Medical Mishap and Negligence: It happens in the Outpatients too

When we consider medical negligence and clinical error we think of busy hospitals late at night and at week-ends. We think of crowded emergency medicine departments, complex surgery and the critically ill ICU patient. We think of prescribing errors in the administration of psychoactive or psychotropic therapy. We think of high risk specialties such as obstetrics, anaesthesia and surgery. We are less likely to think of ambulatory care or non-interventionist specialty as an important source of litigation. This is remis on our part. Risks in this setting have gone relatively unnoticed. There 30 times more outpatients than inpatients annually. In the US there are 900 million outpatient visits compared with 30 million inpatients. It is not surprising that this quantum of patient-doctor interaction should also be a source of litigation claims. Furthermore it is likely to continue rising with the increased numbers of procedures now being undertaken at outpatients.

Bishop et al in an analysis of 10739 malpractice cases found that 47.6% of claims were for inpatients, 43.1% of claims were for outpatients and the remaining 10% of claims involved both. For, inpatients surgical mishaps and treatment problems predominated while diagnostic errors were the main cause for outpatients. Wachter et al in a more detailed but similar analysis found that the causes of outpatients mishaps were failure to undertake a proper history or physical examination, failure to order an appropriate test 55%, incorrect interpretation of test results 37%, the risk of compliant response 49%. In 80% of outpatients the patient presented late and were found to have a pre-existing condition. They also noted that patients are often aware of the medicolegal aspects of their care. Wachter et al in an editorial in this issue highlights the future importance of the Electronic Health Record. EPIC has made great strides in this area but hospitals lag far behind. In the current system it is very difficult for the doctor in the outpatients to bring together the case notes, laboratory results, radiological findings, the discharge medication and the correspondence from other specialists. Algorithms and care pathways for common conditions and bundles of symptoms can improve the general diagnostic standards. Care pathways are particularly relevant with their emphasis on time. Failure to act or diagnose in a timely fashion is a common criticism of outpatient activity.

One reservation is whether a reduction in malpractice will accurately reflect an improvement in clinical care or just mechanisms of avoiding liability. At its outset the purpose of the liability system was to encourage institutions to provide an optimal safety level. The idea is that it would encourage doctors to use greater care in practice. On the negative side it may cause doctors to avoid high risk sick patients. It will also encourage low volume patients to be referred inpatient care in the hope of avoiding negligence claims. Furthermore it is likely to continue rising with the increased numbers of procedures now being undertaken at outpatients.

All commentators are in agreement that there needs to be an increased culture of safety in the organisation of the outpatients. Ambulatory practice must be developed along the lines of inpatient care. This will require additional investment. One of the challenges is that there are many more patients to see compared with inpatient. Also since the older are too small to have sufficiently well-trained staff. The outpatient problem can be significantly alleviated with the roll out of information technology. The goal must be to develop and invest in electronic medical records. Electronic programmes can track results and referrals which are two of the commonest causes of breakdown in the outpatient setting. The PACS system for storing and reporting radiological investigations has been a major advance in patient care and may reduce some of the commonest causes of breakdown in the outpatient setting. The purpose of the liability system was to encourage institutions to provide an optimal safety level. The idea is that it would encourage doctors to use greater care in practice. On the negative side it may cause doctors to avoid high risk sick patients and to make unnecessary tests and referrals. It may drive up the cost of health care leading to poorer access and lower quality of care. Much remains to be learnt about litigation in the outpatient and ambulatory setting. There needs to be increased emphasis and analysis of this aspect of medical activity.

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