



# CASE REVIEW

A Review of Case Studies for MLMIC-Insured Physicians & Facilities

November 2018

## CASE STUDY #1

### *Procedural Deviations Result in Incorrect Hodgkin's Lymphoma Diagnosis*

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A 22-year-old university student presented to her university's health center on April 16, 2013, and was seen by a pediatrician. The patient complained of an unintentional 13-pound weight loss, as well as diffuse right cervical and post occipital adenopathy. A monospot test was negative. Laboratory test results revealed 26% lymphocytes.

The patient returned on May 6, 2013, with complaints of a hard, enlarged lymph node that had been present for two days. The pediatrician ordered an EBV titer and additional laboratory tests. The titer was negative, and the patient's lymphocytes had dropped to 12.4%. The patient was referred to a pathologist for a fine needle aspiration.

A MLMIC-insured pathologist performed a fine needle aspiration of the right cervical lymph node that was inconclusive. The patient was referred to a surgeon for a biopsy and underwent a cervical lymph node excision. The same pathologist reviewed the slides. His diagnosis

was "classical nodular sclerosing Hodgkin's lymphoma." The facility's policy was to obtain a second opinion for all positive diagnoses, which could take up to ten days. Because the patient was returning to California for treatment, the pathologist did not send the slides for a second opinion as he was concerned this would delay the patient's oncology treatment.

The patient went to an oncologist in California, who did not request the pathology slides from the nodal biopsy. The plaintiff underwent egg harvesting. A bone marrow biopsy showed no evidence of bone marrow involvement. A PET/CT scan showed involvement of the palatine tonsils, cervical lymph nodes, supraclavicular nodes, as well as possibly some axillary lymph nodes. She received four cycles of ABVD chemotherapy, during which she lost her hair and experienced nausea and vomiting. A subsequent PET/CT scan showed interval resolution. She then underwent radiation. During

this time, she suffered from anxiety and depression.

The plaintiff was considered to be disease free and subsequently completed her college courses. She then obtained a position as a research assistant at Massachusetts General Hospital (MGH). Her physician there requested the original slides from the fine needle aspiration and the node biopsy. Four pathologists from MGH performed blind readings of the slides. They all concurred that the slides were consistent with mononucleosis.

The patient commenced a lawsuit against the university, the student health center, the pediatrician, the MLMIC-insured pathologist and the MLMIC-insured hospital where the pathologist worked. They alleged that our insureds were negligent in diagnosing the plaintiff with Hodgkin's lymphoma when in fact she only had mononucleosis.

The pathologist indicated that at least seven hematologic slides

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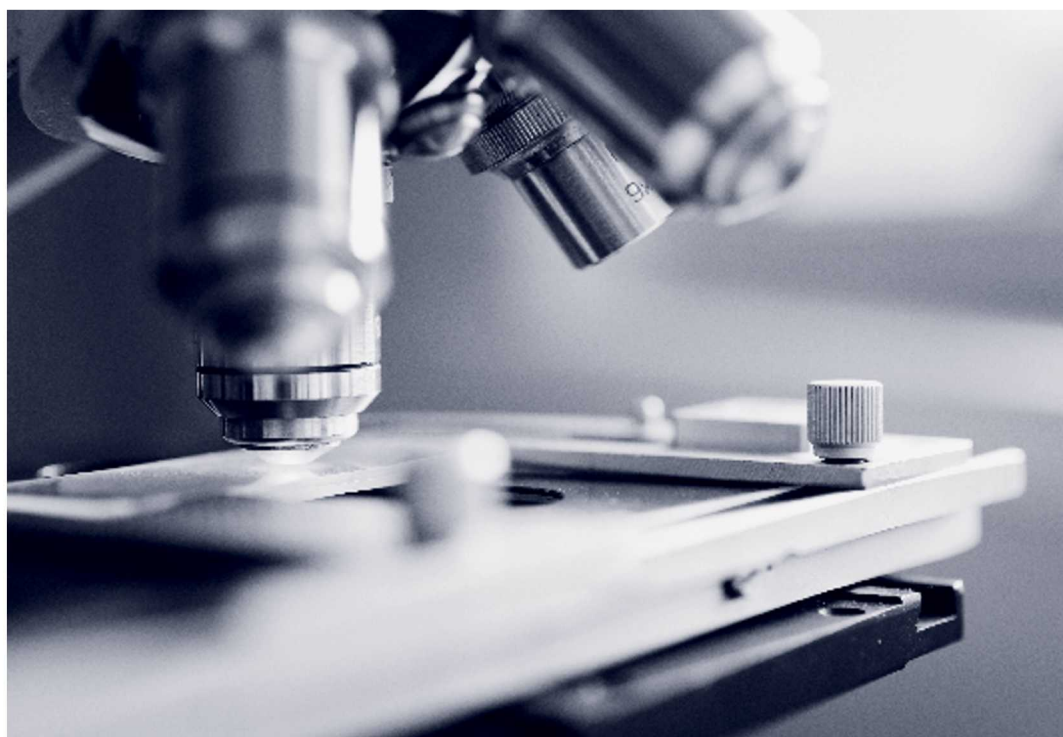
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**Case #1** *continued*

were generated from the node biopsy: a hematoxylin stain; an eosin stain slide; and five immunostain slides as well as a negative control, which is not stained with an immunohistochemical antibody. The negative control slide was prepared to make sure there was no false positive staining. To assist in his readings, the pathologist performed the CD15 stain, which was positive for scattered large cells with perinuclear and Golgi staining pattern, as well as background neutrophils and basophils. The CD3 stain was a T-cell marker that was diffusely positive in the background cells, consistent with Hodgkin's lymphoma. The CD20 stain was a B-cell marker that stains Reed Sternberg cases in 20% of cases, and that stain had some positivity. The CD30 stain is a prototype Reed Sternberg cell pattern stain, which stained positively in the patient's large cells with a classic Golgi staining pattern. The

EMA stain was used to rule out whether the patient had a condition mimicking Hodgkin's lymphoma, and that stain was negative or weak. Therefore, the pathologist believed that these slides showed an early proliferative stage of Hodgkin's lymphoma. Classic binucleated Reed Sternberg cells were identified. The architecture of the patient's cells was disrupted and effaced. The cells were atypical with large nuclei, ample cytoplasm, and macronucleoli. Finally, he noted increased connective tissue forming vaguely nodular areas.

MLMIC experts in pathology reviewed the slides and had varying critical opinions. Criticisms of the original reading of the slides included that the morphology of the cells were inconsistent with Hodgkin's lymphoma. Reed Sternberg cells were not present, the cells were not effaced, but rather the landmarks were preserved and the paracortex was expanded. Overall, the patient's





large mononuclear cells were misdiagnosed as Hodgkin's cells, rather than benign immunoblasts.

The experts felt that the insured pathologist did not test a sufficient number of stains or markers. All of the reviewers agreed that the pathologist failed to meet the standard of care by not obtaining a second review of the slides. Based upon these significant criticisms, the pathologist consented to settle this litigation.

Because the plaintiff alleged numerous and significant side effects and damages from the treatment she underwent, MLMIC retained an expert oncology reviewer who then evaluated what her potential side effects might be. He opined that the patient was at a slightly elevated risk of sustaining a cardiomyopathy from Adriamycin and radiation.

This risk will likely subside after her childbearing years have passed. She will need to undergo biannual ultrasounds, EKGs, and echocardiograms and be closely monitored during any pregnancy for cardiac symptoms. She has a low risk of infertility. Secondary to radiation exposure, she is four to six times more likely to develop breast cancer. Therefore, she should receive annual mammograms starting between the ages of 30-35 and alternate with MRIs. She has a 1% risk of leukemia for five to ten years after her treatment. If she develops leukemia, she is more likely to have a poor outcome. Treatment with bleomycin placed the patient at a slight risk of future pulmonary complications such as shortness of breath. She cannot have oxygen doses as high as a typical patient.

Radiation has made her more prone to dental abscesses.

The patient initially demanded \$2 million to resolve the lawsuit. The university, the student health center and the pediatrician were discontinued from the case. The MLMIC defense attorney performed a verdict analysis which revealed that a verdict of \$1 million or more would likely be sustainable on appeal. The lawsuit settled at mediation for \$585,000 on behalf of only the MLMIC-insured pathologist.

## CASE STUDY #1 – A LEGAL & RISK MANAGEMENT PERSPECTIVE

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In the university population, mononucleosis is a relatively common occurrence. The physician in this case used the monospot test to attempt to diagnose this illness. However, this test frequently results in both false positives and false negatives. In fact, in a May 8, 2018, online article, the CDC National Center for Immunization and Respiratory Diseases stated that the monospot test is not recommended for general use because of this fact. While it is not clear how long the patient had

been symptomatic, it seems reasonable that the physician should have considered doing further testing for mononucleosis, or waiting at least a month prior to performing a cervical lymph node excision.

Once the excision was performed, the specimen was viewed only by the insured pathologist. However, hospital policy required that a second reading be obtained from a known cancer treatment center before a final diagnosis was to be given to a patient. The pathologist

failed to send the slides for a second reading as required, deviating from the hospital's policy and procedure.

The MLMIC pathology experts who reviewed this case opined that the pathologist further deviated from the standard of care by failing to test a sufficient number of stains. Unfortunately, his failure precipitated a long chain of untoward events for the patient. Not only did she undergo extensive treatment, but

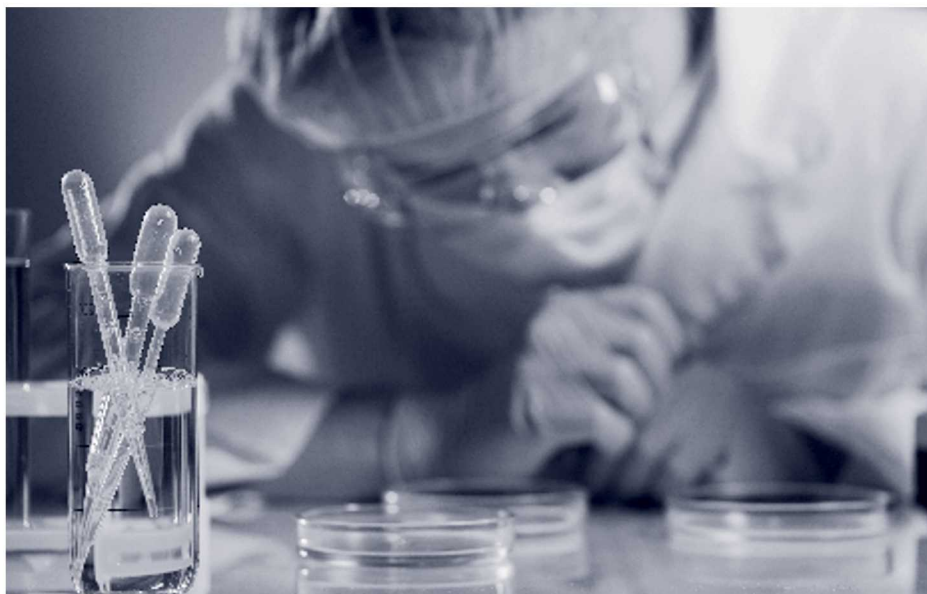
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## Case #1 *continued*

she suffered serious current sequelae and future risks of other sequelae as a result of that treatment. Therefore, defending the pathologist would have been very difficult. Further, his defense counsel performed a verdict search which indicated that the pathologist was potentially subject to sustaining a verdict well beyond his primary policy limits. A verdict search is a review of cases in a given state that contain similar facts and/or injuries that allows the defense counsel to determine the potential value of a verdict against his or her client. It is a necessary and valuable tool when trying to resolve a case such as this. As a result of both the expert opinions and verdict search, the defense counsel, rather than going to trial, made vigorous attempts to settle the lawsuit against the pathologist.

Interestingly, the plaintiff did not sue the California oncologist. However, he too clearly deviated from the standard of care. He failed to view or even ask to review the slides of the patient's biopsy before commencing aggressive treatment. In fact, he had the last clear chance to prevent the patient from being injured. Although it was not clear why the patient sued only the MLMIC-insured pathologist, it may have been related to the California cap on non-economic damages, which limits those damages to \$250,000.

This case again reflects the critical need to have appropriate communication between all providers (pathologists and oncologists), as well as the importance of having pathology slides reviewed by a second physician prior to initiating aggressive anti-cancer treatment. That review



did not take place either in California or where the defendant pathologist practiced. However, only the pathologist was found legally responsible for the patient's present and possible future sequelae.

The pathologist's \$585,000 settlement was then reported to the National Practitioner Data Bank (NPDB) as required by law. The purpose of the NPDB is to alert state licensing boards, hospitals and other healthcare facilities when there is a malpractice settlement or verdict, misconduct sanctions by the New York State Department of Health Office of Professional Medical Conduct (OPMC), or negative actions by a facility's medical staff where a physician is practicing. This information is used not only for purposes of credentialing and licensure, but also to prevent professionals from going to another state to practice without the new facility or state having full knowledge of his or her

prior record. Additionally, a settlement must be reported to the NPDB to enable hospitals, other healthcare facilities, and insurers to properly re-credential their medical staff. Finally, the New York State Physician Profile website requires that settlements be promptly reported, and information updated within 30 days of a change such as a verdict or settlement. All profile information must generally be updated within six months prior to the expiration date of the physician's renewal of licensure registration. This is mandatory and failure to do so could be considered misconduct by the OPMC.<sup>1</sup>

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1. New York State Public Health Law 2995-a (4)



## CASE STUDY #2

# *Multiple Communication Failures Contribute to Death From Aortic Aneurysm*

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*MLMIC Insurance Company*

A 72-year-old female had been a longtime patient of the MLMIC-insured family practitioner. The patient only came to see her physician for acute problems and was not compliant with her medication regimen. She was a longtime smoker. The patient was also being treated by a rheumatologist and an endocrinologist. Her past medical history included hypercholesterolemia, hypothyroidism, constipation, dermatitis, and seasonal allergies. Her father and uncle both had a history of myocardial infarction.

At her visit on October 21, 2011, the patient advised that she had been taking atenolol 50 mg for her blood pressure but had stopped this medication for approximately one week because her blood pressure (BP) was increasingly low. She stated that she routinely monitored her BP and self-adjusted her medication, as needed. At this visit, her vital signs were: pulse 90, blood pressure 144/80, and temperature 96.4. She weighed 148 lbs. The physician advised the patient to take her atenolol once a day and return to his office in one month for further monitoring and follow-up.

The patient returned to the office on November 21, 2011. She stated that she had been taking 25 mg atenolol when her blood pressure was high. Her blood pressure was 158/82 and her pulse was 92. The physician

counseled the patient that she must take the atenolol daily and that only if she became lightheaded could she either decrease her dose to 12.5 mg or come to the office to be seen. The patient was advised to return to his office in six weeks.

On January 10, 2012, the patient returned to see the physician. She stated that she had been taking 25 mg of atenolol and that her blood pressure remained low. However, in the office, the patient's blood pressure was 152/90 and her pulse was 78. The physician placed the patient on amlodipine and told her to return in three to four weeks.

The patient returned to the office on January 26, 2012. She reported that, in the interim, she had undergone allergy testing and also had been seen by her rheumatologist. She told the physician that her liver enzymes and rheumatoid factor were both elevated. However, while the physician had not received any correspondence from her other treating physicians, he had received a copy of her recent laboratory test results. Her potassium was low, her ALT, AST, and rheumatoid factor were high, and her ANA was mildly elevated. The physician ordered a CRP, a TSH and free T4, a liver profile, and an abdominal ultrasound.

On January 31, 2012, the patient did undergo both the laboratory

tests and the abdominal ultrasound. The abdominal ultrasound revealed fatty liver changes and a 3.1 x 3.6 cm abdominal aortic aneurysm. Her TSH, LFT, CRP and C reactive protein were all elevated and her liver function tests were abnormal.

On February 9, 2012, the patient returned to see the physician complaining of sore knees and hands. Her right side and hips were also painful. The physician reviewed the results of the patient's laboratory tests. Although he claimed he also reviewed her abdominal ultrasound, he did not discuss the results of that test. Rather, he focused on whether the patient had rheumatoid arthritis and liver disease. He placed the patient on a short-term course of prednisone, which was to be tapered, and told her to continue taking all her other medications and return to see him in one week.

On February 16, 2012, the patient returned. She stated that she was able to move better, especially with the 40 mg of prednisone. However, she advised him she was taking the amlodipine only "as needed," dependent on her blood pressure readings. The patient was told to continue the 40 mg of prednisone for one week and then taper the dose to 30 mg.

On February 22, 2012, the patient returned to the physician's

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## Case #2 *continued*

office. Although he again reviewed her laboratory test results, he failed to disclose the results of the abdominal ultrasound to her. On March 7, 2012, he received a report of an abdominal CT scan and the aneurysm was present and still more than 3 cm in size.

The patient did not return to see the physician until November 4, 2013. She complained of congestion, a blocked right ear, a cough, sore throat, headache, and slight nausea. The physician examined her lungs and found bilateral rhonchi and wheezing with rare crackles. Her heart rate was regular. He diagnosed an upper respiratory infection and bronchitis and treated her with antibiotics.

The next day, the patient called the office to say she was experiencing difficulty breathing. She was advised to promptly go to the emergency room. When she arrived, she was immediately intubated and seen in consultation by a cardiologist. Her echocardiogram revealed minimal systolic contractures of the left ventricle. The patient expired in the emergency department.

An autopsy was performed and revealed a 6.0 cm abdominal aortic aneurysm that had ruptured, and

400 cc of blood in the peritoneal cavity. The patient's urine tested positive for opiates and methadone. Further, she had atherosclerotic heart disease but without evidence of an acute occlusion. However, microscopic studies of the myocardium revealed an acute myocardial infarction. Finally, there was pathological evidence of an arrhythmogenic right ventricular dysplasia.

The patient's family commenced a lawsuit against the family practitioner, the cardiologist, the emergency department physician, the radiologist, and a nurse practitioner. The allegations included the failure to notify the decedent that she had a dangerous and deadly medical condition that was seen on the ultrasound ordered by the family physician more than a year prior to her demise. The patient's infrarenal aortic aneurysm had also been recognized by the radiologist and described in the radiology report sent to the family physician. Yet he failed to notify the decedent of this abnormality and refer her promptly to a higher level of care. Because the aortic aneurysm went untreated, it ultimately led to the decedent's untimely death.

The family practitioner initially claimed that he only saw the patient for acute problems. Further, he tried to defend himself to his attorney by blaming the other providers who managed her blood pressure and other chronic conditions. He also claimed that the 3.6 x 3.1 aneurysm seen on the ultrasound was an "incidental finding" and that, at 3 cm in size, it was not dangerous. He advised that if the aneurysm was larger than 5 cm, he would have been concerned and promptly moved to have the aneurysm investigated and addressed by specialists.

All of the physician's claims were of grave concern to the family practice experts who reviewed the case for MLMIC. This case was also reviewed by MLMIC experts in internal medicine and vascular surgery. All of the experts were concerned about the deficits in the care provided, and unanimously recommended that the lawsuit be promptly settled only on behalf of the family practitioner. Thus, his consent to settle was obtained early in the lawsuit prior to depositions. The lawsuit was then settled for \$400,000 on behalf of the family practitioner.

## CASE STUDY #2 – A LEGAL & RISK MANAGEMENT PERSPECTIVE

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This case was replete with risk management issues. The patient was known to be noncompliant and had a history of smoking, a family

history of heart disease, and elevated cholesterol levels. Yet her family practitioner did not seem to make and document any efforts to encour-

age her to: discontinue smoking; consistently take her medications for hypertension; see a pulmonologist when she became symptomatic; or



even recommend regular x-rays of her lungs. Thus, he failed to comply with the standard of care for a patient with those risk factors. From a risk management perspective, his failure to deal with the patient's noncompliance led to her demise.

The radiologist also deviated from the standard of care. When a radiologist identifies a key abnormal finding such as an aortic aneurysm, this physician must not only document this clearly on the report, but is also obligated to pick up the telephone and actually speak to the ordering physician, which this radiologist failed to do. Further, there was no indication that the family practitioner actually reviewed the radiology report. He failed to initial the report, if it had arrived at his office in paper form, or respond to it in the electronic record. In fact, there was no evidence that he had ever reviewed the results. However, if he had reviewed the results, he then failed to notify the patient promptly of the test result by telephone and did not discuss them with her at her next visit. Ironically, that visit was only two weeks after the test had been performed and the aneurysm identified.

This case not only exemplifies the very critical importance of communication between a radiologist and a family physician, it also highlights the importance of communication between the physician and patient. The failure of both physicians to communicate to the patient the abnormal results of the test ordered by the family physician led to the patient's death from the eventual rupture of this aneurysm. It also

confirms the importance of having a tickler system to advise a physician as to whether a report has been received after a test is ordered and to follow up on that result when it is received.

It is difficult to understand why, only two weeks after the ultrasound results were received, this physician failed to discuss those test results with the patient. This raises the question of whether he even reviewed his notes from the patient's most recent visit before or during this visit. If he had done so, he should have noticed that he had ordered this test. The ques-

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tion most often posed by a plaintiff's attorney to a jury is why would a physician order a test if he or she is not interested in seeing the results? There is no justifiable answer to this question.

Another concern was the physician's failure to respond to the patient's continued noncompliance to adhere to the treatment regimen for her multiple medical problems. When a patient is consistently noncompliant and only comes in for acute problems, it is the physician's duty to both warn the patient of the risks of such noncompliance verbally, as well as to document those warn-

ings. If the patient's noncompliance continues, the physician must consider the risk of liability incurred by continuing to treat a noncompliant patient. If the risk is substantial, discharging the patient from the practice due to noncompliance must be considered.

Consistently noncompliant patients place physicians at serious risk for liability. This is particularly true with the new extended statute of limitations of seven years for the discovery of a cancer or tumor. Although this case did not involve such findings, the patient's continued presence in his practice did extend the family physician's liability over a longer time period of continuous treatment. Therefore, it is important to consider whether it is appropriate to discharge such patients when the patient does not permit the physician to practice within the reasonable and appropriate standard of care.

The final risk management issue identified was the family physician's failure to refer the patient – a known smoker – to a pulmonary specialist when she initially became symptomatic with shortness of breath and coughing. He was well aware of her history of smoking, and never considered ordering a chest x-ray before prescribing medications or making a referral earlier in her care. If he had done so, perhaps he might have averted the rupture of the sizeable aneurysm and the patient's death. Certainly, he should have discussed such a referral with her and documented that he had done so.



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