
HOSPITALIST CLOSED CLAIMS STUDY

An Expert Analysis of Medical Malpractice Allegations

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At The Doctors Company, our mission has remained constant for 40 years: to relentlessly defend, protect, and reward doctors and to advance the practice of good medicine.

Our commitment extends to delivering tools and services to help our members identify potential sources of patient injury, increase quality, and enhance safety in all practice environments.

INTRODUCTION

We rigorously analyze the claims experience of our 78,000 members and translate the findings into industry-leading patient safety initiatives that protect our members and their patients. Analyzing the collective experience of so many physicians provides broader, more reliable information. It also expands knowledge beyond the experiences of any single person—even if that knowledge is gained over a lifetime of practice.

We are pleased to share the results of our Hospitalist Closed Claims Study. We hope that the information presented here will prompt physicians to collaborate with hospital leadership by identifying system weaknesses, thereby reducing the risk of harm to patients.

STUDY DESIGN

We analyzed 464 claims* against hospitalists that closed from 2007–2014. The study, based on the claims experience of more than 2,100 hospitalists insured by The Doctors Company, includes all claims and lawsuits (cases) in which a hospitalist was named as a defendant.

Regardless of the outcome, all cases that closed from 2007–2014 were included in this analysis—an approach that helps us better understand what motivates patients to pursue claims and to gain a broader overview of the system failures and processes that resulted in patient harm.

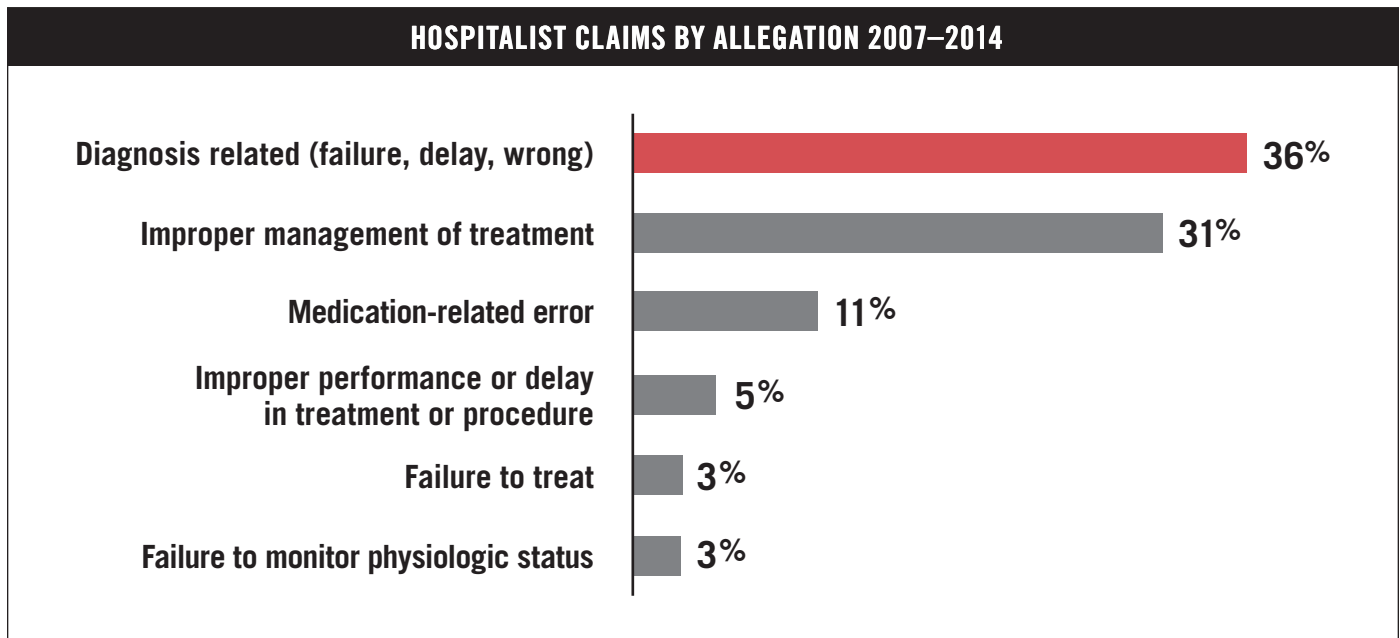
This study provides an overview of the most common types of claims, expert insights into the specific elements that led to patient injury, and risk mitigation strategies.

*A written notice, demand, lawsuit, arbitration proceeding, or screening panel in which a demand is made for money or a bill reduction and which alleges injury, disability, sickness, disease, or death of a patient arising from the physician's rendering or failing to render professional services.

MOST COMMON PATIENT ALLEGATIONS

Seventy-eight percent of all claims against hospitalists included the three most common allegations, as demonstrated in Figure 1 and discussed below.

FIGURE 1



36% Diagnosis related (failure, delay, wrong). This allegation was made when the patient’s condition was incorrectly diagnosed or the diagnosis was delayed to the detriment of the patient’s health. The conditions that most commonly involved incorrect or delayed diagnosis included intestinal disorders, such as obstruction, perforation, and vascular insufficiency (16 percent), cerebral artery occlusion and acute cerebral vascular accident (CVA) (7 percent), acute myocardial infarction (MI) and cardiac arrest (6 percent), sepsis and toxic shock syndrome (5 percent), pulmonary embolism (PE) (5 percent), spinal epidural abscess (4 percent), lung cancer (4 percent), viral and bacterial pneumonia (3 percent), subacute and acute endocarditis (3 percent), and aortic dissection or aneurysm (3 percent).

Physician reviewers noted that 35 percent of these cases resulted from an inadequate initial assessment, consequently decreasing the chance that the hospitalist would arrive at the correct diagnosis.

CASE EXAMPLE: *A 50-year-old female presented to the ER with a three-day history of fever, chills, and pain in her neck and back. Assessment revealed weakness in her right arm and dysuria. The WBC was 21,000 with a left shift. The patient reported a history of IV drug abuse.*

The patient was admitted with a diagnosis of pyelonephritis. She was unable to move her neck, and her grip in both hands was weak. The hospitalist prescribed an antibiotic and pain medication. An MRI was considered but not ordered because C-spine x-rays showed no abnormalities.

On the third day of her hospitalization, the patient complained of extreme upper extremity pain and decreased bilateral extremity movement. Following a shift change, a different hospitalist was called to see the patient and suspected a cervical epidural abscess. He ordered an urgent MRI that confirmed this diagnosis. The patient was immediately taken to surgery but became quadriplegic due to spinal cord compression. The first hospitalist was found liable for failing to order an MRI, which resulted in the delay in diagnosis.

31% Improper management of treatment. This allegation is related to decisions about the patient’s care after diagnosis. Examples include inadequate assessments of foot and decubitus ulcers resulting in sepsis and inadequate management of diabetic patients resulting in ketoacidosis, pyelonephritis, DIC, and loss of lower extremities.

In some of these cases, the patient was not assessed or managed for a period of time that experts considered excessive.

CASE EXAMPLE: *A postpartum patient was readmitted with severe back pain and placed on antibiotics. Low serum potassium was noted, but there was no further workup or testing. Two days later, the patient collapsed and died from cardiac arrest due to low potassium.*

CASE EXAMPLE: *An elderly patient was admitted from the ER with congestive heart failure and pneumonia. After an initial workup, the patient was not seen again by a hospitalist for four days. The patient's condition deteriorated, with increased lower lobe opacity, worsening congestive heart failure, and pulmonary edema—significantly delaying her recovery.*

CASE EXAMPLE: *A 63-year-old male admitted with shortness of breath was diagnosed with pneumonia. The hospitalist's impression was that the patient had acute bronchitis with mild respiratory distress. The hospitalist ordered antibiotics and breathing treatments. Later that day, the patient, in severe respiratory distress with neck swelling, was unable to swallow. He was transferred to the ICU. Otolaryngology and pulmonary consults were ordered (not STAT).*

Fifteen minutes after admission to the ICU, the patient had respiratory arrest. Intubation was difficult due to his swollen neck. He was initially resuscitated but died a short time later. An autopsy revealed a mediastinal abscess and sepsis. The infected soft tissues surrounding the pharynx completely obstructed the upper airway, which led to respiratory arrest and death. Expert reviewers noted that signs of sepsis were present at admission and not recognized.

11% Medication-related error. This allegation was raised in a number of situations: sepsis or loss of limb from lack of antibiotics, respiratory failure from excessive doses of narcotics, venous thrombosis in patients with risk factors for thrombosis that were not addressed, retroperitoneal hematomas and bleeding from various sites (resulting from failure to discontinue anticoagulants prior to surgery), and toxicity resulting from a failure to monitor medications (such as gentamycin and vancomycin). In other cases, multiple system failures led to an injury or death.

CASE EXAMPLE: *A female diabetic on an insulin pump was removed from the pump and received a long-acting and sliding-scale insulin. The electronic health record defaulted to insulin twice daily with meals. The gastroenterologist then*

changed the patient's diet to clear liquids. Blood glucose levels were not checked by the hospitalist. Early the next morning, she was found unresponsive with a blood sugar <5 mg/dL. She was diagnosed with anoxic brain injury and expired.

CASE EXAMPLE: *A male patient with leg trauma and a hand laceration was admitted for emergency surgery. The nurses assessed him as being at risk for deep venous thrombosis (DVT) and PE. Heparin was ordered, but discontinued by the hospitalist the next day. The patient then began complaining of shortness of breath. He was placed on oxygen, but O₂ saturation levels continued to decrease. A chest CT was ordered by a pulmonologist, but the patient suffered a respiratory arrest and expired. An autopsy revealed a PE. Experts were critical of the discontinuance of heparin prophylaxis.*

5% Improper performance or delay in treatment or procedure. Examples of improper performance allegations include placement of central IV lines resulting in damage to other vessels and attempts to intubate patients resulting in esophageal intubation or causing tracheal lacerations/perforations.

Patients also alleged delays in treatments or procedures, including delayed transfusion for gastrointestinal bleeding resulting in hypovolemia and chest tube placement for pneumothorax that was delayed until after the patient suffered respiratory arrest.

3% Failure to treat. An example is when a patient's cardiac symptoms are not addressed prior to transfer or discharge, resulting in MI or cardiac arrest. Other examples include failure to treat urinary tract infections leading to sepsis, failure to treat diabetic ketoacidosis resulting in dehydration and renal failure, and lack of treatment for cardiac tamponade leading to cardiac arrest.

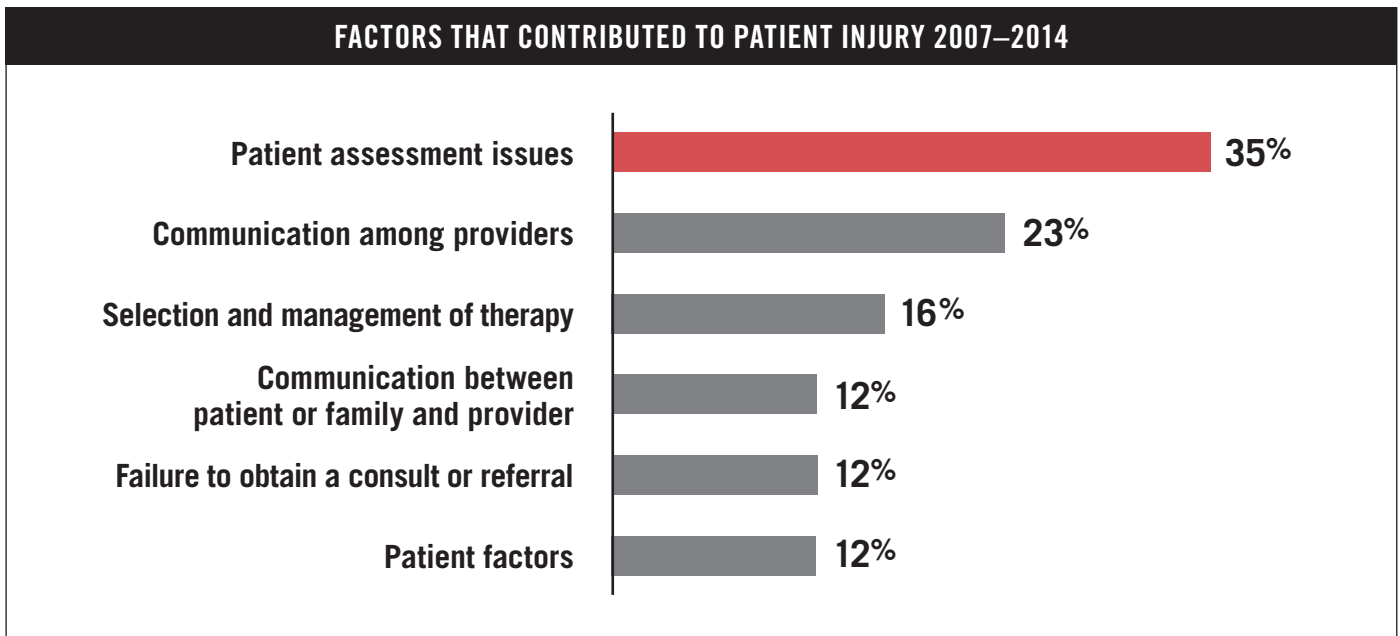
3% Failure to monitor physiologic status. This allegation was made when patients who exhibited cardiac symptoms were not monitored prior to suffering cardiac arrest. Other examples include brain damage resulting from failure to monitor patients who experience hypoglycemia following changes to their insulin orders and respiratory arrest in patients diagnosed with obstructive sleep apnea who were prescribed narcotic pain medications.

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FACTORS CONTRIBUTING TO PATIENT INJURY

Our physician reviewers identified factors that contributed to patient injury (see Figure 2). Here are their findings on the top six factors, along with some clinically specific points and examples.

FIGURE 2



Note: Some claims had more than one contributing factor.

35% Patient assessment issues. Inadequate assessments included the following:

- Failure to establish a differential diagnosis.
- Failure or delay in ordering diagnostic tests.
- Failure to consider available clinical information (lab values, diagnostic tests, symptoms, nursing observations).

CASE EXAMPLE: A 20-year-old female presented to the ER with fever, chills, and pain radiating to her back from her right side. She was admitted, and pulmonary and infectious disease consults were ordered. D-dimer levels were elevated. Her chest x-ray showed a right lower lobe infiltrate. The patient was diagnosed with pneumonia and started on antibiotics by the hospitalist.

Subsequently, she complained of shortness of breath and periods of confusion. Her O₂ saturation levels ranged from 86 to 89 percent. She later collapsed and died. The cause of death was PE. Expert reviewers concluded that the elevated D-dimer levels along with other factors indicated possible venous thrombosis and risk for PE. Failure to order appropriate diagnostic tests and to consider available clinical information were identified as factors contributing to the patient's death.

23% Communication among providers. This factor contributed to patient harm when important information was not communicated to other healthcare practitioners. In some cases, nurses identified patients who were at risk for DVT or PE or who exhibited changes in neurological status, but they failed to notify a physician. Other cases involved physicians who failed to see or find important clinical information documented in the medical record and, therefore, were unaware of changes in the patient's condition or unaware of alterations to medications, diet, and therapies. These types of oversights resulted in lack of coordination of care and, in some situations, caused harm.

CASE EXAMPLE: A 49-year-old male was admitted with chest pain, headache, back pain, and numbness and tingling in his lower extremities. Blood pressures were 154/53 mmHg in the right arm and 117/56 in the left arm. The nurse failed to document these abnormal blood pressure findings in the medical record or to call them to the attention of the admitting hospitalist. The patient was discharged but later found unresponsive at home and died. An autopsy revealed aneurysmal dilatation of the ascending aorta with mediastinal hemorrhage secondary to an aortic dissection. Lack of communication between nursing and the hospitalist was identified as a critical factor in the patient's death.

16% Selection and management of therapy. Physician reviewers identified problems with selection and management of treatment and medications. This included cases of mismanaged pneumonia, asthma, infections, sepsis, cardiac arrhythmias, MI, and traumatic injuries. It also applied to improper selection and management of medications, including failing to order any medication, failing to order the most appropriate medication, or ordering the wrong medication. Claims involving do not resuscitate (DNR) orders are also included in this category.

CASE EXAMPLE: *A 75-year-old female was admitted for pneumonia and showed signs of decreased levels of consciousness. She had uncontrolled type II diabetes, so the hospitalist started her on a sliding scale of insulin and Lantus. Two days later, the patient's pneumonia was improving, and another hospitalist assumed care. He discontinued Lantus and changed insulin to Humalog in the morning and evening. The patient experienced several episodes of hypoglycemia, with her last glucose reading being 15 mg/dL. The patient arrested and died. Reviewers raised concerns about the quality of nursing documentation and the second hospitalist's decision to change the insulin orders without consulting an endocrinologist.*

CASE EXAMPLE: *An elderly patient fell and fractured several ribs. The patient's family requested that she be admitted for observation, with possible placement in a skilled nursing facility (SNF). The hospitalist ordered several pain medications. Later, a nurse practitioner ordered a Duragesic patch, which was monitored for four hours; the hospitalist countersigned the order and then discharged the patient to her home since she did not meet criteria for an SNF admission. The next day, the patient experienced respiratory distress and was found unresponsive. When EMS arrived, the family told them that the patient had a DNR order, so no effort was made to resuscitate her. It was later learned that the patient did not have a DNR order. The family alleged that the patient's respiratory depression was due to failure to monitor the Duragesic patch for 24 hours as recommended by the manufacturer.*

12% Communication between patient or family and provider. The fourth most common factor was found in cases in which physicians had poor rapport with patients or when language barriers and inadequate medication instructions resulted in harm to the patient. This illustrates the challenges of building rapport with patients and their families over a short time period. Problems also arose when patients expected to see their family physician in the hospital, and they were surprised to learn that a hospitalist had taken charge of their hospital care.

Communication challenges also included educating patients about their conditions and treatment plans. In 12 percent of

cases, failure to comply with treatment plans that included medication instructions contributed to the unwanted outcome (see Patient factors below). In cases in which a patient was harmed by a medication, reviewers often identified deficiencies in patient education regarding the risks of the medication. In some situations, patients had not been told to contact their physician if they experienced side effects that required intervention.

12% Failure to obtain a consult or referral. There were two types of cases in this category: Either the hospitalist failed to recognize that the patient's condition warranted the assistance of other specialists, or the hospitalist believed that he or she could manage the patient without assistance.

CASE EXAMPLE: *A female patient presented with cellulitis of the hand and arm and lymphangitis. She was admitted and started on an antibiotic. She was discharged two days after admission but returned to the ER later that day with complaints of hand pain and difficulty extending a finger. A hand surgeon took the patient to surgery and found septic arthritis. The patient's condition improved, but she now has chronic edema and decreased function of the finger. The hospitalist was criticized for not consulting with a hand surgeon when admitted.*

CASE EXAMPLE: *A 43-year-old obese female was admitted with complaints of chest pain radiating to her shoulder, vomiting, and shortness of breath. The hospitalist ordered lab tests and an EKG. The initial cardiac enzymes indicated cardiac ischemia. The second set of enzymes suggested an acute MI, and the second EKG showed a sizeable anterior wall MI, but the hospitalist took no action. Following the third set of enzymes, 12 to 14 hours after admission, the hospitalist ordered a cardiology consult. The patient suffered extensive cardiac damage.*

CASE EXAMPLE: *A 45-year-old female patient presented to the ER with severe headache, difficulty swallowing, slight ptosis of the right eye, and some mild visual disturbance. A CT of the head was within normal limits. Medications for pain and hypertension reduced the severity of her headache. The hospitalist's neurological exam was within normal limits. The patient was discharged and advised to follow up with her primary care provider.*

When seen the following day, her physician noted hemiplegia and dysphasia. She was promptly admitted to the hospital, where an MRI showed right lateral vertebral artery dissection with occlusion. The hospitalist was criticized for failing to consult a neurologist. The fact that he failed to consider stroke was also determined to be below the standard of care.

12% Patient factors. Patient behaviors also affected the outcome of care, highlighting the important role that patients play in their own care and recovery. Examples include patients who were noncompliant with treatment plans, follow-up appointments, and medication plans. A high percentage of claims in this category involved patients who were noncompliant with testing regimens required to monitor anticoagulants and blood glucose levels.

CASE EXAMPLE: A female patient with an undiagnosed spinal epidural abscess refused to allow the hospitalist to examine her. Although the patient was losing her ability to walk, she refused an assessment and demanded to see a different physician. The hospitalist's partner saw the patient

later, ordered an MRI, and diagnosed spinal epidural abscess. She was taken to surgery but, postoperatively, had no sensation below her waist. The expert reviewers determined that the delay caused by her refusal to allow an examination contributed to the paralysis.

CASE EXAMPLE: A 78-year-old male was taken to surgery for femoral-popliteal bypass. The surgery was successful, but the patient refused to follow the postoperative care regimen and developed a decubitus ulcer.

PATIENT INJURY SEVERITY

Claims arising from hospitalist care are more likely to have a higher injury severity than other physician specialties (see Figures 3 and 4). Hospitalists manage high-acuity patients, have limited access to patients' past medical histories, and often receive patients with serious conditions. These situations require thorough assessments, comprehensive testing, quick diagnoses, timely referrals, and rapid initiation of treatment.

FIGURE 3

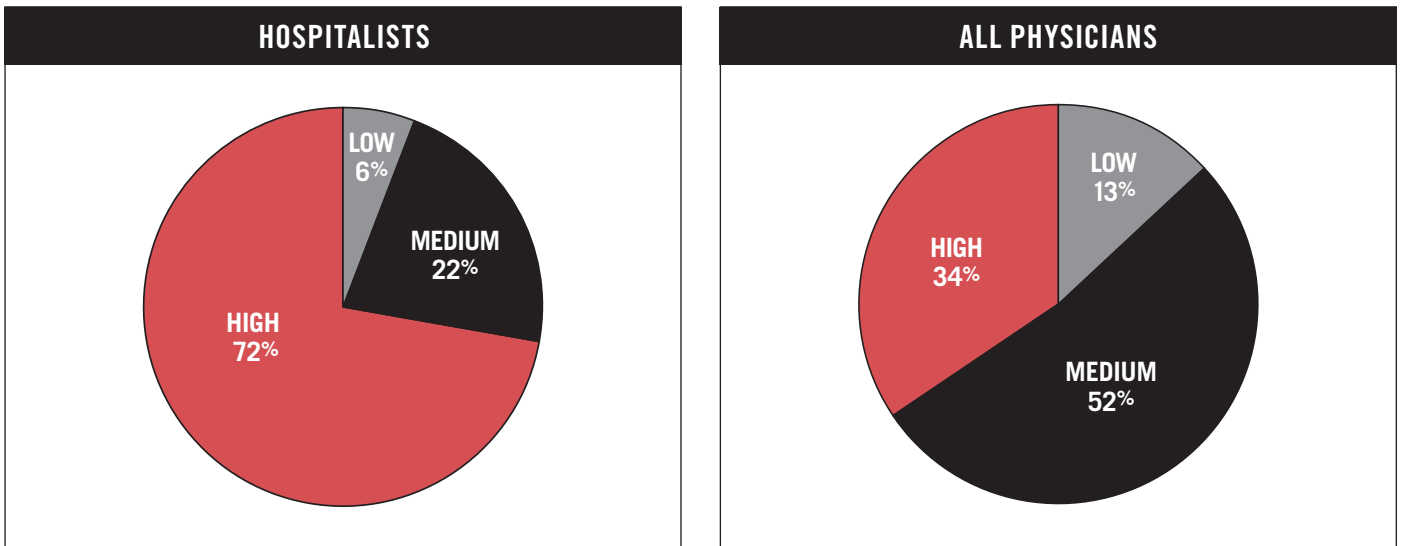


FIGURE 4

NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS (NAIC) INJURY SEVERITY SCALE	
Low Severity	
1. Emotional only	
2. Temporary insignificant	Lacerations, contusions, minor scars, rash, no delay in recovery
Medium Severity	
3. Temporary minor	Infections, fractures, missed fractures, recovery delayed
4. Temporary major	Burns, surgical material left in patient, drug side effect, recovery delayed
5. Permanent minor	Loss of fingers, loss or damage to organs, nondisabling injuries
High Severity	
6. Permanent significant	Deafness, loss of limb, loss of eye, loss of one kidney or lung
7. Permanent major	Paraplegia, blindness, loss of two limbs, brain damage
8. Permanent grave	Quadriplegia, severe brain damage, lifelong care or fatal prognosis
9. Death	

OBSERVATIONS

- Hospitalists are on the frontline of patient care and often coordinate the care provided by other specialists on a team. Communication and coordination are essential parts of the hospitalist’s role.
- Common themes in hospitalist cases include the timeliness of diagnoses and the selection of treatment modalities. Often, these decisions depend on the speed that diagnostic studies are ordered and performed. Another factor is how quickly other specialists become involved in a patient’s assessment and treatment. Several of these steps depend on how quickly the hospitalist reviews reports and seeks the assistance of other specialists.
- Patient complaints are the first source of information to assist the hospitalist in arriving at a correct diagnosis. It is essential to take a detailed medical history and conduct a thorough patient assessment.
- Claims arising from hospitalist care are more likely to have a high-severity injury than other physician specialties (see Figures 3 and 4). This fact underscores the importance of vigilance and effective communications and coordination of care with nurses and other physician specialists.
- Some diagnoses have similar presenting patterns. Symptoms of pneumonia with respiratory distress are similar to symptoms of pulmonary embolus. Pulmonary emboli may cause decreased oxygen saturation with confusion and loss of consciousness that can be similar to stroke and hypoglycemia. Any change in mental or other neurological status warrants immediate assessment and evaluation.
- There are a variety of causes of patient harm. In some cases, physicians failed to follow protocols. In other cases, the patient’s presentation was not typical and did not point to a specific diagnosis. The largest number of cases revealed weaknesses in the systems and processes used by members of the healthcare team. Important clinical information can be difficult to locate in electronic health records or be obscured by lengthy progress notes resulting from copy and paste over-documentation. Communications between nurses and hospitalists can fail. Handoffs between hospitalists may not convey critical information, and efforts to reach physicians in other specialties are sometimes unsuccessful.

RISK MITIGATION STRATEGIES

The following strategies can help hospitalists avoid some issues uncovered in this study:

- Timely diagnosis often depends on how quickly diagnostic studies are performed and interpreted. If a differential diagnosis has the potential for serious sequelae or death, alert other specialists as early as possible of the potential need to involve them in the patient's care.
- Some diagnoses, like spinal epidural abscess, have historically been rare but are now appearing in medical malpractice claims with increased frequency. The symptoms of spinal epidural abscess now have a recognized pattern. When those patterns are identified (neck or back pain, loss of neurological control or sensation, and fever), an MRI should be ordered STAT to confirm the diagnosis. Surgeons should be consulted early in the diagnostic process to expedite treatment and preserve neurological function.
- Be accessible and responsive to nurses. Build rapport. Don't create an environment in which nurses hesitate to reach out because they are afraid of the response.
- Communicate concerns and fears for specific patients when handing off to fellow hospitalists. Provide advanced warning about patients who have confusing presentations or deteriorating conditions.
- Build rapport with the other physician specialists you contact for patient referrals. Stay engaged after the other specialists have joined the case. Clarify your responsibility to coordinate care with the rest of the clinical team, including the specialists.
- Document patient noncompliance or refusal to follow the treatment plan, using exact quotes from the patient and family.
- Take time to introduce yourself to the patient. Explain your role and the primary care physician's role during the patient's hospitalization.
- Review all documentation to ensure that you are aware of all consultation reports, consultant orders, and any subtle changes in the patient's condition that nursing has noted.

LEARN MORE

We provide extensive online resources, including a self-paced interactive guide and content specifically for hospitalists. Find more information on how we're helping hospitalists enhance patient safety and avoid claims at www.thedoctors.com/patientsafety.



The guidelines suggested here are not rules, do not constitute legal advice, and do not ensure a successful outcome. The ultimate decision regarding the appropriateness of any treatment must be made by each healthcare provider in light of all circumstances prevailing in the individual situation and in accordance with the laws of the jurisdiction in which the care is rendered.