Physician’s Cognitive and Communication Failures Result in Cancer Treatment Delay

Abstract: The estate of a 60 year old male alleged negligence against a gastroenterologist in failing to properly evaluate a cancerous rectal polyp following a colonoscopy, resulting in metastasis of cancer to the patient’s liver. Read more…

The Case

The patient’s primary care physician referred him to a gastroenterologist (GI) to evaluate symptoms of intermittent rectal bleeding with streaks of blood in his stool.

The patient’s medical history included: hypertension and diabetes. The patient reported he did not drink or smoke. He was 5’11” tall and weighed 296 pounds. His medications included: Lisinopril, HCTZ, Albuterol, Glyburide, and Amitriptyline.

The patient underwent a colonoscopy during which a 1.0 cm polyp was identified in the distal transverse colon and a 2.5 cm polyp was identified in the rectum. Both were entirely removed with snare polypectomy and cautery. The patient was taken to the recovery room in good condition.

The pathologist reported his findings as follows: “Transverse colon polyp: adenomatous polyp. Rectal polyp: 22 mm mixed villous-adenomatous polyp containing a centralized 12 mm moderately differentiated adenocarcinoma of colon with submucosal invasion. Microscopic examination revealed…a centralized 12mm adenocarcinoma that invades to and through the muscularis mucosae with desmoplasia. The tumor is composed of: A) individual glands B) complex glands with back to back architecture C) some lymphovascular space invasion (or tumor embolization) is noted.”

In his deposition, the gastroenterologist (GI) stated that after he reviewed the pathologist’s report, he was convinced that the entire cancer had been removed; that it was contained within the polyp; that clear margins existed with no invasion of the cancer beyond the submucosa layer of the rectum; and that there was no reason to refer the patient to a surgeon for bowel resection for wider margins.
The GI was comfortable recommending the patient return for a repeat colonoscopy in one year. The next year the GI removed an 8mm polyp from the patient, but lost it in the colon. According to the physician, the previously biopsied areas in the patient's colon and rectum appeared to have healed well, with no apparent signs of recurrence. The GI submitted two biopsies from the healed area for pathological evaluation. The pathologist reported these two tissue biopsies were benign. The patient was advised to return again in one year.

One month after this colonoscopy, the patient went to the hospital emergency room with severe abdominal pain, constipation, urinary retention and weakness. During his hospital admission, he was diagnosed with advanced metastatic colon cancer that had spread beyond the bowel to the liver and adjacent organs. The patient was immediately started on a course of chemotherapy, but expired a month later secondary to complications of advanced adenocarcinoma metastatic to the liver.

**Allegation:** The plaintiff alleged the GI was negligent in failing to recognize the significance of the first pathology report which stated the cancer had invaded through the submucosal layer of the bowel. It was the plaintiff's contention the patient should have been immediately referred for a surgical evaluation, and that prompt surgical resection of the bowel and surrounding tissue, in conjunction with other oncological treatment, would have prevented the spread of cancer and increased the patient's chances of survival.

**Disposition:** The case was determined to be difficult to defend. It was settled on behalf of the GI for a large amount of money.

**Risk Management Commentary:**

The experts who reviewed this case opined the major cause of diagnostic error in this case was the lack of communication between the GI and the pathologist regarding the pathology findings.

The expert reviewers agreed:

- The pathologist should have called the gastroenterologist to explain he could not clear the margins in the specimen submitted, and advised the GI the cancer could have invaded the muscularis and surrounding tissue.
The gastroenterologist failed to appreciate the finding on the pathology report of mucosal invasion of the cancer from a very large polyp with a large portion of it being cancerous. Further, one reviewer couldn’t understand why the GI did not ask the pathologist about “clear” margins.

The patient should’ve been re-scoped within 3-6 months after this finding. Instead, the patient was advised to return in one year.

When the gastroenterologist performed a repeat colonoscopy a little over a year later, he saw no evidence of recurrence of disease in the old biopsy site. This was because the cancer was advancing extramurally into the lymphatic system and surrounding organs.

After the patient was admitted to the hospital, another gastroenterologist performed a colonoscopy revealing an obstructive cancer located in the bowel at the old biopsy site.

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**What were the chief factors contributing to the delay in the treatment of this patient’s colon cancer?**

A. Gastroenterologist’s cognitive bias  
B. Relying on initial diagnostic impression, despite subsequent information to the contrary  
C. Failure to communicate further with the pathologist about “clear” margins  
D. Pathologist’s failure to communicate with the Gastroenterologist to explain he could not clear the margins
Best Answer: All

Two chief factors contributed to the delayed treatment of colon cancer in this case:

(A and B) Cognitive bias on the part of the gastroenterologist

Clinicians frequently use heuristics (shortcuts or “rules of thumb”) to come up with a provisional diagnosis, especially when faced with a patient with common symptoms. While heuristics are useful, researchers in cognitive psychology have developed categories to classify several types of errors that clinicians commonly make when incorrectly applying them.

In this case, the gastroenterologist’s cognitive bias was an “anchoring heuristic” or premature closure, relying on initial diagnostic impression, despite subsequent information to the contrary.

(C and D) Underlying health care system problems also contribute to missed and delayed diagnoses.

Missed or delayed diagnoses (particularly cancer diagnoses) are a prominent reason for malpractice claims, and much of the research into systems causes of diagnostic error arises from studies of closed malpractice claims. Poor teamwork and communication between clinicians have been identified as predisposing factors for diagnostic error, particularly in emergency medicine and surgery.
Source:


Additional reading:


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