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SAMPLE CONTENT -- ABBREVIATED

Failure to Diagnose Cancer

What’s the Risk?

According to the National Patient Safety Foundation (NPSF), diagnosis errors are the most frequent allegation in medical professional liability (MPL) claims involving death and the number one cause of MPL claims for all primary care specialties, radiology and emergency medicine.\(^1\) Causes are related to both systems factors and human factors.\(^2\)

Claims alleging a failure to diagnose cancer are among Coverys’ most numerous and most costly. Of 1,888 outpatient claims paid by Coverys between 2008 and 2012, 1,077 alleged a failure to diagnose. Five hundred and sixty of these claims involved the alleged failure to diagnose cancer. In a recent study published in the Journal of American Medicine (JAMA), researchers examined the primary care closed claim experience of two MPL carriers and found that most primary care claims alleged misdiagnosis and most of the misdiagnosis claims
involved cancer. The most common cancer misdiagnosis claims were colorectal, lung, prostate and breast cancer.

For a number of years, breast cancer claims surpassed all other in both frequency and indemnity payments. In the recent past, however, claims alleging a failure to diagnose or a delay in treating colorectal cancer have begun to approach and, most notably in the specialties internal medicine and family medicine, exceed those alleging negligence in the diagnosis and treatment of breast cancer. In other specialties, including radiology and obstetrics and gynecology, breast cancer remains the focus of most MPL cases involving cancer.

**When Is This Risk an Issue?**

Several issues underlie many of the cancer claims: failure to offer or provide appropriate cancer screening, failure to consider cancer part of the differential diagnosis, and inadequate follow-up.

In some cases, the outcome would not have changed no matter the screening, diagnostic or therapeutic approach. With respect to other claims, however, a systems approach to cancer screening, the practitioner’s willingness to “think cancer” before ruling it out, and a commitment to comprehensive follow-up might have facilitated quicker actions which may have prevented metastasis and death.

**Screening Guidelines**

Different organizations have issued different guidelines for screening. For example, the United States Preventive Services Task (USPSTF), American Cancer Society (ACS), American College of Physicians (ACP), and American College of Obstetricians and Gynecologists (ACOG) all have guidelines for breast cancer screening. It is important for a practice to examine existing guidelines and adopt guidelines for the practice.

Sometimes guidelines issued by one group ignite controversy and confusion. For example, the USPSTF recommends delaying the onset of screening mammography until age 50, reducing the frequency of screening from every one to two years, and discontinuing teaching patients to perform breast self-examinations (BSEs). In contrast, the ACS continues to recommend annual screening mammography beginning at age 40 and that providers discuss the benefits and limitations of BSEs with patients.

The suggested guidelines of a group such as the ACS do not have to be adopted by the practice. However, if the guidelines the practice uses differ significantly from those commonly used...
How Can I Reduce Risk?

The following suggestions, when implemented by a practice, will assist in reducing the risk associated with the failure to diagnose cases of cancer:

<table>
<thead>
<tr>
<th>Implement Screening Guidelines</th>
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<tbody>
<tr>
<td>Establish and adhere to cancer screening guidelines</td>
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<tr>
<td>Stay up to date with guidelines</td>
</tr>
<tr>
<td>Document family/personal history</td>
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<tr>
<td>Encourage screening</td>
</tr>
<tr>
<td>Screen high-risk patients earlier</td>
</tr>
<tr>
<td>Teach self-exams</td>
</tr>
<tr>
<td>Document screening</td>
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<tr>
<td>Document refusal of screening</td>
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</tbody>
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Think Cancer

**Rule out cancer**
- Investigate all objective data and work to actively rule out cancer before making a definitive diagnosis whenever presenting symptoms suggest the possibility of cancer.

**Beware of false assumption**
- Do NOT attribute a breast mass to fibrocystic disease, rectal bleeding to hemorrhoids, or a persistent sore throat to smoking because of assumptions that the problem is benign or that the patient does not fit the stereotypical picture of someone with cancer.

**Do not give false hope**
- Do NOT tell a patient that a mass or lesion is “probably benign.” This may lull them into a false sense of security that may result in a failure to follow-up with the needed diagnostic study.

**Re-evaluate persistent problems**
- Re-evaluate problems that persist or resist treatment. Establish a follow-up plan and document accordingly.

Follow-Up

**Send reminders**
- Implement a system for reminding patients when they are due for a cancer screening test. Utilize a system that lets patients know when a repeat test needs to be scheduled.

**Track tests**
- Implement a system for tracking all screening and diagnostic tests. Include the patient’s name, name of test, date test was ordered, date test report was received, date patient notified of test results, and suggested follow-up. For more information on follow-up, see the chapter titled *Follow-Up & Tracking*.

**Act on abnormal or suspicious findings**
- Evaluate any abnormal or suspicious findings, and if necessary, follow through to the next diagnostic step. Do NOT think it is adequate to simply dismiss a positive finding and direct the patient to return in a year for their next annual exam.

**Be aggressive in follow up**
- Be aggressive in follow-up, as it is better to do too much too soon than too little too late.
Follow-up with patients who have a palpable breast mass and negative mammogram

• Focus on the palpable mass and follow it through to a diagnostic conclusion, in order not to miss a potential breast cancer.

Consider referral

• Consider referring the patient to another practitioner when a screening test reveals a need for a diagnostic workup that might include a procedure, such as a biopsy, with which you do not have significant experience.

References

2. Ibid.
4. Ibid.

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