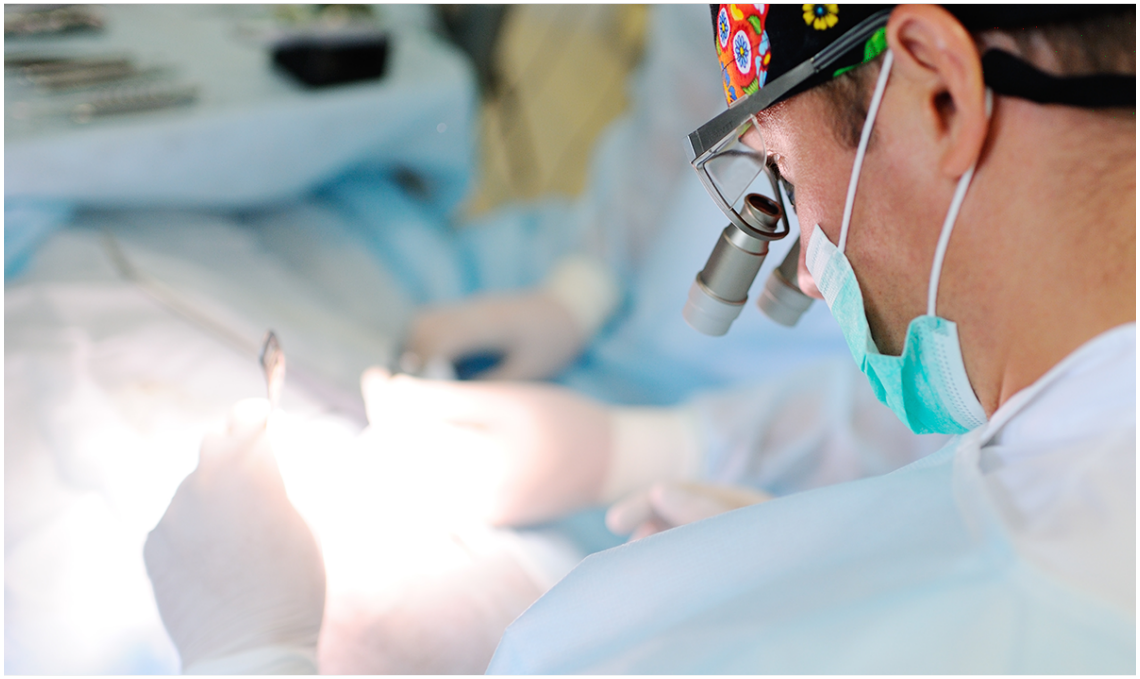
Action Required



By Judy King Reneau, JD, BSN

Rose Campbell[1], a generally healthy 74-year-old, had been a patient of family practice doctor, Dr. Morris, for more than ten years. Although she had tried to quit smoking many times, Rose was a life-long smoker. She had seen Dr. Morris in Spring 2014 for a checkup and had only minor complaints, including “feeling tired.”

A follow-up appointment was scheduled for mid-summer the same year, but due to increasing back problems, Rose cancelled the appointment with Dr. Morris, and instead, went to see neurosurgeon, Dr. Strong, about her back. After an examination and testing, a laminectomy was scheduled, and Rose was admitted to Maximum Care General Hospital the next day under the service of Dr. Young, hospitalist. Dr. Young ordered a chest x-ray and other testing in order to provide clearance for the surgery. The chest x-ray was interpreted by a radiologist and reported to contain a 1.5 cm density which could have

represented “scarring or possibly neoplasm.” The radiologist recommended a CT of the chest.

Rose underwent the laminectomy a few days later and did well. Later Rose was scheduled for discharge from the hospital. No CT was ordered on her chest and the discharge summary made no mention of the radiologist’s findings relating to the chest x-ray. The discharge summary did recommend follow up with her family physician in one week.

The discharge summary, x-ray report, and related documentation were sent to Dr. Morris’ office. As a result of the recommendation to follow up in one week, Dr. Morris’ staff contacted Rose to schedule an appointment. However, Rose refused the appointment and indicated she had scheduled a follow-up appointment with Dr. Strong. The hospital record, along with the chest x-ray and report, was scanned into the electronic record at Dr. Morris’ office, and Dr. Morris noted receipt of the record. However, since Rose was not following up with him after the hospital admission, he only gave the records a cursory review and did not perform a detailed assessment of the records as he would have done if she were coming in for a follow-up visit. Dr. Morris did not make note of the findings on the chest x-ray or the recommendation for a follow-up CT.

Over the following months, Rose lived her life as she always had. While being the mother of a son and a daughter, she was not particularly close to her children. Both children were adults with families of their own and both lived in states hundreds of miles away. Rose was an amateur painter, a hobby which she enthusiastically pursued. As the months after her disk surgery went by, Rose noticed that the pain in her back was returning. Eight months after her surgery she returned to Dr. Strong, her neurosurgeon, with the comment that the new back pain was like the pain she had experienced a year before. Dr. Strong, concerned about more spine issues, ordered films. When the reports came back, there was a more concerning finding. Something was “eating away” at another disk. A PET-CT was performed which showed widespread bone metastasis, as well as extensive hilar, mediastinal, supraclavicular, upper lobe malignancy and bilateral lung metastasis. The testing also showed adrenal metastasis and liver metastasis. Bronchoscopy was performed a few days later which revealed malignant cells. This finding was consistent with adenocarcinoma. Rose was informed that her disease was incurable and that she had only months to live. Her question to Dr. Strong was “Who dropped the ball?”

Both of Rose’s children became involved at this point, travelling to her home in a rural area of the state in order to assist her during her last days. Suit was filed naming Dr. Morris and his practice, Dr. Young and his practice, and the hospital as defendants.

It became clear early in the development of the suit that the x-ray report showing a suspicious lesion prior to the disk surgery was in both the hospital record and Dr. Morris' office record. Discovery revealed that Dr. Young had ordered the chest x-ray and had received the report. He had not attempted to contact either Dr. Strong or Dr. Morris to inform them of either the abnormal finding or the radiologist's recommendation to perform a follow-up CT. Likewise, a review of Dr. Morris' electronic medical record showed that he had noted receipt of the report when it was received by his office.

The difficult reality was that neither doctor followed up with the patient for a year, leading to a disastrous result for Rose. She succumbed to her disease 13 months after the original chest x-ray taken in midsummer 2014.

This case illustrates the hardship in managing the volume of information that bombards the physician in a busy practice and the difficulty in focusing on critical details that require follow up. As the ordering physician, Dr. Young had a duty to look for the result of the test he ordered, to inform the patient of the results and to report the critical finding to the patient's primary care physician.

As for Dr. Morris, he had a duty to pay attention to the abnormal x-ray report that came into his office and to contact his patient so that she could be appropriately cared for in a timely fashion. The ball was dropped by both physicians in this case. Both doctors and the hospital settled before trial, with Dr. Young paying the largest percentage of the settlement.

[1] All the names have been changed to protect the identities of the parties.
