Malpractice Case: Did Misplaced Test Result Lead to Death?

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This case highlights the importance of having a system to assure follow-up on ordered tests and underscores the significance of communication among clinicians about patient safety.

A female infant was born with [Down syndrome](https://emedicine.medscape.com/article/943216-overview). The patient's pediatrician ordered a cardiology consult after hearing a murmur on the second day of her life. An [echocardiogram](https://emedicine.medscape.com/article/1820912-overview) was performed the same day. Two days later, it was interpreted by a cardiologist as being significantly abnormal and requiring a cardiology consult and further imaging.

The cardiologist dictated the report and faxed it to the hospital. He did not, however, contact anyone at the hospital to confirm that the report had been received. The murmur seemed to resolve, so the patient was discharged home. Two days after discharge, the patient was seen for a follow-up visit for slight jaundice. No murmur was detected at that time.



Ten days later, the patient was seen by her pediatrician. According to hospital personnel, the echocardiogram report was still not available. One month later, the patient received immunizations but was not evaluated by her pediatrician. The echocardiogram report was still not available.

The parents relocated and did not return to the baby's original pediatrician. The baby failed to thrive and died at home before age 2 years. An autopsy revealed the same cardiac abnormalities that were reported by the cardiologist.

When the original pediatrician was notified that the baby had died, he reviewed the chart and found that the echocardiogram report had never been received. When he called the hospital, staff had difficulty locating the report because it had been filed with the mother's record.

The parents filed a claim against the pediatrician. Experts felt that the patient would have had a good chance of survival had the defect been surgically repaired. Legal experts were critical about the pediatrician failing to follow up on the echocardiogram report he had ordered. They also criticized the cardiologist for not verbally communicating the abnormal results and the hospital for mishandling the report. The attending physician who took over the patient's care after the parents' relocation had a duty to request medical records from the hospital and from the pediatrician who first treated the patient. This case was settled.

How to Prevent Lawsuits Like the One Above: Dr Feldman's 3 P's

1. *Prevent adverse events* by having reliable systems in place and engaging in good communication between clinicians. Systems need to be designed for special conditions (such as a newborn with their mother's name attached to reports) and for assurances that the reports will follow the patient. Evidence-based policies need to be in place for the communication of abnormal test results, like in this case, which was significantly abnormal but nonemergent at the time. As seen here, systems are needed both in hospitals and physicians' offices.
2. *Preclude malpractice claims* by having good communication with patients and families. Having patients and families aware of what to expect at home after discharge builds collaboration and trust. Patients who understand their expectations and follow-up instructions are likely to be more engaged and ask more questions about their care. As with the prevention of adverse events, systems can be helpful to be sure that physicians communicate results to patients in a timely way. One example is an automatic reminder about communicating a test result that is set up when the test is ordered.
3. *Prevail in lawsuits* by having documentation in place. This claim illustrated the lack of documentation about the echocardiogram report. The pediatrician's office should have had clear documentation in the patient's chart showing their attempts to obtain the report.