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Risk Management Review

PATIENT SAFETY & RISK SOLUTIONS

Physician Fails to Adequately Work Up Atypical Patient, Resulting in Death From Myocardial Infarction

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Introduction

One of the great dilemmas faced by any diagnostician is the atypical patient who presents with symptoms of a serious condition. What and how much workup is appropriate? When these circumstances accompany an element of patient noncompliance, the potential for a catastrophic outcome is significantly elevated. This interesting case from the Midwest demonstrates how it can happen.

Facts

The patient, a 32-year-old man with no pertinent medical history, was in good physical condition and had a physically active lifestyle. He presented as a walk-in to the emergency department (ED) of Hospital #1 in the morning of Day 1 with complaints of back pain lasting several days and no trauma history. The patient described the pain as intermittent, and he said that muscle relaxants somewhat relieved it. His blood pressure was 158/43, and his pulse was 84.

The patient was administered 60 mg of ketorolac tromethamine, and a chest X-ray was interpreted as normal. He was diagnosed with acute upper back pain, received prescriptions for naproxen and methocarbamol, and was discharged with instructions to follow up with his primary care physician.

On Day 6, the patient presented to Dr. C, an internist, with complaints of muscle spasms causing chest pain that radiated to the jaw and both arms. When Dr. C learned that an electrocardiogram (ECG) had not been performed at Hospital #1 (5 days earlier), she administered one in her office, which showed "sinus tachycardia with marked T wave abnormality."

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Dr. C directed the patient to go directly to a hospital for further workup. The patient went to Hospital #2 and complained of back pain radiating into the arms, neck, and jaw lasting 10 to 15 minutes at a time. Another ECG was run, which also was abnormal, suggesting to consider "ischemia in the anterior-lateral leads." The ED arranged for the patient to follow up with the cardiology practice on call (as an outpatient) and discharged the patient.

The patient returned to Dr. C, who immediately contacted Dr. S (a MedPro-insured cardiologist who was not part of the on-call group). Dr. S instructed the patient to return to Hospital #2 for "a proper cardiac workup."

The patient returned to Hospital #2. Labs performed at approximately 4:00 p.m. showed a .12 troponin point-of-care i-STAT level, which was considered a critical value. However, his troponin T level was interpreted as normal, and a chest X-ray was also normal. Dr. S admitted the patient and ordered a coronary computed tomography angiography (CCTA). At 12:30 a.m. on Day 7, the patient's blood pressure was 141/88 and his pulse was 55.

The CCTA demonstrated calcification of the left anterior descending artery (LAD), but the patency of the vessel could not be determined because of artifact. Left ventricular hypertrophy was noted, with a left ejection fraction of 64 percent. Repeat labs showed a troponin T level of .03, interpreted as the "gray zone." Dr. S documented the following in the patient's health record: "CCTA shows no CAD or coronary anomaly." The only other entry he documented in the health record was "OK for discharge from cardiac standpoint." During the discovery phase of litigation, Dr. S insisted that he had reviewed the patient's hospital-run ECG; however, the patient's health record did not reference this review.

Also during discovery, Dr. S insisted that he had spoken to the patient when he was still hospitalized, and he urged the patient to remain in the hospital to undergo further testing (such as a cardiac catheterization). However, the patient left the hospital, citing no health insurance. Since this conversation was not documented, its exact timing could not be determined, nor could it be reconciled with the "OK for discharge from cardiac standpoint" health record documentation.

On Day 9, the patient saw Dr. J, an osteopathic family practitioner. The patient complained of pain in the thoracic spine and indicated that he had recently had a cardiac

workup, “which was negative.” The patient thought he had a pinched nerve in his neck and requested “an adjustment.” Dr. J identified muscle spasms of the cervical and thoracic spine on palpation and performed osteopathic manipulation to the area with “excellent results.”

On Day 19, the patient returned to Dr. J for another adjustment. Dr. J identified less spasming and again provided osteopathic manipulation to the cervical and thoracic spine. In the intervening 10 days, no evidence indicated that the patient followed up with Dr. S or any other cardiologist (although the patient was advised to do so when discharged from the hospital).

Early in the morning of Day 20, the patient was found unresponsive at his home, and resuscitation was unsuccessful. On autopsy, the cause of death was determined to be “atherosclerosis of the left anterior descending coronary artery (approximately 85 percent obstruction) and hypertensive heart disease.”

A medical malpractice lawsuit was instituted against Dr. S and Hospital #2. At the doctor’s request, the case was settled on his behalf during the pre-suit phase with a payment in the midrange and defense costs in the high range. The hospital also made a payment, but the amount is unknown.

Discussion

As indicated above, this case was settled in the pre-suit phase for two reasons: (1) the cardiology expert who reviewed it could not support the clinical care provided; and (2) the nonclinical evidence needed to support the doctor was either inadequate or incorrect.

First, the defense cardiology expert was concerned with the ECG performed on Day 6, which showed “marked T wave abnormality,” specifically deep T wave inversions in the anterior and lateral leads. She felt the results clearly implied a significant cardiac event.

Second, the troponin leak suggested mild muscle damage. The cardiology reviewer also opined that the CCTA indicated an abnormality in the LED. Although she would not have performed a CCTA (she would have proceeded directly to a cardiac catheterization), she said that a catheterization also would have demonstrated a significant problem with LAD. She recognized that the patient was not typical for major cardiac problems, but she felt a more aggressive investigation was warranted because of the ominous clinical findings.

Third, Dr. S's documentation of this matter also was not helpful. Again, although he insisted during discovery that he had reviewed the patient's ECG during his hospitalization, the patient's health record contained no reference. Dr. S stated that the CCTA showed no cardiac anomaly; however, it is known that the ECG should have provoked significant concern (given the deep, inverted T waves), yet no documentation was found.

Fourth, Dr. S claims to have had a very important conversation with the patient the night before he left the hospital against medical advice. During discovery, Dr. S insisted that he had urged the patient to remain in the hospital so that he could be further evaluated to determine whether his pain was orthopaedic or cardiac in origin. However, this conversation was not documented in the patient's health record.

If documentation of the doctor's advice and the patient's response (that he had no health insurance and could not afford a longer hospital stay) existed, the doctor's efforts and the patient's noncompliance would have been much clearer. Instead, the only additional documentation was "OK to discharge from cardiac standpoint," which seems to imply that the doctor was fine with the patient leaving the hospital.

A patient leaving against medical advice is a particularly high-risk situation requiring careful documentation of the doctor's concerns, his/her communication of those concerns to the patient (along with his/her recommendations), and the patient's response. Without personal knowledge of the facts, Dr. S's documentation of this case leads to a significant misunderstanding of those facts.

Summary Suggestions

The following suggestions may be helpful to providers treating patients with unlikely — but potentially very serious — medical conditions:

- Any component of the differential diagnosis that can have critical health consequences must be aggressively investigated to its conclusion, even when the patient is not considered at high risk for the condition.
- The documentation of patient care must fully explain what has occurred so that it can be understood by subsequent reviewers of the patient's health record, including legal reviewers.

- It is appropriate and often useful to directly quote difficult and/or noncompliant patients in the health record documentation. This detailed documentation helps subsequent reviewers understand the patient's reasoning and state of mind at the time of treatment.
- When a patient makes a decision against medical advice, it is best — when possible — for the doctor to explain his/her medical advice in writing, urge the patient to reconsider, and explain the possible consequences of not doing so.

Conclusion

In these days of patients' rights and autonomy, patients sometimes make treatment decisions that may not be in their best interests, at least from the physician's perspective. When such decisions are made, the physician serves himself/herself — and the patient — well when a careful explanation of the advice is provided, preferably in writing. Armed with that information, the patient can make a well-informed decision, and the physician has fulfilled his/her legal and ethical obligation to the patient.

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