Contributing Factors to Medical Malpractice Claims: Study Examines Difference Between No-Payment and Indemnity Claims

Jacqueline Ross, RN, PhD, Coding Director, Department of Patient Safety and Risk Management, The Doctors Company, Part of TDC Group

According to The Doctors Company's data, the frequency of claims against our insured clinicians has decreased, dropping from 17 claims per 100 physicians in 2000 to fewer than seven claims per 100 physicians in 2019. Concurrently, and nationwide, medical malpractice claim severity (the cost of the average claim) has increased dramatically; we have witnessed a sharp increase in the number of claims with indemnity payments higher than $500,000. As a medical professional liability insurer, our overarching goals include better understanding claim risk factors and helping medical professionals mitigate them to improve patient outcomes and decrease financial outlays.

The Doctors Company uses an evidence-based taxonomy from a data collaborative of medical professional liability insurers and health systems to analyze its medical malpractice claims data.[1] By examining the disposition of closed malpractice claims and their accompanying contributing factors, we provide insight into improvement strategies for healthcare practitioners.

In November 2023, The Doctors Company released a study on diagnosis-related medical malpractice claims with an indemnity over $1 million. The findings from this study highlighted the importance of patient assessment, consultation, and communication, as well as the need for practitioner awareness around cognitive bias.

To expand our understanding, we have conducted a new analysis with the guiding question: Do contributing factors differ between malpractice claims with no payment and claims with indemnity payments?

The study included malpractice claims closed by The Doctors Company from the loss years of 2013 through 2023. It included a total of 11,122 malpractice claims, excluding dentists and oral surgeons. The top major allegations were surgical treatment (n=4,163; 37 percent), medical treatment (n=2,698; 24 percent), diagnosis related (n=1,927; 17 percent), medication related (n=688; 6 percent), anesthesia related (n=533; 5 percent), and obstetrics related (n=460; 4 percent). Almost a third of the malpractice claims (n=3,404; 30.6 percent) concluded with an indemnity payment. We compared the leading subcategory contributing factors in the no-payment claims to those in the indemnity claims. We conducted a chi-square analysis to discover any statistically significant differences between the two disposition types. (See Table 1.)

Table 1. Contributing Factors* Comparison of No-Payment and Indemnity Claims

Contributing Factor Subcategory (n=11,122)	No Payment (n=7,718)	Indemnity Payment (n=3,404)
Technical Performance (n=5,253)	3,683 (48%)	1,570 (46%)
Patient Assessment† (n=3,568)	1,729 (22%)	1,839 (54%)
Patient Factors (n=3,336)	2,497 (33%)	839 (25%)
Communication Between Patient/Family and Providers (n=2,801)	1,891 (25%)	910 (27%)
Selection and Management of Therapy† (n=2,371)	1,032 (13%)	1,339 (39%)
Communication Among Providers† (n=1,877)	921 (12%)	956 (28%)
Insufficient / Lack of Documentation† (n=1,766)	848 (11%)	918 (27%)

*Claims may have multiple contributing factors.
†Significant difference at $p < 0.01$.

Four subcategories of contributing factors showed statistically significant differences between their prevalence in no-payment vs. indemnity-paid claims: patient assessment, selection and management of therapy, communication among providers, and insufficient / lack of documentation. Each of these four contributing factor subcategories is discussed below. The remaining subcategories—technical performance, patient factors, and communication between patient/family and providers—did not reach statistical significance, in terms of any differences between no-payment and indemnity-paid claims.

Patient Assessment

Our findings showed that patient assessment factors occurred more frequently in indemnity claims. A comprehensive patient assessment is key to the practitioner's ability to make accurate recommendations for the patient's care. Daniel Kahneman, PhD, describes two types of decision making: System 1 is fast and instinctive, using mental shortcuts; System 2 is slower and more logical. Relying on System 1 may lead to cognitive bias and result in a medical malpractice claim grounded in patient assessment factors, such as failure to establish a differential diagnosis or failure to appreciate the patient's signs and symptoms, leading to a premature discharge. Our analysis highlighted these factors in the majority of settled claims. In practice, take a diagnostic time-out. Ask a colleague to provide an opinion. Include the patient in your thought process. Use checklists (such as the Society to Improve Diagnosis in Medicine's Clinician Checklists).

A poor history and physical is another example of a patient assessment factor seen more frequently in indemnity claims than in no-payment claims. A comprehensive history and physical, an essential part of each patient visit, guides the practitioner's decision-making process. Update the patient's history during every encounter. Ensuring a good history entails patient input. Because patients have different levels of health literacy, practitioners must assess each patient's level of understanding and adjust their questioning to obtain information. Patients need to understand the importance of providing an accurate,

updated health history. Practitioners need to reassure patients that the information they share is protected under HIPAA and applicable state privacy laws. Encourage patients to collect and share their family health history through the CDC's Family Health History tools and resources.

Case Example

A patient over 50, who smoked cigarettes (1ppd) and medical marijuana, came to the emergency department (ED) with complaints of shortness of breath and chest pain. This patient also had a history of hypertension and a strong family history of aneurysms (sibling died; parent living with an aneurysm). The patient's spouse informed the physicians and nurses of the family history of aneurysms, but it was not documented. The patient's blood pressure was elevated. The CXR was negative. An EKG showed T-wave inversion but was negative for ischemia. The ED physician noted a low suspicion for pulmonary embolism or dissection and considered acute coronary syndrome or drug effects from marijuana use. The patient was admitted for a cardiology evaluation. A cardiologist diagnosed unstable angina. The patient had a normal cardiac catheterization and was discharged the next day. Two days later, the patient returned to the ED by ambulance with complaints of chest and left flank pain. En route to the ED, the patient had supraventricular tachycardia that required adenosine. The renal ultrasound was negative. No CT was done. The patient was in atrial fibrillation and exhibiting signs of renal failure. Consultations with cardiology and nephrology were ordered. An echocardiogram, which was completed but not read until after discharge, showed a mildly dilated ascending arch of the aorta. The patient was discharged but returned to the ED a few days later complaining of chest pain and anxiety. The EKG and CXR were negative. The patient was again discharged but went to a different ED. The patient was diagnosed with a dissection of an aortic aneurysm and taken to surgery. The postoperative complications included an anoxic brain injury. The patient, who now uses a wheelchair, can no longer work.

Selection and Management of Therapy

Our analysis identified the selection and management of therapy as another significant factor in claims with indemnity payments. This factor includes the selection and management of the right procedure, surgery, therapy delivery method, or medication for the patient.

Practitioners strive to ensure that patients are appropriate candidates for surgery or a procedure through careful assessment and management. Allegations involving the selection and management of therapy can indicate a clinical judgment issue: The practitioner has the correct diagnosis for the patient; however, in hindsight, their decisions were not the best decisions for the patient.

In this study, two factors were more prominent in claims with indemnity related to surgical and medical procedures. One factor was procedure selection. We noted several claims in which surgeons proceeded with complicated elective surgeries without medical clearance or conducted multiple procedures in one day rather than completing surgeries over several sessions. For additional information on this topic, read our article "Why Medical Clearance Is Really a Preoperative Evaluation."

Issues related to medication also presented selection and management issues that our study identified in indemnity claims. Some case examples included the use of oxytocin during labor with fetuses experiencing fetal distress. Others involved the inappropriate use of propofol during sedation for diagnostic procedures. For additional resources on medication management and safety, read "What Your Practice Can Do About Medication Safety" and "Dispensing Sample Medications: Risk Management Strategies."

Communication Among Providers

Communication among providers was a significant factor contributing to the studied claims. This finding agreed with a recent study (coauthored by researchers from The Doctors Company and researchers from the American College of Cardiology) in *Risk Management and Healthcare Policy* that highlighted the significance of communication among practitioners—particularly in claims filed in relation to high-severity injuries. That study also noted the importance of communication regarding the patient's condition.

In our analysis, issues around the failure to read the medical record appeared in a higher percentage of indemnity-paid claims than no-payment claims. Such issues often included a failure to examine reports, such as radiological reports (or only reading the impression section of the report), a failure to review updated lab results, or requesting/reading old records. Frequently, systems factors were present, such as insufficient alerts to draw the practitioner's attention to a new finding.

Another result showed that poor handoffs were more frequently associated with indemnity claims than with no-payment claims. Miscommunication can lead to poor outcomes. For more information and risk mitigation strategies, read our article "Miscommunication and Hurried Handoffs Threaten Patient Safety."

Case Example

A patient was referred to a urologist by an urgent care facility for complaints of recurrent urinary tract infections. The urologist's plan of care included a CT of the abdomen and pelvis, as well as a cystourethroscopy. Although the CT was read by the radiologist as showing no abnormality with the urinary tract and kidneys, the patient had a thickening of the sigmoid colon with enlarged lymph nodes suspicious for malignancy. The radiologist suggested a follow-up colonoscopy. The urologist signed off on the review of the electronic report but did not recall reading the report. About seven months later, the patient returned to the urgent care facility, complaining of abdominal pain and rectal bleeding. The urgent care practitioner reviewed the EHR, read the CT report, and ordered a colonoscopy. The colonoscopy, which was completed within one week, showed stage IV colon cancer with metastasis to the liver and lung. The patient underwent a colon resection and palliative chemotherapy but died within a year of diagnosis. After this unfortunate outcome, the urologist's office changed its process and now sends copies of reports to all referring practitioners whenever tests are performed.

The urologist's oversight was significant; also, the radiologist should have called the urologist with this abnormal finding suspicious of malignancy, as well as urgent care and/or the primary care physician and the patient. Just sending the report to another practitioner, without bringing a serious abnormal finding to their attention, isn't enough.

Emerging Communication Issues

We identified the following areas as potential emerging communication issues for practitioners.

Texting/Emailing Patients: Although we did not perform a statistical evaluation, we found that a higher percentage of settled claims in our study had contributing factors related to texting and emailing than those with no payment. Texting and emailing are quick and efficient ways to communicate, but practitioners must be aware that texts and emails can and will become part of the medical record. Do not use a personal or unsecure messaging system to send texts or emails. Keep the language appropriate and patient focused and be aware of HIPAA and state privacy laws, which have strict rules regarding

emails and texts. Develop a policy that addresses when it is appropriate to send a text or email. For more information, read our article "Smartphones, Texts, and HIPAA: Strategies to Protect Patient Privacy."

Patient Portals: Patient portals are a newer factor added to the claim analysis taxonomy. We found a higher percentage of portal issues in the indemnity claims than the no-payment claims.

Patient portals are being implemented in more medical practices, and more patients are accessing them. This reality requires some education and communication between practitioners and patients (and the patients' families) on what to expect with patient portals.

Given the increase in the number of messages sent to practitioners through portals, it is important to discuss portal communication expectations with patients. The American Medical Association's article "What Doctors Wish Patients Knew About Using a Patient Portal" has some helpful tips for practices using a patient portal.

For instance, practitioners can let patients know, both verbally during visits and in writing in the patient portal, that messages may not receive a response for up to 72 hours and that other members of the team may respond instead of the practitioner. Patients should also understand that the portal is not meant for communications regarding urgent conditions. Develop an understanding with your patients that if the message requires more than 100 words, then an appointment is likely needed. Discuss with your patient that they will see test results, but they should allow the healthcare team time to review and respond to the results. A conversation about portals and their use during routine visits is helpful for patient engagement.

Insufficient or Lack of Documentation

Various documentation insufficiencies were observed more frequently in the studied indemnity claims than in the no-payment claims. Our analysis found that most issues involving insufficient documentation or lack of documentation centered on clinical findings and lack of description. In some examples, patients had experienced complications, but the practitioners' operative or procedural notes were sparse. Other records lacked documentation of the patient's complaints during a visit, such as missing any note regarding a headache for a patient who later suffered a stroke.

The following resources provide additional documentation strategies:

- The Faintest Ink: Documentation to Defend Quality Patient Care
- Remember the Basics of Good Documentation
- Informed Refusal

Conclusion

This comparison of contributing factors in medical malpractice allegations with indemnity-paid claims and no-payment claims identifies areas of risk. Among the studied claims, four contributing factors stood out as appearing more frequently in indemnity-paid claims than in no-payment claims: patient assessment, selection and management of therapy, communication among providers, and insufficient / lack of documentation.

Our goal in identifying these contributing factors is to help prevent future poor outcomes. We offer these insights to help practitioners direct their attention and their patient safety resources to best enhance safety and mitigate risks.

Acknowledgments

1. CRICO-Candello Clinical Taxonomy Manual, V4.0, 2021. Copyrighted by and used with permission of Candello a division of The Risk Management Foundation of the Harvard Medical Institutions Incorporated, all rights reserved. As a member of the Candello community, The Doctors Company participates in its national medical malpractice data collaborative.