



One of the major responsibilities of a major medical malpractice liability company is to help policyholders reduce risk. The risk management departments of many major medical professional liability insurers have become effective in realizing this goal by aggregating and analyzing their claims data to identify risk exposures that are particular to both practices and specialties. Corrective action takes the form of risk-specific suggestions that are presented as enduring materials, lectures, electronic programs, simulation training, and published studies. Physicians and other health care providers who follow these suggestions can mitigate their risk of involvement in litigation, increase patient safety, and realize premium savings.

Using medical malpractice closed claims data

to reduce surgical risk and improve patient safety

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The risk management department of ProMutual Group, the largest medical malpractice insurance company in the Northeast, is very active in the risk prevention arena. Members of the department routinely meet with physicians and other health care providers to assess clinical practice, determine strengths and needs, and help develop a strong risk management program. In addition, they routinely analyze closed claims data to determine specific and general trends and patterns. Results are shared with the company's insured physicians. An example is a recently published ProMutual Group study, *Failure to Diagnose: Putting the Pieces Together*.*

Closed claims data

To determine the major risk areas in the seven medical specialties that account for more than half of the company's closed claims and indemnity payments each year, in early 2006 the company's risk management department performed an analysis of the 1,162 medical malpractice cases closed by the company in those specialties in the three-year period ending December 31, 2004. Cases involved 1,487 defendant physicians from the following specialties: family medicine, general surgery, internal medicine, obstetrics and gynecology, orthopaedic surgery, pediatrics, and radiology.

Most cases, or 67.6 percent, closed without payment, indicating either lack of pursuit of the case by the plaintiff or a jury finding in favor of the defendant physician. The remaining one-third, or 377 cases, closed with an aggregate indemnity of \$153 million. Some were jury verdicts. The majority were settlements made in the absence of a jury trial. In addition, \$41.4 million was paid to defend all cases.

The number of cases closed by specialty ranged from a low of 58 in pediatrics to a high of 309 in internal medicine. The lowest aggregate indem-

*Greenwald L. *Failure to Diagnose: Putting the Pieces Together*. Boston, MA: ProMutual Group; 2006.

Table 1: Cases and indemnity payment by specialty

	Total	Closed with payment	Indemnity payment
Family medicine	140	44	\$15,963,000
General surgery	180	55	19,628,000
Internal medicine	309	105	40,554,000
Obstetrics-gynecology	191	74	40,187,000
Orthopaedic surgery	165	45	12,988,000
Pediatrics	58	17	8,026,000
Radiology	119	37	15,963,000

nity payment was \$8 million in pediatrics; the highest, \$40.6 million in internal medicine (see Table 1, this page). These figures are not indications of greater or lesser proclivity to negligence or litigation but more likely a reflection of the fact that the company insures more internists than physicians in any other specialty.

To assess the risk areas within each specialty, risk managers, working with consulting physicians, relied not on numbers but on the substance of the cases. They extracted data from and reviewed almost all cases that closed with payment and selected cases that closed without payment. One allegation emerged as a major trend across all specialties: failure to diagnose.

Failure to diagnose

Failure to diagnose was the principal allegation in 452, or 38.9 percent, of the cases in the study. A breakdown by specialty is shown in Table 2, on page 29. A total of 168 of these cases closed with an aggregate indemnity payment of almost \$71 million. More than half that sum, or \$37.8 million, was paid to close the cases that alleged failure to diagnose cancer.

The cancers that were responsible for the greatest numbers of cases and the highest indemnity payments are shown in Table 3 on page 29.

Most of the breast cancer cases were found in radiology (37 cases), obstetrics-gynecology (12 cases), internal medicine (nine cases), and general surgery (seven cases). The majority of

Table 2: Failure to diagnose cases as a percentage of total closed claims by specialty

Family medicine	54.3%
General surgery	20.0
Internal medicine	51.5
Obstetrics-gynecology	15.0
Orthopaedic surgery	15.8
Pediatrics	63.8
Radiology	74.8

Table 3 : Failure to diagnose cancer cases

	Total	Closed with payment	Indemnity payment
Breast	69	26	\$13,225,000
Colorectal	42	2	11,470,000
Lung	22	8	4,331,000
Prostate	12	8	2,700,000

the colorectal cancer cases were clustered in internal medicine (28 cases) and family medicine (nine cases). One-third of the 36 cases of failure to diagnose within general surgery involved cancer. Four of these cases, including three breast cancer cases and one involving lung cancer, closed with an aggregate indemnity payment of \$1.1 million.

The issues in some of the cancer cases were specialty-specific. For example, many of the breast cancer cases alleging negligence on the part of radiologists involved the misreading of mammograms, several cases involved physicians' failure to follow up on the negative mammogram of a symptomatic patient, and at least two of the surgical cases involved failure to perform an excisional biopsy. In most instances, however, the problems were more general and related to cases in all specialties. These problems were as follows:

- Failure to have or to adhere to a cancer screening protocol
- Failure to include cancer in the differential diagnosis
- Inadequate follow-up

In an attempt to stem the number of cases alleging delay in the diagnosis of or failure to diagnose cancer, the company's risk management department offers specific suggestions not only to primary care physicians but also to specialty physicians who become the primary care physician for one or more patients (see box, page 30).

Cancer cases in surgery

In one of the surgical cases included in the Failure to Diagnose study, the surgeon was faulted by defense experts for not having performed annual cancer screening. In a medical malpractice case, the surgeon or other specialist who acts as a primary care physician for a patient will be held to the standard of care required of the primary care physician, most assuredly with respect to cancer screening. This means the surgeon who assumes the role of a primary care physician for one or more patients must develop a cancer screening protocol and use it for all of his or her primary care patients. Rather than assume that another physician will perform cancer screening, the surgeon should ask the patient who will order or perform a mammogram, Pap smear, fecal occult blood test, colonoscopy, prostate-specific antigen, or other screening test, and document the conversation.

Another issue specific to surgeons with respect to diagnosing cancer is selecting the correct diagnostic procedure. In several cases in the study, defendant surgeons were faulted by defense experts for performing or settling for the results of

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Risk management suggestions for failure to diagnose cancer

- Develop and adhere to a cancer screening protocol
- Know the cancer history of the patient's family
- Consider cancer first, not last
- Do not discount cancer because of age or absence of risk factors
- Avoid assumptions, working symptoms through to diagnosis
- Be aggressive in follow-up
- Develop a tracking system for tests and missed appointments
- Coordinate care with other physicians
- Document thoroughly

inadequate biopsies when the patient's clinical presentation required more. Physician experts reviewing the medical records for ProMutual Group wrote in their report:

The presence of suspicious cells seen on a needle aspiration biopsy needed further evaluation. The two core biopsies alone do not represent an adequate evaluation of the concerned area. Given the discrepancies between the [fine needle aspiration] and the core biopsies, it was necessary for the patient to have additional tissue sampling done.

An enlarging mass in a 36-year-old patient must be considered breast cancer until proven otherwise.... The negative biopsy should have led to another procedure.

The standard of care required that a directed biopsy be performed when there is a finding of a nodule on ultrasound.

Negligent surgery cases

Cases alleging failure to diagnose were neither as numerous nor as costly in general surgery as they were in the primary care specialties and radiology. Only 36 of the 180 surgical cases alleged failure to diagnose. Almost double that number, or 70 cases, alleged negligent surgery. The largest single event involved laparoscopic cholecystectomy, an issue in the company's surgical cases for the past 10 years. The overriding injury was a clipped, transected, punctured, or otherwise injured bile duct. Defense experts who reviewed the cases acknowledged that such

injuries are an intrinsic risk of the procedure. However, they held defendant surgeons accountable for some or all of the following:

- Inadequate informed consent
- Improper technique
- Failure to convert to an open procedure when the anatomy was not clear
 - Delay in diagnosing a ductal injury
 - Improper repair of an injured duct
- Inadequate documentation

Conclusion

Failure to diagnose and negligent surgery are the two most significant allegations made against general surgeons in ProMutual Group's medical malpractice lawsuits. The company's ability to analyze the cases in its large data bank, determine exactly what went wrong, identify trends, and then develop risk management programs has helped other physicians learn and profit from their colleagues' experience. Medical malpractice insurance companies are uniquely positioned and have strong incentives to provide this important function. Ω

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