# Medical Office and Clinic-Based Cases

## Data Insight

## 2025

MedPro Group
a Berkshire Hathaway company

MLMIC
MLMIC Insurance Company
a Berkshire Hathaway company

# Report Scope

- **This report details stories and data from MedPro and MLMIC closed cases which arose in medical offices/clinics**. Even though well-meaning providers intend to provide the highest quality of care, failures in the process of care do occur, and can result in a long-lasting impact on both patients and providers.
- We trust you'll read our data and associated case stories with an eye on both clinical risk management and on how these events might have been prevented, for the benefit of patients and providers.

**Throughout this report, we'll answer the following questions, among others, and support the answers with data:**

Which case types are most common?

Who is responsible for the patient injuries, and how serious are the injuries?

How do failed processes of care, known as contributing factors, impact patient outcomes?

# Key Points

| | |
|---|---|
| **Over 6,000 clinically coded closed cases were referenced for this report.** | As context, medical office/clinic-based cases are most common across the entirety of the MedPro and MLMIC closed case data set, representing 24% of all closed cases. |
| **Diagnostic and broad-spectrum medical treatment case types are most common.** | Across the diagnostic cases, malignancy and circulatory system diagnoses are most often identified. Management of courses of medical treatment and procedural performance-related cases together account for more than three-fourths of medical cases. |
| **By responsible service, primary care and orthopedics account for the largest volume of cases.** | Primary care services (family and internal medicine), followed by dermatology, are most common in the medical cases, with orthopedics and ophthalmology services in the surgical cases. Physician assistants, nurse practitioners and technicians/assistants are often identified as involved provider roles. |
| **A variety of contributing factors are identified.** | More than three-fourths of all cases reflect clinical judgment issues. Half of all cases also reflect communication issues. Cases reflecting sub-optimal communication (among providers and between providers and patients/families), insufficient documentation, and breaks in the process designed for diagnostic test tracking and follow-up (clinical systems) are, on average, most expensive to defend. |

# Clinical Risk Analysis

The following section details clinical risk insights from closed cases arising in a medical office or clinic setting, across case open years 2014-2023.

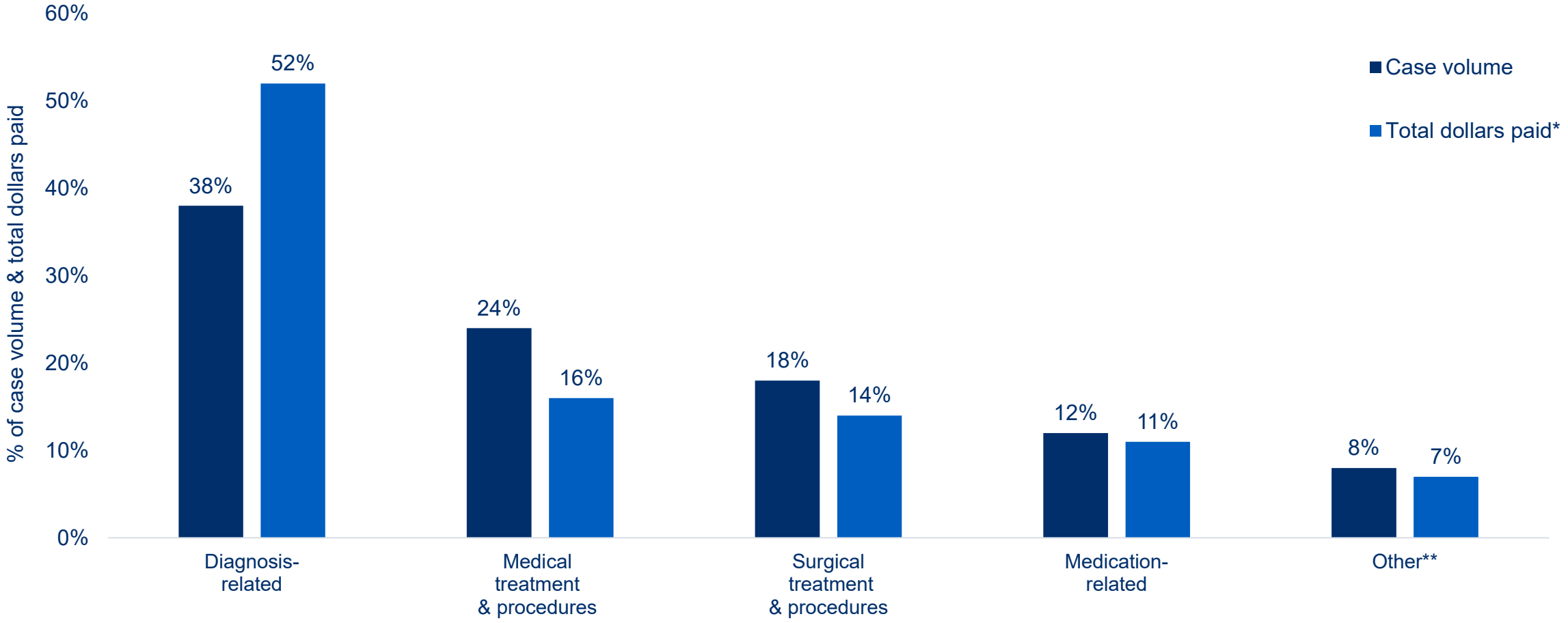
A key point of the clinical coding process involves the categorization of cases into types. Case types characterize the underlying processes of care which most directly impacted the patient's outcome, and/or initiation of a claim/suit.

There is always one primary case type*, and often several secondary types.

*See case type definitions at the end of this report.

# Primary Case Type Categories & Financial Severity

Diagnosis-related cases are most common and account for half of the financial severity. Additional insights into the most common case types are provided later in this report.



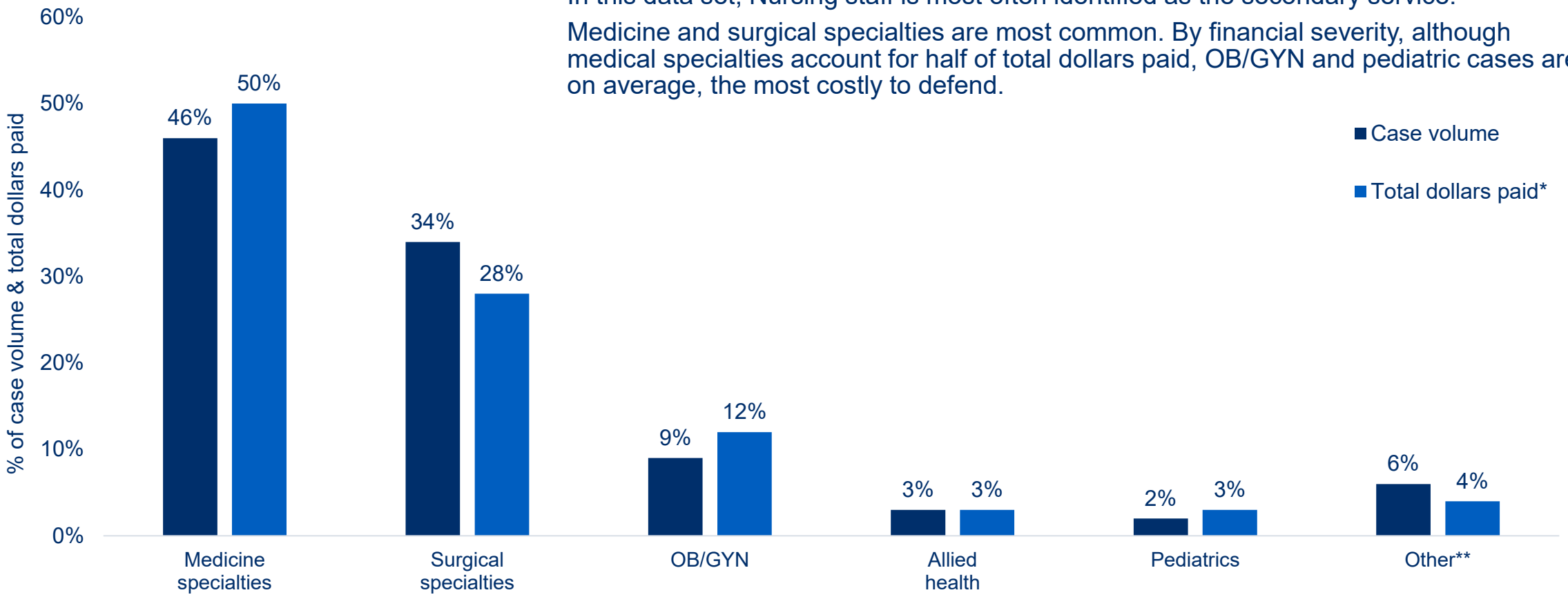

MedPro Group & MLMIC closed medical office/clinic-based cases opened 2014-2023 (N=6,384); *Total dollars paid = expense + indemnity; **Other includes case types for which no significant case volume exists

# Primary Responsible Service Categories & Financial Severity

Responsible services indicate the clinical service of the provider(s) most directly responsible for the patient's care at the time of the event. There is always one primary service, and often several secondary services.

In this data set, Nursing staff is most often identified as the secondary service.

Medicine and surgical specialties are most common. By financial severity, although medical specialties account for half of total dollars paid, OB/GYN and pediatric cases are, on average, the most costly to defend.

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# Primary Responsible Service Details

**Medicine specialties**

46% of overall case volume

**Most common (% of medicine specialty case volume)**

| | |
|---|---|
| Family medicine | 29% |
| Internal medicine | 22% |
| Dermatology | 14% |
| Pain medicine | 8% |
| Cardiology | 5% |
| Gastroenterology | 5% |

**Surgical specialties**

34% of overall case volume

**Most common (% of surgical specialty case volume)**

| | |
|---|---|
| Orthopedics | 33% |
| Ophthalmology | 15% |
| Podiatry | 11% |
| Plastic surgery | 10% |
| Urology surgery | 9% |
| Otorhinolaryngology | 7% |

MedPro Group & MLMIC closed medical office/clinic-based cases opened 2014-2023 (N=6,384)

# Primary Responsible Service Details, continued

**OB/GYN** — 9% of overall case volume

| (% of OB/GYN case volume) | |
|---|---|
| Gynecology | 58% |
| Obstetrics | 35% |
| Fertility/Reproductive | 4% |
| Maternal-Fetal | 3% |

**Allied health** — 3% of overall case volume

| (% of allied health case volume) | |
|---|---|
| Chiropractic | 38% |
| Optometry | 29% |
| Other* | 33% |

MedPro Group & MLMIC closed medical office/clinic-based cases opened 2014-2023 (N=6,384); *Other includes allied health services for which no significant case volume exists

# Primary Responsible Services by Their Most Common Case Types

**Medicine specialties**

Diagnosis-related
Failure/Delay/Wrong

Medication-related
Improper management of medication regimen

**Surgical specialties**

Surgical treatment & procedures
Improper management of surgical patient

Diagnosis-related
Failure/Delay/Wrong

**OB/GYN**

Diagnosis-related
Failure/Delay/Wrong

Surgical treatment & procedures
Improper management of pregnancy

**Allied health**

Medical treatment & procedures
Improper performance of treatment/procedure

Diagnosis-related
Failure/Delay/Wrong

**Pediatrics**

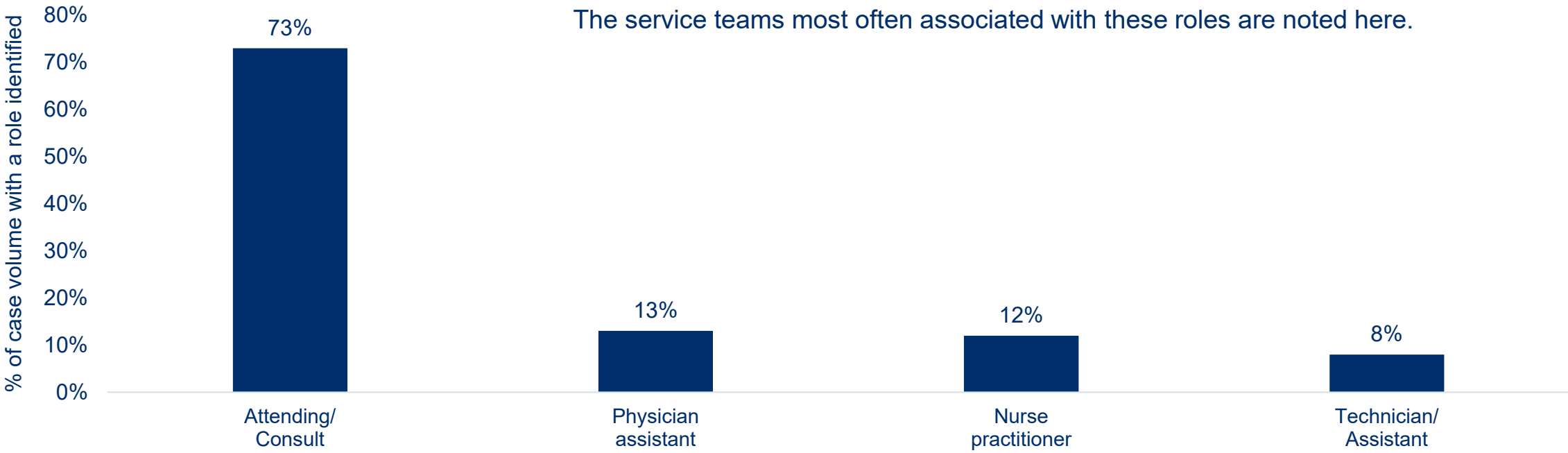
Diagnosis-related
Failure/Delay/Wrong

Medical treatment & procedures
Improper performance of treatment/procedure

# Most Common Primary Responsible Service Roles

Roles reflect the specific position(s) within the service team involved at the time of the event. There may be multiple roles identified in a single case within the same service team (i.e., a physician assistant and an attending/consult – both practicing medicine under the orthopedic service).

The service teams most often associated with these roles are noted here.




Physician assistant
- Primary care (Internal & Family)
- Orthopedics
- Dermatology
- Pain medicine
- Gynecology

Nurse practitioner
- Primary care (Internal & Family)
- Gynecology
- Pain medicine
- Orthopedics
- Pediatrics

Technician/Assistant
- Primary care (Internal & Family)
- Dermatology
- Ophthalmology

# Clinical Severity*

| Clinical severity* categories | Sub-categories | % of case volume | Definitions |
|---|---|---|---|
| **LOW** | Emotional Injury Only | **8%** | Mental distress or suffering that is generally temporary; includes HIPAA violations, discrimination, involuntary stay |
| | Temporary Insignificant Injury | | Lacerations, contusions, minor scars, rash; no delay in recovery |
| **MEDIUM** | Temporary Minor Injury | **43%** | Infection, fracture set improperly or a fall in the facility, where recovery is complete but delayed |
| | Temporary Major Injury | | Burns, drug side effect; recovery delayed |
| | Permanent Minor Injury | | Loss of fingers or loss or damage to organs; includes non-disabling injuries |
| **HIGH** | Significant Permanent Injury | **49%** | Deafness, loss of limb, loss of eye or loss of one kidney or lung |
| | Major Permanent Injury | | Paraplegia, blindness, loss of two limbs or brain damage |
| | Grave Injury | | Quadriplegia, severe brain damage, life-long care or fatal prognosis |
| | Death | | Death |
| | | **18%** | **% of cases resulting in patient death** |

MedPro Group & MLMIC closed medical office/clinic-based cases opened 2014-2023 (N=6,384); *Severity codes reflect National Association of Insurance Commissioners (NAIC) injury severity scale

# 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.

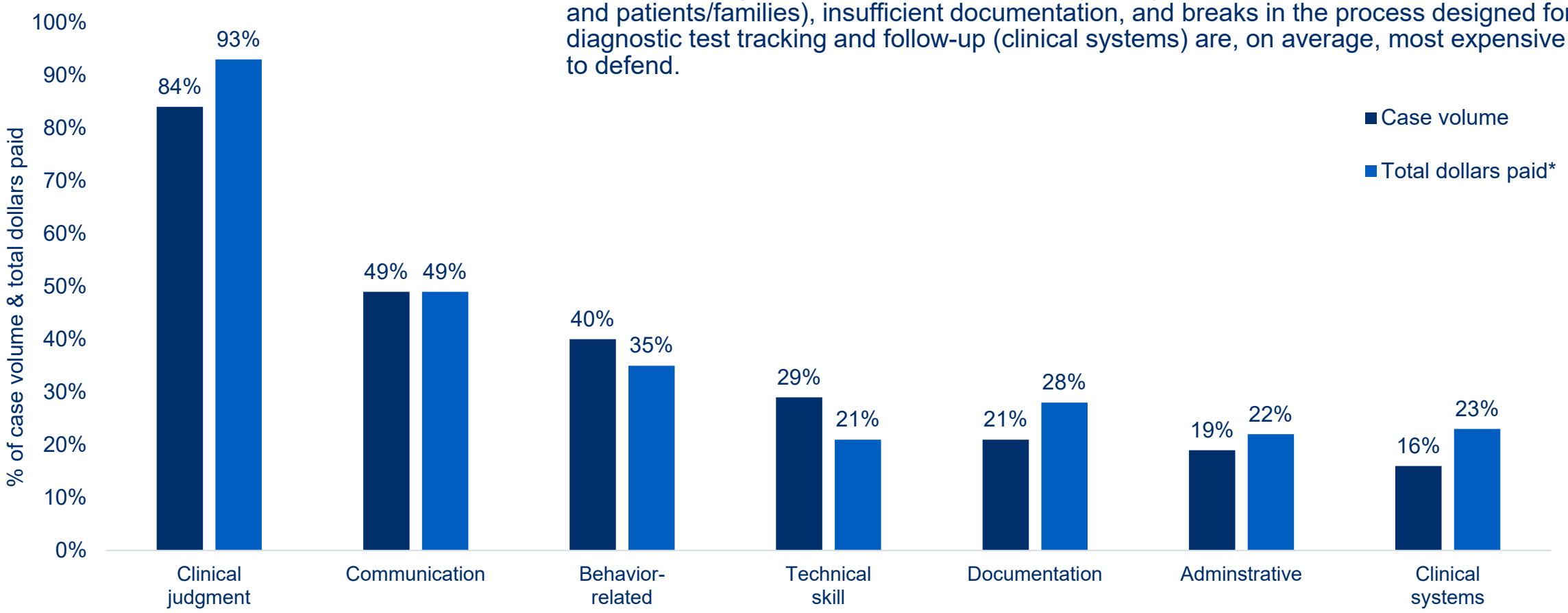
Multiple factors are identified in each case because generally, there is not just one issue that leads to these cases, but rather a combination of issues.

*See contributing factor definitions at the end of this report.

# Most Common Contributing Factor Categories & Financial Severity

More than three-fourths of all cases reflect clinical judgment issues, most often involving inadequate patient assessments.

Cases reflecting sub-optimal communication (among providers and between providers and patients/families), insufficient documentation, and breaks in the process designed for diagnostic test tracking and follow-up (clinical systems) are, on average, most expensive to defend.

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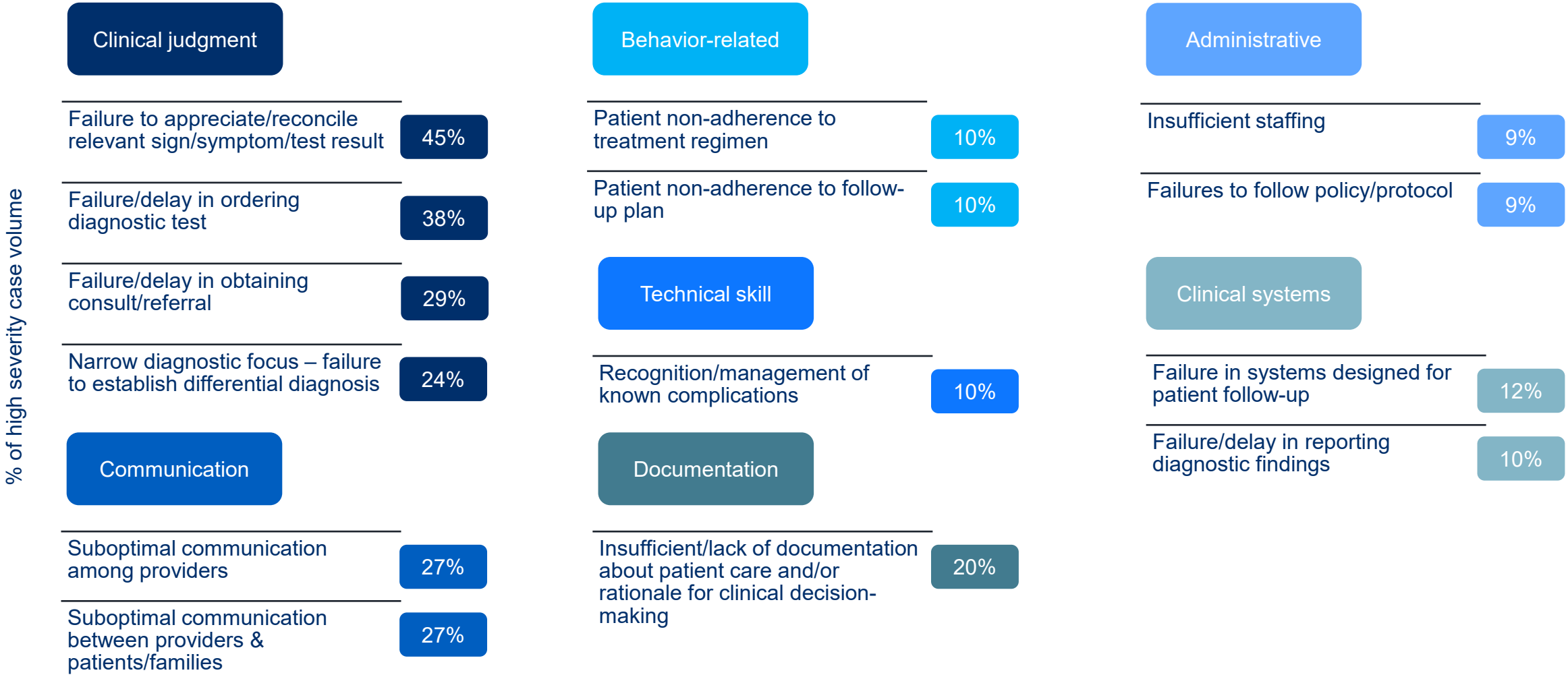
# Contributing Factor Details: Drivers of Clinical* Severity

These failures in the process of care are among those most commonly noted in cases involving a high clinical severity outcome.

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# Case Examples: Contributing Factors as Drivers of Severity*

## Clinical judgment

### Failure to appreciate signs/symptoms

Chest CT for patient with extensive smoking and asbestos exposure history revealed ill-defined nodular density in lung noted as "cannot exclude malignancy". PET imaging was recommended. Subsequent treating pulmonologist did not order PET, and treated patient over next two years for variety of worsening pulmonary symptoms with accompanying weight loss. When PET scan was finally ordered, it revealed metastatic small cell carcinoma. Patient died one month later. ***($550K indemnity paid)***

## Communication

### Suboptimal communication among providers and with family

At age 8, patient noted by pediatric practice to be obese and pre-diabetic. Was referred to endocrinology, and then back to pediatrics. For the next 3 years, was seen by multiple providers in the practice; repeated instances of inconsistent chart documentation, no evidence that providers were communicating findings/plan of care with each other, failures to order blood glucose testing, and failures to recommend a medication regimen. Patient's family failed to perform weekly weight checks and to obtain ordered lab work when at one point, he was referred to a dietician and bariatric specialist (English noted as family's second language). Ultimately, at age 15, patient developed diabetic ketoacidosis, resulting in anoxic brain injury. ***($700K indemnity paid)***

## Behavior-related

### Patient non-adherence to medication regimen

Patient of pain medicine clinic weaned herself off of oxycodone. Two years later, she returned to the clinic requesting opiates due to lower back pain. A 7-day supply was prescribed, and an MRI was ordered (not obtained by patient). No urine drug screen was done. Prescription refilled by phone as a 30-day supply one week later, again with no drug screen. Then patient was required to present monthly to the clinic. Nurse practitioner noted patient's intent to wean herself from opiates again, and mental health screen noted to be normal; a second refill was ordered. Patient overdosed one day later. ***($375K indemnity paid)***

## Technical skill

### Failure to recognize/manage post-operative complication

At the first post-op visit following repair of ankle fracture, patient's foot was dusky, with "pins and needles" feeling. No vascular workup was done; orthopedic surgeon prescribed a short leg cast and scheduled a return visit for 2 weeks. At that time, symptoms had worsened, ultimately resulting in a below-the-knee amputation due to gangrenous tissue. ***($2M indemnity paid)***

# Case Examples: Contributing Factors as Drivers of Severity*

## Documentation

### Lack of documentation about plan for patient care

Optometry patient with family history of glaucoma found to have high intraocular pressures on separate visits two years apart; no documentation about exact readings. Note entered into chart that patient should be scheduled for third visit, but no documentation about whether that appointment was made or kept. No documentation about differential diagnoses, nor whether the patient was advised of the concern for glaucoma. Patient then referred to ophthalmologist one year later, but no documentation as to who initiated the referral. Found to have bilateral severe glaucoma and is now legally blind. ***($800K indemnity paid)***

## Administrative

### Failure to follow policy

Due to patient's unexplained chest pain and a variety of other symptoms, primary care provider ordered consults with cardiology and gastroenterology. Office policy required scheduling to be done by office staff, and that an inability to schedule must be communicated to the provider. Gastroenterology consult was scheduled, but cardiology consult was not, due to an inability to find an available date. Primary care provider was not notified. The patient then missed a follow-up primary care appointment but was not contacted to reschedule (as per policy). Two weeks later, the patient suffered a fatal myocardial infarction. ***($650K indemnity paid)***

## Clinical systems

### Failure to follow-up on diagnostic testing

Patient discharged from ED with suspected viral illness with several diagnostic test results pending, including one for Rocky Mountain Spotted Fever (RMSF). Call placed by patient to primary care provider later the same day for continued symptoms. ED record was reviewed but patient was told no appointment needed. A second call was made the following day; patient was again told no appointment was necessary, and the provider did not obtain now-available test results. Patient admitted to hospital that evening. Lab results were positive for RMSF. Patient became septic and sustained permanent damage, including amputation of his fingers and neurological impairment. ***($700K indemnity paid)***

# Focus by Case Type

The following pages provide additional insights by case type.

# Focus on Diagnosis-Related Cases

Inclusive of wrong diagnoses, failures/delays, and misdiagnoses

No additional differentiation is made between wrong diagnoses, failures/delays and misdiagnoses.

% of case volume

Most common…

## Diagnoses:

Malignancies: 45% (lung, colon, prostate, breast)

Circulatory system: 13% (cardiac & cerebrovascular disease)

Complications of treatment: 9%

## Injuries:

Malignancy: 41%

Infection: 7%

Organ damage: 5%

Embolism/Thrombosis: 4%

## Responsible services:

Family medicine: 20%

Internal medicine: 16%

Orthopedics: 7%

Gynecology: 7%

## Contributing factor details:

Failure to appreciate/reconcile relevant sign/symptom/test result: 50%

Failure/delay ordering diagnostic test: 48%

Narrow diagnostic focus (failure to establish differential diagnosis): 34%

Suboptimal communication among providers: 16%

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# Focus on the Diagnostic Process of Care

Note key opportunities to reduce errors along the diagnostic process of care*. Each percentage indicates the volume of cases impacted by the issues in each phase.

## Phase 1

**Initial diagnostic assessment**

88%

- Patient notes problem & seeks care
- History & physical
- Patient assessed, symptoms evaluated
- Differential diagnosis established
- Diagnostic testing ordered

## Phase 2

**Testing and results processing**

25%

- Performance of diagnostic tests
- Interpretation of diagnostic test results
- Test results transmitted to/received by ordering provider

## Phase 3

**Follow-up and coordination**

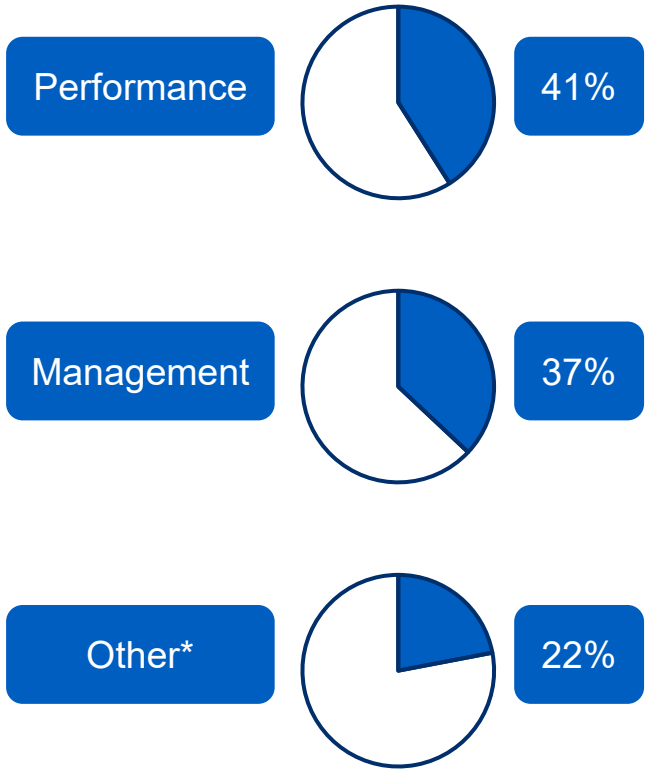
70%

- Physician follows-up with patient
- Referrals/Consults
- Patient information communicated among care team
- Patient compliance with follow-up plan

MedPro Group & MLMIC closed medical office/clinic-based cases opened 2014-2023 (N=6,384); *Each step reflects a combination of contributing factors; ambulatory diagnostic process of care algorithm courtesy of Candello, a division of CRICO Strategies

# Focus on Medical Treatment & Procedure Cases

Performance and management issues drive the majority of medical case volume.




Most common…

## Procedures in performance cases:

Therapeutic procedures (i.e. steroid injections, laser treatment): 14%

Skin lesion excisions: 11%

## Management case details:

Treatment and management of the patient through the pre- and post-procedure periods; includes recognition and management of complications

## Injuries in all case types:

Burn: 12%

Infection: 9%

Puncture/Perforation: 5%

## Responsible services in all case types:

Dermatology: 14%

Family medicine: 10%

Internal medicine: 8%

Orthopedics: 8%

Pain medicine: 7%

## Contributing factor details in all case types:

Recognition & management of complications: 30%

Failure to appreciate/reconcile relevant sign/symptom/test result: 22%

Procedural decision-making process, including appropriateness of the patient for the procedure: 20%

Suboptimal communication with patient/family re management of expectations: 19%

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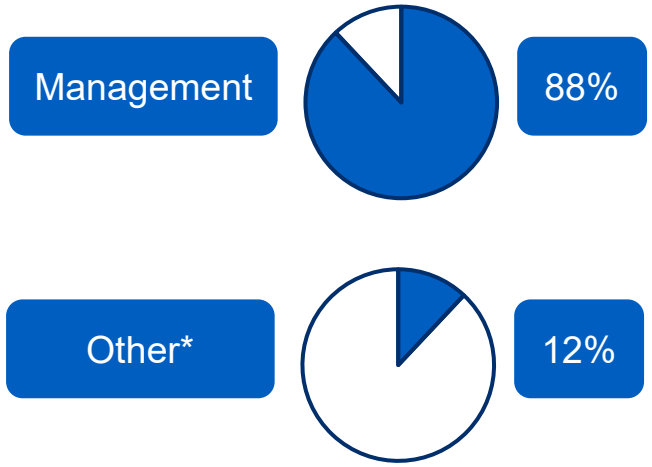
# Focus on Surgical Treatment & Procedure Cases

Management issues drive the majority of surgical case volume.




% of case volume

Most common…

## Management case details:

Treatment & management of the patient through the pre- & post-surgical periods; includes recognition & management of complications

## Injuries in all case types:

Infection: 18%
Nerve damage: 7%
Malunion/Nonunion: 6%
Aggravated/Worsened condition: 5%

## Responsible services in all case types:

Orthopedics: 35%
Podiatry: 11%
Ophthalmology: 11%
Plastic: 9%

## Contributing factor details in all case types:

Procedural decision-making process, including appropriateness of patient for invasive procedure: 63%
Recognition & management of complications: 47%
Failure to appreciate/reconcile relevant sign/symptom/test result: 45%
Patient dissatisfaction with care & seeking other providers: 27%
Suboptimal communication with patient/family re management of expectations: 23%
Failure/delay in ordering diagnostic test: 22%
Inadequate response to repeated patient concerns/symptoms: 21%

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# Focus on Medication-Related Cases & the Process of Care

**Most common medications:**

Analgesics/Narcotics: 23%
Anticoagulants: 10%
Antibiotics: 10%

**Most common responsible services**

Family medicine: 21%
Internal medicine: 14%
Pain medicine: 11%

Note key opportunities to reduce errors along the medication process of care*. Each percentage indicates the volume of cases impacted by the issues in each phase.

## Phase 1

**Ordering**
**10%**
**of cases**

Includes failures to order, & wrong medication/dose/route orders

## Phase 2

**Dispensing**
**0%**
**of cases**

Includes pharmacy dispensing of wrong medication/dose/method (route)

## Phase 3

**Administration**
**5%**
**of cases**

Includes failures to medicate, administration wrong medication/dose/route

Includes technique involved with medication administration

## Phase 4

**Monitoring & management**
**66%**
**of cases**

Includes management of regimen/patient response/reaction

Includes monitoring immediately after medication administration

## Phase 5

**Other**
**18%**
**of cases**

Includes other process of care issues not captured in the previous steps, including patients with unknown allergies & cases in which medication shortages, contaminations or recalls impact the delivery of care

MedPro Group & MLMIC closed medical office/clinic-based cases opened 2014-2023 (N=6,384); *Each step reflects a medication-related case type; medication process of care algorithm courtesy of Candello, a division of CRICO Strategies

# Definitions

Case Types & Contributing Factors

# Definitions: Most Common Primary Case Types

**Anesthesia-related:** Management and treatment of the anesthesia patient; inclusive of pre-, intra-, and post-anesthesia periods, including performance of anesthesia procedures, diagnosing complications and immediate post-procedure pain management

**Diagnosis-related**: Encompasses delayed, missed and wrong diagnoses; inclusive of management of incidental findings

**Medical treatment & procedures**: Management and treatment of patients to address diseases and disorders; inclusive of the performance of medical and diagnostic procedures

**Medication-related**: Reflective of the medication delivery process, including ordering, dispensing and administering; inclusive of technique issues during administration

**OB-related:** Management and treatment of pregnancy; inclusive of antepartum, labor, delivery and post-partum periods; inclusive of diagnosing pregnancy-related maternal and fetal health conditions and performing OB procedures

**Patient environment**: Inclusive of falls and other preventable injuries during care, including physical safety (i.e., injury from equipment, surgical fires), infection control in the patient care areas, and security issues (i.e., assault)

**Patient monitoring:** Reflective of bedside observations and response to patients' physiologic or psychiatric reactions to disease, condition, injury or treatment

**Provider behavior**: Inappropriate behavior, including sexual misconduct

**Surgical treatment & procedures:** Management and treatment of the surgical patient; inclusive of pre-, intra-, and post-operative periods, performance of surgical procedures, and retained foreign bodies

# Definitions: Most Common Contributing Factors

**Administrative:** Factors related to the reporting of adverse events, adequacy of staffing, staff education/training, ethics, failure to follow and/or need for policy/protocols

**Behavior-related**: Factors related to patient non-adherence 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 diagnostic testing, reporting findings, follow-up systems, patient identification, specimen handling, nosocomial infections

**Communication**: Factors related to communication between providers, among patient/family and providers; includes electronic communication (texting, email, etc.) and telehealth/tele-radiology

**Documentation**: Factors related to inaccuracy, insufficiency, altered or inappropriate content

**Supervision**: Factors related to supervision of nursing, staff, advanced practice clinicians

**Technical skill**: Factors related to improper use of equipment, medication errors, retained foreign bodies, and the technical performance of procedures

# MedPro Group & MLMIC Data

**MedPro and MLMIC are partnered with Candello,** a national medical malpractice data collaborative and division of CRICO, the medical malpractice insurer for the Harvard-affiliated medical institutions.

**Derived from the essence of the word candela**, a unit of luminous intensity that emits a clear direction, Candello's best-in-class taxonomy, data, and tools provide unique insights into the clinical and financial risks that lead to harm and loss.

**Using Candello's sophisticated coding taxonomy to code claims data**, MedPro and MLMIC are better able to highlight the critical intersection between quality and patient safety and provide insights into minimizing losses and improving outcomes.

**Leveraging our extensive claims data**, we help our insureds stay aware of risk trends by specialty and across a variety of practice settings. Data analyses examine allegations and contributing factors, including human factors and healthcare system flaws that result in patient harm. Insight gained from claims data analyses also allows us to develop targeted programs and tools to help our insureds minimize risk.

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