MODEL EXPERT OPINION #1

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Date

Investigator/Medical Consultant (requesting review)
Medical Board of California
Street Address (of District Office requesting review)
City CA Zip

Re: Jane Doe, M.D.
Case: 17-2008-000000
Patient: Joe Smith

MATERIALS REVIEWED:

1. Investigation report
2. Memorandum from District Medical Consultant
3. 801 Report
4. Curriculum vitae of Dr. Jane Doe
5. Operative/Pathology report
6. Certified medical records from Dr. Jane Doe
7. Certified medical records from Dr. Jon Deere
8. Certified medical records from Eastside Community Hospital
9. Medical photographs
10. CD of interview of Dr. Jane Doe
11. CD of interview of Dr. Jon Deere

SUMMARY OF CASE:

This case was initiated by the Medical Board of California upon receipt of a Business and Professions Code, Section 801 report. Eighty thousand dollars was awarded to Joe Smith (patient) by XYZ Indemnity Company on behalf of their insured, Dr. Jane Doe. According to the report, the right side of the colon was removed on 7/26/04 for treatment of what appeared to be a colon cancer.
Review of the medical records of Dr. Doe showed that Dr. Deere had performed a colonoscopy for persistent abdominal pain on 7/25/04 (page 2). Dr. Deere obtained photographs of biopsy specimens of what he interpreted to be a right colon mass. Both Dr. Deere (gastroenterologist) and Dr. Doe (surgeon) agree that Dr. Deere contacted Dr. Doe the same day of the colonoscopy and asked him to operate on the patient (page 3 of Dr. Deere's records, page 1 of Dr. Doe's records). The patient was admitted to Eastside Community Hospital that afternoon (page 1 of hospital records). Dr. Deere gave the patient a bottle with a biopsy specimen to be hand carried to the hospital (Dr. Deere's records, page 3). Dr. Doe claimed that Dr. Deere (referring physician) had instructed her to operate on patient John Smith without awaiting for biopsy results because the colonoscopy findings were consistent with cancer. The surgeon, Dr. Doe claimed that Dr. Deere had told her that this was a very fragile patient, who just had undergone an extensive bowel preparation and he wanted to avoid the patient the trauma of a second bowel preparation (page 3 of Dr. Doe's records). Dr. Deere stated that as shown by the colored photographs, colonoscopy findings were "consistent with colon cancer."

Preoperative work up showed that there were electrocardiographic abnormalities consisting of T-wave inversions and some ST depressions (page 7 of hospital records). Chest x-ray disclosed a 7 mm coin lesion of the right lung (page 9 of hospital records).

A partial colectomy was performed by Dr. Doe on the day following colonoscopy (page 12 of hospital records). All involved parties agreed that at that time, no biopsy results of colonoscopy specimens were available. At operation, a mass like structure was palpated by the surgeon in the ascending colon (page 25 of hospital records). There was no documentation of a thorough evaluation of the remainder of the large bowel nor of a complete abdominal exploration. Dr. Doe performed removal of the right side of the colon (page 16 of hospital records). She re-established the continuity of the bowel transit by bringing together the terminal small bowel with the remaining colon. Upon removal of the operative specimen, she opened it and realized that what appeared to be tumor was actually a conglomerate of hard feces (page 16 of hospital records). She told the patient and the patient's family of her error. She watched the patient postoperatively. Hospital records showed that on 7/30/04 and 7/31/04, serum potassium was 2.5 and 2.6, respectively (pages 31 & 32 of hospital records). There was no documentation in records showing that the patient received aggressive treatment of this low serum potassium. The patient was discharged on 8/4/04.

MEDICAL ISSUES:

1. Initial evaluation of the patient by the surgeon

- Standard of Care:

Elective colon resection for colon cancer requires a positive diagnosis. This is achieved by awaiting the written pathologist's report of the biopsies taken at colonoscopy, or at least the pathologist's verbal report.

- Analysis:

Dr. Doe operated on this patient based on the verbal report of the colonoscopist and her own assessment of the photographs obtained at colonoscopy. She alleged that she wanted to avoid another bowel preparation to the patient. This is not a valid reason. The risk of performing an unnecessary colon resection by far outweighs the risks of another bowel preparation and waiting for a definitive pathology result.

- Conclusion:

Extreme departure from the standard of care for performing colon resection without a pathology report corroborating the suspected diagnosis of cancer.

2. Medical clearance for operation

- Standard of Care:

The standard of care is to evaluate the suitability for operation prior to performing general anesthesia and colon resection. This is best done by an internist, a cardiologist or a pulmonologist. Preoperative clearance for operation by the surgeon is acceptable if the surgeon has comparable knowledge, orders and interprets all required preoperative tests and properly acts upon evaluating the test results.

- Analysis:

This patient had co-morbid conditions. There was no documented discussion about the

abnormal electrocardiographic results which showed myocardial ischemia. No reason was documented of why the possibility of myocardial ischemia was not further evaluated prior to subjecting this patient to elective surgery. The presence of a lung coin lesion may or may not be related to spread of an alleged cancer. Its mere presence is not a contraindication for operation because even if this would be a small metastasis of the cancer, an unchecked colon lesion exposes a patient to early death due to bleeding, obstruction or perforation.

During the subject interview, Dr. Doe stated she referred the patient to cardiologist, Dr. Buck. However, Dr. Doe admitted that she did not document her evaluation of the patient, nor the referral to the cardiologist.

- Conclusion:

Simple departure from the standard of care for failure to document an evaluation for possible myocardial ischemia prior to elective operation.

3. Intraoperative evaluation of the mass

- Standard of Care:

The standard of care is to perform a thorough intraoperative evaluation of the suspected mass. This should include a thorough palpation to ensure that the mass is actually attached to the bowel wall and not merely bowel contents. It should comprise an evaluation of the adjacent bowel wall to detect the degree of penetration of the lesion into the wall. A comparison of the operative findings with the colonoscopic findings should be performed. Bowel palpation can determine whether the mass has the softness of stool or the hardness of a malignant tumor. The remainder of the colon should be evaluated to determine whether there is a single lesion or multiple ones. Thorough exploration should be performed to determine extension of tumor into the lymph nodes or other abdominal organs. The presence of peritoneal seeding by cancer should be checked by running the small bowel from the ligament of Treitz to the ileocecal valve. The surgeon should confirm the actual presence of a mass and to dispel any doubts regarding its presence, prior to proceeding with resection.

- Analysis:

In this particular case, the surgeon alleged to have performed "palpation of the small and large bowel" intraoperatively but she did not document a thorough examination of the colon nor

small bowel. She did not document evaluating the "mass" to rule out any entity simulating a tumor such as hard bowel contents. There was no mention in her report of any attempt to evaluate for bowel wall involvement, mobility of the suspected mass and staging of tumor. The surgeon's reliance on the colonoscopic findings was not justified. The colonoscopist had told her that the bowel was well prepared. The whole objective of proceeding promptly with operation was to take advantage of such alleged bowel emptiness. At operation, the surgeon corroborated that the bowel was not empty. Further reliance on the colonoscopist's contentions could not be justified.

- Conclusion:

Extreme departure from the standard of care for inadequate intraoperative evaluation and staging of suspected colon cancer.

4. Medical records keeping

- Standard of Care:

The standard of care is to proceed with operation after a history and physical had been documented in records.

- Analysis:

The history and physical of this patient was dictated five weeks after admission. It was performed after a surgical error and its consequences were known.

- Conclusion:

Simple departure from the standard of care for proceeding with operation without a history and physical examination in records.

5. Coverage of the postoperative internal medicine needs of the patient

- Standard of Care:

The standard of care is that the internal medicine needs of an operated patient be properly taken care for. This is usually done by an internist or hospitalist. It could also be properly

performed by a knowledgeable surgeon.

The standard of care is to keep the potassium level within normal limits (3.6-5.5 MEQ/L).

- Analysis:

In this particular case, laboratory tests showed persistently low potassium. No internist was consulted. The surgeon chose not to add a potassium "rider" but to slowly replenish the potassium level over several days.

- Conclusion:

Simple departure from the standard of care for failure to increase potassium level in a more rapid manner.

(Signature) Robin Jones, M.D. (Date) 1/5/09
ROBIN JONES, M.D., F.A.C.S.

References: