Failure to diagnose myocardial infarction

by Tanya Babitch, Manager, Risk Management

PRESENTATION

A 66-year-old man came to the emergency department (ED) at 9:11 p.m. with chest pain. He was triaged at 9:14 p.m. The patient reported shortness of breath and chest pain that began that morning and continued throughout the day. He stated that the chest pain was worse on deep inspiration.

The patient had a history of myocardial infarction, and his medications included megestrol, hydrochlorothiazide, and verapamil. The patient’s vital signs upon admission to the ED were blood pressure 158/66 mm Hg; pulse 114; respirations 20; temperature 96.9 degrees; and oxygen saturation 98% on room air. His pain was evaluated at a level of approximately 6.

PHYSICIAN ACTION

ED staff performed an electrocardiogram at 9:42 p.m. and started the patient on IV fluids. There were no previous EKGs available for comparison. The emergency medicine physician interpreted the EKG approximately 46 minutes after the patient’s arrival. Results from the EKG revealed a left bundle branch block and sinus tachycardia.

The emergency medicine physician examined the patient at 10 p.m. The patient was awake and alert, and reported continued pain. He stated that the pain began after moving a heavy chair a day earlier. The patient denied any direct trauma.

He had a history of myocardial infarction, but indicated that the pain was different — that it hurt to take a deep breath. There was no arm, jaw, or back pain, and no nausea or vomiting. The results from the physician exam — which included a cardiovascular exam — were normal. The physician ordered a chest x-ray, which revealed “no active cardiopulmonary disease.”

The physician ordered ibuprofen and hydrocodone, and the patient was observed for the next few hours. No further laboratory tests or evaluations were performed. Vital signs taken at 1 a.m. revealed a blood pressure of 124/84 mm Hg; pulse 88; and respirations 18.

The patient appeared to be stable, and was discharged with a diag-

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nosis of atypical chest pain. He was given prescriptions for ibuprofen and hydrocodone/acetaminophen, and was given chest pain precautions and instructions. He was advised to follow up with his physician, or to return to the ED if the problem persisted or there was increased pain.

At 2:03 p.m. that day, the patient called 911 complaining of stomach pain. The EMS personnel arrived at 2:07 p.m. The patient gave a history of taking pain medications on an empty stomach, and did not complain of chest pain or shortness of breath. After examining the patient, the EMS personnel decided not to take him to the ED.

The patient’s family arrived home later and found the patient sitting up, but unconscious and blue in color. The family contacted EMS at 3:16 p.m. EMS arrived quickly and took the patient to the hospital. The patient arrived at the emergency room at 3:45 p.m. in full cardiopulmonary arrest. He was pronounced dead at 3:50 p.m.

An autopsy was performed and the medical examiner concluded that the patient died from hypertensive and atherosclerotic cardiovascular disease with severe coronary artery stenosis.

ALLEGATIONS
A lawsuit was filed against the emergency medicine physician. The plaintiffs alleged that the physician was negligent in failing to appreciate the patient’s cardiac history while addressing the complaints of chest pain. They alleged that the physician should have initiated a full cardiac work up with a cardiac consultation. It was further alleged that the patient would have survived if this had been done.

LEGAL IMPLICATIONS
Two emergency medicine physician consultants reviewed the case. The first consultant felt that the ED physician should have ordered labs including cardiac enzymes, electrolytes, and coagulation studies. The second consultant felt that the patient may have died from sudden cardiac arrhythmia unrelated to ischemia. In addition, the second consultant stated that the pain described by the patient in the ED was atypical for pain of a cardiac origin. Both consultants felt that upon reviewing the EKG finding of the left bundle branch block, the emergency medicine physician should have admitted the patient.

The consultant cardiologist who reviewed the case pointed out that the autopsy findings did not state that the patient died due to a myocardial infarction. In addition, the patient’s chest pain did not appear to be cardiac in nature. As such, he did not believe that the emergency medicine physician missed the diagnosis, but did admit that many ED physicians would have admitted the patient, obtained cardiac enzymes, and consulted a cardiologist.

While the autopsy did not specify that the patient died from a myocardial infarction, it became clear after meeting with the medical examiner that he would testify that it was an MI that killed the patient.

RISK MANAGEMENT CONSIDERATIONS
In this case, consultants felt that the patient’s history of myocardial infarction combined with the electrocardiogram results should have prompted the emergency medicine physician to admit the patient. Missed diagnosis of myocardial infarction is a common allegation against ED physicians. In this case, the patient’s reported pain did not entirely match the usual symptoms for acute myocardial infarction. In addition, the patient reported to the physician that the pain he was experiencing was not similar to the pain he experienced during his prior incident of MI.

“Because chest discomfort due to myocardial ischemia tends to be similar in location and quality during recurrent episodes, it is helpful diagnostically if the symptoms are consistent with prior episodes.”

The lack of these symptoms, and the patient’s statement that symptoms did not feel like his prior MI, may have acted as a “red herring” in this case. However, even with the somewhat atypical reported symptoms, the consultants felt that the emergency medicine physician should have exercised caution and ordered a full cardiac work up.

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

SOURCE

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Online reputation management for physicians

by Laura Hale Brockway, ELS

As more patients go online to find information about physicians, your reputation is being built and managed on the Internet. And like it or not, your online reputation plays a role in acquiring new patients and maintaining trust with existing patients and colleagues. It is imperative for physicians to have a plan and focus on online reputation management.

Online reputation management is the process of preventing and repairing threats to your online reputation. It is done by tracking what is written about you and using techniques to address or moderate the information on search engine result pages or in social media. The goal is to promote positive or neutral content while suppressing negative content.

For physicians, online reputation management involves addressing information in three areas:

1. information found on search engine results pages (Google);
2. information found in social media (LinkedIn, Facebook, blogs); and
3. information on rating websites, such as Vitals, HealthGrades, Rate MDs, Yelp, and Angie’s List.

Recently, a physician received an email from a company offering online reputation management services to help him mitigate negative online reviews on sites such as Yelp, Google, and health care review sites such as Vitals.

There are hundreds of companies out there offering these services. However, physicians are urged to use extreme caution when choosing a reputation management company. Some companies engage in questionable techniques that could lead to disciplinary action by the Texas Medical Board (TMB).

Specifically, the company that emailed this physician said they “will post reviews for our clients to over 40 social media websites … We post up to 25 reviews per month.”

This claim is alarming in the context of medical practice. How are they managing to post reviews from the patients of a particular physician? Are they making up reviews and then posting them?

It is unethical and dishonest to post reviews on these sites that are not from actual patients. Physicians are held to a different standard than other businesses, and posting fake patient reviews is inappropriate. Doing so would also violate TMB advertising rules, as this type of advertising (and the TMB does consider this to be advertising) would be considered “misleading.”

Here are a few techniques for managing your own online reputation.

KNOW WHAT IS BEING SAID.
Conduct web searches on yourself and your practice regularly. Review the first 30 hits of the search. (Any hit past 30 is generally considered extraneous and not likely to be read.) Among the top 30 hits, what are these sites saying about you? Continue to monitor these online discussions.

KNOW WHAT YOU CAN AND CANNOT DO ABOUT NEGATIVE REVIEWS.
Because of health care privacy laws, physicians cannot respond to online reviews. The fact that a patient's identity is protected information directly hinders the physician's ability to refute a complaint. Simply acknowledging publicly that the complaining party is a patient breaches confidentiality and violates HIPAA.

CONSIDER GIVING PATIENTS MORE CONSTRUCTIVE WAYS TO OFFER THEIR FEEDBACK.
Conducting a patient survey, for example, would be a good way for patients to express their dissatisfaction and feel empowered.

Another option is to talk to the patient directly if you can identify who made the comment. This should be done in person or over the phone. Begin by asking the patient why he or she is dissatisfied.

It is also a good idea to investigate the patient's complaints. Is the complaint legitimate? Was the problem with a procedure, a staff member, or the patient's wait time? Can the problem be fixed?

OPTIMIZE YOUR WEBSITE FOR SEARCH ENGINES.
Optimizing your website for search engines will ensure that anyone typing in your name or your practice name will see your website at the top of the search list. Optimizing your site involves creating comprehensive and targeted meta tags and website page titles that help search engines index your site.

More sophisticated techniques include editing your site's content, HTML, and associated coding; removing barriers to the indexing activities of search engines; increasing inbound links; or purchasing related web addresses.

CREATE YOUR OWN BLOG.
You cannot control what other people say about you online, but you can create your own (Continued on page 4)
CREATE A LINKEDIN PROFILE.
Your LinkedIn profile is another aspect of your online presence that you create. Add information about where you went to school, your specialty, and your practice. Make your profile public so that patients and potential patients can learn about you in a way you can control.

TAKE ADVANTAGE OF THAT “THANK YOU.”
The next time you receive a thank you note or email from a patient or family member, ask that person to post their comments on your blog, on your LinkedIn profile, or on physician rating sites.

Keep in mind that with the prevalence of smartphones and tablet PCs, patients can post a review of you — a positive or negative review — at any time and from anywhere. Even from your waiting room. Don’t ignore what’s being said.

For more information on online reputation management, please see the following TMLT resources:


Sources
1. Hoffman T. Online reputation management; cleaning up your image is hot, but is it ethical? Computer World. February 12, 2008.