Malpractice Trends in Urgent Care and Retail Medicine

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Over the last 6 years I have written a number of articles on medical malpractice in urgent care medicine. The good news is that I am seeing fewer cases despite the fact that there are more urgent care centers and more patient visits. The bad news is that I am still seeing the same fact patterns time and again.

Failure to diagnose is still the most common claim in all malpractice suits, including those in urgent care medicine.[1] One study of primary care, including urgent care centers, found that "[p]neumonia, decompensated heart failure, acute renal failure, cancer, and urinary tract infections were the most commonly missed diagnoses, although each consisted of less than 10% of the errors."[2,3] Other accounts vary in regard to which diagnoses are most commonly missed.[4]

To date, there has not yet been a malpractice suit against a retail health clinic (RHC) that I have been able to discover. However, physician supervisors in RHCs may face liability under an agency theory for the actions of (NPs) and physician assistants who act as the primary providers in these settings.

An urgent care center's status is not exactly a primary care office, but also not an emergency department, making it unique both in the marketplace and in terms of liability exposure.[5] In addition, physicians may face vicarious liability suits for negligent care given by midlevel providers under their supervision.[6] Although there does not seem to be a compilation of malpractice statistics for urgent care centers, the anecdotal evidence available from these practices closely matches the overall statistics for primary care.

Failure to diagnose is the most common malpractice allegation against primary care providers, representing 20% of all claims.[1] One study suggests that this may be due in large part to failure to reevaluate patients appropriately during the course of their illness.[7] In addition, providers often fail to adequately document pertinent negatives, leaving themselves open to suit for conditions that were not present or were not detectable at the time a patient was evaluated.[7] Another common theme is a lack of continuity of care in urgent care centers.

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Overview and Urgent Care Case Sample

Each of the following fact patterns is consistent with failure to diagnose. In addition, they are also consistent with other causes of action that may be unique to the urgent care setting. Specifically, they are illustrative of failure to report patients' conditions to a primary care provider, failure to appropriately provide for follow-up care, and failure to refer patients to a more appropriate setting for their specific emergent conditions.

$3.75M Settlement for Failure to Diagnose Cerebral Hemorrhage

A 37-year-old woman presented to an urgent care center complaining of new-onset headache, nausea, and dizziness.[8] No imaging was ordered nor performed. The patient was given a Toradol injection and instructed to return if the headache did not subside. She returned the following morning with continued headache. A different physician saw her, prescribed intramuscular Toradol and Vistaril, and discharged the woman with instructions to return if the headache returned. The woman returned that evening and while being seen by a third physician at the same urgent care center, she lost consciousness. The woman was transferred to the emergency department where computed tomography revealed a hemorrhaging arteriovenous malformation. The patient survived but with severe impairment. There is some suggestion that the payout would have been even larger, but the woman had returned to her native country (Honduras) for ongoing care, thus reducing her lifetime cost of care.

Take-Home Point: Important to document nature of headache (thunderclap); if it is the worst headache of the patient's life; the absence of meningeal signs and focal neurological deficits, and any family history of cerebral aneurysms.

$250,000 Arbitration Award for Failure to Diagnose Glass Fragments in Superficial Laceration

A 9-year-old girl was brought to an urgent care center after cutting her knee on a glass surface.[9] The laceration was cleaned and sutured, but not x-rayed. Two years later, the girl developed sudden swelling and tenderness in the effected knee. Investigation revealed glass left in the knee, which required surgical removal. Cartilage damage was significant enough to force the girl to stop participating in gymnastics. These facts are consistent with reports that failure to appropriately image or evaluate wounds is a common problem for acute care practitioners.[8]

Take-Home Point: When in doubt, x-ray and explore. If you x-ray and don't see it and explore and document lack of a foreign body, you have at least met the standard. The standard does not require perfection, only that you thought about a foreign body and attempted to locate it.

Failure to Diagnose Pulmonary Emboli

A 44-year-old man reported to an urgent care center with pleuritic pain.[10] He was initially prescribed PO anti-inflammatories and pain medication.[1] When his pain did not subside, the man returned to the urgent care center. This time, an x-ray was performed, revealing atelectasis and an early infiltrate. The physician diagnosed pneumonia and prescribed PO antibiotics. The man's pain improved, but he developed hemoptysis. The urgent care center physician instructed the man to continue the antibiotics and return for a follow-up chest x-ray in 6 to 8 weeks. The man died of pulmonary embolism 13 days after he first presented to the urgent care center. A malpractice suit against the urgent care center and physicians resulted in a settlement for an undisclosed amount.

In a similar case, a patient reported to an urgent care center after experiencing 6 to 8 weeks of "trouble breathing, chest tightness, sore throat, runny nose, chills, and fatigue."[11] The physician auscultated rhonchi and rales and performed a chest x-ray. The patient was diagnosed with pneumonia, and prescribed PO antibiotics and pain medications. The patient was instructed to return or to see her primary care physician if her symptoms got worse or if she vomited. Two days later the patient was transported from home to the emergency department with sudden onset of nausea and vomiting. She died of a pulmonary embolus (PE). The jury in this case returned a verdict for the defense.

Take-Home Point: Always consider PE for any patient presenting with respiratory symptoms. PE is an underdiagnosed, high-risk miss in urgent care medicine. Documenting a PERC or WELLS score on the chart goes a long way to demonstrate that you met the standard of care.

"Always consider PE for any patient presenting with respiratory symptoms."

Failure to Diagnose Sepsis

A patient reported to an urgent care center with severe "flu-like" symptoms.[12] His vital signs were taken by a nurse, and he was evaluated by the urgent care physician, who diagnosed a pulled abdominal muscle and prescribed rest and acetaminophen. The patient was told to return to the urgent care center if his symptoms continued. Ultimately, the patient was suffering from sepsis. The next morning he suffered cardiac arrest and died less than 24 hours later after being seen in the urgent care center.

Unfortunately, the published opinion did not include the patient's vital signs, or any other details of the evaluation at the urgent care center. Specifically, the decision does not include the patient's heart rate, blood pressure, or temperature, which may have been indicative of his impending septic shock. However, the fact pattern is consistent with a study reporting that 16% of patients with a very abnormal vital sign were discharged from urgent care centers without reevaluation of that vital sign.[7]

Take-Home Point: Document vital signs. If abnormal, address the abnormality and retake.

Failure to Diagnose Cancer

A patient reported to an urgent care center with a painful lump in her thigh. The physician diagnosed a pulled muscle and discharged her.[13] She returned with the same problem and a different physician diagnosed thigh strain after ruling out a deep venous thrombus. Two months later the patient returned with the same complaint, which was diagnosed as muscle spasm. Five months later the patient returned, this time with significant swelling of the thigh. A CT scan was performed, and in combination with a biopsy a week later, revealed cancer.

Take-Home Point: The facts in this case are a bit vague. My only admonition is that when a patient keeps coming back without resolution of the symptoms, consider a referral for further evaluation. The provider did order a venous Doppler, which was a good thought. I wonder in this particular case if an x-ray of the patient's femur would have showed the lesion.

Each of these fact situations is representative of an urgent

care provider's failure to diagnose. These situations are consistent with the statistics showing that failure to appropriately reevaluate is a common contributor to malpractice suits based on inappropriate diagnosis. In addition, urgent care centers may be open for liability under other theories. RHCs, on the other hand, are not a common target for malpractice suits but may be an emerging source of physician liability.

Retail Health Clinics

RHCs differ significantly from urgent care centers both in the market and in terms of liability exposure. As of the latest available information, there has never been a malpractice suit against a RHC.[14] That may be due to most RHCs' practices of transferring or referring any patient who presents with anything other than the most straightforward of complaints. Although on the surface, this seems like a logical course of malpractice risk mitigation, identifying subtle presentations of significant pathology is in itself very challenging.

Also note, the physician-as-distant-supervisor model potentially opens physicians to significant liability. In addition, recent developments in the law surrounding NPs may increase the potential for physician liability in these settings.[14]

Emerging Areas of Physician Liability for Remote Supervision

Courts have consistently held that physicians may be liable under a respondeat superior theory for the negligence of NPs under the physician's supervision.[14,15] In addition, physicians may be directly liable for failure to meet the standards of supervision.[14] This, combined with two developments in NP law, likely creates increased liability exposure for supervising physicians.

First, there has been a sharp increase in malpractice suits against NPs. It has been speculated that this is due primarily to the increased number of NPs practicing in America, but the true cause of the increase in the number of suits is not known. However, the reason for this increase may not matter to physicians attempting to avoid liability. What is important to the physician is that as the number of suits against NPs rises, the inevitability of a suit against a NP under the physician's supervision becomes a reality. Given the likelihood that the physician is believed to have "deeper pockets" and may be better insured, it is also likely that physicians will increasingly be named in these suits under a theory of vicarious liability.

Second, in part because of increasing concern over the popularity of RHCs and the increased number of lawsuits against NPs, many states have begun instituting stricter requirements for NP practice and supervision.[16] The idea behind these regulations is to decrease the possibility of NPs delivering care that is below the standard. Whether that policy goal will be realized remains to be seen. However, the regulations also create greater demand on the physicians acting as the NPs' supervisors. Although it is not yet entirely clear what the legal ramifications will be for a supervising physician whose subordinate NP fails to meet these new requirements, it is certain that supervising physicians must remain vigilant to ensure they understand the regulations and are aware of whether they are being followed.

RHCs arguably serve a vital role in alleviating a significant problem with access to affordable primary care.[17] They also create unique liability concerns for physicians attempting to oversee the care provided in this setting. To our knowledge, there has not yet been a successful malpractice suit filed against a RHC, but it seems that such a suit is inevitable. In addition, recent legal developments point to increased avenues for physician liability in this setting, and increased complexity in the liability issues physicians will face.

Conclusion

No malpractice statistics specific to urgent care centers have yet been compiled. However, the anecdotal evidence reflects the fact that urgent care malpractice suits closely follow the overall patterns of primary care. Although it is not clear which conditions are most commonly missed, failure to diagnose is almost certainly the most common cause of action against urgent care centers and physicians. RHCs, on the other hand, have not yet faced a malpractice suit. Nonetheless, these suits and some theories of liability unique to the RHC setting seem to be inevitable. ■

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