Risk Management Review

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Inadequate Urgent Care Workup Leads to Sudden Death From Pneumonia

Introduction

Every day, primary care, urgent care, and emergency physicians see patients who have symptoms of acute illness. Normally, these patients are properly diagnosed, treated, and make a quick and complete recovery. This interesting case from the Northwest shows what can happen if symptoms are not properly appreciated and an adequate workup is not performed.

Facts

The patient was a 45-year-old obese male who smoked, but generally was in good health. He presented to an urgent care facility at 5:36 p.m. complaining of increasing shortness of breath, which had lasted for approximately 7 days; cough with yellow sputum, but no congestion; fever; palpitations; chest pain; vomiting; and diarrhea. At that time, he was taking Lortab® and Flexeril®.

On examination, the patient's heart rate was 126. His lungs had scattered wheezing throughout, but no crackling or signs of fluid. Additionally, he had no edema in his extremities and no external signs of congestive heart failure. His oxygen saturation was 95 percent on room air.

A chest X-ray was done, and it was read by Dr. A, a physician who was board certified in emergency medicine. Dr. A interpreted the X-ray as being consistent with double pneumonia. Because the urgent care was a stand-alone facility that closed at 7:30 p.m., there was no opportunity to have the X-ray over read, as the radiologists were already gone for the day. When a radiology over-read was done 3 days later, it indicated possible congestive heart failure, viral pattern pneumonia, or COPD. No ECG was performed in the urgent care facility because, according to Dr. A, none was indicated. Instead, the patient was discharged home at 6:28 p.m. with an inhaler, cough medicine, and antibiotics.

According to the patient's wife, he had a "restless night" at home and was found on the porch the following morning suffering from extreme dyspnea. EMS was summoned; however, the patient was in cardiac arrest when they arrived. Despite attempts at resuscitation at the scene and hospital, the patient expired. The family denied tissue and organ donation, and no autopsy was performed. Instead, a coroner's exam was done; the coroner noted the cause of death as "pneumonia, time interval, days." Toxicology was performed; however, it was negative for anything contributory to the cause of death.

A malpractice lawsuit was brought against Dr. A, her employer, and the urgent care facility. With their consent, the case was settled in the high range, with expenses in the low range.

Discussion

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A review of data from the National Practitioner Data Bank (NPDB) shows that diagnosis-related allegations are the most frequent source of malpractice claims.[1] The third most frequent source of claims is treatment-related allegations; however, if you "drill down" into those claims, you will discover that incorrect diagnosis is often an underlying factor.

It is essential that physicians make every effort to provide accurate diagnoses. Yet, making an accurate diagnosis is likely more challenging for primary care physicians (PCPs) than specialists, because of the wide variety of presenting symptoms that PCPs encounter. To add another complexity, although acute care physicians practice in a variety of environments, in many cases — including this case involving Dr. A — the PCP would be held to the standard of care of an emergency physician, even though Dr. A was working in a facility with much less diagnostic and treatment support.

The case described above was difficult to evaluate from a legal standpoint because no autopsy was performed, which probably would have determined the cause of death (although the coroner's conclusion is likely correct). In fact, the six board-certified physician experts who reviewed this case (three emergency physicians, a family physician, a radiologist, and a pulmonologist) were unanimous in their opinion that this case would be very difficult to defend. Although they differed somewhat on what caused the patient's death, they all agreed that, given the

1. National Practitioner Data Bank Public Use File, Dec. 2012

symptoms, Dr. A should have referred the patient to the emergency department (ED).

Generally, the experts believed that the patient's condition worsened quickly overnight, likely leading to rapidly developing pulmonary edema and eventual cardiac arrest. The experts all felt that a referral to the local ED would have resulted in a more complete workup, including ECG, appropriate labs, and an immediate radiologic over-read.

Further, a referral to the ED would likely have resulted in observation for a minimum of 23 hours. Then, when the patient's condition worsened, appropriate intervention could have immediately occurred.

Although the pulmonologist disagreed on the diagnosis (he thought the patient had acute eosinophilic pneumonia, a somewhat uncommon and difficult-to-diagnose condition), he stated that if the patient had been under observation in the hospital when his condition worsened, he could have received ventilatory support and steroid treatment, and a full recovery would have been expected.

Another important issue in this case is Dr. A's failure to provide written discharge instructions to the patient. Discharge instructions could have advised the patient to call EMS or go to the ED immediately if his condition worsened overnight (which it clearly did).

Although the value of discharge instructions is sometimes underappreciated, sending the patient home with written information has several advantages.

First, the patient has the opportunity to review the instructions they were given. Studies have demonstrated that, for many reasons, patients retain a relatively low percentage of the verbal information they receive during medical appointments.

Additionally, family members or caretakers (who may not have accompanied the patient to the medical visit) can review the instructions and learn about warning symptoms and when to seek help.

Further, asking the patient to sign the discharge instructions and keeping a copy with signature in the patient's file conclusively establishes what the patient was told at the time of discharge, eliminating the "she didn't tell me" allegation.

Summary Suggestions

The following suggestions may be helpful to physicians who regularly see patients in the acute care setting.

- Be mindful of the limitations, including both hours and resources, of the practice environment.
- Be thorough in the development of the differential diagnosis. If the most serious conditions in the differential diagnosis cannot be ruled out with sufficient certainty, arrange an appropriate referral.
- Do not assume that patients are aware of the potential seriousness of their conditions.
- In cases in which an immediate referral is not made, supply the patient with appropriate written discharge instructions. Ask the patient to acknowledge receipt of the instructions with a signature.
- Keep a copy of the signed instructions in the patient's record.

Physician Perspective

The Medical Protective Emergency Medicine Advisory Board

Whether it is a physician's office, an urgent care facility, or another healthcare setting, the potential for misdiagnosis increases significantly if a physician is practicing in an environment that has limited resources. There is great wisdom in erring on the side of caution when the physician is not completely satisfied that all critical diagnoses have been ruled out. Outcomes are enhanced and professional liability exposure is minimized when the examining physician "goes the extra mile."

Conclusion

Despite physicians' best efforts, it is unlikely that misdiagnoses can be completely avoided. Mistakes will be made, and patients do not always follow instructions. However, adhering to the principles discussed herein will minimize the likelihood of a misdiagnosis, and, if one does occur, minimize the likelihood of a catastrophic outcome.