was successful in placing the balloon and administered the Misoprostol 25mcg. **CNM and residents managed the labor as the OB hospitalist was in house, but was never called about this laboring mother.**

At 8:51pm, the mother was laboring with good progress; no signs or symptoms of uterine hyperstimulation and FHR had good variability and accelerations. Exam by CNM identified balloon had fallen into the vagina from the cervix; other findings: 4-5cm dilated, 80% effaced, vertex -2 station. **By 8:59pm, mother was progressing rapidly and requested OB attend the birth.** CNM contacted OB at home to come in for delivery. **At 9:20pm mother complained of sudden tearing pain with contractions** and a few minutes later there was a spontaneous rupture of membranes with bloody amniotic fluid. FHR decelerated down to 90s, then 60s. Resuscitative measure taken, but FHR remained low 60s.

CNM did not get fetal scalp monitor placed until 9:28pm, not picking up a FHR. At 9:30pm, **OB noted loss of station (signs of uterine rupture); rather than immediate transfer to OR, OB asked for ultrasound** - FHR in 70s. Mother to OR 9:43pm; baby without signs of life was extruded from uterine rupture 8cm long, uterine vein and artery noted to have several tears, several liters of blood in abdomen. Infant handed off to NICU staff who were unable to resuscitate. Mother's uterus was repaired, and she was transferred to PACU in stable condition.

Case Examples

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

SETTLED

\$1.0M

CONTRIBUTING FACTORS

Behavior-related

Patient factors (refusal of additional testing and MFM consult)

Clinical judgment

Misinterpretation of diagnostic studies

Inadequate history/physical

Failure to appreciate/reconcile relevant signs/symptoms/test results

Failure to order consult and ECHO and diagnostic testing better suited for identifying chromosomal defects

Clinical system

Clinician did not receive test results

FAILURE TO DIAGNOSE CONGENITAL ANOMALIES (DIGEORGE SYNDROME) RESULTING IN WRONGFUL LIFE

Patient was G3P1, in her mid 30s, with a history of prior pregnancy with 2-vessel cord that resulted in delivery of a healthy baby. Patient presented to Obstetrician (OB) for prenatal care and was followed regularly during pregnancy. At that time, MaterniT21 prenatal screening was done (as opposed to nuchal translucency screening and a quad blood screen - more accurate test for chromosomal defects); results were unremarkable. **Alpha-fetoprotein results were not complete, but the test was not repeated.**

An ultrasound was done at 19 weeks gestation; view of fetal anatomy was limited. The fetal heart was visualized but **outflow tracts were limited so a repeat ultrasound ordered for two weeks later.** Two weeks later, a 4-chamber heart was again not well seen, and a 2-vessel cord was noted. On the second page of the ultrasound report there was a recommendation for a fetal echocardiogram (ECHO). **However, OB did not receive this page and was not aware of the recommendation.**

The following day, the ultrasound was repeated where a fetal heart was well visualized and noted to be within normal limits by radiology. The radiologist did not speak with or evaluate patient. **No recommendation for fetal ECHO made with this test. OB did not order fetal ECHO.** The patient told both the OB and the ultrasound technician that previous baby had 2-vessel cord and was 'fine' and **declined further testing or maternal fetal medicine consult.**

The remainder of the pregnancy was unremarkable. Baby was born at term; APGARS 8,9. The next day, baby developed tachypnea and was transferred to higher level of care where he was diagnosed with DiGeorge syndrome, a chromosome 22 defect. Baby did not have facial anomalies, cleft palate or thyroid dysfunction but did have lower heart defects requiring surgery. **Patient claims she was deprived of a prenatal diagnosis and the choice to terminate the pregnancy** as well as costs associated with raising a child with special needs.

Conduct an appropriate and thorough assessment of the patient, screening for risk factors and incorporating patient and family medical history.

- Carefully consider repeated patient complaints or concerns when making clinical decisions about patient care and additional diagnostic testing.

Communicate with each other.

- Focus on team training, which encourages clear communication across all providers, even during shift changes and evenings/weekends during lesser-staffed hours.

Recognize that inexperience with high-severity situations can be mitigated with situation-specific drills and team training.

- Ongoing evaluation of procedural skills and competency with equipment is critically important.

Be aware of the potential impact to patient care during ‘off-shift’ times including evenings/nights, weekends and holidays.

Document. Verify that documentation covers all clinically significant information, including the clinical rationale for the method of delivery.

- Be aware that lack of access to outpatient prenatal records, containing documentation of maternal risk factors such as pre-eclampsia, as well test results for congenital fetal conditions, can significantly impact the decision-making of the inpatient team during labor and delivery.

Enable a culture where ‘chain of command’ policies are routinely followed in both the labor & delivery unit and in the OR, and acted upon in the event of delayed response from the managing physician/surgeon.

- Focus on repetitive drills for managing fetal distress so that next steps in the escalation of care are well-established.

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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