

# 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 potent intravenous therapy. We think of high risk specialties such as obstetrics, anaesthesia and surgery. We are less likely to think of outpatients/ ambulatory care or a non-interventionist specialty as an important source of litigation. This is remiss 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<sup>1</sup> 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<sup>2</sup> in a more detailed but similar analysis found that the causes of outpatients mishaps were a 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 misplaced results as 40% of hospitalised patients have pending tests at the time of discharge, failure in judgement 79%, insufficient knowledge 48%. There is an average of 3 breakdowns per negligence case. Major injury and death were the 2 most common outcomes in both inpatient and outpatients negligence cases. Patients appear to be very aware of medical error in the ambulatory setting. In a survey of 1697 patients 15% stated that their doctor had made a mistake. Thirteen per cent reported a wrong diagnosis and 14% said that they had changed doctors because of an error.

Vigilance in the outpatients is more difficult. Inpatients are more acutely ill and their condition declares itself at an earlier stage. In outpatients, on the other hand, the signal-noise ratio is lower. The doctor may see 100 patients with chest pain before encountering one with myocardial infarction. It can be difficult to decide in the absence of positive clinical findings whether a non-specific symptom simply requires reassurance or a list of investigations.

Preventive measures and risk-management activities have tended to concentrate on the avoidance of inpatient injury. The outpatients department has received less attention and focus on safety issues. Ten times more money is directed at inpatient safety and research. This needs to be reviewed. A new approach is required. In order to be effective it will need to be different to that employed for inpatients. There are a number of important differences between inpatient and outpatient care. Outpatient management is by its very nature more prolonged and less organised than inpatient care. It is less well staffed and receives less funding. The lines of communication between specialists are less clearly defined. There are no grand rounds in the outpatients.

The increase in outpatient malpractice claims is ill understood. It may in part reflect the shift in the delivery of care from inpatient to outpatient. Doctors are seeing more patients with less time for each consultation. The amount of paperwork has increased with large volumes of test results. A primary care doctor processes 900 laboratory reports weekly. Good organisation and attention to detail is needed in order to identify and act correctly on the positive ones.

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 sites to monitor compared with inpatients. Also some of the sites 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 safety. The integration of the system nationally with NIMS will mark a further important achievement. Oá Mahony in an editorial in this issue discusses the future importance of the Electronic Health Record. GPs have 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 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.

JFA Murphy  
Editor

1. Bishop TF, Ryan AK, Casalino LP. Paid malpractice claims for adverse events in inpatients and outpatients settings. JAMA 2011;305:2427-31.
2. Wachter RM. Is ambulatory patient safety just like hospital safety only without the "stata"? Ann Intern Med. 2006;145:547-9.
3. Kistler CE, Walter LC, Mitchell CM, Sloane PD. Patient perceptions of mistakes in ambulatory care. Arch Intern Med. 2010;170:1480-7.
4. Zuccotti G, Sato L. Malpractice risk in ambulatory settings- an increasing and underrecognized problem. JAMA 2011;305:2464-5.
5. Kachalia A, Mello MM. New directions in medical liability reform. N Engl J Med 2011;364:1564-72.
6. Oá Mahony B. Latecomers to the electronic health record table. Irl Med J 2011;104:166-7.