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Risk Management Review
PATIENT SAFETY & RISK SOLUTIONS

Physician Fails to Pursue Abnormal Finding and to Diagnose Cancer

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Introduction

When risk management professionals analyze cases that result in patient injury, the Swiss cheese model is often used. In this model, professionals identify how errors can line up like the holes in slices of Swiss cheese, thus allowing them to flow through to a suboptimal outcome. This case from the Southwest aptly illustrates this concept.

Facts

The patient was a 65-year-old female with a medical history that was unremarkable except for recent sciatica. She began to experience lower abdominal pain accompanied by a change in her bowel habits in February of Year 1. When she visited Dr. B, her primary care physician, she indicated that she had discontinued her celecoxib (prescribed for the sciatica) because it bothered her stomach.

When the patient returned to Dr. B in March, she complained about a stomach issue consisting of slight nausea without vomiting. She said she had no diarrhea but had seen a slight blood tinge to her stools on a few occasions, which she attributed to an external hemorrhoid. Dr. B thought that the patient might have gastroenteritis or colitis resulting from recent antibiotics taken and suggested taking probiotics.

When the patient saw Dr. B in April of Year 1, she complained about lower abdominal cramping and stools that appeared to be smaller and flatter than usual (but not loose). She had lost 4 pounds since her March visit. Dr. B also noted that she had never had a colonoscopy; he recommended it, but she resisted. She did promise Dr. B that she would see a gastroenterologist.

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In August, the patient saw Dr. N, a MedPro-insured gastroenterologist. She reported that she had begun noticing bloody mucus in her stools. She also mentioned that she was having small stools multiple times per day, rather than her typical pattern of one larger stool daily.

Dr. N noted that the patient had lost 10 pounds (total) since her March visit with her primary care physician. Dr. N also thought that the patient probably had antibiotic-associated colitis and recommended that she increase her fiber intake and schedule a screening colonoscopy when she was feeling better.

The patient returned to see Dr. B in October of Year 1. She stated she was eating well but had not gained weight. Although she was feeling better, she still had occasional gas and cramps, but no loose or bloody stools. Dr. B again recommended a colonoscopy; however, the patient waited until March of Year 2 to see Dr. N. By this time, she had lost 20 pounds (almost 15 percent of her total body weight) since the previous March.

The patient had a colonoscopy in June of Year 2. When Dr. N attempted to advance the colonoscope during the procedure, he encountered a mass in the lumen of the colon that was sufficiently large to prevent the passage of even the smallest scope. Dr. N aborted the colonoscopy, but he did acquire a specimen of colon tissue adjacent to the mass and sent it to a lab for pathologic analysis.

The pathology report stated that "the tissue may represent a hyperplastic polyp or hyperplastic reaction to some adjacent process not demonstrated in the tissue obtained. No malignancy is seen and the changes do not appear to be adenomatous."

Dr. N next attempted to schedule a barium enema study, but a national shortage of barium prevented it. However, the barium study was done the following week at another hospital within the system, and a radiologist with whom Dr. N was not familiar read the results. Dr. W, the radiologist that read the study (who was also a defendant in this case), did not find any suspicious strictures or masses.

Relying on the study's results, Dr. N told the patient that her condition was most likely irritable bowel syndrome. At no time did either Dr. N or Dr. W contact each other to discuss the inconsistency between their respective findings.

Following the barium enema study, the patient did not receive any further medical care until February of Year 3, when she returned to Dr. B's office complaining of severe constipation with no bowel movements for 5 days. She was sent to the emergency department where she had an enema that led to several bowel movements. She also had an obstruction series that showed no evidence of intestinal obstruction or other acute abnormality in the abdomen. Following the series, she was sent home.

The patient continued to not feel well and contacted Dr. N in March of Year 3 to schedule an appointment within a few days. However, Dr. N had to cancel that appointment because of his own illness. So the patient returned to the emergency department. On this occasion, an obstruction series and computerized tomography (CT) scan indicated a colonic obstruction and an annular mass at the retrosigmoid junction.

Shortly thereafter, the patient was diagnosed with Stage II colon cancer, and a resection and temporary colostomy was performed. At the time of that surgery, all lymph nodes tested negative. A medical oncologist also saw the patient. Even though chemotherapy is not normally used for this patient's condition, the oncologist followed his instincts and ordered oncotype testing. The results of this testing indicated that the patient would benefit from chemotherapy.

However, the patient was not counseled about it nor was chemotherapy instituted because of an apparent failure in communication between Dr. N and the medical oncologist. The error was not identified until 5 months later, at which time it was too late for the patient to benefit from the chemotherapy.

Dr. N performed a follow-up colonoscopy in December of Year 3 that yielded normal results, and the colostomy was reversed in January of Year 4.

Unfortunately, in May of Year 4, the patient was diagnosed with metastatic disease in her liver, pelvis, and the site of the original anastomosis. She underwent palliative treatment in the fall of Year 4, but her prognosis was very grave.

A medical malpractice lawsuit was initiated against Dr. N and Dr. W. With the doctor's consent, the case against Dr. N was resolved before trial with a payment in the high range and defense costs in the midrange.

Although Dr. W also resolved this case with a settlement, the amount of that payment is unknown.

Discussion

A careful reading of this case illustrates numerous opportunities to correctly diagnose the patient's condition. A variety of defense experts reviewed this case for MedPro, and the greatest amount of criticism involved the gastroenterologist (Dr. N). It appears that he made several missteps throughout this case from the beginning to the end of his involvement. However, several other physicians also had the opportunity to recognize the inconsistent findings and lack of communication and take corrective action.

The defense gastroenterology expert criticized Dr. N for allowing a 3-month delay between when he recognized the need for a colonoscopy (including numerous gastrointestinal symptoms and a 15 percent weight loss) and when it was actually performed. No documentation in the health record indicates that the delay resulted from any patient action or inaction. Once the colonoscopy was performed, and Dr. N encountered the obstructing mass, several red flags emerged.

First, the pathology report (which identified hyperplastic tissue) should have alerted Dr. N to an abnormal growth. Second, when the barium enema study indicated nothing abnormal, there was clear dissonance between it and what Dr. N had observed, combined with the pathology report. The defense gastroenterology expert felt that — at a minimum — Dr. N should have contacted Dr. W to attempt to reconcile this dissonance, especially because the barium enema study has a 10 percent margin of error.

Similarly, assuming that Dr. W had access to the clinical information including the operative report for the colonoscopy and the pathology findings, it would have been appropriate for him to initiate the conversation aimed at resolving this dissonance.

Third, it is noteworthy that the patient's earlier presentation to the emergency department included an obstruction series that indicated no obstruction. Assuming the emergency department physician had access to the patient's earlier health records, another opportunity was missed to identify and attempt to reconcile inconsistent findings. No documentation indicates that Dr. N received or

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reviewed the results of this obstruction series, resulting in another missed opportunity.

The patient was finally diagnosed when she presented to the emergency department the second time and another obstruction series, including a CT scan, was performed. The defense gastroenterology expert opined that it would have appropriate for Dr. N to order a CT after the barium enema, and, if Dr. N had done so, it is likely that it would have resulted in a correct diagnosis approximately 9 months earlier.

In addition to the lack of communication between Dr. W, the first emergency physician, and Dr. N, communication was also a significant issue in other parts of this case. For example, the health record indicates that although the oncologist identified an opportunity for treatment that would have significantly diminished the risk of metastasis, no direct communication between the oncologist and Dr. N or anyone else occurred.

Interestingly, although Dr. B saw the patient for more than a year, where she presented with continuing complaints of bowel irregularities and sustained a 15 percent weight loss, Dr. B was not sued.

The defense experts opined that a more aggressive investigation by Dr. B would have been appropriate, or — at a minimum — that she should have had one or more direct conversations (written or oral) with Dr. N about a potentially serious condition that was not resolving.

Summary Suggestions

The following suggestions may be helpful in avoiding patient injury resulting from errors in diagnosis or miscommunication:

- Any pathology report that indicates the possibility of an ongoing disease process must be investigated to its conclusion.
- Significant inconsistent findings must also be investigated to the point of explanation or resolution.
- When testing or direct examination yields inconsistent results, if additional testing is likely to be beneficial, it should be considered sooner, rather than later.
- It is critical that contemporaneously treating physicians communicate well. This communication includes reviewing the patient's health record to see what

others have written as well as communicating directly with each other (oral or written) when any ambiguity, inconsistency, or questions remain.

- Physicians must aggressively pursue textbook symptoms of a serious condition until a clear diagnosis is established.
- Providers should assume that patients do not understand the seriousness of their symptoms. Lack of knowledge, denial, financial limitations, or weariness of the healthcare delivery system can cause patients to underappreciate potentially serious conditions.

Conclusion

Healthcare providers will make cognitive errors. Providers must always be vigilant to ensure that patients receive proper diagnoses and treatment, regardless of which provider directly gives that care.

Systems must also continue to be developed to assist in the identification of errors before patients are injured. This identification is the essence of medical risk management, and when it is done well, injuries are avoided and lives are saved.

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