Introduction

Many of the past issues of Risk Management Review have discussed failures in the process of healthcare delivery that ultimately led to suboptimal outcomes. This issue of Risk Management Review focuses on two central themes of medical risk management — communication and documentation — that, when not done well, may result in disappointing treatment outcomes and possible allegations of malpractice. This interesting case from the Southwest illustrates these points particularly well.

Facts

The patient was a 53-year-old male with an extensive history of cardiac problems, including occlusion of his right coronary artery, recent stenting of his left anterior descending (LAD) coronary artery, and implantation of an internal defibrillator following a cardiac arrest at home in the previous 30 days. The patient presented to an emergency department (ED) with severe dyspnea following coitus. The ED staff quickly determined that the patient had pulmonary edema, and an ECG was performed. The ECG was abnormal, but it did not show any ST elevation. At that time, the patient’s oxygen saturation was in the 80 percent range and he was intubated. Prior to intubation, a second ECG was done that showed ST elevation in some leads.

Following intubation and the passage of some time, the patient’s oxygen saturation improved and his troponin was normal. A third ECG was performed, which again was abnormal but with minimal ST elevation. The attending emergency medicine physician was uncomfortable leaving the patient’s side to contact the on-call cardiologist and directly discuss the case, so he instructed the emergency medicine resident to contact the cardiologist; however, their conversation was not documented in the medical record.

The patient was admitted to the medical ICU, where he experienced hypotension. Because the results from the three previous ECGs were not included in the patient’s medical record, the ICU resident performed another ECG. He faxed the results of that ECG to the
cardiology consultant (who had not come into the ED, presumably because of the conversation he had with the emergency medicine resident).

Based on the fourth ECG, which was the first one that the cardiologist saw, he indicated that it was unnecessary to activate the cardiac catheterization laboratory. Throughout the evening, patient’s troponin level elevated to 1 and then to 11; however, subsequent ECGs did not indicate ST elevation.

The cardiologist did not see the patient until the afternoon of the following day (approximately 24 hours after the patient presented to the ED). At that time, a catheterization was performed, which indicated 100 percent occlusion of the LAD distal coronary artery to the point of a previously placed stent. This occlusion was successfully opened; however, the patient remained in acute heart failure with ejection fractions in the range of 15 percent. Not long after that, the patient was transferred to a major tertiary care center where he remained for 8 months before dying from chronic heart failure and related complications.

Ultimately, a medical malpractice lawsuit was filed against the attending emergency medicine physician, the emergency medicine resident, and the on-call cardiologist. A payment was made on behalf of the attending physician (the only MedPro insured) in the high range, with defense costs also in the high range. Payments also were made on behalf of the emergency medicine resident (an employee of the hospital) and the cardiologist. Although the exact amount of these payments is not known, they were smaller than the payment made on behalf of the attending physician.

**Discussion**

An important first point in the analysis of this case is acknowledging that the patient was very ill at the time he presented to the ED. This fact would normally make the case much more defensible or amenable to settlement for a modest amount. However, the plaintiff’s experts and the defense’s experts sharply disagreed about the state of the patient’s condition and how it should have been managed while he was in the ED and in the immediate time following his transfer to the medical ICU.

The plaintiff’s experts felt that the ST elevation in the second ECG was indicative of a major infarction and that the patient should have undergone cardiac catheterization as soon as possible. The defense’s experts felt that the less serious ECGs — which were done both before and after the second ECG — indicated a less serious condition.

The attending emergency medicine physician contended that the patient was ill enough that he (the attending physician) was not comfortable leaving the patient’s side to contact the on-call cardiologist and directly discuss the case. The attending physician recalled that he instructed the emergency medicine resident to contact the on-call cardiologist, explain the gravity of the case, and request that he come in immediately to
evaluate and possibly treat the patient. The emergency medicine resident had no independent recollection of the conversation; however, she indicated that given the patient’s condition and the instructions of the attending physician, she would have requested the cardiologist’s immediate presence. Yet, because no documentation of this conversation existed, and the resident’s recollection was “sketchy” at best, she was not very persuasive on this point.

For his part, the cardiologist indicated that if he had been informed of how ill this patient was and had received the first three ECGs (which he did not), then he would have activated the catheterization lab and immediately responded. The cardiologist also had no independent recollection of the conversation with the emergency medicine resident and did not document it, resulting in a “he said/she said” situation.

The importance of the conversation between the resident and the cardiologist cannot be overstated. Given that the cardiac catheterization done the following day eliminated the LAD distal coronary artery occlusion (and produced some improvement in the patient’s condition), persuading the jury that an earlier intervention would not have made any difference was difficult.

The results from the first three ECGs also were an important point in this case. From a clinical standpoint, it would have been helpful for the emergency medicine resident to fax the ECG results to the cardiologist. Doing so would have provided the cardiologist with additional objective data to help him decide whether the patient needed immediate treatment. The data would have been particularly valuable given that, up to that point, all of the information the cardiologist had received was from a physician still in training. Because of the uncertainty about what the emergency medicine resident actually told the cardiologist, ascertaining his exact knowledge base about the case and determining whether he met the standard of care were difficult.

In the end, such a large settlement amount on behalf of the attending emergency medicine physician was due to all of the uncertainty regarding who was told what and when they were told. Unfortunately, “the buck stops” with the attending physician, who it seems was trying to do his best for the patient. However, facts without proof are of little value in a medical malpractice trial. The evidence in this case simply was not sufficient to substantiate the attending physician’s assertion that the case was correctly handled.

Summary Suggestions

The following suggestions might help physicians who supervise residents and communicate with on-call consultants:

- Provide clear and succinct instructions when communicating with any other healthcare providers, particularly those in training.

- Provide objective data (such as results from lab work, ECGs, and X-rays) when communicating with on-call physicians; objective data can be very valuable in
helping an on-call physician determine how to respond to the situation.

- When receiving a call from a resident or other healthcare provider in training, be diligent in determining whether you have received all necessary information.
- Thoroughly document patient care and treatment in the medical record, including results from lab work and tests. Very few physicians view documentation as the best part of their job; however, when a retrospective review occurs (whether for peer review, litigation, or for another reason), documentation is crucial to understanding what was communicated during critically important discussions.

**Conclusion**

Communication is the foundation of understanding, and miscommunication is an almost certain precursor to misunderstanding. In healthcare, misunderstandings increase the likelihood of suboptimal treatment decisions, which may result in poor outcomes for patients.

Thorough communication and adequate documentation facilitate a clear understanding of each clinical situation and assist clinicians in correctly analyzing each case and identifying potential errors. Good communication and documentation can lead to improvements in the overall healthcare delivery process, leading to greater patient safety and the successful defense of physicians who have performed within the standard of care.