An Illusion of Communication

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"The single biggest problem in communication is the illusion that it has taken place." - George Bernard Shaw

SVMIC has written articles and given seminars over the years about the importance of communication as it relates to providing medical care to patients. This article focuses on a case in which the breakdown in communication between physicians resulted in a medication loading dosage being continued inadvertently and is another reminder of how miscommunication between multiple physicians can result in harm to the patient.

Randy Richardson*, a 71-year-old male patient with multiple health issues, was admitted to the hospital for treatment of chest pain. Mr. Richardson had a medical history of obesity, sleep apnea, hypercholesterolemia, hyperthyroidism, arthritis, and ulcers, as well as a surgical history that included back surgery, thyroidectomy, and transcatheter intravascular stent placement. Dr. Samuel Carter, an interventional cardiologist, diagnosed Mr. Richardson with paroxysmal atrial fibrillation. Dr. Carter ordered nuclear stress testing, which was unremarkable, and transesophageal echocardiography (TEE), which demonstrated no evidence of atrial thrombus.

Dr. Carter initially planned a cardioversion at the time of the TEE, but Mr. Richardson had numerous episodes of paroxysmal atrial fibrillation with spontaneous conversion to normal sinus rhythm during the TEE. Because of Mr. Richardson's atrial fibrillation, Dr. Carter ordered intravenous Amiodarone, followed by oral Amiodarone, loading at 400 mg po tid. (Amiodarone is an antiarrhythmic agent that is often sold under the brand names of Cordarone and Pacerone.) Dr. Carter also prescribed Pradaxa 150 mg po bid as an anticoagulant agent. Mr. Richardson was discharged from the hospital by a hospitalist rather than by Dr. Carter. At discharge, the loading dosage of Amiodarone 400 mg po tid was continued with no recommended dosing reduction, with a scheduled follow up office visit four weeks later.

At the follow-up visit, Dr. Carter documented in his office note that Mr. Richardson was taking Amiodarone 200 mg po bid, when in fact Mr. Richardson was still taking the loading dosage of 400 mg po tid. The 200 mg po bid dosage is what Dr. Carter would have anticipated the discharge orders to contain, but he did not review the discharge summary and instead assumed the discharging physician had appropriately reduced the dosage. Mr. Richardson described symptoms of increasing shortness of breath and dizziness at that visit. Laboratory follow-up for Amiodarone toxicity was planned for three months later, with anticipated thyroid function tests, liver function tests, and pulmonary function tests at

that time. Despite these new complaints, Dr. Carter did not review the dosage of the Amiodarone, nor did he otherwise review the dosage with Mr. Richardson.

Mr. Richardson had several office visits with various healthcare providers (who were not sued) over the next few months, with continuing complaints of weakness, dizziness, gait instability, and imbalance. During this time, his Amiodarone dosing continued at 400 mg po tid. This loading dosage of Amiodarone was eventually discontinued about four months after it began, having been discovered by another physician who saw Mr. Richardson for frequent falls and discussed the medications with Dr. Carter. Mr. Richardson was admitted to the hospital approximately ten days later with increasingly debilitating shortness of breath, weakness and tremor, and focal symptoms involving his right leg, with a CT scan showing a subacute left frontal cerebrovascular accident (CVA). Mr. Richardson was diagnosed with pneumonitis four days later. A wedge resection lung biopsy demonstrated necrotizing bronchopneumonia with diffuse alveolar damage. Mr. Richardson died a month later, and the autopsy found the cause of death to be necrotizing pneumonitis with multiple lung abscesses.

Mr. Richardson's estate filed suit against Dr. Carter, two other physicians who treated Mr. Richardson after his initial admission to the hospital, and the pharmacy that filled the prescriptions for the Amiodarone. It came as no surprise that Mr. Richardson's estate alleged that all of the symptoms that were present over the last few months culminating in the CVA and bronchopneumonia were caused by the improper dosage of Amiodarone. A normal dosing strategy for Amiodarone therapy typically begins with 400 mg po tid for one week, then 400 mg po bid for two weeks, then 200 mg daily thereafter. The patient usually returns to the clinic two to four weeks later on a dosage of 200 mg po bid, and further dosing changes are guided by patient response and tolerance thereafter.

The three physicians who were treating Mr. Richardson while he was in the hospital did not communicate with each other about the need to titrate the Amiodarone over time from a loading dosage to a maintenance dosage. During his deposition, the discharging physician testified that he was not aware of the dosage requirements of Amiodarone, as this is normally managed by the cardiologist. It is unclear why Dr. Carter's office note showed Mr. Richardson was on the maintenance dosage at his first office visit after discharge from the hospital, and it is unclear why the pharmacy continued to fill prescriptions for the loading dosage when the time period for titrating the loading dosage to the maintenance dosage had passed.

If the documentation and the communications between the three physicians had been better in this case, the overdosing of the Amiodarone and the subsequent harm to Mr. Richardson could have been avoided. There were several points during Mr. Richardson's care where better communication could have changed the outcome. This could have been accomplished by provider-to-provider verbal communication or more clear documentation of the Amiodarone dosage strategy in the medical record. This case shows that it is important for a physician to document future treatment plans, such as titrating medication, and communicating those plans with subsequent treating physicians.

Also, as a physician downstream in the care, verification of the orders and medication dosages are important and help ensure that the communication between providers is complete. In this case, multiple assumptions without communication resulted in a case that could not be defended, and the case was settled with contributions from all of the defendants.

* All names and identifying information have been changed