

## Patient Dies From Cancer After Refusing Treatment Recommendations; Malpractice Lawsuit Follows

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### Introduction

An essential part of medical care is the provider formulating treatment recommendations for the patient. These recommendations are part of the informed consent and decision-making process, which should include education about the patient's illness or injury, a recommended treatment plan, benefits and risks of the recommended plan, and alternative options. When the patient declines the provider's recommendations (informed refusal), what are the potential liability exposures? This interesting case from the South examines that question.

### Facts

The patient was a 52-year-old female who had a 34-year history of smoking one pack of cigarettes per day. She previously had suffered

from deep vein thrombosis and pulmonary embolism, which had been successfully treated. She also previously had been evaluated following a suspicious mammogram (on that occasion, the problem was a cyst). Importantly, her family medical history included two aunts who had developed breast cancer in their fifties.

In October of Year 1, the patient saw Dr. M, a MedPro-insured general surgeon, regarding a solid mass in her right breast. Results from both a mammogram and ultrasound raised suspicion of malignancy. Dr. M recommended excising the mass, which was accomplished that same month. The pathology report on the mass stated *"Infiltrating poorly differentiated mammary carcinoma. High grade, focally extending to inked margin of excision."*

Following the surgery, the patient received CT and PET scanning, producing the following results:

*There is mildly increased radiotracer accumulation, correspondent to the patient's known right breast neoplasm. There is no other scintigraphic evidence of metastasis.*

Next steps were discussed with the patient, and she elected to have a modified radical mastectomy with reconstruction. In December of Year 1, Dr. M performed the mastectomy, and a plastic surgeon performed the first phase of the reconstruction. Dr. M did not excise or biopsy any axillary lymph nodes at the time of the mastectomy.

In January of Year 2, Dr. M met with the patient and told her that clean margins had been confirmed. The patient was then referred to a hematologist/oncologist for further treatment. The patient saw the hematologist/oncologist that same month, and he recommended four doses of doxorubicin and cyclophosphamide with pegfilgrastim and two doses of paclitaxel.

The patient experienced many side effects from her chemotherapy, including dyspnea, nausea, fatigue, and leg swelling. She was

unhappy with these side effects and transferred her care to Dr. S, a MedPro-insured hematologist/oncologist. Dr. S concurred with the previous treatment and continued her treatment with three more doses of paclitaxel 175.

In May of Year 2, because of the continuing side effects, Dr. S recommended that the patient switch to treatment with docetaxol followed by radiation therapy to prevent local recurrence. At that time, the patient refused any further treatment involving chemotherapy or radiation. Dr. S documented his extensive conversation with the patient regarding her decision as follows:

*After thorough discussion, the patient decided she does not wish any further systemic chemotherapy of any type. She does understand the risks of recurrence of the carcinoma but has decided not to have any further chemotherapy.*

*We discussed radiation therapy and obtaining a radiation oncology opinion to prevent local recurrence. High risk of recurrence was discussed with the patient because of the large size of the tumor. The patient has again decided against radiation therapy. She does understand the*

*high risk of local as well as systemic recurrence, but she decided against any further radiation or chemotherapy.*

Dr. M removed the patient's port-a-cath in June of Year 2. The patient next saw Dr. M in January of Year 3, complaining of pain and swelling in the right axilla and right anterior chest. A core biopsy of the right axilla showed "high grade metastatic poorly differentiated carcinoma with necrosis." One of the patient's right chest lesions also was infiltrating the chest wall. The patient's condition deteriorated rapidly, and she developed a large metastatic brain tumor. She was moved into hospice care and died in May of Year 3.

A medical malpractice lawsuit was commenced against Drs. M and S. At Dr. M's request, the case against him was resolved with a payment in the low range and defense expenses in the midrange. The case against Dr. S was resolved without a payment, but with defense expenses also in the midrange.

## Discussion

When this case was evaluated for purposes of defensibility, three key issues surfaced. First, the defense experts were concerned that Dr. M's failure to excise the right axillary

lymph nodes during the patient's modified radical mastectomy could be construed as a deviation from the standard of care. Second, at least one defense expert was concerned about the lack of communication between Drs. M and S. Third, an important consideration in the case was the patient's refusal of further care, which would have almost certainly extended her life and possibly even given her a period of remission.

In relation to the first issue, one defense expert noted that although the lymph nodes typically are removed during a modified radical mastectomy, removal of them in this case would have been only of prognostic – not therapeutic – value. However, it was already known from analysis of the original breast tissue that the patient's cancer was very aggressive, as was the therapeutic approach being taken. Therefore, even if the lymph nodes had been positive for metastases, the treatment regimen and the patient's clinical course would not have differed.

Although this logic might be sound, it can be difficult to convince a jury of laypersons of the validity of this concept, particularly because metastases ultimately did appear in the lymph nodes (although the metastases to the

right chest and brain were far more ominous). In the end, it's not likely that the defense counsel could have convinced a jury that the failure to excise the lymph nodes wasn't clinically relevant.

Regarding the second issue, it is normal in cases similar to this one for the surgeon and hematologist/oncologist to have at least one conversation regarding the patient's care. Although neither doctor in this case had documentation of such a conversation, Dr. S testified at deposition that his normal habit and practice is to discuss the case with the surgeon. He testified that he had no doubt that he discussed this case with both the previously treating hematologist/oncologist and with Dr. M. In this case, Dr. S' testimony seemed to settle this potential issue; however, in general, failure to document conversations about patient care and management can cast doubt on whether they occurred.

Finally, the patient's decision to forego further treatment was very significant from a damages perspective. No one disputes that the decision to forego treatment was the patient's to make (given the misery she was suffering from the chemotherapy side effects,

her decision was not irrational); however, this decision arguably shortened her lifespan.

Dr. S' excellent documentation regarding his discussion of treatment options with the patient made it very clear that she understood the implications of foregoing further chemotherapy and/or radiation. She (and her survivors) could not very well contend that her suffering following the recurrence of the disease and/or her shortened lifespan were the result of anything other than her own treatment decisions. Dr. S' informed consent discussion with the patient (and the related documentation) was a major factor in the case settling for a very modest amount on behalf of Dr. M and no payment at all for Dr. S.

## Summary Suggestions

The following suggestions might be helpful to physicians who are treating seriously ill patients:

- Physicians who perform a medical procedure in a nonstandard way should document in the patient record a rationale for the deviation from the normal procedure.

- When contemporaneously treating physicians discuss patient care and management, both parties should document the substance of the conversation in their respective patient record.
- Physicians should engage patients in thorough informed consent discussions, including clear explanations and education about their conditions, recommended treatment options, benefits and risks, alternative options, and the likely sequelae from limited or no treatment.
- Informed consent discussions with patients about treatment options should be carefully documented, including quoting the patient when appropriate.

## Conclusion

The provider-patient partnership serves as an effective model for providing the patient with excellent care, while respecting the patient's right to consent to treatment based on his/her personal values, goals, and preferences.

Careful explanation of the likely effects of the patient's choices, combined with thorough documentation of these discussions, will ensure that responsibility for the patient's ultimate outcome is properly understood.

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