

Insufficient Medical History Contributes to Delayed Diagnosis and Catastrophic Outcome

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Introduction

A critical component of getting to know a new patient is taking a complete and accurate medical history. Without a complete history, it is possible that a practitioner will make a diagnostic error, which will likely result in a disappointing treatment outcome. As illustrated by this interesting case from the Southwest, the outcome following an incorrect diagnosis can sometimes be catastrophic.

Facts

The patient was a 50-year-old woman who presented to Dr. A, a board-certified family physician, on November 24. At that time, her only complaint was a headache; she mentioned no other symptoms. However, prior to seeing Dr. A, the patient had visited a local emergency department (ED) on October 18 with complaints of a headache and fever. Following the ED visit, she saw an internal medicine physician on October 21. At that visit,

she complained of headache and dizziness accompanied by nausea and vomiting. When the patient saw Dr. A on November 24, she did not volunteer any information regarding her prior treatment.

Further, it appears that Dr. A did not investigate the patient's history of headaches beyond noting "headache on-and-off on left side for several weeks duration" and "worse over the past few days." No mention of any nausea or vomiting was noted in the patient's record.

Working from this limited information, Dr. A's differential diagnosis was "headache, tension versus migraine, anxiety, and increased blood pressure from stress." Based on this diagnosis, the patient was discharged home with appropriate medications and instructions.

The patient returned to Dr. A's office on November 30, complaining of the same symptom, as well as nausea and vomiting. At this visit, Dr. A's diagnosis was "dehydration, acute abdominal pain, and headache."

The patient was given IV fluids, multivitamins, and Zantac®. Dr. A also recommended that the patient have an MRI scan of her head, and he advised her to go to an ED if her condition did not improve.

Things did not improve, and the patient was admitted to a major medical center on December 2, through the ED, with an admitting diagnosis of acute pancreatitis. (Note: The patient had elevated lipase levels that supported this diagnosis). Once the patient was admitted to the medical center, the recommended MRI of the head was accomplished. The MRI indicated an infarct, which became the focus of treatment.

While the patient was hospitalized, Dr. A continued as her attending physician, and he requested consults from gastroenterology, neurology, and psychiatry. A CT scan of the head indicated no significant bleeding from the infarct, and lab values were generally normal, including no bacteria in the spinal fluid.

The patient continued to deteriorate over the next several days; by December 10, the neurologist began to suspect meningitis. An infectious disease specialist was consulted. The patient ultimately was diagnosed with tuberculous-meningoencephalitis, a very rare condition. (This diagnosis was in addition to pancreatitis.)

Unfortunately, by the time the TB-meningoencephalitis was diagnosed, it was grade III, and the patient was essentially vegetative. On December 21, life-support was discontinued and the patient died.

The patient's estate sued Dr. A, the neurologist, the infectious disease specialist, and the medical center for malpractice. The case was tried, and the verdict favored the plaintiff in all instances. Following the verdict, a settlement was negotiated on Dr. A's behalf. This settlement was in the high range, with defense costs also in the high range. The other defendants were not MedPro Group insureds; thus, the amounts paid on their behalf are not known.

Discussion

One distinction between primary care and specialty care is the typical duration of the doctor-patient relationship. It is not uncommon for primary care relationships to last for many years. When a person presents to a primary care practice as a new patient, even if he or she is perfectly healthy, a thorough medical history is essential. The initial visit is an opportunity to establish a baseline for many different systems (orthopaedic, cardiology, neurologic, etc.).

In both primary and specialty care, when a patient presents with a specific complaint, the practitioner might need to do some considerable "detective work" to accurately identify when and how symptoms first manifested.

In this specific case, the patient presented to Dr. A's primary care practice as a new patient and also with a specific complaint (one of the most challenging symptoms that physicians encounter). This would have been a prime opportunity for Dr. A to thoroughly "work up" the patient; however, at a minimum, closely

investigating this difficult and potentially serious symptom was essential. The knowledge that the patient had been suffering symptoms for over a month — and that she had presented to an ED and an internal medicine physician — presumably would have helped Dr. A. However, subsequent investigation showed that the patient did not volunteer this information, and Dr. A did not inquire about it.

In his deposition for the malpractice suit, Dr. A was not able to recall what questions he asked the patient as part of her initial visit (and, obviously, what the patient's answers were). Although no one would expect the doctor to remember the fine details of each new patient interview, it is reasonable to expect that he would document the information in the patient's chart.

Unfortunately, Dr. A's documentation was minimal at best, which is problematic in two ways. First, the information would not be available to Dr. A during subsequent patient care encounters (or to any other treating physician who reviews Dr. A's chart). Second, Dr. A's chart was not of much value to his defense in the malpractice case; instead, his very poor documentation made him look careless.

All of the experts in this case agreed that (a) the patient's diagnosis of TB-meningo-encephalitis is rare, and (b) many physicians may never encounter this condition throughout their careers. Further, the patient had symptoms of, and was diagnosed with, other serious conditions (a brain infarct and pancreatitis). The presence of these conditions

complicated the diagnostic process and may have contributed to the physicians' lack of consideration of meningitis.

Together, all of these factors should have been helpful in the defense of this case. However, because it appears that none of the physicians gave any significant consideration to the possibility of meningitis, these facts did not help them.

Of all the defendants, Dr. A was the least defensible because he had the most extended contact with the patient and, presumably, had the best opportunity to diagnose the meningitis at a time when it was treatable. The jury very likely considered whether a more comprehensive initial medical history might have prompted Dr. A to consider meningitis as a diagnosis and provide appropriate treatment.

Summary Suggestions

The following suggestions may help clinicians prevent diagnostic errors:

- Take an accurate and thorough medical history, including any previous treatment received for the symptoms or suspected condition. Be diligent, as many patients are poor historians.
- Carefully document all information acquired through the history-taking process in the patient's chart for future reference.
- Review the patient's previous treatment records if they are available.

- When the patient allows it, talk with family/caregivers familiar with the patient's condition. Doing so might help elicit information that the patient failed to mention.
- Ensure timely ordering of tests and consults to prevent problems associated with ruling out or documenting abnormal findings.
- Reconsider the differential diagnosis if new symptoms emerge.
- Even when a diagnosis is confirmed, be alert to the presence of symptoms that might indicate other, undiagnosed conditions.

Conclusion

Experience has shown that an incorrect or incomplete diagnosis will likely result in suboptimal treatment. Unfortunately, the diagnostic process can be complex, and patients afflicted with multiple conditions are particularly challenging. When it comes to diagnosis, the standard of care is never perfection. However, practitioners should exercise diligence when assessing patients, including taking a thorough medical history, doing a complete physical exam, establishing a differential diagnosis, considering appropriate diagnostic tests and consults, and documenting the patient's care in detail.

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