



Understanding Diagnosis-Related Medical Malpractice Claims With Indemnities Over \$1 Million

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Among physician members of The Doctors Company, the frequency of medical malpractice claims has decreased over a roughly 20-year period, from a high of 17 per 100 physicians in 2000 to fewer than seven per 100 in 2019. During that same time period, however, the percentage of medical malpractice claims with [high-indemnity payments \(greater than \\$500,000\) has increased dramatically](#). Over the past several years, [41 states have reported verdicts greater than \\$10 million](#). Identifying and concentrating on factors related to high-indemnity claims can help improve patient outcomes and reduce financial losses.

Improving Diagnosis in Healthcare

A landmark report by the National Academy of Medicine, *Improving Diagnosis in Health Care*, stressed the necessity to [focus on diagnostic error](#). The report found that diagnostic errors constituted the most costly type of paid malpractice claims, and patients who experienced diagnostic errors were twice as likely to die than those patients who had filed other types of medical malpractice claims. Thus, understanding more about how to protect against and prevent diagnostic errors is paramount to patient safety.

Study Design

At The Doctors Company, a recent addition to our taxonomy for the coding and analysis of malpractice claims has been the ability to identify primary drivers. Primary drivers are those contributing factors pinpointed as the main catalysts for the events that caused the major injury or negligence.

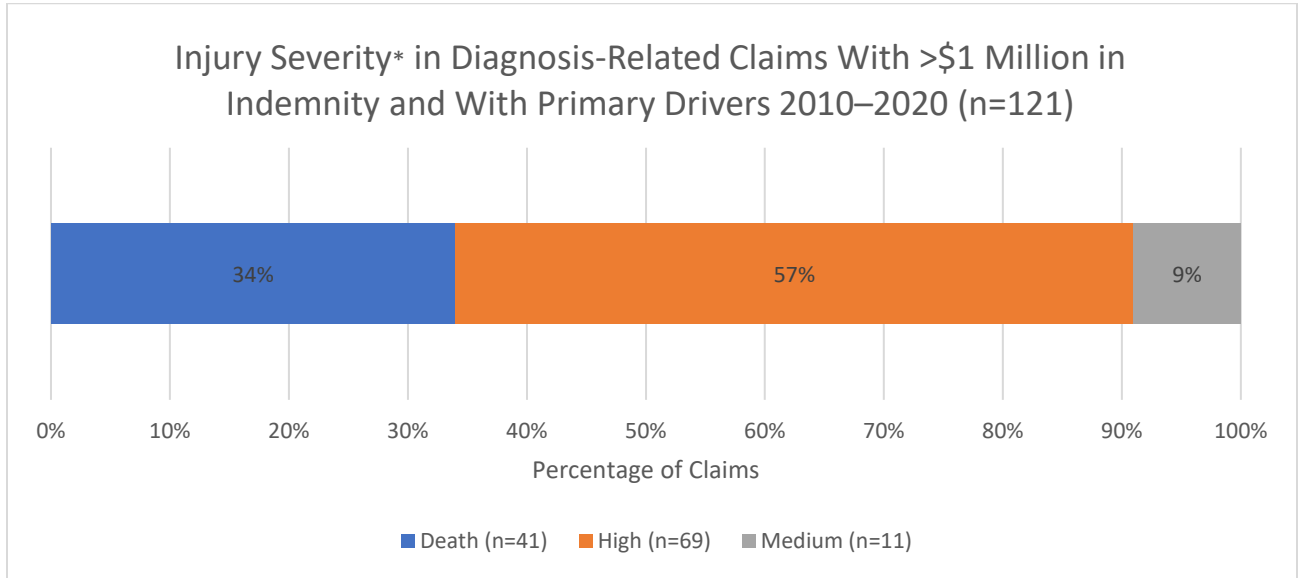
This exploratory, descriptive analysis included those closed diagnosis-related claims against members of The Doctors Company from the loss years of 2010 to 2022 that concluded with an indemnity payment of \$1 million or more and that had a primary driver coded. Each claim included in this study, 121 total, had at least one primary driver coded (claims may contain more than one primary driver).

Results

- The average number of primary drivers per claim was 2.7.
- The mean age of the patient was 41.9 years old (total range was 0 to 81 years old).
- Patients included 59 females (48.8 percent) and 62 males (51.2 percent).
- The mean indemnity payment was \$1.61 million.
- The median indemnity payment was \$1.40 million.

- Injury severity, based on the National Association of Insurance Commissioners (NAIC) Severity of Injury Scale, was high overall, with 91 percent of patients experiencing either death (34 percent; n=41) or a high-severity injury (57 percent; n=69). (See Figure 1.)

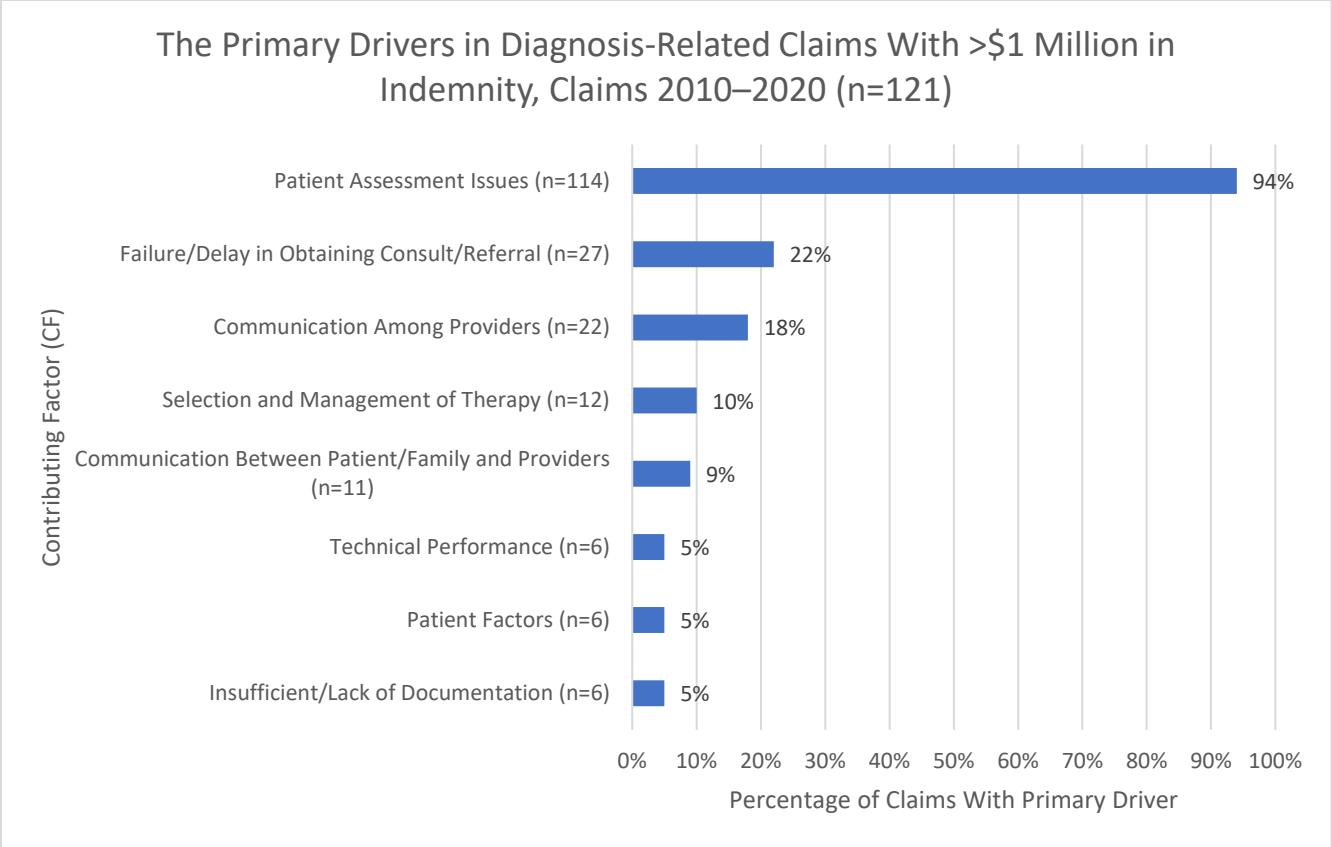
Figure 1. Diagnosis-related case types and injury severity



*Injury severity based on National Association of Insurance Commissioners (NAIC) Severity of Injury Scale.

The primary driver of patient assessment was found in 94 percent of all high-indemnity claims (n=114). The failure to obtain a consultation or referral and communication among providers were also common primary drivers. (See Figure 2.)

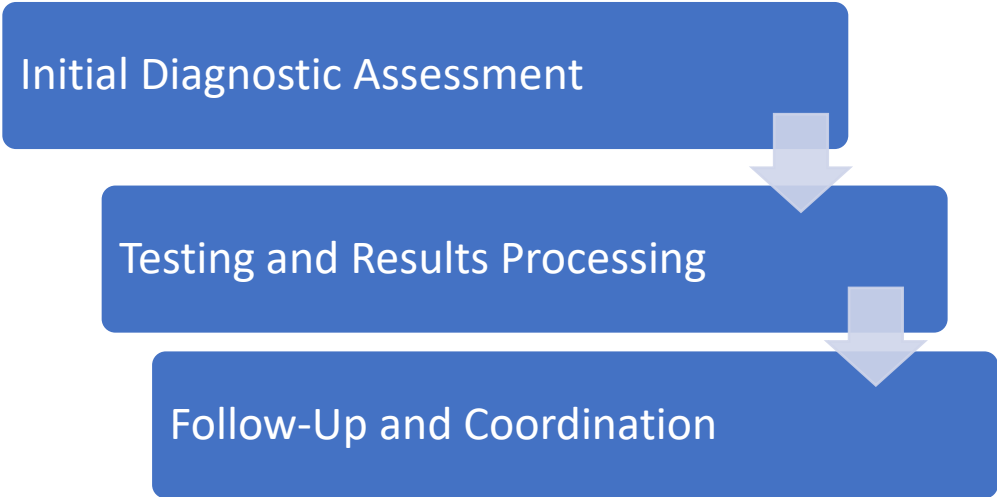
Figure 2. Diagnosis-related case types and contributing factor subcategories



Diagnosis-Related Process of Care Framework

Many diagnosis-related errors have been identified as having preventable contributing factors; therefore, understanding more about these claims is essential. The use of the Diagnosis-Related Process of Care framework from Candello, a data collaborative of medical professional liability insurers and health systems, has been helpful in studying diagnosis failure. Our analysis used this framework with high-indemnity diagnosis-related claims that included primary drivers.

Figure 3. Candello Diagnosis-Related Process of Care



The first phase in the Diagnosis-Related Process of Care is the initial diagnostic assessment. This phase begins when the patient enters the healthcare setting for care and continues through the initial assessment. This phase incorporates five steps encompassing contributing factors associated with clinical judgment, as well as documentation related to the patient's history, diagnosis, and orders.

Over 80 percent of the claims (n=97) had primary drivers in the initial diagnostic assessment phase. The top primary drivers in this phase were the failure to or a delay in ordering a diagnostic test (39 percent of total claims; n=47); failure to appreciate signs, symptoms, and test results (33 percent of total claims; n=40); failure to establish a differential diagnosis (33 percent of total claims; n=40); lack of/inadequate history and physical (17 percent of total claims; n=16); and a narrow diagnostic focus that assumes the presence of a chronic illness and/or a previous diagnosis (10 percent of total claims; n=12).

The second phase in the Diagnosis-Related Process of Care is testing and results processing. This phase includes scheduling, performing, interpreting, and managing various diagnostic tests. The contributing factors in this phase entail the communication occurring among healthcare providers, the cognitive skills needed by providers for interpretation of these tests, and possible breakdowns in the testing systems.

Forty-five percent of the claims (n=55) were determined to have primary drivers in the testing and results processing phase. The top primary driver in this phase was the misinterpretation of diagnostic studies, such as x-rays, slides, etc. (37 percent of total claims; n=45).

The last phase in the Diagnosis-Related Process of Care is Follow-Up and Coordination. It encompasses contributing factors related to communication. The communication can be between healthcare providers or between the healthcare provider, the patient, or the family. System failures can influence or impede communication. This phase includes factors focused on patient adherence.

Fifty percent of the claims (n=60) had primary drivers in the Follow-Up and Coordination phase. The top primary drivers in this phase were the failure to or a delay in obtaining a consult (27 percent of claims; n=33) and communication among providers about the patient's condition (12 percent of claims; n=14).

The missed, delayed, or wrong diagnoses found in this study were:

- Malignancies (n=28; 23 percent). Breast cancer was the most common malignancy (n=9/28; 32 percent).
- Infection (n=14; 12 percent).
- Embolism/thrombosis (n=10; 8 percent).

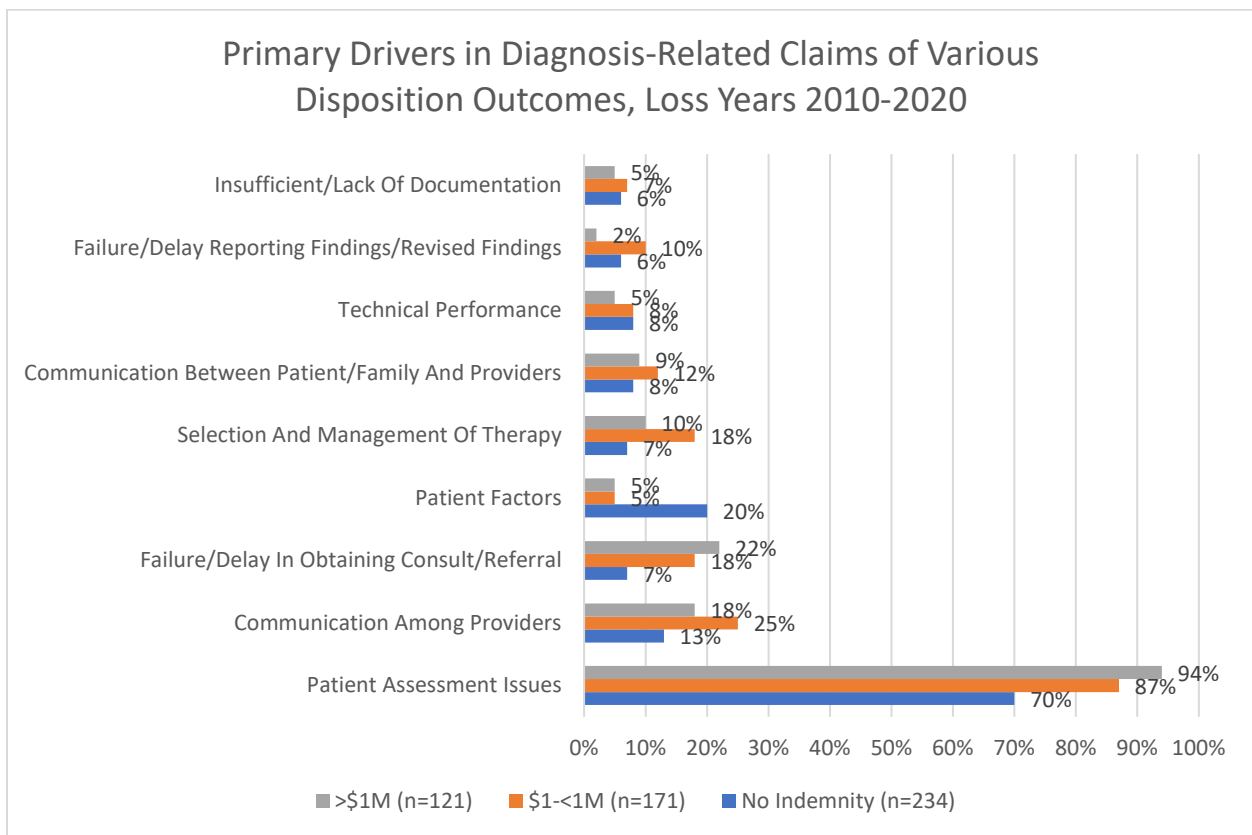
Comparing Different Types of Diagnosis-Related Claims

To comprehend primary drivers in claims with different disposition outcomes, we completed a comparison among similar diagnosis-related case types with different verdicts. We set claims with indemnities above \$1 million alongside claims with indemnities less than \$1 million, as well as claims with no indemnity paid. For each category, primary drivers were coded. That said, it is important to highlight that the use of primary drivers in the coding process is new, and it may require several years to fully appreciate trends.

Differences emerged in how these primary drivers appeared within the compared claims. (Refer to Figure 4). In terms of patient assessment contributing factors, the high-indemnity (>\$1M) claims had the highest percentage of primary drivers, and both the indemnity groups had over 17 percent frequency in the category of patient assessment primary drivers.

The primary drivers that appeared more frequently in indemnity claims were the selection and management of therapy, patient assessment, communication among providers, and the failure to or delay in obtaining a consult. The primary drivers that appeared more frequently in no-indemnity claims were patient factors and technical performance, such as a known complication from a procedure. Other primary drivers (insufficient documentation, communication between providers and patient/family) appeared with similar frequency among the three types of disposition outcomes.

Figure 4. Differences among primary drivers within diagnosis-related high-indemnity claims, other indemnity claims, and no indemnity claims



Discussion and Risk Mitigation Strategies

The top three final diagnoses in our analysis paralleled [the “Big Three” diagnostic errors](#) in a 2020 national study. The “Big Three” diagnoses encompass missed vascular events, infections, and cancers, which in the 2020 study accounted for around 75 percent of all diagnostic errors found in malpractice claims. Our analysis observed breast cancer (n=9/28; 32 percent) as the most common malignancy, whereas the national results recorded lung cancer (22.5 percent) as most common, with breast cancer (8.9 percent) being second-most common.

The Diagnosis-Related Process of Care framework can be applied to determine where to focus risk mitigation efforts. We have completed previous studies using this framework, including one on [diagnostic error in general surgery](#). Likewise, Candello has published a [ten-year assessment](#) with insights into malpractice cases from a variety of specialties. That said, this analysis may be the first study in any venue to exclusively focus on high-indemnity claims (>\$1M) with identified primary drivers. In contrast with some earlier studies that were not focused on primary drivers, our findings illustrate how primary drivers were prevalent during the Initial Diagnostic Assessment and Testing and Results Processing phases. Our findings were similar to the other studies for the last phase, Follow-Up and Coordination.

Countering Cognitive Bias

These results may reflect the influence of cognitive bias. Although cognitive bias has been identified within all areas of the diagnostic process, the first two phases are heavily laden with gathering, receiving, and processing information, making these phases especially vulnerable to any flaws in reasoning. To improve patient safety, it is essential for practicing clinicians to acknowledge the potential for cognitive bias within daily practice. Here are some [strategies for countering cognitive bias](#) from The Joint Commission:

- Familiarize yourself with some of the [more common cognitive biases](#), such as the availability bias—i.e., the understandable tendency to lean toward a diagnosis that comes readily to mind, perhaps because the clinician has seen it frequently and recently. There is also anchoring, whereby the clinician “anchors” onto one key piece of the patient’s presentation up front, and does not shift their thinking as new information becomes available. The anchoring bias may be expressed using the old phrase, “leaping to conclusions.”
- Slow down for just a moment and reflect. The Joint Commission describes this as a “diagnostic time-out.”
- Pause to ask, “What else could this be?” Looking for confirmation can become a habit—but disconfirmation is the key to the scientific method.
- Discuss clinical cases with peers to reveal potential bias. If you have opportunities to attend such discussions, take them when you can. If your organization is lacking in such opportunities, consider making a request.

Further strategies to improve patient safety and mitigate provider liability include:

- Access tools for self-assessment related to diagnostic issues, such as [Calibrate Dx](#) from the Agency for Healthcare Research and Quality (AHRQ). This AHRQ tool was developed by researchers at Baylor University and the MedStar Institute for Quality and Safety as a means for healthcare providers to hone their diagnostic decision making. This four-step process includes reflection and a review of sample claims in your practice.
- Create systems to close the loops and ensure that patients complete their tests, consultations, and appointments. Forty-five percent of the high-indemnity claims in this analysis had primary drivers in the testing and processing phase. To this end, a [systems engineering framework](#) has been proposed to improve patient safety via closed-loop systems for daily practice, moving away from low-reliability processes that can lead to diagnostic failure. For primary care offices, AHRQ provides a guide to improving the [reliability of a practice’s testing process](#).

- Encourage patients and their families to be more involved in their healthcare. Support and encourage active listening and information sharing within the patient-provider encounter, especially during the assessment phase, to develop a collaborative partnership between patients, their families, and the care team. The AHRQ has resources available for providers, including the [Guide to Patient and Family Engagement in Hospital Quality and Safety](#) and the [Guide to Improving Patient Safety in Primary Care Settings by Engaging Patients and Families](#).

Conclusion

This analysis focused on high-indemnity diagnosis-related case types. Among claims that result in any indemnity, diagnosis-related cases occur frequently, and as previously discussed, many diagnosis-related errors can be prevented. This analysis concentrated on primary drivers, or those factors considered as the main catalysts to the events that caused the major injury or negligence. This analysis may be the first to focus on the primary drivers of malpractice claims. The application of the Diagnosis-Related Process of Care framework provided another method to use primary drivers. Understanding where to place patient safety initiatives and work with healthcare providers can improve patient outcomes and reduce injury. As the coding of primary drivers increases, the next step for patient safety will be to predict potential harm and intervene in diagnosis-related case types.