A pain in the back

Difficult patient, difficult diagnosis

NICOLE KROESCHE BA/LLB(Hons)
WALID JAMMAL MB BS, FRACGP, DCH, MHL

This is the first in a series of articles highlighting common medicolegal issues in general practice. Written by the claims and advocacy team at medical defence organisation Avant, the series is based on actual cases, with some details changed for privacy. Here, a patient's history of drug-seeking behaviour distracts his GP from a rare physical problem.

General practitioners often report difficulties in managing patients who exhibit drug-seeking behaviour, and these difficulties are evident from the cases that present to medical insurers. Drug-seeking behaviour can be a distraction from underlying physical and psychological problems, sometimes with serious consequences for patients, as illustrated by the following case.

Case history

Mr Smith, aged 42 years, had a multitude of medical problems. These included renal impairment, hypertension and an undifferentiated connective tissue disorder that was associated with chronic pain at various sites. He also experienced chronic back and neck pain following a previous workplace accident.

Mr Smith had been going to see Dr Jones, a GP, for many years. Their relationship was strained at times, as Mr Smith would often attend (sometimes without an appointment) complaining of pain and asking for repeats of analgesic prescriptions. Dr Jones was concerned about Mr Smith's long-term use of analgesics and the dosages he required but continued to prescribe them to him.

After not attending Dr Jones's surgery for some months, Mr Smith presented complaining of back pain that was much worse than usual. Dr Jones did not conduct a physical examination. He thought that the patient might have been exaggerating his pain to obtain a further script and did not order any imaging or make any referral. Four weeks before this visit, Mr Smith had an abscess drained on his foot by another GP. The patient did not volunteer this information to Dr Jones because, he later claimed, Dr Jones 'did not ask many questions'. Dr Jones advised rest.

Mr Smith's pain continued, and a few days later he returned to Dr Jones again complaining of increased back pain. Dr Jones prescribed pain relief but did not order any tests or make a referral. He did not document an examination of the patient.

One week later, Mr Smith went to the emergency department of his local hospital, complaining of severe back pain. Noting the long-standing history of chronic pain, the hospital doctors thought that he was exaggerating his symptoms. Mr Smith reported some 'leg weakness', but this was not investigated. He insisted that he not be discharged from hospital as the pain was too severe. He continued to complain of pain over the next week while an inpatient.

A week after hospital admission, an MRI was ordered and showed an epidural abscess in the lumbar spine. Despite specialist intervention at this time, Mr Smith suffered permanent spinal injury and is now wheelchair bound. According to the experts in the case, this poor outcome was attributed to the delay in diagnosis. The source of the infection was thought to have been the foot abscess.

A 'failure to diagnose' claim was lodged against the hospital and Dr Jones. This article discusses the issues relating to Dr Jones.

Discussion

The law of negligence

Proving negligence against a medical practitioner is a complicated legal process. Importantly, failing to diagnose a patient does not necessarily translate into a successful claim. For a claim in negligence to succeed, the plaintiff must prove (on the balance of probabilities) a series of steps:

- duty of care – that the medical practitioner had a duty of care to the patient
- standard of care – that the practitioner failed in discharging

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Ms Kroesche is Team Leader of Claims, Avant Mutual Group, Sydney. Dr Jammal is a General Practitioner; Senior Medical Advisor–Advocacy, Avant Mutual Group; Clinical Lecturer in the Faculty of Medicine, University of Sydney; and Conjoint Lecturer in the School of Medicine, University of Western Sydney, Sydney, NSW.

1. RISK-MANAGEMENT TIPS[3-5]

Managing patients with chronic illness and pain

- Managing patients with chronic illness and pain can be difficult. A multidisciplinary approach can help to develop and monitor a broad-based treatment plan
- Before embarking on a course of medication for a patient with chronic pain, ask yourself the following questions:
  - What is the plan here?
  - Is there evidence to support the use of this medication in this setting?
  - Are all other available nonprescription strategies in place?
  - What is the maximum dose I will prescribe?
  - What is the plan for stopping the prescriptions?
  - What prescribing boundaries will I put in place?[3]
- A lack of appropriate prescribing boundaries over the longer term may increase the prescriber's frustration with the patient, which in turn may contribute to poor clinical judgement when new problems arise
- The patient's treatment and management plan requires regular review
- Adequate documentation in the medical records is crucial (see Box 2)

Managing patients with worsening pain on a background of chronic pain

- A marked change in the pattern of pain may indicate a new and harmful underlying condition
- Continuity of care is very important. When a patient returns to see you, ask whether they have received medical care elsewhere
- A history of chronic pain and analgesic use can be distracting, but:
  - Consider all other possible causes of the worsening pain
  - Review the file and the last time the patient attended a specialist or had any investigations[4]
  - Actively manage the instinct to prejudge or jump to conclusions too early; are you able to maintain a relationship of mutual trust inherent in the doctor/patient relationship? The best interests of the patient need to be carefully considered

the duty of care as judged by a reasonable standard

- causation – that a harm occurred as a result of the practitioner failing to perform their duty. The harm, or damage, must have been foreseeable and able to be linked to the failed duty of care.

A judge will be guided by expert evidence in determining the issues of standard of care and causation.

Did Dr Jones act appropriately?

Compared with all other causes of back pain, epidural abscess is rare. Most GPs will never see a case, and diagnostic delay is not unusual.[1] Yet one of the main legal issues faced in this case was not whether the GP failed to diagnose the epidural abscess but rather whether he acted appropriately at the two relevant consultations. Several questions and issues were raised, as follows.

- Did Dr Jones take (and document) an adequate history?
- Did he perform (and document) an adequate examination, and what would he have found?
- To what extent was he influenced by the patient's history of chronic pain and drug-seeking behaviour?

2. RECOMMENDATIONS FOR CLINICAL RECORD-KEEPING

Medical records should always contain:

- the history obtained from the patient, including positive and negative features
- examination findings, including both positive and negative findings that impact on the differential diagnosis
- the provisional diagnosis reached
- any differential diagnoses considered
- the management plan, including options discussed with the patient, treatment recommended, prescriptions given and tests ordered

- Would a different course of action taken by Dr Jones have changed the outcome?

Notwithstanding the patient's difficult and atypical presentation, these questions needed answers. Unfortunately, Dr Jones could not confidently provide them. His documentation was brief; no vital signs were ever recorded; no neurological examination was documented; and the history recorded was limited. On reflection, Dr Jones realised that he prejudged the patient at presentation, which is common in these circumstances. In this case, he fell into the trap of 'premature diagnostic closure', a common cause of diagnostic error. Combined with the poor records, this made defending the claim very difficult.

Outcome

This was a high-value, complex claim, both legally and medically. All parties undertook extensive investigations, particularly looking at the impact of the delay in diagnosing the epidural abscess. The claim was settled at mediation prior to a hearing.

Risk management

This case illustrates some potential pitfalls in treating patients who are perceived as 'difficult' and drug-seeking. The concept of the 'difficult' patient assumes that patient factors are the sole determinant, but more recent studies have recognised the contribution of clinician factors, such as preconceived assumptions and poor communication strategies.[2] Tips for risk management when treating patients with chronic pain are summarised in Box 1.[3-5] Adequate documentation in the medical records is crucial; recommendations for clinical record-keeping are summarised in Box 2. MT

References

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