Abstract

According to the Joint Commission, cognitive biases have been identified as key contributors to a number of sentinel events, particularly diagnostic errors that may result in a delay of treatment. Among these biases are anchoring bias, which places inordinate weight on initial impressions without adjusting to new information; diagnostic momentum, wherein momentum sets in once the diagnosis is made, reducing one's ability to consider other alternatives; and ascertainment bias, which bases decision-making on prior expectations, e.g., gender and age stereotyping.1

A review of 10,618 Coverys closed professional liability claims over a five-year period (2013 – 2017) revealed diagnostic-related failures to be the number one root cause of medical malpractice claims. Of these claims, 53% involved poor clinical decision-making, 54% were high-severity cases of which 36% resulted in death, and 36% stemmed from outpatient/office settings. A majority (27%) of the diagnosis-related allegations involved breast, colorectal, lung, and prostate cancers. As part of the patient evaluation, a thorough physical exam and patient and family history is essential to identifying an accurate and timely diagnosis.2

Coverys offers a comprehensive resource on these issues in A Dose of Insight: Diagnostic Accuracy: Room for Improvement.

Case Overview

A 49-year-old married man with two teenage daughters had been the defendant’s longstanding primary care patient. Ten years into the relationship, the patient reported blood in his stools, and a rectal exam was deferred. Over the next five years, he continued to report bloody stools, and during this time, one rectal and occult stool exam were negative. A year later, he called the clinic complaining of increased pressure and frequency in bowel movements including diarrhea. He was told to make an appointment with the defendant, who was out of the office on vacation. Six months later, the plaintiff was seen by the defendant and reported occasional blood on his toilet paper, but no further changes in bowel movements. He was seen several times over the next two years with the same complaints. The defendant felt the cause of the bloody toilet paper and stools were hemorrhoids, and no further diagnostic tests were suggested.

Nine years from the initial complaint of bloody stools, the plaintiff reported a significant increased pressure to defecate and frequency of diarrhea with blood. Six weeks later, a colonoscopy revealed polyps, and further pathology showed an aggressive high-grade invasive cancer of distal sigmoid with lymph node and liver metastasis.

The plaintiff deposed that he had told the defendant about his family history, specifically his father’s colon cancer and his sister’s cancerous polyps. Two years prior to the colon cancer diagnosis, MR notation identified family history, including that his father died from lung cancer and his brother died from metastatic liver disease. The plaintiff’s spouse testified that he had complained of pressure, diarrhea, and bloody stools over the preceding four years, and that he was consistently told the cause of his bleeding was from hemorrhoids and the frequency of bowel movements was due to the removal of his gall bladder.

Injury

Colon cancer, metastatic disease.
Negligence Allegations

Failure to diagnose colon cancer.

Expert Opinions

There were mixed reviews regarding whether the standard of care had been breached. Plaintiff counsel opined a breach in the standard of care by not investigating the cause of the patient's rectal bleeding. Defense counsel believed that due to lack of clear-cut guidelines regarding colonoscopy screening under 50 years of age, it was difficult to ascertain whether the care deviated from the standard of care. Regardless of these opposing opinions, the consensus opined that the defendant should have performed rectal exams to determine if the patient actually had hemorrhoids.

Failure to order a colonoscopy may not be considered a violation in the standard of care due to age, but due to the plaintiff's complaints and ongoing symptoms, prudent practice would have been further investigation, including ordering a colonoscopy.

Experts all agreed that a non-cancerous polyp would likely have been detected early by colonoscopy. Early detection followed by close monitoring in a tumor surveillance program would have most likely diagnosed a curable colon cancer. The failure to identify the polyp or early adenocarcinoma led to a terminal metastatic malignancy.

Damages

Metastatic cancer with a life expectancy of less than 12 months.

Outcome

The plaintiff requested his case be resolved prior to his death. The case settled for $990K. Incurred defense costs were $175K.

Discussion

An accurate family history is a well-established method to recognize risk and susceptibilities for potential health problems, such as hypertension, diabetes, and breast and colon cancers. Consideration of family history can aid in a treatment plan focused on preventative measures and early detection of disease, such as increased surveillance, lifestyle changes, prophylactic medical measures, surgical intervention, or genetic testing.  

Positive family history of colon cancer coupled with years of ongoing symptoms, including bloody stools, pressure to defecate, and bowel changes, should have been a red flag for the defendant that further investigation was needed. Through the course of patient complaints, one negative rectal and occult stool exam was completed, yet the patient was diagnosed with hemorrhoids without a documented physical exam indicating such. Had an early colonoscopy been completed, it is highly likely the polyps would have been detected and removed, preventing terminal metastatic disease.

Risk Mitigation Strategies

• Develop a policy for performing a history and physical examination that requires obtaining and documenting specific elements of the patient’s and family’s history and of the patient's physical examination.

• Include a documented comprehensive history on all new patients. Identify risk factors, including lifestyle habits (smoking, alcohol intake, substance abuse), environmental exposures, medical and surgical history, and a family history, including a family history of cancer. If there is no history of cancer, document “no history of cancer.”

• Utilize a template to serve as a checklist when performing a comprehensive history and physical.

• Increase patient engagement by encouraging them to disclose their medical and family history, including periodic updates such as medical conditions and family history changes. This promotes a sense of responsibility and partnership in healthcare management.

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- Reevaluate and update patients’ medical profiles and problem lists, including family history and risk factors, annually or more frequently as indicated by condition and the practice’s policy. Update this list as new issues are identified.
- Institute appropriate interventions, including increased surveillance, education promoting healthy lifestyle changes, prophylactic medical measures, surgical interventions, or genetic testing.
- Institute and adhere to cancer screening guidelines and stay up to date on established guidelines.
- Screen at-risk patients earlier, e.g., those with a positive or personal family history, or risk related to work or lifestyle.
- Rule out cancer before making a definitive diagnosis. Do not make false assumptions. For example, a patient may not fit the stereotypical picture of someone with cancer, such as a younger person experiencing rectal bleeding.
- Institute a consultation policy that includes criteria to consider when determining need for outside consultation, when a consultation must be obtained, and when a consultant must directly manage the patient.
- Provide patients with written discharge instructions in laymen's terms that include the diagnosis, treatment provided, symptoms that require action and which actions to take, referral information for more definitive testing, medications and their expected response, and other pertinent information.
- Evaluate any abnormal or persistent problems. Re-evaluate persistent problems.
- For more risk management recommendations, see A Dose of Insight: Diagnostic Accuracy: Room for Improvement.

References

2. Robert Hanscom, JD; Maryann Small, MBA; Ann Lambrecht, RN, BSN, JD, FASHRM. “A Dose of Insight: Diagnostic Accuracy: Room for Improvement,” https://coverys.com/PDFs/Coverys_Diagnostic_Accuracy_Report.aspx

Grants to Improve Diagnostic Accuracy

Last month, Coverys published Diagnostic Accuracy: Room for Improvement, a whitepaper focusing on our largest category of claims – missed, delayed, or wrong diagnoses. This report outlines multiple layers of contributing factors underlying diagnosis-related MPL claims and suits. In a related call to action, the Coverys Community Healthcare Foundation (CCHF) recently committed $3 million in grant funds to prompt research and demonstrate innovative concepts that show promise in improving diagnostic accuracy and reducing both process and cognitive variability. The Request for Proposal is located on Coverys.com. All providers are eligible to submit a proposal.
Save the Date: 2018 Coverys Risk Management Summit

The Coverys Risk Management Summit is a two-day annual meeting that offers attendees the opportunity to network with peers as well as participate in presentations by thought leaders and national experts in health care risk management. Topics include cybersecurity, human trafficking, telemedicine, RCA, and scope of practice.

This year's live conference will be held October 18-19 at Hotel Indigo in Traverse City, Michigan, and livestreamed to Coverys-hosted locations across the country. Attendees at all locations will experience a rich, interactive meeting by participating in polls, submitting questions in real time, and taking part in group discussions.

Registration will be active soon – please watch for more information.