Why Patients Sue Physicians: Risk Management Strategies

Zachary R. Paterick, JD, MBA, CPA,* Elizabeth Ngo, MD, † Nachiket Patel, MD, ‡ Timothy E. Paterick, MD, JD, MBA,§ Krishnaswamy Chandrasekaran, MD,¶ and A. Jamil Tajik, MD**

Physicians may head off allegations of negligence by developing a comprehensive understanding of why patients sue physicians and by appreciating what activities commonly lead to patient injury. With this knowledge, physicians can develop risk management strategies to reduce the likelihood of being named in a negligence lawsuit. We outline the common reasons why patients sue physicians, and what activities frequently lead to patient harm. The case examples emphasize the factors that can lead to allegations of negligence and patient harm.

KEY WORDS: Detailed medical history; comprehensive physical examination; broad differential diagnosis; due diligence; fiduciary; negligence; patient injury; risk management principles.

Physicians are on the front lines of patient care, providing healthcare and coordinating recommendations of specialty physicians. Communication and coordination of patient care by physicians is vital. Allegations of negligence against physicians often include failure to diagnose, delayed diagnosis, or wrong diagnosis; inadequate or incorrect treatment; medication-related error; inadequate performance of, or delay in performing, a procedure; delay in initiating a treatment; failure to treat; and failure to monitor a response to treatment.

Common factors contributing to patient injury include the timeliness of a diagnosis and the selection of therapies. The clinical decisions made by physicians often depend on the promptness of diagnostic studies being ordered, performed, and interpreted. Another important factor is the timeliness of specialty involvement in a patient’s diagnosis and treatment strategy.¹,³

Effective communication and coordination of care is the cornerstone of timely and accurate diagnoses.

Patient symptoms and physical examination findings are the first source of information to assist physicians in establishing a correct diagnosis. A detailed medical history and comprehensive physical examination are essential. The integration of the medical history and physical examination findings allows the physician to synthesize a broad differential diagnosis. The ability to integrate and synthesize this historical and examination data epitomizes the skill of a physician. The skilled physician must effectively communicate the differential diagnosis to the healthcare team and implement and coordinate the evaluation, treatment, and monitoring of the patient’s care.

Effective communication and coordination of care is the cornerstone of timely and accurate diagnoses. It requires clinical, social, and emotional intelligence. The complexity of the clinical diagnosis process is reinforced by the fact that symptoms overlap between various disease processes. The common symptom of chest pain, for example, can represent a variety of disease processes, including angina, myocardial infarction, pulmonary embolism (PE), pericarditis, gastroesophageal reflux, and chest wall pain. Symptoms of respiratory distress secondary to pneumonia can mimic PE. Both pneumonia and PE can cause decreased oxygen saturation with altered mental status that can be similar to the findings in a stroke syndrome or hypoglycemia. The possibility of overlapping symptoms across a broad range of clinical presentations highlights the complexity of making an accurate diagnosis and treatment plan.

This article provides an overview of the common patient allegations of negligence, common contributing factors to patient injuries, case examples highlighting these
allegations and contributing elements to injury, and risk management strategies.14

ALLEGATIONS OF NEGLIGENCE

The most common patient allegations of negligence include:
- Failure to diagnose, delayed diagnosis, or wrong diagnosis;
- Improper/wrong treatment strategy;
- Medication-related error;
- Improper performance or delay of a procedure;
- Failure to initiate treatment; and
- Failure to monitor the response to treatment.

Failure to Diagnose, Delayed Diagnosis, or Wrong Diagnosis

Case example: A 50-year-old woman presented with a three-day history of atypical chest pain, neck pain, and back pain. The patient was admitted to rule out acute coronary syndrome. The initial electrocardiogram (ECG) and biomarkers for myocardial ischemia were normal. Subsequent blood work demonstrated an elevated troponin level that went unrecognized. In the early morning on the second day of admission, the patient had substernal chest pain, elevated ST segments in leads V4–6, and elevated biomarkers, suggesting acute infarction. She was immediately taken to the cardiac catheterization laboratory and found to have an occluded left anterior descending coronary artery. The patient experienced a myocardial infarction. The treating cardiologist was found liable for delay in the diagnosis of a coronary syndrome because ordered blood tests were not followed up in a timely fashion.

Discussion: Conditions that are most commonly involved in delayed diagnosis, or failure to make a diagnosis, include myocardial infarction, cerebrovascular events, vascular insufficiency, sepsis, intestinal obstruction, PE, spinal epidural abscess, viral and bacterial pneumonia, subacute and acute endocarditis, and aortic dissection.

The failure to diagnose or a delay in diagnosis often results in a catastrophic event. It behooves all physicians to use a broad differential thought process when confronted with complex medical presentations. Comprehensive thinking allows a physician to consider all possibilities that could account for the presenting symptoms. It prevents silo thinking and anchoring.

Improper or Wrong Treatment Strategy

Case example: A 53-year-old man was admitted with dyspnea and pneumonia. There was a history of intravenous drug abuse. The physician evaluating the case diagnosed acute bronchitis and ordered antibiotics and breathing treatments. Later in the day, the patient’s condition deteriorated, his neck became swollen, and he was unable to swallow. He was transferred to the intensive care unit (ICU). Soon after entering the ICU he experienced respiratory arrest, and intubation was unsuccessful due to his swollen neck. He died after an attempt at resuscitation. An autopsy revealed a mediastinal abscess, and laboratory tests revealed positive blood cultures. The legal judgment found inadequate clinical assessment and lack of recognition of sepsis, particularly in light of intravenous drug use.

Discussion: Examples of improper or wrong management that commonly occur in clinical practice include inadequate assessment of foot and decubitus ulcers that subsequently result in sepsis and possible loss of limb. Another example would be inadequate management of patients with diabetes, resulting in ketoacidosis, pyelonephritis, disseminated intravascular coagulopathy, and, ultimately, loss of lower extremities. Many of these cases, when reviewed by experts, suggest that the time interval between assessments and management decisions were excessive.

Medication-Related Error

Case example: A 56-year-old woman was admitted with complaints of abdominal pain, nausea and vomiting, dizziness, confusion, and double vision for five days.

She had been discharged from the hospital just 10 days prior to this admission, following placement of a right coronary artery stent that had occurred 12 days before discharge. Prior to the catheterization her creatinine was normal. She had atrial fibrillation with poorly controlled rate and was treated with atenolol 50 mg per day. She denied any other medication except aspirin and Plavix.

At the time of the second admission, her heart rate was junctional, at 37 beats per minute. She was unresponsive to atropine therapy. Her creatinine was found to be 6 mg/dL (.5-1.2 mg/dL). The patient coded and died.

The legal judgment was failure to recognize digoxin toxicity in a setting of classic presenting symptoms: junctional rhythm unresponsive to intravenous atropine and ECG changes of junctional bradycardia in the setting of acute renal failure. In addition, the physician did not communicate with the primary care physician, who had started digoxin therapy five days earlier to control the ventricular response.

Discussion: Medication error is a common allegation of negligence in a number of common situations, including renal failure from medications such as gentamicin and vancomycin; respiratory failure from excessive doses of narcotics; retroperitoneal hematoma and bleeding from failure to discontinue anticoagulants; and failure to adjust insulin doses in the setting of changing a patient’s diet. Frequent review of medications and medication interactions is necessary, as is consultation and communication with the pharmacy team when using multiple medications.
Improper Performance or Delay of a Procedure

Case example: A 49-year-old obese man with known sleep apnea was admitted to the hospital for leg swelling and increasing shortness of breath. Nursing assessment documented in the notes suggested the patient was at high risk for deep venous thrombosis (DVT). Heparin was started, but no testing for DVT was performed. On the second day, heparin therapy was discontinued, without any note documenting the rationale for the change. That evening the patient complained of shortness of breath. He was placed on supplemental oxygen, but oxygen saturations continued to decline. A pulmonary physician was consulted and ordered a chest CT, but the patient experienced a respiratory arrest and died. An autopsy revealed a PE as the cause of death.

Legal judgment was critical of failure to recognize new symptoms, and failure to follow the patient’s lung status and to monitor blood sugars following changes in insulin doses and respiratory arrest in patients with obstructive sleep apnea following prescribed narcotic pain medications without appropriate monitoring.

Failure to Monitor the Response to Treatment

Case example: A 74-year-old man with known severe coronary artery disease, congestive heart failure, and ectopic atrial tachycardia was admitted to the coronary care unit for evaluation and treatment. The patient had reduced kidney and liver function, but no preexisting lung disease. The patient received a loading dose of amiodarone and then was continued on amiodarone at 400 mg per day. After six months, the patient was experiencing shortness of breath, to the point of being able to walk no further than 10 feet. No blood levels were monitored, and no chest radiography was done until 18 months after he started therapy. Finally a chest radiograph was obtained that revealed new bilateral alveolar/interstitial infiltrates compared with his baseline radiographs; however, there was no change in the cardiac size or vascular pedicle width, and there were no new effusions. The patient underwent chest CT, which confirmed multiple bilateral infiltrates. Despite early corticosteroid treatment after exclusion of all other differential diagnoses, the patient died one month later in the ICU from respiratory failure due to severe pneumonitis.

Legal judgment was critical of failure to recognize new symptoms, and failure to follow the patient’s lung status while taking a medication that has known pulmonary toxicity.

Discussion: All medications must be monitored and reviewed on a regular basis. A physician should verify at all followup visits that all medications are necessary for management of the patient’s medical conditions. Medication errors are common causes of adverse medical events, including sentinel events. Medication errors are extremely common and often are the etiology of many adverse medical events.

Factors that Contribute to Patient Injury

The most common factors that contribute to patient injury include:

- Patient assessment issues;
Communication (or lack thereof) among providers;
Selection and management of therapy;
Communication between patient/family and provider; and
Failure to obtain a specialty consult.

**Patient Assessment Issue**

**Case example:** A 30-year-old woman who was taking a birth control medication presented to the emergency department with fever, chills, and pain radiating into her interscapular region. D-dimer levels were elevated. Her chest radiograph revealed a right lower lobe infiltrate. The presumptive diagnosis was pneumonia, and she was started on antibiotics.

In the early evening she complained of shortness of breath. Subsequently she was confused, and her oxygen saturation dropped to 86%. Later in the evening she died suddenly. The autopsy revealed a massive PE. Legal and expert review identified failure to consider available clinical factors to develop a broad differential diagnosis, failure to consider available information (elevated D dimer), and failure to order appropriate tests as contributing to the patient’s death.

**Discussion:** The failure to develop a broad differential diagnosis, act on available information, and obtain appropriate tests all can contribute to patient injury and, as in this case, death.

**Communication Among Providers**

**Case example:** A 49-year-old man was admitted with chest pain, headache, back pain, and numbness and tingling in his lower extremities. Blood pressure was 160/50 mm Hg in the right arm and 105/56 mm Hg in the left arm. The nurse failed to document these abnormal blood pressure findings, and she did not call the findings to the attention of the physician. The physician did not take the patient’s blood pressure. The patient was discharged home and later that evening was found dead. An autopsy revealed an aortic dissection. Lack of communication between the nurse and the physician and the physician’s lack of assessment were found to be critical factors in determining liability.

**Discussion:** Nurses failing to notify physicians of their findings is a common theme in liability determination for serious patient harm. Other cases involve physicians failing to read important clinical information documented in the medical record, and therefore being unaware of the changing clinical condition resulting in patient injury. Physician approachability and demeanor can play a critical role in nursing staff communication.

**Selection and Management of Therapy**

**Case example:** An 80-year-old woman with chronic obstructive pulmonary disease fell and fractured her femur. The patient successfully underwent rod placement for the fractured femur and recovered without adverse consequences. The family desired placement in a skilled nursing facility (SNF). The patient was discharged to a SNF on a Duragesic patch for pain management.

After two days at the SNF, the patient developed respiratory distress and became unresponsive. The staff did not respond because they believed the patient had a do not resuscitate (DNR) order in place. It was subsequently identified that the patient did not have a DNR order. The patient’s family alleged that the patient’s death was secondary to failure to monitor the impact of the Duragesic patch on the patient’s respiratory status, and failure to communicate the orders regarding resuscitation among the nursing staff. The case was settled before legal judgment.

**Discussion:** Cases of selection and management of therapy arise under various circumstances, including mismanaged pneumonia, sepsis, cardiac rhythm disturbances, and traumatic injuries, to name a few. Also, improper selection of medication, failure to order the most appropriate medication, or ordering the wrong medication are common allegations of contributing factors to a patient’s injury or death. Failure to carry out DNR orders fall within this category.

**Communication Between the Patient and Family and the Provider**

**Case example:** A 75-year-old woman with dilated cardiomyopathy, atrial fibrillation, and heart failure was hospitalized for increasing shortness of breath. The patient was anticoagulated and had a transesophageal echocardiogram before a cardioversion. The cardioversion procedure resulted in sinus rhythm. The patient was started on amiodarone, in addition to maintenance medications of digoxin and warfarin. The patient was discharged with a followup appointment in two weeks.

In 10 days, the patient returned after experiencing syncope resulting in a subdural hematoma. Her heart rate was 30 beats per minute. She was found to have digoxin toxicity, and her bleeding time was elevated. The subdural hematoma expanded, and she died in the hospital. The family sued because they were never instructed to decrease the digoxin level, and no digoxin level was ever drawn. They also argued they were never instructed regarding the interactions between digoxin, warfarin, and amiodarone. The case was settled prior to legal judgment.

**Discussion:** Communication skills challenge our society. It is important for physicians to communicate well, including educating patients and families about their medical conditions and treatment plans. Patient failure to understand medication effects and side effects and treatment plans is a common contributing factor to patient injury. Communication should occur and then be carefully documented in the medical record.
Failure to Obtain a Specialty Consult

Case example: A 62-year-old obese woman was admitted to the hospital with complaints of chest pain radiating into the left arm and shortness of breath. She had had similar complaints two weeks earlier and was admitted to the hospital. During the prior admission, myocardial injury had been ruled out. On the second admission, her initial ECG revealed nonspecific changes, but the troponin was mildly elevated in the setting of mildly impaired kidney function. The second set of enzymes was significantly elevated, and a STAT echocardiogram revealed a large anterior wall myocardial infarction. After the echocardiogram was obtained, a cardiology consult was ordered. The critical expert review identified that there was a failure to obtain a timely cardiology consult, which would have resulted in preventing injury to the patient.

Discussion: This category includes two situations: (1) the physician caring for the patient does not recognize the patient’s medical condition; and (2) the physician caring for the patient believes he or she can manage the case without assistance.

RISK MANAGEMENT PRINCIPLES

Risk management principles arise directly from an understanding of the common themes seen in allegations of physician negligence and patient injuries. The case examples we have discussed allow the reader to develop a collective understanding of the issues that require due diligence when practicing medicine to prevent allegations of negligence. The following are the golden rules of risk management when practicing medicine in a fast-paced medical environment:

- It is essential to perform a detailed medical history and comprehensive physical examination allowing for a broad-based differential diagnoses.
- Timely diagnosis is essential and depends on a thorough evaluation, timely ordering of diagnostic tests, and timely interpretation.
- If the generated differential diagnosis has the potential for serious sequelae or death, it is imperative to involve other specialists immediately.
- Communication and coordination of medical care is essential to good patient outcomes. Physicians must be accessible and responsive to nursing and paraprofessional staff.
- Communicating the differential thought process, pertinent performed evaluations, and pending test results to physicians when handing off patients to fellow physicians is imperative.
- Emphasize diagnostic dilemmas and patients with deteriorating medical conditions.
- Stay engaged with the specialist as the case evolves.
- Document noncompliance or refusal to follow treatment regimens using exact quotes from the patient and family.
- Take time with every patient. Build a rapport, and make the patient understand you have a partnership and that you are his or her fiduciary.
- Review all documentation to ensure awareness of all orders, consults, and changing conditions as reported in the nursing notes.
- Document all medical actions, all activities involved in coordination of care, and all discussions with patients, families, nurses, and physicians.
- Document all reviewed test results and action to be taken in response to diagnostic testing.

REFERENCES

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