Physiatrists and physical therapists work to improve and restore functionality to patients who have injuries and impairments affecting the musculoskeletal system and the brain/spinal cord. These providers are an integral part of a patient’s rehabilitation care team, and are not immune to the risk of allegations of malpractice.

Allegations noted in Figure 1 are the most frequent across this data set.

**Figure 1. Top Allegation Categories by Responsible Service Type**

<table>
<thead>
<tr>
<th>Category</th>
<th>Physiatrist</th>
<th>Physical Therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnosis-related</td>
<td>24%</td>
<td>4%</td>
</tr>
<tr>
<td>Medication regimen mgmt.</td>
<td>24%</td>
<td>10%</td>
</tr>
<tr>
<td>Performance of treatment</td>
<td>33%</td>
<td>8%</td>
</tr>
<tr>
<td>Mgmt of course of treatment</td>
<td>14%</td>
<td>3%</td>
</tr>
<tr>
<td>Patient falls</td>
<td>22%</td>
<td>9%</td>
</tr>
<tr>
<td>Mgmt of post-op surgical patients</td>
<td>5%</td>
<td>5%</td>
</tr>
<tr>
<td>Other patient safety events</td>
<td>1%</td>
<td>14%</td>
</tr>
</tbody>
</table>

Diagnostic delays/failures and management of medication regimens are most frequent in the physician-involved claims, while physical therapists are most often involved in claims of patient injuries occurring during rehabilitation sessions, including patient falls, burns, and worsening of existing injuries. A few inpatient instances of inadequate pressure ulcer prevention were noted as well. Several case examples are noted beginning on page 3.
**Clinical Setting**

**Figure 2. Patient Type**

Almost two-thirds (62%) of claims arise from outpatient settings, including offices, clinics and therapy facilities. Inpatient claims arise in rehabilitation facilities and patient hospital rooms. Physiatrists are most often associated with the inpatient claims while physical therapists are noted more frequently in outpatient claims (Figure 2).

**Clinical & Financial Severity**

Diagnostic and medication-related events are associated with a much higher percentage of clinically severe patient outcomes (Figure 3).

**Figure 3. Clinical Severity by Allegation Category**
Higher clinical severity injuries are also associated with inpatient claims more often than with outpatient claims.

Treatment-related claims, which most often involve performance of patient therapy sessions and administration of pain management injections (particularly those involving the spine), account for 32% of total dollars paid (expense + indemnity). Diagnostic claims account for 26% of the total dollars, but on average are more than twice as expensive as any other rehab-related claim.

Physiatrist-involved claims are, on average, twice as expensive as physical therapy claims.

**Case Examples**

**Diagnostic:** A patient in his mid-40’s was referred to a physiatrist for evaluation of bilateral leg spasticity and an abnormal gait. Lumbar and thoracic MRIs were ordered and revealed multi-level degenerative changes in the spine. A cervical MRI was not ordered. The radiologist called the physiatrist to inform her that the degenerative changes noted would not explain the patient’s leg symptoms. However, no additional testing was ordered. Five months later, the patient’s symptoms had not improved despite ongoing therapy, and he was then involved in a vehicle accident which necessitated a cervical MRI. That test revealed significant spinal cord impingement from C4-C6 due to disc bulges. Despite surgery, the patient sustained permanent damage to his spinal cord due to what was discovered to be long-term compression resulting in pain and gait difficulties.

Note: Missed and delayed diagnoses in this data set were varied, and also included instances of deep vein thrombosis, clostridium difficile, fractures and post-operative surgical complications.
Medication: A patient in her late 60’s with a history of long-term narcotic use was referred to a physiatrist for management of intractable lower back pain. Extended release morphine was prescribed, and a controlled substance agreement with the patient was signed. The patient went through a course of physical therapy and sacroiliac injections. One month later, she returned with complaints of significant pain even while on the morphine. The physiatrist performed another sacroiliac injection and prescribed fentanyl patches. The patches were refilled several times thereafter at a pharmacy, but there were no further office visits and no documented refill authorizations in the patient’s office chart. The patient was found unresponsive in her home; an autopsy revealed death due to fentanyl intoxication.

Performance of treatment: During an initial therapy evaluation, the therapist was testing the strength and flexibility of the patient’s legs. The therapist asked the patient to point with his big toe on the left leg and then stretch with all weight on the right leg. The patient felt a snap and his right knee began to swell immediately. An x-ray revealed a torn meniscus which required surgical repair. The exercises used by the therapist were acceptable, but were deemed to be too aggressive for this particular patient.

Management of treatment: A patient who was taking an anticoagulant received a cortisone injection to his hip following complaints of recurrent pain with movement. A few days later, he was experiencing severe hip pain. He was found to have a hematoma which complicated his healing process. The physiatrist’s record did not note whether or not consideration had been given to stopping the anticoagulant prior to the injection, nor whether or not the patient had been informed of the risk of bleeding with injection.

Patient fall: An elderly patient who had recently undergone a total hip revision was referred for physical therapy. During one session, while the therapist was not standing within reach of her, the patient lost her balance and fell forward, dislocating her shoulder, tearing her rotator cuff and fracturing her left femur.
**Management of post-operative patients:** A patient who had recently undergone surgical repair of a pelvic fracture was referred for inpatient therapy. Orders were in place for non-weight bearing except during transfer. The day after admission, the patient ambulated during a physical therapy session. The physiatrist participated in the patient’s case conference, and noted that she had been ambulating well. No mention was made of the original non-weight bearing orders. Two weeks later, the patient was noted to have non-union of the surgical repair. She required an additional surgery and 12 weeks of immobility.

**Other patient safety events:** A patient in his mid-70’s was undergoing physical therapy as he recovered from a total knee replacement. The foot rests on his wheelchair had been removed during therapy, allowing the therapist to follow closely behind him as he ambulated with a walker in case he became tired and needed to sit down. Upon completion of the session, the therapist did not replace the foot rests while she pushed the patient in his chair back to his room. The patient was unable to hold up his surgical leg; it dropped and became caught in the wheel. He sustained a tear of the patella tendon.

**The Intersection of Events: Risk Factors**

Adverse patient outcomes rarely arise from a single cause; inadequate patient assessments, ineffective communication between members of the patient’s rehabilitation team, improper performance of therapeutic interventions and even patient behaviors can all contribute to an adverse outcome.

Analysis of risk factors aids in the understanding of process of care deficiencies in physical rehabilitation cases. Most cases involve more than one risk factor, and all categories noted in Figure 4 consist of several sub-categories (as displayed in Figure 4a).
Many of the factors noted in Figures 4 and 4a are common across both therapist and physician-involved claims. Diagnostic testing and referral issues are of course more prevalent in the physician data, while inadequate patient monitoring and instances of worsening of injuries during therapy sessions or the occurrence of new injuries were more common in the therapist data.

Communicating effectively in a collaborative environment is a high priority in healthcare. Successful communication is vital to ensure rehabilitation patient safety and to reduce the risk of errors. However, communication breakdowns were noted in almost one-fourth of the
rehabilitation claims. Failure to clarify surgeon or primary care provider orders for rehabilitation medication regimens (especially anticoagulants) and permissible activity levels were the most prevalent communication-related scenarios.

**Resources**

- Checklist: Effective Communication
- Article: Clinical Judgment in Diagnostic Errors
- Article: Bias in Pain Management

**Data Source**

MedPro Group closed claims data, 2008-2017

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