Common Examples Of Malpractice in Cardiology

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Goals
What is the position of cardiology as regards malpractice lawsuits?

What is the position of cardiology?

• Unique position in the medical malpractice field because
  – Diverse physician-patient interactions (proceduralists and non-proceduralists)
  – Invasive procedures on very sick patients.
What is the position of cardiology?

• The annual percentage of cardiologists facing malpractice claim was 8.6%, compared to 7.4% among overall physicians.
Why it is important to study malpractice lawsuits?

• We cannot avoid all future malpractice lawsuits.

• However, studying previous suits may help us:
  – Decrease incidence of lawsuits
  – Provide excellent healthcare.

How can we learn about the commonest cardiology malpractice pitfalls?
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- Analysis of the details of closed claims of cardiology cases from:
  - Insurance companies
  - Medicolegal files

What are the most common forms of malpractice?

“the categories of negligence are never closed”
Negligence may occur at the stage of:

- Diagnosis
- Treatment
- Follow up

Documentati on

“What was not documented was not done”

“Good record is good defense.
Bad record is bad defense.
No record is no defense.”
Common pitfalls: Diagnosis

- Missed diagnosis (25% of closed cases).
- The most common misdiagnoses are:
  - **Myocardial infarctions**: by both cardiologists & other physicians.
  - **Non-cardiac conditions** that may present similarly to cardiac diseases, e.g. pulmonary embolism, aortic dissection, or cancer.
Case study: Atypical Pain

• A 44-year-old man had sudden back and shoulder pain while straining to start a snowmobile.
• He had a past history of MI
• The emergency physician interpreted ECG to have signs of old MI only.
• The diagnosis was muscle strain and patient was discharged home.

Case study: Atypical Pain (Cont.)

• A short time later, the patient’s pain was worsening & his friend called the same ED.
• Another emergency physician answered & prescribed diazepam for the patient’s pain - without asking for re-examination.
• The patient died at home 5 hours after his ED visit.
• Autopsy: the patient had extensive triple-vessel coronary disease & cause of death was acute MI.
Case study: Atypical Pain (Cont.)

• Lessons from this case:
  – Discharging this patient was improper.
  – The patient's chart was poorly documented.
  – The ED physician relied on the initial, normal ECG.
  – The second physician on phone call did not recommend re-examination; depriving the patient from a second chance to be correctly diagnosed.

Common pitfalls: Treatment
Common pitfalls: Treatment

- Lawsuits were raised against interventionalists, non-interventionalists, & electrophysiologists.
- Even expected complications triggered malpractice lawsuits.

We should ask why?

Common pitfalls: Treatment - Interventions

- Lawsuits stemmed from vascular complications: e.g. retroperitoneal bleeding, embolism, or coronary artery damage.
- Nearly 60% of the lawsuits against interventionalists involved left heart catheterization.
Case study: Delayed intervention

• A 55-year-old man suffered from substernal chest pain for 3 hours that was not relieved by nitroglycerin tablets.
• Past history of CAD and angioplasty 2 years ago.
• He presented to ED with pain, pallor, & diaphoresis.
• Vital signs, examination, & initial ECG were unremarkable.
• Pain persisted despite nitroglycerin, morphine, & aspirin.
• Heparin was withheld because of history of peptic ulcer.

Case study: Delayed intervention (Cont.)

• The on-call cardiologist advised urgent cardiac catheterization because of persistent symptoms.
• This procedure was not available in the hospital; and the cardiologist advised transfer to another nearby hospital.
• The patient was a member of a managed care organization (MCO) and wanted to obtain preauthorization for the transfer.
• Repeated cardiac enzymes and ECG were still normal.
Case study: Delayed intervention (Cont.)

- The managed care plan used a 3rd hospital for invasive cardiology, but no bed was available at that hospital after 1.5 hours.

- The patient’s pain continued. The cardiologist refused to come in. Six hours after presentation, a third ECG revealed acute anterolateral changes.

- Before transfer, the patient died 8 hours after presentation.

- The lawsuit was raised against the ED physician, the on-call cardiologist, the hospitals, the PCP, and the MCO.

Case study: Delayed intervention (Cont.)

- Lessons from this case:
  - Stabilization, specialty consultation, & transfer (if required), should be done promptly, inconsiderable of insurance or payment status.
  - The emergency physician assumes full responsibility for patient care while awaiting consultation or transfer.
  - Good documentation of all contact with consultants & other hospitals.
**Common pitfalls: Treatment - electrophysiology**

- Common malpractice lawsuits stem from:
  1) Arterial laceration during a pacemaker implantation or electrophysiology study
  2) Atrioventricular node damage during ablation that required pacemaker placement
  3) Pulmonary vein stenosis after ablation.

**Common pitfalls: Treatment - Medications**

- Lawsuits may arise from:
  - Non-prescription or delayed therapy
  - Adverse effects of the medications, e.g. lung & liver side effects from amiodarone, or severe bleeding from warfarin
**Case study: Contraindications to Thrombolytic Therapy**

- A 65-year-old male presented to ED with chest pain that started 2 hours ago.
- The diagnosis was acute anterolateral MI.
- Thrombolytic therapy was indicated in this patient.
- He had a past history of hypertension, DM, & vague history of stroke.
- The patient's chart did not show any CI to thrombolytics.
- The patient’s BP on admission was; and repeated BP measurements were nearer to the present 176/118 ing blood pressure.

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**Case study: Contraindications to Thrombolytic Therapy (Cont.)**

- The patient received IV nitroglycerin & thrombolytic therapy.
- 20 minutes after start of treatment, the patient became lethargic.
- A cardiologist was consulted (but didn't examine patient) and requested a head CT scan.
- Thrombolytics still continued, & patient began to complain of headache, & had slurred speech.
- Immediately after the CT scan the patient had a seizure.
- Thrombolytics were discontinued; CT scan showed intracerebral hemorrhage. The patient had severe neurologic deficit.
Case study: Contraindications to Thrombolytic Therapy (Cont.)

• Lessons from this case:
  – The patient’s previous stroke was hemorrhagic. The ED physician could have asked for a discharge summary.
  – Thrombolytics are relatively CI with high diastolic BP.
  – Patient's BP was poorly controlled. Use of BB or other drug was required.
  – Poor documentation on the chart of the blood pressure and the risks and benefits of thrombolytics.

Common pitfalls: Follow-up

SUCCESS is in the Follow Up!
Common pitfalls: Follow-up

- Failing to act promptly to routine or expected complications.
- Failure to detect &/or refer of non-cardiac conditions, e.g. non follow up of an incidental mass in a chest x-ray or CT scan (late-stage cancer).

*Take home message*
• Cardiologists should become aware of the most common diagnostic or procedural errors
• Meticulous informed consent. Autonomy, autonomy, autonomy.
• Careful documentation & follow up after a complication occurs.
• Look for the big picture: Non-cardiac issues should be carefully watched.