MIEC

Write On!

MIEC'S DOCUMENTATION NEWSLETTER

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MIEC's "Large Loss" Claims analysis: trends and lessons learned

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To reach MIEC 6

Spanish American philosopher George Santayana (1863 – 1952) is credited with the familiar saying, "Those who cannot remember the past are condemned to repeat it." In this issue of Write On!, we examine our own past – our largest claims between 1999 and 2008 – with an eye toward identifying trends and pitfalls that can be avoided in the future.

We conducted an in-depth analysis of claims defined as "large loss" claims – those with losses of over $250,000. Losses include both the damages paid to plaintiffs ("indemnity") and costs associated with defending the case. From 1999 to 2008, MIEC defended approximately 340 such cases. Over two-thirds of the closed claims reviewed had indemnity payments of $250,000 or greater (Figure 1), and an average of approximately $173,000 in defense costs per claim.

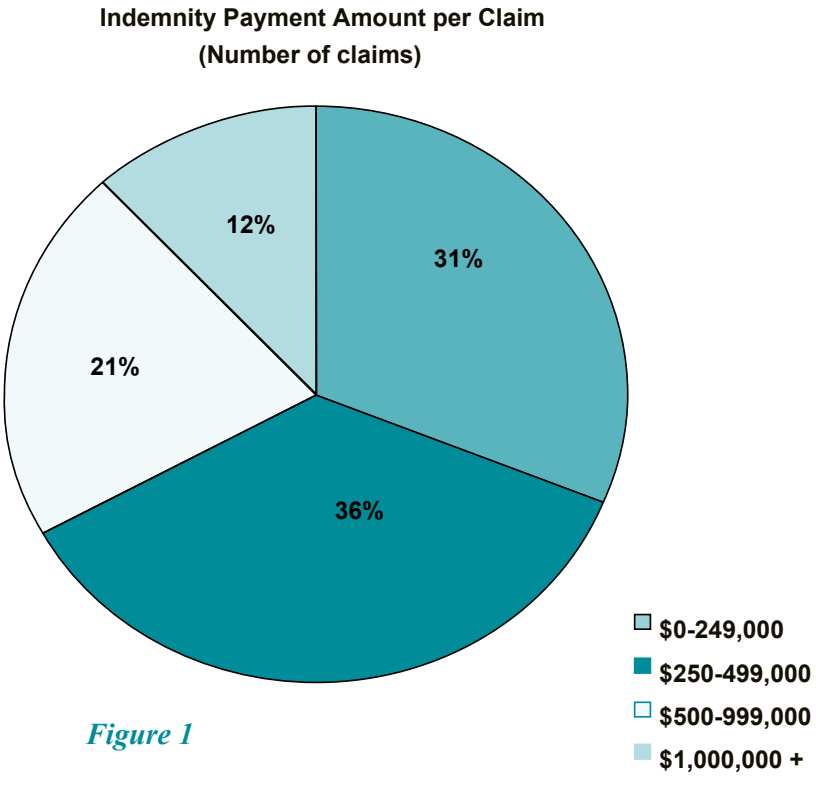

Figure 1

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The claims were grouped together in broad categories of allegations: Failure/Delay in Diagnosis; Improper Performance of Surgery (technical error in surgery or other surgery-related event); Improper Treatment; Medication Mismanagement; Birth Injury; and Negligent Post-op Care.

Of these allegations, Failure/Delay in Diagnosis is by far the prevalent category represented in MIEC's largest claims (Figure 2). This may be attributed to the fact that primary care physicians comprise a large percentage of MIEC's policyholder base. According to the Physician Insurers Association of America (PIAA) Data Sharing Project, Failure/Delay in Diagnosis is the leading allegation against primary care physicians. Analysis of MIEC's Failure/Delay in Diagnosis claims reveals a broad range of missed clinical diagnoses, the top three being cancer, aortic dissection/aneurysm, and myocardial infarction followed by stroke, pulmonary embolus, and meningitis.

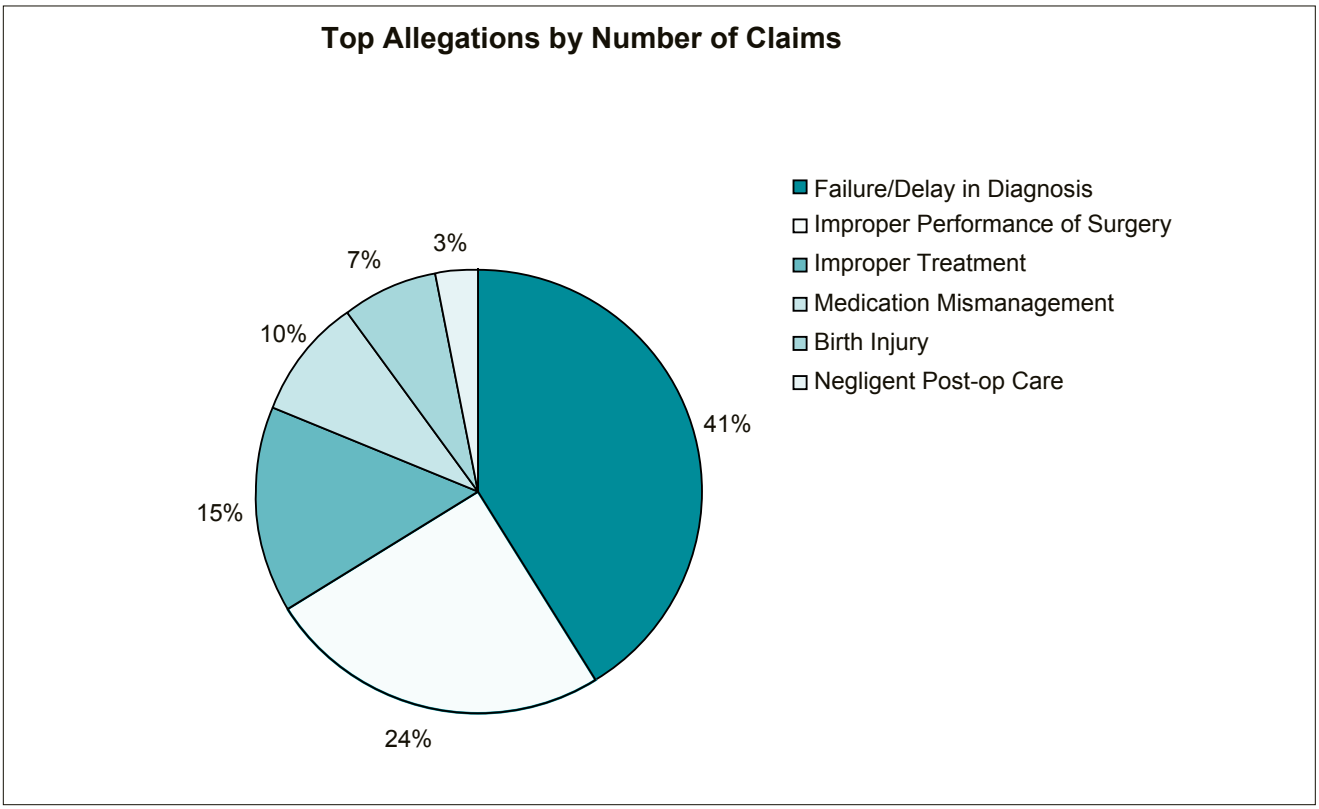

Figure 2

Analysis also reveals the most frequent associated issues which, in conjunction with the errors in medicine, had a deleterious effect on the overall outcome of the claim. In over 30% of the cases analyzed, there were systems and/or documentation issues that contributed to the patient's injury and compromised the physician's defense. Cases with these associated, non-medical issues are all the more tragic because, in many cases, the injury to the patient could have been avoided with the implementation of policies and procedures aimed at mitigating those risks.

Medical record documentation problems were the most commonly identified associated issue. Good documentation is not only important for good patient care; in the event of a lawsuit, documentation that fails to adequately demonstrate a physician's decision-making and/or patient management can greatly hinder the defense of a case (Figure 3).

Top Five Associated Issues
1. Documentation problems 2. Poor communication with co-treater(s) 3. Failure to follow up on test results 4. Lack of/Inadequate informed consent/refusal 5. Failure to follow up on specialist referral

Figure 3

The cases discussed below are based on a sampling of MIEC's most costly claims that include errors in medicine and/or associated systems issues. Names and some details of the cases have been changed to protect the identities of both plaintiffs and defendant physicians. **Of note:** All of the cases were settled before the scheduled trial date for significant sums.

Case 1: Allegation – Negligent clearance of a 6 month old patient for surgery resulting in post - operative death

The patient, a 6-month-old boy, was born with a heart abnormality and pulmonary hypertension. He was monitored after his birth by a pediatric cardiologist, Dr. Ray. Dr. Ray recommended close evaluation once a month and, as long as the patient was asymptomatic, no surgical intervention was warranted. Dr. Ray last examined the patient when he was 5 months old and felt that he was stable from a cardiac standpoint at that time.

Around this time, the patient began vomiting frequently and was seen by his pediatrician, who felt he might be suffering from an allergy. The vomiting did not cease after two weeks and the patient was admitted to the hospital for dehydration. The pediatrician consulted with a pediatric gastroenterologist, who felt the patient had GERD and might need a fundoplication procedure; he held off on formally recommending surgery pending further tests. While waiting for a confirmed diagnosis and plan, the pediatrician called Dr. Ray and stated that the patient might need surgery and asked if he foresaw any problems from a cardiac standpoint. Dr. Ray stated that based on his last exam the month before, he thought the patient could tolerate surgery. Dr. Ray later stated that he was under the impression that the surgery had not yet been scheduled and his response was theoretical, not a formal clearance for surgery. He did not document the conversation.

A series of faulty and/or inadequate communications followed. After her conversation with Dr. Ray, the pediatrician went to the hospital and told the gastroenterologist that Dr. Ray had cleared the patient for surgery and documented the information in the patient's chart. The next day, the gastroenterologist consulted with a surgeon who agreed to perform the procedure. The surgery was scheduled for two days later. Dr. Ray was never notified that the surgery was scheduled.

The pediatrician saw the patient on the morning of surgery and noted that he had a low temperature the night before and some mottling but was otherwise stable. The pediatrician did not discuss these results with Dr. Ray or the surgeon; the surgeon stated that he was aware of the patient's low temperature the night before, and the mottling, but that he deferred to the pediatrician as to whether it was a matter of concern. The patient's oxygen saturation was low immediately prior to the surgery but the anesthesiologist felt it was due to the fact that the baby had been crying. The anesthesiologist and the surgeon relied on the pediatrician's note that the patient had been cleared for surgery and did not independently verify the clearance. Dr. Ray was not made aware of any of the information regarding the low temperature, mottling or low oxygen saturations.

The procedure proceeded as planned and was relatively uneventful. In the ICU, the patient's heart and lung function began to deteriorate. A Code was called and the patient was resuscitated, but he suffered hypoxic brain injury.

A week later, he was taken off life support and expired.

Associated issue: Communication between co-treaters. The cardiologist expert reviewer stated that when a physician is asked for a theoretical opinion about a patient's appropriateness for surgery, it is imperative that the physician makes it clear that it is a theoretical opinion only. The physician should

emphasize that in order to officially clear the patient for surgery, he/she must examine the patient and render a formal opinion. In this case, the pediatrician was under the mistaken impression that Dr. Ray cleared the patient for surgery during their telephone conversation; apparently there was enough ambiguity in their conversation for her to draw that conclusion. The only documentation of the conversation was the pediatrician's note stating that Dr. Ray cleared the patient for surgery.

In addition, the experts faulted all of the physicians for not providing each other with the necessary information to make an informed decision about whether the patient was an appropriate surgical candidate. The surgeon and the anesthesiologist did not have a discussion concerning the patient's clinical findings before the surgery or provide Dr. Ray with the new information. Dr. Ray stated that had he known about the patient's clinical status before the surgery, he would have recommended the surgery be postponed.

Case 2: Allegation – Eight month delay in diagnosis of ovarian cancer

The patient, a 42-year-old female, was referred to gastroenterologist, Dr. Jones, by her primary care provider for complaints of recurring lower GI pain. Dr. Jones ordered CT scans of the abdomen and pelvis to rule out diverticulitis. The CT report noted no evidence of significant diverticulitis. The report also noted retained secretions in the uterus and a left adnexal cystic process; a pelvic ultrasound was recommended. The name of the patient's primary care provider did not appear on the report.

Upon receipt of the CT report, Dr. Jones determined that the findings were not significant with respect to her GI complaints. He did not discuss the incidental findings of the retained fluid in the uterus or the cyst with the patient, erroneously assuming that the patient's primary care provider would receive a copy of the report and follow up with the patient. Dr. Jones saw the patient on several more occasions and eventually referred her to a different GI specialist. Neither the patient nor her primary care provider was aware of the findings on the ultrasound and the radiologist's recommendations.

Eight months passed before the patient underwent a repeat pelvic ultrasound which revealed a large cystic mass. The patient was diagnosed with ovarian cancer and was given a poor prognosis.

Associated issue: System failure - failure to follow up on test results. Experts felt that Dr. Jones, as the ordering physician, had the obligation to make certain the information in the report was provided to the patient and the patient's PCP. The fact that the CT findings were not GI-related did not alleviate the ordering physician's responsibility to ensure that appropriate follow-up occurred.

Case 3: Allegation – Delay in diagnosis of MI resulting in reduced life expectancy

The patient presented to Dr. Wilson, his primary care physician, and reported chest pain and that he had pulled a muscle while moving furniture several days earlier. Dr. Wilson did not take any vitals or perform an EKG. Dr. Wilson felt that the patient's presentation was consistent with muscle strain and not an MI. Her documentation of the visit was minimal.

Dr. Wilson later stated that if she had suspected MI she would have referred the patient right away to the ED. She stated that she told the patient to return or go to the ED if symptoms continued; she did not document the instructions.

The patient presented to the ED nine days later with worsening pain. He was diagnosed with recent MI, cardiogenic shock and severe mitral regurgitation. He had a rocky course with several procedures performed and was eventually discharged one month later. Experts felt that the patient's life expectancy was significantly reduced due to these events.

Associated issue: Poor documentation. The experts also faulted Dr. Wilson's documentation as it did not demonstrate her thought process and the decision-making, which led to the diagnosis of muscle strain. She failed to document the basis for her decision not to perform an EKG and she did not document that she had considered an MI but her analysis allowed her to rule it out. The lack of documentation to support her medical decision-making severely compromised the defense of the case.

Case 4: Allegation – One year delay in diagnosis of renal cancer

The patient is a 36-year-old male who was referred to a urologist, Dr. Smith, after being seen in the Emergency Department with blood in his urine and right flank pain. The urologist suspected kidney stones and ordered an IVP. Dr. Smith interpreted the study as negative and called the patient to advise him of the results. The patient's complaints continued and he returned to see Dr. Smith, who ordered a cystoscopy and retrograde pyelogram; the results came back as normal. Dr. Smith determined that the patient must have passed the stone and advised the patient to return on an as-needed basis. The patient never returned to Dr. Smith's office.

Associated issue: System failure – report filed before review. A few days later, the final IVP report from the radiologist was filed in the patient's chart before Dr. Smith saw it, a clear violation of office policy. The report stated "abnormal right kidney…with changes consistent with extrinsic mass. CT recommended." Because Dr. Smith was not shown the report, neither he nor the patient was aware of the recommendation.

One year later, the patient called Dr. Smith and told him that he had been diagnosed with stage IV renal cancer and his condition was grave.

Case 5: Allegation – Eighteen month delay in diagnosis of Hodgkin's lymphoma

The patient presented to his PCP, Dr. Brown, because he had noticed a swelling on the left side of his neck. Dr. Brown believed it was an inflammatory mass and prescribed an anti-inflammatory medication. The patient was seen a week later and the mass was unchanged. Dr. Brown ordered a sonogram.

Associated issue: System failure – failure to follow up on specialist referral. The patient returned one month later. Dr. Brown discussed the sonogram report which noted a complex left neck mass and told the patient he needed to see a surgeon for a biopsy. Dr. Brown wrote "question of lymphoma, rule out malignancy." The patient was given a referral to a surgeon and a follow-up appointment was scheduled for three weeks later. The patient did not return for the visit and no follow-up was done with the patient.

The patient next presented to Dr. Brown five months later because of skin itching. Dr. Brown noted that the patient had not completed the lab work that he had ordered on a prior visit; he did not note anything about the neck mass or the surgeon referral.

The patient returned several times for routine visits unrelated to the neck mass. Again, no mention was made in the notes about the neck mass.

A year and a half after the patient first presented to Dr. Brown with neck swelling, the patient returned and reported the mass had grown. The mass was now 4-5 cm. The patient was subsequently diagnosed with Hodgkin's lymphoma and was given a poor prognosis.

Loss Prevention Recommendations:

MIEC offers the following recommendations to help our policyholders keep their patients safe and avoid costly claims:

Clinical Risk

1) Identify areas of significant clinical risk within your practice and implement policies and/or procedures to help mitigate those risks.

2) Stay current with accepted standards of care for your specialty.

Office Systems

3) Establish a process to ensure that lab, imaging and other diagnostic test reports are reviewed before they are filed in the chart, including:
    a. Initial as evidence of review;
    b. Review results in progress notes; and
    c. Document that the patient was notified of the results.

4) Ensure that all abnormal findings, including incidental findings, are acted upon. The ordering physician is ultimately responsible for follow up on test results.The ordering physician must ensure that either the patient or the patient's primary care provider is notified. Do not assume that another physician is aware and following up on abnormal findings.

5) Develop a follow-up system to track ordered diagnostic tests to ensure that patients obtain recommended studies and the results are received in the office.

6) Ensure continuity of care by developing a follow up system to track patients who have been referred to specialists. If the patient failed to see the specialist, remind the patient of the reasons why the referral was made, if appropriate. Document your efforts to contact the patient and any conversations you have with the patient.

7) Communicate significant medical information to co-treaters and document the communication in the medical record.

8) Be cautious when asked to comment on a case without a formal consultation request. If you choose to offer an opinion, make it clear that your comments are general in nature and include a disclaimer that your opinion is based on incomplete information and should not be considered a formal consultation. Consider documenting the conversation; note the date, the name of the inquiring physician, and the nature of the informal opinion.

9) Specialists – Establish a process to ensure that a patient is an appropriate surgical candidate. Avoid sole reliance upon the patient's primary care provider or the anesthesiologist for the assurance.

Medical Record Documentation

10) Document sufficient details of exam findings in the progress notes. Document your thought processes, particularly when there is justification for deviation from accepted or customary standards of care. Indicate "why" and "how" differential diagnoses are considered and/or ruled out, including positive and pertinent negative exam findings.

11) Resolve medical problems from previous visits in the chart. Medical problems reported on prior visits that were not resolved should be "red-flagged" to remind the physician of the need for follow-up.

12) Document a patient's non-compliance in the chart, including the patient's failure to follow advice, see a specialist, obtain diagnostic studies, or take a medication. It is also important to document that you have conveyed to the patient the risks and potential consequences of refusing to follow your recommendations (e.g., "informed refusal" discussion).

For more Loss Prevention resources and recommendations to help increase patient safety and reduce liability risks, please visit the MIEC website, www.miec.com.

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