Appendix D

The following appendix contains examples of various errors encountered in physicians' responses. Since it is difficult to precisely define "appropriate response" this study used a very lenient measure of "appropriateness", focusing on whether physicians acted upon the communicated information rather than the adequacy of their medical decision. Appendix D, however, includes, descriptions of errors in clinical management (*) and indications of suboptimal management (†), as identified by the reviewer [EJ], that were not part of the studies' evaluation criteria. For example, ordering a wide spectrum penicillin antibiotic for a patient with a healthcare associated infection and a documented allergy to penicillin. Per our evaluation criteria, this was flagged as an "appropriate" response (i.e., the physician considered the communicated information about recent hospitalization and persistent fever under antibiotics), but the clinical decision itself is questionable.

Case	**Remarks**
Behavior	†MD acknowledges that Cerebrovascular Accident (CVA) may have caused the altered mental status, but only asks to reduce the hydromorphone (Dilaudid) and reevaluate.
Behavior	†RN recommends restraints. MD orders computed tomography (CT) and asks about oxygen saturation but no other questions directed at finding the etiology of altered mental status.
Behavior	MD doesn't investigate at all, just orders restraints.
Behavior	†MD acknowledges sodium but only requests repeat labs and focuses on pain control as the reason for altered mental status.
Behavior	MD orders anxiolytic without looking further for etiology of altered mental status.
Behavior	MD notes mental status change and hyponatremia but doesn't looks for an etiology other than opiate overdose (which have actually been discontinued the previous day). The MD does not give any order to address the hyponatremia.
Behavior	†MD doesn't look for an etiology; orders 500cc 0.9% NaCL + furosemide and recheck of sodium in a patient with altered mental status.
Behavior	†MD doesn't ask any questions directed at finding the etiology. Instead proceeds directly to give orders for CT and cultures.
Behavior	MD acknowledges there is a change of mental status but attributes it to sedating medications without inquiring further.
Behavior	MD acknowledges the hyponatremia and elevated white blood cell count, but doesn't order any workup or treatment; orders haloperidol.
Chest Pain	*RN recommends CT Angiogram (CTA) and MD agrees (despite renal failure)
Chest Pain	†MD recognizes the possibility of pulmonary embolism only after the RN stresses the issue.
Chest Pain	*MD orders CTA despite a significant chronic kidney disease.
Fever	RN suggests the pt. might have urinary tract infection (UTI) in addition to kidney stones. MD fails to address the problem.
Fever	*RN mistakenly reports that blood cultures are positive for *S. Aureus.* MD orders Piperacillin/tazobactam (Zosyn) in spite of penicillin allergy. MD did not look for source of fever just ordered therapy (Tx).

Fever	MD only asks for acetaminophen Tx and for liver function tests to make sure the medication is not contraindicated.
Fever	MD states several times that they should check the culture results but never actually asks the nurse to look for them.
Fever	*MD orders vancomycin despite a likely false positive (contaminated) blood culture.
Fever	†MD focuses only on the possibility of Staph sepsis in a health care associated infection. Doesn't check for other possible etiologies.
Fever	†MD asks about cultures and labs but doesn't ask about the medical history directed at finding the etiology.
Fever	†MD asks for a chest x-ray and orders to escalate antibiotic Tx. without inquiring about the medical history of the patient.
Fever	MD acknowledges persistent fever yet doesn't order anything.
Glucose	Very short talk. The MD thinks it is a simple glucose problem even though the reported order is for 50% Dextrose (D50) and insulin
Glucose	MD fails to recognize the connection between the reported order for insulin + D50 and hyperkalemia.
Glucose	MD fails to notice the connection between hyperkalemia and tacrolimus.
HTN	*MD orders a beta blocker for a patient already being treated with non dihydropyridine calcium channel blocker.
HTN	*MD orders increase of diltiazem without inquiring about heart rate.
HTN	*MD orders increase of diltiazem in spite of noticed bradycardia.
HTN	MD inquires about chronic home meds but never gets an answer.
Medication	MD asks only for age and vitals. Asks nothing relevant to contraindication for sleep medications and orders zolpidem.
Medication	RN stresses discontinued Continuous Positive Airway Pressure (CPAP) therapy twice and still MD disregards. MD orders diphenhydramine despite relative contraindication.
Medication	MD orders a benzodiazepine without asking about liver function tests, even though the RN communicated hospitalization for severe acute liver injury.
Medication	MD disregards CPAP even though RN stresses the issue twice. MD orders benzodiazepine in spite of reported hospitalization for acute liver injury.