If You Order a Test, Follow Up On It

By Judy King Reneau, JD, BSN

Peggy Sue White* was a busy lady. At 73 years of age, she was described by her husband of 57 years as his “whole world.” They had seven children together, 19 grandchildren and 11 great-grandchildren. She took care of him due to his poor health, made his doctor appointments and attended the appointments with him. She gave him his medicine and kept him on schedule. She did the grocery shopping, cooked the meals, helped him with his bath, washed the clothes and cleaned the house. And, importantly, she listened to his worries and helped him make decisions, while helping him provide advice to their children and grandchildren. She paid the bills, balanced the check book and monitored the bank account. She did almost everything in this household.

In the midst of all this activity, Peggy Sue developed back pain. As a long-time patient of Dr. William Steele, she was under treatment for coronary artery disease and high blood pressure. Back in 2007, she had undergone a CT scan of the chest (without contrast) and was found to have a significantly elevated calcium scoring index and was diagnosed with non-symptomatic left main, left anterior descending, and circumflex coronary artery disease. Then, in March of 2013, Dr. Steele ordered a stress test and cardiology referral. After extensive testing, the cardiologist found nothing significant. With this history, Peggy Sue presented to Dr. Steele with complaints of back pain in 2014. He had knowledge of these findings and considered them during the office visit.

Dr. Steele was aware that Peggy Sue disliked taking medicine and was known to be reluctant to take it as prescribed. At her appointment that Friday, which happened to be Good Friday, she described pain in her back that did not radiate to her chest, but activities such as bending over and reaching exacerbated the discomfort. Dr. Steele did a careful examination and documented that Ms. White complained of upper thoracic chest pain for the past four days that was described as both sharp and aching. It radiated into her arms. The patient was tender to palpation and seemed to have spasm in her neck. In addition, the patient had posterior tenderness along the thoracic spine, with tenderness spreading from T2 to T5. Dr. Steele ordered thoracic spine x-rays, PA and lateral chest x-rays. Dr. Steele felt that the patient’s symptoms were related to an exacerbation of her chronic back pain, but he ordered an EKG out of an abundance of caution. It was later noted that the EKG was performed with the patient’s medical record number on the tracing, but not her name, and according to the medical record, it was performed on a date that was in error. Dr. Steele did not see the EKG the afternoon it was ordered, and the office was closed over the weekend. On the following Monday, Dr. Steele was notified that the patient’s chest x-ray and spine films were interpreted as negative or nonrevealing, but the EKG showed significant injury pattern. Dr. Steele could see that the findings were virtually

diagnostic of an acute myocardial infarction. He received the EKG report on Monday morning after his nurse discovered it lying face down on her desk where it had been placed, presumably, on Friday afternoon after he and his nurse had left early for the holiday weekend.

Dr. Steele immediately called Mrs. White to report the results of the tests and was told that the patient had expired the day before. Mr. White told him that she had experienced more chest pain, along with nausea and shortness of breath, on the previous morning, and that the patient died shortly thereafter.

In the summer of 2015, a suit was filed by the surviving husband, Mr. White, against Dr. Steele, his group, the EKG lab and the hospital who owned the lab. In the complaint, Mr. White alleged that his wife was allowed to leave the facility without knowing the results of her EKG, and that Dr. Steele failed to timely follow up on the results of the test. He alleged that Dr. Steele failed to recognize and appreciate the seriousness of Mrs. White's condition. He also alleged that the defendant lab and the hospital failed to timely notify Dr. Steele of Mrs. White's abnormal EKG results on the same day of the test. He also stated that Mrs. White was never notified of her abnormal EKG, and as a direct result, Mrs. White sustained a fatal cardiac event.

Dr. Steele expressed deep regret about Mrs. White's death under the circumstances. He explained that, according to typical office procedure, he would send a patient to the lab located in the same building as his office. The lab would perform the procedure or test that he ordered. And then, the result, especially if abnormal, would be called in to him or brought down to his office and given to his nurse. On this Friday, however, he and his nurse left early for the holiday weekend. Since Mrs. White had come in for her office visit early in the day on Friday, an MI was low on his differential, and she had gone to the lab for her EKG early in the morning, he made the assumption that the result was normal. He had not called to check on the results before leaving for the day.

Dr. Steele's defense counsel was not able to locate an expert who could support his care in this instance. However, our potential experts understood Dr. Steele's predicament. He ordered the EKG to be thorough and thought the patient had a back strain. He was not expecting an abnormal finding. If the lab's procedures had been followed, the test results should have been taken to any other available doctor in the office. The physician receiving this information would have likely sent the patient to the ER for an assessment, and the events that led to this lawsuit would probably have never occurred . Unfortunately, once the lawsuit was filed, each of the defendants tried to explain how this event happened and how it was not his or her fault. In the end, counsel for Dr. Steele recommended that a reasonable settlement be attempted. Given the dynamics between the defendants, the negotiations were difficult and protracted, but a resolution by settlement was ultimately achieved by all of the defendants.

Providing good patient care is a team effort between physicians, staff, hospitals, labs, and patients. In this scenario, the abnormal test result was left on a physician's desk after he and his nurse had left the office for the weekend. This unfortunate event was due to

breakdown in the normal procedures and should not have happened. In the face of an adverse outcome, processes and procedures are reviewed, analyzed, and corrective measures implemented to demonstrate an improvement. All of those involved in this situation, through this mishandling of the transmission of one test result, were devastated by the outcome because the patient did not receive a timely assessment and treatment. In the end, everyone lost. Take the time to evaluate your office processes so that you can provide your patients with the best possible care no matter the circumstances.

*All names have been changed

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