When the Biggest Mistake Yields the Smallest Impact

In February 2007, a 65-year-old man consulted an internist. A blood test showed an infection. Antibiotics were administered successfully, and the patient was declared free of infection. He was noted to have a heart murmur, however, prompting the internist to refer him to a cardiologist, Dr K., for an echocardiogram.

But the internist's nurse practitioner provided the wrong clinical indication for the referral. As a result, Dr K., unaware of what to look for, read the echocardiogram as negative. The internist and NP did not realize the mistake, because they never requested a copy of the results.

The internist later sent the patient to an infectious disease (ID) specialist, Dr G., to rule out endocarditis. Dr G.'s opinion was that there was no infection.

The patient's condition deteriorated, however, and he was admitted to a hospital in early May 2007. Two day later, he was diagnosed with endocarditis. He subsequently underwent open-heart surgery and received antibiotics. He died later that month.

OUTCOME

A $1.2 million settlement was reached, with Dr K. paying $500,000, the internist and NP paying another $500,000, and Dr G. responsible for $200,000.

COMMENT

Here, the causal problem was a communication breakdown between the primary care provider and the cardiologist.

When ordering a test, the indication may be as important as the choice of modality. Be mindful to include the indication and patient history wherever relevant—particularly when you as the referring clinician do not directly speak to the specialist. This holds true for *all* diagnostic studies, but particularly for laboratory analysis and imaging studies, when the clinician and the appropriate department do not communicate verbally.

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Imaging always involves the selection of modality, which may not be chosen correctly if the technician does not know or understand what the clinician is looking for.

The same is true with laboratory analysis: While a complete blood count and electrolyte measurements are automated, other tests aren't. When a lab technician performs a manual differential or reviews a stool specimen for ova and parasites, a human is selecting a technique and interpreting the results. When a pathologist analyzes a specimen, a human process of evaluation and interpretation is rendered based on an understanding of the issue.

Don't order tests in a vacuum. Give your human interpreters—technicians, pathologists, radiologists—as much information about the clinical case as you reasonably can. Any unusual cases involving zebra hunting are ripe candidates for misunderstanding and require a phone call.

Clearly communicating the patient history and indication also may be helpful when the clinician has ordered an incorrect or suboptimal study. If you order a standard forearm radiograph, you will get imaging of the bones. However, if you are looking for soft-tissue foreign bodies, a soft-tissue technique is better. When the indication is communicated, it gives the technician a chance to call the unknowing clinician to discuss the better option. Keeping diagnostic staff in the dark helps no one.

Finally, when you are the evaluator, protect yourself and the patient. When asked to review a

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study, in your report echo back the indication for the study and what you've been asked to address. This ensures the ordering clinician knows how the study was undertaken and what you were looking for, and it provides an opportunity to restudy if needed. Make sure to discuss limitations in the test modality and what follow-up or repeat studies would be required to properly address the indication. Make sure the report is forwarded to the ordering clinician. If the indication is unclear or the wrong test was chosen—call the ordering clinician.

Here, the internist's NP ordered an echocardiogram to evaluate a heart murmur. We don't know what the stated indication for the echocardiogram was, but it was not endocarditis. The cardiologist interpreted the echocardiogram as normal. Would he have detected valvular vegetations if he knew the ordering clinician was concerned about endocarditis?

The jury was persuaded that the cardiologist's negative interpretation of the echocardiogram breached the standard of care—even given the fact he was given the wrong indication for the study. The jury also faulted the primary care clinicians, likely in part for providing the wrong indication and in part for failing to review the report.

Interestingly, the ID specialist was held least culpable (in payment terms), despite being explicitly requested to rule out endocarditis—and failing to do so. This is probably due to a short interval between the ID physician's evaluation and the patient's final admission. Even given the massive breach of the standard of care in failure to diagnose endocarditis, a short delay would have a relatively modest causal role in the patient's deterioration.

Thus, even though the ID physician arguably made the biggest mistake, it may have had the least impact on the patient's overall condition—leaving the ID physician less legally culpable in terms of damages. **—DML** **CR**