

the Reporter

INTERNAL MEDICINE CLOSED CLAIM STUDY FAILURE TO DIAGNOSE AND REFER

By Tanya Babitch
Risk Management Representative

The following closed claim study is based on an actual malpractice claim from TMLT. This case illustrates how action or inaction on the part of physicians led to allegations of professional liability, and how risk management techniques may have either prevented the outcome or increased the physician's defensibility. The ultimate goal in presenting this case is to help physicians practice safe medicine. An attempt has been made to make the material less easy to identify. If you recognize your own claim, please be assured it is presented solely to emphasize the issues of the case.

Presentation

A 67-year-old man came to his internist on August 1st with complaints of dizziness, lack of appetite, an 11-pound weight loss over three months, decreased bowel movements, and back pain that radiated into his right arm. The patient's past history was unremarkable with the exception of hiatal hernia. The patient's social history was negative for any drug abuse, positive for alcohol consumption three to four times per week, and four cigarettes daily. There was a family history of father with heart disease and mother with past MI.

Physician action

Vital signs were normal with blood pressure 110/70 mm Hg, pulse 78, and normal temperature. Heart examination revealed normal sinus rhythm and no evidence of murmurs. Peripheral pulses were normal. The physician diagnosed weight loss, abdominal pain, anorexia, dizziness and anemia, and ordered extensive lab testing, abdominal ultrasound, and GI consult to exclude underlying disease. Lab results indicated slightly elevated lipids and PSA of 4.9. General chemistries, urinalysis, and CBC were normal. Abdominal ultrasound on August 6th revealed a suspected polyp in the gallbladder. PA and lateral chest were negative for acute disease.

A little more than one month later, the patient came to the office for pain in the left lower quadrant of the abdomen. He had not yet seen a GI consultant as recommended at the last visit. Once again, he was referred to a gastroenterologist, who saw him the next day. The abdominal exam noted mid-epigastric tenderness with no masses. Differential diagnoses included pancreatic disease, kidney disease, and colon disease. The recent negative ultrasound was noted, but abdominal CT scan was ordered and performed on September 13th. The CT scan revealed wedge-shaped defects in the midpole of the right kidney in addition to multiple wedge-shaped defects seen in the spleen, highly suggestive of "infarcts, likely embolic." The pancreas was unremarkable, the liver was slightly enlarged, and atherosclerosis involving the abdominal aorta was noted. Pelvic CT was suggestive of an ileus of the cecum and slightly enlarged prostate. The gastroenterologist and the internist reviewed and discussed the results of the CT scan in a phone conversation that was not documented in the patient's record.

On September 18th, the patient was seen in the internist's office, where the CT scan results were reviewed. Upon examination, the right calf was tender, and a lower extremity venous Doppler study was ordered. Diagnoses from the visit included back pain, aneurysm and multiple emboli, rule out phlebitis. The internist prescribed Celebrex and Plavix, and recommended that the patient have a colonoscopy. The Doppler study performed the same day revealed no evidence of deep venous thrombosis. The patient had a colonoscopy performed on September 28th, which revealed ischemic colitis.

On October 18th, the patient underwent additional lab testing, which revealed a mildly elevated sedimentation rate. The patient saw his internist on October 23rd, and mentioned that he had experienced a detached retina that had been treated at a local hospital a week and a half before. The patient's weight had dropped another seven pounds since the initial

continued on page 2

visit. He was not experiencing any back pain, thus was not taking anti-inflammatory medications. The patient had mild edema in one leg, and recommendations were to decrease salt and fluid intake and continue to take aspirin and Plavix. Chart notes for this visit included a referral to a cardiologist.

On October 30th, the patient was seen in a local emergency department for complaints of pain in his legs. Examination revealed a lack of pulses in the lower extremities, and the patient was diagnosed with intermittent claudication and referred to a cardiovascular surgeon. The cardiovascular surgeon evaluated him on November 7th, noted possible right popliteal clot from previous Doppler, diagnosed lymphedema secondary to renal problems, and referred him back to a primary care physician. On November 8th he saw a primary care physician at a local medical clinic who noted a temperature of 100.3 degrees and an evident heart murmur. The patient was hospitalized immediately with a probable diagnosis of subacute bacterial endocarditis.

Echocardiogram revealed mitral insufficiency, aortic insufficiency, and vegetations on both the mitral and aortic valves. Open-heart surgery with placement of St. Jude's prosthetic heart valves in the mitral and aortic positions was performed on November 9th. Although the surgery was performed successfully, the patient developed right ventricular failure requiring insertion of an intraaortic balloon pump.

The patient had a difficult post-operative course and over the next few days his condition deteriorated until he died on November 13th. The internist's last chart note on November 19th documents a phone call to the patient's wife expressing sympathy for her loss.

Allegations

The plaintiffs alleged that the internist failed to properly evaluate the patient and failed to properly treat him for the developing emboli and endocarditis, which lead to his death. They also alleged that the referral note to a cardiologist on the October 18th visit notes was added after the internist learned of the patient's death.

Legal implications

Consultant reviewers all agreed that endocarditis can be very difficult to diagnose, but felt that the September 13th CT scan results required an urgent cardiology consult. The consultants conceded that the patient's visit on August 1st would not necessarily have triggered concerns of endocarditis. The patient failed to exhibit symptoms highly suggestive of endocarditis, such as fever, chills, or heart murmur, and lab results were not indicative of endocarditis. Upon receipt of the September 13th CT scan results, however, they felt that investigation into the cause of the emboli should have begun. One reviewer questioned whether the GI physician might have also had some responsibility to respond to the abnormalities on the CT scan. The GI consultant testified that he called the internist to discuss the CT results, and that they reviewed the potential causes of emboli. Because the patient still had no fever and no heart murmur, they together decided that the next step was colonoscopy, to be followed by cardiology consult if negative. Conversations between the GI consultant and the internist were not documented in the medical record.

Although the September 18th visit note suggests that the internist was aware of the embolic concerns, no cardiology referral was documented until the October 23rd visit. The internist reported that he had given the patient the names of two cardiologists, but the patient told him that he had his

own cardiologist. Although a referral was documented on October 23rd, the consultants questioned why it was not done at the September 18th visit. The consultants felt that the five-week delay in referral could have seriously affected the patient's outcome.

Several consultants also questioned why the internist excluded the leg veins as a source of the emboli, and not the heart. They opined that the emboli causing liver and splenic abnormality would have to come from arterial circulation supplying those organs, and would not have been likely to originate in the venous system. They did concede that in light of the patient's leg swelling, ordering the Doppler was reasonable, but they felt that the normal Doppler study did not exclude the need for the cardiac evaluation.

The plaintiffs also alleged that not only did the internist not refer the patient to a cardiologist immediately after the CT scan, but that he never referred the patient at all. They alleged that the referral documented in the October 23rd chart note was made after the physician learned of the patient's death. The defense had the chart reviewed by a forensic document examiner, who opined that there was evidence that the chart notes referring the patient to a cardiologist were added after the patient's death.

Disposition

Expert opinion from a forensic document examiner that chart notes were added after the patient's death damaged the defense of the case. Due to the lack of expert support for the treatment decisions and possible alteration of records, the case was settled on behalf of the internal medicine physician.

Risk management considerations

Unfortunately, defense of this case was compromised by the suspicion of record alteration. Record alteration leads to questions about a physician's credibility, and can render a case indefensible. Physicians are often tempted to add information to the medical record after a bad outcome is learned, or after a claim or lawsuit is filed. Medical record alteration is almost always discovered, and plaintiff's attorneys will use the information to discredit the physician. Although the addition to the notes may genuinely reflect what happened at the visit, it is never helpful to add notes after the event or claim.

Although all reviewers agreed that upon receipt of the CT scan results there should have been immediate referral to a cardiologist, documented treatment rationale might have helped to explain the internist's actions. There was no documentation of discussion between the internist and the GI consultant, although both stated that they had discussed the CT scan results the day results were received. Because the patient had no symptoms of endocarditis, they both felt that colonoscopy was appropriate, and if negative, then request a cardiology consult. The GI consultant also emphasized that his telephone discussion with the internist took place while the patient was in the office. According to the GI consultant, the patient was aware of the importance of a cardiology evaluation. Documentation of their discussions may have shed light on why the internist chose to proceed with a colonoscopy before referral to a cardiologist, or at least helped to defend the decision. Telephone calls between physicians are often overlooked when documenting in the medical record. They are an integral part of treatment, and help subsequent reviewers to understand the physician's treatment decisions. Timely and detailed documentation of all telephone calls, whether between patient and physician, or physician to physician, is always recommended.

risk management 101

PIAA releases national internal medicine closed claim data

The following is a summary of internal medicine malpractice claim data submitted by more than 40 member companies of the Physician Insurers Association of America (PIAA). The PIAA is a trade association of liability insurance companies that insure approximately 60% of physicians, dentists, hospitals, and other health care professionals. TMLT submits claim data to the PIAA data study, but these data are reported in a codified manner. Names are not reported. This information is designed for use as a risk management tool to inform internists about the nationwide risk trends for their specialty.

The PIAA database contains information on 185,120 claims from 28 specialties, closed between January 1, 1985 and December 31, 2003. For all claims, 30.68% were closed with indemnity payment, and the average indemnity payment was \$183,961. The total indemnity paid out on behalf of all physicians in the database is \$10.4 billion.

Of the 24,791 internal medicine closed claims reported, 26.56% were closed with indemnity payment. The total indemnity paid on behalf of all internists is \$1.23 billion. The cumulative average indemnity for internists is \$186,945. The highest indemnity payment during this period was \$9.78 million.

Of the 28 specialty groups included in the PIAA database, internists rank second in the number of claims reported and second in the amount of indemnity paid.

Table 1 lists the 10 most prevalent medical misadventures reported against internists. Errors in diagnosis was the most prevalent medical misadventure, and was reported as the primary issue in 33.97% of internal medicine claims during this time. For claims involving diagnostic errors, malignant neoplasms of the bronchus and lung was the most prevalent condition incorrectly diagnosed. Other errors in diagnosis are listed in Table 2.

The most common patient condition for which claims against internists were paid was acute myocardial infarction. Other prevalent patient conditions are listed in Table 3.

Table 1: 10 most prevalent medical misadventures (1985-2003)

Misadventure	Closed claims	% claims paid	Average indemnity	Total indemnity
Errors in diagnosis	7,030	33.97%	\$224,395	\$535,855,455
No medical misadventure *	6,117	4.46%	\$170,027	\$46,417,345
Improper performance	2,767	29.45%	\$147,504	\$120,215,919
Failure to supervise/monitor case	2,587	34.56%	\$181,474	\$162,238,154
Medication errors	1,872	36.06%	\$134,448	\$90,752,366
Not performed	747	38.69%	\$219,100	\$63,320,034
Failure to recognize a complication of treatment	686	29.59%	\$144,547	\$29,343,067
Performed when not indicated/contraindicated	665	33.23%	\$144,481	\$31,930,270
Failure/delay in referral or consultation	581	41.48%	\$207,810	\$50,082,324
Delay in performance	402	40.30%	\$210,896	\$34,165,185
Totals	23,454	26.27%	\$188,982	\$1,164,320,119

Table 2: Errors in diagnosis (1985-2003)

Procedure	Closed claims	% claims paid	Average indemnity	Total indemnity
Malignant neoplasms of bronchus, lung	380	38.95%	\$211,050	\$31,235,442
Acute myocardial infarction	339	43.95%	\$224,980	\$33,521,955
Malignant neoplasms of colon, rectal region	266	48.12%	\$288,890	\$36,977,927
Malignant neoplasms of female breast	198	45.96%	\$186,084	\$16,933,609
Chest pain, not further identified	126	42.06%	\$313,205	\$16,599,852
Totals	1,309	43.47%	\$237,731	\$135,268,785

Table 3: Claims by 10 most prevalent patient conditions (1985-2003)

Condition	Closed claims	% claims paid	Average indemnity	Total indemnity
Acute myocardial infarction	1,008	33.73%	\$211,873	\$72,036,917
Malignant neoplasms of bronchus, lung	661	32.38%	\$205,941	\$44,071,312
Diabetes	448	26.79%	\$151,796	\$18,215,579
Chest pain, not further identified	427	29.51%	\$262,458	\$33,069,666
Malignant neoplasms of colon, rectal region	482	40.87%	\$271,579	\$53,501,151
Symptoms involving abdomen, pelvis	406	25.62%	\$202,214	\$21,030,213
Malignant neoplasms of female breast	437	37.53%	\$183,844	\$30,150,436
Pneumonia	353	26.06%	\$135,597	\$12,474,883
Renal failure	334	15.57%	\$170,311	\$8,856,180
Regional enteritis, colitis	319	31.97%	\$222,146	\$22,658,890
Totals	4,875	30.99%	\$209,176	\$316,065,227

* No medical misadventure occurs when there is no allegation of inappropriate medical conduct, but the claim has legal merit because of associated issues, such as problems with medical records, consent issues, communication between physicians, vicarious liability, product liability, etc.

the Reporter



Pre-sorted Standard
U.S. Postage
PAID
Permit No. 90
Austin, Texas

TEXAS MEDICAL LIABILITY TRUST

P.O. Box 160140
Austin, TX 78716-0140
800-580-8658 or 512-425-5800
Fax: 512-425-5998
E-mail: barbara-rose@tmlt.org
Web address: www.tmlt.org

Editor

Jane Holeman

Managing Editor

Barbara Rose

Staff

Tanya Babitch

The Reporter is published by Texas Medical Liability Trust as an information and educational service to TMLT policyholders. All articles and any forms, checklists, guidelines and materials are for general information only, and should not be used or referred to as primary legal sources nor construed as establishing medical standards of care. They are intended as resources to be selectively used and always adapted — with the advice of the organization's attorney — to meet state, local, individual organizations and department needs or requirements. The Reporter is distributed with the understanding that Texas Medical Liability Trust is not engaged in rendering legal services. © 2005 TMLT



earn
CME
online

www.tmlt.org

Earn CME when and where you need it with TMLT's online risk management courses. By completing an online course, you will not only learn how to reduce your chances of being involved in a malpractice claim, but you can earn CME credit, ethics hours and a 3 percent premium discount (maximum \$1,000) per course. These courses are available at www.tmlt.org:

- He's Not My Patient Is He? Commonly Misunderstood Situations That May Give Rise to a Physician's Duty
- Fraud and Abuse Prevention: What Physicians Need to Know
- Hot Topics in Risk Management
- How You Can Stay on the Right Side of the Law: Beginning, Maintaining and Ending Physician/Hospital Relationships
- On the Lookout: Current Risk Issues and How to Cope
- TSBME Investigations

For more information, please visit the TMLT web site at www.tmlt.org or call (800) 580-8658.

