

# 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?**

## **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?**

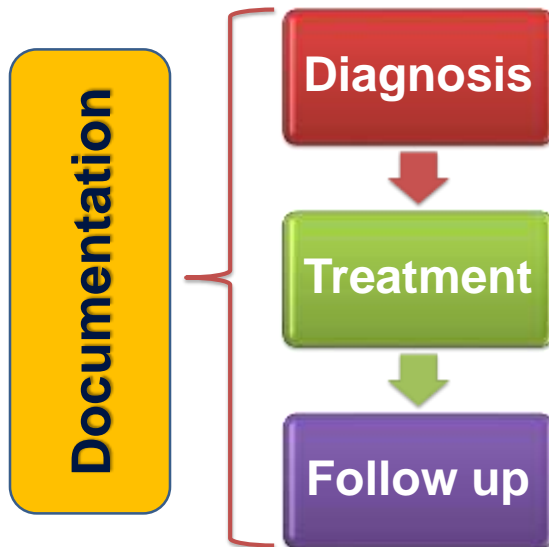
## **How can we learn about the commonest cardiology malpractice pitfalls?**

- 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:



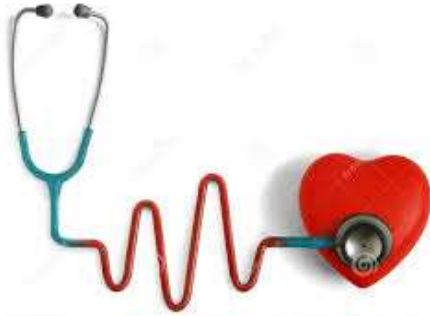
**Documentati  
on**



**“What was not documented was not done”**

**“Good record is good defense.  
Bad record is bad defense.  
No record is no defense.”**

## Diagnosis



### 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.*)

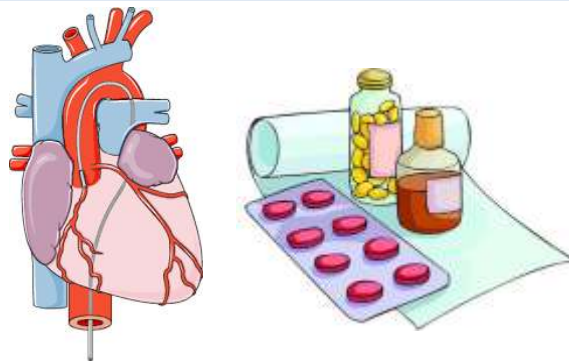
- A short time later, the patient's pain was worsening & his friend called the same ED.
- Another emergency physician answered & prescribed diazepam for the patient's pain - without asking for re-examination.
- The patient died at home 5 hours after his ED visit.
- Autopsy: the patient had extensive 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 3<sup>rd</sup> 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 mmHg blood pressure.


### **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*





## THE **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.

