

Failure to Follow Up After Primary Treatment Causes Second Condition to Go Undiagnosed

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Introduction

In the movie *The Perfect Storm*, a fishing vessel is imperiled when it is caught in the confluence of two massive storm systems with disastrous results. Unfortunately, a circumstantial “perfect storm” can also occur in healthcare delivery, as illustrated in this case.

Facts

Dr. S, an internal medicine (IM) specialist insured by MedPro, practiced in a large IM group in a major city. The patient was a 59-year-old Caucasian female who had been Dr. S’s patient for several years. Her medical history was unremarkable, and she enjoyed very good health even though she did not see Dr. S on a regular basis (only for specific complaints).

On March 6 of Year 1, she contacted Dr. S because she had had an insurance physical, which included a carcinoembryonic antigen

(CEA) test that indicated a level of 7 ng/ml (elevated). Dr. S documented that one possible cause of an elevated CEA test is cancer and that he was “committed” to finding the problem.

Because he suspected colon cancer (based on how the patient was feeling at that time), Dr. S ordered a CT of the abdomen and pelvis and referred the patient to Dr. T, a gastroenterologist. The CT revealed an 8 cm cystic ovarian mass. Upon receiving the CT report, Dr. S also referred the patient to a gynecologic oncologist. The patient testified in her deposition that Dr. S told her that the ovarian mass was the cause of the elevated CEA result.

On March 13, the patient saw Dr. T, who, based on the finding of the ovarian mass (and no other CT findings), also concluded that the test levels resulted from the ovarian mass. He did not take any immediate action but planned to perform a colonoscopy following her

treatment with the oncologist, and he asked the patient to schedule an appointment 2 to 3 months after her recovery from the expected surgery.

On March 16, the patient saw the oncologist, and on March 24, the oncologist surgically removed the mass. The pathology was negative for malignancy, and on April 10, the oncology practice told the patient that they did not need to see her any further, and she should follow up with her primary care physician. The oncology practice also sent a letter to Dr. S, indicating they were referring her back to his care. Based on what she had been told by Drs. S and T, the patient assumed that the CEA issue had been resolved.

Unfortunately, the letter to Dr. S arrived at his practice at the exact time he had left to join a new practice in the same area. He never saw the oncologist's letter, and no evidence indicates that anyone else from the former practice saw it either. Based on her assumption that her problem had been resolved, the patient did not schedule a follow-up appointment with Dr. S; she also did not schedule the appointment requested by Dr. T.

Three years later, in February of Year 4, the patient underwent another insurance examination, including a CEA test, which indicated a

level of 50 ng/ml (highly elevated). The patient located Dr. S at his new practice, and a subsequent workup revealed lung cancer, with metastasis to the brain and bone. The patient has undergone aggressive treatment and is considered terminal.

A medical malpractice lawsuit was brought against Drs. S and T. The case was resolved with payments by both doctors in the high range. Defense costs also were in the high range.

Discussion

In previous editions of *Risk Management Review*, we have discussed the “Swiss cheese” principle, wherein certain events occur that alone do not produce harm, but they combine to create a circumstance that is likely to cause a failure. That is what happened in this case.

Any time the care of a patient is transferred from one provider to another (referred to as a “handoff”), the risk of miscommunication or no communication occurs. This commonly happens in situations such as hospital shift changes or, as in this case, referrals amongst providers.

A root cause analysis of this case would likely identify several failures; one of the most concerning was the original IM practice's lack of a

protocol to ensure continuity of care when a provider departs. Ideally, when a provider decides to leave (e.g., retirement or relocation), the practice should begin planning 3–4 months in advance of their departure date.

Planning should identify who will assume responsibility for the departing provider's patients, allowing time to discuss how to manage their ongoing care and to notify patients in advance so they can plan accordingly. Occasionally, it is not possible to plan for a departure in advance (e.g., when a provider passes away), but fortunately, that is uncommon.

Even if Dr. S had not left his practice, both he and Dr. T could be criticized for not having a more comprehensive plan for follow-up after the patient had been released from the surgeon's care. Both appeared to rely on the patient to initiate follow-up, which — particularly with this patient's history — was not a good idea. They could have easily scheduled a follow-up appointment with her during her last presurgical appointment and — if she failed to keep that appointment — followed up with a call or letter. Alternatively, they could have entered a timely reminder for follow-up in the electronic health record system.

Certainly, the patient had some responsibility to follow up with her provider when she has

been requested to do so (and that may have provided some defense in this case), but it is still difficult for the provider to justify not taking one of these simple steps as an additional fail-safe measure.

The defense expert witnesses opined that the standard of care required a follow-up CEA test following the completion of the patient's surgical care, and that this would most appropriately be the primary care physician's responsibility. Presumably, if a follow-up test had been performed and indicated an elevated result, Dr. S would have investigated further and identified the lung carcinoma. The experts also opined that in April of Year 1, the carcinoma would have been identifiable (when it was at a curable stage) via a chest CT and possibly even an X-ray.

Summary Suggestions

The following suggestions may be helpful when providing ongoing primary care to patients:

- Develop a process and appropriate timeframes for following up with patients about pertinent clinical findings, critical test results, and missed or canceled appointments.
- When testing indicates a condition and that condition is then treated, be sure to

order follow-up testing to verify that the treatment was successful.

- Define appropriate processes for referrals and consultations, such as how providers and staff should handle urgent communications, consultation reports, informed consent, and follow-up.
- When referring patients for evaluation or treatment, have a method to “track” the patient to ensure continuity of care.
- When patients return for further treatment of a previously treated condition, thoroughly review previous treatment documentation to ensure a clear clinical picture and to prevent oversight of potentially critical information.
- Whenever possible, encourage patients to actively participate in their

care. Engaging patients in the treatment process can provide an additional safeguard to prevent them from slipping through the cracks of the system.

- Put a protocol in place to ensure that patients will receive uninterrupted ongoing care when a provider becomes unavailable for any reason.

Conclusion

Despite our best efforts in healthcare delivery (as in all human endeavors), mistakes will occur. When well-designed systems and processes are properly executed, the likelihood that these mistakes will negatively affect patient care is minimized. When this occurs, both the patient and provider benefit.