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PRF NEWS

Volume 6, Number 2

Covering Practice and Risk Management Issues for Physicians

Failure to Diagnose

BY STEPHEN J. SCHEIFELE, M.D.

This issue of PRF News is intended to increase physician awareness that diagnostic errors are a significant cause of malpractice litigation. Not only does failure to diagnose (FTD) represent almost one out of every five lawsuits against physicians, but FTD errors are the most difficult of all malpractice allegations to defend and the most likely to result in an indemnity payment. The cost of settling FTD claims against physicians has risen more than 260 percent since 1985, with an average indemnity payment that approaches $250,000.

The increase in FTD litigation can be attributed to several factors. One is a heightened public belief that early diagnoses can save lives. When this awareness is combined with a proliferation of sophisticated diagnostic technology, an expectation of diagnostic perfection may result. Other contributing elements to FTD litigation may lie outside the medical sphere and include delays that can occur during the processing of managed care authorizations and the increased physician vulnerability espoused by the legal theory of "vicarious liability."

Significant risk factors for FTD lawsuits include:

- **Problematic Clinical Presentations** - These can include not only patients with a complex medical history, but presentations where the clinical picture does not make sense or the patient presents with a seemingly trivial or objectively non-substantiated complaint.
- **Distracted Practitioners** – Physicians who are stressed, fatigued, or overworked are less likely to listen carefully to patients and more likely to make cognitive errors.
- **System Breakdowns** - Delayed consultations, authorizations, or reporting of results as well as incomplete records or documentation.
- **Challenging Patients** – Patients who miss appointments, call frequently, or have intrusive families.

The hospital departments most vulnerable to FTD allegations are Emergency, Obstetrics, Radiology, and Pathology, with physicians found ultimately responsible in more than 90 percent of claims. For members of PRF, employing risk management strategies in the ER and labor floor are particularly important.

IN THE EMERGENCY ROOM:

- Clearly define the indications/requirements for performing a consultation.
- Employ the terminology "working diagnosis" or "clinical impression."
- Follow up on any X-ray discrepancy.
- Use clinical guidelines for high-risk conditions.
- Do not send a patient home with a diagnosis that could warrant an admission, e.g. r/o MI, possible intra-abdominal bleeding, etc.
- Provide clear written discharge instructions.
- Be sure the ultimate responsibility for care between you and the ER physician is clearly defined and that the patient has a referral for follow-up care.

ON LABOR & DELIVERY

- Be aware of vulnerabilities that arise from physician-nurse interactions; develop and implement clinical guidelines that identify when nursing staff should contact the physician.
- Make sure that only trained personnel monitor laboring women and interpret fetal heart tracings; make certain that nurses are properly trained.
- Assure that adequate personnel are available, especially during evening and night shifts.
- Be sure that OB risk management strategies are directed toward strengthening collaboration among providers; disagreements among health providers

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Inside PRF News

Early Diagnosis of Breast Abnormalities

BY STEPHEN J. SCHEIFELE, M.D.

Failure to diagnose (FTD) breast cancer is the most common allegation in lawsuits filed against primary care physicians. Yet when these cases are reviewed, one or more of the following "red flags" is usually found. Read the tips for dealing with each of these situations:

- **The patient's complaints were disregarded.** Regard any new breast symptom as an urgent problem and aggressively evaluate the complaint.
- **The breast exam by the clinician was unremarkable.** Clinical breast exam has a high rate of false negatives. Further diagnostic evaluation (usually a mammogram) may be in order. Even with a normal mammogram, pursue patient concerns with a referral to a specialist or arrange for a repeat exam two to three months later.
- **The mammogram was negative or ambiguous.** Mammography has a 10 to 15 percent false negative rate. Refer persistent, unexplained breast changes for tissue evaluation.
- **The patient was given inappropriate reassurance.** Patients need to be made aware of the concept of shared responsibility. Do not offer premature or unsubstantiated reassurance that allows the patient to ignore subsequent concerns or changes.
- **There was no tracking system to assure follow-up.** Use a tracking procedure to coordinate care and detect missed appointments. Schedule consultations and diagnostic tests for your patient as well as a follow-up visit before they leave the office. In many cases of diagnostic delays, the patient did not follow the doctor's advice for follow-up evaluations. Follow the "two phone calls and a letter" rule if your patient fails to keep future appointments.
- **Standardized breast screening procedures were neglected.** Because physicians often focus on the presenting complaint, use a health maintenance flow sheet to track your recommendations for breast screening.

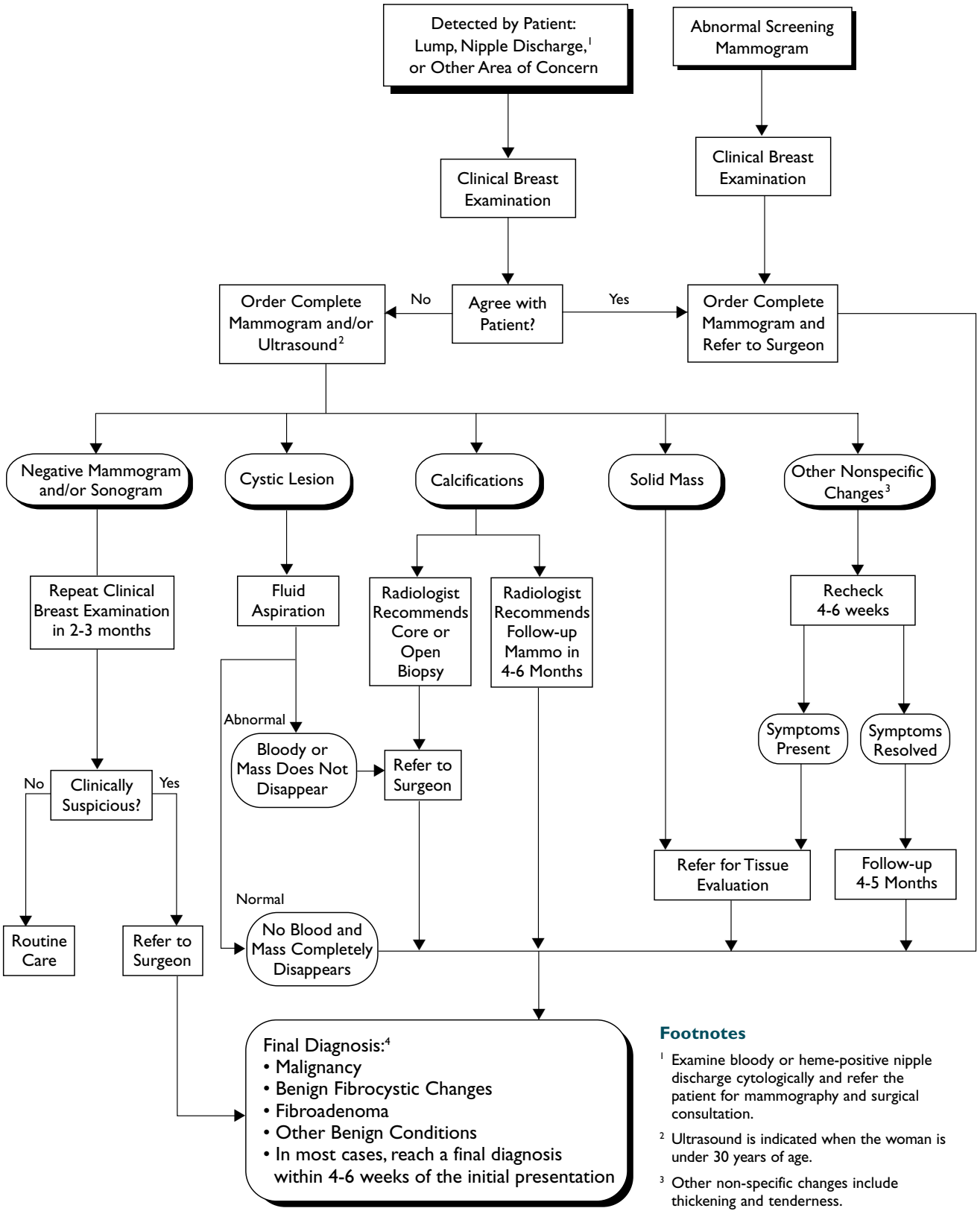
Frontier Healthcare and Preferred Professional Insurance Company (PPIC) have developed the breast screening protocol shown on the next page, which may prevent three out of four lawsuits for FTD breast cancer. Although this protocol was developed as a guideline and not a standard of care, the intent is to improve the quality of care for women, promote a consistent approach among various specialties, and reduce malpractice lawsuits for FTD. ■

BRIEFCASE

NO PREMIUM INCREASE

PRF is pleased to announce that **there will not be an increase in premium** for the general membership for year 2004. PRF premiums for 2004 will remain the same as they were in 2003. If you have any questions, please call the PRF office at (415) 921-0498. ■

Breast Screening Protocol



Footnotes

[1] Examine bloody or heme-positive nipple discharge cytologically and refer the patient for mammography and surgical consultation.

[2] Ultrasound is indicated when the woman is under 30 years of age.

[3] Other non-specific changes include thickening and tenderness.

[4] The final diagnosis is reached when cytology or biopsy has confirmed a benign or malignant process or both patient and physician agree the lump has completely disappeared.

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Stephen Scheifele, MD, Executive Editor
Robert D. Nachtigall, MD, Editor

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Physicians Reimbursement Fund, Inc.
1409 Sutter Street
San Francisco, CA 94109
(415) 921-0498 - voice
(415) 921-7862 - fax
June@PRFrrg.com

June Riley
Executive Director

Soad Kader
Director of Membership

DIRECTORS
George F. Lee, MD
Stephen Scheifele, MD
Damian Augustyn, MD
W. Gordon Peacock, MD
Michael Abel, MD
Andrew Sargeant, ACA, CFA
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W. Gordon Peacock, MD
Chair of Peer Review Committee

Physicians' Diagnostic Errors[1]

BY NANCY CARTERON, M.D.

Diagnostic errors are a significant cause of medical malpractice litigation that can frequently be traced to errors in information processing. Studies suggest that physicians reach a diagnosis by processing information in three stages: decoding, memory, and pattern recognition. Each stage may be a source of errors which culminate in the failure to arrive at an accurate diagnosis.

Decoding errors occur as the physician translates information into medical terminology. Ambiguous histories, physician inattention, and illegible written notes all can contribute to decoding errors. Medication names and dosages are especially vulnerable to misinterpretation.

- Avoid many decoding errors by listening carefully and documenting neatly and accurately.
- Avoid abbreviations, QD, QID, "u" for units.
- Use leading zeros before decimal points: 0.125, not .125.
- Eliminate trailing zeros: 2 mg, not 2.0 mg.
- Specify dosage: Tylenol 650 mg, not Tylenol 2 tabs.

Memory errors occur because we can process only a relatively limited amount of information at once. Physicians attempt to process more information by discarding clinical facts deemed unimportant and grouping the remaining information into combinations of signs and symptoms. Errors can occur if "unimportant" information (e.g. lifestyle or family risk factors) has been ignored or the information grouping is inappropriate, e.g. ascribing a benign diagnosis to a new breast mass based on previous benign breast biopsy results.

- Avoid fatigue and burnout - physicians under stress take mental shortcuts that potentially ignore key clinical information.
- Reduce the chance for memory errors by tracking clinical information through problem lists or flow sheets.

Pattern recognition errors occur when decisions are made before information gathering is complete or when symptom complexes are erroneously matched to a diagnosis. Especially when operating under the pressure of time constraints or in the face of an ambiguous presentation, physicians may fail to think beyond the usual associations in order to reach the correct diagnosis. Pattern recognition errors can also occur when the patient presents with his or her own diagnosis that the physician too readily accepts. Sometimes a physician's recent experience with a particular diagnosis will cause them to apply the same diagnosis inappropriately. Finally, failures in pattern recognition due to a deficiency in medical knowledge are usually a result of physicians practicing outside of their area of expertise.

- Be certain to consider the diagnoses that have the most harmful outcome.
- Refer for consultation when faced with unfamiliar presentations.
- Question other professional opinions and negative test results, e.g. mammograms.
- Reduce stress to keep your thought processes from becoming overly rigid. ■

[1] Information for this article was taken largely from "Physicians' Cognitive Errors and Their Liability Consequences" by Edward E. Bartlett, PhD, ARM, *Journal of Healthcare Risk Management*, Fall 1998, p 62-69.

Failure to Diagnose *(continued from page 1)*

regarding the extent of fetal distress is an invitation to litigation.
- Always double check your calculation of the due date.

COMMUNICATING WITH PATIENTS

Reducing your risk of exposure to FTD lawsuits is often a matter of improving your communication skills with patients. Recommended strategies include:

- Minimize patient denial or inappropriate expectations by clearly sharing your diagnostic reasoning.
- Make sure the patient understands the arrangements for follow-up care.
- Reduce patient non-compliance through appropriate counseling and/or educational materials.
- Directly address patient concerns following a less-than-favorable outcome. ■