

Patient Fails to Follow Physician's Repeated Recommendations, Resulting in Fatal Myocardial Infarction

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Introduction

One of the most frustrating aspects of care for physicians of all specialties is patients who do not adhere to their treatment plans. The physician formulates a plan of care that he/she believes is most likely to result in an optimal outcome for the patient, but is met with passive resistance or, less commonly, active resistance. Occasionally, as in this case from the Southwest, a patient's nonadherence can have catastrophic results.

Facts

The patient, a 47-year-old male, began seeing Dr. S, a MedPro-insured family medicine physician. The patient had diabetes, mild obesity, hypertension, and hyperlipidemia; he also smoked cigars. Before starting treatment

with Dr. S, he had undergone angioplasty and had suffered a myocardial infarction (MI). The patient was no longer seeing the cardiologist who had previously treated him.

At the patient's first appointment in March of Year 1, Dr. S renewed the patient's cardiac medications and noted that he would "*get the patient hooked up with a cardiologist in the area.*" In July, he noted that "*The patient has yet to see a cardiologist for his diabetes and prior history of having an MI. The patient was reminded to make the appointment with the cardiologist.*" Dr. S also noted having an extensive discussion with the patient regarding the need for cardiac follow-up.

In August of Year 1, the patient went to an emergency department (ED) with symptoms

of an MI. He received stents to relieve occlusion of three of his cardiac vessels and was given clopidogrel. This treatment was successful, and he was cleared to return to work 2 weeks later by the treating cardiologist. He also continued to see Dr. S, who regularly reminded the patient to measure his blood pressure (BP) daily and contact his cardiologist if it was consistently elevated. All of these reminders were carefully noted in Dr. S' health record for the patient.

The patient continued to see both doctors into Year 2. His electrocardiograms (ECGs) remained stable, indicating a previous MI but no ongoing ischemia.

In May of Year 3, the patient saw an endocrinologist because of his uncontrolled diabetes. He told the endocrinologist that he was having anxiety attacks and chest discomfort; however, this information was not communicated to Dr. S.

In June of Year 5, Dr. S noted that the patient continued to have uncontrolled diabetes. He referred the patient back to the endocrinologist and the cardiologist, noting *"needs nuclear stress test done – overdue for follow-up on stents."* The patient did not follow up on either referral.

The patient saw Dr. S in December of Year 5, and Dr. S noted that the patient had a cardiology appointment scheduled for February of Year 6. The patient failed to keep that appointment. When he was seen in April of Year 6, his BP was 152/88, and Dr. S noted *"pt is past due for f/u with cardiology and was strongly encouraged to do so."* Dr. S also saw the patient in June of Year 6 and noted *"pt has follow-up with cardiologist in Aug."*

In July of Year 6, the patient presented to Dr. S' office with a complaint of constant heartburn that worsened with exertion. The patient's BP was 98/68. He indicated that he had some relief using his nitroglycerine spray, but then the heartburn would return.

Dr. S diagnosed heartburn/reflux and advised the patient to return if the symptoms did not improve or worsened. Dr. S again encouraged the patient to see his cardiologist and advised him that if he had any crushing chest pain to call 9-1-1 immediately and then chew four children's aspirin and take his nitroglycerine.

On August 10th of Year 6, the patient was awakened by chest pain and pressure at about 3 a.m. He took aspirin and nitroglycerine, but he did not go to the ED until about 7 a.m.

At the hospital, he underwent urgent cardiac catheterization, but he died in the intensive care unit a short time later.

A medical malpractice lawsuit was brought against Dr. S alleging that he was not adequately attentive to the patient and did not sufficiently appreciate his symptoms, causing the patient's cardiac disease to progress to the point of his demise. This case was vigorously defended and resulted in a verdict in favor of Dr. S. Defense costs were in the mid-range.

Discussion

A patient's failure to adhere to his/her physician's recommendations can be at best frustrating for the physician and at worst dangerous to the patient's health. This non-adherence can take one of two forms: passive resistance or active resistance, of which the former is more common.

1. Passive resistance: Situations in which the patient simply fails to follow through with recommendations, often without the doctor's knowledge

2. Active resistance: Situations in which the patient is well aware of the doctor's recommendations but decides to willingly disregard them

These forms of nonadherence should be handled differently. When the patient clearly indicates that he/she is not going to comply with the physician's recommendations, the doctor-patient relationship has become dysfunctional, with the patient taking a defiant stance and the physician having limited recourse.

Generally, if the patient is not prepared to enter into a collaborative relationship with the physician, with each having their defined roles, the doctor-patient relationship should be terminated.¹ If the physician did proceed with the dysfunctional relationship and the patient suffered harm, the physician's actions could be legally indefensible.

Dealing with passive resistance can be more complicated. The first priority is to be aware of the patient's nonadherence, which necessitates having a good system to track and follow up with patients. For example, if the patient

¹ MedPro's guideline [Terminating a Provider-Patient Relationship](#) provides guidance and risk strategies for physicians considering this approach.

is asked to have a specialist consultation (e.g., with a cardiologist) or a test (e.g., an ECG), the referring doctor would expect to receive a report or results. A manual tracking system can be used, or the practice's electronic health record system can be configured to alert the physician if the report or results are not received. The physician can then follow up with the patient to determine whether the report was lost or whether the patient never kept the appointment.

If a practice makes many referrals, it may not be practical to track all of them. In this situation, the practice should track its high-priority referrals – i.e., the referrals associated with cases for which the physician has serious concerns.

Once passive nonadherence is identified, the physician can initiate a discussion with the patient and try to identify any nonobvious reasons for the nonadherence, such as fear, denial of a problem, economic or other circumstantial factors, or other potential causes. If the physician can identify barriers to

adherence, he/she might be able to work with the patient to find a suitable solution.

If no barriers are identified and nonadherence continues, the physician should consider having a frank discussion with the patient about the consequences of nonadherence, including possible termination of the doctor-patient relationship. However, prior to terminating the relationship, the physician might want to consider using a patient care contract or behavior contract that details the responsibilities of both the physician and the patient relative to the care plan. Both the physician and the patient should sign the contract to indicate their commitment to the treatment plan.²

It is not in anyone's best interests – the physician's or the patient's – for the relationship to continue unchanged. In the absence of appropriate care, the patient will likely experience suboptimal outcomes and could suffer a crisis. Further, the physician might ultimately find himself/herself charged with what is known as “supervised neglect.”

² MedPro's guideline [Using Behavior Contracts To Improve Patient Adherence and Address Behavior Issues](#) provides guidance and risk strategies for physicians considering this approach.

One reason that the defense was able to prevail in Dr. S' case was the fact that Dr. S' documentation was excellent. In defending a medical malpractice case, two critical elements are (1) that the physician practiced in full compliance with the standard of care, and (2) that this compliance can be proven. In trials of any type, the jury does not necessarily decide the case based on the facts; rather they decide the case based on the evidence presented to them.

In many medical malpractice trials, the task of the defense attorney is to reconstruct the case for the jury to show that the doctor acted in compliance with the standard of care (if the doctor did). Although evidence of facts can consist of many things (e.g., eyewitness testimony, lab tests, photographs, operative and consultant reports, etc.), the written narrative of the patient's treatment experience (as contained in the patient's health record) is invaluable.

Dr. S' documentation was especially helpful because, in addition to a good narrative of the events of the case, he had frequently quoted the patient and himself when he documented his discussions with the patient regarding following up with a cardiologist and other

specialists. Introduction of these quotations into evidence "personalizes" the conversations, which can carry a lot of weight with a jury. In this case, it appears that the jury (at least partly due to Dr. S' documentation) attributed the patient's poor outcome to his unwillingness to address his health problems.

Summary Suggestions

The following suggestions might be helpful for physicians who are trying to address issues of patient nonadherence:

- Implement a functional patient tracking system to help identify issues of nonadherence. Set alerts to indicate the receipt of consultation reports and test results, particularly in relation to patients who have critical conditions.
- During encounters with nonadherent patients, ask open-ended, probing, and nonjudgmental questions to identify factors influencing nonadherence. Consider using various communication techniques – e.g., motivational interviewing – to empower patients to set goals they believe are attainable.
- When talking with a nonadherent patient, emphasize the importance of

following the recommended care plan. Explain the possible consequences of not following the agreed-upon plan.

- Use the **teach-back** (or repeat-back) technique to ensure that the patient fully understands the information and instructions provided. Patients from all racial, ethnic, socioeconomic, and educational backgrounds may have limited health literacy, which can lead to non-adherence.
- Document a description of all clinical nonadherence and any education provided to the patient regarding the consequences of not following the care plan. Use subjective statements from the patient and objective information obtained through patient encounters. Avoid disparaging remarks or

editorializing when documenting information related to a patient's nonadherent behaviors.

- If the patient continues to be non-adherent and makes no reasonable progress, consider implementing a patient care contract or terminating the provider-patient relationship.

Conclusion

The provider-patient relationship should be a partnership formed to optimize the results of medical care. However, cases will occur in which this partnership is minimal to nonexistent, leaving the physician unable to provide appropriate care. In these situations, follow-up, communication, and documentation are essential to determine whether solutions to nonadherence can be identified and put in place or whether other actions are necessary.

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