EMERGENCY MEDICINE
CLOSED CLAIMS STUDY

As the nation's largest physician-owned medical malpractice insurer, The Doctors Company has an unparalleled understanding of liability claims against emergency medicine physicians. Our data-driven approach enables us to anticipate emerging trends and deliver innovative patient safety tools to help our members reduce risk. And when a member's reputation and livelihood are attacked, insights gained from these studies help us provide the most aggressive defense in the industry.

To learn more about events that place emergency medicine physicians at risk, we reviewed 332 emergency medicine claims that closed from 2007–2013. The results presented here reveal underlying vulnerabilities in the practice of emergency medicine.

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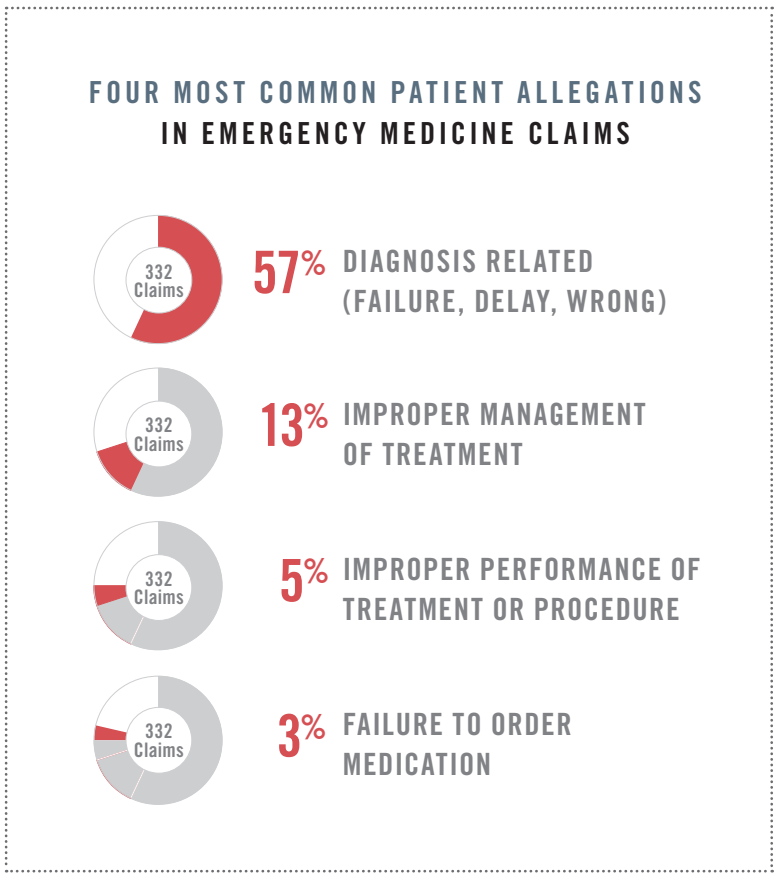
EMERGENCY MEDICINE CLOSED CLAIMS STUDY FINDINGS

MOST COMMON PATIENT ALLEGATIONS

We analyzed allegations made by patients in 332 closed emergency medicine claims. Here are the four most common:

1. Diagnosis related (failure, delay, or wrong diagnosis) (57 percent). Patient assessment issues included failure to establish a differential diagnosis, failure to order diagnostic tests, failure to address abnormal findings, and failure to consider available clinical information. Other issues influencing diagnosis included failing to obtain a consult and discharging patients from the emergency department too soon.



The conditions that were most often misdiagnosed included acute cerebral vascular accident and myocardial infarction (MI), spinal epidural abscess, pulmonary embolism, necrotizing fasciitis, meningitis, torsion of the testis, subarachnoid hemorrhage, septicemia, lung cancer, fractures, and appendicitis.

2. Improper management of treatment (13 percent). Examples included failure to stabilize a patient's neck following an accident with trauma to head and neck, resulting in paraplegia, and failure to explore a wound that was infected or found to contain foreign bodies.

3. Improper performance of a treatment or procedure (5 percent). Examples of these claims included intubation of the respiratory tract, suturing, x-rays or imaging procedures, and insertion of an IV or central line for medications.

4. Failure to order medication (3 percent). Fibrinolytic therapy was not initiated in acute MI or stroke patients within recommended time frames. Antibiotics were not ordered in cases of suspected pneumonia that resulted in death, fever that resulted in sepsis and death, and localized infections that spread.

FACTORS CONTRIBUTING TO PATIENT INJURY

Our expert physician reviewers identified specific factors contributing to patient injury. Here are their findings:

1. Patient assessment issues (52 percent) were identified as the most common factor that contributed to patient injuries. Physician reviewers noted that clinicians sometimes failed to establish a differential diagnosis or to use clinical information that was available to them that should have prompted further investigation. This resulted in a failure to address abnormal findings and order diagnostic tests. A narrow diagnostic focus also influenced clinician decision-making when patients were discharged prematurely. Inadequate patient assessments also influenced the fourth most common allegation: the failure to order medication, including tPA and antibiotics.

2. Patient factors (21 percent) were identified as the second most common finding by physician reviewers. Factors included physical characteristics such as obesity—which, in some cases, delayed the delivery of care due to a lack of adequate equipment for treating or evaluating obese patients (such as open MRIs). These factors also included patient behaviors, such as nonadherence with treatment plans or follow-up appointments.

3. Communication among providers (17 percent) was the third most common factor contributing to patient injury. Issues included failure to communicate, failure to review the medical record, and poor professional rapport.

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TOP SIX FACTORS CONTRIBUTING TO PATIENT INJURY

52% PATIENT ASSESSMENT ISSUES

- Failure to establish a differential diagnosis.
- Failure to order diagnostic tests.
- Premature discharge.
- Failure to address abnormal findings or use available clinical information.

21% PATIENT FACTORS

- Physical characteristics (such as morbid obesity) that caused delay in care.
- Nonadherence with follow-up calls or appointments.
- Nonadherence with treatment plan.

17% COMMUNICATION AMONG PROVIDERS

- Failure to communicate.
- Failure to review the medical record.
- Poor professional relationships/rapport.

14% COMMUNICATION BETWEEN PATIENT/FAMILY AND PROVIDERS

- Poor rapport with patient.
- Inadequate patient education regarding follow-up instructions.
- Language barrier.

13% INSUFFICIENT OR LACK OF DOCUMENTATION

- Failure to record information.
- Failure to review the medical record.

12% WORKFLOW AND WORKLOAD

- Evening, weekend, or holiday staffing inadequate for patient needs.
- Long wait time for patients with chest pain or abnormal vital signs.

Note: Some claims had more than one contributing factor.

FACTORS CONTRIBUTING TO PATIENT INJURY

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4. Communication between patient/family and providers (14 percent) was the fourth most common factor. Communication issues with patients and families were inadequate follow-up instructions or language barriers. Having resources available to effectively communicate with non-English-speaking patients is essential.

5. Insufficient or lack of documentation (13 percent) was the fifth most common factor that contributed to patient injury. This issue is related to communication among providers, the third most common contributing factor. Physician reviewers found inadequate documentation about clinical findings, follow-up efforts, history, and phone advice to the patient. This lack of documentation resulted in important information not being disseminated to other healthcare providers.

6. Workflow and workload (12 percent) was the sixth most frequent issue. When the incident leading to a claim occurred on a weekend, at night, or over a holiday, fewer staff or services were available. Another factor was the level of activity and chaos in the emergency room, highlighting the fact that the emergency department's working environment can affect patient care.

The goal of this study is to alert physicians to the most common risks of emergency medicine practice. It is hoped that these insights will lead to system and process improvements that contribute to patient safety.

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For more information on how we're helping emergency medicine physicians enhance patient safety and avoid claims, call (800) 421-2368, or visit www.thedoctors.com/patientsafety.

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