Through the Retrospectroscope: When Connecting the Dots to Diagnosis Comes Too Late

By Kathleen W. Smith, JD

Most of the time, diagnosing a patient's medical problem is a straightforward process. The patient's symptoms are recognizable, and the solution becomes clear to the clinician after formulating a list of differential diagnoses. On rare occasions, a clinician will encounter a confounding constellation of symptoms that do not correspond with any known diagnosis. Faced with this issue, the clinician easily recognizes that the patient needs to be referred elsewhere for further investigation.

Presenting the greater challenge for the clinician, however, is the patient who, at the time of the encounter, presents with non-specific symptoms or symptoms commonly seen in multiple medical conditions. The clinician makes his/her determination of the underlying problem and treats the patient consistent with the presumed diagnosis. Meanwhile, the patient's actual medical issue (often a more unusual or less likely condition) is allowed to progress unchecked. It is not until the patient experiences a bad outcome because of his untreated condition that the real medical problem is diagnosed. Knowing the outcome, however, and viewing the earlier encounters in hindsight, the clinician may then recognize hints of the true diagnosis that were present all along but simply were not appreciated at the time of the care. This is the problem of the "retrospectroscope."

A retrospectroscope is a colloquial term used in the context of medical malpractice litigation. The McGraw-Hill Concise Dictionary of Modern Medicine defines "retrospectroscope" as "the resolution of diagnostic dilemmas if viewed in hindsight."[1] It is through the lens of hindsight that claimants, lawyers, experts, and juries view the medical care rendered to the patient. Retrospectroscope cases can be very dangerous, particularly if the patient's outcome was significant or tragic, because it can be challenging to explain how the clinician failed to recognize what was actually happening with the patient. When everyone knows the ending, that knowledge, that hindsight bias, that retrospectroscope, colors everything that happened before.

Such was the unfortunate case for Michael Jones[2], a twenty-three year old male patient who first presented to family practice physician Dr. Jane Greene on June 13, 2016 complaining of ankle pain for three days. Mr. Jones reported that he was unaware of any injury to his ankle. Dr. Greene noted swelling and bruising of the ankle. Dr. Greene

diagnosed Mr. Jones with an acute ankle sprain and prescribed an anti-inflammatory.

Michael Jones returned to Dr. Greene for a second time on June 27, 2016. At this visit, he complained of continued right ankle pain, present now for three weeks. Dr. Greene took an x-ray of the patient's ankle, which was negative for fracture. She instructed the patient to continue taking the anti-inflammatory medication and treat the ankle with rest, ice, elevation, and wrapping. Dr. Greene's diagnosis at this visit was right ankle sprain.

Michael Jones returned again to Dr. Greene on July 25, 2016. At this third visit, Mr. Jones complained of constant bilateral swelling and pain in his calves, ankles, and feet. For the first time, he advised Dr. Greene that he suffered from "mild" and "random" stomach symptoms for the past five years, including diffuse abdominal pain, vomiting, and weight loss. Dr. Greene documented that the ongoing stomach issue "sounds like IBS." As for the lower extremity complaints, she ordered a Doppler ultrasound, which was negative for DVT. Various lab work was also ordered, including CBC and CMP. The CBC was performed in Dr. Greene's office laboratory. The CMP was sent to an outside lab for processing. Mr. Jones' CMP results were returned to Dr. Greene's office the following day, reporting a very low albumin level.

No action was taken by Dr. Greene to follow-up on the July 25, 2016 CMP results. In fact, Michael Jones was lost to follow-up for almost seven months until February 20, 2017, when he returned to Dr. Greene complaining of diffuse and sharp abdominal pain, continued ankle swelling, joint pain, fatigue, and excessive thirst. Mr. Jones reported that he did well initially on his iron supplement for his anemia (this was not prescribed or recommended by Dr. Greene, suggesting that the patient had seen an unknown medical provider during this seven-month interim), and even experienced a little weight gain before losing weight again. Dr. Greene ordered and performed a repeat CBC in her office, which showed low hematocrit and hemoglobin. Dr. Greene did not order another CMP lab. Furthermore, based on her documentation for this visit, it appears that she did not even recognize or address the July 25, 2016 low albumin level. Instead, Dr. Greene diagnosed unspecified anemia, unspecified joint pain, and unspecified abdominal pain. She recognized the need to rule out multiple serious conditions, including both Crohn's disease and ulcerative colitis. However, her note is completely devoid of any documentation about how she intended to further investigate these possibilities or what treatment plan she recommended to address the patient's ongoing problems.

Regardless, Michael Jones returned to see Dr. Greene only two days later, on February 22, 2017. His appointment followed a phone call earlier in the day from his girlfriend reporting that Mr. Jones passed out at work and inquiring whether she should take him to the Emergency Room or just bring him to the office. Dr. Greene recommended that Mr. Jones come to the office for evaluation. Upon presentation, Mr. Jones complained of mild abdominal pain and acute dizziness. Dr. Greene's diagnosis remained unspecified abdominal pain. She prescribed the patient a Medrol dose pack. In her office note, Dr. Greene recognized the need to do further work-up "soon," but there was no documentation of what work-up was recommended or planned.

Only hours after leaving Dr. Greene's office, Michael Jones experienced a sudden cardiac arrest at home. His girlfriend was with him at the time of his arrest and called 911. The paramedics were able to resuscitate Mr. Jones, but not before he experienced a debilitating anoxic brain injury which left him unable to care for himself or live independently. Mr. Jones was ultimately diagnosed with pancolitis, ulcerative colitis of his entire colon, which had progressed so severely as to render him profoundly hypokalemic, thus causing the cardiac arrest. A lawsuit was filed on behalf of Mr. Jones, and the claim was ultimately settled for a significant amount.

In retrospect, Michael Jones exhibited symptoms of ulcerative colitis beginning with his first appointment with Dr. Greene, specifically, the atraumatic ankle injury. By his third appointment with Dr. Greene, the patient's low albumin level and lower extremity swelling and joint pain were additional symptoms of his undiagnosed and progressing inflammatory bowel disease. Likely, at the time of each individual office visit, Dr. Greene was reassured by Mr. Jones' otherwise young and healthy presentation, and the complaints, when assessed in isolation at the time of each individual office visit, did not cause Dr. Greene to suspect ulcerative colitis. However, when the visits are viewed back-to-back, knowing Mr. Jones' ultimate diagnosis and tragic outcome, the retrospectroscope makes one question how this family practitioner missed the diagnosis.

So, what can be learned from Dr. Greene's failure to connect the dots to Mr. Jones' diagnosis of ulcerative colitis? How can this case help clinicians recognize the "zebra" who may be sitting in your exam room?

1. Be attentive to the patient's complaints and presentation during the encounter.

2. Be thorough when writing the record for the encounter, including your presumptive diagnosis and any treatment and/or follow-up plans. If the patient refuses the care you have recommended, document the refusal, including any reason the patient gives for refusing the recommended care.

3. For those patients returning repeatedly with ongoing or worsening symptoms, dig deeper into the situation, or consider referring the patient for a second opinion or to the relevant specialist.

4. Implement and utilize a reminder system to follow up on outstanding lab results, test results, imaging studies etc., then act appropriately on those results once received.

5. Implement and utilize a reminder system for patients, too, who are in need of follow-up, and have your staff contact them to schedule a return visit should they fail to follow-up on their own. If the patient refuses to schedule the recommended follow-up appointment, again document the refusal, including any reason the patient gives for refusing to make the appointment. Also, ask your staff to notify you of and document those instances when the patient makes but fails to keep appointments.

6. Seek out records, information, etc. for relevant care rendered by other providers whom the patient identifies.

7. Take the time to perform a more comprehensive review of your chart for the patient. This allows you to look back over the recent appointments, viewing the patient's complaints globally over time. This is also another opportunity to look for prior test results or recommended treatment and see if any follow-up is indicated or has been scheduled but not

[1] ("Retrospectroscope." McGraw-Hill Concise Dictionary of Modern Medicine. 2002. The McGraw-Hill Companies, Inc.)

[2] The names have been changed to protect patient and physician privacy.