Office-based Malpractice Cases 1997–2006: An Incentive for Action

by Deborah LaValley, BSN, RN, CPHQ

Ms. LaValley is a Senior Loss Prevention Specialist for CRICO/RMF and Issue Editor of Forum.

The majority of health care is carried out in outpatient settings (primarily physicians' offices and emergency departments).[1] Malpractice cases reflect this: from 1997-2006, more than 800 CRICO-insured clinicians were named in 623 office-based cases.[2] Those cases accounted for more than one-quarter of CRICO's total cases, defendants, and incurred dollars *(see* Table 1).

Mirroring the national trend,[3] more than half (52 percent) of CRICO's office-based claims alleged either a delayed or missed diagnosis (Table 2). The most common diagnoses identified within these cases were cancers (Table 3). Also frequently alleged were: failure to diagnose infection, myocardial infarction, benign tumors, and strokes. The key issues in office-based failure to diagnose cases were: poor clinical judgment (i.e., patient assessment), poor clinical systems (patient follow-up, reporting findings, identifying provider coordinating care) and inadequate communication and documentation. Table 4 illustrates where along the diagnostic path errors are most frequently alleged. Conducting an adequate history/physical, ordering of diagnostic tests, and test interpretation are key areas of concern.

Cases alleging mismanaged medical treatment or medication errors (both 13 percent) were the next most common allegations made in CRICO's office-based claims. The treatment cases frequently alleged improper performance of a treatment or procedure, inadequate patient assessment, and communication breakdowns. The majority of medication cases were related to improper medical management or education/communication errors.

Table 1

CRICO Office-based Cases

Asserted 1997–2006 (N=623 cases, $233M incurred losses[a])

From 1997–2006, office or clinic-based events accounted for:

- 27% of all CRICO cases
- 25% of all CRICO defendants
- 29% of all total incurred losses

	All CRICO Cases	Office-based Cases
Claims and suits	2,340	623
Defendants	4,803	1,220
Closed cases	2,299	617
Closed with payment	725 (32%)	200 (32%)
Total incurred losses	$812,000,000	$233,000,000
Average indemnity payment	$487,000	$469,000
Defendants	**All CRICO Cases**	**Office-based Cases**
Staff physicians	1,963	637
Residents	419	35
Fellows	101	17
Non-MD clinicians	659	132[b]
Institutions	1,661	399
Total	**4,803**	**1,220**

a Aggregate of expenses, reserves, and payments on open and closed cases
b Includes 27 registered nurses and 20 nurse practitioners

The Challenge

While some types of medical error occur in all settings, ambulatory care presents unique challenges for patient safety improvement. Primary care providers' job functions are increasingly complex; more of those providers are non-physician personnel, and patients are frequently handed off between clinicians.[4]

Despite the prevalence of outpatient care—and the accompanying malpractice allegations—office practice patient safety efforts have received little of the attention (and funding) devoted to hospital-based initiatives. But the problem is not hidden from those in a position to fix it. In response to an electronic survey in 2003, American medical leaders identified the top five actions they felt could improve the quality of office-based health care:

1. institute affordable, standards-based, common language EMR/EHR including lab, radiology, and hospital connectivity;
2. create functioning caregiving teams of physicians, nurses, pharmacists, and others;
3. institute e-prescribing;
4. better educate patients; and
5. implement office-based decision support systems.[5]

Over the past 10 years, most of the CRICO-insured institutions have employed many, if not all, of those ideas in the inpatient settings through a comprehensive commitment of resources and culture change. Spreading and adapting those initiatives to individual office practices requires a different model (probably many different models) and an unprecedented collaboration between the hospitals and their satellite providers.

Despite numerous systems and strategies that can be used to improve practice performance, the outcomes are still heavily reliant on the practice culture,[6] and, the incentive of not being sued. Miller and Bovbjerg found that safety improvements were less influenced by litigation-related financial costs than by ancillary costs, including:

- physician morale and psychological costs, which can exact a substantial toll on individual physicians and demoralize other medical group members;
- intellectual capital costs, especially costs of diverting scarce manager and support staff resources into time-consuming, organizationally disruptive litigation-related activities; and
- reputation costs, such as the effect on the group's reputational assets, and thus, future revenues.[3]

Continued on next page

Table 2

CRICO Office-based Cases
Asserted 1997–2006
(N=623 cases, $233M incurred losses[a])

Just over half (52 percent) of the office-based cases involved an allegation of diagnostic error.

- 50% of office-based diagnosis-related cases involved cancer
- 38% of office-based diagnosis-related cases alleged an indicated diagnostic test was not ordered
- 55% of office-based diagnosis-related cases alleged poor follow-up of a referral or test result

Top Allegations	Cases	Incurred Losses
Diagnosis-related	324	$170,507,000
Medication-related	84	$20,409,000
Medical treatment-related	24	$21,493,000
Communication-related	24	$2,971,000
Surgery-related	20	$6,144,000

Top Risk Management Issues[b]	Cases	Percent of Cases
Failure/delay in ordering test	142	23%
Inadequate communication of patient information among providers	80	13%
Narrow diagnostic focus	66	11%
Insufficient education re: medication	64	10%
Failure to obtain a consult/referral	62	10%
Failure to establish differential diagnosis	60	10%
Failure to rule out abnormal finding	56	9%
Poor selection/management of medication	45	7%
Failure to identify provider coordinating care	43	7%
Inadequate history/physical	39	6%

a Aggregate of expenses, reserves, and payments on open and closed cases
b A single case may involve multiple risk management issues

Table 3

Top Diagnosis-related Cases
Office-based cases asserted 1997–2006
(N=324 cases, $154M incurred losses)

Diagnosis	Cases	Incurred Losses[a]
Colorectal cancer	39	$29,744,000
Prostate cancer	23	$13,294,000
Infection	20	$9,156,000
Lung cancer	19	$9,760,000
Myocardial infarction	18	$9,207,000
Breast cancer	17	$10,252,000
Benign tumor	11	$3,685,000
Head/neck cancer	9	$7,219,000
Pulmonary embolism	8	$5,288,000
Cardiovascular disease	8	$3,819,000

a Aggregate of expenses, reserves, and payments on open and closed cases

Table 4

Malpractice Allegations Along the Diagnostic Path
Office-based cases asserted 1997–2006
(N=324 cases, $154M incurred losses)

Diagnostic Path	Cases[a]	Incurred Losses[b]
Patient notes problem and seeks care	4%	3%
Physician performs history/physical	27%	38%
Order of diagnostic lab tests	62%	68%
Performance of tests	8%	8%
Interpretation of tests	25%	29%
Receipt/transmittal of test results	14%	11%
Follow-up plan and referral (if indicated)	56%	65%
Patient adherence with plan	10%	5%

a A single case may cite errors in more than one step in the diagnostic process
b Aggregate of expenses, reserves, and payments on open and closed cases

Continued from previous page

Miller and Bovbjerg also found providers who felt that liability impeded patient safety improvement by increasing the fear of pretrial discoverability of information. That fear, in turn, restricts the free flow of information 1) within the group, 2) between the group and the hospitals where it admits patients, and 3) between the group and specialist subcontractors. Fear that disclosure could increase the number of claims and make those cases actively pursued harder to defend essentially drives information underground… a form of negative defensive medicine.[3]

Although malpractice data are only the tip of the iceberg when looking at medical errors, they provide a means for focusing on those processes that contributed to patient harm. The major drawback is that the events often took place three or more years prior. For more timely assessment, the use of office practice patient safety evaluations can help organizations identify potential risks currently resident within that setting. CRICO/RMF, through its Office Practice Evaluation (OPE) incentive program, is now rewarding practices that meet specific safety standards as measured through the survey process.[7] That process serves to pinpoint opportunities for improvement, to highlight best practices that address key claims-related risks, and to encourage the application of those best practices before an untoward event occurs.

Change happens slowly in complex systems and organizations, but patients should not have to wait for preventable errors to be identified and addressed. To that end, CRICO/RMF is working to accelerate the development of improvements that can be shared across the CRICO-insured community, through its patient safety research grants[8] and its ongoing support of education and training for both inpatient and outpatient health care providers. ■

Notes and References

1 Berwick D, Kilo C. Idealized design of clinical office practice: an interview with Donald Berwick and Charles Kilo of the Institute for Healthcare Improvement. *Manag Care Q.* 1999 Autumn;7(4):62–9.

2 Professional liability claims and suits filed against a CRICO-insured physician, institution, or employee by patients seen in a physician's office or clinic. Cases stemming from ambulatory care in an emergency department or day-surgery center were excluded.

3 Miller RH, Bovbjerg RR. Efforts to improve patient safety in large, capitated medical groups: description and conceptual model. *J Health Polit Policy Law.* 2002;27(3):401–40.

4 Pope C. Quality quagmire: why systems and processes are important to your practice but often ignored. *MGMA Connex.* 2005;5(2):40–5.

5 Lundberg GD. Improving the quality of care in physician office practice. *MedGenMed.* 2003;5(4):38.

6 Kaissi A, Kralewski J, Dowd B, Heaton A. The effect of the fit between organizational culture and structure on medication errors in medical group practices. *Health Care Manage Rev.* 2007;32(1):12–21.

7 Since 1998, the CRICO/RMF Office Practice Evaluation program has surveyed nearly 600 practices within the Harvard-affiliated health care networks.

8 CRICO/RMF and its subsidiary, Healthcare Safety Research Institute (HSRI), award grants for research and demonstration projects aimed at achieving greater understanding of patient safety issues, their etiology, and potential interventions. For details see www.rmf.harvard.edu/research-resources/grants.

Click here for the complete issue.