Who's In Your Net?

By Tim Rector, JD, MBA

In military communications parlance, your “net” is defined as several people on the same radio frequency channel as you. An axiom followed by leaders in the United States Army in order to win on the battlefield is, “Shoot, move, and communicate.” Timely and effective communication is the key principle in completion of any mission, and without it, you are likely to fail. Failure can cause injuries and even losses. Much the same can be said when it comes to the practice of medicine. The following case study illustrates an avoidable failure to timely and effectively communicate an intention that led to a bad result for this patient.

Meet Tom, a 41-year-old male with severe aortic regurgitation and moderate aortic stenosis, a prior history of Hodgkin’s lymphoma and radiation therapy, and worsening symptoms of congestive heart failure and associated pulmonary hypertension. Tom was appropriately referred by his cardiologist to a cardiovascular surgeon for consideration of surgical aortic valve replacement surgery. The procedure was done on Wednesday, April 10. Tom’s course was largely uneventful, except for fluctuations in his post-operative PT/INR values that required close monitoring. After beginning anticoagulation with heparin and Coumadin dosing on April 12, this chart provides Tom’s Coumadin dosing and INR values after surgery:

Date	Days PostOp	Coumadin Dose Given
April 12	2	5mg
April 13	3	10mg

April 14	4	0-Withheld
April 16	6	5mg Oral

On Tuesday, April 16, the cardiovascular surgeon considered him stable enough for discharge home later that day on 5 mg daily oral dose of Coumadin. The cardiovascular surgeon's NP gave written discharge instructions for the patient to follow-up with his primary referring cardiologist, "late this week or early next week," for repeat PT/INR.

Based on the discharge instructions, the hospital scheduler contacted the scheduler at the cardiologist's office on April 16 to set the appointment for Wednesday, April 24 - eight days after discharge. However, on April 23, the day before his follow-up visit, Tom presented to the hospital complaining of recent onset of weakness and fatigue. His bloodwork revealed an INR of 12, and he was diagnosed with a pericardial effusion resulting in cardiac arrest, pulmonary arrest, ischemia, and damage to his kidneys and liver.

Tom filed suit against the hospital, the cardiovascular surgeon, the cardiovascular surgeon's NP, and his cardiologist alleging they failed to timely and properly test and monitor his coagulation status following his April 10 valve replacement surgery and especially after discharge from the hospital on April 16. There was no question that the cardiologist agreed to follow Tom's INR after discharge, but the question surrounds when this obligation became her responsibility. The cardiovascular surgeon's NP recognized the INR follow-up was set for Wednesday, April 24, consistent with the order "later this week or early next week." Essentially, the hospital scheduler and the cardiologist's scheduler determined the date of Wednesday, April 24 was acceptable for the follow-up with the cardiologist. The schedulers testified that they interpreted a "Wednesday" as falling within the meaning of "early next week." The scheduler at the cardiologist's office further testified he knew the importance that patients on Coumadin therapy should be seen in a "few days," but he did not think eight days was significant enough to raise it with the cardiologist. The experienced NP knew the repeat PT/INR needed to be done within four days of discharge but failed to recognize the follow-up cardiology visit was set eight days after discharge. The cardiovascular surgeon assumed the patient's follow-up visit with the cardiologist would be set within four days of discharge. The cardiovascular surgeon and the cardiologist did not follow-up on the date the appointment was set.

The plaintiff's experts focused on the handling of the INR and Coumadin in the post-discharge period. The allegation was that setting the first lab check at eight days after discharge falls outside the standard of care. There was a breakdown in communication with scheduling a follow-up appointment between the cardiovascular surgeon's office, the hospital, and the cardiologist's office. Should a certain date or a time frame (within four days of discharge) have been communicated that fits within the standard of care? Unfortunately, we were unable to find an expert who would support that eight days complied with the standard of care. All of the defense's consulting experts said the follow-

up appointment should have been no more than four days after discharge. The defendant providers were critical of each other, and the case settled at mediation for a significant six-figure sum.

Why is effective communication so important? Let me introduce a Gettysburg vignette where ineffective and vague communication resulted in a bad impact that had “significant consequences.” On the first day of the Battle of Gettysburg, Confederate attacks drove Union troops through the town to the top of Cemetery Hill, a half-mile south. At first, the battle appeared to be another Confederate victory; however, General Lee could see that, so long as the enemy held the high ground south of town, the battle was not over. He knew that the rest of the Union Army of the Potomac must be hurrying toward Gettysburg, so his best chance to clinch the victory was to seize and hold hills and ridges before the Union troops arrived. General Lee gave General Richard Ewell discretionary orders to attack Cemetery Hill “if practicable.” Had Stonewall Jackson still lived, he undoubtedly would have found it practicable to attack. But Ewell was not Stonewall Jackson. Thinking the enemy position too strong, Ewell arguably lost his nerve and did not attack – thereby creating one of the controversial “ifs” of Gettysburg that have echoed down the years. It has been debated that Ewell’s decision not to take Cemetery Hill cost the Confederacy the war.[1]

What does “if practicable” mean? When it comes to Tom, what did “later this week or early next week” mean? Is it sufficient to not be specific when, as in this instance, days can be the difference between well-managed INR or an adverse outcome? As a physician, it is imperative that you communicate clearly – both verbally and in written form. Understand that your success as a physician depends on your ability to think critically and creatively, to communicate your intentions and decisions to others in your “net”, which may include the patient, consultants, your staff, hospital staff, the patient’s family members, and others, and to follow-up to make sure your intentions are understood and acted upon.

[1] https://opinionator.blogs.nytimes.com/2013/07/02/general-ewells-dilemma/

https://www.statnews.com/2016/09/01/gettysburg-teach-hospital-leadership/
