

# Poor Documentation and Other Missteps Result in Delayed Cancer Diagnosis for Pediatric Patient

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## Introduction

The discipline of healthcare risk management had its beginnings in the 1970s, and it has developed and become more sophisticated in the ensuing decades. One of the foundational tenets of healthcare risk management is that adequate and appropriate documentation of patient care positively influences patient outcomes. Conversely, documentation failures can contribute significantly to suboptimal outcomes, as illustrated in this tragic case.

## Facts

The patient was a newborn male who was delivered without any difficulty in May of Year 1, following a normal, full-term pregnancy. His parents initiated care at a five-person pediatric practice. MedPro insured all five physicians and their professional corporation.

At the practice, patients did not have assigned physicians; rather, they were scheduled based on physician availability. To minimize any effects from the lack of continuity, the physicians met monthly to “round table” the patients.

Dr. J performed the patient’s first examination, and he was normal and healthy in all respects. He was then seen at 6 days (by Dr. A), 1 month (by Dr. D), 2 months (by Dr. M), and 3 months (by Dr. A). At all of these visits, he was healthy and developing normally.

In September, at a 4-month visit, Dr. A documented that the patient had no deformities or spine or skin lesions; however, the patient’s father pointed out a pea-sized lump on the upper left back adjacent to the spine. Dr. A examined the lump and concluded it was either a cyst, hemangioma, or lipoma. He indicated that

it was not concerning and would be observed for any changes. Dr. A did not record this lump in the patient's record.

At an October visit, Dr. A observed that the patient was developing normally (although the lump was now the size of a dime). For some reason, this visit was not documented in the patient's record. In November, Dr. A saw the patient again, and the exam was normal. However, the patient's mother pointed out the lump to Dr. A (who otherwise didn't notice it). At that point, it was about the size of a nickel.

After examining the lump, Dr. A concluded that it was a lipoma and didn't require lab work or specialty consultation. He stated that they would continue "watchful waiting." Again, the presence of the lump and Dr. A's examination of it were not documented.

Dr. M conducted the patient's December visit and found nothing concerning. His examination of the lump caused him to also conclude it was either a cyst, hemangioma, or lipoma, and that continued observation was appropriate. Dr. M's documentation of the visit did not include any mention of the lump.

Later in December, the patient's mother called the office and talked to Dr. H (another doctor in the practice) because the patient was having

trouble sleeping. The mother could not tell if the trouble sleeping was related to the lump, and she did not mention it to Dr. H on the phone. After reviewing the patient's record, Dr. H did not have the patient brought in for an examination; she simply advised the mother regarding consoling and soothing techniques to help with sleep.

In January of Year 2, the mother consulted with Dr. G — a pediatric orthopedist not affiliated with the pediatric group — because the lump continued to grow and was the size of a quarter. The patient was still having trouble sleeping, but the mother couldn't tell whether the sleep issues were related to the lump. Dr. G ordered an X-ray of the spine, an ultrasound of the lump, and a complete blood count.

The patient was taken to the pediatric practice for the lab work, but no examination was performed. The lab work showed elevated platelets (433,000), low neutrophils (7 percent), elevated lymphocytes (78 percent), elevated monocytes (13 percent), and a normal sedimentation rate.

The ultrasound showed a 5 cm x 1.1 cm x 2.9 cm solid mass (correlating with the clinically palpable lump), with areas of increased echogenicity. Follow-up with MRI was recommended but not performed at that time.

At the end of January, Dr. J saw the patient for an upper respiratory infection. A full exam was not performed, and no mention of the lump was made in the patient's record. In February, Dr. A saw the patient for a well-baby visit. The mass was noted at that visit, and — at the mother's insistence — an MRI was ordered.

The MRI showed a well-circumscribed, enhancing left paraspinal mass extending from T10–L2, without involvement of the spine. The patient was immediately referred to a tertiary cancer center. A biopsy revealed a FOXO1 fusion-positive alveolar rhabdomyosarcoma, Stage 3, with no metastasis at that time.

The patient began chemotherapy and had a complete resection, followed by radiation therapy throughout Year 2. He suffered nausea and vomiting, sleep disturbances, constipation, and weight loss. An MRI in April of Year 3 indicated a new paraspinal/pleural lesion, adjacent to T9. A CT scan of the chest also indicated polygonal lesions. Because these chest lesions were considered inoperable, chemotherapy was resumed. Additional imaging in January of Year 4 indicated further metastasis, and it was believed that the patient would not survive to age 5.

A medical malpractice lawsuit was commenced against Drs. J, A, M, and H. At the conclusion

of discovery, Drs. J and H were dismissed because of their limited involvement in the case. The case against Drs. A and M proceeded, and it was ultimately settled (at their request) with a payment in the high range. Defense costs were also in the high range.

## Discussion

To start, some explanation of the patient's condition is helpful. A rhabdomyosarcoma is an extremely rare but very aggressive cancer (about 500 cases annually in the United States). The literature suggests that when the condition is diagnosed and treated before it reaches 5 cm in size, the outcomes are generally considerably better. In this case, the mass was not diagnosed until it had crossed the 5 cm threshold, thereby complicating treatment and diminishing the likelihood of a favorable outcome. In short, time is of the essence when diagnosing this type of cancer.

A root cause analysis of this case identifies some deficiencies that, if they had not occurred, might have allowed for an earlier diagnosis. The first issue was the practice of not assigning patients a primary care physician, but instead having them see whichever of the five physicians was available. This presented a serious challenge from a continuity-of-care standpoint. Although the physicians

“round-tabled” their patients to ensure that they were all on the same page, doing so does not replace the familiarity with the patient/parents that the assigned-doctor approach provides.

An important event in this case was the September (4-month) visit with Dr. A. The defense expert provided some important context for this and subsequent visits in stating that “lumps and bumps” are not uncommon in newborns, and the pea-sized lump was not something that should have triggered aggressive investigation. However, Dr. A’s failure to notice it at all (the father pointed it out), and to then document “no spine or skin deformities,” is somewhat hard to understand.

Significantly, when the patient was seen in October, the visit was not documented at all. Hence, the details of that visit are not known. He was next seen in November by Dr. A, and the documentation was basically identical to the September visit (no skin or spine deformities), even though the lump had grown to the size of a nickel. The defense expert opined that the change in size should have at least piqued Dr. A’s interest. Yet, without prior documentation, Dr. A was likely unaware of the size difference.

In December, Dr. M saw the patient, and the lump was quarter-sized. When Dr. M examined

it, he concluded it was no cause for concern. (According to the mother, Dr. M actually laughed when she expressed her concern.) Dr. M may have thought differently about the lump if he knew that it had grown to its present size from pea-sized since September. At this point, the lump was approaching the 5 cm threshold, if it was not already there.

Later in December, the mother had a telephone conversation with Dr. H regarding the patient’s sleep issues, which appears to have been appropriately handled from the standpoint of the chief complaint. Because the mother did not mention the lump, and the patient’s record had no documentation about it, Dr. H cannot be faulted for her failure to evaluate it.

By January, the mother had consulted the pediatric orthopedist, which ultimately led to the correct diagnosis (although it’s unclear why the MRI did not occur sooner).

## Summary Suggestions

The following suggestions may be helpful when providing ongoing care to a large volume of patients:

- In multiple-physician practices, try to ensure that patients have an assigned physician as their primary provider. Although it may not always be possible for

patients to see their primary provider, it is much easier for that provider to “keep up” with their assigned patients, thus enhancing continuity of care.

- Develop thorough documentation policies, including guidance related to “copy and paste” in electronic health records. Dr. A’s record entries for September and November were almost identical, suggesting he may have copied and pasted from one entry to the next. Although convenient, this documentation shortcut can lead to the incorrect proliferation of information and can seriously undermine the credibility of the health record.
- Routinely audit patient records to ensure they capture adequate information, to check for errors, and to verify consistency with organizational documentation policies. A record audit in this case might have identified the copy/paste issue as well as the missing documentation.
- Always document clinically significant findings in the patient record. As mentioned earlier, “lumps and bumps” are common in newborns, which would tend to suggest that they are not significant. However, when parents or caregivers point out concerns (even if the problem

is likely benign), documenting their worries is prudent. Doing so allows providers to follow up at subsequent visits and facilitates continuity of care if multiple providers see the patient.

- Be aware of common cognitive biases that may lead to diagnostic errors, such as anchoring and availability bias. When the lump in this case was first identified, it was reasonable to initially think it was benign. However, the index of suspicion should have increased each time the lump grew larger. A bias referred to as “zebra retreat” may have been at play. Zebra retreat is related to availability bias and occurs when clinicians retreat from a rare diagnosis in favor of a more likely explanation or more common condition — even when the rarer diagnosis becomes more probable.
- Engage patients and their families in the diagnostic process through education, access to health records, and opportunities to provide feedback about the diagnostic process and any issues related to the care provided. In this case, the parents repeatedly raised concerns about the patient’s lump, but they were quickly dismissed. Had the parents been

viewed and included as active participants in the healthcare team, their concerns might have been more carefully investigated, which could have resulted in a timelier diagnosis.

## Conclusion

Many healthcare practices have long-term relationships with patients, and these patients experience continuous changes in their health

and other life circumstances. One of the great challenges is “keeping tabs” on these patients over time.

Thorough documentation of previous care and patient/caretaker input can greatly assist in identifying clinically significant developments, addressing them in a timely manner, ensuring the best possible outcomes, and limiting liability exposure.

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