2016 CARDIOLOGY

the REPORTER

TMLT
Texas Medical Liability Trust

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FAILURE TO DIAGNOSE AND TREAT ACUTE MYOCARDIAL INFARCTION

PRESENTATION

At approximately 1 p.m., a 30-year-old man with a history of chronic back pain came to a hospital ED with complaints of back and chest pain.

PHYSICIAN ACTION

Emergency Physician A ordered an EKG, which was performed at 5:30 p.m. The EKG reading was interpreted as abnormal, indicating acute myocardial infarction (MI). The patient's cardiac enzymes were reported as normal and the white blood cell count was elevated. The physician discussed these results with Cardiologist A, the on-call specialist, whose differential diagnosis was 1) pericarditis, 2) ST segment elevation myocardial infarction (STEMI).

A repeat EKG was performed at 8 p.m. It was again machine interpreted as abnormal, indicating acute MI. Cardiologist A documented, "cannot rule out anteroseptal infarct (possible acute) and inferolateral injury pattern."

The patient was transferred to a hospital in a larger, nearby city. At approximately 10 p.m., he arrived at the second hospital and was admitted to the ICU to the care of Primary Care Physician A. The admitting diagnosis was pericarditis. Primary Care Physician A gave telephone orders for lab work but did not come to the hospital.

The on duty Emergency Physician B ordered a third EKG. It was read as abnormal, but this time with elevated cardiac enzymes. Emergency Physician B phoned Cardiologist B, the on-call cardiologist at the second hospital, and requested a cardiology consult. Cardiologist B noted he received the call at approximately 11 p.m.; the patient's diagnosis was pericarditis; and the patient's cardiac enzymes were normal.

At 1:15 a.m., an attending nurse phoned Cardiologist B to provide him with the patient's lab values. The nurse then called Primary Care Physician A to report the patient's lab work. Primary Care Physician A noted that the nurse informed him that the patient's troponin level was 18 and that she had provided the same report to Cardiologist B. Primary Care Physician A assumed that treatment decisions would come from Cardiologist B.

This closed claim study is based on an actual malpractice claim from Texas Medical Liability Trust. This case illustrates how action or inaction on the part of the physicians led to allegations of professional liability, and how risk management techniques may have either prevented the outcome or increased the physician's defensibility. This study has been modified to protect the privacy of the physicians and the patient.

At 9 a.m., a hospitalist saw the patient and ordered a repeat EKG and echocardiogram. She noted that a cardiology consult had been requested. At 9:30 a.m., the hospitalist called Cardiologist B and reported an elevated troponin level. Cardiologist B arrived at the hospital at approximately 10 a.m.

At 11 a.m., an echocardiogram was performed and interpreted as showing an ischemic-type cardiac injury. The patient was taken to the cardiac catheterization lab and diagnosed by Cardiologist B as having a 100% occlusion of the left anterior descending (LAD) artery. Approximately 20 minutes later, Cardiologist C attempted to perform a percutaneous transluminal coronary angioplasty (PCTA). He was able to place a stent, but when he attempted to evacuate a large thrombus from the LAD artery, the patient stopped breathing. He could not be resuscitated.

ALLEGATIONS

The patient's family filed a lawsuit, initially naming several physicians and both hospitals as defendants.

Allegations against Primary Care Physician A and Cardiologist B included:

- failure to adequately and personally evaluate the patient;
- failure to question the diagnosis of pericarditis;
- failure to diagnose acute coronary syndrome;
- failure to order appropriate medications;
- failure to ensure and provide immediate cardiology consult; and
- failure to ensure the patient received immediate reperfusion therapy (Cardiologist B only).

The suit alleged that these actions were below the standard of care, and led to a twelve-hour delay in treatment that caused the patient's death.

Allegations against Cardiologist C included failure to administer appropriate medications (anticoagulants) during the PCTA.

LEGAL IMPLICATIONS

Defense consultants were critical of Primary Care Physician A for assuming the role of admitting physician and then failing to go to the hospital to see the patient. They felt that he should have performed his own examination and evaluation.

These experts were also critical of Cardiologist B for failing to respond more quickly to see a patient with a troponin level of 18. Cardiologist B testified that when the nurse called him to report the patient's lab values, she did not mention the elevated troponin level. He claimed to have only learned of the elevated troponin the following morning when the hospitalist phoned him. At that time, he immediately went to the hospital.

However, the experts felt Cardiologist B should have gone to the hospital when he was first asked to serve as a consult for the patient. They believed he should have reviewed the EKGs himself and directed the patient to the catheterization lab sooner. Had the patient been taken to the catheterization lab sooner, his chances of survival might have been greater.

Cardiologist C was also criticized for not administering proper medications during the PCTA. One expert suggested the patient should have been pre-treated with aspirin and anticoagulants and treated during the procedure with glycoprotein IIB/IIIa receptors due to the large thrombus in the LAD artery.

DISPOSITION

Due to the strength of the allegations and the damages involving the death of a 30-year-old patient, the case was settled on behalf of Primary Care Physician A, Cardiologist B, and Cardiologist C.

RISK MANAGEMENT CONSIDERATIONS

The physicians' failure to personally evaluate the patient was a factor listed in the family's allegations. When the abnormal troponin level was reported to each physician, no immediate action was taken. The patient was under the care of Primary Care Physician A, who then deferred care to Cardiologist B without communication between the two physicians. Due to the inaction of each physician, a second telephone call from the hospital was required to initiate a face-to-face evaluation from Cardiologist B.

Patient care needs to be delivered appropriately, thoroughly, within the standard of care, and in a timely manner. This claim involved a breakdown in communication, as both physicians made assumptions about the other without direct confirmation or discussion.

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LAW ENFORCEMENT EXCEPTIONS TO HIPAA

As a service to policyholders, TMLT risk management representatives are available during business hours for confidential phone or email consultations. Recent policyholder concerns have focused on HIPAA guidelines, including the release of protected health information (PHI) to law enforcement.

QUESTION: I SUSPECT THAT SOME NEW PATIENTS IN MY PRACTICE ARE VICTIMS OF HUMAN TRAFFICKING. CAN I REPORT MY SUSPICIONS TO THE POLICE? WOULD THAT VIOLATE PATIENT PRIVACY?

You may report your suspicions to the police. HIPAA's Privacy Rule is balanced to protect individual privacy while allowing law enforcement activities to continue.

A covered entity may — when consistent with applicable law and standards of ethical conduct — use or disclose PHI if the covered entity believes in good faith that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health and safety of a person or the public. (45 CFR 164.512(j)(1)(i)).[1]

Other circumstances under which it is acceptable for covered entities to release PHI to law enforcement include:

1. **To comply with a court order or court-ordered warrant, a subpoena, or summons issued by a judicial officer, or a grand jury subpoena.** (45 CFR 164.512(f)(1)(ii)(A)-(B)).
2. **To respond to an administrative request.** The Rule requires requests to include or be accompanied by a written statement that the information requested is relevant and material, specific and limited in scope, and de-identified information cannot be used (45 CFR 164.512(f)(1)(ii)(C)).
3. **To identify or locate a suspect, fugitive, material witness, or missing person.** PHI disclosures must be limited to name and address, date and place of birth, social security number, ABO blood type and rh factor, type of injury, date and time of treatment, date and time of death, and distinguishing physical characteristics. Additional PHI may be disclosed in response to a court order, warrant, or written administrative request (45 CFR 164.512(f)(2)).

   This same limited information may be reported of the following individuals.

   - **About a suspect whose alleged victim is a member of the covered entity's workforce** (45 CFR 164.502(j)(2)).
   - **To identify or apprehend an individual who has admitted participation in a violent crime,** provided that the admission was not made in the course of or based on the individual's request for therapy, counseling, or treatment related to this type of violent act (45 CFR 164.512(j)(1)(ii)(A), (j)(2)-(3)).

4. **To respond to a request for PHI about a victim of a crime, and the victim agrees.** If, because of an emergency or the person's incapacity, the individual cannot agree, the covered entity may disclose the PHI if law enforcement officials confirm:
   - the PHI is not intended to be used against the victim;
   - the PHI is needed to determine whether another person broke the law;
   - the investigation would be adversely affected by waiting for the victim's agreement; and
   - it is the covered entity's professional judgment that doing so is in the best interests of the individual whose information is requested (45 CFR 164.512(f)(3)).

   Where child abuse victims or adult victims of abuse, neglect, or domestic violence are concerned, other provisions of the Rule apply:

   - **Child abuse or neglect may be reported** to any authorized law enforcement official; the agreement of the child in question is not required (45 CFR

164.512(b)(1)(ii)).

- **Adult abuse, neglect, or domestic violence may be reported** (45 CFR 164.512(c)):
  - if the alleged victim consents to the disclosure;
  - if the report is required by law;[2] or
  - if the report is necessary to prevent serious harm to the individual or others, or in certain other emergency situations (45 CFR 164.512(c)(1)(iii)(B)).
  - Notice to the individual of the report may be required (45 CFR 164.512(c)(2)).

5. **To report PHI to law enforcement when required by law to do so** (45 CFR 164.512(f)(1)(i)), such as incidents of gunshot, stab wounds, or other violent injuries.

6. **To alert law enforcement when there is a suspicion that a death resulted from criminal conduct** (45 CFR 164.512(f)(4)). PHI about a decedent may also be shared with medical examiners or coroners to assist them in their authorized duties (45 CFR 164.512(g)(1)).

7. **To report PHI that the covered entity in good faith believes to be evidence of a crime that occurred on the covered entity's premises** (45 CFR 164.512(f)(5)).

8. **When responding to an off-site medical emergency, as necessary to alert law enforcement about criminal activity** (45 CFR 164.512(f)(6)). Does not apply if the individual in need of care is a victim of abuse, neglect, or domestic violence. (See provisions for these circumstances above.)

9. **When consistent with applicable law and ethical standards.** Please see 45 CFR 164.512(j)(1)(i) and 45 CFR 164.512(j)(1)(ii)(B).

10. **For certain, other specialized governmental law enforcement purposes,** such as:
    - to federal officials under the National Security Act (45 CFR 164.512(k)(2)); or
    - to respond to a request for PHI by a correctional institution or in relation to the lawful custody of an inmate (45 CFR 164.512(k)(5)).[1]

MINIMUM NECESSARY DETERMINATION

Except when required by law, disclosures to law enforcement are subject to a minimum necessary determination by the covered entity (45 CFR 164.502(b), 164.514(d), and 45 CFR 164.514(d)(3)(iii)(A)). Moreover, if the law enforcement official making the request is not known to the covered entity, the identity and authority of such person must be identified prior to disclosing information (45 CFR 164.514(h)).[1]

To ask a risk management question, please contact TMLT's Risk Management Department at 800-580-8658 from 8 am to 5 pm, Monday through Friday. You can also send an email to risk@tmlt.org.

SOURCES

1. U.S. Department of Health and Human Services. Health information privacy. Available at http://www.hhs.gov/ocr/privacy/hipaa/faq/disclosures_for_law_enforcement_purposes/505.html. Accessed December 1, 2015.
2. Code of Federal Regulations. Title 45 - Public Welfare. Section 164.512 (a). Security and Privacy. Uses and disclosures for which an authorization or opportunity to agree or object is not required. Available at http://www.ecfr.gov/cgi-bin/text-idx?SID=6d6240a46511803897a619e2da04f8d3&mc=true&node=pt45.1.164&rgn=div5#se45.1.164_1512. Accessed March 28, 2016.

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