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Introduction

As medical science advances, the process of healthcare delivery becomes increasingly complex. In a typical hospital case, a number of healthcare providers will likely be involved, each of whom is either providing important information or depending on information from other providers.

With all of these “moving parts,” communication has never been more important, and well-organized internal processes are essential to ensure that critical information is not missed.

In this interesting case from the Northwest, several communication and process failures occurred, resulting in the death of a patient.

Facts

The patient was a 46-year-old female who had many preexisting medical problems, including type 2 diabetes, hypertension, obstructive sleep apnea, recurrent urinary tract infections, a hiatal hernia, and childhood epilepsy. She also was morbidly obese, with a body mass index of 53.

The patient came to the hospital emergency department (ED) complaining of moderate chest, abdominal, and neck pain. Upon presentation to the ED, the patient’s vital signs were as follows: blood pressure = 133/78 mmHg; pulse = 75 beats per minute; respirations = 16 breaths per minute; temperature = 98.9 degrees F; and oxygen saturation = 97 percent.

The patient’s lab results were generally within the normal range. Following an enhanced head CT and chest X-ray, which were unremarkable, she was admitted to the hospital under the care of Dr. A.

Upon being contacted by the ED, Dr. A requested that the patient have an abdominal X-ray stat. The X-ray was done and immediately read by Dr. B, a radiologist. Dr. B completed his interpretation of the X-ray by 6 p.m. on Day 1, and he determined that the
patient had free air in the abdomen under her right hemi-diaphragm.

Recognizing this as a critical finding, Dr. B instructed the clerk in the radiology department to fax the results to the floor and contact the floor to alert them that a critical finding was coming to their attention. The radiology clerk spoke to a nurse on the floor regarding the faxed report.

After speaking to the radiology clerk, the nurse contended that she notified Dr. A about the critical result; however, the nurse did not document the notification in the patient’s record. Instead, she documented the notification on the fax cover sheet for the radiology report. This detail is significant because the hospital’s medical records policy did not consider fax cover sheets to be part of the medical record; thus, staff immediately disposed of the fax cover sheet. When Dr. A later claimed that the nurse never told her about the critical finding, no documentation was available to clarify what had actually occurred.

At 1:15 a.m. on Day 2, Dr. A ordered a CT scan of the abdomen and pelvis, which was going to be done later that morning. At 8:30 a.m. (prior to the scan), the patient suddenly became hypotensive, and the intensity of her pain increased significantly. A rapid response was called, and repeated attempts were made to reach Dr. A, but she was not answering her pages. At 10 a.m., a decision was made to move the patient to the intensive care unit (ICU) without Dr. A’s direct approval, as she still was not answering her pages.

Dr. A eventually answered the pages, came to the hospital, and, after reviewing the films, ordered a surgical consult. A very complicated surgery was performed at 4 p.m. on Day 2. The surgeon encountered multiple adhesions of the small bowel to the abdominal wall and large bilateral hernias. The hernia on the right side contained most of the patient’s small bowel and was the site of a perforation. Following release of the adhesions and a resection of the bowel, the surgeon closed the abdominal cavity as best he could. He intended to explore the abdomen again once the patient stabilized.

The patient was returned to the ICU in critical condition. In the hours that followed, she progressed into renal and respiratory failure. Her condition continued to deteriorate into the morning of Day 3, at which time she went into cardiac arrest and died. Her final diagnoses were listed as bowel perforation, septic shock, acute renal failure, hypotension, and acute respiratory distress syndrome.

Subsequently, a malpractice suit was commenced against Drs. A and B, the nurse who had received the call from the radiology clerk, and the medical center. With their consent, a payment was made on behalf of the medical center and the nurse (the only two defendants insured by member companies of MedPro Group). This payment was in the midrange, with defense costs in
the high range. Additional payments were made on behalf of Drs. A and B by their professional liability carriers.

**Discussion**

This case proved to be extremely difficult and costly to defend, despite the fact that the patient had many preexisting conditions that may have contributed to her death at a young age. Even more important, some of the errors that occurred in this case could cause a catastrophic outcome in any situation in which a critical finding is not promptly and properly addressed.

The first issue in this case involved Dr. A’s order for the abdominal X-ray. Even though it was ordered stat, it’s not clear whether Dr. A was overly concerned about the patient’s diagnosis or prognosis at that point. However, when Dr. B identified the critical finding, it was essential to immediately communicate that information to Dr. A, with absolute certainty she received it.

The hospital’s system for communicating critical findings involved a radiology clerk faxing a copy of the report and then following up with a phone call to alert the floor that the report was coming. A better approach would have been for Dr. B to call Dr. A directly to discuss the findings. That way, Dr. B would have been certain that Dr. A received the information, and Dr. A could have asked any questions she might have had.

Similarly, no evidence confirms that Dr. A attached any urgency to the surgical consult she ordered on Day 2. Given the patient’s movement to the ICU that morning because of her deteriorating condition, a direct conversation between Dr. A and the surgeon would have seemed warranted.

Another issue that occurred in this case was Dr. A’s delay in responding to the urgent pages. On the morning of Day 2, the patient began to rapidly decompensate, and her nurses needed guidance from her attending physician. Physicians can fail to answer their pagers for many reasons, such as a mechanical failure of the pager, being engaged in an activity that they cannot leave (such as treatment of another patient), or being incapacitated (such as by illness).

Because these failures can and do occur regularly, hospitals must have a well-organized “chain of command” in place to provide guidance in the attending physician’s absence. This strategy will ensure appropriate continuity of care and protect other caregivers from having to make decisions that may not be within their expertise or authority.

A final point to consider in this case is the documentation of the flow of information. After advising Dr. A of the critical X-ray finding, the floor nurse documented the communication on the fax cover sheet, which was discarded shortly thereafter. Although other evidence in the case indicates that Dr. A did receive the information in a timely manner (even though she denied it), the lack of documentation made the case difficult to defend. Further, it would have
been helpful to have the documentation when the case was reviewed for quality assurance purposes.

If the floor nurse had documented her conversation with Dr. A in the patient’s record, no doubt would exist regarding whether and when Dr. A received this vital information.

**Summary Suggestions**

The following suggestions may help healthcare providers prevent communication errors that can adversely affect patient care:

- When a healthcare provider orders a test or consultation, it is a best practice for the ordering provider to have a tracking system in place to ensure that all requested information is received promptly.

- A good rule of thumb for consulting providers is as follows: The more critical and/or urgent the findings, the more important it is for the providers to have some form of direct communication. When third parties are part of the communication conduit, the risk of miscommunication increases significantly.

- In a critical case, direct communication between the attending physician and the surgeon is desirable to ensure that critical findings and expectations between the doctors are clearly understood.

- Careful consideration should be given to the possibility that communication between providers may not always be possible. Contingency plans (such as appropriate chain-of-command protocols) should be implemented, so that they can be activated immediately if a communication breakdown occurs.

- Proper documentation of patient care, including all critical communication, is an important part of the healthcare process. Being able to reconstruct what occurred in a given case can be very important in understanding the patient’s history and progress, evaluating previous care, and defending that care in court if necessary.

**Conclusion**

As in so many transactions in life, communication in the healthcare setting is critical to the success of the treatment and safety of patients. The more direct the communication, the greater the likelihood of an optimal outcome. Attention to the processes of communication, including planning for potential failures or gaps, is an essential component of all patient safety efforts.