Patient's Serious Condition Goes Undetected as Multiple Physicians Become Involved

Gerald White was 69 years old when he presented at approximately 4 p.m. on Friday, September 8, 2006, at the office of Tom Zimmerman, M.D., a primary care physician practicing in a small rural community.

Experiencing discomfort in his left lower abdomen that began after lunch that day, Mr. White said the pain was of sudden onset and persistent. At times, he said, the pain would become severe and sharp, but it did not radiate.

Mr. White had been active that morning and denied experiencing any discomfort, fever, chills sweats or vomiting, though he felt somewhat nauseated prior to eating lunch. He also denied any history of urinary symptoms or diarrhea, and said his bowel movements were normal five hours before his appointment with Dr. Zimmerman.

Mr. White's medical history was significant for hypertension, obesity and borderline elevated lipids. His surgical history included bilateral inguinal hernia repairs several years earlier. Mr. White's current medications included Dyazide and Atenolol 50 mg daily, and he had no medication allergies he was aware of.

Dr. Zimmerman noted in the charts that Mr. White was a stocky male at 5' 10" and 205 lbs. The patient was able to sit comfortably on a chair and move to the exam table without difficulty—he was not in acute distress. Mr. White's exam and family history revealed:

- Father, deceased age 72, of MI
- Mother, deceased age 78, of stroke
- Brother has hypertension and had an MI at age 64
- Patient smoked a pack of cigarettes a day for 40 years
- Blood pressure 146/84
- Pulse 88
- R 16
- Temperature 98.4

Further, Mr. White's ENT showed no signs of infection, his lungs were clear, and his heart rhythm and rate were normal with no indication of murmur. Though Mr. White had mild diffuse tenderness in his lower abdomen, he had no guarding or rebound, his abdomen was slightly rounded and soft, and his bowel sounds were normal. Dr. Zimmerman noted the patient's femoral pulses were full and equal, and extremities showed no edema.

To gather more information, Dr. Zimmerman performed a CBC and UA, which revealed the patient's urine was clear, WBC-7900 with normal diff. Hb-14.1 and platelets 280,000.

Though he didn't have sufficient information to provide a diagnosis, Dr. Zimmerman believed Mr. White needed further workup. So, he called Dr. Xander, an internist he trusted and often referred patients to. Dr. Xander advised sending Mr. White to a local hospital ER where the internist would provide a consultation.

Discussion

Dr. Zimmerman recognized that Mr. White required more work up than he could provide in the office, and he appropriately referred Mr. White to Dr. Xander.

Mr. White arrived at the ER around 7 p.m., and he was evaluated by Dr. Blythe, an ER physician, who noted the patient's vital signs were stable, but he had lower abdominal tenderness. Dr. Blythe ordered several tests including CBC, UA, Amylase, Lipase and Chem panel, liver function tests—all of which were unremarkable. Flat and upright abdominal films were also taken, and Dr. Blythe read them as normal.

Dr. Blythe called Dr. Xander multiple times without response. Eventually, he learned that Dr. Yost, Dr. Xander's partner, was on call and contacted him.

Dr. Blythe told Dr. Yost that he hadn't made a definite diagnosis yet; however, he believed Mr. White to be in serious condition with an unknown etiology. As a result, Dr, Blythe suggested that Mr. White be admitted for observation. Upon agreeing to accept Mr. White to his service, Dr. Yost stated he would order further testing in the morning; however, Dr. Yost did not come to the hospital to see Mr. White that night.

Discussion

Communication breakdowns can be a real issue when a case is shared. Did Dr. Xander inform Dr. Yost that Mr. White would be going to the ER? Dr. Xander should have told Dr. Zimmerman that Dr Yost was the on-call physician and would see Mr. White in the ER. This information also should have been shared with Mr. White.

Mr. White was admitted to a medical floor with orders for pain medications written by Dr. Blythe. At 6:30 a.m., Mr. White called the floor nurse with throbbing abdominal pain. He was found to be diaphoretic with blood pressure at 80/40 and a pulse of 134.

Dr. Yost was called, and he provided phone orders for Mr. White to be moved to the ICU, receive IV fluids and a stat bedside ultrasound. The working diagnosis was now a ruptured aortic aneurysm, which was confirmed by the radiologist. At that point, Mr. White was taken to the operating room, but unfortunately, he did not survive the surgery.

Immediately after Mr. White's death, the radiologist who was present during surgery read the X-rays taken in the ER. He noted a small calcified line in the abdomen that outlined an aneurysm.

After these facts came to light, a lawsuit was filed by the family against Dr. Blythe for failure to diagnose and against Dr. Yost for contributing to the delayed diagnosis. The hospital was also named in the suit. All parties settled out of court for undisclosed sums.

Risk Management Lessons

Abdominal aortic aneurysm is a challenging diagnosis, with patients typically presenting with no symptoms or only vague, nonspecific symptoms. Diagnostic tests are often normal or inconclusive. Rupture is, therefore, associated with high urgency and high morbidity and mortality. It is a condition frequently seen in medical malpractice litigation with allegations of failure to diagnose or delayed diagnosis. For all of these reasons, the following questions warrant consideration in this case:

1) **Was effective communication in place** for Dr. Zimmerman, Dr. Xander, Dr. Blythe and Dr. Yost? Specifically:
   - Was accurate information shared with members of the healthcare team?
   - Did Dr. Zimmerman know that Dr. Yost would provide follow-up care to Mr. White for Dr. Xander?
   - Did Dr. Xander provide a report on Mr. White to Dr. Yost?
   - Did either Dr. Xander or Dr. Yost discuss this patient with the ER prior to Mr. White's arrival in the ER?
   - Were appropriate on-call coverage policies in place?
   - Was the hospital and/or answering service notified as to which physician was on-call.
2) **Should Dr. Blythe, the ER physician, have been able to make the diagnosis?** Many physicians reviewed the plain films of the abdomen. There was significant debate as to whether the calcified line should have been seen or was even present.

   With only a diagnosis of abdominal pain, would most surgeons or radiologists been able to make this call? This subtle finding was only noted by a radiologist who already knew the diagnosis.

   Physical and laboratory findings did not lead Dr. Blythe to ask the radiologist to read the film that evening. Had a CT scan been done that evening, this patient may have been diagnosed in the ER. Perhaps if Dr Yost had evaluated Mr. White at admission or shortly thereafter, he may have ordered further testing that revealed the aneurysm.
3) **Was this case approached with a high index of suspicion?** Of course, hindsight is 20/20, and during litigation everyone will already know the actual diagnosis. At the same time, doctors must approach cases like this one with the appropriate caution and suspicion that there may be an underlying problem if something doesn't jibe with the presenting symptoms. In this case, Mr. White fit the prototype of a typical aneurysm patient. He was age appropriate, obese, male, hypertensive and a smoker. Obviously, not every patient presenting with complaints of abdominal pain is experiencing a dissecting aneurysm. However, with all these factors, an abdominal aortic aneurysm should have been high on the list of differential diagnosis options.
4) **Did the physicians agree to settle the case?** With PSIC, no case will be settled without the physician's specific agreement. This consent-to-settle option ensures that physician defendants have the opportunity to have their day in court should they choose to pursue this option.