Failure to diagnose myocardial infarction

by Brian Dittmar and Tanya Babitch

Presentation
A 57-year-old man came to the emergency department (ED) by ambulance after developing chest tightness and shortness of breath followed by an unwitnessed syncopal episode. The defendant emergency medicine physician saw the patient 11 minutes after his arrival. The patient reported that he used alcohol and tobacco. His medications included simvastatin, aspirin, quinapril, and metoprolol. He reported that he had a history of hypertension and a prior heart attack treated by placement of a coronary stent. The patient indicated that his episodes of chest tightness had been ongoing for several weeks and were worse upon exertion.

Physician action
The emergency medicine physician examined the patient and noted that he was bradycardic with diaphoresis and “pale skin color.” The patient’s lungs were “clear to auscultation bilaterally without wheezes, rales, rhonchi, or stridor.” Evaluation included a 12-lead EKG, cardiac enzymes, B-natriuretic peptide, CBC with differential, chemistry panel, and chest x-ray.

The emergency medicine physician interpreted the EKG as “normal sinus rhythm without ectopy or ST segment changes.” The computer interpretation recorded the findings as “sinus bradycardia (heart rate 53), inferior infarct — age undetermined.” The chest x-ray revealed congestive heart failure. Cardiac enzymes were interpreted as normal, with the exception of the B-natriuretic peptide, which was slightly elevated at 128 (normal range 0-100). In addition, the patient’s CO2 was slightly low at 21 (normal range 22-30).

The physician’s diagnosis was chest pain, stable angina, congestive heart failure, coronary artery disease, and hypertension. The patient was discharged 1 hour and 20 minutes after his arrival in what was noted to be stable condition. He was given a prescription for nitroglycerin and was advised to follow up with his cardiologist in two days or to return to the ED if he developed chest pain again.

The patient was found unconscious in his vehicle the next morning. EMS was notified and CPR was immediately instituted. The patient was intubated and an IV started. He was immediately transported by helicopter and arrived in the ED in full arrest. He was intubated and continued on appropriate CPR protocol with the use of epinephrine, atropine, bicarbonate, and lidocaine, but the patient died.

continued on page 2

This closed claim study is based on an actual malpractice claim from Texas Medical Liability Trust. This case illustrates how action or inaction on the part of the physicians led to allegations of professional liability, and how risk management techniques may have either prevented the outcome or increased the physician’s defensibility. An attempt has been made to make the material less easy to identify. If you recognize your own case, please be assured it is presented solely to emphasize the issues of the case.
No formal autopsy was performed. The death certificate was signed by the patient’s cardiologist listing the cause of death as sudden cardiac death secondary to ventricular tachycardia resulting from ischemic cardiomyopathy.

**Allegations**

Lawsuits were filed against the emergency medicine physician and the hospital. It was alleged that when the patient initially presented to the ED, he showed classic symptoms of coronary artery disease, unstable angina, and/or myocardial infarction. It was further alleged that the defendant physician knew that the EKG was abnormal and demonstrated ischemia and sinus bradycardia. Plaintiffs alleged that the emergency physician breached the standard of care by his failure to order more than one blood test to determine the levels of the cardiac enzymes; his failure to order more than one EKG; his failure to order an exercise electrocardiography test and cardiac perfusion scan; and his failure to obtain a cardiology consult prior to discharge.

**Legal Implications**

Physicians who reviewed this case for the defense were critical, suggesting that this patient’s presentation required admission to the hospital and urgent cardiac consultation. It was noted that a single set of cardiac serum markers — particularly those obtained in the first 4 hours after the onset of chest pain — is unreliable in establishing or excluding a diagnosis of MI. The finding of congestive heart failure suggests acute decompensation of a stable status that should be evaluated. Additionally, syncope in a patient with structural heart disease requires evaluation.

**Disposition**

The case was settled on behalf of the emergency medicine physician and the hospital.

**Risk Management Considerations**

In this case, consultants felt that the emergency medicine physician should have been alerted to the possibility of acute myocardial infarction due to the patient’s reported syncope. The patient was not evaluated for the syncope, and this may have been significant. They stated that the patient’s combination of history, symptoms, and the computer-interpreted abnormal EKG, should have prompted further action on the part of the defendant. They felt that current literature indicated that a single set of cardiac serum markers, particularly ordered within the first 4 hours after onset of chest pain, is unreliable in ruling out a diagnosis of myocardial infarction.

Consultants felt that the physician should have considered and documented coordination of care with a cardiologist, ordered serial EKGs or cardiac enzymes, or admitted the patient.

Missed diagnosis of acute myocardial infarction is a common allegation against emergency medicine physicians. Emergency departments do physicians a service by implementing detailed, time-sensitive chest pain protocols. Protocols, however, have their limits and may not be able to address every possible patient scenario.

In addition, physicians are encouraged to consider the “big picture” and evaluate not only the patient’s medical history, but review all the patient’s reported symptoms. It is important that physicians recognize the limitations of diagnostic tests and consider the possibility of ordering further studies. Considering the “worst case scenario” in a chest pain case may prompt a physician to order serial EKGs or cardiac enzymes, to consult cardiology, or to admit the patient to the hospital.

Brian Dittmar can be reached at brian-dittmar@tmlt.org. Tanya Babitch can be reached at tanya-babitch@tmlt.org.
TMLT adds employment practices liability coverage to all policies

by William Malamon, ABC

The area of law that deals with these kinds of events is referred to as employment practices liability. Typical allegations in employment practices lawsuits include harassment, discrimination, FMLA violations, hostile work environment, and wrongful termination. Employment practices claims are not only embarrassing, but can also be expensive to defend or settle. Insurance that covers these types of claims is called employment practices liability insurance (EPLI).

The good news for TMLT policyholders is that beginning February 1, 2013, EPLI will be added to all policies at no extra charge. Policyholders will begin receiving information about this new coverage as they renew their policies.

EPLI claim statistics

Approximately 100,000 employment-related claims were filed through the Equal Employment Opportunity Commission (EEOC) in 2012, totaling $364 million paid to claimants (excluding awards through litigation). Approximately 30,500 discrimination claims were filed with the EEOC and Fair Employment Practices Agencies (FEPA) in 2012. 1

Regarding the types of claims, there were three notable increases in recent years:

Discrimination based on religion

- 3,790 in 2010
- 4,151 in 2011
- an increase of 9%

Retaliation

- 36,258 in 2010
- 37,344 in 2011
- an increase of 3%

Discrimination based on national origin

- 11,304 in 2010
- 11,833 in 2011
- an increase of 4.6%

The cost of settlements and verdicts from employment-related claims can be huge. For example:

- In 2009, Wal-Mart settled a race bias suit for $17.5 million. 2
- In 2008, New York City paid more than $20 million to settle a racial discrimination suit filed against their Department of Parks and Recreation. 3
- In 2003, California’s public pension fund paid $250 million to settle an age discrimination suit. 4

TMLT’s EPLI coverage

Beginning February 1, 2013, all TMLT policies will include an EPLI endorsement. The endorsement covers several kinds of alleged, wrongful employment practices including:

- violation of any federal, state, local, or common law, prohibiting any kind of employment-related discrimination;
- harassment, including any type of sexual or gender harassment as well as racial, religious, sexual orientation, pregnancy, disability, age, or national origin-based harassment and including workplace harassment by non-employees;
- abusive or hostile work environment;
- wrongful discharge or termination of employment, whether actual or constructive;
- breach of an implied employment contract or promissory estoppel (an understanding based on a previous action or statement);
- breach of an actual or written employment contract as long as another wrongful employment practice is also alleged;
- wrongful failure or refusal to hire or promote, or wrongful demotion;
- wrongful failure or refusal to provide equal treatment or opportunities;
- employment termination, disciplinary action, demotion or other employment decision that violates public policy or the Family Medical Leave Act or similar state or local law;

continued on page 4
Liability coverage ... continued from page 3

- defamation, libel, slander, disparagement, false imprisonment, misrepresentation, malicious prosecution, or invasion of privacy;
- wrongful failure or refusal to adopt or enforce adequate workplace or employment practices, policies, or procedures;
- wrongful, excessive, or unfair discipline;
- wrongful infliction of emotional distress, mental anguish, or humiliation;
- retaliation, including retaliation for exercising protected rights, supporting in any way another’s exercise of protected rights, or threatening or actually reporting wrongful activity of an insured such as violation of any federal, state, or local “whistle blower” law;
- wrongful deprivation of career opportunity, negligent evaluation or failure to grant tenure;
- violation of the Uniformed Services Employment and Reemployment Rights Act; or
- negligent hiring or negligent supervision of others, including wrongful failure to provide adequate training, in connection with training.

Limits of liability are $50,000 per claim (including both defense costs and indemnity payments) with a $5,000 deductible. The yearly aggregate limit is also $50,000.

A claim must be reported to TMLT as soon as practicable, but no later than 60 days from the date the policyholder becomes aware of the claim. Policyholders can also report circumstances they believe might lead to a claim.

For more information about EPLI coverage visit our web site or contact your underwriter at 800-580-8658.

**Sources**


William Malamon can be reached at william-malamon@tmlt.org.