Failure of Patient Tracking Leads to Missed Diagnosis and Patient Death

Theodore Passineau, JD, HRM, RPLU, CPHRM, FASHRM

Introduction

A very important component — and common failure — in both primary and specialty care is efficient and effective patient tracking. The process of keeping track of patients is critical in ensuring that no one slips through the cracks and, as a result, fails to get appropriate care. In this interesting case from the Southwest, multiple failures in tracking a patient occurred, resulting in a missed diagnosis and the patient’s death.

Facts

The patient was a 59-year-old male who was married and the father of three children, all of whom have special needs. His medical history included chronic sinusitis, bronchitis, obesity, hypertension, dyslipidemia, and a remote history of smoking. He also suffered from post-traumatic stress disorder (PTSD) as a result of prior military service.

On December 2 of Year 1, the patient presented to the local emergency department (ED) complaining of a cough and chest congestion. A chest X-ray showed no evidence of congestive heart failure, pneumothorax, infiltrates, masses, cardiomegaly, or pleural effusion. He was treated with albuterol and advised to follow up with his internist.

On December 8, the patient returned to the same ED, now complaining of a cough, chest congestion, fever, and shortness of breath. Despite his complaint of congestion, he did not complain of any discomfort, tightness, heaviness, or palpitations in his chest. Cardiac enzymes, including CPK and troponin, were normal, as was a resting ECG.

A CT scan of the patient’s chest revealed no evidence of pulmonary embolism, infiltrates, pleural effusion, cardiomegaly, or any other chest abnormality. He was discharged again with instructions to follow up with his internist.

On December 19, the patient presented to the office of a MedPro-insured pulmonologist (on referral from his internist), and he was seen by a physician assistant (PA). At the time of his evaluation, the patient complained of
a persistent, dry, nonproductive cough that worsened when lying flat or in cold temperatures. These symptoms had developed over a 2-month period and started with fever, chills, and sweats.

The PA reviewed the records from the two recent ED visits and performed a thorough physical exam, which was unremarkable for any cardiac symptomology. The PA ordered a pulmonary function test, an echocardiogram, and a sleep study and instructed the patient to return on February 20 (after the testing had been completed).

Before the patient left the office that day, this plan was reviewed, discussed, and approved by the pulmonologist, who was the supervising physician for the PA and ultimately in charge of the patient’s care in the pulmonology office.

On December 29, the patient underwent an echocardiogram at the local hospital. The report stated:

- Normal left ventricular size and normal left ventricular systolic function
- Mild concentric left ventricular hypertrophy
- Probable mild and discrete regional wall motion abnormality in the lateral wall

The report was faxed to the pulmonology practice on December 31. The same day, the patient underwent a pulmonary function test, which another physician in the pulmonology practice administered. The test revealed “mild restrictive defect with a concomitant mild diffusion impairment that corrects for alveolar volume. No change following inhaled bronchodilators. Pattern may be related to the patient’s body habitus.”

On January 16 of Year 2, the patient was seen at a Veterans Affairs (VA) hospital for a primary care follow-up. The VA records note that the patient was being followed in the community for his medical health, stating “He was seen in the ED for cough and x-rays, echo, pfts were done. No definite answer yet but cough is gone. He was asked for the results of the tests and instructed to follow up in 2 months with lab results and BP log.”

The patient never underwent the sleep study that the PA at the pulmonology practice ordered, and he did not return to the pulmonology practice for his scheduled follow-up appointment on February 20. Because the pulmonary workup was not complete, the pulmonologist never sent a report of the patient’s exam results and recommended testing to his internist.

On March 8 of Year 2, the patient again went to the local ED, now complaining of a lump in his neck. He had another chest X-ray, which showed no signs of infiltrates, pneumothorax, mass, cardiomegaly, or pleural effusion. He had no complaints of chest pain or other cardiovascular or respiratory symptoms at that time, and auscultation of his chest yielded clear breath sounds bilaterally.
On July 20 of Year 2, the patient returned to the VA hospital for ongoing treatment of his PTSD. The VA records contain no further mention of the prior echocardiogram or the request for results from the previous testing.

The patient continued to see his internist, consisting of nine visits between December 18 of Year 1 and October 6 of Year 2. On September 23 of Year 2, the internist saw the patient for sinus and chest congestion, cough, and poison ivy. The patient also noted complaints of chest tightness and shortness of breath, which were attributed to the coughing. On October 6 of Year 2, his internist saw him again for complaints of a chronic wheeze and a cough that he was treating using Robitussin® with codeine.

Two days later, on October 8, the patient was found dead in his home. The medical examiner listed the cause of death as “sudden cardiac death due to arteriosclerotic coronary disease, with cardiomegaly associated with recent respiratory infection.”

A medical malpractice lawsuit was filed against the pulmonologist and the internist. The case against the pulmonologist was settled with the doctor’s consent. Indemnity and defense costs were in the high range. Although a payment also was made on behalf of the internist, the amount was not disclosed.

Discussion

Patient tracking is not a new concept in the field of medical risk management; however, it has proven challenging for many years. The well-accepted rule is that a physician who orders a test or consultation must review the resulting report and act on it if appropriate — or, the physician must take appropriate steps to determine why he or she did not receive the report.

Given the large number of tests and consultations that are ordered in certain specialties, tracking them all can be onerous; yet, the standard of care generally does not excuse the failure to do so. Techniques are available to facilitate the tracking process in healthcare practices using paper records and in those using electronic health records (EHRs).

In this case, several tracking failures occurred. As a result, the patient’s healthcare providers did not identify or provide appropriate and timely treatment for his serious cardiac issues.

The first failure occurred when the pulmonary practice received the faxed echocardiogram results. Documentation from the sending hospital shows that the fax was sent to the practice and they received it; however, no evidence shows that the PA or pulmonologist reviewed the results. Further, the results were not filed in the patient’s medical record.

Many situations can occur that prevent a practice from receiving test and study results. Examples include (a) failure of the patient to report to the testing facility, (b) failure of the testing facility to generate a report, or (c) failure of the testing facility to properly communicate the report to the requesting practice.
In such cases, the requesting practice will likely not notice the report is missing unless some sort of effective tracking mechanism is in place that alerts them.

In this case, it is known that the patient presented for the procedure, that the report was produced, and that it was properly transmitted to the practice. What happened to the faxed report after it reached the practice has never been determined.

Even when the results of a test or consultation are properly reported and communicated, process issues within the practice can prevent the ordering practitioner from seeing the test results. Sometimes, as in this case, the report disappears — possibly as a result of misfiling or another clerical error. Regardless of the cause, the ordering practitioner never reviewed the report, which prevented the provider from acting on a medically significant finding.

A second failure on the part of the pulmonary practice involved the sleep study that was ordered but never completed. As a result, the practice never received the study findings, but they failed to follow up to determine why.

Next, the pulmonary practice scheduled the patient for a return visit after the desired testing was completed, but the patient failed to keep that appointment. If his follow-up appointment had been tracked, and if the pulmonologist or PA had been advised that the patient had missed the appointment, appropriate steps could have been taken to reschedule the visit. Additionally, this notification also would have given the practitioners an opportunity to recognize that they did not have all of the information they had requested.

The pulmonary practice’s reporting protocol stipulated that they did not generate a report to the referring physician until they had reviewed all necessary test results and completed appropriate follow-up. Thus, the practice never generated a report from the pulmonologist to the patient’s internist. In this regard, the internist also dropped the ball in not recognizing that he had never received a consultation report from the pulmonology practice.

Presumably, if the internist had recognized this failure, he could have contacted the pulmonary practice to question why the report had not been received. That communication would have given the pulmonary practice an opportunity to review the patient chart and identify any lapses in follow-up.

In retrospect, one can see that if any of these tracking steps had occurred, the likelihood that this patient would have gone undiagnosed for this length of time would have been greatly decreased. As the expression goes, “the devil is in the details,” which certainly seems to be the situation in this unfortunate case.
Summary Suggestions

The following suggestions might help healthcare practices organize their patient tracking processes:

• When a test or consultation is ordered, it is imperative that the ordering practitioner review the results or be aware that the review is still outstanding.

• When used properly, techniques such as “tickler systems” or “test/referral logs” are effective methods of tracking test and consultation reports in a practice using paper records.

• In practices utilizing EHRs, the system should be configured so that ordered tests or consultations automatically trigger a reminder to the practitioner after an appropriate period of time.

• Patients should be utilized as an additional failsafe in the test-tracking process.

• Rather than giving patients the “no news is good news” message, office policy should require that all test or consultation reports are communicated to the patient.

• Practitioners should advise patients to contact the practice immediately for their test results if they have not heard back from the practice after a designated amount of time.

Conclusion

The appropriate processing of patient information is more challenging in today’s complex medical delivery system than it ever has been. However, appreciation of the danger of inadequate patient information management can minimize the risk of suboptimal patient outcomes and also may reduce professional liability exposure to healthcare practices.