CARDIOLOGY
CLOSED CLAIMS STUDY

As the nation's largest physician-owned medical malpractice insurer, The Doctors Company has an unparalleled understanding of liability claims against cardiologists. 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 cardiologists at risk, we reviewed 429 cardiology claims that closed from 2007–2013. The results presented here reveal underlying vulnerabilities in the practice of cardiology.

THE DOCTORS COMPANY

CARDIOLOGY CLOSED CLAIMS STUDY FINDINGS

MOST COMMON PATIENT ALLEGATIONS

We analyzed allegations made by patients in 429 closed cardiology claims. Here are the five most common:

1. Diagnosis related (failure, delay, or wrong diagnosis) (25 percent). This allegation is similar to the findings of expert reviewers, who identified patient assessment issues as the most common factor contributing to patient injuries. Patient assessment issues included failure or delay in ordering diagnostic tests, establishing a differential diagnosis, considering available clinical information, and addressing abnormal findings (from echocardiograms, EKGs, vital signs, and lab results, for example).

FIVE MOST COMMON PATIENT ALLEGATIONS IN CARDIOLOGY CLAIMS

The conditions most frequently associated with failure to diagnose included pulmonary embolism with infarction, carcinoma of the lung, acute myocardial infarction (MI), coronary artery atherosclerosis, puncture or laceration during a procedure, and aortic dissection. Cardiologists were named in claims involving lung neoplasms when they failed to follow up on incidental lung lesions identified in imaging studies they had ordered for another purpose. This was the second most common diagnosis prompting an allegation of failure or delay in diagnosis; it accounted for 6 percent of the claims in this category.

2. Improper management of treatment (14 percent). These cases involved decisions about therapeutic measures. In several cases, patients suffered cardiac arrest during an intervention for cardiac tamponade or pericardial effusion. Other examples involved the appropriateness of ordering stress tests for patients who suffered cardiac arrest during the procedure.

3. Improper performance of treatment or procedure (12 percent). Examples of these claims included hematomas, retroperitoneal bleeding, cardiac tamponade, punctured external iliac artery, aortic laceration from cardiac catheterization, and esophageal perforation during transesophageal echocardiogram.

4. Improper performance of surgery (11 percent). This finding is closely related to improper performance of procedure. Cases involving surgical procedures included arterial injury during mitral valve repair, incorrectly placed leads and infections from pacemaker implantation, cardiac damage during ablations resulting in the need for a pacemaker, cardiac tamponade, and retroperitoneal bleeding from arterial punctures during coronary catheterization with stent placement.

5. Improper medication management (6 percent). Most of these cases included improperly monitoring and managing anticoagulants, leading to stroke, retroperitoneal bleeding with exsanguination, and lower extremity compartment syndrome.

FACTORS CONTRIBUTING TO PATIENT INJURY

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

1. Patient assessment issues (25 percent) were identified as the most frequent cause of patient injury. Cardiologists sometimes failed to establish a differential diagnosis or to use clinical information available to them that should have prompted further investigation. This narrow diagnostic focus resulted in failure to address abnormal findings and failure or delay in ordering diagnostic tests.

2. Technical performance (21 percent) was the second most common finding. Although this category might seem to imply negligence, reviewers found that most performance issues were related to known complications disclosed to the patient prior to the procedure and were not necessarily due to substandard care. A very small percentage of claims were due to problems with technique, inexperience with a procedure, or misidentification of an anatomical structure.

When patients alleged improper performance of treatment or procedure or improper performance of surgery, it was often due to a known complication. It is important for the physician to engage the patient and family during discussions about the patient's condition and prognosis. It is also important to link the patient's experience to information provided during the informed consent discussion. Although the patient may continue to be unhappy with the outcome of care, a patient who feels engaged in his or her care and treatment may be less inclined to attribute the outcome to negligence or to bring a liability claim against the physician.

continued on next page

TOP SIX FACTORS CONTRIBUTING TO PATIENT INJURY

25% PATIENT ASSESSMENT ISSUES

- Failure to establish a differential diagnosis.
- Failure to use available clinical information.
- Failure or delay in ordering diagnostic tests.
- Failure to address abnormal findings.

21% TECHNICAL PERFORMANCE

- Injury was a known complication.
- Poor technique.
- Misidentification of anatomical structure.

20% PATIENT FACTORS

- Nonadherence with treatment plan.
- Nonadherence with medication plan.
- Nonadherence with follow-up calls or appointments.

18% SELECTION AND MANAGEMENT OF THERAPY

- Inappropriate surgical or other invasive procedure.
- Failure to order medication.
- Failure to use the most appropriate medication.

15% COMMUNICATION AMONG PROVIDERS

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

14% COMMUNICATION BETWEEN PATIENT/FAMILY AND PROVIDER

- Inadequate patient education regarding risks of medications.
- Poor follow-up instructions.
- Poor rapport (includes unsympathetic response).

FACTORS CONTRIBUTING TO PATIENT INJURY

continued from previous page

3. Patient factors (20 percent) were identified as the third most common factor associated with patient injury. This category, which is related to patient behaviors, includes cases in which patients did not follow treatment or medication plans or missed follow-up appointments. This contributing factor is closely related to the sixth most common factor, communication between patient/family and provider.

4. Selection and management of therapy (18 percent) was identified as the fourth most common factor. Examples included selection of the procedure, such as implantation of a pacemaker before trying a temporary pacemaker or performing coronary stent placement rather than using medical management. In some cases, reviewers found that a patient was not an appropriate candidate for a procedure. In other cases, reviewers noted that delayed interventions resulted in patient harm, as when an echocardiogram should have been done sooner to identify tamponade. This category also included failure to order medication and cases in which the selection of medication was not the most appropriate for the patient's condition.

5. Communication among providers (15 percent) was the fifth most common factor contributing to patient injury. This included ineffectively sharing information about the patient's condition and failure to review the medical record. It also included situations in which reviewers identified poor relationships between professionals as having a deleterious effect on patient care.

6. Communication between patient/family and provider (14 percent) was the sixth most common contributing factor. Expert reviewers found that noncompliance increased when the patient was given inadequate information about the risks of medications, medication plans, and follow-up instructions.

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

Note: The American College of Cardiology provides a collection of evidence-based quality improvement recommendations at www.cardiosource.org.

By Darrell Ranum, JD, CPHRM, Vice President, Department of Patient Safety
By David B. Troxel, MD, Medical Director, Board of Governors

LEARN MORE

For more information on how we're helping cardiologists enhance patient safety and avoid claims, call (800) 421-2368, extension 1243, or visit www.thedoctors.com/patientsafety.

THE DOCTORS COMPANY
www.thedoctors.com