# The Rest of the Story

## By Kenneth W. Rucker, JD

**“The memories of men are too frail a thread to hang history from.” John Still**

Paul Smith[1], a 52-year-old male, presented to the emergency room in a small community-based hospital with complaints of chest pain, shortness of breath, and nausea. Mr. Smith was quickly triaged and shortly thereafter Dr. Steve Andrews began his initial assessment. The patient underwent a chest pain protocol work up, including an EKG and lab work. The troponin level returned at 0.10ng/mL (N<0.01ng/mL). This caused the patient to fall within the facility’s classification for moderate risk of myocardial infarction. The EKG machine indicated that the EKG was abnormal based upon its computerized algorithm, but it was not indicative of an acute cardiac event. The patient was given a GI cocktail and monitored over the course of several hours and then discharged with a diagnosis of unspecified chest pain. Instructions were given for the patient to follow-up with his cardiologist, take Nitroglycerin sublingually, and to return as needed.

Exactly one week later, a family member found the patient collapsed on the floor at his home. EMS was called and resuscitation efforts were unsuccessful. The patient was taken to the local hospital where he had been treated the prior week and announced dead upon arrival.

A lawsuit was filed by Mr. Smith’s estate seeking damages for the wrongful death of Mr. Smith due to alleged negligent care provided by Dr. Andrews. The lawsuit asserted that Dr. Andrews needed to admit the patient, consult with a cardiologist, or transfer the patient to a tertiary care center for treatment. Based upon the facts noted above, one may be surprised to learn that Dr. Andrews was shocked to be named in the lawsuit and could not believe the accusations that were being lodged against him. Variations of this fact pattern are seen time and time again in malpractice litigation. A patient is determined not to be having a cardiac event in the ER and then discharged only to suffer a fatal cardiac event within a few days of discharge, making it easy to second guess the decision making process of the ER physician.

The Complaint that was filed was based upon the information that had been documented in the medical record. All who reviewed the medical record, including the defense experts, noted that the documentation was scant. The rest of the story in this situation is not what was *in* the medical record but what was *not* in the record.

*Now Dr. Andrews’ view*:

*Dr. Andrews recalled the events of Mr. Smith's presentation to the ER quite well because he had learned that Mr. Smith had died and recalled that he seen him the previous week in the ER. Dr. Andrews recounted his handling of the care while it remained fresh in his mind. After doing so, he felt that he had managed the case in an appropriate fashion.*

*Dr. Andrews walked in to see Mr. Smith and, despite his complaints of pain, he was well enough to have a friendly discussion about some mutual friends, as this was a small community. Dr. Andrews inquired about Mr. Smith's past medical history, and Mr. Smith related that he had a history of chest pain and discomfort over the last several months and had been evaluated by a cardiologist. The cardiologist had diagnosed him with moderate coronary disease and had prescribed nitroglycerine to be taken as needed for chest pain. Just the day before, the cardiologist had stated that he felt that the patient's symptoms were related to a hiatal hernia and had made a referral to a gastroenterologist for further evaluation.*

*Dr. Andrews was concerned by the patient's level of pain, which was described as a 10/10, and this pain level had resulted in the patient coming to the ER for assessment, as the symptoms were not new. After the work-up described above, Dr. Andrews remained concerned about a possible cardiac event and recommended that the patient be transferred to a tertiary care center for further evaluation due to the abnormal EKG and pain level. Dr. Andrews had spoken to a physician who was willing to accept the patient with a cardiac treatment center, but Mr. Smith refused (or declined) the transfer since he felt much better after receiving the GI cocktail. Dr. Andrews was uneasy discharging the patient. However, the patient's explanation that he had been evaluated by his cardiologist and the fact that the patient's cardiologist had just concluded that the chest pain was not believed to be cardiac-related caused Dr. Andrews to acquiesce to the patient's request. The patient's chart was noted to simply reflect a diagnosis of unspecified chest pain with instructions to follow-up with the patient's cardiologist. Dr. Andrews relied exclusively on the history provided by Mr. Smith related to the cardiac work-up and did not confirm or discuss Mr. Smith's presentation with the treating cardiologist. However, the information conveyed was ultimately proven accurate.*

Unfortunately, the documentation of the full discussion of the past medical history and the decision making process was absent from the medical record. Dr. Andrews did not feel the need to document in detail the interaction and only put minimal documentation in the chart. Instead, Mr. Smith and he had agreed upon what Dr. Andrews believed was a reasonable course of action in light of the fact that the patient's cardiologist had just determined that the patient's symptoms were not cardiac related the day before this ER visit. The desire of Dr. Andrews to transfer the patient for further assessment, the phone call placed to the tertiary care center, and the patient's declining this transfer was likewise not documented. When the patient died just a week later, the patient's family (who was not present for the ER visit and only had the medical records to recount the events of the day) consulted with an attorney, and the decision was made to file a lawsuit against Dr. Andrews.

While no one knows for certain, if the medical record had more fully documented the patient encounter, a lawsuit may never have been filed. Based upon the medical record only, the family was able to secure an expert who opined that Dr. Andrews had not done enough at this ER presentation and that his care was beneath the standard of care. Dr. Andrews provided testimony in his deposition about the entirety of the events related to his treatment of Mr. Smith, but the plaintiff's attorney attempted to discredit Dr. Andrews' version of the events due to the lack of documentation. In the end, the documented medical record and Dr. Andrews' deposition testimony created a fact question that would ultimately need to be determined by a jury if not resolved through settlement.

It is impossible to document every event that occurs in the physician/patient interaction, but only a few additional facts documented in the medical record could have made this case appear quite differently to an outside observer. When medical malpractice claims are brought, the medical judgment is evaluated based upon the reasonableness of the decisions made. It is key that the important facts be documented and, while Dr. Andrews felt his decision making was sound, he acknowledged after-the-fact important details had been omitted from the record which hampered his defense. In the end, Dr. Andrews wanted the case to be settled because he was concerned that a jury might not find his testimony to be credible. It was unfortunate because contemporaneous documentation would have almost entirely removed this credibility issue and would have allowed the case to rise and fall on the medical decisions, which Dr. Andrews believed were appropriate under the circumstances.

[1] All names and identifying information have been changed.

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