Closed Claim: Communication Breakdown

By Jeff Williams, JD

"Communication breakdown, it's always the same
Havin' a nervous breakdown, drive me insane" – Lyrics from "Communication Breakdown" by Led Zeppelin

The truism here is communication breakdowns, in a healthcare setting, will drive us all insane. But there are many ways breakdowns happen, and it's usually not the same.

Communication between the many medical professionals who are caring for a patient with a critical condition can be a life-or-death matter. Hospitals and physicians' offices have systems in place so that communication across all providers is executed effectively. Protocols, electronic medical records, cell phones, call services, secure messaging systems, and, in this story, pagers (aka "beepers")[1] are used to establish lines of communications amongst the many healthcare providers involved in the care of each patient. Even when multiple systems function properly, providers must proactively

participate in the process for patient care to be carried out in a safe manner. The consequences in a healthcare setting can be dire when there are multiple breakdowns in communication.

Mary Cutler[2] was a 71-year-old retiree who presented on a Friday to the emergency department with complaints of significant chest pain for three days. Cardiologist Dr. Mays Cario took over her care from the E.D. and admitted Mrs. Cutler onto the telemetry floor. Prior bloodwork obtained at an outside rural hospital revealed elevated troponin indicative of an NSTEMI (Non-ST-Elevation Myocardial Infarction). She was started on a heparin drip and a statin. An echocardiogram showed reduced cardiac function. Mrs. Cutler was told that a diagnostic catheterization was necessary. She had expressed a general distrust of doctors and told Dr. Cario not to perform any unnecessary procedures that would "run up the bills." Her initial hesitancy in deciding to undergo the diagnostic procedure caused a delay into the weekend. Ultimately, she consented to the diagnostic catheterization which occurred on Saturday. While the results indicated a severe coronary blockage, Dr. Cario deemed her condition non-emergent as her chest pain had subsided. After being told the results of the diagnostic procedure, Mrs. Cutler agreed to a stenting procedure. Because it was the weekend, she was scheduled for a percutaneous coronary intervention the following Monday.

Hospitalist Dr. Seth Patel was working at the hospital over the weekend. The hospital nursing staff was tasked with monitoring Mrs. Cutler until the stenting procedure could be performed. On Sunday evening, she complained of back pain which was relayed to Dr. Patel. He ordered an EKG, CT scan, and lab work. The EKG indicated concerning changes in Mrs. Cutler's cardiac condition showing ST segment elevations, but the results were not regarded as requiring urgent attention. Less than two hours later, a nurse informed Dr. Patel by phone that Mrs. Cutler's blood pressure was low, and she was again complaining of chest pain. Mrs. Cutler was repositioned, and a saline bolus was ordered. She was put on a vasoconstrictor to increase her blood pressure. During this time, Dr. Patel ordered her to be moved to the ICU. Another EKG was obtained, again indicating concerning results, but not recognized as critical. In hindsight, had the second set of EKG results been recognized as urgent, the hospital's STEMI protocol likely would have been invoked, necessitating immediate cardiac intervention.

While being transferred to the ICU, Mrs. Cutler asked a nurse, "Am I going to die?" She knew something was gravely wrong and was noted to be blue in the face. In an apparent attempt to convey the urgency of the patient's condition, a nurse sent a report to Dr. Patel indicating that the patient had asked if she was going to die. Mrs. Cutler also asked to be seen by a physician. Dr. Patel was the physician in the hospital responsible for her care. He never saw her in person; opting to communicate with the nursing staff by phone.

Once Mrs. Cutler was in the ICU, a nurse attempted to contact the cardiologist, Dr. Cario, by various means. There was an appreciable delay in getting in touch with him. Later, a nurse was finally able to reach Dr. Cario on his cell phone. He was on his way into the hospital. Mrs. Cutler went into cardiac arrest while undergoing the CT scan. Unfortunately,

resuscitative measures administered by the nursing staff were unsuccessful. By the time Dr. Cario arrived at the hospital, it was too late.

Throughout these events, Dr. Cario and Dr. Patel never communicated in any manner.

The family filed a lawsuit naming Dr. Cario, Dr. Patel, and the hospital as defendants, alleging various acts of negligence that led to the untimely death of Mrs. Cutler. The case was focused on the lack of communication between the hospital nurses and the physicians involved in the care of Mrs. Cutler. Throughout the case multiple depositions were taken of family members, hospital nurses, and the physicians. The testimony showed that each side had its own take on who was communicating and who was not. As usual, each party produced multiple medical experts to bolster their positions. The Plaintiff would eventually pursue distinct theories against the hospital, Dr. Cario, and Dr. Patel. The cases against the two physicians are detailed below.

Attempts to Contact the Cardiologist

Dr. Cario maintained throughout the suit that he should have been contacted sooner than he was. Not surprisingly, this was one of Plaintiff's theories of the case also. He testified in his deposition that he should have been called when the first EKG reflected signs of cardiac distress. Mrs. Cutler was also experiencing chest pain, low blood pressure and other symptoms on Sunday evening, yet another reason to call the cardiologist.

When the hospital staff tried to contact him, he could not be reached. The multiple attempts to contact Dr. Cario were as follows: 1) by pager; 2) by a secure messaging system maintained by the hospital; 3) by a call service at his office; and 4) by his cell phone. The first three methods of communication did not result in a response from Dr. Cario. Ultimately, a nurse was able to contact Dr. Cario by calling his cell phone number.

There were several issues with the attempts to contact Dr. Cario. First, Dr. Cario no longer used his pager. In fact, he believed the number was disconnected. Nonetheless, the pager number was listed in the hospital system as a preferred way to contact Dr. Cario. Next, when the nurse called Dr. Cario's answering service on Sunday night, the service responded that it did not know how to contact Dr. Cario and suggested that the nurse call Dr. Cario's office (on the weekend). When the nurse sent a message through the secure messaging system, Dr. Cario was unaware that he had received the message.

The Case Against the Hospitalist

A concerning allegation against Dr. Patel was that he never saw the patient at bedside, even though he was at the hospital the entire weekend. This was despite Mrs. Cutler's deteriorating condition, and her request to be seen. While not physically seeing the patient was defensible from a standard of care perspective, it was anticipated that Plaintiff's counsel would bring this to the jury's attention at trial. The optics were concerning. In addition to not seeing the patient, the EKG results that went unrecognized as critical were problematic for the defense. The proof developed through Plaintiff's medical experts

suggested that if Dr. Patel or a nurse had contacted Dr. Cario earlier, the outcome would have been different. Plaintiff's expert hospitalist laid out a timeline in his deposition which strongly implied that if Dr. Patel had intervened earlier, Mrs. Cutler would have had a greater chance of surviving. As expected, Plaintiff's experts were highly critical of Dr. Patel for not seeing the patient at bedside and never communicating with Dr. Cario.

While each defendant was able to disclose medical experts supportive of their positions, the case had weak points that Plaintiff's counsel could exploit at trial. The reality was Mrs. Cutler suffered from a condition that was treatable if medical intervention had occurred earlier. Further, it became clear there was going to be finger pointing between the hospital, Dr. Patel, and Dr. Cario related to the various communication issues. Most cases only get better for the plaintiff when defendants blame each other. The decision was eventually made to settle and avoid the substantial risk of an adverse verdict if the case was tried.

The Takeaways

- In cases where communication among providers is in question, call logs, digital messages (text messages, secure messages, text messages, and emails) are all trackable. The physician should expect that the messages will be requested and scrutinized in the discovery phase of litigation. *Whether or not the messages are responded to will be evident.* Keep in mind, while the content of the message was not in question in this case, be cautious not to make comments that will be used against you in the future. Communicate as if each message will be scrutinized. Keep it professional.
- For providers working in hospitals, an office setting, or other medical facilities that will need to contact you on an emergent basis, be sure your up-to-date contact information is on file at the facility. Check it periodically.
- While medical care can be communicated over the phone or by various messaging services, if it is possible to physically see a patient that has a critically acute condition, consider doing so.
- Be proactive, not passive in your communications. Practitioners should not hesitate to pick up the phone and call the specialist involved in the patient's care.

[1] According to Wikipedia, pager usage in America was in rapid decline by 2002. See https://en.wikipedia.org/wiki/Pager.

[2] Names have been altered.