# A FAILURE TO DOCUMENT PATIENT'S REFUSAL

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## DESCRIPTION

A 60-year-old male's allegation of a failure to diagnose colon cancer was complicated by his undocumented refusals of recommended cancer screenings.

## KEY LESSONS

- Inadequate documentation of a patient's refusal of cancer screening falls below the standard of care.
- A patient's refusal of cancer screening, risks related to the refusal, and alternatives offered to the patient should always be documented in the patient's medical record.
- Provide patient education on the importance of cancer screenings and document the patient's level of understanding in the medical record.

## CLINICAL SEQUENCE

A 60-year-old, obese male, with a history of smoking, hypothyroidism, and borderline hypertension presented to his primary care provider (PCP) for an evaluation of abdominal discomfort. A ventral hernia was identified, but no other findings were noted. The PCP recommended a digital rectal examination (DRE) and a colonoscopy, however, the patient refused both. This discussion, including the patient's refusal, was not documented in the patient record.

Over the next seven years, the patient saw his PCP irregularly for problem-oriented exams and exhibited a pattern of non-adherence to care. Colonoscopy and DREs were recommended several times, which the patient refused. Those recommendations and refusals were not documented.

Eight years after his PCP's initial recommendation for a DRE and colonoscopy, the patient presented to the hospital with complaints of generalized weakness for several weeks, decreased appetite, and dark stools. A CT scan revealed an enlarged liver with numerous lesions consistent with metastasis. A colonoscopy showed a mass in the cecum; biopsy showed moderately differentiated adenocarcinoma. At this time, the patient was not a surgical candidate and was transferred to the medical oncology service for chemotherapy, with a life expectancy of one year.

## ALLEGATION

The patient alleged that his PCP failed to his diagnose colon cancer, resulting in metastasis and decreased life expectancy.

## DISPOSITION

Lacking documentation that the PCP and patient had discussed the need for a colonoscopy, the case was settled in the high range.

## ANALYSIS

**Expert review of this case found that the provider did not meet documentation standards**

Over a seven-year period, the patient refused colon cancer screening as recommended by his PCP. The PCP breached the standard of care by failing to document any discussions regarding the necessity for screening, or the patient's refusals.

A defense expert opined that, if the cancer were diagnosed seven years prior, the patient would have been a surgical candidate and would have had a life expectancy greater than five years with an 80 percent survival rate prognosis.

**Documentation is critical**

Once a claim is asserted, poor documentation increases provider risk. Plaintiffs assert that the medical record has unquestioned reliability, and testimony will be based on it. Documentation needs to be specific, timely, objective, and indicative of the provider's and the patient's behavior.

Refer to this document for some ideas on how to record this sort of note: CRICO Documentation Best Practices.

**Patient education regarding screenings**

Confirm a patient's understanding of recommended cancer screening. If a patient refuses screening, the risks of refusing should be explained to the patient (in the context of the patient's personal risk factors, if any) and the conversation documented.