The Case

A middle-aged patient presented to his primary care physician (PCP) with complaints of decreased appetite, weight loss, and an increase in arthritis pain. The PCP assessed the patient for chronic obstructive pulmonary disease (COPD) and ordered a chest x-ray. The radiologist noted a suspicious mass in the left lung. Radiology sent the report to the PCP’s office, recommending follow-up CT and PET scans. When the report arrived, the PCP’s receptionist intercepted it for the purpose of making the CT and PET scan appointments. The PCP never reviewed the report. Later the receptionist stated that she called the patient and left messages concerning his CT and PET scan appointments. These messages were not documented in the patient’s record. The patient and his wife testified they knew nothing about them.

At the patient’s follow-up examination two weeks later, the PCP heard coarse breath sounds with occasional wheezing. The PCP made no mention of the radiologist’s chest x-ray report, the radiologist's recommendations to have further imaging studies, nor did the PCP document a follow-up action plan concerning imaging studies. The plan was to recheck the patient’s pulmonary function status, although there were no follow up notes referencing pulmonary function studies. The receptionist did document that she called the patient’s home and left a message that she had scheduled a pulmonary function study for him at the local hospital. The PCP’s office did not follow-up to see whether the patient went for any of the ordered studies. The patient never returned to this PCP’s office.

Nine months later, the patient saw a different PCP who reviewed the patient’s initial chest x-ray films and
accompanying radiology report. That PCP immediately sent the patient to the hospital’s Radiology Department for the previously recommended CT and PET scans and a bronchoscopy. The CT scan revealed the patient’s left lung mass had grown significantly since the time of the original radiology report. The biopsy of the mass revealed a Stage 3 non-small cell lung cancer. The patient underwent chemotherapy and radiation therapy, with surgery twice, to remove metastatic brain lesions. He died from complications of metastatic lung cancer shortly after filing his lawsuit.

Allegations: The allegations were that the PCP and office staff (1) failed to inform the patient of the abnormal chest x-ray results, (2) failed to initiate the appropriate follow-up and treatment, and (3) failed to diagnose the lung cancer by more than a year, resulting in delayed treatment and decreased life expectancy.

Disposition: The case was settled at mediation for a moderate amount of money.

Risk Management Commentary:

The experts who reviewed this case were not supportive of the care this patient received from his PCP or the PCP’s healthcare organization. The oncologist reviewer was the only expert who believed the tumor was so aggressive that the delay in diagnosis likely made no difference in the outcome. The experts also criticized the radiologist for not calling the PCP with the abnormal radiology report and discussing the recommendations. The office secretary had no documentation of phone contact with the patient and therefore the experts could not support her.

This case represents three classic office system failures: (1) the lack of a strong system for processing patients’ labs and diagnostic reports, (2) the lack of communication between the PCP and radiologist and (3) the lack of follow up to ensure the patient kept appointments with the PCP, as well as with physician(s) to whom the patient was referred.

Once a chest x-ray had been ordered and felt to be an important piece of the diagnostic puzzle, it was critical that the PCP follow up on the results AND communicate with other providers and the patient.

This communication/documentation should have included:

- PCP’s rationale for treatment and plan of care
- reason for the radiology consultation and patient history
- discussion between the patient and the physician as to why an x-ray was ordered
- PCP tracking the results of labs, diagnostic reports and consultation visits
- PCP ensuring there is an office policy for physician review and sign–off on all diagnostic and lab reports, with subsequent scanning and/or filing these reports into the patient’s medical record

When the patient didn’t show for his follow-up appointment with the PCP, it was incumbent upon the PCP to have contacted the patient. If not successful in contacting the patient by phone, the PCP could have sent him advisory letters. After all, the PCP was in diagnostic pursuit.

The radiologist was also responsible for communicating directly with the referring physician and the patient. The radiologist’s responsibilities included:

- Communicating the findings and recommendations to the referring physician and patient, in a timely manner. In cases like this one, we recommend radiologists telephone unexpected findings that may have serious implications to the ordering physician.
- Providing a complete copy of the radiology report to the referring physician.
- Notifying the referring physician when the patient did not keep a scheduled appointment.
The case report presented is composite drawn from MagMutual's case files. Any similarity to a specific case is both coincidental and unintended.

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