The Big Three: Don’t Miss the Two by Four

A PPIC® Closed Claim Case Review by Deborah J. Price, RN, MSN, PhD, Director, Risk Services

ABSTRACT

PPIC continues to see claims of wrong, failed, or delayed diagnosis of acute myocardial infarction (AMI), abdominal aortic aneurysm (AAA), and pulmonary embolus (PE); i.e., the Big Three. Opinion has long held that emergency department (ED) physicians have the most exposure to Big Three-related claims. In fact, chest pain ranks behind abdominal pain as the second most common ED complaint, prompting an estimated six million ED visits per year (http://www.cdc.gov/nchs/data/databriefs/db43.pdf). Yet multiple specialties have exposure risk, as shown in PPIC data below.

An overview of several PPIC claims related to the Big Three:

<table>
<thead>
<tr>
<th>Presenting Symptom</th>
<th>Final Diagnosis</th>
<th>Malpractice Theory</th>
<th>Severity</th>
<th>Indemnity Paid</th>
<th>Specialty</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chest pain</td>
<td>MI</td>
<td>Wrong diagnosis</td>
<td>Death</td>
<td>500,000.00</td>
<td>Emergency Medicine</td>
</tr>
<tr>
<td>Epigastric pain</td>
<td>MI</td>
<td>Failure to diagnose</td>
<td>Death</td>
<td>500,000.00</td>
<td>Internal Medicine</td>
</tr>
<tr>
<td>Chest pain</td>
<td>MI</td>
<td>Failure to diagnose</td>
<td>Death</td>
<td>200,000.00</td>
<td>Family Practice</td>
</tr>
<tr>
<td>Chest pain</td>
<td>AAA</td>
<td>Failure to diagnose</td>
<td>Death</td>
<td>675,000.00</td>
<td>Emergency Medicine</td>
</tr>
<tr>
<td>Abdominal pain</td>
<td>AAA</td>
<td>Wrong diagnosis</td>
<td>Death</td>
<td>1,000,000.00</td>
<td>Radiology</td>
</tr>
<tr>
<td>Diaphoresis</td>
<td>AAA</td>
<td>Failure to diagnose</td>
<td>Death</td>
<td>800,000.00</td>
<td>Emergency Medicine</td>
</tr>
<tr>
<td>Abdominal pain</td>
<td>PE</td>
<td>Failure to diagnose</td>
<td>Death</td>
<td>900,000.00</td>
<td>General Surgery</td>
</tr>
<tr>
<td>Cough</td>
<td>PE</td>
<td>Failure to diagnose</td>
<td>Death</td>
<td>200,000.00</td>
<td>Internal Medicine</td>
</tr>
<tr>
<td>Abdominal pain</td>
<td>PE</td>
<td>Failure in diagnosis</td>
<td>Death</td>
<td>600,000.00</td>
<td>Obstetrics</td>
</tr>
</tbody>
</table>

The next chart represents a random sampling of Big Three-related patient claims over a ten year period. The chart does not list the total number of claims, as several providers may have been included in a suit filed by any one patient.

<table>
<thead>
<tr>
<th></th>
<th>2012</th>
<th>2007</th>
<th>2002</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients suffering an MI</td>
<td>8</td>
<td>10</td>
<td>4</td>
</tr>
<tr>
<td>MI deaths</td>
<td>7</td>
<td>8</td>
<td>3</td>
</tr>
<tr>
<td>Patients suffering an AAA</td>
<td>1</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>AAA Deaths</td>
<td>0</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Patients suffering a PE</td>
<td>4</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>PE deaths</td>
<td>4</td>
<td>6</td>
<td>2</td>
</tr>
</tbody>
</table>

The brief case reviews that follow are drawn from each condition. All case theories involve failure to diagnose.

AMI CASE

A 53-year-old female presented to the ED at 12:30 a.m. with a chief complaint of chest pain radiating into both arms. The patient had a long history of esophagitis, and ingestion of Rolaids and milk prior to arriving at the ED had provided her no relief. She stated that the pain had started about two hours prior and was worse in her left arm and neck/throat. She also stated that previous chest pain episodes had never radiated into her arms or neck. She denied a family history of heart disease and had quit smoking about four months earlier.

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On examination, the patient’s skin was warm, dry, and pink. There had been no nausea, vomiting, or diarrhea and her abdomen was soft and non-tender. She was alert and oriented X3. Temp 98.6, Pulse 76, BP 157/90, Respirations 28, SaO2 96% on room air, with pain self-rated as 8 on a 1-10 scale. Her stated weight was about 290 pounds. The EKG showed nonspecific ST changes, which the ED physician documented as normal. Cardiac markers were within normal limits and were not repeated. No other diagnostic studies were completed.

After the patient received a GI cocktail, she rated her pain at 3-4. She was discharged about two hours after her arrival with a diagnosis of esophagitis. The ED physician documented that the patient was stable at discharge. Discharge instructions directed her to follow up with her PCP and to return to the ED if the pain worsened.

Eight hours later, the rescue squad returned the patient to the ED in full arrest. Resuscitation was not successful. The autopsy showed MI as the cause of death. The case settled prior to trial for $500,000.

AAA CASE

A 34-year-old male presented to the ED with recent onset of diaphoresis and mid-sternal chest pain radiating into his neck. The pain increased with deep breathing and upright sitting. He had not experienced the symptoms prior to this event. He denied family history of CAD and history of hypertension.

Presenting vital signs were BP 153/87, Temp 97.1, Pulse 70, Respirations 20, Sao2 96% on room air, and pain rated as 7 on a 1-10 pain scale. A serial EKG and posterior/anterior and lateral chest x-rays were documented as normal.

Initial treatment included a GI cocktail, IV with normal saline, Tagamet 300 mg and Carafate 300 mg. After one hour the patient’s pain remained at 7 and the Torodol administered did not provide relief. Vital signs at that time were BP 124/86, Pulse 82, and Respirations 20.

One hour later, he continued to rate pain at 7 with persistent symptoms and was given Tylox. Vital signs at that time were BP 97/46, Pulse 74, and Respirations 20. He was discharged shortly thereafter with a diagnosis of costochondritis and a prescription for Motrin. His instructions were to return to the ED if the pain worsened and to call his PCP for follow up.

Eight hours after discharge, a rescue squad returned the patient to the hospital in full arrest. Resuscitation was not successful. An autopsy determined the cause of death to be a dissecting ascending aortic aneurysm with spontaneous rupture into the pericardial sac. The case settled prior to trial for $800,000.

PE CASE

A 59-year-old woman was admitted for bladder suspension surgery. Her orders included sequential compression device (SCD) boots to be applied while she was in bed, removed for ambulation, and continued on page 4
reapplied following ambulation. On post-op day one the patient was ambulated to the bathroom, at which time the SCD boots were removed. When she returned to bed, the SCD boots were not reapplied. In fact, the SCD boots were never reapplied throughout her three-day stay. She died from pulmonary embolism two days after discharge.

On the surface this case seems to be more of a nursing issue than a physician issue, but the physician was included in the lawsuit because he visited the patient daily and failed to note that the SCD boots were not being used as ordered. The hospital was also included in the suit on behalf of the nursing staff. The case went to trial and the jury awarded the family $1.75 million.

DISCUSSION

While each case is very different, the outcomes of death were consistent. Common issues between the cases include:

- Lack of appropriate documentation
- Failure to recognize atypical presentation
- Failure to recognize that EKG is not 100% sensitive
- Higher rates of EKG misinterpretation
- Failure to recognize that EKG and chest x-rays are not always diagnostic
- Failure to take and record a careful history, including family history
- Reluctance to admit with vague symptoms
- Misguided use of labs
- Low suspicion for certain patient groups
- Involvement of younger patients
- Failure to recognize red flags

RISK LESSONS

- Stratify risk using sound clinical judgment or tools such as:
  - Thrombolysis in Myocardial Infarction (TMI) Score
  - Acute Cardiac Ischemia Time Insensitive Predictive Instrument Score
  - Grace Risk Score
  - Heart Score
- Recognize atypical presentations
- Develop alternate pathways
- Document
- Take complaints of persistent pain seriously
- Strongly consider new symptoms
- When in doubt, admit

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References


NCHS Data Brief No. 43 September 2010 http://www.cdc.gov/nchs/data/databriefs/db43.pdf

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