



# Risks of Delays and Errors in Diagnosing Cancer

Joyce Tedford, RN, BSN, CPHRM  
October 9, 2014

## Coverys Risk Management

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# Learning Objectives

- Name the most frequent types of cancer diagnostic delays in medical professional liability claims.
- Identify risk management issues that typically dominate a delay in diagnosis claim.
- Implement risk management strategies to improve the likelihood of making a cancer diagnosis without delay.

# Facts About Diagnosis Error

- Diagnosis Errors are Frequent and Harmful
  - Most frequent allegation in malpractice claims involving death
- Diagnostic Errors are the #1 cause of outpatient claims and #2 in hospital claims
- #1 cause of malpractice claims for all primary care specialties, radiology and emergency medicine
- Causes are related to both systems factors and human factors

# Coverys Paid Claims: Outpatient (2008-2012)

- 1888 paid claims
- Most claims = failure to diagnose (1077)
- Most failure to diagnose claims = cancer (560)
- Most common failure to diagnose cancer claims (264)
  - Colorectal
  - Lung
  - Breast

# Primary Care Closed Claims Experience

- Researchers studied patterns of primary care medical professional liability (MPL) claim types, causes and outcomes of 2 MA MPL carriers
- Most primary care claims = alleged misdiagnosis
- Most misdiagnosis claims = cancer

Source: JAMA Intern Med. *Primary Care Closed Claims Experience of Massachusetts Malpractice Insurers*. doi:10.1001/jamainternmed.2013.11010. Published online September 30, 2013.

# Most Common Cancer Misdiagnosis Claims

- Colorectal
- Lung
- Prostate
- Breast

Source: JAMA Intern Med. *Primary Care Closed Claims Experience of Massachusetts Malpractice Insurers*. doi:10.1001/jamainternmed.2013.11010. Published online September 30, 2013.

# Case Example: Breast Cancer

- 34-year-old woman with family history of breast CA presents for annual PE
  - No breast masses noted. No mammogram ordered.
- Following year, patient returns for annual exam:
  - Vague area of nodularity noted
  - MD orders mammogram. Advises patient to contact office for appointment after mammogram completed.
  - Patient never has mammogram
- 10 months later, patient presents to different MD complaining of right breast mass and finally has mammogram
  - 5 x 4 cm, non-tender mass found with multiple axillary adenopathy
  - Biopsy reveals adenocarcinoma

# Case Example: Risk Management Issues

- Failure to develop and implement screening guidelines
- Failure to follow-up

# Risk Management Recommendations

- Develop and implement screening guidelines for both low-risk and high-risk patient.
- Develop a follow-up system to track tests and referrals

# Case Example: Breast Cancer

- Patient presents to OB/GYN with complaint of left breast lump
  - MD notes small, non-tender nodule in left, upper, outer quadrant not fixed to skin or chest wall
  - Ultrasound reveals poorly defined 10 x 6 mm heterogeneous lesion
  - Radiologist notes, if clinically indicated, attempt needle aspiration
- Following month, OB/GYN notes no change to nodule
  - OB/GYN “advises” patient that cyst most likely benign. Patient “declines” fine needle aspiration.
- 7 months later, patient complains that breast lump is larger
  - Repeat ultrasound reveals 1.8 x 1 cm lesion
  - Needle aspiration positive for malignancy

## Case Example: Risk Management Issues

- Failure to aggressively follow-up on breast mass
- Failure to adequately inform patient of the risks, benefits and alternatives of not undergoing a fine needle aspiration
- Failure to document “informed refusal” discussion

# Risk Management Recommendations

- Be aggressive in following up on breast mass
- Think cancer
- Thoroughly explore a patient's complaint of a self-discovered breast mass
- Act upon the advice or recommendation of a radiologist
- When necessary, conduct and document informed refusal discussions

# Case Example: Colorectal Cancer

- 43-year-old asymptomatic male presents to internist/cardiologist for routine annual PE and completes history questionnaire
  - Maternal grandmother died of cancer (unspecified)
  - Both mother and father had cancer (unspecified)
  - Brother had surgery to remove colon polyps
  - No rectal exam performed
- 2 years later, patient presents with episode of rectal bleeding
  - “Advises” that dad was diagnosed with colon cancer at age 53
  - NP performs rectal exam, diagnoses hemorrhoids and “advises” patient to have colonoscopy.
- Nine months later, patient undergoes colonoscopy, which reveals 4 x 5 cm polyp, 3 cm from anal verge. Patient diagnosed with rectal cancer, with metastasis to the liver.

## Case Example: Risk Management Issues

- Failure to obtain and document accurate family history
- Failure to perform rectal exam as part of annual PE
- Failure to adequately investigate complaints of rectal pain and bleeding
- Failure to document informed refusal discussion

# Risk Management Recommendations

- Obtain an accurate family history
- Document all recommendations for CRC screening Remember informed refusal.
- Investigate all complaints of rectal pain and bleeding for CRC
- Expect to be held to the standard of a PCP when acting as a PCP
- When necessary, refer the patient to another practitioner for appropriate screening. Document and follow-up on referrals

# Case Example: Prostate Cancer

- 60-year-old male presents to internist for annual PE.
  - DRE = Normal prostate in size and contour
  - PSA = 5.95
- Following January
  - PSA = 5.4
  - MD reassured, no DRE
- Nine months later
  - PSA = 7.25
  - DRE = enlarged prostate
  - Prostate biopsy revealed CA.
  - Patient became impotent after radical prostatectomy
- During Discovery Phase
  - PSA = 2.3 (5 years prior)

## Case Examples: Risk Management Issues

- Failure to follow-up on elevated PSA levels.
- Failure to refer
- Failure to inform patient of impotence risk.

# Risk Management Recommendations

- Follow-up on PSA levels that show an increase over previous levels
- Request results of previous PSA tests
- Do NOT feel reassured by a small ↓ in PSA
- Follow-up on symptomatic patient who has a (-) DRE
- Consider referral to an urologist when a patient's PSA is elevated
- Include risk of impotence in prostatectomy consent discussion

# Case Example: Lung Cancer

- 54-year-old female who smokes two packs a day has chest x-ray ordered by neurosurgeon before discectomy for a herniated disc
  - Radiologist notes a 2.5 cm mass in the right lung; follow-up imaging recommended
  - Surgi-center nurse notes contacting patient's PCP
- Following year, patient experiences right-side chest pain and undergoes another chest x-ray
  - 5 cm mass identified and lung cancer diagnosed

# Risk Management Issues

- Failure to follow up on abnormal test result

# Risk Management Recommendations

- Recognize that some lung cancers are diagnosed as a result of tests for other medical conditions
- Communicate incidental findings better to the PCP. Formally hand off to the PCP accountability for incidental findings (Radiologists, Specialists)
- Implement a follow-up system for all abnormal test results (PCPs)

# Implement Follow-Up System

- Send reminders
- Track tests
- Track referrals
- Act on abnormal or suspicious findings
- Be aggressive in follow-up
- Consider referral

# Consider Screening Guidelines Carefully

- Examine existing guidelines
- Adopt most widely-encompassing guidelines
- Be prepared to defend deviations from commonly accepted guidelines

# Implement Screening Guidelines

- Establish and adhere to cancer screening guidelines
- Document family/personal history
- Encourage screening
- Screen high-risk patients earlier than low-risk patients
- Teach self-exams
- Document screening
- Document refusal of screening

# Stay Up-to-Date With Guidelines

- Recognize that screening guidelines change; for example, new American Cancer Society (ACS) lung cancer screening guidelines for high-risk patients
  - Screening Criteria
    - Patients 55 – 74 years old in fairly good health
    - History of heavy smoking (30 pack-year)
    - Still smoke or quit within the last 15 years
  - Screening Method
    - Low dose computed tomography (CT) in facility with experience in lung cancer screening
- Review and regularly update established screening guidelines in the practice

# Think Cancer

- Rule out cancer
- Beware of false assumptions
- Refrain from giving false hope
- Reevaluate persistent problems

# Ensure Coordinated Care

- Define who will be in charge
- Communicate and share information

# Engage Patients

- Consider using the National Patient Safety Foundation (NPSF) four-part *Patient's Toolkit for Diagnosis*
  1. Prepare for My Medical Appointment
  2. My Symptoms or Pain
  3. My Medications
  4. After My Doctor's Visit, What's Next?

Source: National Patient Safety Foundation. *The Patient's Toolkit for Diagnosis* accessed at <http://www.npsf.org/wp-content/uploads/2014/03/PatientsToolkitforDiagFINAL.pdf> on April 28, 2014.

# Radiologists and Delayed Cancer Diagnosis

- Breast cancer is most common delay in diagnosis  
cancer claim against radiologist
- Common reasons include:
  - Misreads due to distractions, fatigue, or high volume
  - Failure to compare current films to prior films
  - Poor quality films

Source: ProMutual Group. *Risk Management Protocols for the Medical Office Practice.*

# Risk Management Recommendations for Radiologists

- Read mammograms in a dedicated, quiet place
- Beware of fatigue
- Compare current and prior films
- Err on the side of too much rather than too little
- Repeat films of poor or uneven quality

# *Questions/Discussion*



