



Protecting Providers.  
Promoting Safety.

---

# Safer Care for Office Practice

Assessment and Diagnosis:

*Missing/Dismissing Signs & Symptoms*

---

# Opportunities for Improving Patient Safety

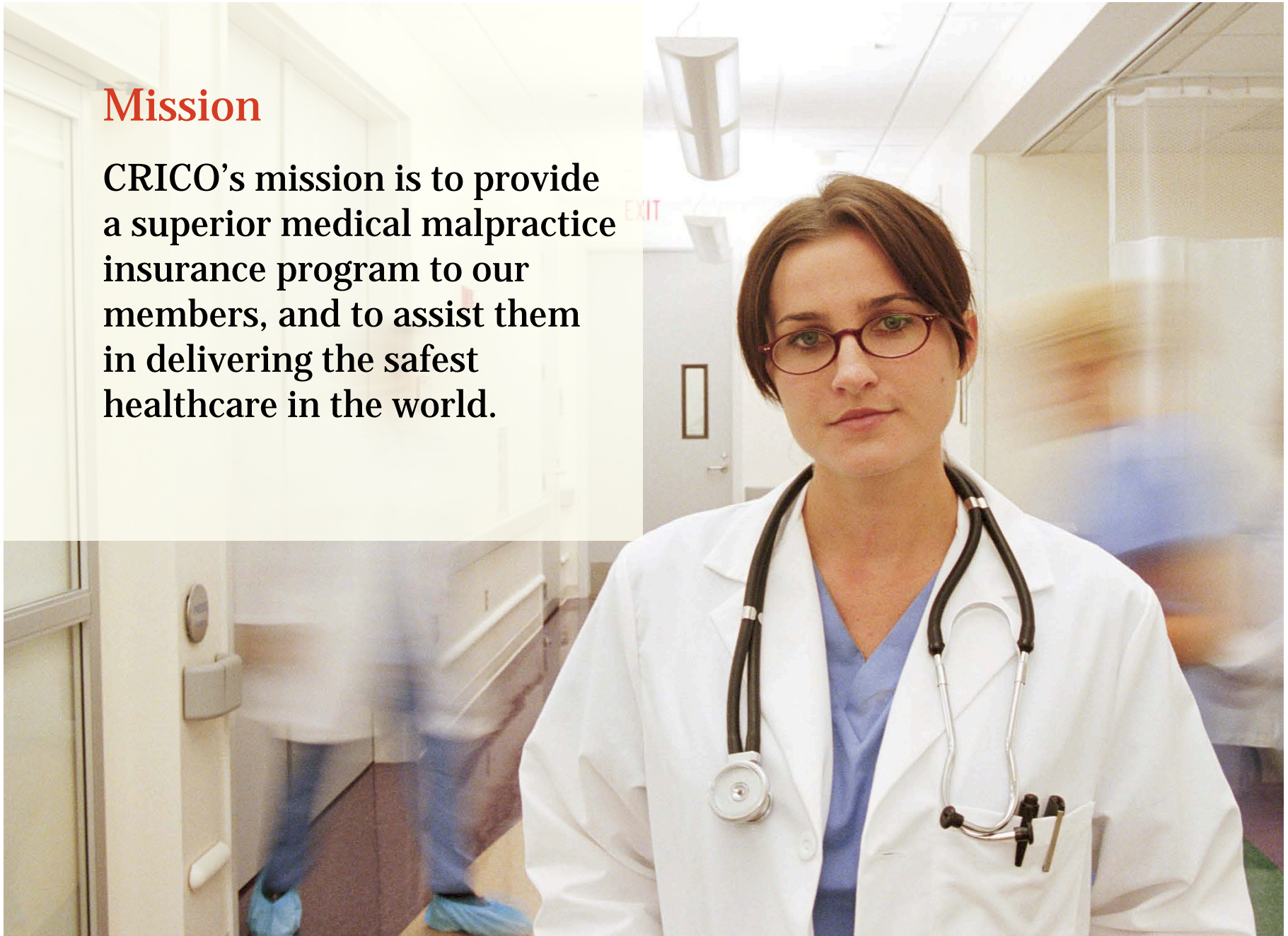
- **Identified through** CRICO's Office Practice Evaluation program and analysis of medical malpractice case data
- **Based on** real events that have triggered malpractice cases
- **Valuable lessons** in communication, clinical judgment, and patient care systems

## Purpose

- Help all members of office-based teams reduce the risk of patient harm in the course of diagnosis and treatment.
- Raise awareness and begin discussions about the patient safety issues that most commonly put ambulatory care patients and providers at risk.

## Mission

CRICO's mission is to provide a superior medical malpractice insurance program to our members, and to assist them in delivering the safest healthcare in the world.





# Controlled Risk Insurance Company (CRICO)

- Captive insurer of the Harvard medical institutions
- Provides member organizations medical professional liability, general liability and other insurance coverage for:
  - 12,400+ physicians (*including nearly 4,000 residents and fellows*)
  - 32 hospitals
  - 100,000+ employees (nurses, technicians, etc.)
- Services include underwriting, claims management, and patient safety improvement
- CRICO has been analyzing medical malpractice data to drive risk mitigation for more than 30 years

## CRICO Member Organizations

- Atrius Health
  - Dedham Medical
  - Granite
  - HVMA
- Boston Children's Hospital
- Cambridge Health Alliance
- CareGroup
  - Beth Israel Deaconess Medical Center
  - Beth Israel Deaconess Needham
  - Beth Israel Deaconess Milton
  - Mount Auburn Hospital
  - New England Baptist Hospital
- Dana-Farber Cancer Institute
- Harvard Pilgrim Health Care
- Presidents and Fellows of Harvard College
  - Harvard Medical School
  - Harvard School of Dental Medicine
  - Harvard T. H. Chan School of Public Health
  - Harvard University Health Services
- Joslin Diabetes Center
- Judge Baker Children's Center
- Massachusetts Eye and Ear Infirmary
- Massachusetts Institute of Technology
- Partners HealthCare System
  - Brigham and Women's Hospital
  - Brigham and Women's Faulkner Hospital
  - Massachusetts General Hospital
  - McLean Hospital
  - North Shore Medical Center
  - Newton-Wellesley Hospital
  - Spaulding Rehabilitation Hospital



# Malpractice Data Overview

## Focus: Ambulatory Diagnosis-related Allegations

# 47% of CRICO malpractice cases occur in the ambulatory setting.

35% of ambulatory cases allege a wrong or delayed diagnosis.

**1,161**  
cases

**\$618M**  
losses\* • filed 2009–2013

**544**  
cases

**\$237M**  
losses\* • filed 2009–2013, *and*  
• involving ambulatory care\*\*

**194**  
cases

**\$162M**  
losses\* • filed 2009–2013, *and*  
• involving ambulatory care,\*\* *and*  
alleging a wrong or delayed diagnosis

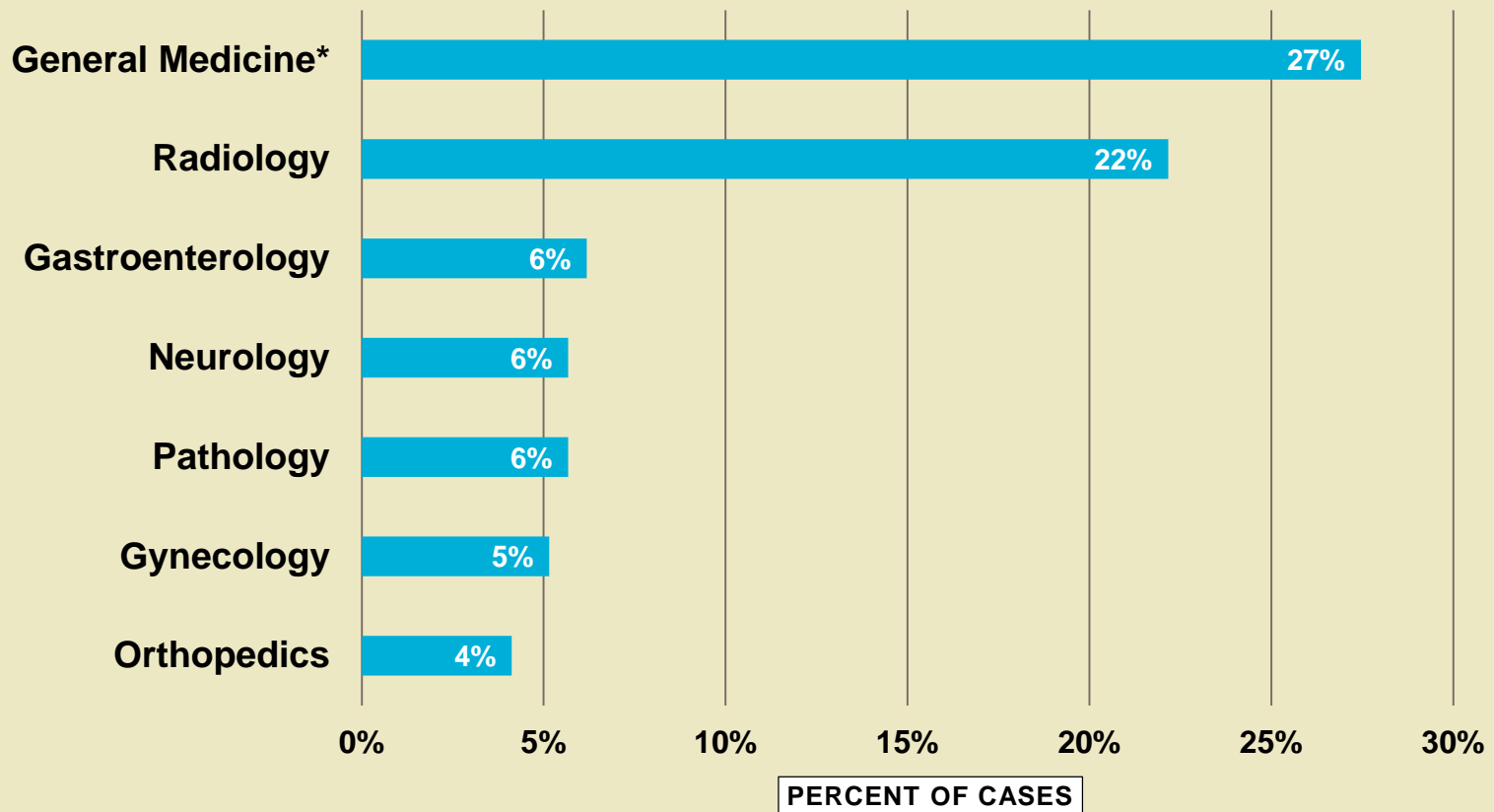
\*Losses are “total incurred losses,” which includes reserves on open and payments on closed cases.

\*\*Ambulatory care cases involve an outpatient but exclude cases occurring in Emergency departments.



# General Medicine and Radiology are most frequently involved.

The Clinical Service Responsible for the Patient's Care at the Time of the Event

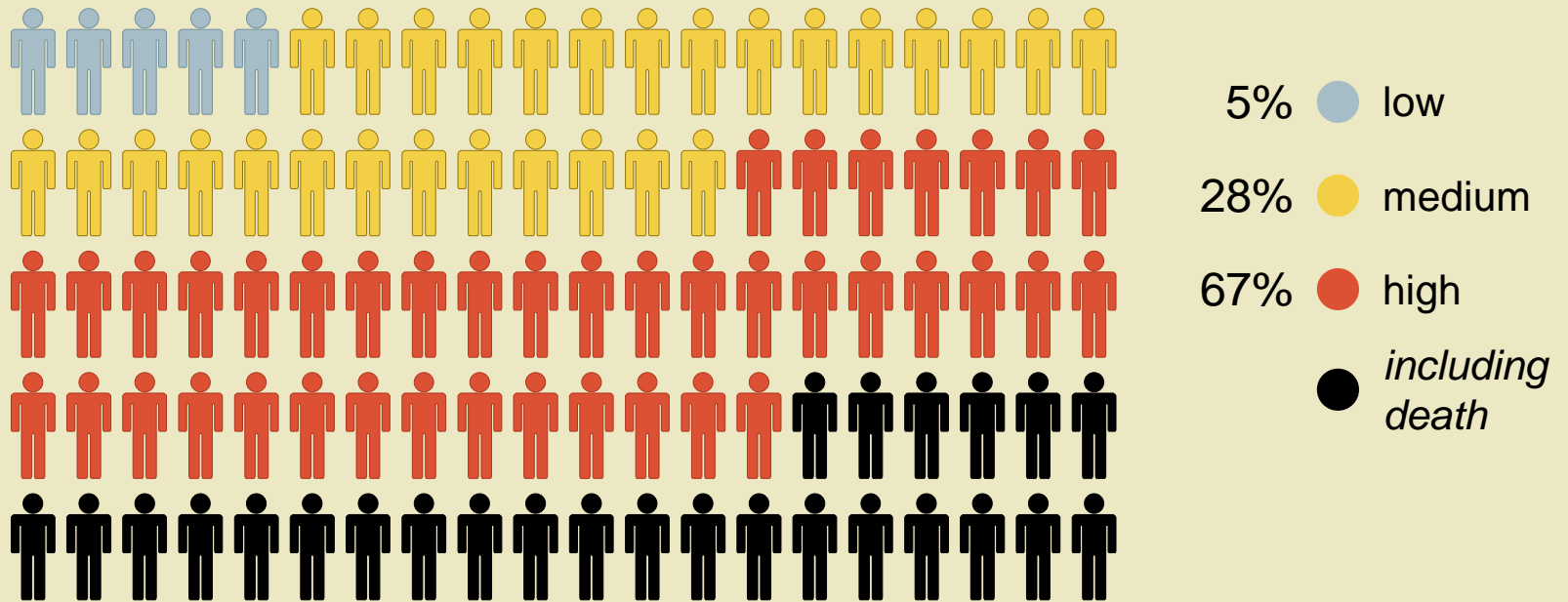


CRICO N=194 MPL cases asserted 1/1/09–12/31/13 involving ambulatory care and alleging diagnostic failure.

\*General Medicine includes Internal Medicine and Family Practice.

# Two-thirds of cases involve permanent injury or death.

## Injury Severity in Ambulatory Diagnosis Cases



CRICO N=194 MPL cases asserted 1/1/09–12/31/13 involving ambulatory care and alleging diagnostic failure.

Severity Scale: High=Death, Permanent Grave, Permanent Major, or Permanent Significant  
Medium=Permanent Minor, Temporary Major, or Temporary Minor  
Low= Temporary Insignificant, Emotional Only, or Legal Issue Only

## 60% of 194 ambulatory diagnosis-related cases involve a cancer-related allegation.

- The top ambulatory diagnosis-related allegations in CRICO ambulatory malpractice cases are:
  - Cancers (top three: breast, lung, colorectal)
  - Diseases of the heart
  - Fractures

# Case Study: Assessment and Diagnosis

## Missing/Dismissing Signs & Symptoms

The following example is from a closed malpractice case.

# CRICO maps contributing factors to the way care is experienced by the patient.

## CRICO Diagnostic Process of Care

STEP	CRICO % CASES	CBS % CASES
1. Patient notes problem and seeks care	2%	1%
2. History/physical	8%	7%
3. Patient assessment/evaluation of symptoms	39%	26%
4. Diagnostic processing	45%	34%
5. Order of diagnostic/lab test	43%	31%
6. Performance of tests	6%	3%
7. Interpretation of tests	32%	23%
8. Receipt/transmittal of test results (to provider)	3%	5%
9. Physician follow up with patient	26%	18%
10. Referral management	11%	19%
11. Provider-to-provider communication	13%	12%
12. Patient compliance with follow-up plan	8%	15%

\*A case will often have multiple factors identified.

CRICO N=194 MPL cases asserted 1/1/09–12/31/13 involving ambulatory care and alleging diagnostic failure.

CBS (Comparative Benchmarking System) includes >300,000 medical malpractice cases across the nation

CBS N=2,685 MPL cases asserted 1/1/09–12/31/13 involving ambulatory care and alleging diagnostic failure.

# Malpractice case study focus: Assessment and Diagnosis

45%

of cases

had an error in **diagnostic processing** identified as a contributing factor, i.e., a narrow diagnostic focus, failure to establish a differential diagnosis, or reliance on a chronic condition or previous diagnosis

CRICO N=194 MPL cases asserted 1/1/09–12/31/13 involving ambulatory care and alleging diagnostic failure.

## Case Study



### *Patient*

Ted, 57-year-old male w/history of two MIs, sleep apnea, and hypertension

### *Day 1*

Ted is seen in his PCP's office for complaints of jaw pain (8/10 severity) and chest tightness. Vital signs are reported as normal; exam reveals good range of motion in jaw.

## Case Study

Ted, 57-year-old male



### *Day 1 (continued)*

Ted's PCP believes his jaw pain may be related to the CPAP mask Ted uses for sleep apnea. He diagnoses temporomandibular joint (TMJ) disorder.



## Case Study

Ted, 57-year-old male



### *Day 1 (continued)*

Ted had two previous EKGs showing myocardial damage, however, the provider does not retrieve them at the time of the visit and no cardiac workup is performed.

## Case Study

Ted, 57-year-old male



### *Day 5*

Ted presents to the ED with nausea and vomiting. Upon further evaluation, he is diagnosed with an MI, then progresses into cardiogenic shock.

## Case Study

Ted, 57-year-old male



### *Outcome*

- Further testing reveals a lateral wall myocardial rupture, requiring surgery.
- Ted's condition worsens, he suffers kidney and liver failure, and subsequently dies from advanced system failure.

## Case Study

Ted, 57-year-old male



### *Vulnerability*

Fixation on Ted's complaint without full assessment of his symptoms and history led to a narrow focus and a missed diagnosis.

### *Safer Care Recommendation*

Be aware of any tendency toward cognitive fixation. Techniques to avoid this include:

- Expanding differential diagnoses
- Seeking additional information from the patient and the medical record
- Engaging a peer consult for patients with continued, unresolved symptoms

# Practice Assessment

Has this type of event ever happened here?

## Practice Assessment

### Assessment and Diagnosis: *Missing/Dismissing Signs & Symptoms*

*What type of trigger or templates do we use to obtain and update patient history that may be missed (e.g., family history, previous testing or procedures)? Whose responsibility is it to update this information?*

### *Recommended Practice*

- To avoid narrow diagnostic focus, broaden the list of diagnostic possibilities via history and physical.

# Practice Assessment

Assessment and Diagnosis: *Missing/Dismissing Signs & Symptoms*

*Do we cut and paste information in medical records (without reviewing it)?*

## *Recommended Practice*

- Review all content that is not originated in an individual patient's record for appropriateness and accuracy.

## Practice Assessment

Assessment and Diagnosis: *Missing/Dismissing Signs & Symptoms*

*Do we have a process to retrieve and update pertinent patient medical records?*

### *Recommended Practices*

- Use checklists for triggering questions related to patient history that may be missed (e.g., family history, previous testing)
- Embed decision support tools in EHR to assist in maintenance of patients histories.



## Practice Assessment

Assessment and Diagnosis: *Missing/Dismissing Signs & Symptoms*

*Does our culture support/encourage providers to ask for peer help when the patient situation is confounding?*

### *Recommended Practice*

- Seek a consult for patients who return repeatedly for the same symptoms.

# Practice Assessment

Missing/Dismissing Signs & Symptoms

*What else can we do to avoid a similar event?*

# Additional Resources

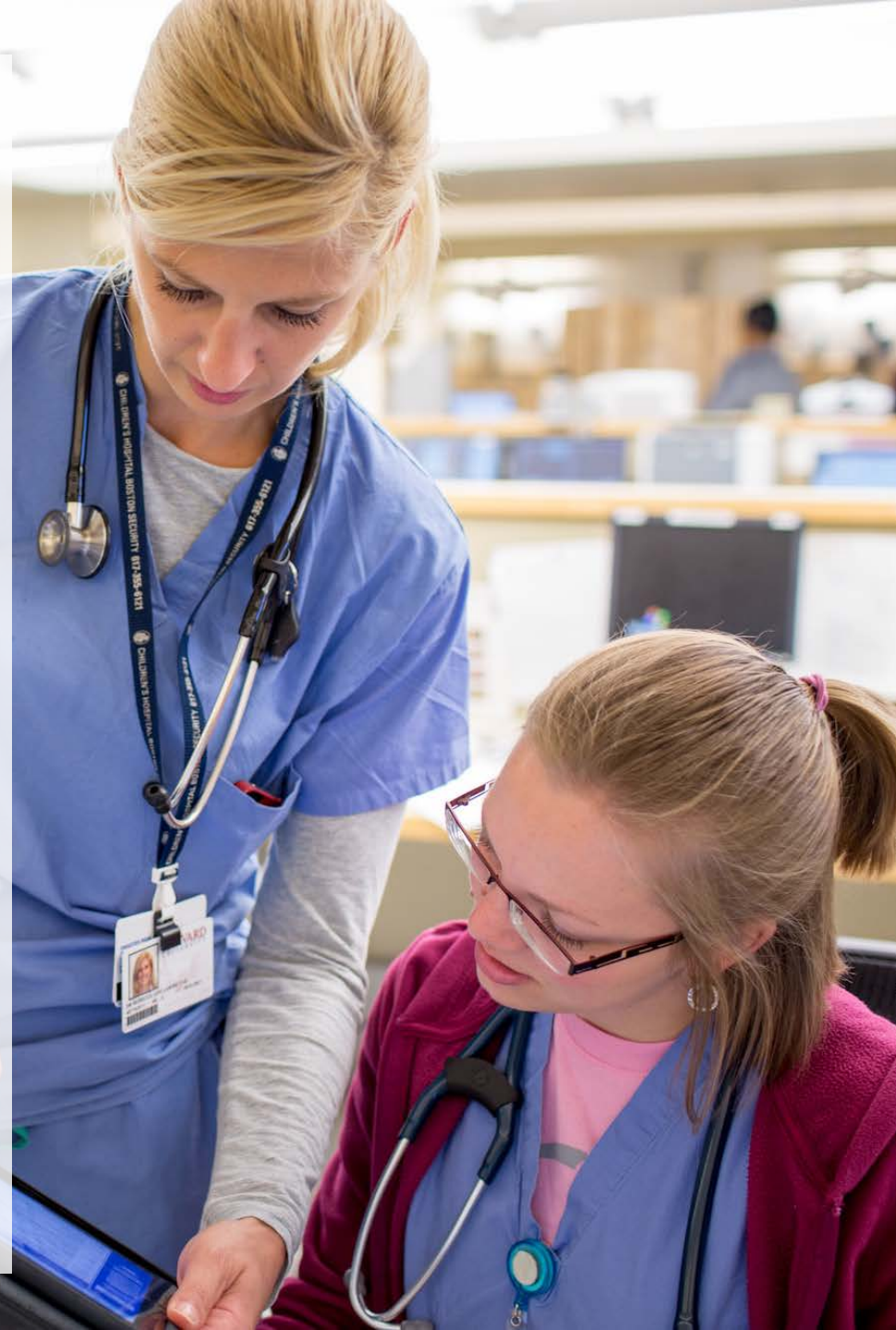
Assessment and Diagnosis:  
*Missing/Dismissing  
Signs & Symptoms*

[Safer Care extras](#)

For more information

[Email](#)

[safecare@rmf.harvard.edu](mailto:safecare@rmf.harvard.edu)



# Facilitator's Guide

This Guide supports presentation of a CRICO *Safer Care* module via the print, online, and presentation format.

---

## Purpose

CRICO's [Safer Care modules](#) provide a brief overview illustrating how a systems-based problem in an office practice led to an actual malpractice case. For each module, the vulnerabilities that most likely triggered the malpractice allegation are highlighted, along with recommended best practices, discussion questions, and prompts to assess your practice's processes related to the risks identified in the case. Together, the components of each module can help you identify opportunities to improve your practice.

---

## Audience

The *Safer Care* modules draw on experiences from primary care providers in Internal or Family Medicine practices. However, many of the inherent lessons are applicable to outpatient specialty care practices. The modules are intended for all members of your team (physicians, advanced care providers, nurses, medical assistants, allied health professionals, administrative staff). Each module highlights ambulatory patient safety risks/vulnerabilities to stimulate discussion and help your practice identify opportunities to assess and (if necessary) improve systems.

---

## Feedback to CRICO

Please help improve and expand the value of the *Safer Care* modules by sharing feedback about the content and the learning process with CRICO via [safercare@rmf.harvard.edu](mailto:safercare@rmf.harvard.edu).

## WHAT YOU WILL NEED

- Computer and projector, or handouts
- Enough time (e.g., 30 minutes) to discuss the patient safety concerns that relate to your practice

## PREPARATION TIPS

- Do a test run (preferably in the actual venue) to ensure that all equipment is working correctly

## PRESENTATION COMPONENTS

(applies to all *Safer Care* module slide presentations)

1. Background (slides 1–6): CRICO's role in patient safety
2. Malpractice data (slides 7–11): focus on ambulatory diagnosis related allegations
3. Diagnostic process of care vulnerabilities (slides 13–14): vulnerabilities identified in the diagnostic process of care via malpractice cases. CRICO's coding taxonomy enables data analyses from patient access to the health care system to diagnosis to follow-up plan, and helps identify common breakdowns throughout the process.
4. Closed malpractice case chronology: follows the case from initial presentation to outcome
5. Vulnerabilities from case: one or two aspects of the case that most likely triggered the allegation of malpractice, with recommendations for avoiding similar missteps
6. Practice assessment and improvement opportunities: each module features a quick assessment, with questions related to the case example and the underlying patient safety issues. While each module features topic-specific questions, all begin with "Has this type of event happened at our practice?"
7. [Safer Care extras](#): Links to additional topic-related content on the CRICO website, including case studies, decision support tools, and evidence-based articles.

## Facilitator's Guide: Assessment and Diagnosis

**Risk:** Missing/dismissing signs and symptoms



### Discussion Tips

Each Safer Care module includes prompts for discussing the vulnerabilities exposed by the case example, and for assessment of your practice/systems. Focus on the broader patient safety issues that may impact future care. Limit narrow analyses of the facts, this case is an illustrative example to initiate discussion.

- Acknowledge that discussions about medical errors, delays in care, or patient grievances are difficult for the individuals involved and impacts the entire care team/practice.
- Frame the conversation, for example: the purpose of this discussion is to learn from what occurred, identify opportunities to improve the system, and prevent recurrence of a similar event
- Recognize that everyone comes to work to help others but, at times, systems do not support the individual.
- Engage multiple perspectives in discussions related to patient safety vulnerabilities by soliciting input from all disciplines.

### Practice Assessment & Improvement Tips

This is a team-wide opportunity to review whether this could happen at your practice and identify improvement opportunities.

### CASE CHRONOLOGY

*57-year-old male with a history of two myocardial infarctions, sleep apnea, and hypertension*

#### Day One

- Patient seen in PCP's office for jaw pain (8/10 severity) and chest tightness. Vital signs are normal, physical exam reveals good range of motion in jaw.
- *Result:*
  - PCP suspects jaw pain related to CPAP mask, diagnoses temporomandibular joint (TMJ) disorder
  - PCP does not review medical records (which includes two EKGs showing myocardial damage)
  - PCP's differential diagnosis did not include a cardiac etiology. No further diagnostic studies or evaluation were completed

#### Day 5

- After feeling unwell (nausea and vomiting), Ted goes to ED for evaluation
- Diagnosed with an MI
- Progresses into cardiogenic shock

### OUTCOME

- Further testing reveals lateral wall myocardial rupture, requiring surgery
- Condition worsens, patient suffers kidney and liver failure, and subsequently dies from advanced system failure
- *Case Disposition: Settled in the mid-range (\$100,000–\$499,999)*

### KEY LESSONS

- Beware of any tendency toward cognitive fixation. Techniques to avoid this include:
  - expanding differential diagnosis—explore key aspects of case with peers to broaden thinking;
  - seeking additional information from the patient and the medical record—ask for family history at each encounter (i.e., this is not static information)—changes may have occurred since the last visit that would trigger a different diagnostic workup; and
  - engaging a peer consult for patients with continued, unresolved symptoms—repeating presenting symptoms may be a sign that diagnosis is not accurate—convene and consult with peers to expand diagnostic thinking.