Sometimes, Action Is Required

By John T. Ryman, JD

Mr. Smith was 72, with a long history of various medical issues including coronary artery disease, carotid artery stenosis, chronic obstructive pulmonary disease, and peripheral vascular disease, when he was referred to cardiovascular surgeon, Dr. Jones. The referral to Dr. Jones was by Mr. Smith's primary care physician for evaluation and possible carotid endarterectomy. At his initial visit on May 1, 2010, Dr. Jones determined that surgery was appropriate and ordered a chest X-ray in preparation for surgery. The chest x-ray was performed the following day and interpreted by the radiologist as showing an indistinct opacity in the left mid-lung. The radiologist recommended follow-up with a CT evaluation to confirm or exclude a pulmonary nodule. This report was faxed to Dr. Jones, who initialed the report implying that he had reviewed it. The report was filed in the patient's chart without further action. On May 3, Dr. Jones performed the endarterectomy surgery on Mr. Smith. The surgery went well, and the patient continued to do well through his six-month follow-up office visit with Dr. Jones. The patient was not seen by Dr. Jones thereafter.

In April 2011, Mr. Smith presented to his PCP with complaints of congestion, coughing, and left hip pain. An x-ray and CT of the chest were ordered. These studies indicated that Mr. Smith had lung cancer in the area where the suspicious opacity was previously seen on the May 2010 x-ray. Mr. Smith underwent several months of treatment for metastatic lung cancer and died in early 2012.

A lawsuit was filed by Mr. Smith's estate alleging wrongful death resulting from Dr. Jones' failure to follow-up as recommended by the radiologist in 2010.

Dr. Jones admitted that he saw the report and failed to follow up on the recommendation for further evaluation. There was no credible argument that Dr. Jones had not deviated from the standard of care in this case. On review of the records, an oncologist gave the defense team the opinion that the lung cancer was probably Stage II in May 2010 and was Stage IV in April 2011. It was debatable whether earlier diagnosis would have made a difference in treatment and outcome. Defending the case on the basis that the delay did not change the outcome, and thus there was no injury caused by the error, was the only possible avenue of defense. In every case there are various legal, medical, and practical considerations. In the class of cases involving failure to diagnose cancer, it is well known that for many years the public has been told that early diagnosis equals a better outcome. For many patients this is true. Thus it is very difficult to convince a group of jurors that earlier diagnosis in this specific case would not have made any difference when they have been taught that early diagnosis saves lives. Therefore, successfully defending this case

based on causation was going to be difficult.

In his care of this patient, Dr. Jones initialed the chest x-ray report indicating that he had read its content and that he did not believe any further action was warranted. The report, which indicated further follow-up was needed as to the distinct opacity in the lung, could not be overcome. The plaintiff was able to paint a picture that this finding was simply ignored or not appreciated by Dr. Jones, leaving the consequences of Dr. Jones' failure to fall upon the patient. Findings in radiological reports that suggest further follow-up is needed, require action by the reviewing physician in order to be defensible under the standard of care. Otherwise, convincing a jury that the failure to follow-up did not cause an injury to the patient will be the only chance that the provider has to escape liability. Such cases are challenging for the defendant. In this particular case, Dr. Jones gave his consent to settle, and it was settled.
