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Risk Management Review

Patient Assessed for Risk of Deep Vein Thrombosis Subsequently Dies; Malpractice Lawsuit Follows

Theodore Passineau, JD, HRM, RPLU, CPHRM, FASHRM

Introduction

One of the most difficult challenges for many medical specialties is accurate diagnosis of the presenting condition. At times, providers must use their best judgment regarding how much testing is enough to determine a diagnosis, while realizing that they may not yet be seeing the whole picture. This interesting case from the Southwest illustrates how this dilemma can cause liability exposure and an unfortunate outcome.

Facts

The patient was a 34-year-old female who presented to a family practice as a new patient in April of Year 1. At that time, her medical history was limited to seasonal allergies, a benign lipoma, and a previous knee injury from which she had fully recovered. She was a nonsmoker and had taken oral contraceptives for 17 years. A physical exam was performed, and it was unremarkable.

The patient returned to the practice in November of Year 2, complaining of right calf pain. Dr. G, a MedPro-insured family physician, saw her that day. The patient explained to Dr. G that she had flown to Florida the previous week for vacation and had walked on a lot of uneven sand. The pain was worse when she straightened out her leg. Initially, she thought she had just strained her leg, but when it failed to improve, she thought she should seek medical advice. She denied any direct injury, swelling, or shortness of breath.

Dr. G examined the patient's calf because it was slightly warm and showed some slight swelling, but no "cording" was found. A positive Homan's sign was also elicited. Because of her concern about the possibility of a deep vein

thrombosis (DVT), Dr. G arranged for a same-day Doppler study. The radiologist read the study and indicated it was negative; the study was faxed to the family practice later that day. Dr. G's partner reviewed the report, and no further action was taken (including no further communication with the patient). However, no evidence indicates that Dr. G saw the report.

Approximately 2 weeks later, as the patient was preparing for work, she suddenly felt dizzy and became unconscious and incontinent. Emergency medical services (EMS) were summoned. Upon their arrival, the patient was conscious and oriented, with no complaints of chest pain or shortness of breath.

The patient arrived at the emergency department (ED) at 10:00 a.m. Diphenhydramine and diazepam were administered intravenously to the patient. She explained to the ED physician that she had recently seen the family practice physician for right calf pain, which had continued since then (without her reporting it to Dr. G). A computed tomography (CT) scan was taken of the patient's head that indicated normal results.

Shortly after noon, as the patient was being helped to the bathroom, she collapsed again and quickly progressed to cardiac arrest. After being successfully resuscitated, she was taken to the cardiac catheterization lab for placement of a temporary pacemaker. While there, the patient arrested a second time and was again successfully resuscitated. Because a pulmonary embolism was suspected, tissue plasminogen activator (TPA) was administered at 1:30 p.m. The patient received a subsequent chest CT scan that suggested pulmonary emboli, and the venous Doppler study conducted on her showed a large thrombus in the right popliteal vein. The patient was admitted to the intensive care unit (ICU).

The following morning, the patient had CT and MRI imaging taken of her head that showed profound anoxic encephalopathy. Several specialists who saw the patient in the ICU concluded that cardiac arrest secondary to pulmonary embolism caused the brain damage and indicated that her prognosis was very poor. Life support was withdrawn from the patient 5 days later, and she died.

A medical malpractice lawsuit was subsequently commenced against Dr. G and the family practice; however, as discovery progressed, the family practice was dropped and the case continued against Dr. G as the sole defendant. Ultimately, at Dr. G's request, the case was settled with a payment in the high range and defense costs in the mid-range.[1]

Discussion

In any medical malpractice lawsuit, the ultimate question is whether the defendant's performance was within the standard of care (that is, what a reasonable person trained in the specialty would do or not do under the same or similar circumstances). This question is where expert witnesses are critical; the plaintiff's experts will assert that the defendant did not meet the standard of care (for their reasons), and the defense experts will opine that the defendant did meet the standard of care (again, for their reasons).

In this case, the patient's symptoms were somewhat "nuanced," so it was very difficult to make a clear determination of whether Dr. G met the standard of care. If the clinical symptoms indicated no risk of DVT, then according to the American College of Chest Physicians (ACCP) guidelines, the negative Doppler study was all that was necessary. However, if the symptoms indicated moderate risk, another Doppler or a D-dimer test within 7 to 10 days was indicated. It is significant that the patient's crisis occurred 15 days after the initial test, suggesting that if a second test had been performed within 7 to 10 days of the initial test, it may have indicated the patient's worsening condition.

What factors could have indicated either moderate or no risk? In concluding the patient was at moderate risk, the plaintiff's expert first cited the fact that the patient had recently had a several-hours-long airplane ride that kept her stationary in a seated position. He also cited her 17-year history of oral contraceptive use and her (arguable) clinical symptoms of DVT (including the warmth and slight swelling at the appropriate point on the calf, along with a positive Homan's sign). The defense experts concluded that these factors, in their entirety, were not sufficient to indicate moderate risk. In the end, a jury of laypersons would be charged with determining whether Dr. G's conclusion that the patient was at no risk of DVT was reasonable or not (there is no presumption of "innocence" in civil litigation). The outcome of this trial was far from certain.

From a risk management perspective, certain actions may have helped minimize the risk to the patient. The first consideration is that Dr. G never reviewed the Doppler results. When the Doppler report was completed, it was faxed to the family practice; Dr. D, who had not seen the patient for this complaint, reviewed and approved it. Technically, the results were reviewed, but this review, without the benefit of the clinical exam and conversation with the

patient, was not ideal. An accepted risk management principle is that the provider who orders the test should review the results (or know that they haven't); that did not happen in this case.

Providing patient education is another action that may have minimized risk to the patient. She was smart and educated; it can be assumed that if she had been properly informed of the symptoms of a continuing problem, she would have promptly notified Dr. G. Unfortunately, there was no documentation of such a discussion, and Dr. G testified that she had no independent recollection of her conversation with the patient. Since the patient died and no third person had been present, there is no way of knowing (or proving) what was said or not said during this patient visit.

This unfortunate situation could have easily been avoided by providing the patient with a written patient information sheet containing details about symptoms to report. Either purchased commercially or created by the practice, patient information sheets should be used in all appropriate cases. They can provide three important legal and risk management benefits:

1. Patient information sheets give patients the opportunity to review what they were told at their own time and pace. Many studies have shown that patients only retain a portion of the information they receive during a clinical visit. The opportunity to review the material later can increase patient comprehension and, in many cases, their adherence to the provider's instructions.
2. Patient information sheets also are an excellent way to communicate with people who are not present for the patient visit, especially when the patient is an older adolescent (where the parents may not be present at the visit) or an elderly person (where the adult children of the patient are attempting to help their parent, but are not present for the visit). In these cases, the secondary party may help the patient with adherence if they have the necessary information.
3. Patient information sheets provide clear proof of what information was imparted to the patient during their visit. When a copy of the patient information sheet is provided as evidence, the jury has an opportunity to evaluate the patient's contribution (if any) to their poor outcome. Obviously, this information would have been valuable in the defense of this case.

Summary Suggestions

The following suggestions may be helpful to providers when a definitive final diagnosis cannot be made:

- Be sure to carefully document the physical findings, as it is important to verify the thoroughness of the examination. Document any significant changes in the patient's condition.
- Use some form of test-tracking mechanism so that the ordering provider has the opportunity to personally review the test results (or is aware that they have not done so).
- Give the patient a written patient information sheet to reiterate what the provider explained to the patient and improve the patient's adherence to follow-up instructions.
- When possible, make follow-up phone calls to patients. These calls can be very valuable because they demonstrate a high level of engagement with the patient. In most cases, it may not be necessary. However, if uncertainty regarding the final diagnosis exists, calling the patient may provide valuable additional information (such as learning about symptoms not resolving).

Conclusion

Although healthcare providers do their best, perfection in diagnosing patients is not possible, and it is not expected. When it can be proven that providers were diligent and acted reasonably in their assessment of patients, the law can be expected to support them. Hopefully, this allows providers to focus their full attention on the task at hand, providing maximal benefit to both provider and patient.

Endnotes

[1] Dr. G's state of mind throughout the discovery process could best be characterized as suffering severe "litigation stress," a reaction to the rigors of the legal process that can occur at any time during litigation. Providers who may be struggling with feelings of uncertainty, fear, or despondency during the litigation process are urged to discuss it with their MedPro claims manager or their defense attorney. This website, www.physicianlitigationstress.org, also provides informational and supportive materials to help physicians manage litigation stress.