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In-Office Procedures:

Risks, Routine, and Complacency

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The guidelines suggested in this newsletter are not rules, do not constitute legal advice, and do not ensure a successful outcome. They attempt to define principles of practice for providing appropriate care. The principles are not inclusive of all proper methods of care nor exclusive of other methods reasonably directed at obtaining the same results. The ultimate decision regarding the appropriateness of any treatment must be made by each healthcare provider, considering the circumstances of the individual situation and in accordance with the laws of the jurisdiction in which the care is rendered.

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In-Office Procedures:

Risks, Routine, and Complacency

INTRODUCTION

In the ambulatory care setting, outpatient procedures considered routine still carry inherent risks with the potential for severe injury. As serious complications from these “everyday” procedures are rare, medical professionals and support staff may become more relaxed about following protocols and best practices. Even for the most familiar procedures, patient safety and minimizing exposure should be prioritized. Informed consent, practicing within scope, adherence to evidence-based guidelines and practices, and comprehensive documentation remain vital risk management strategies.

“Our study is an alarm bell. About 1-in-4 people every month are touched by outpatient care, yet we do not know enough about its safety. If we do not measure outpatient safety, we cannot start to improve care for all patients.”

– David Levine, MD, MPH, MA, coauthor of *“The Safety of Outpatient Health Care”*¹

People receive most of their healthcare in the outpatient care setting. Yet, compared to inpatient and certain types of specialty care, large-scale, comprehensive studies on outpatient patient safety are scarce, and a greater focus on this care setting is necessary. In 2024 multiple Boston-area hospitals, led by researchers at Mass General Brigham, studied the prevalence of patient safety events in ambulatory care. Reviewing over 3,000 electronic medical records of patients aged 18 years or older treated at 11 outpatient facilities, the study found that 7 percent of patients experienced an adverse event, 1.9 percent of which were preventable. While medication events were by far the most common issue, outpatient procedures accounted for 14.2 percent of the patient adverse events. The takeaway from the study’s findings was that interventions were needed to avoid preventable outpatient harm.¹



CASE ONE:

Lack of Training and Expertise and Failure to Obtain Informed Consent

Physicians intending to add cosmetic procedures to their practice should carefully consider whether they have acquired an appropriate level of education, training, and expertise to treat patients.

A 2023 study published in *Plastic and Reconstructive Surgery—Global Open* reviewed publicly available litigation records for malpractice actions involving minimally invasive cosmetic procedures. The review included cases from 1979 to 2022 that went to verdict and excluded those settled prior to trial. Over half of the cases that went to trial involved healthcare practitioners practicing out of scope. In these instances, procedures were performed by practitioners without an American Board of Medical Specialties accreditation in plastic surgery. Nearly 47 percent of these cases were performed in a private practice setting. The most common allegations were permanent injury or disfigurement, failure to obtain informed consent, and postoperative complications. Plastic surgeons provided expert testimony for the plaintiff more than 40 percent of the time, regardless of whether the defendant practitioners had the qualifications of a plastic surgeon.²

Defendant physicians who practice outside of their specialty tend to be judged more harshly by colleagues—both by patients' subsequent treating physicians and physician consultants who provide expert reviews in malpractice litigation. Physicians practicing outside of their specialty are held to the standard of care of a specialist in the new area. Consequently, physicians who choose to practice outside their areas of specialty must be particularly careful to obtain adequate training, develop sufficient expertise, choose patients wisely, and refer when necessary.

In the following case, the physician believed sclerotherapy required only minimal experience and training. She failed to realize the patient needed the procedure in an area of the body that required additional expertise.

Consider how this physician could have lessened the risk of injury to the patient.

A patient scheduled sclerotherapy for spider vein treatment with her gynecologist. The gynecologist had taken a weekend sclerotherapy course and had since treated approximately five patients. At the start of the procedure, the patient's reaction to the first three injections in the left shin indicated the concentration was too strong. Therefore, the gynecologist completed the rest of the procedure with a weaker solution. Following the procedure, the patient developed blisters on the shin where the solution had been too concentrated. Over the next six weeks, the gynecologist treated the patient's wounds but ultimately sent a referral to a plastic surgeon for debridement and follow-up care. When the 4 x 2-inch depressed, hyperpigmented scar on the left shin that was not expected to improve, the patient filed a lawsuit.

The patient sued the gynecologist for malpractice. The lawsuit alleged the gynecologist did not have the proper training to perform sclerotherapy and treat the complications of the procedure. It also alleged that the patient did not receive proper informed consent.



DISCUSSION

Multiple issues complicated the defense of this case. Although the patient suffered from recognized complications of sclerotherapy, there was no documentation to prove informed consent. The gynecologist stated that the possibility of extravasation, ulceration, and necrosis would have routinely been discussed; however, without documentation, it was the physician's word against the patient's—a credibility contest.

The patient also alleged that the gynecologist should have disclosed that their training consisted of a two-day course and that they had performed the procedure on only five prior occasions. Additionally, the patient claimed they would not have undergone the procedure if they had known about the gynecologist's qualifications. Although the gynecologist felt confident in their abilities, experts who reviewed the case noted that the injured area required a heightened level of expertise. Sclerotherapy on the shin can be complicated because the capillaries are very small and pass over bone; therefore, the solution must not be too concentrated, and the pressure must be gentle to avoid extravasation. Experts believed the large area affected could be used as evidence of poor technique and inadequate qualifications.

The American Medical Association's Opinion 2.2.1, "Informed Consent," asserts that physicians owe their patients information so patients "can make well-considered decisions about care," and "successful communication ... supports shared decision making."³ This Opinion does not specifically address physician disclosure of qualifications, training, or expertise regarding recommended treatment or procedures. However, certain state statutes or case law may find a healthcare practitioner's professional experience and competence relevant to a patient's decision to proceed with the recommended treatment performed by that practitioner.^{4,5}

The experts also questioned the gynecologist's wound care treatment. Although the care was acceptable for healing and infection control, the gynecologist did not achieve the most cosmetically pleasing result possible. Experts believed that a plastic or cosmetic surgeon would have approached wound care from a cosmetic perspective, and the patient would have had a better outcome. They also believed the gynecologist should have referred the patient to a plastic surgeon sooner.



RISK REDUCTION STRATEGIES

NECESSARY TRAINING FOR COSMETIC PROCEDURES

Consider the following recommendations:

- Do not perform a cosmetic procedure that is outside of your training, skill, or comfort level.
- Carefully consider whether it is in the patient's best interest to receive treatment from you as opposed to receiving treatment from a physician with more training and expertise.
- Be prepared to manage complications associated with a cosmetic procedure (e.g., wound care) in a cosmetically acceptable manner.
- Recognize when the management of a complication exceeds your scope of expertise and have a plan for prompt referral if you or your practice cannot manage the situation.
- Maintain competence through hands-on training and didactic continuing medical education courses to keep up with cosmetic procedure technique improvements.
- Be prepared to state your qualifications to perform any treatment or procedure you offer to patients. If a patient asks about your credentials or experience performing the proposed procedure, respond truthfully.
- Ensure your medical liability insurance adequately covers new areas of practice.

INFORMED CONSENT FOR COSMETIC PROCEDURES

The informed consent process should not be viewed as a burden, nor should it be delegated to staff other than the treating physician. It provides busy clinicians with a structured opportunity to build rapport, manage expectations, and give patients strategies for achieving the best possible outcome.

Consider the following recommendations when preparing a patient for a cosmetic procedure:

- Be extra vigilant in discussing risks and alternatives, and document all such interactions.
 - ▶ Discuss the expected outcome and healing stages. Help the patient understand how many sessions may be necessary to achieve optimal results.
 - ▶ Inquire if the patient engages in activities that are likely to compromise the cosmetic result. Explain the risks of the activity and document that the patient has been warned about the risks of nonadherence.
 - ▶ Ensure consent forms adequately cover risks and alternatives. Personalize informed consent forms and include patient-specific comorbidities that can affect outcome and healing (e.g., smoking, diabetes, and obesity).
 - ▶ Provide the patient with a copy of the consent documents and document in the medical record that the patient received copies.
- Accurately inform patients about non-Food and Drug Administration approved or compounded medications and off-label use in conjunction with outpatient cosmetic procedures.
 - ▶ The use of these drugs may be excluded from professional liability insurance coverage. Contact your agent or call your medical professional liability carrier to determine whether use of the intended drug is covered.
- Do not exaggerate the benefits of the procedure. Do not guarantee results.
- Adequately discuss wound care and follow-up requirements. Ensure the patient understands postoperative precautions, such as the risks of smoking, need for mobilization, and use of support garments when applicable.
 - ▶ If the patient does not follow instructions, reiterate the message and document the patient's nonadherence.
 - ▶ Exercise caution and avoid relying on consent forms prepared by device manufacturers or pharmaceutical companies. These forms can supplement your discussion with the patient regarding risks, but as the physician administering the treatment, you should have your own informed consent process.
 - ▶ Conduct a separate informed consent process for revisions and additional procedures.



CASE TWO:

Failure to Explain or Document Deviation from Injection Best Practices

Patient treatment plans are determined by the treating physician, who identifies the best clinical course for each specific patient, while following evidence-based best practices. Any departure from treatment guidelines or standard policy should trigger focused dialogue and understanding, enhanced consideration, and meticulous documentation as to the clinical rationale for the deviation. In the following case, a physician appeared to blatantly disregard medication warnings, which caused the patient's injury and complicated the defense of the case.

Consider how a proper informed consent process may have changed the clinical outcome or final case disposition.

A patient in their 30s saw an allergist. With a 10-year history of significant allergic rhinitis symptoms, they complained of itchy, watery eyes, rhinorrhea, nasal congestion, itchy nose and throat, and occasional sneezing attacks. The allergist's impression was rhinitis and allergic conjunctivitis, and they prescribed a nasal spray and over-the-counter allergy medication. Three months later the patient returned with a chief complaint of hives and a 10-day history of pruritus since visiting a tanning booth. The allergist noted the patient "did not quite have hives," but had a "fine rash." A general exam was performed, and the impression was chronic urticaria. The plan was to increase the over-the-counter allergy medication and administer triamcinolone acetonide intramuscularly (IM) for general inflammation and other allergy symptoms.

The medical record notes only that the "risk of injection was discussed" with the patient. After conversing with the allergist, the office's licensed vocational nurse (LVN) administered 40 mg of triamcinolone acetonide IM to the patient's right deltoid. The LVN was surprised that the allergist's verbal order was for a deltoid injection site instead of a gluteal muscle, but they did not consult with the physician. Following the injection, the patient was advised to keep the area clean and call if there was redness, swelling, or pain.

Four months after the injection, the patient saw a plastic surgeon who noted the visit as management of lipoatrophy resulting from triamcinolone injury to the patient's right shoulder. The patient told the surgeon that they felt immediate shoulder pain during the injection, and then the shoulder area became sunken and discolored. An exam of the upper arm revealed a depressed area of soft tissue overlying the right deltoid muscle and a smaller central area of hypopigmentation, with no hypervascularity or telangiectasis appreciated. The plastic surgeon noted the patient had a complication from a steroid injection suspected to be subcutaneous, resulting in fat atrophy. Future options for filling the defect were a fat transfer or injections of fat stroma or hyaluronic acid filler.

Three months later the patient returned to the plastic surgeon for a follow-up appointment. The patient felt the injury was wider and more painful. A mechanic, the patient now found that holding various tools was very uncomfortable. Daily activities, such as getting ready for work, washing dishes, or carrying groceries, fatigued the arm. The patient reported feeling too embarrassed and distraught to continue bodybuilding, a hobby they greatly enjoyed. The plastic surgeon noted a progression of the depressed area near the right deltoid, now with a sharp demarcation of the surrounding area, as though it were "punched out." Although the surgeon remained optimistic about improvement without intervention, they agreed to consider a fat graft if the area did not improve in a year.

Nine months after the triamcinolone injection, the patient returned to the allergist's office. The allergist recognized the complication and placed a referral for a specialist at a local teaching hospital.

The patient sued the allergist for permanent disfigurement, pain, embarrassment, mental and emotional distress, and lost income. The lawsuit alleged a lack of informed consent and a breach of the standard of care in ordering the triamcinolone injection into the deltoid.



DISCUSSION

Experts opined that the choice of treatment and dosage of triamcinolone was appropriate. However, there was concern about the lack of documentation of the allergist's clinical rationale for ordering the injection in the deltoid. Also, despite their apprehension as to the physician's verbal order to inject into the deltoid area, the LVN did not share their concern, ask any questions, or reverify the location of injection.

The package insert warned that unless a deep intramuscular injection is given, local atrophy is likely to occur. It stated that, because of a significantly higher incidence of atrophy when the medication is injected into the deltoid area, this injection site should be avoided in favor of the gluteal area. As the subsequent treating plastic surgeon documented in the patient chart, and experts agreed, the steroid likely went into the tissue subcutaneously instead of intramuscularly, introducing the known risk of atrophy and necrosis. In this instance, the medical record was silent about why the deltoid injection site was selected—and why the allergist felt comfortable with this decision throughout the case.

The medical record indicated that “risks of injection were discussed with the patient,” but there was no accompanying written consent form and no specific mention of the actual risks, benefits, or alternatives considered. The patient was an enthusiastic bodybuilder, and their shoulder area's deformed appearance exacerbated their previously diagnosed anxiety and depression. Later, the patient testified that they would not have agreed to the injection had they known the possibility of sunken skin, discoloration, and disfigurement complications.

Patients are entitled to be fully informed about the risks, benefits, and alternatives of recommended treatment, so they can make a voluntary and knowledgeable decision. In this case, the patient's personal focus on bodybuilding would have led them to decline the injection in the proposed location if they had been advised of the risks of skin atrophy, discoloration, and distorted contouring.

The patient's injuries were cosmetic and expected to improve at least somewhat, with a low likelihood of continued pain. Yet, the case was settled due to the difficulty of overcoming both the lack of informed consent and the absence of a documented clinical rationale for the injection site's location, especially given the medication's warnings.



RISK REDUCTION STRATEGIES

This patient's clinical course presented distinct opportunities to both change treatment direction and record the justification for the ordered treatment plan.

- Reward early reporting of concerns and risks, empowering staff to make inquiries and share worries without fear of punishment.
 - ▶ Clinic leadership should support and model psychological safety⁶—the organizational norm which encourages staff to speak up confidently when something seems risky or wrong, knowing that leadership is supportive.
- Engage in thorough informed consent for each patient, including detailed documentation.
 - ▶ Despite the potential for a common outpatient treatment to feel mundane, informed consent must remain meaningful.
- Clearly note the rationale and decision-making for choices that deviate from clinical guidelines and medication package insert instructions.
 - ▶ In the above case, considering the explicit product warnings to avoid the deltoid area, it was imperative for the physician to note the clinical basis for the decision.
- Perform a time-out before an injection procedure to verify the correct route, site, indication, and purpose, and then document that the time-out was performed.
 - ▶ In this instance, a time-out may have prompted further reflection on the indicated deltoid injection site, since this was out of the ordinary.

EGGSHELL PLAINTIFF DOCTRINE: LIABILITY WHEN INJURIES ARE MORE SEVERE THAN EXPECTED

The “eggshell plaintiff rule,” also known as the “thin skull” rule, is a long-standing legal notion that applies to medical malpractice cases. According to Cornell Law School’s Legal Information Institute, the rule asserts that regardless of whether the wrongdoer is aware of the plaintiff’s preexisting fragility, liability for the wrongful act extends to all resulting harm, even when those injuries are more severe because of an underlying condition or unique susceptibility. Essentially, the defendant must “take the victim as they find them.”⁷

In the above case, the patient alleged the injury aggravated their preexisting anxiety and depression, causing additional mental distress and cost of care. As a bodybuilder, they claimed embarrassment and mental and emotional distress due to their disfigured deltoid area. This patient may be considered an eggshell plaintiff, as related to their heightened vulnerability to mental and emotional distress injuries and resulting damages.

ADDITIONAL RESOURCE

ProAssurance Guidelines: [Informed Consent Process and Patients’ Rights](#)



CASE THREE:

Patient Falls in an Ambulatory Setting

According to ECRI, a best practice patient safety organization, falls were the most frequently reported sentinel event to the Joint Commission between 2019 and 2023. Elders and children aged 14 and younger are more susceptible to fall injuries. One in four older adults falls each year, and children's falls account for two million emergency room visits per year.⁸ Fall prevention in ambulatory settings presents a unique set of challenges. Patients have more autonomy and may arrive at each outpatient visit with new or different symptoms. They may also be more mobile than patients at inpatient or skilled nursing facilities, where fall risk assessments are typically conducted at or near the time of admission.

In 2024 *Patient Safety* published an article on the University of Pennsylvania Health System's (UPHS) initiative to reduce ambulatory patient fall risk, piloting the effort in a neurology clinic with 6,500 monthly visits. By focusing on better patient screening, fall risk identification, and response, UPHS reduced its fall rate 22 percent over 18 months and by 37 percent over 30 months. The study also noted that falls with major injury have a greater net impact than direct patient harm and potentially delayed treatment for other conditions. The authors commented that falls also negatively affect staff morale and organizational reputation, while increasing medicolegal risk.⁹

What policies, procedures, or protocols, if any, do you think may have prevented the patient's fall?

PATIENT OBSTACLES TO FALL PREVENTION

In ECRI's guidance, "Preventing Slips, Trips, and Falls in the Office Setting," patient perspectives and feelings that may complicate and hinder fall prevention include:⁸

- Fear of falling and being a burden
- Denial of fall risk and physical limitations
- Pride
- Lack of social support
- Perception of fall prevention activities as painful, embarrassing, or inconvenient
- Lack of motivation that feeds noncompliance

A patient in their 60s was completing a cervical spine MRI on-site at an outpatient orthopedic clinic. They had a history of anxiety and, as was approved by the physician, took sedatives to help keep them calm during the MRI. According to the patient, they began to panic and feel nauseous during the exam. The patient said they pressed the emergency call button three different times during the exam. They told the MRI tech they had begun to vomit, but swallowed it back. The patient alleged that when the MRI was over and the patient was out of the MRI tube, the tech turned around and hurried to leave the room, kicking a trash can to the patient, and mumbling about not being able to handle vomit. Unable to reach the trash can from the raised bed, the patient reported falling while trying to retrieve it, breaking their radius and ulna.

The MRI tech's version of what led to the patient's injuries greatly differed. The tech recalled that the patient used the call button once during the scan, stating that they had to cough and was starting to feel sick. The tech asked whether the patient was able to continue for about two more minutes, as they were almost done and the patient responded affirmatively. In addition, the tech insisted that the patient did not say they felt nauseated, had vomited, or wanted to end the procedure. According to the tech, if the patient said that they had vomited, the tech would have ended the scan without delay and prioritized getting the patient out of the machine.

The tech remembered the patient pressed the call button again after the MRI's completion. The tech told the patient they were on their way, and then they walked in. They brought the MRI tray out of the machine and remained in the room, taking three large steps to get the trash can when they heard the patient gagging. Bringing the trash can close to the side of the machine, the tech immediately removed the neck coil from the patient.

The tech recalled moving very quickly, noting concern for aspiration if the patient were to vomit. Once the neck coil was off, the tech began to lower the table, which requires a continuous push of a button. The patient then shot up from the supine position and, before the table was fully lowered, tumbled forward off the table onto the ground before the tech had time to react. As the patient was in pain and holding his wrist, the tech helped the patient obtain x-rays, and the patient was referred to the local hospital. The tech contended that they routinely and calmly tell their patients what to do and when; they had never had a patient try to get off the table while it was still in the air. While lowering the table, the tech regularly cautions patients not to get up until the table is fully lowered. However this patient surprised them by bolting upright so quickly that they were unable to warn the patient in time.

The patient filed a lawsuit alleging permanent disability, pain, and loss of income due to negligent lack of proper assistance during and following the MRI scan. They had multiple wrist surgeries, including a torn cartilage repair and insertion of a plate, seven screws, and three wires.



DISCUSSION

Experts believed the key aspect of this case was the interaction between the tech and the patient during the MRI. While the tech's version of events sounded reasonable and within guidelines, the medical chart did not have a single note—by the tech or any other MRI center staff member—about what occurred before the patient's fall. The patient was sympathetic, and the missing contemporaneous documentation complicated the tech's defense, which would hinge on whether a jury believed them or the patient. Although the tech's testimony appeared to align with common sense, good practice, their substantial experience, and the machine's setup, the medical record did not support it, undermining the tech's credibility. Because such divergent narratives would make case resolution unpredictable at trial, the case was settled.



RISK REDUCTION STRATEGIES

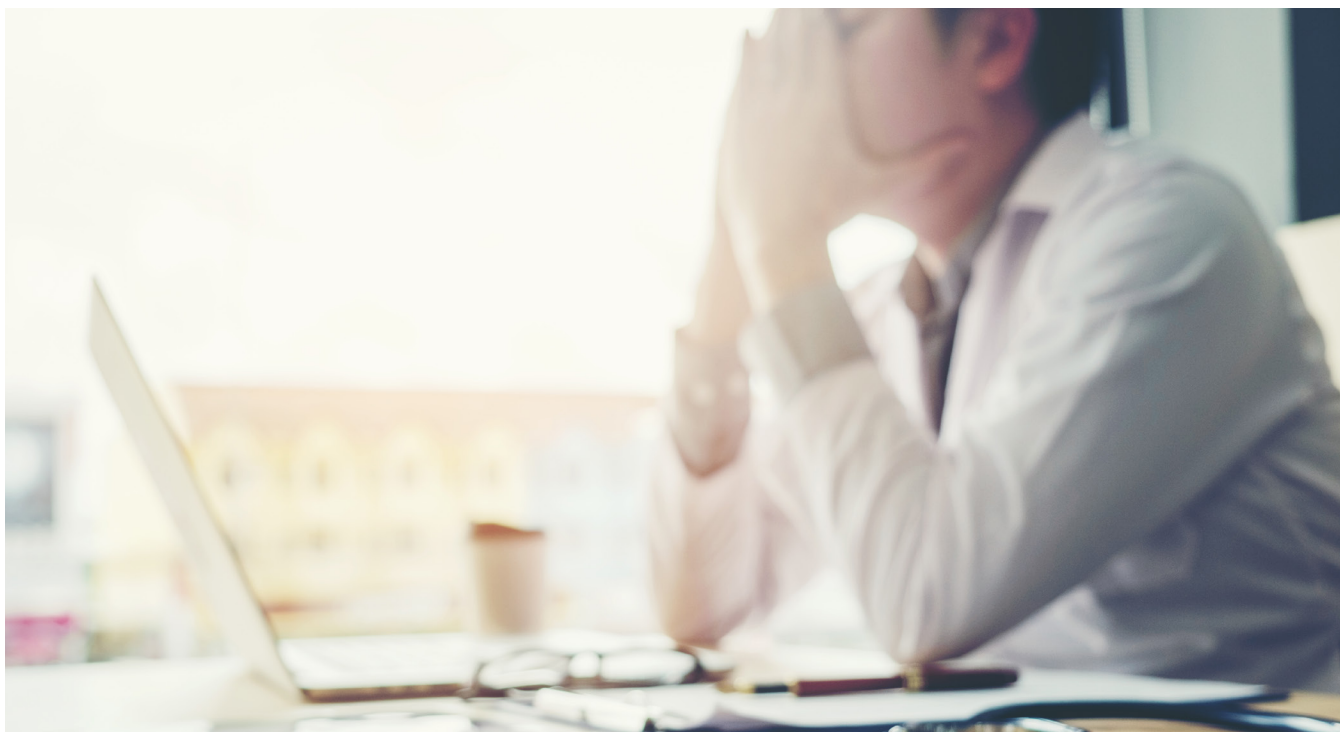
The following risk reduction strategies address unforeseen or emergent situations that may occur during outpatient procedures:

- Be prepared for emergent events, especially those that are more likely to occur in a particular care setting.
 - ▶ Document staff competencies that reinforce readiness for these emergencies, evidence of appropriate training, and knowledge of specific policies and procedures.
 - ▶ Ensure staff clearly understand their individual roles and responsibilities to assist patients in distress.
 - ▶ Teach staff to recognize red flags so they can promptly pause procedures and summon assistance.
- Take proactive steps to monitor patients with known fears, general anxiety, or claustrophobia, especially if the outpatient procedure is unfamiliar to the patient.
 - ▶ Help keep patients calm and manage expectations during a procedure by narrating each care step to the patient, explaining each action and why it is being taken.
 - In the above case, the MRI tech could have narrated care with statements such as: "I'm walking in to get you out of the machine now. I'm going to press the button, and the tube will come out. I am taking off your neck coil. Please wait just a moment, I'm grabbing the trash can for you. Now, I'm going to lower the bed."
- Document contemporaneously to substantiate patient care actions and help avoid a "he said-she said" situation.
 - ▶ Avoid divergent narratives far removed from the date of care that create a defensibility problem.
 - The lack of timely, precise documentation by any staff member detailing the patient's condition and actions leading to the fall undercut the defense's credibility in the case just discussed.
- Confirm and record the details of when patients take any pre-procedure sedative, including the drug, dose, and the time taken. Include whether the patient has had anything to eat or drink, and whether they have previously used the medication for this purpose.
 - ▶ Screen the patient to check their orientation and understanding. Document whether the patient is at risk of side effects and verify all patient monitoring in the chart.
- Ensure your practice has a protocol in place to assess fall risk for patients undergoing radiologic procedures.
 - ▶ Consider use of a fall risk assessment tool to determine whether precautionary fall measures should be implemented in accordance with your policy.
 - ▶ Use of these tools can improve patient safety and strengthen the defensibility of fall-related claims.

ADDITIONAL RESOURCES

Centers for Disease Control and Prevention: [Outpatient Care: STEADI—Older Adult Fall Prevention](#)

Pennsylvania Patient Safety Authority: [Radiology Falls Risk Assessment Tool](#)



In-Office Procedures:

Risks, Routine, and Complacency

CONCLUSION

Promoting patient safety during routine outpatient procedures is the best way to reduce malpractice liability risk exposure. As a starting point, physicians and other practitioners should limit treatment options to those they can provide competently and within the standard of care, with requisite proficiency and training.

Many turnkey products and medical solutions exist that physicians can offer their patients with minimal training. However, even the most experienced specialists encounter adverse outcomes. When a patient is injured by a physician practicing outside their specialty, a malpractice claim's defense can be difficult, since the physician may be inadequately prepared or experienced to address a complication as a specialist would. An informed consent must be intentional, personal, and clear with specific documentation of the procedure's risks, benefits, and alternatives, and the patient's comorbidities. Recognizing the risks associated with performing any particular procedure in an office-based setting is equally important. Use established criteria to evaluate patients for the appropriateness of a given procedure, and to assess the office for adequate monitoring and emergency response capabilities.

Contemporaneous documentation lends far more credibility to the defense of a lawsuit than the mere recollection of a defendant witness long after the incident. Physicians and practices must place patient-centered safety as a foremost priority even—and especially—for routine, everyday procedures.

ENDNOTES

The documents referenced in this article, along with many other risk management resource documents and past editions of *Claims Rx*, are available on the [ProAssurance website](#), by calling Risk Management at 844.223.9648, or by emailing at RiskAdvisor@ProAssurance.com.

1. David M. Levine et al., "The Safety of Outpatient Health Care: Review of Electronic Health Records," *Annals of Internal Medicine* 177, no. 6 (May 7, 2024): 738–748, <https://doi.org/10.7326/M23-2063>.
2. Steven P. Moura et al., "Out-of-Scope Cosmetic Surgery: A Review of Malpractice Lawsuits against Nonplastic Surgeons," *Plastic and Reconstructive Surgery—Global Open* 11, no. 3 (March 10, 2023): e4873, <https://doi.org/10.1097/GOX.0000000000004873>.
3. American Medical Association, "Informed Consent," *Code of Medical Ethics*, Opinion 2.1.1, accessed June 15, 2026, <https://code-medical-ethics.ama-assn.org/ethics-opinions/informed-consent>.
4. Thomson Reuters, "Informed Consent in Health Care," *Practical Law: The Journal*, February 1, 2026, <https://www.reuters.com/practical-law-the-journal/legalindustry/informed-consent-health-care-2026-02-01/>.
5. John D. Banja, "Disclosure of Experience as a Risk Factor in Informed Consent for Neurosurgery: The Case of Johnson v. Kokemoor," *AMA Journal of Ethics*, January 2015, <https://journalofethics.ama-assn.org/article/disclosure-experience-risk-factor-informed-consent-neurosurgery-case-johnson-v-kokemoor/2015-01>.
6. Peggy Atherlay, "The Power of Psychological Safety in Health Care Teams," Yale School of Medicine, April 25, 2025, <https://medicine.yale.edu/news-article/psychological-safety-in-health-care-teams/>.
7. Legal Information Institute, "Eggshell Skull Rule," Cornell Law School, accessed June 15, 2026, https://www.law.cornell.edu/wex/eggshell_skull_rule.
8. ECRI, "Preventing Slips, Trips, and Falls in the Office Setting," accessed May 27, 2026, <https://members.ecri.org/guidance/preventing-slips-trips-and-falls-in-the-office-setting> (available with membership).
9. Patricia Macolino et al., "A Quality Improvement Project Aimed at Reducing Patient Falls in Ambulatory Clinics," *Patient Safety* 6, no. 1 (September 17, 2024), <https://doi.org/10.33940/001c.122084>.