[redacted]

[redacted]

VIA UPS NEXT DAY AIR

District of Columbia Board of Medicine
Health Regulations and licensing Administration
[redacted]
Washington , DC 20005

Re: [redacted]
District of Columbia License No.: [redacted]
Self-Report of Settlement, Payment and NPDB Report

To Whom It May Concern:

The purpose of this letter is to provide official notification to the Board of a recent settlement, payment and report to the National Practitioner Data Bank. For the Board's convenience, I provide the case information below:

[redacted]
State of [redacted], County of [redacted], In the [redacted] Superior Court 1
Cause No.: [redacted]
Date filed: [redacted]
Date of settlement agreement: [redacted]
Date dismissal was granted: [redacted]
Date of payment: [redacted]
Date payment reported to the NPDB: [redacted]

Below I provide the facts and a summary for this case.

FACTS:

[redacted] (now deceased), a 55-year-old white male at the time, presented to the [redacted] Hospital Emergency Room [redacted] on July 20, 2008, for assessment of renal stones and flank/abdominal pain. An abdominal CT scan without contrast was obtained at 8:33 p.m. While working under contract to [redacted], I reviewed the CT scan at my workstation in my home in [redacted]. According to [redacted] contract with [redacted] Radiology, I was to provide a final report that would not necessarily be reread by a local physician (versus a preliminary

report that would be over read by the onsite radiologist at the hospital). However, the typewritten report produced by co-Defendant, [redacted], M.D., a radiologist in [redacted], also added his name to the report in this case. Dr. [redacted] has asserted that his name was affixed to the report as a clerical matter and that he had no involvement with the patient.

Based upon the July 20, 2008 typewritten report, I interpreted the CT scan as showing a 5 mm. kidney stone in the right ureter, which was the primary reason for this study being ordered. I did go on to evaluate other structures apparent on the images. My interpretation concluded that the "noncontrast evaluation of the remainder of the abdomen and pelvis shows no other acute abnormality." My report did state that the spleen was enlarged, but noted that the liver, gall bladder, pancreas and adrenals were unremarkable.

On July 22, 2008, Mr. [redacted] saw his primary care physician, Dr. [redacted], for a follow-up from his emergency room visit. Labs drawn that day were very slightly abnormal. Dr. [redacted] declared them acceptable and would recheck them at Mr. [redacted] next visit in six months. On December 12, 2008, Mr. [redacted] saw Dr. [redacted] for a routine preventative exam. The physical exam stated his abdomen was negative. A basic metabolic panel was ordered but not completed. A release of information for these records stated that the test had been cancelled; when or why is not known at this time.

Mr. [redacted] presented to the emergency room at [redacted] on January 4, 2009, for a presumed pulled muscle. A CT scan of the chest was ordered and interpreted by another physician which revealed a mass in the pancreas. Consultations quickly followed, with surgery scheduled to remove the cancerous lesions in Mr. [redacted] abdomen performed on February 2, 2009. Subsequent comparison of the previous CT scan taken on July 20, 2008 with the CT taken on July 22, 2009 indicated that the mass was present on the scan taken on July 20, 2008, and there was an increase in the tumor size of 6-7 cm. on July 22, 2008 to 8.5 cm. on January 8, 2009, with probable spleen and liver metastases. Mr. [redacted] underwent surgery on February 2, 2009 to remove his pancreas, spleen, gallbladder and part of his liver.

After his surgery, Mr. [redacted] began chemotherapy under the supervision of Dr. [redacted] at [redacted] Hospital, then Dr. [redacted] at [redacted] Center. Mr. [redacted] failed initial chemotherapy and enrolled in a drug trial as a last resort option.

Mr. [redacted] office visit notes from September of 2009 reveal that he was doing pretty well physically considering his untreatable pancreatic cancer. Notes suggested that he might even return to a light duty job at [redacted]. Dr. [redacted] note from March 9, 2009 indicates that his prognosis has an average survival of 6 months for metastatic pancreatic cancer and 25% of patients survive more than one year. Dr. [redacted] stated to Mr. [redacted] that he could not give an accurate estimate of survival but hoped for 1-2 years.

Mr. [redacted] died of his cancer in late June 2010, approximately 18 months after his pancreatic cancer was initially diagnosed.

[redacted]

PLAINTIFF'S ALLEGATIONS:

The Plaintiffs contended that there was negligence in the reading of the July 20, 2008 CT scan in failing to identify the pancreatic lesion.

Response: After reviewing the July 20, 2008 CT films that I interpreted for this case, it was apparent that even without contrast the pancreatic mass was in fact *very* evident on the films. I indicated to defense counsel that I was not sure how or why I missed the mass and that I would be surprised that a second physician reading over the films would also not see the pancreatic mass. However, experts who reviewed this case on my behalf stated that a 5 ½ month delay in detecting a lesion that was already 6-7 centimeters in July of 2008 likely did not change Mr. [redacted] result. When Mr. [redacted] was asked during a deposition whether any of his doctors told him that earlier diagnosis of his cancer would have made a difference, he stated that Dr. [redacted] (his oncologist in [redacted]) is the only doctor who he asked that question directly and that Dr. [redacted] did not really give him a straight answer. Mr. [redacted] did state that Dr. [redacted] at [redacted] Cancer Center told him that an earlier diagnosis would have prompted less invasive surgery and some different treatments; however, she never said one way or another it would have changed his prognosis. Mr. [redacted] performed some research on the internet and believed that earlier treatment would have given him a better chance of surviving, although he acknowledged that he did not see any research that suggested that he would have been cured if his cancer would have been found five months earlier.

During his deposition taken on May 24, 2010, Mr. [redacted] was asked about his September 30, 2008 visit with his family physician, Dr. [redacted], scheduled because he was having urinary symptoms. Dr. [redacted] note recommended that Mr. [redacted] have a pelvic CT scan or at least a KUB X-ray. Mr. [redacted] agreed that Dr. [redacted] made those recommendations, but he declined those additional studies because he had just had a CT scan two months earlier that was read as negative and because he had experienced previous kidney stones and would know without a CT scan whether this was an evolving kidney stone or not.

With respect to his symptoms prior to diagnosis, Mr. [redacted] stated that for the most part he felt relatively normal health-wise until the last week of 2008, when he was having some back and chest pain that he thought was a pulled muscle. He acknowledged that the symptoms probably were a result of the cancer that had been ongoing since back in July 2008, but he stated that he really did not have many symptoms prior to that last week in December 2008. Up until that time he was working his normal shift as a [redacted] with the [redacted] Department [redacted]. When asked whether he would have done anything differently from a personal standpoint during the fall and winter of 2008 if he had been aware that he had pancreatic cancer as of July 20, 2008, Mr. [redacted] simply stated that he would have had a lesser surgery sooner and would have undergone the treatments at an earlier stage.

EXPERT RESPONSES:

Plaintiff's Experts:

[redacted], M.D. (Radiology). [redacted]

Dr. [redacted], a radiologist retained by plaintiff's counsel, stated that the 7 cm. mass in the tail of the pancreas should not have been missed on the July 20, 2008, CT scan. Metastases and involvement of the spleen were new developments as of the CT scan of January 4, 2009.

[redacted], M.D., Ph.D. (Oncology/Pathology). [redacted]

Dr. [redacted], Oncology and Pathology expert retained by plaintiff's counsel, stated the 5.5 month delay in the diagnosis of Mr. [redacted] pancreatic cancer decreased his chance of survival by as much as 40%, **IF** it was resectable in July 2008, which Dr. [redacted] claims was the case. Specifically, Dr. [redacted] claims (based upon his own research on the drug, Gemzar) that the drug likely would have been more effective for Mr. [redacted] if initiated five months earlier.

Defense Experts:

[redacted], M.D. (Oncology), [redacted]

On March 3, 2010, my attorney spoke at length with our causation expert, [redacted], M.D., who specializes in internal medicine and oncology. Dr. [redacted] stated that in all probability the delay in diagnosing and treating Mr. [redacted] pancreatic cancer from August 2008 until January 2009 had no effect upon his chances of survival, the length of survival, or quality of life. In fact, because Mr. [redacted] had proven to be unresponsive to the chemotherapy (Gemzar) which he was given, in all likelihood the delay in diagnosis actually gave Mr. [redacted] four months of a higher quality of life before his condition was diagnosed and he began treatment.

Dr. [redacted] stated that he believed it was "more likely than not" that the lesion actually had metastasized to the liver as of August 2008, based upon its size and the length of time that it must have been growing to reach that size. A review of the literature available at the time did indicate at least single digit chances of survival at the three and five year levels if the patient only has microscopic liver metastases; however, this was not the case with Mr. [redacted].

Dr. [redacted] thought for all practical purposes the five-month delay in treatment probably had no effect on Mr. [redacted] chances of survival. Therefore, as stated above, the delay in treatment probably resulted in a better quality of life for Mr. [redacted] prior to the actual diagnosis of his pancreatic cancer.

Dr. [redacted] stated that although earlier treatment could have extended Mr. [redacted] lifespan if he had fallen into the group of individuals who were susceptible to a successful regimen of chemotherapy, it

does not appear that in reality he fell in that category. The lack of positive response to Gemzar indicates that earlier treatment would not have lengthened Mr. [redacted] lifespan.

Dr. [redacted] also stated that pancreatic cancer simply has a very dismal prognosis. Unfortunately, no treatment has been devised thus far that really shows a significant improvement in cure rate for pancreatic cancer. He stated that only one in five patients have a positive response to Gemzar; randomly one in ten show any real benefit in terms of reduction of tumor or extension of lifespan. In most instances, Dr. [redacted] normally ends up suggesting clinical trials for patients in hopes that some new treatment may have an effect that is more positive than the existing treatments that have been approved by the FDA.

[redacted], M.D. (Radiology), [redacted]

On August 12, 2009, my attorney spoke with our radiology expert, [redacted], M.D., who is head of the Abdominal Imaging section of the [redacted] School of Medicine. Dr. [redacted] was not supportive of my interpretation of the CT images. Dr. [redacted] did state that his first impression upon reviewing the film was that if someone missed this mass it was probably because they did a cursory report focusing just on the kidney stone, which was the reason the study was ordered. However, when he reviewed my actual report, he saw that it was very thorough, logical and appropriate. Dr. [redacted] stated to my attorney that it was obvious to him that I am a well-trained and qualified radiologist, but that I just somehow missed this lesion. Dr. [redacted] empathized that this just happens sometimes even to the best radiologists. He did mention that I had commented on areas other than the ureter and kidney stone and had correctly noted the size of the spleen and other anatomic findings on the images. Dr. [redacted] did state that a radiologist is obligated to look at all of the structures on the image whether they comment on them or not. The fact that I commented on the other structures indicates that I was attempting to view all images.

Dr. [redacted] described the abnormality that was missed by me as follows: "Arising from the tail of the pancreas is an obvious large (5-7 cm.) lobulated mass, partially solid, partially cystic with some calcifications. The tumor abutted the hylum of the spleen and was near the stomach, but it is unclear whether the tumor actually invaded the stomach."

Dr. [redacted] did not provide a prognosis for a patient with this type of lesion. However, he did state that given the substantial size of the lesion, we probably would be talking about how long a patient might survive, not whether the patient could be cured.

BASIS FOR SETTLEMENT

During the course of this litigation, a decision in 2011 by the [redacted] Supreme Court mandated that attorney fees are now recoverable in wrongful death cases in [redacted]. Because of this, and the provisions of [redacted] liberal loss of chance case law that states Plaintiff may recover the percentage of total wrongful death damages by which his chance of recovery was reduced by the Defendant's negligence (with no requirement for a minimum percentage chance of survival), the decision was made by counsel and my insurance carrier to settle this case. Following an extensive period of litigation which

included mediation, this case was settled on my behalf in the amount of $433,000.00. For the Board's convenience, I have included a copy of the NPDB Medical Malpractice Payment Report.

CONCLUSION

This was a very difficult and emotional case for all parties involved. As stated in my summary, upon an additional review of the images I discovered that I missed a lesion on the July 20, 2008 CT scan. I have learned a great deal from this case, and I continue to constantly seek improvement to my skills as an interpreting radiologist. To that end, I complete several hours of Continuing Medical Education courses each year and participate in continual feedback with my colleagues and the medical leadership at [redacted].

[redacted] tracks all discrepancies reported by [redacted] clients. In addition, [redacted] randomly audits a percentage of all of the final interpretations provided to our clients. Discrepancies reported by our clients as well as those generated from the internal audits are reviewed and rated by the reading radiologists and physician members of the [redacted] Quality Assurance Committee. The rating system characterizes the severity of the error and if there is an impact on the patient's care. This data is compiled and used to provide feedback to the reading radiologist and [redacted] Medical Directors on a quarterly basis. I regularly review my discrepancy data and think critically about how I can avoid discrepancies in the future.

If additional information or documentation is needed, please contact me.

Professionally,

[redacted]

[redacted]

[redacted]