Who's On First, and Who's On Second?

Who is ultimately responsible for notifying the patient of important test results? If the ordering physician fails to do so, does any responsibility flow to the next provider in line, for example, the physician's nurse practitioner? Does responsibility flow outward to other providers who were not involved in ordering the test? Unfortunately, if someone drops the ball, these questions may be answered by a judge or jury in a negative way. Consider the following scenario from a case settled by SVMIC:

Eliza James* was a 70-year-old female, post-CABG (at age 67) with multiple health concerns as well as evidence of early dementia. Mrs. James was placed on low-dose aspirin, Coumadin and Plavix by her cardiologist, Dr. Aaron Smith, for atrial fibrillation. No clear-cut plan for lab work or anti-coagulation parameters were set out in her chart. Dr. Smith is a very talented, Board-certified cardiologist who employs several nurse practitioners in his busy practice, and they all saw Mrs. James.

Sporadic PT/INR levels were done for three years following Mrs. James' CABG. She ultimately required a femoral artery angiogram. Dr. Smith noted afterward that she should be on full anti-coagulation therapy. Her prior prescriptions were refilled but again, no clear orders or lab parameters were noted in her chart or in the discharge orders after the hospital procedure. (Dr. Smith later testified the discharge nurse should have included the lab orders.) Her last levels were drawn about two months prior to the procedure.

Three weeks later, Mrs. James was seen in routine follow-up by Dr. Smith's NP. Her findings included bruising—the extent and location weren't recorded—and that Mrs. James had recently restarted Coumadin *in addition to* her aspirin and Warfarin. The NP may have realized that no labs had been ordered by Dr. Smith and she apparently gave a written lab order to Mrs. James. The draw was not done for ten more days and we do not know what counseling was given to the patient about its importance.

Ironically, just five days later, Mrs. James was seen in the ED by her own PCP, Dr. Kelvin, who charted that she was on Coumadin and aspirin. She was given Keflex for an infected insect bite, which allegedly potentiated the effect of her anticoagulants.

The following day, Mrs. James was seen by Dr. Smith who charted "patient is off Coumadin but did not know why." Dr. Smith's office refilled the Coumadin on a phone request from the pharmacy. No mention was made of the pending order for PT/INR testing, nor was the patient educated about it.

Four days later, Mrs. James had her blood tested at the hospital lab per the order provided by Smith's NP (ten days earlier). The results revealed critical levels, and the hospital lab employee called Dr. Smith's office. Since it was after-hours, the answering service contacted Dr. Smith. We are uncertain about what happened at this point, but the report

was faxed to the offices of both Dr. Smith and Dr. Kelvin. It was scanned into the PCP's office notes without comment, and no action was taken.

The fax with critical values was later reviewed by a nurse at Dr. Smith's office, who wrote "handled by Dr. Smith over the weekend" and filed it in the chart. Dr. Smith testified that he called the hospital lab technician and instructed her to have Mrs. James discontinue her Coumadin. This was disputed by the technician, and there was no telephone record indicating such a call. Mrs. James' family testified that they were not notified by anyone of the result or told to discontinue the Coumadin.

Three days later, Mrs. James was seen in her PCP's office. There was no medication review and none were listed. She was given Prilosec, which allegedly potentiated the effects of anticoagulants. Though the faxed lab report was available, it was not addressed. *Keep in mind that the PCP was prescribing Aricept for diminished mental capacity/Alzheimer's type; his chart noted digitalis toxicity two years earlier and recommended that she not live alone.*

One week later, Mrs. James was seen by her PCP's nurse practitioner, who also noted bruising. Again, there was no update done of her medications and no labs were done. She was given a prescription for Omnicef, which allegedly potentiated the effect of anticoagulants.

The following day, Mrs. James was seen in Dr. Smith's office by his nurse practitioner. The chart once again documented "Off Coumadin, patient does not know why." However, the notes also indicate she was taking Coumadin along with Warfarin and aspirin daily. There was no discussion of the recent labs.

Later that same evening, Mrs. James was taken to the ED with complaints of vomiting and abdominal pain. [25-33], with elevated WBC and low RBCs. (These values were higher than upper threshold capability of hospital's equipment.) She was aggressively treated but expired two days later, allegedly from Coumadin toxicity.

What, if anything, could have been done differently that might have changed the outcome for this lady? Had Dr. Smith's office had protocols in place to address critical reports, the lab report would have been timely addressed. Some offices place medication lists and most lab reports at the chart front for each visit, requiring an active review. How does your practice handle these issues?

Should the labs have been repeated by Dr. Kelvin or his NP? He firmly believes they had no duty to monitor a medication prescribed and being monitored by a specialist. When his NP noticed bruising, she should have confirmed the INR had been done and would have seen the critical values. Also, heightened awareness of the patient's mental status warranted extra care by all parties when discussing, monitoring or changing the patient's medications.

There were talented players on the field who watched the game being lost, yet there was

no team approach, no communication, no pre-game signals worked out, that might have led to victory instead of a very sad strike-out.

*All names and locations have been changed to protect the parties' privacy.
