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Updated 2021 Lung Cancer Screening Guidelines Can Save Even More Lives

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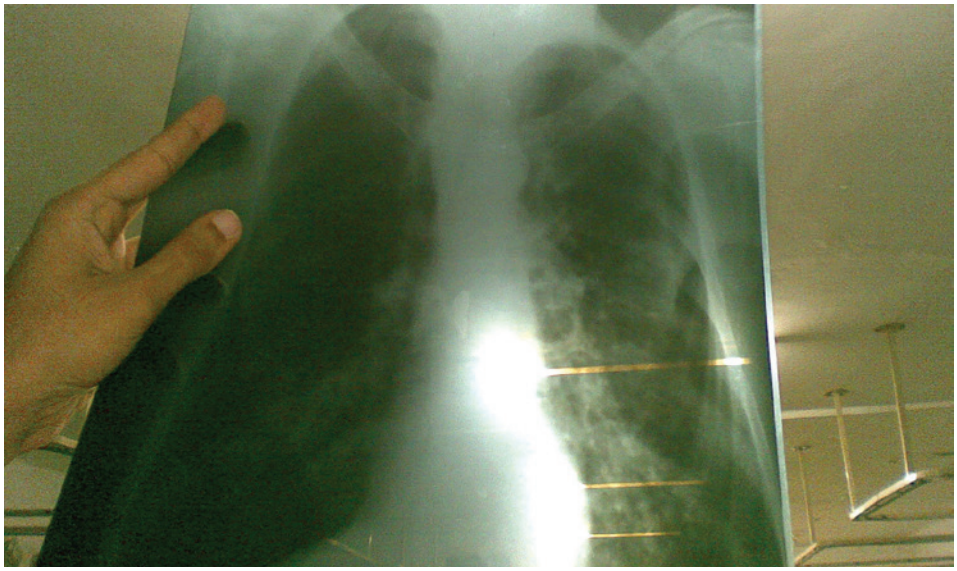

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Lung cancer is the second most common cancer and the leading cause of cancer death in the United States. Over 225,000 people will be diagnosed and over 135,000 people will die this year from lung cancer. In 2013 the United States Preventative Task Force (USPTF) recommended annual low dose CT lung cancer screening for individuals ages 55-80 with a 30 pack-year smoking history (e.g., a pack a day for 30 years or 2 packs for 15) and were smoking or had smoked in the last 15 years. The USPTF asserted this had the potential to save 12,000 lives annually.

Now the USPTF has updated its recommendation for annual screening to start earlier at 50 years of age with the requirement of only a 20 pack-years smoking history. Eligible individuals should continue screening until age 80 or until 15 years have elapsed since their last cigarette. They estimate that 24,000 lives can now be saved if implemented, with the largest increase in lives saved among women and minority men.

The amount of radiation used to perform a screening test is extremely low, and people should not be reluctant to have a low-dose CT scan. The radiation from a screening scan is less than what a person is exposed to each year from background radiation. The average annual radiation exposure per person from the sun and other sources is 2.4 mSv (milliSeivert). The amount of radiation from a screening exam is between 0.65 to 2.26 mSv.

Unfortunately, available data show that the use of lung cancer screening in the community is low, with only 14% of eligible smokers being screened within the last year ("State Variation in Low-Dose CT Scanning for Lung Cancer Screening in the United States," The Journal of the National Cancer Institute, November 2020). Increasing lung cancer screening discussions and offering screening for eligible individuals is necessary to reduce lung cancer deaths. This requires two important things to happen: Physicians must avoid implying guilt or smoke-shaming patients, so patients are encouraged to disclose their complete smoking histories. Patients also need to be encouraged to give a full and accurate history to their physicians about how much they smoke. Then, physicians and patients can have a meaningful discussion about

cessation therapy and lung cancer screening—24,000 lives depend on it.

These updated lung cancer screening guidelines mean that either more patients with lung cancer will be treated at an early stage and cured, or there will be more lawsuits for patients who are diagnosed with late stage disease because of a failure to screen. The balance between these two outcomes depends on whether primary care physicians follow the now seven-year-old recommendation and going forward, the new guidelines, into practice.

As early as 2008 and then consistently since 2011, the primary care medical community has known the benefits of low-dose CT lung cancer screening in long-term smokers. In 2013, the guidelines identifying the smoking population at risk and the recommendation for annual screening was adopted by the USPTF. Medicare and Medicaid made lung cancer screening a covered service in 2015. When a primary care physician fails to appropriately document smoking history and/or fails to offer lung cancer screening to eligible patients today, such conduct falls below the standard of care.

Successful failure-to-screen-for-lung cancer cases have shared certain characteristics. The lung cancer must be non-small cell lung cancer because of the difficulty proving avoidable injury with small cell lung cancer. The client must have advanced stage (3 or 4) non-small cell lung cancer to have a viable claim, as the pre-existing condition charge given in accord with *Scafidi v. Seiler, 119 N.J. 93 (1990), and Verdicchio v. Ricca,* 179 N.J. 1 (2004), limits recovery based on avoidable difference in outcome.

There should be a true primary care relationship between the patient and physician during at least the two years before the cancer diagnosis; longer is better. Lung cancer screening, like breast and colon cancer screening, is part of primary preventive care, which is typically provided during annual examinations and not during acute problem visits. During the annual examination, the need for social interventions and health care screenings are made. An important part of this process is for physicians to encourage the patient to be fully forthcoming when answering questions about social history, and particularly questions about smoking. Without full smoking information, such as starting age, the number of packs smoked a day, periods of increased or decreased smoking, stop date if any, calculating the number of pack-years becomes more of a challenge. Evidence the patient has complied with other health and cancer screening interventions is relevant. Lung cancer screening is less invasive than colonoscopy, mammography and prostate examination. Patients reluctant to undergo invasive testing such as colonoscopy are often willing to undergo a non-invasive life-saving screening procedure.

When looking at the primary care records in a potential case, one looks for documentation of smoking history to determine the pack-year history. When smoking is documented in the chart, smoking cessation is typically offered, but unfortunately lung cancer screening generally is not. While many electronic medical record (EMR) systems provide point-of-care prompts for other screenings, such as breast cancer, colon cancer, and diabetes, many EMRs do not provide any for lung cancer screening and, despite the ability to adjust these prompts, few physicians request that a screening prompt for low dose CT lung cancer scan be added. There has been one instance where a primary medical care group added the prompt to its EMR after being sued for failing to offer lung cancer screening.

Family practice and internal medicine physicians provide most of the annual wellness preventive care examinations. Remembering the requirements of the New Jersey Patient First Act, identifying internal medicine and/or family practice experts to opine on the standard of care in any case is essential. Initial evaluation of any potential claim requires review of primary care records, and any chest imaging done. Chest x-rays rarely show early-stage lung cancers. If they do, then one is dealing with a failure to diagnose and not a screening case. More importantly, a previous normal chest x-ray can help establish that screening would have made a difference. Remember, screening detects lung cancer before any symptoms arise or they are detectable on a plain chest x-ray. Once symptoms arise, there may be a claim, but it is harder to prove the desired difference in outcome because symptoms usually accompany more advanced cancer.

Besides a primary care liability expert, additional experts may be required in oncology, thoracic surgery, and economic loss. Special

considerations include establishing the standard of care and/or causation through the use of literature. The use of literature is controlled by the standard established in *Jacober v. St. Peter's Hospital,* 128 N.J. 475 (1992), that a "text will qualify as a "reliable authority" if it represents the type of material reasonably relied on by experts in the field."

Counsel will need to have a qualified expert testify that the literature establishing the benefit of this testing is of the type reasonably relied upon in their field. These would include the articles in the *New England Journal of Medicine* entitled, "Survival of Patients with Stage I Lung Cancer Detected on CT Screening" from 2006, "Reduced Lung-Cancer Mortality with Low-Dose Computed Tomographic Screening" from 2011, and "Selection Criteria for Lung-Cancer Screening" from 2013; an article from the *Annals of Internal Medicine,* "Screening for Lung Cancer With Low-Dose Computed Tomography: A Systematic Review to Update the U.S. Preventive Services Task Force Recommendation," from 2013, in addition to the 2013 and 2021 USPTF recommendations.

Literature published after the date the care was rendered may not be used to establish the standard of care, unless it can be established as based upon information that was readily available to the medical community at the time of the care. However, literature regarding causality and survival published subsequently is admissible to prove the percentage of lost opportunity required under *Scafidi* and is progeny.

Since these cases involve a relatively easily available and non-invasive test, a jury should be presented with evidence regarding the failure to offer the test. Under *Gardner v. Pawliw,* 150 N.J. 359 (1997), "when a physician's deviation from the prevailing standard of care consists of the failure to perform a diagnostic test, a complication arises because the very failure to perform the test may eliminate a source of proof necessary to enable a medical expert to testify to a degree of reasonable medical probability concerning what might have occurred had the test been performed." *Id*. at 380. As such, the Supreme Court held that in cases involving failure to perform a diagnostic test, the first prong of *Scafidi*, requiring the plaintiff to demonstrate to a reasonable degree of medical probability that the test would have resulted in avoiding the harm, is eliminated. Rather, the plaintiff must demonstrate to a reasonable degree of medical probability that failing to give the test increased the risk of harm from the preexisting condition. A plaintiff may demonstrate an increased risk of harm even if such tests are helpful in only a small percentage of cases. *Id*, at 387. The court explained that it reached this result so that plaintiffs' cases could reach the jury, and defendants would be prevented from benefitting from their negligent failure to test and the evidentiary uncertainties that failing to test created. *Id*.

As a practical matter, the proof of damages will not only require establishing the costs of medical care and the typical economic loss evaluation of a wrongful death claim, where appropriate, but should also consider life care needs between diagnosis and demise, as well as the "value of gratuitously furnished health care services in determining the extent of an injured plaintiff's lost capacity and in assessing the totality of the injuries." *Bandel v. Friedrich*, 122 N.J. 235, 244 (1991).

When picking a jury, the court needs to allow counsel to carefully query about juror attitudes toward smoking and should not allow the dying or deceased to suffer from a societal bias against smokers as causing their own harm. Cigarettes are addictive; smokers should not be victimized both by an industry that produces these products, or by the medical community or community at large which blames them for the harm caused by the habit.

As lawyers, we have opportunities at times to bring about social changes that can save lives. In these cases, we have the chance to reinforce medicine's chance to save 24,000 lives each year!

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ATTORNEYS AT LAW

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