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Risk Management Review

Patient Declines Testing but Sues Physician for Failure to Diagnose

Theodore Passineau, JD, HRM, RPLU, FASHRM

Introduction

The concept of patient autonomy has undergone significant changes over time, and today's empowered patients are free to accept or decline recommended testing and/or treatment. Unfortunately, a patient's decisions may lead to suboptimal outcomes, as illustrated in this case.

Facts

The patient was a 67-year-old female with a history of bunion, jaw, knee, nasal, and tonsil surgery. Her medical history included anemia, chickenpox, mumps, dizziness, migraines, Raynaud syndrome, rosacea, and thyroid problems.

On December 4 of Year 1, the patient saw Dr. D, a MedPro-insured otolaryngologist (ear, nose, and throat [ENT] specialist). She was experiencing left ear pain and congestion, decreased hearing in the left ear, and dizziness. These symptoms had been present intermittently over 3 months. Her hearing had been normal prior to the onset of these symptoms.

Prior to seeing Dr. D, the patient was treated by her primary care physician (PCP) for an upper respiratory infection, wax impaction, and fluid in her ears. At the time of her presentation to Dr. D, she had taken azithromycin, fluticasone nasal spray, fexofenadine, ciprofloxacin/dexamethasone ear drops, and one round of cefdinir. This was in addition to her usual medications (estradol, levothyroxine, simethicone, and levocetirizine).

An in-office audiogram showed normal hearing on the right side but only 36-percent discrimination on the left (which is considered moderate-to-profound hearing loss). Dr. D ordered an MRI of the brain and internal auditory canals. He also started the patient on triamterene/hydrochlorothiazide for dizziness and asked her to restrict salt intake.

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She next saw Dr. D on January 8 of Year 2, when she reported that the dizziness was markedly better but there had been no change in her hearing. An audiogram during that visit showed 12-percent discrimination on the left side. The patient explained that she attempted to have an MRI but it was terminated because she experienced nausea and was uncomfortable with the loud noise. Dr. D explained the importance of performing an imaging study and emphasized that an MRI would be the best option.

However, the patient declined to attempt an MRI again, so Dr. D ordered a CT scan with and without contrast. The CT scan was read by a teleradiologist, Dr. S, who stated that the only patient history she received was, “Dizziness. MRI contraindicated. Look at Pineal Gland.” Dr. S’s impression was that the internal auditory canals were “grossly unremarkable,” concluding “Unremarkable CT of the temporal bones with and without contrast.” The patient called Dr. D’s office on February 3 and was told the CT results were normal. She canceled her appointment with Dr. D for later that week and indicated that she would contact the office in 2 weeks to give an update.

The patient did not contact the office again until March 17 (about 6 weeks later) and was seen the following day. She stated that her symptoms had improved for a short time but were now worse, including sharp, shooting pains in the left ear with no change in hearing. Dr. D removed a small amount of wax from the left ear and found no pain with palpation of the jaw (temporomandibular) joints. Nothing further was done at this appointment.

Dr. D told the patient that she was welcome to return at any time if she had new developments, but that she should return within 10 months for a repeat audiogram. This was the last time the patient saw Dr. D.

The patient did not seek further medical care until June 21 of Year 3 (more than 15 months after her last visit with Dr. D). At that time, she presented to a hospital emergency department with dizziness, headache, and left jaw numbness, which she had been experiencing for about 1 month. She was seen by a neurosurgeon, who ordered a CT scan of the head. The scan showed a 2.9 cm mass centered on the left cerebellopontine angle, most likely a meningioma, causing mass effect and hydrocephalus. She was diagnosed with acoustic neuroma and pneumonia and admitted to the hospital.

The patient had surgery on June 26 (a left retromastoid craniotomy and tumor debulking)

and, because of swallowing difficulties following surgery, required placement of a PEG tube. She also had a cerebrospinal fluid shunt placed. On July 10, she was transferred to skilled nursing and rehabilitation care. Her discharge diagnosis from rehab included oropharyngeal dysphagia and dysphonia. She has residual weakness on the left side of her face and balance difficulties, and because of continued difficulties swallowing, she is dependent on gastrotomy tube feeding. She permanently resides in a nursing home.

A medical malpractice lawsuit was commenced against Drs. D and S and the facility that performed the original (incomplete) MRI. The case against Dr. D was resolved with a payment in the midrange, with expenses also in the midrange. The imaging facility made a similar payment, and the suit against Dr. S was dismissed without payment.

Discussion

This case highlights the tension that can occur between patient autonomy and responsibility. It is well established that, with a few rare exceptions, patients must consent to all medical testing and/or treatment performed on them. The current state of the law regarding informed consent requires that, prior to consenting, the patient must receive sufficient information to allow them to reasonably deliberate their available options.

The plaintiff's ENT expert criticized Dr. D for not telling the patient that she could receive antinausea and antianxiety medications before another MRI attempt or that an open MRI might be available. The plaintiff testified at her deposition that, if she had known of these options, she would have consented to another MRI attempt. She also said that Dr. D did not explain why he preferred an MRI over a CT scan.

The plaintiff's ENT expert also criticized Dr. D for not giving more information to Dr. S (the teleradiologist who read the original CT); not doing acoustic reflex testing, which might have provided further indication of an acoustic neuroma; and not ordering a repeat CT (if the patient still refused an MRI) in March of Year 2, which might have given some indication of the neuroma.

However, strong arguments could be made in Dr. D's defense. The defense's ENT expert indicated that acoustic neuromas typically grow slowly, so rushing to surgery is rarely necessary and watchful waiting is usually appropriate. This fact would tend to minimize any harm caused by Dr. D's failure to diagnose the neuroma during the time he saw the plaintiff.

Second, the plaintiff did not return to Dr. D after 10 months as instructed, depriving Dr. D of the opportunity to do additional testing (MRI or CT scan). Finally, the defense's ENT expert opined that the plaintiff's difficulty swallowing (a major portion of her claimed damages) was likely caused by poor technique of the neurosurgeon who performed the debulking procedure, not the neuroma.

While Dr. S was also sued, there was minimal criticism of her because her reading of the CT scan was correct and she was in a teleradiology role (i.e., unable to directly communicate with Dr. D). The criticisms of the imaging facility (a free-standing facility) were that they did not forward the MRI images that had been completed before the imaging was terminated to anyone (Dr. D did not know they existed) and did not arrange to have a local radiologist overread the CT scan.

Dr. D's defense team felt that Dr. D would be an excellent defendant and that they could successfully defend the case. However, Dr. D retired during the pendency of this case and was understandably concerned about the chance (albeit slight) that a verdict for the plaintiff could exceed his coverage limits. At his request, the case was settled.

Summary Suggestions

The following suggestions may be helpful when educating patients about testing/treatment options and navigating shared decision-making in patient care:

- Engage in thorough informed consent discussions with patients and ensure they have adequate information about their diagnoses and treatment options. Use a method such as the teach-back technique to gauge patients' comprehension of information.
- When a patient declines recommended testing and/or treatment, clearly explain the possible/likely consequences and carefully document the conversation in the patient's health record. In critical cases, it may be appropriate to reiterate this information in a letter to the patient or obtain an informed refusal form. A copy of one of these should be saved in the patient's health record.
- When another physician is going to examine images or specimens, be as specific as possible regarding the request for an overread to give the examining physician optimal opportunity to identify relevant findings.

- When a teleradiologist does the initial interpretation of images, request an overread by a local radiologist to support diagnostic accuracy.
- If a study is incomplete, request to have a limited read. Despite incomplete results, the limited read and images may contain important diagnostic information.
- When patients are given a return date or timeframe, implement a mechanism (e.g., a health record alert) to ensure compliance or to follow up as needed. Document all follow-up attempts in patients' health records.

Conclusion

Some patients will make decisions regarding their health that are not in their best interests. These situations cannot always be avoided. However, providing patients with solid advice regarding these decisions, combined with the best care possible under the circumstances, will facilitate the best possible outcome for patients and minimize professional liability exposure for providers.

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