Medical Consultant Report and Summary

Case No: MD[redacted] **Physician:** [redacted] M.D
Date: July 25, 2009 **Medical Consultant:** [redacted] MD

1. **Detailed (Chronological) Analysis:** A 59 year old woman, [redacted] was under the care of Dr. [redacted] for 19 years. The physician reported that the patient was healthy and on no medications. On the morning of February 9, 2007, the patient called her physician complaining of two weeks of dyspnea (shortness of breath) on exertion, dry cough and atypical chest pain. The patient was seen at 4 PM by the physician. Her heard rate was increased from previous exams; the physician reports that the patient was in no distress and did an EKG on the same day (February 9) which showed no change since October 2006. Other orders were sent to rule out anemia and thyroid disease. The patient was sent home with an appointment with a cardiologist in five days on February 12, 2007. ON February 11, 2007 at 9:55 AM, EMS found the patient at her home in cardiac arrest and brought her to [redacted] ED. EMS performed CPR, noting a blood pressure of 97/12, heart rate of 0, respiratory rate of 0, temperature of 30° with bilateral fixed and dilated pupils and no breath sounds. Atropine, epinephrine and bicarbonate were given by IV. Patient was brought to the Emergency Room at [redacted] where the ER Nurse [redacted] documented intubation with assisted breathing with bluish and cool skin, clear lung sounds, abdominal distention, bilateral, nonreactive pupils and no distal pulses in the feet. CPR continued without change in patient's status. AT 10:10 AM, despite intervention, patient continued to be unresponsive. AT 10:16 AM, CPR ceased and the patient was pronounced by Drs. [redacted] (resident) and [redacted] (attending). At 14:30, the Medical Examiner was notified of the patient's death; patient was sent to the morgue. [redacted] MD, forensic pathologist, wrote the pathological diagnosis as 1) bilateral pulmonary embolism (PE) 2) bile duct adenoma and 3) fractures in the left ribs 1-6 and right ribs 2-5, probably secondary to the resuscitative efforts. Cause of death was cited as bilateral pulmonary embolism (with right main pulmonary arteries completely occluded (closed) by thrombus (clot) extending fully into right upper middle and lower lobes and the left main pulmonary artery was also occluded (closed) by a thrombus (clot) into the left lower lobe with some in the left upper lobe of the lungs.

2. **Proposed Standard(s) of Care:** The standard of care for a middle-aged woman with acute shortness of breath, cough, and atypical chest pain requires a thorough history, exam including vital signs such as blood pressure, heart rate, respiratory rate, temperature as well as exam of lungs, heart, abdomen, and extremities, and routine blood count and chemistries as well as an ABG (arterial blood gas), D-dimer and an EKG to rule out pulmonary as well as cardiac disease.

3. **Deviation from the Standard of Care:** The deviation from the standard of care occurred in Dr. [redacted] exclusive focus on cardiac work up and failure to consider an important differential diagnosis. Despite the patient's acute cough, shortness of breath and atypical chest pain, he failed to consider pulmonary diseases including pulmonary embolus, pneumonia, COPD and asthma. Specifically, the doctor did not order a CBC (complete blood count) in a timely fashion and failed to order an ABG (arterial blood gas) or D-dimer.

4. **Actual Harm Identified:** By not considering and identifying serious pulmonary diseases, the doctor did not recognize an acute situation requiring immediate attention with the need to transfer to the hospital emergency department. This failure ultimately led to the patient's death.

5. **Potential Harm Identified:** (See "Actual Harm Identified.)

6. **Aggravating Factor(s):** None identified.

7. **Mitigating Factor(s):** None identified

8. **Consultant's Summary:** This evaluator feels that Dr. [redacted] did not meet the standard of care for a short of breath, tachycardic, coughing adult with chest pain because he did not consider reasons other than cardiac for her symptoms. He failed to do other necessary tests promptly including an ABG, CBC, and D-dimer. Because he dismissed her symptoms and signs after reviewing a normal EKG, she was not sent to a hospital immediately. Had she gone immediately, she would have received the necessary assessment tests in addition to Ventilation/Perfusion (V/Q) scan or contrast-CT scan that would have uncovered her disease (PE) and treatment (anticoagulation) which might have saved her life.

9. **Records Reviewed:**

October 4, 2006: Physician Office Notes
February 9, 2007: Physician Office Notes
February 11, 2007: [redacted] Emergency Department Records, nurses notes, physician notes, progress reports
February 11, 2007: Postmortem routine, pathology notes/report
February 11, 2007: Death Certificate
April 30, 2009: Physician letter

10. **Additional Documents and Information Necessary:**
ACP-Medical Knowledge Self-Assessment Program (MKSAP) 14: Pulmonary and Critical Care Medicine; p. 42-43.

11. **Investigational Questions for Physician:** None

[redacted] MD July 25, 2009

Print Name Date

[redacted] MD

Signature