Communication Failures between Patient and Physician result in Lymphoma Treatment Delay

Abstract:
A young adult male presented to an otolaryngologist with complaints of a neck mass. A lymph node biopsy performed eight months later, was diagnostic for Hodgkin’s lymphoma. The otolaryngologist never communicated the pathology results to the patient, or the urgency for follow-up, and the patient did not return to him. Ten months later, the patient had a lengthy and complicated admission to the hospital where he underwent several rounds of chemotherapy, radiation therapy, and an autologous stem cell transplant. The patient claimed total, permanent disability...... Read more....

The Case:
A young adult male was referred by his primary care physician (PCP) to an otolaryngologist for complaints of a non-tender, left-sided neck mass. The physician ordered a CT scan with fine needle aspiration. The patient refused the needle aspiration, but had a CT scan of his head and neck. In her report, the radiologist noted non-necrotic non calcified opacities, consistent with adenopathy. She also saw nodules in the patient’s chest, and recommended a chest CT. She included lymphoma in the differential, but did not call the otolaryngologist to discuss her findings. As scheduled, the patient returned to the first otolaryngologist, who advised him to have the fine needle aspiration, and to
return to him once this test was completed. At the time, the patient did not have healthcare insurance, and this physician’s medical record notes did not reflect that he had had a discussion with patient about the urgency of having this test.

Three months later, the patient had obtained healthcare insurance, and went to a second otolaryngologist who was on his insurance plan. This physician ordered CT scans of the neck and chest, along with a fine needle aspiration. The neck CT was highly suspicious for lymphoma, but the fine needle aspiration pathology report did not confirm it. The patient began complaining of left-sided facial weakness.

The hospital sent copies of these radiology and pathology reports to both otolaryngologists. However, the first otolaryngologist never saw, nor reviewed them. His staff had placed the reports in the patient’s medical record, without the physician’s review.

The second, and ordering, otolaryngologist recommended a deep cervical node biopsy and/or nasal biopsy, but the patient did not return to him for these tests.

Instead, the patient returned to the first otolaryngologist, who performed a deep lymph node biopsy. The biopsy result made the diagnosis of Hodgkin’s lymphoma. The first otolaryngologist did not place an operative note in the patient’s medical record; did not mention the abnormal lab results to the patient, nor did he impress upon the patient the urgency of follow-up. Despite the results, this otolaryngologist continued to believe the patient had lymphadenopathy. The patient did not return to him.

Almost a year later, the patient was admitted to the hospital by his PCP. According to the patient, he had never been advised he had Hodgkin’s lymphoma. By now, he was suffering from hepatic encephalopathy, and bilateral retinal detachments, secondary to lymphoma. The patient underwent several rounds of chemotherapy, radiation therapy, and an autologous stem cell transplant. At the time he filed the lawsuit, the patient was said to be in remission. His prognosis was unknown; He claimed total, permanent disability.

Allegations:

Plaintiffs alleged the first otolaryngologist failed to meet the standard of care on a number of levels: (1) did not perform a fine needle aspiration and lymph node biopsy upon initial presentation; (2) later, did not communicate the lymph node pathology results to the patient; (3) failed to rule out cancer; and (4) failed to communicate the urgency of follow up and obtaining treatments to the patient.

Disposition:

The case was settled for a moderate amount of money through direct negotiations with plaintiff’s attorney.

Risk Management Commentary:

Experts who reviewed this case were unable to defend the first otolaryngologist on standard of care. Although the settlement amount was adjusted to reflect the patient’s level of non-compliance under a comparative negligence analysis, experts opined the physician was negligent in failing to notify the patient of his biopsy results, failing to rule out lymphoma, and failing to follow through on his plan of care. In addition, the physician’s poor medical record documentation did not support his care; he had not documented any attempts to contact the patient to discuss the biopsy results, nor the urgent need for follow up treatments.

An expert testified “…when a 20 year old presents with a neck mass, it is lymphoma until proven otherwise… lymphoma is very curable if caught in the early stages….but once the retina and bone marrow are involved, the chances of recovery are significantly diminished.”

In addition, the physician’s office lacked a test tracking system, failed to follow up missed appointments, failed to track referrals made to radiology, and filed lab and diagnostic reports in the medical record without the physician’s review. All of these errors contributed to a delay in this patient’s Hodgkin’s Lymphoma diagnosis.
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(Choose the correct answer(s).)

Some of the reasons for the first otolaryngologist's delay in diagnosis were:

Answer:

A. His staff filed radiology and pathology reports from the hospital in the patient's office medical record without the otolaryngologist having reviewed them.

B. The first otolaryngologist's apparent failure to track down the results from the deep biopsy he had performed on the patient in order to review them with the patient.

C. The first otolaryngologist appears to have made no attempts to communicate with the patient his biopsy report results, or to communicate with him the urgent need for follow-up.

D. The first otolaryngologist's first impression that the patient had lymphadenopathy.

Answer: All of the above selections are correct. It appears that a strong lab and diagnostic report tracking system was lacking in this otolaryngologist's practice. In addition, this practice did not have an office policy and procedure directed both towards communicating results to patients, patient contact procedures, and documenting patient follow-up for missed appointments, and or following up scheduling referrals. These office policies and procedures would have most likely assisted the physician in making an earlier diagnosis, and communicating it to the patient. In addition, if the physician had properly documented these steps in the patient’s medical record, he would have likely had strong support from the experts who reviewed his care. Not having a clearly documented medical record, specifying his diagnostic work-up rationale, led the reviewers to believe the first otolaryngologist relied on a subconscious integration of somewhat haphazardly gathered patient data, rather than on a conscious generation of a rigorous differential diagnosis that is formally evaluated using specific data from the literature. Such informal reasoning may have also contributed to this physicians’ cognitive error in diagnosing the patient’s Hodgkin’s Lymphoma.

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