Findings of negligence followed communication lapses in BC aneurysm case

Karen Capen

Education

Éducation

Ottawa lawyer Karen Capen articled with the CMA's Department of Legal Affairs.

Can Med Assoc J 1997;156(1): 49-51.

In Brief

NEGLIGENCE IS SOMETIMES ESTABLISHED on the basis of lapses in communication and patient care management that, in hindsight, could have been avoided. A recent BC court case concerned a patient who died because of a ruptured aneurysm. A Supreme Court judge found that some of the physicians involved had failed in their duty to diagnose the patient's condition properly, or failed to communicate to one another significant signs of the patient's illness, and failed to refer him in time to the medical specialists who could have diagnosed and treated his condition promptly.

En bref

ON CONCLUT PARFOIS À LA NÉGLIGENCE dans des cas de manque de communication et de problèmes liés au traitement dont il se révèle à l'étude qu'ils auraient pu être évités. Dans un cas récent, en C.-B., où un patient est mort d'une rupture d'anévrisme, un juge de la Cour supérieure a conclu que certains des médecins en cause avaient négligé leur devoir en ne diagnostiquant pas convenablement l'état du patient ou en ne communiquant pas entre eux au sujet de ses symptômes, et en ne référant pas à temps le patient à un spécialiste qui aurait pu établir le diagnostic et entreprendre le traitement sans délai.

Jason Law died as a result of bleeding caused by a ruptured aneurysm. What makes his case remarkable is the sequence of events that followed a visit to his family physician in British Columbia for investigation of recurring headaches.

In fact, Jason Law saw 9 physicians in the 3 months prior to his death, some of them more than once. They included his family physician, her locum tenens, an ophthalmologist, a neurologist, an internist in an emergency department, an emergency physician he consulted en route to Victoria, and a succession of neurosurgeons — 2 in Victoria and 1 in Vancouver.

In 1994 the British Columbia Supreme Court ruled that the problems leading to the patient's death were caused by inadequate communication concerning physicians' observations and suspected diagnoses as the patient was referred from doctor to doctor.

The plaintiff was Law's widow, the administrator of her husband's estate, who was seeking damages for negligence. The defendants were the family physician who had looked after Law for 7 years, the locum tenens, the ophthalmologist and the emergency department internist.

According to the May 1994 judgement filed by a trial judge of the British Columbia Supreme Court, the chronology of events that ended with Jason Law's death unfolded this way.

On Jan. 17, 1991, Law and his wife, Nancy, went to see his family physician, Dr. A, because of a severe headache. They discussed his level of stress and he was given a renewed prescription for pentazocine and diazepam. Dr. A was then away from her practice until Mar. 3, but Dr. B covered for her as a locum tenens.

Law saw Dr. B on Feb. 25 because of another severe headache localized over his right temple. After examining the patient and noting ptosis and a slight slug-

© 1997 Karen Capen

gish reaction in his right pupil, she referred him to Dr. C, an ophthalmologist.

When Dr. C saw Law Feb. 27, he ruled out glaucoma and raised the possibility of ptosis of the right eye only. He did not observe any sluggish reaction of the right pupil. Dr. C later decided that Law should be investigated for a possible intracranial lesion, partly based on the patient's report of a sharply increased sexual appetite. However, he suspected that most of the patient's problems were caused by anxiety.

The judge ruled that it was the manner in which Dr. C returned the patient to Dr. B that led to a serious lapse in communication. Dr. C testified that he gave a note containing his findings to the patient, which was to be delivered to Dr. B; no such note was delivered. The note was not mentioned in Dr. C's records.

Dr. C also tried to phone Dr. B, but when he was unable to reach her directly he wrote a full consultation report, which he delivered personally on Mar. 6.

Around noon on Feb. 28, the day after seeing the ophthalmologist, Law was taken to an emergency department. There he was examined by an internist, Dr. D, who was the first physician available. That morning, still suffering from a headache, Law had felt a "pop" behind his right eye while straining on the toilet; he also experienced a dramatic increase in the level of pain. Dr. D described him as being in obvious distress, and injected meperidine, followed by a second injection 25 minutes later. While examining Law Dr. D did not notice any slowness of the pupil nor any ptosis. He found no neurological deficit, nor was there evidence that he had been told that in addition to the more severe pain Law was experiencing he had also vomited. He concluded that there was no neurologic cause, but thought Law had a "cluster-type" headache.

Dr. D then reported his diagnosis to Dr. B, who mentioned her observation of the slightly slowed reaction in the right pupil but did not refer to ptosis nor mention that Law had been referred to an ophthalmologist the day before. (At that time, she had not received the ophthalmologist's report.) Dr. B's mention of the slowed pupil reaction did not change Dr. D's diagnosis.

At the trial, testimony indicated that Dr. D did not observe the signs and symptoms typical of a burst aneurysm. (He stated that the pain reported by Law was in the wrong location for a ruptured aneurysm.)

Dr. B did another neurologic examination later that afternoon, but when asked by two of Law's friends to order a computed-tomography (CT) scan she told them it was unnecessary. She explained that she had checked for the "neck sign" — pain that develops when the patient's head is moved, which points to a ruptured aneurysm or other intracranial bleeding — and it was not present. The patient was given more meperidine and a prescription for additional analgesics. He was told to schedule a follow-up visit with Dr. B and sent home around 6 pm.

Law decided to wait for the return of his family physician, and made a Mar. 6 appointment with Dr. A. At that time Dr. A had Dr. B's notes from the Feb. 25 visit and the emergency hospital admission of Feb. 28, as well as the report from the emergency department internist. She may have received but not yet read the ophthalmologist's report, which the judge determined was delivered to her by Dr. B that same day. Dr. A concurred with the diagnosis reached by Dr. B and the internist, that Law was experiencing a "cluster-type" headache.

Law was to see Dr. A again on Mar. 11, but the meeting was rescheduled by his wife, who did not speak directly to the doctor about his condition. When Dr. A saw the patient Mar. 13 he was experiencing continuing pain. She thought his right eye was still sluggish, and at the Laws' request agreed to order a CT scan.

To do that quickly, she sent Law back to the internist, Dr. D, who saw the patient Mar. 15 and arranged a Mar. 18 appointment with a Victoria neurosurgeon. (Dr. D raised the possibility of an aneurysm as a potential diagnosis.)

On the way to Victoria, Law began vomiting and experienced such severe pain that he had to stop at another hospital. He was seen in the emergency department and given more analgesics by an unknown physician, but the records there did not show that a neurologic examination was performed.

Law's condition was finally diagnosed Mar. 18 by the Victoria neurosurgeon, who employed a CT scan; the diagnosis was confirmed a day later by angiogram. Another neurosurgeon consulted in the case urged Law to have the surgery "as soon as possible."

Law asked for a second opinion and was seen by another Victoria neurosurgeon, who confirmed the diagnosis and need for surgery. That surgeon said there was a "moderate threat for rupture" and stated that the surgery would present formidable technical difficulties. It was not clear if he communicated this level of threat to the patient and his wife.

A Vancouver neurosurgeon agreed to perform the operation Mar. 26, but the aneurysm ruptured early on Mar. 25. The surgeon performed emergency surgery and clipped the aneurysm successfully, but the patient died 2 days later as a result of bleeding that occurred following the rupture.

The trial judge said several factors contributed to the delay in diagnosing the problem. "I have been critical of the doctors, but not all of the faults I have noted contributed to the delay in fact. Some were overridden by subsequent events."

Cases such as this illustrate that negligence is sometimes established because of lapses in communication and patient management that, in hindsight, easily could have been avoided. In the end, the judge found 2 of the 4 defendants — Drs. A and B — guilty of negligence.

He ruled that the defendants, some of them in combination, either failed in their duty to diagnose the patient's condition properly or failed to communicate to each other significant signs of Law's illness, and also failed to refer him to medical specialists who could have diagnosed and treated his condition promptly.

The judge found Dr. A negligent for failing to read and act on the ophthalmologist's report when it reached her file on Mar. 6. Once Dr. A had read Dr. C's report, said the judge, she should have recalled the patient at once to begin the process of ruling out or confirming such a threatening condition.

The judge also ruled that Dr. A should have contacted Drs. C and D for an urgent discussion of Dr. C's report and subsequent examinations. Dr. A was bound to take seriously Dr. C's concern about an intracranial lesion, since it was raised by a specialist to whom she had referred her patient.

The trial judge said Dr. C was careless in failing to communicate his suspicion of an intracranial aneurysm more quickly to Drs. A and B. However, he ruled that Dr. C's report was delivered to Dr. A early enough to have triggered an aggressive inquiry, certainly before Mar. 16, and that the failure to communicate therefore did not amount to negligence.

Dr. B was found negligent in law because she had not informed Dr. D about the consultation with the ophthalmologist. Had she done so, a chain of communication probably would have been established that could have uncovered the possibility of intracranial lesion — thereby leading to a more intensive inquiry before Mar. 13.

Finally, the judge ruled that the internist's failure to document adequately his examination on Feb. 28 did not contribute to the delay in getting the patient to Victoria. Dr. D's examination was found to be proper and his cursory record-keeping was not seen to mislead either Drs. A or B. His failure to consider an aneurysm was not found to be negligent, partly because he had been deprived of a vital piece of knowledge — that the ophthalmologist had recommended investigation for a possible intracranial lesion.

The judge noted that during the trial physicians had testified that they felt constrained by the British Columbia Medical Insurance Plan and by standards developed by the British Columbia Medical Association that asked them to restrict the use of CT scans as diagnostic tools. It is important that physicians consider carefully the judge's reaction to these concerns, which had been expressed by both defendants and expert witnesses.

"I respectfully say . . . that if it comes to a choice between a physician's responsibility to his or her individual patient and his or her responsibility to the medicare system overall, the former must take precedence in a case such as this."

He added that "the severity of the harm that may occur to the patient who is permitted to go undiagnosed is far greater than the financial harm that will occur to the medicare system if one more CT scan procedure only shows the patient is not suffering from a serious medical condition."

This issue of physician liability arising from resource-allocation decisions is causing growing concern for physicians. It will be addressed in a future column.

[Drs. A and B appealed the decision of the BC Supreme Court to the BC Court of Appeal, but it was denied in 1995. — Ed.]

Canadian Medical Association

130th Annual Meeting

Aug. 17–20, 1997

Victoria Conference Centre

Host: British Columbia Medical Society

Registration and travel information:
CMA Meetings and Travel
800 663-7336 ext. **2383**
Fax: **613 731-8047**

Association médicale canadienne

130e Assemblée générale

du 17 au 20 août 1997

Centre des congrès de Victoria

Votre hôte: l'Association médicale de la Colombie-Britannique

Pour inscription et information de voyage:
Département des conférences et voyages de l'AMC
Sans frais: **800 663-7336** poste **2383**
télécopieur: **613-731-8047**