RESEARCH LETTER

Medical Professional Liability Claims Related to Esophageal Cancer Screening

Endoscopic screening for esophageal adenocarcinoma has been recommended for patients with chronic symptoms of gastroesophageal reflux disease, but only if they have additional risk factors. Surveys of gastroenterologists indicate that concern about litigation for missing a cancer may drive endoscopy use in patients at low risk for esophageal adenocarcinoma. However, the perception of medical professional liability may not accurately reflect the true incidence of liability claims.

Although the rate of serious adverse events arising from esophagogastroduodenoscopies is small, 6.9 million esophagogastroduodenoscopies were performed in the United States in 2009. We hypothesized that the incidence of medical professional liability claims alleging failure to screen for esophageal cancer is less than the incidence of claims alleging complications from esophagogastroduodenoscopy performed with inadequate indication.

Methods | This study was determined exempt by the Ann Arbor VA human studies committee. PIAA (formerly, Physician Insurers Association of America) is an insurance trade association, representing medical professional liability insurance companies that collectively insure more than two-thirds of private practice physicians. In 2012, approximately 50% of member insurers contributed claims data to PIAA’s Data Sharing Project, the largest US medical professional liability claims database. Data accuracy is enhanced through specific protocols for coding and validating data and training abstractors; however, data accuracy has not been formally evaluated.

We performed 2 queries using International Classification of Diseases, Ninth Revision, codes. First, we identified all claims relating to a diagnostic esophagogastroduodenoscopy (1985-2012), and then restricted to claims alleging inadequate indication for esophagogastroduodenoscopy. Second, we identified claims related to esophageal cancer restricted to those alleging delay in diagnosis. We then excluded claims in which the presenting condition was an alarm symptom or sign (defined as weight loss, dysphagia, or iron deficiency anemia), and those in which the presenting condition was an esophageal or cardia malignancy or an abnormal radiographic finding. Data on the presenting symptom were only available for 2002-2012.

Results | The database contained 278,220 claims filed against physicians in 1985-2012, and 103,381 in 2002-2012. A total of 761 claims in 1985-2012 were related to esophagogastroduodenoscopy (193 paid, 25.4%; average indemnity, $242,414). The leading types of misadventure alleged were improper performance (n = 267), errors in diagnosis (n = 186), and no medical misadventure (ie, claims that did not involve a purely medical error, such as abandonment, breach of confidentiality, or consent issues) (n = 147). Seventeen claims (2.2%) alleged inadequate indication for esophagogastroduodenoscopy (8 paid, 47.1%; average indemnity, $174,634). Due to the small number of cases, database policies restricted access to information regarding presenting condition.

A total of 268 claims in 1985-2012 involved esophageal malignancies, including 122 in 2002-2012 (30 paid, 24.6%; average indemnity, $354,175). Of these 122 claims, 62 (50.8%) alleged delay in diagnosis. Nineteen claims reported nonalarm presenting symptoms (4 paid, 21.1%; average indemnity, $475,000) (Table).

Discussion | We sought to contextualize the incidence of reported medical professional liability claims in acts of omission (failure to screen) by comparing it with the incidence of reported liability claims in acts of commission (arising from complications of esophagogastroduodenoscopy in which the indication was insufficient). We found a low incidence of reported medical professional liability claims against physicians for failure to screen for esophageal cancer in patients without alarm features (19 claims in 11 years, 4 paid). In contrast, in 28 years, there were 17 claims for complications from esophagogastroduodenoscopies with questionable indication (8 paid). This suggests that the risks of medical professional liability claims arising from acts of commission as well as acts of omission in endoscopic screening are similarly low.

Limitations include an inability to distinguish squamous cell carcinoma from adenocarcinoma, potential for misclassification of alarm symptoms, and the lack of data on present-
ing medical symptom for claims alleging inadequate indication for esophagogastroduodenoscopy or how many occurred in 2002-2012.

There may be legitimate reasons to screen for esophageal cancer in some patients, but our findings suggest that the risk of a medical professional liability claim for failing to screen is not one of them. Physicians need to balance the risk of complications from diagnostic procedures, even if those complications are rare.

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Study concept and design: Adams, Rubenstein.

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COMMENT & RESPONSE

Medications for Alcohol Use Disorders

To the Editor The review by Dr Jonas and colleagues1 of the efficacy of medications to treat alcohol use disorders concluded that “well-controlled trials of disulfiram did not show overall reductions in alcohol consumption.” Although the conclusion may be true for the studies included in the review, double-blind randomized clinical trials are not the correct design to test the efficacy of a medication that works because patients know they are taking it and that it will make them sick if they drink alcohol. Participants assigned to receive placebo or active medication are both warned of the disulfiram-ethanol reaction, and they will act based on that belief and take or not take the medication, and avoid alcohol or not, accordingly. Some may experiment with alcohol to unblind themselves, but the majority will not.

More appropriately designed studies to test disulfiram efficacy were performed decades ago and compared monitored (eg, observed or facilitated pill taking) with unmonitored pill taking. Four randomized trials2-5 showed substantial differences in abstinence with durations of 8 weeks (7% vs 40%), 6 months (55% vs 90%), 6 months (47% vs 73%), and 2 years (79% vs 98%). Follow-up in these trials ranged from 78% to 100% except in one study’s unmonitored group, in which it was 39%.2

Medications for alcohol use disorders only work when they are taken. Randomized trials of these medications go to substantial lengths to ensure adherence. But disulfiram is different in that its mechanism of action is closely tied to decisions to take or not take it (it not only has no reinforcing effects, it threatens the patient with severe unpleasantness should they slip and have a drink). The proper trial design is a departure from the traditional placebo-controlled study.

Although disulfiram is difficult to use in practice because of risks and efforts needed to ensure it is actually taken, it should not be avoided for lack of efficacy. All efficacious treatments for this often fatal disease for which there are only modestly efficacious treatments need to be used.

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