Physician’s Inadequate Assessment of Patient Leads to Missed Diagnosis of Ovarian Cancer

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Introduction

One of the most challenging types of patients in the primary care setting is the adult patient who might be legitimately sick, but who — for any of a variety of reasons — is considered “difficult.” Sometimes the behavior of a difficult patient can distract the doctor from identifying symptoms of a serious, occult illness. The following case study from the Midwest illustrates this type of scenario.

Facts

The patient was a 45-year-old female registered nurse who presented to Dr. R, an internist, in the spring of Year 1. The patient had a history of heavy smoking, but she had quit approximately 3 years earlier. Her past medical history included removal of adhesions from around her fallopian tubes, a breast biopsy (benign), a pedunculated adenoma, and an abdominal hysterectomy.

The patient’s initial visit with Dr. R was in the spring of Year 1 for a physical exam and immunizations required for admission to community college. In November of Year 1, she presented to a local emergency department (ED) complaining of a heavy cough with stress incontinence. In January of Year 2, she made an emergency (same-day) appointment with Dr. R due to severe lower back pain. He prescribed pain medication and ordered lab tests, spine X-rays, and a pelvic ultrasound. Dr. R noted that the patient had a variety of nonspecific symptoms, and he did not make an immediate diagnosis. The patient’s back X-rays were read as normal, with some evidence of gallstones.

Shortly thereafter, Dr. M, a radiologist, interpreted the pelvic ultrasound. She noted that the uterus and right ovary were totally absent as a result of the prior hysterectomy. The left ovary appeared normal except for two masses that resembled follicular cysts. The largest mass measured 3.1 cm by 2.8 cm, and the smaller mass was 2.1 cm by 2.0 cm.

Dr. M felt that the masses were not consistent with a malignancy, and she did not recommend any follow-up studies.

An entry in Dr. R’s record for the patient indicated that he intended to send the patient to a gynecologist, Dr. D. In fact, Dr. R’s file for the patient contained a fax cover sheet to Dr. D indicating that the patient was being referred for an evaluation. However, it does not appear that the patient ever consulted with the gynecologist. Dr. R’s file also contained a handwritten note on the pelvic ultrasound report stating that it was forwarded to Dr. D, but no evidence shows that Dr. D ever received the report or that Dr. R followed-up on this referral.

Dr. R testified that during the patient’s January appointment, he asked her to return in a week, but she refused the appointment. The patient did return to Dr. R’s office in February, complaining of fatigue and back pain. The patient alleged that she insisted on a repeat ultrasound in a few months, but Dr. R refused to order a repeat study. (Dr. R’s record has no mention of this request or his response.)

In May of Year 2, Dr. R saw the patient for another emergency visit. According to his record, Dr. R examined the patient’s chest, abdomen, throat, and neck as part of his exam, and all were unremarkable. In June of Year 2, the patient presented to a urologist for treatment of stress incontinence. The urologist referred the patient to a gynecologist (not Dr. D) who, in September of Year 2, performed a transvaginal sling procedure. However, this procedure resulted in the patient having urinary retention; thus, in October of Year 2, she underwent urethrolysis and the sling was released. In March of Year 3, the urologist performed a repeat urethrolysis. The patient’s symptoms improved minimally, as noted during a follow-up visit to the urologist in April of Year 3.

The patient’s next visit with Dr. R occurred in May of Year 3 — an emergency visit after she fell down some stairs and hit her head/neck. She received physical therapy for her neck pain; however, although her pain continued, the patient discontinued the treatment after only a few visits because her schedule was too busy.

In June of Year 3, the patient had another office visit with Dr. R and complained of deep clavicle pain. She became emotional while discussing her history of family stress, social anxiety disorder, and depression. Dr. R prescribed sertraline at this visit, but the patient returned later in June with the same complaints. Dr. R referred the patient to counseling, but she refused to go because she did not think it would help. The patient also stated to Dr. R that she had received oxycodone for her pain from another provider.

Dr. R next saw the patient in July of Year 3 when she presented with the same continuing complaints and requested more oxycodone. Dr. R believed that the patient’s nonspecific symptoms ultimately were indicative of an abdominal problem. He told the patient that oxycodone was very dangerous under the circumstances because it could mask the symptoms of a number of serious conditions,
including gallbladder rupture, ulcer, or bowel problems. Because of his concerns, he referred the patient to the local ED, which she presented to later that day. A chest X-ray and CT scan of the abdomen were performed. The chest X-ray was unremarkable, and Dr. M interpreted the CT scan as unremarkable except for small calcified stones in the gallbladder.

The patient returned to Dr. R’s office again in July of Year 3. Dr. R stated to her that he was not convinced that her problems were all gallbladder related. He also rejected her request for more oxycodone, which caused her to become so agitated that Dr. R considered calling the police to have her removed from the office. Following this visit, Dr. R formally discontinued his doctor-patient relationship with the patient. The relationship was terminated via a letter sent later that day.

In August of Year 3, the patient underwent a laparoscopic cholecystectomy. Multiple peritoneal implants were noted in the abdominal cavity. A whole-body PET-CT scan indicated Stage IV left ovarian malignancy.

The patient began cancer treatment in September of Year 3, and CT scans in November revealed a new tumor on her liver. After extensive treatment, the patient died in December of Year 6.

Prior to her death, the patient initiated a malpractice lawsuit against Dr. R, Dr. M, and the hospital. The case against Dr. M was settled with a payment in the midrange and defense costs in the high range. The case against Dr. R was settled with a payment in the high range and defense costs in the midrange. MedPro did not insure the hospital, so the amount of payment made on its behalf is not known.

**Discussion**

In analyzing this case, we have the advantage that two of the three defendants were insured by MedPro (the third defendant — the hospital — was not).

The patient alleged that Dr. M, the radiologist, failed to correctly diagnose the growths on the patient’s ovary, concluding that they were follicular cysts rather than the early stages of malignancy. Additionally, the patient alleged that Dr. M should have recommended follow-up testing to ensure that the presumed diagnosis was correct. Review of the case by expert radiologists and gynecologic oncologists concluded that Dr. M’s diagnosis likely was accurate at the time it was made, and that she did not deviate from the standard of care. Further, the experts felt that the need for further testing was appropriately deferred to Dr. R, the primary care physician.

Ultimately, the defense felt that Dr. M was included in this litigation for two reasons. First, the case had potential for a very high verdict in favor of the plaintiff (the reasons for which will be discussed further). Thus, Dr. M may have been included as a defendant to access another set of liability limits under her malpractice insurance policy (because it was possible that a plaintiff’s verdict might exceed the liability limits of Dr. R’s malpractice policy). Second, Dr. M
might have been included as a defendant to provide an additional “deep pocket” in the form of the hospital, which potentially could be found vicariously liable for Dr. M’s actions.

Clearly, Dr. R was the primary focus in this case. The plaintiff’s allegations against Dr. R focused on the failure to properly appreciate the seriousness of her complaints, including the failure to adequately consider the possibility of ovarian cancer.

In fairness to Dr. R, this patient was not easy to manage. She was suffering from a variety of personal/social issues throughout her time with Dr. R, resulting in anxiety and depression that could have been the explanation for some of her symptoms. The patient also did not comply with Dr. R’s recommendations; for example, she refused to seek counseling for her emotional issues. Also, repeated requests for pain medication (specifically, oxycodone) could easily raise the concern to Dr. R that the patient was seeking drugs.

Despite these extenuating circumstances, it was difficult to find expert support for Dr. R’s care. The experts felt that he should have been more aggressive in ruling out other potential causes of the patient’s pain (beyond gallbladder disease), which could have helped him narrow his diagnostic focus toward ovarian cancer.

Additionally, a consultation with Dr. D (the gynecologist) would have been helpful as part of the diagnostic process. Although Dr. R maintained that he had made a referral to Dr. D by means of a fax cover sheet, the plaintiff’s attorney alleged that a referral had never actually been made, and that the fax cover sheet was concocted later to make it appear that a referral had occurred (some evidence supported this contention).

Dr. R’s assertion that he had made a referral was not helped by his disposal of the fax machine in question shortly after the lawsuit was filed. Further, Dr. D testified under oath in his deposition that he had never received this referral (and that he would have acted on it if he had). Independent evidence also suggested that Dr. R had altered his records after the lawsuit was filed, completely undercutting the ability to defend him using either his records or his testimony. Ultimately, the defense counsel concluded that Dr. R could not be supported, and that the likelihood was very high of a verdict in favor of the plaintiff.

Other circumstances in this case also supported the likelihood of a plaintiff’s verdict. The patient died an agonizing death at the age of 51 from a condition that could very possibly have been successfully treated if Dr. R had provided an accurate and timely diagnosis. Further, the patient was the sole care provider for her autistic adult daughter, who was a very sympathetic witness at her deposition.

Both defendant physicians, in consultation with their individual defense counsels, were concerned that this case (which had the potential for a payment well into seven figures) could exceed their combined limits of liability
and expose their personal assets. As a result, both physicians requested to settle the case with payments on their behalf.

**Summary Suggestions**

The following suggestions might be helpful to healthcare providers managing patients who have difficult or noncompliant behaviors:

- Be mindful that just because a patient is difficult does not mean that he/she is not really sick.
- Be careful to identify nonclinical distractions for what they are; often, the presenting issue is not the ultimate problem.
- Recognize unique patient circumstances, values, and needs that might create barriers to compliance. Examples include health literacy, financial constraints, cultural beliefs, and lack of social support.
- Consider referring clinically challenging cases to appropriate specialists. Referral is not a sign of weakness; it is the sign of a savvy provider who recognizes his/her scope of expertise.
- Ensure effective processes are in place to track and follow up with patients regarding outstanding care recommendations such as testing, referrals, and missed appointments.
- However unsupportive the documentation of a case may be, never alter it unless it is annotated with clear language identifying it as a correction of a previous error. Forensic document examiners are extremely sophisticated, and they can detect wrongful alteration.

**Conclusion**

The practice of medicine is complex, and the expectation that a provider will “get it right” every time is unrealistic. Fortunately, the legal standard does not require perfection. Rather, acting carefully, ethically, and reasonably in all situations will generally fulfill a provider’s responsibilities to his/her patients. Diligence in each patient encounter, combined with attention to the suggestions above, will reinforce a successful and satisfying provider-patient experience.

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