

# INTERNAL MEDICINE CLOSED CLAIMS STUDY

## An Expert Analysis of Medical Malpractice Allegations

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At The Doctors Company, our mission is to advance, protect, and reward 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 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 hope that the information presented here will prompt physicians to identify system weaknesses in their office and hospital practices, thereby reducing the risk of harm to patients.

### Study Design

We analyzed 1,180 claims\* against internal medicine physicians that closed from 2007–2014. 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 gain a broader overview of the system failures and processes that result in patient harm.

This study, reinforced by expert insights and relevant case examples, focuses on the following areas:

- Most common patient allegations.
- Most common patient injuries.
- Injury severity.
- Factors contributing to patient injury.
- Most common clinical conditions resulting in patient harm.
- Strategies for mitigating risk.

Our approach to studying internal medicine malpractice claims began by reviewing patients' allegations, giving us insights into the perspectives and motivations for filing claims and lawsuits.

Then, we looked at patients' injuries to understand the full scope of harm. Physician experts for both the plaintiffs/patients and the defendants/physicians reviewed claims and conducted medical record reviews. Our clinical analysts drew from these sources to gain an accurate and unbiased understanding of actual patient injuries.

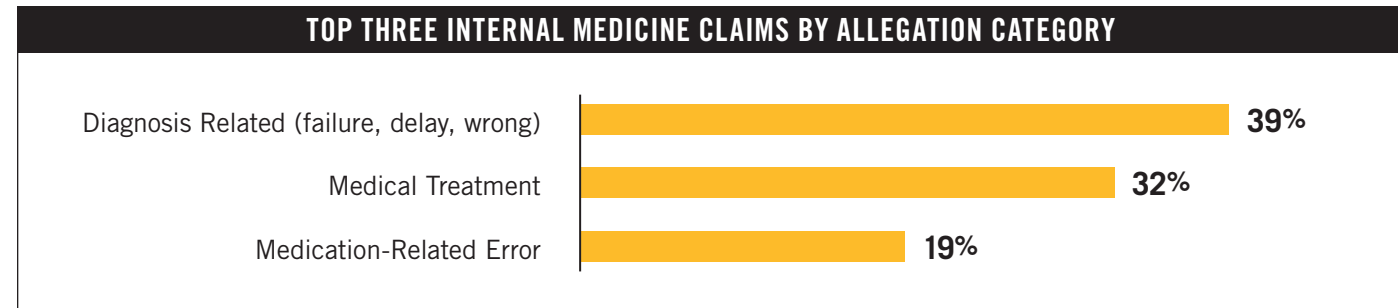
To prevent injuries, it is essential to understand the factors that contribute to patient harm. Contributing factor categories include clinical judgment, technical skill, patient behaviors, communication, clinical systems, clinical environments, and documentation. Contributing factors that led to patients' alleged harm were identified, and physician reviewers evaluated each claim to determine whether the standard of care was met.

\*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 IN INTERNAL MEDICINE CLAIMS**

The top three allegation categories accounted for 90 percent of all allegations, as illustrated in Figure 1 and discussed below.

**FIGURE 1**



**39% 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 final diagnoses that were seen most often with this allegation were myocardial infarction (MI) (6 percent), lung cancer (5 percent), colorectal cancer (5 percent), prostate cancer (3 percent), acute cerebral vascular accident (CVA) (3 percent), female breast cancer (3 percent), pulmonary embolism (PE) (3 percent), spinal epidural abscess (2 percent), and bacterial pneumonia (2 percent). There were 210 other diagnoses seen in fewer than 2 percent of internal medicine claims.

Inadequate patient assessments, which contributed to patient injury in diagnosis-related claims, were found in 56 percent of these claims. Allegations include failure to establish a differential diagnosis, failure or delay in ordering diagnostic tests, failure to consider available clinical information, failure to address abnormal findings, inadequate history and physical, and over-reliance on negative findings for patients with continuing symptoms.

**CASE EXAMPLE:** A 53-year-old male presented to the hospital with complaints of acute chest, epigastric, and back pain with nausea. No pain radiated to the arm or jaw. He gave a history of hypertension, diabetes mellitus, and being a smoker. A brother had died from an MI.

An EKG showed no evidence of ischemia and no significant ST segment changes. Lab test results included lipase of 1,455 U/L (normal range <95 U/L), CK of 78 U/L (total CK normal range for males <235 U/L), and elevated triglycerides of 388 mg/dL (normal range <250 mg/dL). He was admitted to the hospital by an internist and diagnosed with acute pancreatitis, probably due to alcohol abuse. The troponin was mildly elevated at 0.08 ng/mL (normal range <0.03 ng/mL).

The day after admission, the patient complained of pain in the lower chest. His epigastric pain was decreased, and the following day he had no epigastric pain and was eating well. There was chest pain only on palpation, so the internist believed that it was not cardiac in origin. He was discharged with instructions to follow up with the internist in two to three days, but the patient did not schedule an appointment.

Two weeks later, the patient presented to the ER with complaints of substernal chest pain radiating to his neck and jaw. The EKG indicated that he had suffered an MI.

An emergent cardiac catheterization revealed 100 percent occlusion of the right coronary artery and 95 percent occlusion of the left anterior descending artery. An angioplasty was successful.

A claim was filed alleging that the internist failed to diagnose and treat an impending MI. Physician reviewers opined that, even though the pain was atypical for angina and troponin levels were borderline, the patient’s risk factors should have prompted a cardiac workup.

**CASE EXAMPLE:** A 60-year-old female came to her internist’s office complaining of fatigue, abdominal pain, and rectal bleeding. She was referred to a gynecologist, who performed an ultrasound that revealed a likely uterine fibroid. An endometrial biopsy was benign. No other workup was done. She continued to complain of fatigue and of abdominal and rectal pain, but the internist ordered no further diagnostic studies.

Several months later, the internist ordered a CT of the abdomen. It showed a mass displacing the uterus. The patient was diagnosed with stage IV rectal cancer and died soon thereafter.

This physician relied too heavily on the negative ultrasound and biopsy findings in the face of continued patient complaints. The physician also failed to follow up on the patient’s rectal bleeding. She should have been referred earlier for imaging studies.

**CASE EXAMPLE:** A 65-year-old woman went to her internist complaining of nausea, fever, and seeing a dark area in her right eye’s field of vision. A physical exam was done, but it did not include a fundoscopic exam. The internist diagnosed a viral infection.

Four days later, the patient went to an ophthalmologist complaining of no central vision in her right eye. Retinal detachment was diagnosed and reattachment surgery was performed, but it was not successful. The patient now has a permanent loss of vision in that eye. The internist failed to note that a dark area in the visual field is a “red flag” for retinal detachment.

**CASE EXAMPLE:** A 66-year-old male with a history of smoking had a screening chest x-ray that showed a 2 cm density. A follow-up CT with contrast was recommended. The patient saw his internist, who noted the findings and ordered a repeat chest x-ray to be done in the next three months. The repeat chest x-ray was never performed. The patient was subsequently diagnosed with lung cancer and liver metastases and died shortly thereafter.

It was not clear whether the physician communicated to the patient the need for follow-up studies. The office did not make an appointment for the patient to have the follow-up chest x-ray or the CT with contrast. Because the office did not track orders for follow-up studies, there was no mechanism for determining whether the patient had undergone the necessary tests.

**32% Medical treatment.** Complaints about medical treatment, the second most common category of allegations, relate to a patient’s belief that something was wrong with the selection or implementation of a treatment.

Physicians who reviewed these cases identified the following factors:

- Failure or delay in obtaining a consult or referral.
- Failure or delay ordering diagnostic tests.
- Failure to consider available clinical information.
- Inadequate communication among healthcare professionals about a patient’s condition.

**CASE EXAMPLE:** A 42-year-old female nonsmoker presented to her internist for a cough that was nonresponsive to antibiotics and albuterol treatments. A chest x-ray was ordered and showed a 4.2 cm mass. The radiologist stated that a neoplasm could not be ruled out, and a CT scan was recommended. The internist sent a letter to the patient advising her to make an appointment for the CT scan.

The patient did not return to this physician, and the physician made no subsequent attempts to communicate with her. She

saw another internist, but her medical records and chest x-ray report were never sent to the new physician. Eighteen months later, she was diagnosed with stage III lung cancer.

Although patients have responsibility for managing their own healthcare, physicians are expected to make reasonable attempts to communicate when there is a suspected health concern.

In this case, the physician sent a letter advising further studies. It is not clear whether the physician communicated the urgency of performing the studies or if he alerted the patient that failing to investigate the lung mass was potentially life threatening. More than one attempt to contact the patient should have been made. Without tracking mechanisms, opportunities to provide medical treatment are easily lost and forgotten.

**19% Medication-related error.** These allegations were related to medication management, such as failure to appropriately monitor anticoagulants, failure to address medication side effects, and failure to identify drug interactions.

**CASE EXAMPLE:** A 61-year-old male was followed for years by his internist for a depressive disorder. He was treated with lithium. He developed hypertension and was started on a thiazide diuretic containing atenolol and chlorthalidone.

One month later, the patient presented to the ER and was diagnosed with lithium toxicity. A few days later, a panic low serum sodium level was noted and corrected too rapidly. The patient suffered central pontine myelinolysis and died. The internist was criticized for never obtaining a lithium level during the four years he prescribed the medication and for failing to refer the patient to a psychiatrist.

**CASE EXAMPLE:** A 24-year-old female saw an internal medicine physician for back and neck pain resulting from an accident. Examination revealed spasms in the neck and lumbar areas. The internist ordered Xanax, Norco, and Soma in appropriate dosages. The patient was advised about the medications’ addictive properties. The patient returned one month later with ongoing pain and was provided additional pain medications. Two weeks later, she went to the ER with a drug overdose. This incident was not reported to her internist.

A few days later, the patient’s father picked up another prescription for the patient. She returned for two more office visits with the same symptoms and exam findings. The internist again warned her of the addictive properties of opioids and encouraged her to enter a rehab program. A few weeks after the last office visit, the patient died of a drug overdose. It was later discovered that she had also been seeing a pain management physician and had also received pain medications from that provider.

The internal medicine physician failed to monitor the patient’s opioid prescriptions through the state’s drug monitoring program. He should have referred her to a pain medicine specialist and to a rehab program for evaluation and treatment of her addiction.

## MOST COMMON PATIENT INJURIES

This study identified 84 different types of patient injuries, reflecting the extensive variety of conditions and illnesses treated by internal medicine physicians.

Here are findings on the most common types of injuries, including contributing factors, expert insights, and case examples.

### Death

Death was the most common result of injury (44 percent of internal medicine claims). The most common allegation in patient death claims was failure or delay in diagnosis (41 percent).

Physician reviewers identified patient assessment issues as the most common factor in claims in which a patient expired (36 percent). Examples include failure to order diagnostic tests, failure to establish a differential diagnosis, failure to consider available clinical information, and failure to address abnormal findings.

The conditions most commonly related to diagnostic error and patient death include:

- Cardiac dysrhythmias and cardiac arrest (14 percent).
- Medication injuries from opioids, anticoagulants, insulin, antidepressants, and psychotropic agents (12 percent).
- Sepsis and septic shock (8 percent).
- Pneumonia (5 percent).
- Acute MI (5 percent).
- Lung cancer (5 percent).
- Gastric and colorectal cancer (3 percent).

Lack of patient compliance with treatment plans was another factor in patient deaths (22 percent). Examples include failure to make follow-up appointments and deviation from medication plans. Lack of patient compliance was closely associated with ineffective communication between patient/family and provider (16 percent), most frequently involving patient education regarding medication risks. In most of these claims, however, the experts found no breach in the standard of care.

### Infections

Infection was the second most common injury (16 percent). Examples include both nosocomial and community-acquired infections that remained undiagnosed until the patient suffered harm. Nosocomial infections resulted in paid claims 40 percent of the time. Only 24 percent of community-acquired infections resulted in an indemnity payment.

The infections most frequently seen in these claims involved sepsis, pneumonia, and spinal epidural abscess. Claims involving endocarditis, peritonitis from intestinal perforation, and postoperative infections were also seen.

**CASE EXAMPLE:** A 45-year-old male presented to the ER with complaints of vomiting and weight loss. His past medical history revealed poorly controlled diabetes. He had been seeing his internist for a cough and admitted to being noncompliant with Medrol Dosepak.

*The ER physician's impression was hypoglycemia, weight loss due to diabetic gastroparesis, and upper respiratory infection. The WBC was 13,500 with neutrophilia. His temperature was 101 degrees, and Gram stains of the blood culture revealed gram-positive cocci in chains. His condition improved, and he was discharged on antibiotics. Blood culture antibiotic sensitivities had not been completed at the time of discharge.*

*Seven days later, the patient saw his internist. He had less abdominal pain but had no appetite. Three weeks later, he returned with complaints of bilateral lower extremity edema and was started on Lasix.*

*Later the same day, he presented to the ER with complaints of difficulty breathing, a temperature of 101 degrees, and a heart rate of 120. Upon examination, a systolic murmur was noted. An echocardiogram revealed a mitral vegetation with mitral regurgitation and an aortic vegetation. The blood culture was now positive for Streptococcus viridans, and his antibiotics were switched to penicillin and gentamicin.*

*Several weeks later, he underwent mitral and aortic valve replacement. Following surgery, he had congestive heart failure with an ejection fraction of 20 percent. He was placed on a list for heart transplant but expired seven months later.*

*Physician reviewers stated that the internist should have done an aggressive workup to rule out endocarditis when he first received the blood culture Gram stain results. Chains of gram-positive cocci should have suggested Streptococci, and treatment should have been started at that time.*

**CASE EXAMPLE:** A 63-year-old male with a history of smoking and carcinoma of the larynx presented to the ER with complaints of shortness of breath, chest pain, and a temperature of 102.2 degrees. A chest x-ray revealed a right lower lobe (RLL) infiltrate and probable effusion. Cardiac enzymes and CBC were within normal limits. The patient's sodium was low.

*He was diagnosed with RLL pneumonia with possible empyema and admitted to the care of an internist, who ordered IV fluids with normal saline, antibiotics, and Dilaudid. The patient continued to complain of abdominal pain and distention and tightening of the chest with shortness of breath.*

*The patient's empyema was worse despite treatment, and the internist recommended surgical decortication. Lung abscesses were found during surgery. Post-op he received three units of blood. He was transferred to the ICU, where he expired.*

*An autopsy revealed cardiac hypertrophy and severe coronary atherosclerosis. The cause of death was respiratory failure due*

*to progressive pneumonia with lung abscesses and empyema. The internist was criticized for failing to treat the pneumonia and respiratory failure more aggressively.*

### Malignancy

The third most common injury was malignancy (13 percent). Claims resulted from malignant conditions that were not diagnosed or treatment that was not managed appropriately. Contributing factors included the following: (1) physicians' failure to follow up on continuing symptoms or complaints, and (2) patients' failure to follow through with ordered tests or referrals to other specialists.

In some cases, important diagnostic information (lab/imaging test results or pathology reports) was sent to the wrong physician, lost in transit, or filed by staff before being read by the ordering physician. In these cases, the report results were often not discovered until a cancer had progressed to an advanced stage or become untreatable.

**CASE EXAMPLE:** A 66-year-old male saw his internist for an annual physical exam. The screening PSA was slightly elevated at 4.4 ng/mL (normal <4.0 ng/mL). The lab report was initialed and circled by the physician, and the patient received a copy. However, the physician did not talk with the patient about the possible significance of the abnormal result and did not schedule a visit for follow-up testing or refer the patient to a urologist.

*The patient was seen annually over the next two years. He complained of nocturia, but digital exams of the prostate were normal. No subsequent PSA tests were ordered. The medical record did not include the slightly elevated PSA test result, and it is likely the report had been misfiled.*

*Three years later, during conversion to an electronic health record, the patient presented for his annual exam. At that time, the internist found the slightly elevated PSA test result and ordered another PSA test. The result was 95 ng/mL. The patient was referred to a urologist, who diagnosed a Gleason 7 carcinoma of the prostate. The patient filed a claim alleging that the internist's office procedures for filing test results were inadequate and resulted in the delay in diagnosis.*

### Adverse Drug Reaction

The fourth most common injury involved adverse reactions to medications (12 percent). In one-third of the cases, patients stated they had received insufficient information regarding the risks of the medication. In 19 percent of the cases, the prescribed medication was inappropriate for the patient's condition, and in 17 percent of the cases, the monitoring of blood therapeutic drug levels was inadequate.

Adverse reactions to medications included drug toxicity; hemorrhages or hematomas from anticoagulants; confusion,

dysarthria, and dizziness from high doses of antipsychotic medications; kidney damage and hearing loss from poorly monitored antibiotics; and avascular necrosis from excessive doses or long-term exposure to steroids.

**CASE EXAMPLE:** A 54-year-old male presented to his internist with complaints of shortness of breath and right leg pain. A Doppler exam revealed a deep venous thrombosis. The patient was admitted to the hospital the next day with an order for IV heparin. A CT angiogram of the chest revealed a pulmonary embolus. The internist discontinued the heparin and ordered ASA, Lovenox, and Coumadin.

*Four days after discharge, the prothrombin time (PT) was 37.7 seconds (normal range 11–13 seconds), and the international normalized ratio (INR) was 3.5 (therapeutic range 2.0–3.0). Medications were adjusted. Two days later, the PT was 40.4 seconds, and the INR was 3.8. The physician wrote on the lab report to decrease Coumadin, adding that the patient was aware of the anticoagulation risks.*

*Five days later, the patient presented to the ER with complaints of severe abdominal pain, distended abdomen, and low blood pressure. A CT of the abdomen revealed a large hematoma in the right lower quadrant pressing on the femoral artery. It was surgically drained, but he subsequently developed foot drop and ultimately lost function in the right leg because of pressure by the hematoma on the femoral nerve.*

*Physician reviewers stated that too many anticoagulants had been ordered and that all anticoagulants should have been discontinued until the INR was in therapeutic range. Poor communication between the laboratory and internist and the internist and patient contributed to the patient's injury.*

**CASE EXAMPLE:** A 59-year-old male presented to the ER complaining of abdominal pain and fever. Acute diverticulitis was diagnosed, and he was admitted and started on IV Garamycin, Avelox, and Flagyl. Three days later, the patient was discharged with an order for Garamycin. There was no order to monitor serum Garamycin levels.

*Two weeks later, he presented to his internist complaining of dizziness and vertigo, but a Garamycin level was not ordered. He saw another physician five days later and complained of lower left quadrant pain and dizziness. Garamycin toxicity was suspected, and he was admitted with suspicion of vestibular dysfunction. Vestibular tests revealed hypofunction with no balance response. The serum creatinine was elevated, and a nephrologist diagnosed Garamycin nephrotoxicity. He was unable to work due to poor balance, dizziness, and hearing loss.*

*Physician reviewers stated that the patient should have received less toxic antibiotics, or the serum Garamycin levels should have been monitored. Additionally, an infectious disease specialist should have been consulted.*

**INJURY SEVERITY**

Patient injury severity was identified using the National Association of Insurance Commissioners (NAIC) Injury Severity Scale (see Figure 2). The NAIC Injury Severity Scale was rolled into low, medium, and high categories for Figures 3 and 4. (See the NAIC table showing the scale equivalent of low, medium, and high severity.)

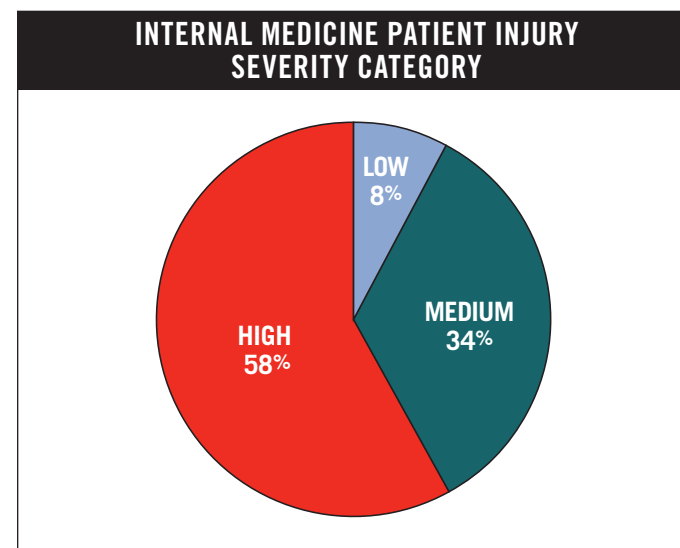
**FIGURE 2**

NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS (NAIC) INJURY SEVERITY SCALE	
<b>Low Severity</b>	
1. Emotional only	
2. Temporary insignificant	Lacerations, contusions, minor scars, rash, no delay in recovery
<b>Medium Severity</b>	
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
<b>High Severity</b>	
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	

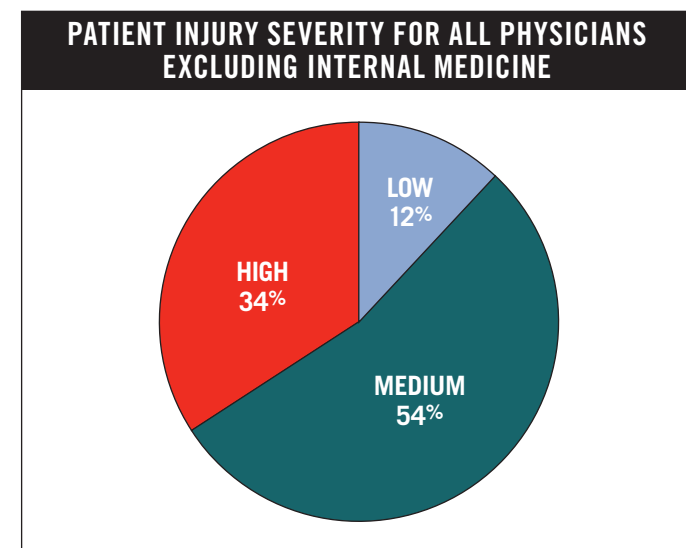
Internal medicine specialists have a significant percentage of high-severity patient injuries compared with a grouping of all other physician specialties (see Figures 3 and 4). This is due to the important role internists have in the diagnostic

process, as well as to the wide variety of conditions they treat. Diagnosis-related issues were identified in almost 40 percent of internal medicine claims. Of claims with diagnosis-related allegations, 70 percent resulted in high-severity injuries.

**FIGURE 3**



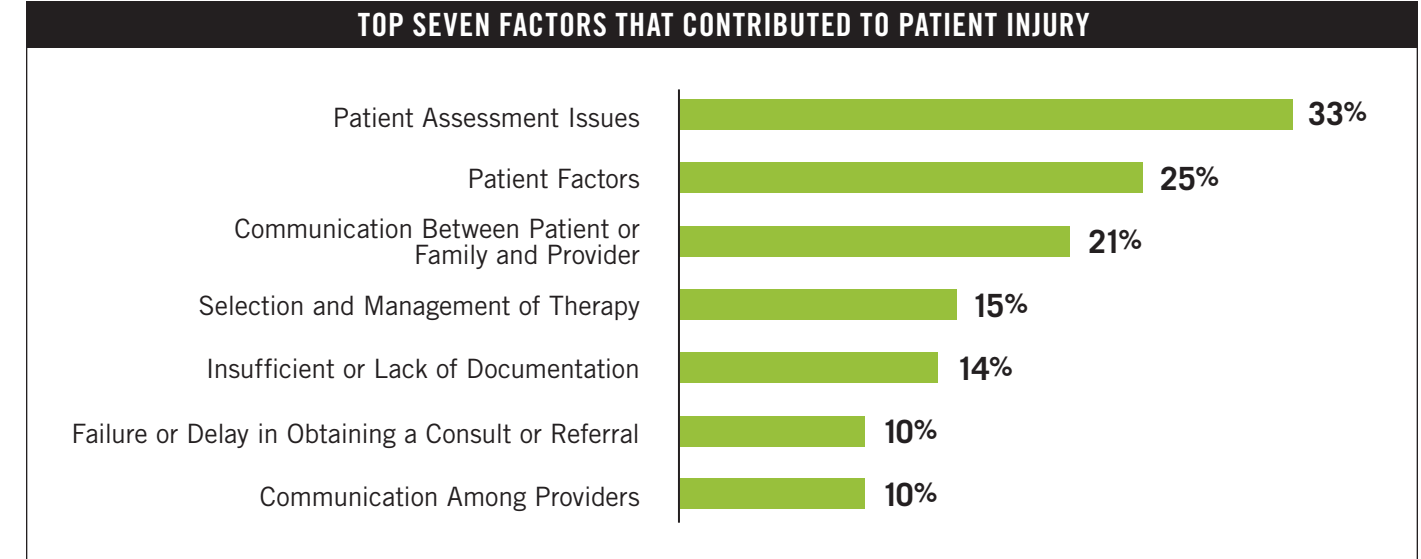
**FIGURE 4**



**FACTORS CONTRIBUTING TO PATIENT INJURY**

Practicing physicians evaluate our malpractice cases and identify factors that contributed to patient injury. Figure 5 illustrates the top seven contributing factors identified by our physician reviewers. Note that because multiple factors often contributed to patient injury, the percentages total more than 100 percent.

**FIGURE 5**



**33% Patient assessment issues.** Inadequate assessments are closely related to a failure or delay in diagnosis. An incorrect diagnosis was often due to failure to establish a differential diagnosis, failure to order diagnostic tests, inadequate history and physical, and failure to address abnormal findings.

Physician reviewers identified the diagnostic tests that internists failed most frequently to order when indicated: blood tests (CBC, electrolytes, enzymes, etc.), CT scan, x-ray, MRI, colonoscopy, biopsy, cultures (blood, wound, urine), ultrasound, EKG/echocardiogram, mammogram, and PET scan.

The 10 diagnoses that were most often incorrect or delayed due to inadequate assessments include prostate cancer, lung cancer, PE, acute CVA, spinal epidural abscess, acute MI, overdoses of opioids and anticoagulants, pneumonia, breast cancer, and colon cancer.

**CASE EXAMPLE:** A 56-year-old male had a screening PSA that was elevated at 6.9 ng/mL (normal <4.0 ng/mL). His internist diagnosed prostatitis, and he was treated with antibiotics.

*Two years later, he requested a referral to a urologist for a vasectomy. The internist did not communicate the PSA findings to the urologist.*

*Three years following the vasectomy, the patient changed providers to a family practice physician who ordered a PSA that was 5.81 ng/mL. He was seen four times over the next eight months, but the PSA result was never discussed.*

*The patient then returned to his internist with complaints of depression. The internist did not request medical records from the family practice physician and was unaware of the PSA result.*

*He then saw the urologist for complaints of frequent urination. The urologist ordered a PSA that was 47 ng/mL. His prostate was tender and a little firm. The urologist ordered Flomax and placed him on gentamicin. A recheck of the PSA three weeks later was 58.4 ng/mL. A prostate ultrasound and biopsy showed a Gleason 7 prostate carcinoma. A PET scan revealed metastases to the lumbar spine and pelvic lymph nodes.*

The patient filed claims against the internist and urologist for failure to diagnose prostate cancer. Physician reviewers indicated that the prostate-related assessments were inadequate. The internist should have done digital exams. He should have requested records from the other treating physicians. There were multiple opportunities to address the elevated PSA results as well as time gaps when follow-up PSA tests should have been performed. Physician reviewers believe that an earlier diagnosis would have changed the outcome.

**25% Patient factors.** Patient engagement is critical. Patients play an important role in their own healthcare outcomes. The most common patient factor was noncompliance with the treatment plan. In 9 percent of internal medicine claims, patients failed to follow physician instructions. In 7 percent of cases, patients failed to make a follow-up appointment or referral. Failure to take medications as prescribed was noted in 4 percent of claims.

**21% Communication between patient or family and provider.**

Communication breakdowns between patients and their physicians may have played a significant role in patient noncompliance. In 8 percent of cases, inadequate education about the risks of medications was an issue. In some cases, patients didn't understand discharge instructions. Inadequate discharge and follow-up instructions were identified in 3 percent of cases. Poor rapport was identified in 4 percent of cases and may have influenced a patient's willingness to ask questions. In 4 percent of these cases, patients went to other providers when they were dissatisfied with the care they had received, eliminating opportunities for the internists to address patients' concerns.

Studies have identified additional barriers to patient compliance, including low health literacy and a patient's lack of ability to purchase medications or pay for the doctor's visit. To avoid costs, some patients don't make follow-up appointments or fill prescriptions.

Other areas of communication breakdown involved inadequate informed consent regarding treatment options (3 percent) and language barriers (1 percent).

**CASE EXAMPLE:** A 25-year-old female presented to the ER with a throat infection and fever. An internist examined her and noted a history of chronic depression and recent methamphetamine use. She was admitted, placed on IV antibiotics, and evaluated by a psychiatrist, who confirmed her major depression.

After the psychiatric exam, the internist ordered escitalopram, atenolol, clindamycin, lorazepam, and antibiotics. Two days after admission, the patient was discharged on escitalopram, lorazepam, and atenolol with a final diagnosis of acute methamphetamine withdrawal and acute pharyngitis. Eight days later, she was readmitted to the psychiatric unit due to depression.

The patient filed a claim and alleged that the internist improperly prescribed medications that exacerbated her worsening depression. She also alleged that the internist did not discuss the risks of the medications with her.

Physician reviewers opined that the internist should not have prescribed escitalopram due to the FDA black box warning that people younger than 25 may experience worsening depression or suicidal thoughts. Experts also testified that the internist should not have prescribed psychotropic medications and should not have prescribed lorazepam due to the patient's habitual drug use and addiction problems with methamphetamines.

**15% Selection and management of therapy.** Physician reviewers identified substandard care related to therapy and medication management in 15 percent of internal medicine claims. However, patients alleged improper medication management and therapy in 34 percent of these cases.

**CASE EXAMPLE:** A 20-year-old morbidly obese male presented to the ER with difficulty breathing and lethargy. He had a recent history of strep throat and was taking antibiotics. Upon admission, his blood pressure was 155/97, heart rate 145, WBC 17,000, and blood glucose 450 mg/dl. He was started on insulin and admitted to the ICU with a diagnosis of diabetic ketoacidosis.

Shortly thereafter, the patient became comatose. A brain CT scan, blood cultures, and neurology consult were ordered. The impression was toxic metabolic encephalopathy, probable sepsis, diabetic ketoacidosis, and rule out meningitis. A lumbar puncture (LP) was attempted, but the patient arrested and CPR was unsuccessful. An autopsy determined that the cause of death was diabetic ketoacidosis.

Physician reviewers were critical that both the dosage of insulin and the IV rate of administration were too low to reduce the ketoacidosis. Concerns were raised about poor nursing communication regarding critical laboratory results and changes in the patient's condition. Some questioned whether the patient aspirated when he was turned on his side for the LP.

**CASE EXAMPLE:** A 39-year-old male was followed by his internist for several years for left atrial enlargement, moderate aortic insufficiency, and probable mild stenosis. The patient was asymptomatic, and referred to a cardiologist, who recommended continued observation and a repeat echocardiogram in a year.

Five months later, the patient called the internist complaining of back pain with inhalation and exhalation. The physician recommended that the patient be evaluated in the office that day, but the patient declined, and an appointment was scheduled for two days later. A chest x-ray revealed cardiomegaly with left ventricular hypertrophy. The patient was referred back to the cardiologist, but the next available appointment was two and a half months later, and the internist did not follow up to confirm that the appointment had been made.

The patient expired before seeing the cardiologist. The cause of death was listed as cardiac hypertrophy with multiple remote MIs due to valvular heart disease. Several physician reviewers said that this patient should not have been treated in a routine fashion. Instead, he should have been seen in an urgent manner or referred for surgical evaluation.

**14% Insufficient or lack of documentation.** Physician reviewers identified insufficient documentation as a factor contributing to patient harm. Medical record entries were criticized for lack of detailed clinical findings, limited reviews of care, incomplete histories, inadequate informed consents, and lack of notations regarding telephone advice. Other documentation limitations included inadequate discharge instructions and failure to document follow-up efforts and patients' refusal of treatment.

**10% Failure or delay in obtaining a consult or referral.**

Decisions to refer patients or seek the advice of other specialists were delayed or did not occur in 10 percent of these cases. (This factor is closely associated with the 10 percent attributed to inadequate communication among providers.)

**CASE EXAMPLE:** A 61-year-old male presented to his internist for a routine exam. The physician noted a nonenlarged symmetric prostate without nodules. The screening PSA was 4.8 ng/mL (normal <4.0 ng/mL). The physician initialed the test result but took no action. The test result was misplaced in the chart.

The following month, the patient went to the internist for a blood pressure check. The internist did not remember receiving the PSA report and stated that he had not received the lab results yet. He didn't check on the status of the test.

Two years later, the patient returned to his internist, and a rectal exam revealed a nodular, mildly enlarged prostate. The PSA was 157 ng/mL. He was referred to a urologist. A biopsy showed high-grade carcinoma of the prostate. Staging showed retroperitoneal and pelvic lymphadenopathy with seminal vesicle abnormalities—consistent with stage IV prostate cancer.

Physician reviewers stated that the internist should have sent the patient to a urologist when the first elevated PSA result was received. They believe that the cancer would have been confined to the prostate at that time and cured. With the delay in diagnosis and treatment, the patient's chance of survival dropped to 50 percent.

“Patient engagement is critical. Patients play an important role in their own healthcare outcomes.”

**MOST COMMON CLINICAL CONDITIONS RESULTING IN PATIENT HARM**

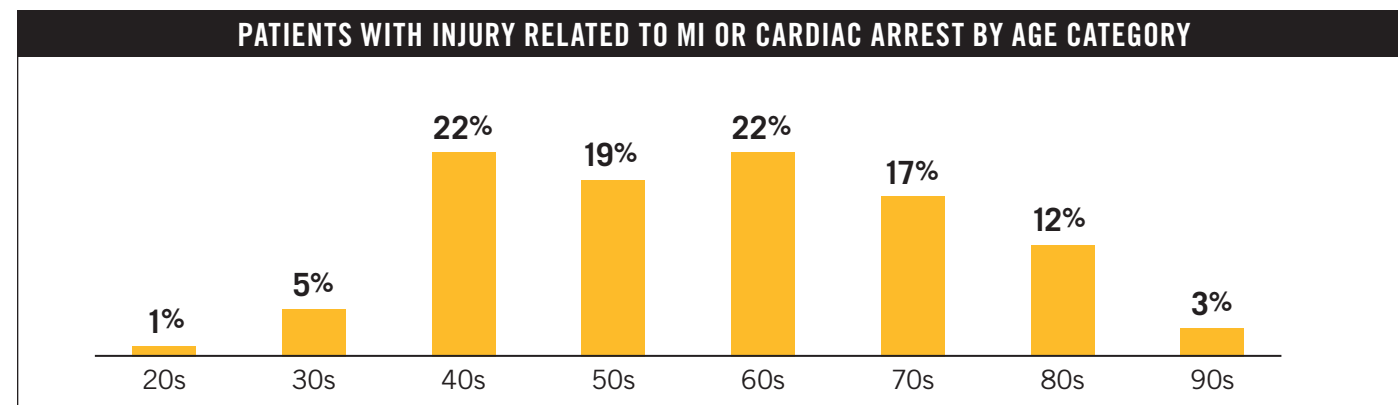
Cardiac-related conditions, lung cancer, and CVA from cerebrovascular thrombosis were the most common clinical conditions that resulted in patient harm. These conditions are often difficult to diagnose due to the wide spectrum of presentations over a broad age range. While these conditions are most often seen in older patients, they can also be found in younger patients.

“The lesson appears to be that patients with suggestive and classic symptoms need to be assessed, regardless of their age.”

**Cardiac-Related Claims**

Cardiac arrest and MI were problematic diagnoses across most adult age groups, but most of the claims arose from patients in their 40s, 50s, and 60s. Figure 6 shows the distribution of cardiac conditions by age for all internal medicine claims in the study.

FIGURE 6



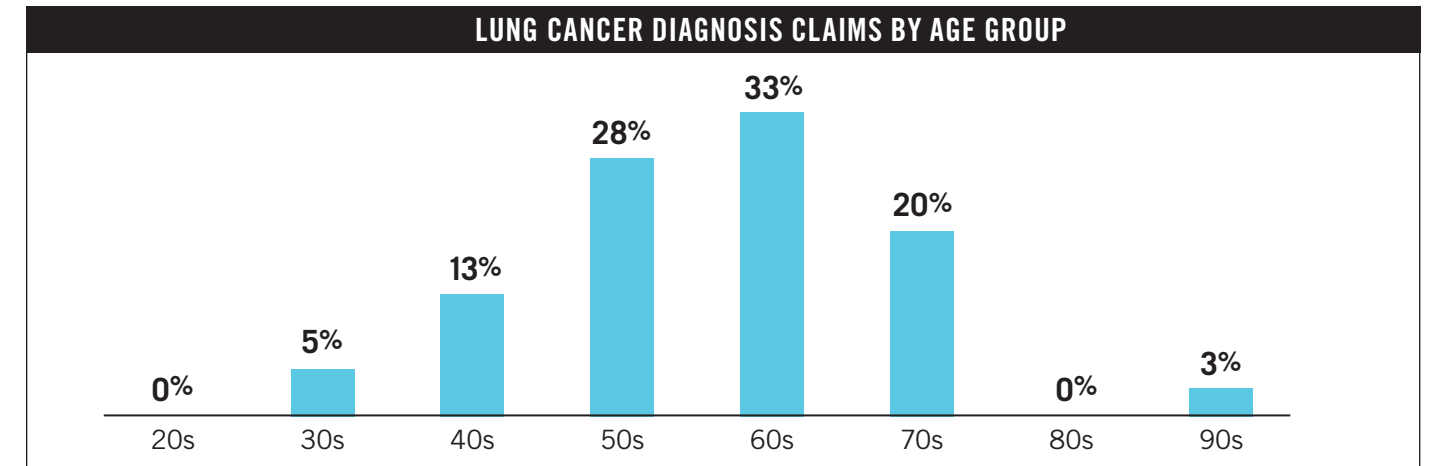
Of significance is that 22 percent of patients who suffered harm related to diagnosis and treatment of a cardiac condition were in their 40s. These patients often had atypical pain

and/or comorbid conditions that deflected attention away from possible cardiac-related diagnoses.

**Lung Cancer Claims**

In claims with a diagnosis-related allegation, lung cancer was the most common diagnosis.

FIGURE 7



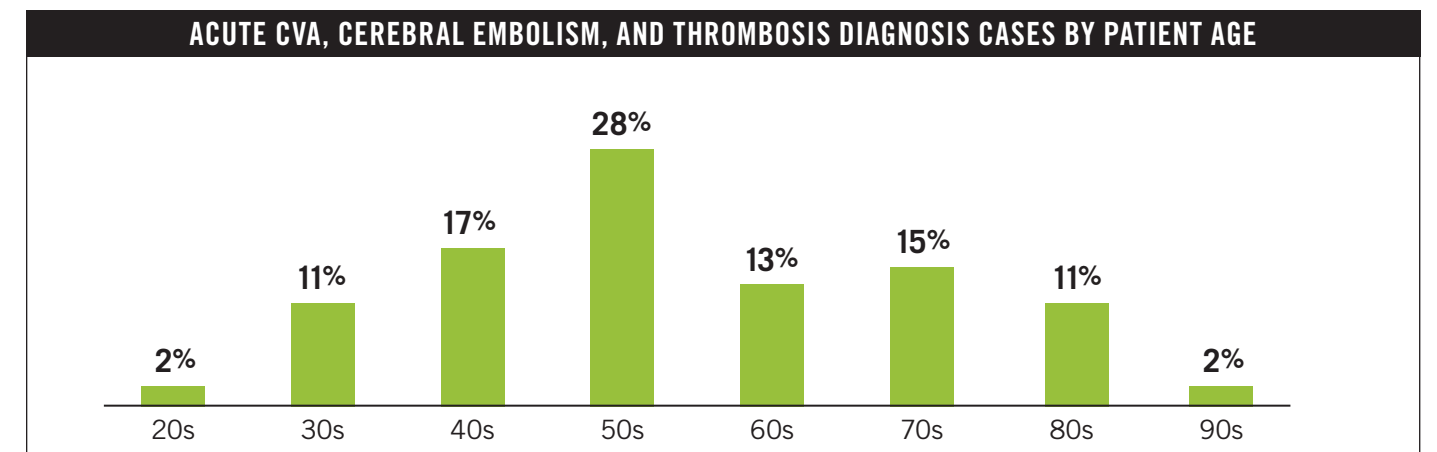
As Figure 7 illustrates, the 60s age group had the most lung cancer claims, followed closely by patients in their 50s. It is noteworthy that some patients in their 30s and 40s

also suffered from a delayed or incorrect diagnosis or from inadequate treatment, making up 18 percent of these claims.

**Acute CVA, Cerebral Embolism, and Thrombosis-Related Claims**

Acute CVA and cerebral embolism or thrombosis-related claims also occurred across multiple age groups (see Figure 8). These cases became claims when diagnosis-related errors occurred or inadequate treatment resulted in patient harm.

FIGURE 8



The significance of this chart is the percentage of patients in younger age groups who suffered from a failure to diagnose or from mismanagement of acute CVA or cerebral embolism.

Almost 60 percent of patients were under the age of 60. Almost one-third of the patients were under the age of 50. It is clear that symptoms of CVA or cerebral embolism in younger

patients should prompt further evaluation. The lesson appears to be that patients with suggestive and classic symptoms need to be assessed, regardless of their age.

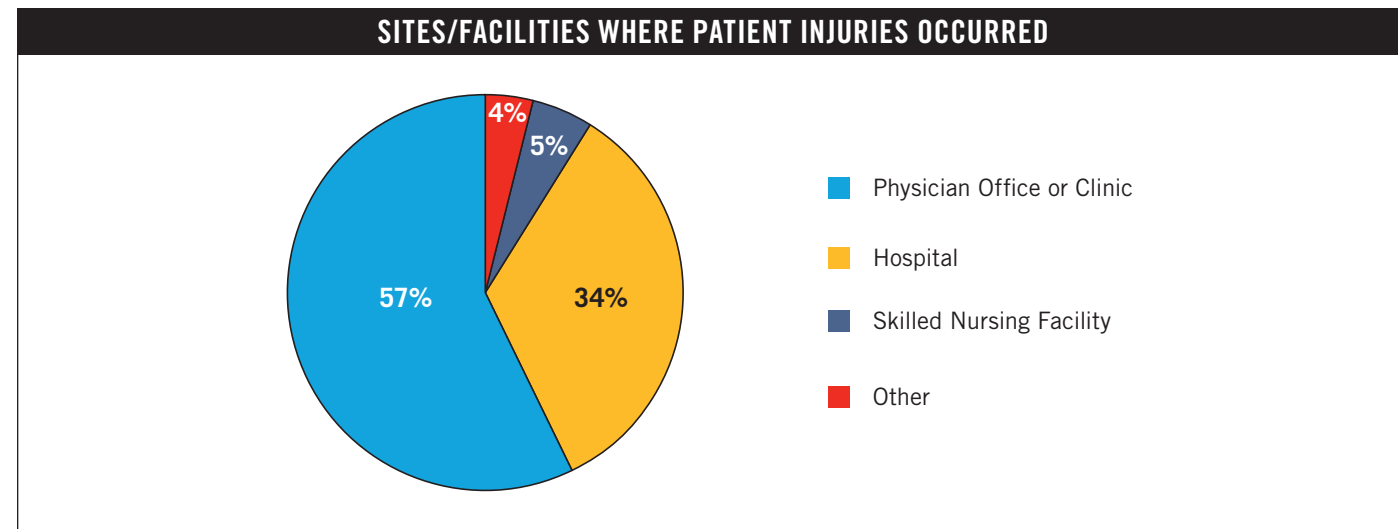
Some cases presented with symptoms that could have been caused by cardiac conditions or PE. Some patients who presented with dizziness also exhibited chest pain, elevated blood glucose, upper respiratory congestion, and extremity

weakness. In one case, the patient experienced symptoms a few days postpartum that were not recognized as a CVA but were later confirmed as a stroke. Many of these patients were initially referred to cardiologists or pulmonologists, delaying involvement by a neurologist.

**PRACTICE SETTING AND PATIENT TYPE**

As illustrated in Figure 9, the majority of patient injuries occur in the office or clinic setting.

FIGURE 9



In recent years, the number of internal medicine claims generated in the inpatient setting has decreased as the number of patients treated in the outpatient setting has increased (see Figure 10). This trend reflects the growth

of hospitalist practice in the inpatient setting and the transitioning of much of the practice of internal medicine to the office setting.

“The Doctors Company segregates its claims data to distinguish whether the internist is in office practice or practicing as a hospitalist.”

FIGURE 10

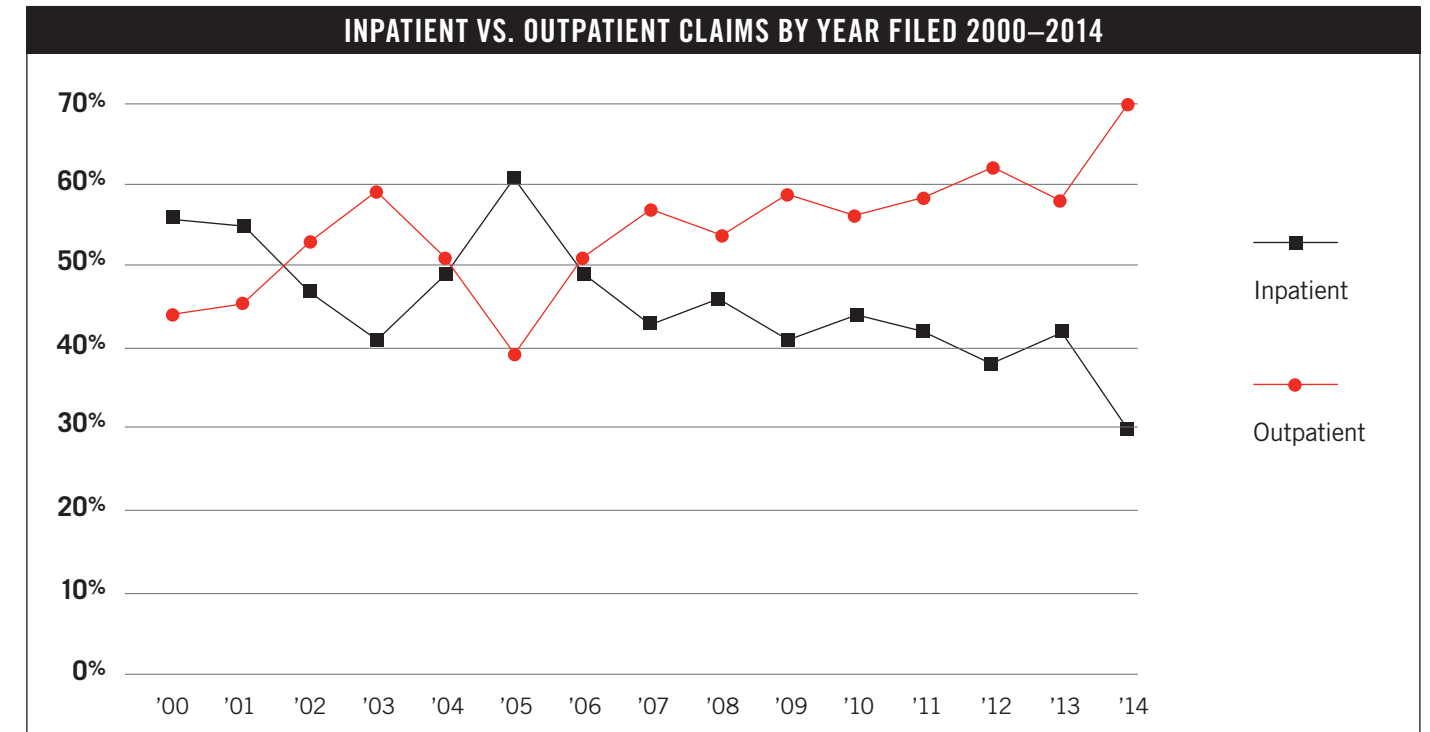
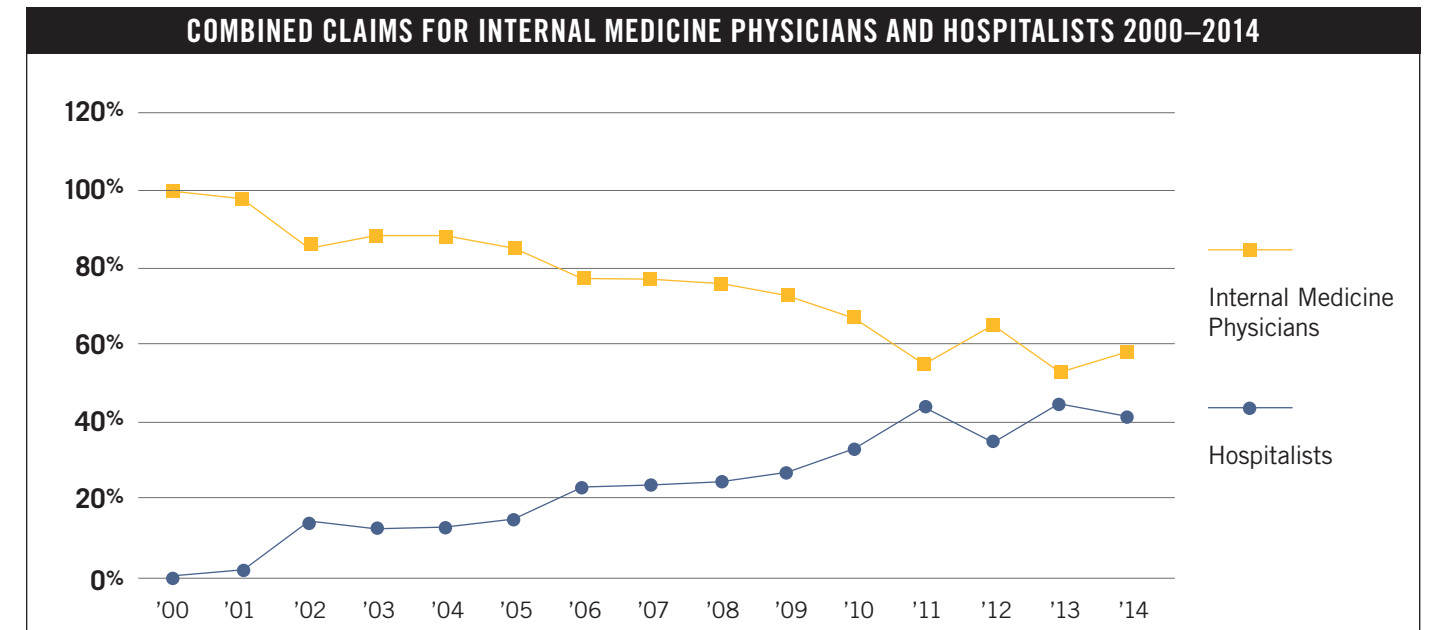


FIGURE 11

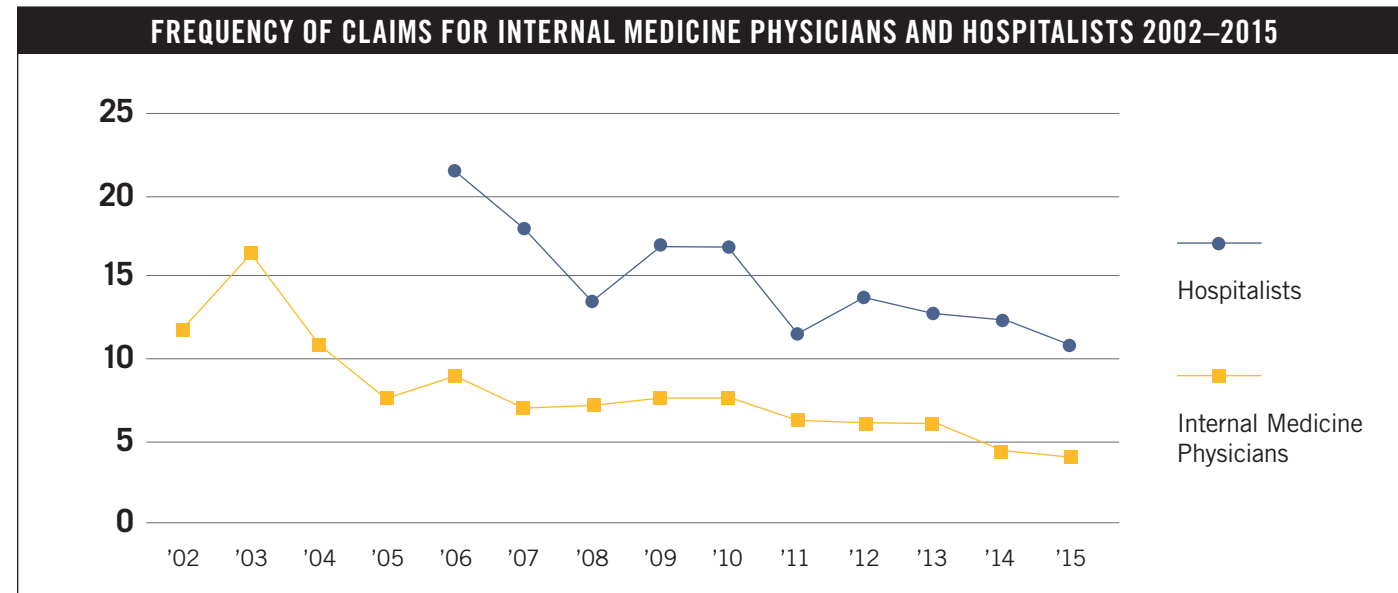


Increased use of hospitalists for acute care may have been a factor in reducing the frequency of internal medicine claims (see Figure 11). Most hospitalists are internists. The Doctors Company segregates its claims data to distinguish whether the internist is in office practice or practicing as a hospitalist. Figure 12 compares the frequency of claims for internal

medicine specialists in office practice with hospitalist claims frequency.

The frequency of claims against both internists and hospitalists has trended downward over the last 10 or more years.

FIGURE 12

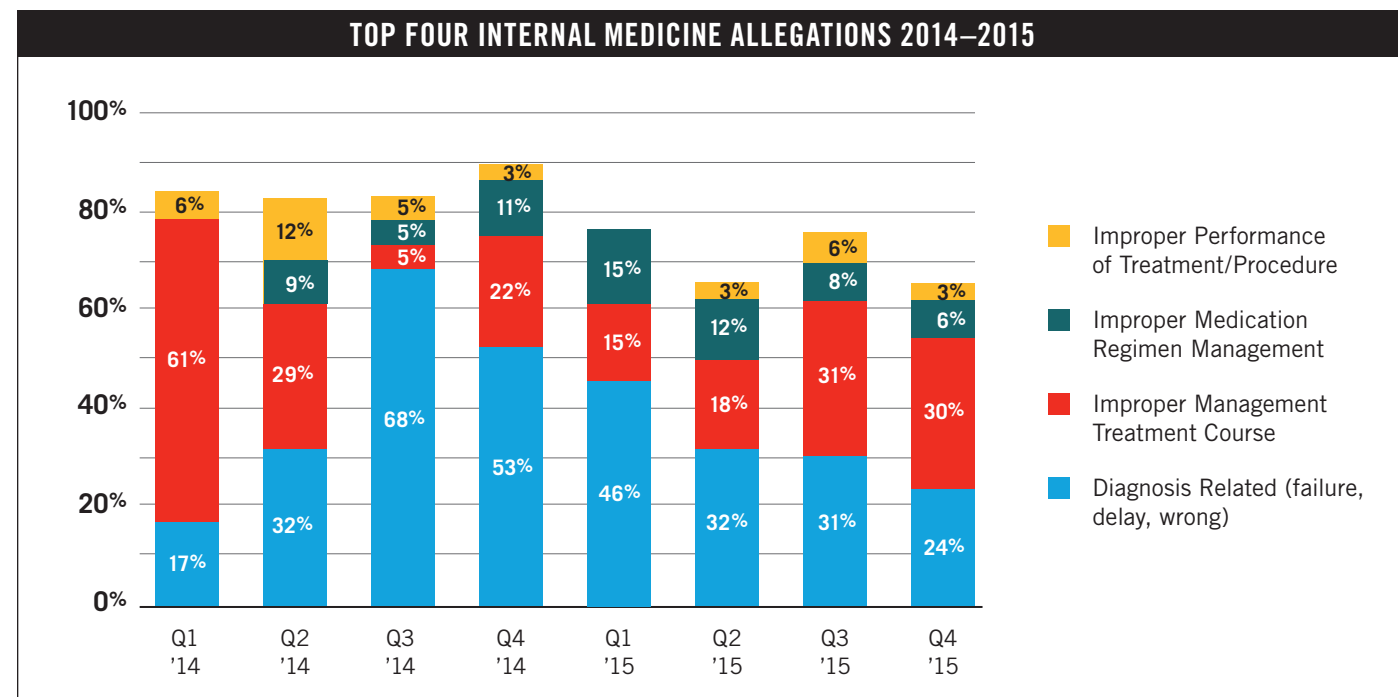


**Note:** Frequency = The number of claims per 100 physician full-time equivalents (FTEs) per year. We began calculating rates of claims for hospitalists in 2006.

**STUDY OF OPEN CLAIMS**

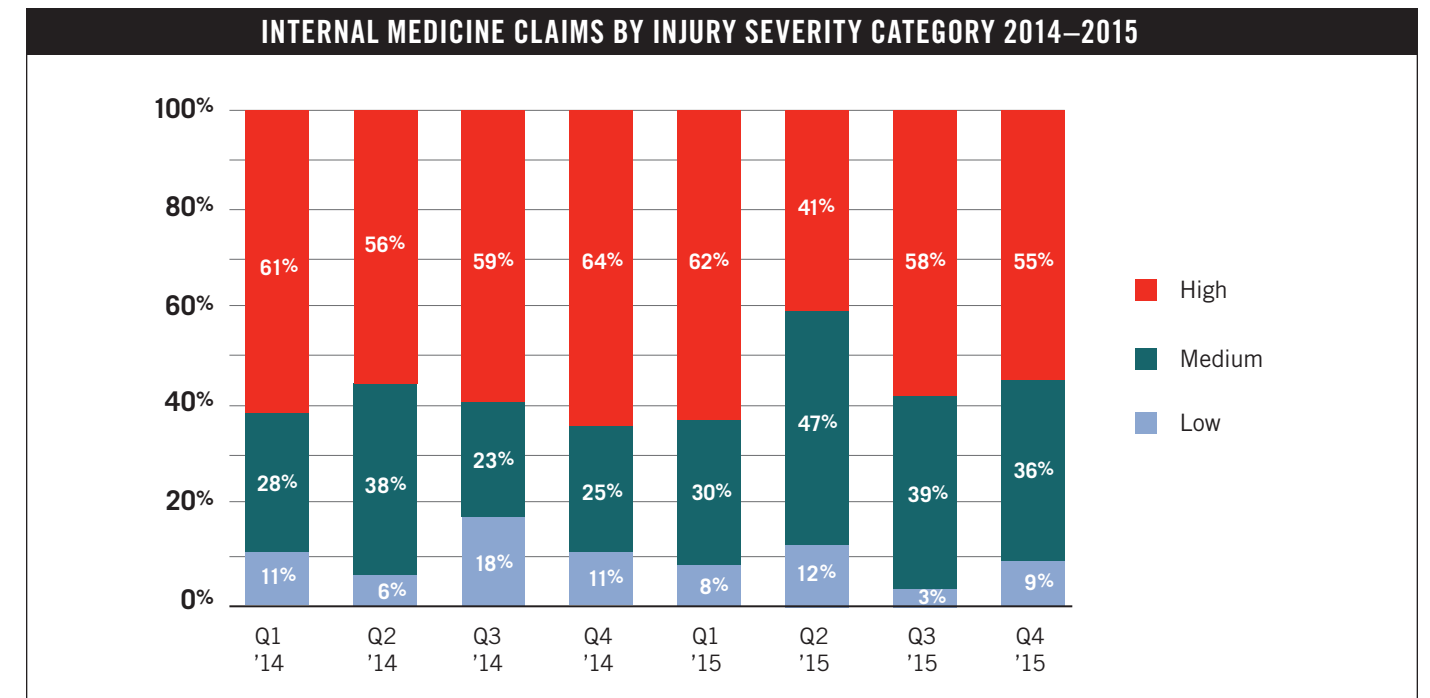
Studying open claims may provide early detection of changes in claim allegations by patients/plaintiffs. A review of eight recent quarters (First Quarter 2014 through Fourth Quarter 2015) revealed that allegations data related to internal medicine is volatile, and no specific trend was identifiable (Figure 13).

FIGURE 13



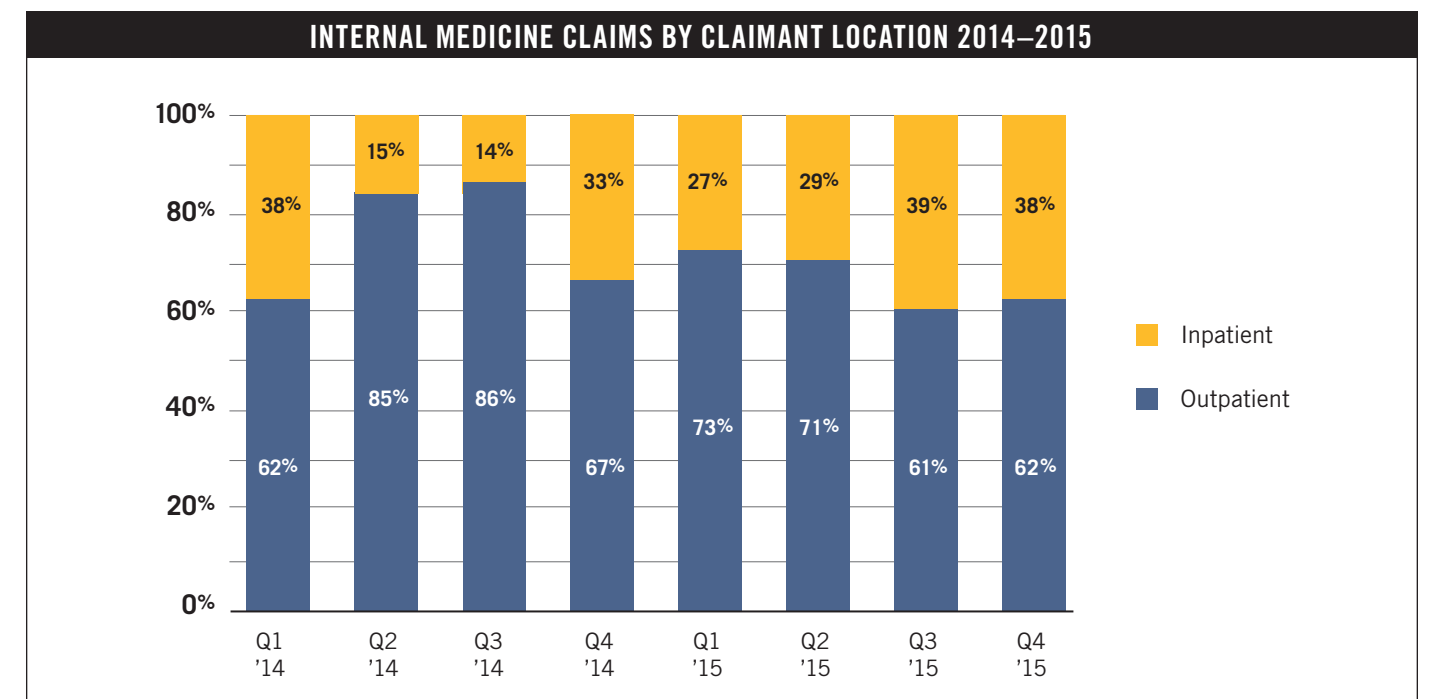
Injury severity was largely unchanged for these eight quarters (Figure 14).

FIGURE 14



We also see little variation in inpatient versus outpatient location (Figure 15).

FIGURE 15



These limited insights into internal medicine claims seem to indicate that, for claims opened in the last two years, the data remain fairly consistent. Where we saw variation in patient allegations, no discernable trend was identified.



### RISK MITIGATION STRATEGIES

The following strategies can assist internal medicine physicians in reducing some of the risks detected in this study:

- Physicians and office staff should take the time to explore patient complaints, especially when the patient makes similar complaints on return visits. Diagnosis and treatment depend on skilled patient assessments. Patient complaints are the first opportunity to gather information. The ability to engage the patient in order to obtain an accurate history is especially important when developing a differential diagnosis.
- Thoroughly evaluate all age groups of patients with atypical chest pain. Twenty-two percent of the patients in this study who had MI or cardiac arrest (the most common injuries) were in their 40s and presented with atypical chest pain.
- Pay close attention to calls and concerns from postoperative patients. Community-acquired and nosocomial infections can be difficult to diagnose. Diagnosing postoperative infections and other complications might be even more challenging. Internists are often called upon to provide postoperative care at a time when patients are unable to determine whether symptoms are a normal part of recovery or are complications that need medical assistance.
- Clearly document the clinical history and physical examination.
- Document the details of telephone advice, and include any follow-up and appointment information.
- Ensure that your office has a clear policy and procedure for staff to track diagnostic test results and consultations. Having a system in place will enable follow-up by alerting staff and physicians when test results have not been received.
- Confirm that the patient understands the treatment plan, follow-up care, and medication regimen by using a teach-back or repeat-back method. Patient compliance is a major problem in internal medicine practices. Often, this is due to patients' failing to understand discharge instructions or not receiving adequate instructions.
- Ask about the patient's intentions to follow instructions or purchase medications. This question provides an opportunity to determine the patient's level of understanding and learn about any affordability concerns. If the patient has a limited ability to pay for medications or follow-up appointments, provide a list of community services that can help him or her receive the treatment needed.

### LEARN MORE

**We provide extensive online resources, including content specifically for internal medicine physicians. Find more information on how we're helping internal medicine physicians enhance patient safety and avoid claims at [www.thedoctors.com/patientsafety](http://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.