Management of patient diagnosed with ischaemic heart disease after discharge (04HDC00656, 19 April 2006)

Rural hospital ~ Medical officer ~ Chest pain ~ Interpretation of ECG recordings ~ Troponin test results ~ Information provided on discharge ~ Transfer of responsibility ~ Documentation ~ Chest pain protocol ~ Hospital systems ~ Rights 4(1), 4(2), 4(5) 6(1)(a)

A woman complained about the care provided to her 54-year-old husband, who was admitted to a relatively small rural hospital for overnight observation following an episode of severe chest pain. The patient was admitted in accordance with the hospital chest pain protocol. He received examination and review, ECG testing, and classic cardiac enzyme testing. The patient's test results also included two normal troponin T "spot" tests, which are taken by the bedside with results available in 15 minutes, and a negative troponin I laboratory test, the results of which are not available immediately as they are sent to a main centre for analysis. The investigations were regarded as normal and the patient was discharged with a diagnosis of gastro-oesophageal reflux disease, without being informed that he had one troponin I blood test outstanding.

The medical officer was informed of an elevated result later that evening but decided that it was not particularly significant. The following morning the patient's file was reviewed by another doctor, who considered that there were indications of ischaemic heart disease, in particular subtle ECG changes and the elevated troponin I test result. The medical officer was notified and he agreed to urgently notify the patient's general practitioner to arrange immediate follow-up. The medical officer contacted the general practitioner around midday. The general practitioner's practice nurse left a message for the patient at his home later that afternoon, without conveying any urgency. In the early hours of the following morning, the patient suffered further chest pain, and died.

It was held that due to the subtlety of the ECG changes, the medical officer could not reasonably have been expected to reach a diagnosis of ischaemic heart disease, nor could he have predicted the patient's subsequent death. However, the patient should not have been discharged to general practitioner care without seeking cardiology input. This constituted a breach of Right 4(1). The doctor did not provide the general practitioner with appropriate information about the urgency of the follow-up, a breach of Right 4(5). In addition, the patient was not provided with appropriate information about his condition at the time of his discharge, breaching Right 6(1)(a), and the doctor's medical records were considered inadequate, a breach of Right 4(2).

The hospital was not held liable for an apparent lack of education and support provided to the medical officer.

This case reinforces the importance of medical officers obtaining advice from senior doctors before making significant clinical decisions, and shows the importance of small rural hospitals providing appropriate education, support and resources for staff.