Failure to diagnose tuberculosis

by Wendy Kaliszewski and Marc Clint

PRESENTATION

A two-year-old boy with a five-day history of intermittent fever and stomachache was brought to his pediatrician. The child was diagnosed with a viral syndrome and treated with simethicone drops, liquid electrolyte replacement, and ibuprofen.

PHYSICIAN ACTION

Six days later – on July 16 – the patient was taken to the ED at a local hospital with continued fever, vomiting, wheezing, and shallow respirations. A chest x-ray was taken and interpreted by Radiologist A as “diffuse moderate perihilar interstitial prominence. Focal consolidation lateral segment right middle lobe and follow-up for pneumonia.” The child was diagnosed with an upper respiratory infection, prescribed amoxicillin, and discharged. The mother was instructed to follow up with their pediatrician.

Over the next few days, the child continued with fever and poor appetite. A neurologic assessment showed a slight deviation of the child’s right eye. Pediatrician A ordered a stat MRI that revealed “diffuse ring enhancing lesions in bilateral cerebral and cerebellar hemispheres.”

The following day, Pediatrician B admitted the patient to the hospital for possible meningitis. Another chest x-ray was taken and compared with the film taken four days earlier. It showed persistent right middle lobe consolidation but slight improvement of the interstitial prominence. The patient was transferred to a children’s hospital.

Pediatric Intensivist A treated the patient. The physical exam revealed the patient had altered mental status and a mild inward deviation of the left eye without any ocular lesions. An MRI revealed “multiple cerebral lesions with ring enhancements.” Pediatric Intensivist A’s impression was the child had probable neurocysticercosis. The differential diagnosis listed multiple abscesses and lymphoma with a secondary diagnosis of hyponatremia due to an inability to secrete ADH.

The patient was prescribed decadron

This closed claim study is based on an actual malpractice claim from Texas Medical Liability Trust. This case illustrates how action or inaction on the part of the physicians led to allegations of professional liability, and how risk management techniques may have either prevented the outcome or increased the physician’s defensibility. An attempt has been made to make the material less easy to identify. If you recognize your own case, please be assured it is presented solely to emphasize the issues of the case.
abendazole. An infectious disease specialist and pediatric neurologist were consulted. Results of a lumbar puncture were negative and the child was transferred to the pediatric ICU.

Pediatric Neurologist A assessed the patient the next day. His examination revealed mild nuchal rigidity. After reviewing the chest x-ray taken at the first hospital, Neurologist A questioned whether the film actually showed “perihilar adenopathy” — a finding generally consistent with tuberculosis in children. He ultimately concurred with the diagnosis of neurocysticercosis.

Radiologist B reviewed the previous chest x-rays and his impression was “right upper and right middle lobe infiltrate/atelectasis, interval improvement from prior study.”

The pediatric infectious disease physician’s impression was also neurocysticercosis. He mentioned that the family traveled frequently to Mexico, but there was no family history of tuberculosis or contact with tuberculosis.

Radiologist C read the chest x-rays taken the following day, July 19. His interpretation was “frontal and lateral views of the chest again show a right middle lobe area of atelectasis and infiltrate without associated atelectasis and/or infiltrate of the right upper lobe in its apical segment. The heart is normal. There is no pleural effusion or pneumothorax.” His impression was no significant change.

Radiologist C also read the chest film taken from the prior hospitalization and mentioned that TB should be considered. However, he did not dictate his report until 3 days later and authenticated it 11 days later.

On July 24, the child became unresponsive. He developed fever and hyponatremia. EEG results suggested encephalopathy. A head CT noted brain edema in the right frontal lobe and left thalamus. A chest CT noted unusual vegetation at the junction of the superior vena cava and right atrium.

The following morning, Pediatric Intensivist B reviewed the chest x-ray from July 24 that showed “hilar adenopathy and right middle lobe process.” He questioned whether tuberculosis could play a role in the patient’s condition.

Pediatric Neurologist A ordered a repeat MRI that showed findings consistent with multiple tuberculoma and tuberculous meningitis. Results of acid-fast stains of gastric aspirate confirmed mycobacterium tuberculosis.

By the time the diagnosis was made, the patient had developed severe cognitive deficits that led to permanent disability.

**ALLEGATIONS**

A lawsuit was filed against three pediatric neurologists, two pediatric intensivists, three radiologists, and the children’s hospital. It was alleged that all three radiologists misread the chest x-rays and failed to consider tuberculosis as a possible diagnosis.

The plaintiff’s allegations focused on Radiologist C and included: failure to immediately notify the attending physician of the potential diagnosis of tuberculosis and failure to timely approve the report electronically.

**LEGAL IMPLICATIONS**

Two defense reviewers stated that tuberculosis should have been high on the list of differential diagnoses based on the clinical presentation and geographical area. A blind radiology review confirmed that tuberculosis should have been listed as a differential diagnosis based on the x-rays on July 11 and July 19. However, because of the number of defense experts involved, there were some inconsistencies in their opinions.

The three-day delay in dictating the radiology reports on July 11 and July 19 created a significant weakness for the defense. Radiologist C failed to mention the possibility of tuberculosis due to the suspected lymphadenopathy on the July 11 report.

The plaintiff’s attorney retained well-credentialed experts, who stated that the clinical presentation of the patient, along with lymphadenopathy on the various chest x-rays, should have made all the physicians suspicious for tuberculosis.

**DISPOSITION**

Due to the sympathetic nature of the case, the potential for a high damage award, and the inconsistencies in the testimonies of the defendants, this case was settled on behalf of all defendants.

**RISK MANAGEMENT CONSIDERATIONS**

Radiologist C was working as a temporary employee and used the hospital’s PACS system, which was similar to the system that he used in his practice. He mistakenly concluded that when he used voice dictation to produce his report, the report would automatically be available for others to view. Radiologist C was unsure what “authenticated” meant. In this system, the report needed to be finalized to generate a report that other physicians could view.

Whether reading x-rays at multiple sites as a locum tenens or a temporary employee, thorough training on the facility’s PACS system is crucial. Although there are similarities, some PACS systems use different methods to finalize and transmit reports.

Additionally, reports should be reviewed for accuracy. Radiologist C read the first chest x-ray as “right middle lobe area of atelectasis and infiltrate without associated atelectasis and/or infiltrate of the right upper lobe in its apical segment.” Later he admitted that he was only aware that this patient had “right middle lobe infiltrate” and that this was a typo.

It is important to review and dictate the patient history, which includes all previous diagnostic studies, especially when the films represent a pattern of serious ongoing problems.

Wendy Kaliszewski can be reached at wendy-kaliszewski@tmlt.org.

Marc Clint can be reached at marc-clint@tmlt.org.
Online reputation management is the process of preventing and repairing threats to your online reputation. It is done by tracking what is written about you and using techniques to address or moderate the information on search engine result pages or in social media. The goal is to promote positive or neutral content while suppressing negative content.

For physicians, online reputation management involves addressing information in three areas:

1. information found on search engine results pages (Google);
2. information found in social media (LinkedIn, Facebook, blogs); and
3. information on rating websites, such as Vitals, HealthGrades, Rate MDs, Yelp, and Angie’s List.

Recently, a physician received an email from a company offering online reputation management services to help him mitigate negative online reviews on sites such as Yelp, Google, and health care review sites such as Vitals.

There are hundreds of companies out there offering these services. However, physicians are urged to use extreme caution when choosing a reputation management company. Some companies engage in questionable techniques that could lead to disciplinary action by the Texas Medical Board (TMB).

Specifically, the company that emailed this physician said they “will post reviews for our clients to over 40 social media websites . . . We post up to 25 reviews per month.”

This claim is alarming in the context of medical practice. How are they managing to post reviews from the patients of a particular physician? Are they making up reviews and then posting them?

It is unethical and dishonest to post reviews on these sites that are not from actual patients. Physicians are held to a different standard than other businesses, and posting fake patient reviews is inappropriate. Doing so would also violate TMB advertising rules, as this type of advertising (and the TMB does consider this to be advertising) would be considered “misleading.”

Here are a few techniques for managing your own online reputation.

**KNOW WHAT IS BEING SAID.**
Conduct web searches on yourself and your practice regularly. Review the first 30 hits of the search. (Any hit past 30 is generally considered extraneous and not likely to be read.) Among the top 30 hits, what are these sites saying about you? Continue to monitor these online discussions.

**KNOW WHAT YOU CAN AND CANNOT DO ABOUT NEGATIVE REVIEWS.**
Because of health care privacy laws, physicians cannot respond to online reviews. The fact that a patient’s identity is protected information directly hinders the physician’s ability to refute a complaint. Simply acknowledging publicly that the complaining party is a patient breaches confidentiality and violates HIPAA.

**CONSIDER GIVING PATIENTS MORE CONSTRUCTIVE WAYS TO OFFER THEIR FEEDBACK.**
Conducting a patient survey, for example, would be a good way for patients to express their dissatisfaction and feel empowered.

Another option is to talk to the patient directly if you can identify who made the comment. This should be done in person or over the phone. Begin by asking the patient why he or she is dissatisfied.

It is also a good idea to investigate the patient’s complaints. Is the complaint legitimate? Was the problem with a procedure, a staff member, or the patient’s wait time? Can the problem be fixed?

**OPTIMIZE YOUR WEBSITE FOR SEARCH ENGINES.**
Optimizing your website for search engines will ensure that anyone typing in your name or your practice name will see your website at the top of the search list. Optimizing your site involves creating comprehensive and targeted meta tags and website page titles that help search engines index your site.

More sophisticated techniques include editing your site’s content, HTML, and associated coding; removing barriers to the indexing activities of search engines; increasing inbound links; or purchasing related web addresses.

**CREATE YOUR OWN BLOG.**
You cannot control what other people say about you online, but you can create your own.
(Continued from page 3)

story and your own content. Your blog could be as simple as one 300-word post per week.

The content could be about services you are offering to patients, the importance of getting a flu shot, or any other health topic that is relevant to your patient base.

CREATE A LINKEDIN PROFILE.
Your LinkedIn profile is another aspect of your online presence that you create. Add information about where you went to school, your specialty, and your practice. Make your profile public so that patients and potential patients can learn about you in a way you can control.

TAKE ADVANTAGE OF THAT “THANK YOU.”
The next time you receive a thank you note or email from a patient or family member, ask that person to post their comments on your blog, on your LinkedIn profile, or on physician rating sites.

Keep in mind that with the prevalence of smartphones and tablet PCs, patients can post a review of you — a positive or negative review — at any time and from anywhere. Even from your waiting room. Don’t ignore what’s being said.

For more information on online reputation management, please see the following TMLT resources:


• “You’ve been criticized online — now what?” the Reporter. May-June 2009. Available at www.tmlt.org/reporter.

Sources
1. Hoffman T. Online reputation management; cleaning up your image is hot, but is it ethical? Computer World. February 12, 2008.