A review of SVMIC Internal Medicine claims from 2009 – 2014, where a loss was paid on behalf of an insured, reveals that failure to diagnose was the primary allegation asserted in lawsuits. Most typically, the diagnostic errors were not the result of lack of knowledge or diagnostic ability on the part of the physician, but rather, as the graph below illustrates, were a product of poor documentation, communication breakdowns and poorly designed or ineffective systems. Medication errors were also present in the cases reviewed.

**DOCUMENTATION ISSUES**

The importance of maintaining a well-documented medical record cannot be overstated from both a patient care and a risk management standpoint. As the graph above illustrates, documentation issues were a factor in 41% of claims paid in Internal Medicine. Of those, 71% were found to have inadequate documentation which can negatively impact the ability to defend the care provided to a patient. Most often there was a failure to completely document patient and/or family history, details of the physical exam, rationale for the diagnosis and treatment plan, patient education, telephone calls and recommendations for screening tests. Specific case examples of inadequate documentation include:

- Failure of PCP to document information received over the phone from Emergency Medicine Doctor suggesting bronchitis in a 59 YOM who was discharged but later died from pneumonia complications.
- Failure to document the recommendation that a 65 YOM undergo a screening colonoscopy. The patient was diagnosed with colon cancer one year later.
- Failure to document the medical need for steroid injections given to a patient, who later developed MRSA in the affected joints.
- Failure to document family history of breast cancer in a 43 YOF who subsequently was diagnosed with the disease.
- Incomplete description of chest pain and other presenting symptoms of a 74 YOM who was diagnosed with GERD. The patient subsequently died of an MI.

**COMMUNICATION ISSUES**

Effective communication is essential in establishing trust and building good patient rapport, which in turn plays a role in a patient’s perception of the quality of care received. 32% of the claims reviewed involved communication breakdowns. Case examples of communication breakdowns leading to a delay in diagnosis and treatment are listed below:

Physician-to-Physician breakdowns:

- Confusion as to who was covering for admitting PCP resulted in a delay in evaluating a 75 YOM
whom EMD had diagnosed with gastritis. The patient deteriorated and died from ischemic bowel complications before the covering PCP saw him.

- Lack of communication between PCP and neurologist as to who was responsible for managing a patient with apparent neurologic symptoms. Delay in diagnosis and treatment resulted in permanent paralysis.
- Less than optimal exchange of information between EMD and PCP relative to a 29 YOM who presented with acute abdominal pain led to the patient coding and undergoing surgery for a gastric perforation before the PCP made it to the hospital to see him.

Physician-to-patient breakdowns: Informed consent and patient education issues were present in many of the cases reviewed. Some examples include:

- Failure to discuss the risks associated with steroid injections.
- Failure to educate on the risks of Coumadin.
- Failure to discuss the risks of forgoing recommended screening exams such as colonoscopy and mammography.
- Inadequate education on the risks or alternatives associated with addictive medications.

Physician-to-staff breakdowns: Most often the cases falling into this category involved mishandling of telephone calls or test results. Examples include:

- 35 YOM called the office complaining of severe coughing that produced some “spots of blood”. The patient had been in the office 2 days earlier with flu-like symptoms. The RN did not confer with the PCP, but rather recommended that the patient continue with treatment prescribed at the earlier appointment. Two days later, the patient went to the ER where a CXR revealed a collapsed lung.
- 67 YOF on Coumadin presented to the office for INR check. The result of 6.2 was “tasked” to the PCP through the EHR system. The PCP read the task the next morning and then tasked instructions back to the nurse to call the patient and advise to discontinue the Coumadin. The nurse was out of the office and didn’t get the message for 3 days. The patient died the next day from internal bleeding.

**MEDICATION ISSUES**

Medication errors were present in 28% of the reviewed cases. Over half of these involved administration and monitoring issues, as well as typical wrong dose/wrong drug situations.

A few examples follow:

- Rocephin IM injection given to 29 YOF by medical assistant resulted in a sunken injection site. A culture revealed MRSA. The patient was referred to a Plastic Surgeon for surgical treatment.
- 70 YOF who was taking Coumadin for a DVT was prescribed Diflucan by her physician who failed to recommend more rigorous PT monitoring. The patient experienced internal bleeding and died.
- PCP wrote an order for 4 times the intended dose of Heparin. 62 YOM developed brain bleed and died.

**SYSTEMS ISSUES**

Effective systems and processes help reduce adverse events and claims by decreasing reliance on memory or informal mechanisms alone. Of the reviewed claims, 16% involved a systems breakdown. The majority of these involved failing to take proper action on an abnormal test result. A classic example involved the case of a 43 YOM, with a history of lung cancer, who was sent for a CT which revealed enlarged nodes. The radiologist recommended further follow-up with a PET scan. However, the office did not receive the CT report and did no investigation as to its whereabouts. Even though the patient was treated for various ailments over the next two years, the missing report went unnoticed. Eventually, the patient returned with complaints of cough and chest congestion and was ultimately diagnosed with a cancerous lung mass and metastatic disease.
LESSONS LEARNED

- Document clearly, completely and accurately, making sure to include a comprehensive medical, family and psychosocial history; the chief complaint or purpose for the visit as expressed by the patient; all relevant positive and negative clinical findings; your diagnosis or medical impression, and the decision-making process for the clearly defined treatment plan.

- Communicate relevant patient information in a timely and clear manner to the covering physician, especially information on patients with anticipated problems.

- When consulting with a specialist, make sure there is a clear understanding as to who is responsible for the patient’s care.

- In order to ensure proper follow-up for patients who require a return office visit, schedule such patients before they leave the office and provide a reminder card with date and time.

- Physicians should review all no-shows and cancellations, especially for all sick visits, to determine appropriate follow-up action.

- Educate patients on the indications, risks, benefits, alternatives, side effects and expected outcomes of recommended treatments. Be sure these discussions are documented in the medical record.

- Staff giving clinical advice should do so pursuant to an approved written protocol. The protocol should be detailed enough to include what clarifying questions the staff should ask in response to various complaints as well as when a patient should be referred to a physician.

- Clearly communicate and document telephonic advice – use teach back to ensure the patient understands advice given.

- To promote continuity of care, implement a system to ensure abnormal test results are clearly flagged for follow-up at subsequent visits.

- If using a tasking system for interoffice communication, be sure to have a surrogate reviewer assigned to check task boxes for anyone not in the office. Educate staff that “critical values” should be communicated verbally rather than relying on tasking.

- To help prevent medication errors: Update medication history at each visit; review and update allergies at every visit and whenever new medications are prescribed; prescribe medications only after reviewing the record; discuss risks, side effects, benefits of, and alternatives to prescribed medications; closely monitor medications with a known toxic effect; train staff who are allowed to administer medications to adhere to the “Five Rights” (right patient, right drug, right dose, right route, right time) and appropriate injection techniques.

- Follow CDC “Guide To Infection Prevention For Outpatient Settings”.

- Be sure you have an effective tracking method for all lab tests and diagnostic imaging. If a test or consult is important enough to order, it’s important enough to track.

- There should be a consistent method for notifying patients of ALL test results and instructing them to call the office if they have not received the results within the expected time frame.