

Obstetrician and Radiologist Miscommunicate, Resulting in Catastrophic Outcome

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Introduction

Treating physicians frequently receive patient data from a variety of sources, especially when dealing with diagnoses that are not straightforward. Ideally, these data harmonize to provide a clear clinical picture. However, when data are inconsistent, treating physicians must be vigilant in reconciling the information.

Additionally, these situations can be further complicated if miscommunication occurs between a treating physician and a specialist consultant. This interesting case from the Southwest illustrates this "perfect storm" of misinformation and miscommunication.

Facts

The patient was a 20-year-old female who presented to the emergency department (ED)

at Hospital 1. She had fallen going up a flight of stairs, landing on her chest and abdomen. She rated her pain as 10 out of 10, particularly in the lower right quadrant.

The ED physician suspected the patient was pregnant because her beta-hCG level was 2,416 mIU/mL. He recorded:

At this point, the differential diagnoses will certainly include ectopic pregnancy. Other possibilities include ovarian cyst disease, urinary tract infection, and appendicitis.

The patient's pain subsided to 5 out of 10 after she received pain medications, and she was admitted for observation under the care of Dr. R, a MedPro-insured OB/GYN. A transvaginal ultrasound was performed and preliminarily reported by Dr. H, a radiologist.

The report noted:

1. *No evidence of intrauterine gestational sac. The endometrium contains complex fluid.*
2. *Right ovary demonstrates a cystic structure with internal cystic structure. This may represent a yolk sac and raises suspicion for ectopic pregnancy. Recommend correlation with serial quantitative beta-hCG levels and short-term follow-up ultrasound as clinically indicated.*

That same morning, Drs. R and H discussed the patient; later, however, they significantly disagreed about what was said. Dr. R stated that Dr. H had said she was 100 percent certain that the ultrasound showed an ectopic pregnancy. However, Dr. H maintained that her advice was only that Dr. R should consider ectopic pregnancy; she noted that, as a radiologist, she would never make a definitive diagnosis because that is the responsibility of the managing physician.

After the conversation, Dr. R recorded the following note:

Right ovary demonstrates a cystic structure with internal cystic structure

resembling a yolk sac, which the radiologist said was an ectopic pregnancy . . .

However, Dr. H's final report states:

Right ovary demonstrates a cystic structure with internal cystic structure. This may represent a yolk sac and raises suspicion for ectopic pregnancy. Recommend correlation with serial quantitative beta-hCG levels and short-term follow-up ultrasound as clinically indicated. The findings were discussed in detail and acknowledged by Dr. R . . .

Following his conversation with Dr. H, Dr. R went to the hospital and examined the patient. She complained of pain "in the center and toward the right side." She was still reporting pain at 5 out of 10 despite several hours of receiving pain medication. Following the patient's examination, Dr. R recorded the following:

The patient was given options for management . . . Risks, benefits, alternatives were reviewed, including expectant management, medical management, and surgical management. After extensive discussion, the patient requests methotrexate treatment.

Later that day, the patient signed an informed consent form and methotrexate was administered. Three days later, the patient returned to the ED of Hospital 1 because of right lower quadrant pain. Her beta-hCG level had now increased from 2,416 to 6,357 mIU/mL.

The ED physician discussed the patient's condition with Dr. R, who indicated that it is not uncommon for methotrexate recipients to have pain 3-5 days postadministration. Arrangements were made for the patient to see Dr. R in his office the following day.

At Dr. R's office, the patient had an ultrasound that showed masses on both sides of the adnexa. She was then transferred to Hospital 2, where a pelvic ultrasound showed an 8 mm intrauterine gestational sac in the normal position. At that point, the patient was informed of the uterine pregnancy and potential outcomes "including miscarriage, normal development, or methotrexate embryopathy." The patient decided to continue the pregnancy (which she had desired).

At 35 weeks gestation, the patient delivered a baby girl by cesarean section. The baby was born with ear malformations and hearing loss, without a rectum, and with kidney and spinal issues.

A medical malpractice lawsuit was brought against Dr. R, which was resolved by a payment in the high range, with defense costs also in the high range.

Discussion

As with most "perfect storms," several factors came together to contribute to the catastrophic outcome in this case.

The first issue was the miscommunication between Drs. R and H. As a radiologist, Dr. H's responsibility is to properly report what is shown on the images, not to provide a diagnosis. Dr. R has a right to rely on that information to determine the final diagnosis (which is his responsibility).

Because of the poor documentation in this case, we do not know with certainty whether Dr. H told Dr. R that she was "100 percent certain" that what she saw was an ectopic pregnancy. If she did say that, she was in error to have provided a diagnostic conclusion; further, Dr. R would have been in error to accept it as a definitive diagnosis.

Also interesting is the fact that Dr. H's preliminary ultrasound report stated that the results showed "no evidence of a gestational sac" when, in fact, an 8 mm gestational sac was

identified at Hospital 2 only 4 days later. For unknown reasons, the plaintiff’s counsel did not pursue this potential issue.

The legal investigative process revealed that 3 months prior to the events in this case, the patient had an ultrasound that indicated a cyst on her right ovary. Because this information was available to both doctors, it was not helpful in Dr. R’s defense and would not have been helpful to Dr. H if she had been sued.

The patient’s informed consent to treatment with methotrexate also was not very helpful to Dr. R’s defense because the substance of the informed consent conversation was not documented. If Dr. R stated to the patient that he was 100 percent certain that she had an ectopic pregnancy (possibly based on Dr. H’s advice), the patient’s consent – based on an incorrect diagnosis – would probably be largely ineffective from a legal standpoint.

The defense’s OB/GYN expert opined that, based on the information at Dr. R’s disposal at the time of the informed consent discussion with the patient, the doctor found himself on the horns of a dilemma. The beta-hCG markers certainly supported the conclusion that the patient was pregnant. If the pregnancy

was ectopic, delay in treatment could have resulted in life-threatening obstetric consequences. On the other hand, the jury – with the benefit of hindsight (including knowledge of the later ultrasound that identified the gestational sac) – could easily conclude that Dr. R “jumped the gun” in administering the methotrexate, causing the catastrophic injuries to the fetus.

Ultimately, Dr. R and his defense team concluded that settling the case, even in the high range, was an appropriate resolution of the matter.

Summary Suggestions

The following suggestions might be helpful for physicians dealing with uncertain diagnoses:

- A clear understanding of clinical roles is important. The responsibility for the final diagnosis rests with the managing physician. Although he/she has the right to rely on the input received from various consultants, their impressions should not be taken as a final diagnosis.
- The potential for misunderstanding resulting from oral communication must be understood. Miscommunication occurs throughout our daily lives; in the

context of clinical discussion, physicians and other healthcare providers should use special care to see that it is minimized.

- Thorough, well-documented communication with patients is critical. Patient understanding and perceptions of information will vary based on their backgrounds, experience, health literacy, and so on. Clear and thorough communication will help patients make informed decisions about their care.
- If an error is discovered that might affect a patient's treatment and/or prognosis, truthful and complete disclosure is recommended. Healthcare providers

are advised to consult with a professional liability risk management or claims professional for disclosure guidance, if time permits.

Conclusion

Unfortunately, the practice of medicine is not an exact science, leaving many opportunities for errors. Everything can be done “by the book” and errors will still occur. It is incumbent on physicians to minimize the opportunity for error by communicating well (with other providers and patients), documenting well, and using and carefully analyzing all available data to identify any inconsistencies. In so doing, physicians are doing all they can to ensure safe and efficacious medical care.