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Don't Be a Maverick; Get a Wingman

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A 39-year-old woman presented to an Arkansas cardiologist on February 12, 2010, with complaints of chest pain. The physician conducted an ankle-brachial index (ABI) test to measure the blood pressure in her lower extremity and interpreted it as less than 0.9%. He then ordered an echocardiogram to gauge the patient's ejection fraction and interpreted the reading at 25%. Both measurements were below the normal average, which prompted the cardiologist to diagnose peripheral vascular disease and congestive heart failure.

The patient was eventually prescribed a course of cardiac medication and monitored over the ensuing months. On April 15, the cardiologist conducted a nuclear stress test; the computer-generated measurement of her ejection fraction was 50%, which the physician adjusted to 42%. In May, the patient underwent cardiac catheterization, which showed no lesions or blockages in the vessels. In the following months, the patient's medication dosages were increased. On September 27, the cardiologist conducted another echocardiogram, which he read as 30%, and reaffirmed his diagnosis of congestive heart failure.

The physician continued to monitor the patient. On November 11, after being diagnosed with congestive heart failure, the patient was admitted to the hospital, where the cardiologist implanted an automated implantable cardioverter defibrillator (AICD).

On May 18, 2011, while running with her 2 daughters and a friend, the patient suddenly collapsed and experienced electrical currents coursing through her body (5 times). She was driven to a hospital, where it was determined that she did not go into cardiac arrest (which she suspected) but rather her defibrillator malfunctioned. The defibrillator was recalibrated to a higher setting, and she experienced no further issues.

In the ensuing years, the patient continued to follow up with her cardiologist. She eventually filed a lawsuit claiming that he had misdiagnosed congestive heart failure and unnecessarily implanted the AICD. Her experts in cardiology and cardiac electrophysiology testified that the defendant's readings of the February 2010 ABI and echocardiogram results were incorrect; the ABIs were in fact .128 and .138 and the ejection fractions were 50% to 55% percent—in both instances, normal results. Furthermore, the September 2010 echocardiogram and another taken in February 2011, which showed little change from the first echocardiogram, were also normal, according to the experts.

The experts also opined that American College of Cardiology/American Heart Association guidelines state that a patient's ejection fraction has to be less than 35% before a defibrillator is placed. Both experts concluded that the plaintiff did not have congestive heart failure and was therefore not a candidate for an AICD. The cardiac electrophysiology expert stated that to be a candidate, a patient must have an enlarged left ventricle—which plaintiff did not have. Moreover, none of the plaintiff's physical findings were ever consistent with congestive heart failure: She did not have fluid in her lungs, as examinations always revealed clear lungs without congestion; there was no distention in her jugular veins; she did not experience sleep apnea; she did not lose consciousness; and she only experienced fatigue with exertion. The cardiology expert further faulted the defendant for failing to adjust the patient's medication dosages to optimize her cardiac repair.

The defense maintained that the defendant's treatment of the patient met the standard of care. According to the defense, the defendant's judgment and interpretation of the patient's ABI and echocardiogram results were medically sound and the defibrillator was necessary.

VERDICT

After a 4-day trial and 3 hours of deliberation, the jury found that the defendant was liable and his actions were a factual cause of injury to plaintiff, who was awarded $1.75 million in damages.

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COMMENTARY

In this case, the defendant cardiologist placed an AICD (also known as an *implantable cardioverter defibrillator*, or ICD). There was no allegation that the placement itself was negligent; rather, the claimed negligence was the *decision* to place it. But the plaintiff's damages arise from the device's malfunction—not the cardiologist's decision to place it.

This case brings up an interesting issue of causation. As most of us know, medical malpractice plaintiffs must show (1) duty, (2) breach, (3) causation, and (4) harm. In law, there are 2 ways to think of causation: "but for" causation and "proximate" causation.

So-called "but for" causation is based on whether any causal relationship exists between an action and an outcome. For example, a drunk driver veers off the highway, through the breakdown lane, and strikes a tree, catching his car on fire. One minute later, a driver in the high-speed lane is captivated by the flaming vehicle, rubbernecks, fails to pay attention to traffic, and rear-ends the vehicle in front of him—injuring the driver of that car. Using "but for" causation, the drunk driver striking the tree "caused" the accident. If that had never happened, the second driver would never have been distracted, and if the driver wasn't distracted, the second accident would not have occurred.

By contrast, "proximate" causation entails the immediate cause, which is foreseeable. Black's Law defines proximate cause as "The result of a direct action and cause of loss to property that sets in motion a chain of events *that is unbroken* and causes damage, injury and destruction *with no other interference*" (emphasis added).[1] Using a proximate causation analysis, the second driver's negligent failure to pay attention to the road would be the proximate cause of the second crash.

Generally, causation analysis is limited to proximate cause on the basis that harm is reasonably foreseeable. A famous example is the case of Palsgraf v. Long Island Railroad.[2]

Mrs. Palsgraf was standing on a train platform. A man carrying an ordinary-looking package rushed to board a moving train, with help from 2 railroad employees (1 in the car and 1 on the platform). As the employees pushed and pulled the man aboard, the package fell onto the tracks. Unbeknownst to everyone but the package's owner, it contained fireworks—which exploded when the rear wheels of the train ran over the package. The explosion caused a large standing scale to fall over and land on Mrs. Palsgraf, injuring her. This is what law professors live for.

Mrs. Palsgraf sued the railroad, arguing that if the employees had not negligently pushed and pulled the man, the package would not have fallen and would not have exploded, and the scale never would have fallen on her. Mrs. Palsgraf won her trial and won her first appeal. In a famous decision by a famous judge, the win was overturned on the basis that Mrs. Palsgraf's injuries "were not a reasonably foreseeable consequence of any possible negligence by the railroad." This case set a foundation of American law regarding reasonable foreseeability, both in terms of identifiable plaintiffs and expected danger.

What does a railroad accident have to do with medical malpractice? In the case described here, we had an arguably negligent medical decision to place the defibrillator. Then we had a malfunction of the device, which caused the plaintiff injury. Was it reasonably foreseeable that the device would malfunction and cause harm—and should the physician be on the hook for that?

Unlike the unforeseeable risk of knocking a simple package to the ground—which unexpectedly turned out to contain fireworks—the risk of device malfunction would be foreseeable. Why? Beyond the usual surgical risks of bleeding and infection, an ICD's leads can dislodge, the device can fail, and devices can shock inappropriately (with younger patients at increased risk for inappropriate shocks).[3,4] These risks are known, and it is highly likely the defendant cardiologist disclosed them on the consent form he asked the plaintiff to sign. The defense could not credibly argue that device malfunction was an unforeseeable risk. The malpractice here was the decision to place the ICD—and because placement wasn't warranted in this patient, neither were the risks.

This brings us to the first malpractice trap: If you practice in a setting where a procedure is routinely offered, and that treatment has a billable cost, be cautious. Your decision-making can be made to appear driven by a profit motive. The lay public (including jurors) is suspicious of profit motive in medicine—a concept most clinicians find alien and repugnant.

Back in 2009, while outlining his rationale for the Affordable Care Act, President Obama made several statements that earned him swift rebuke from physician groups; I include them here not to incite political rants but to demonstrate the keen suspicion the pub-

lic has for profit motives in clinical decision-making. On one occasion, he said, "Right now, doctors a lot of times are forced to make decisions based on the fee payment schedule. ... The doctor may look at the reimbursement system and say to himself, 'You know what? I make a lot more money if I take this kid's tonsils out.'"[5] In another statement, while acknowledging that primary care providers offering preventive diabetes care make "a pittance," Obama added, "But if that same [patient] ends up getting their foot amputated, that's $30,000, $40,000, $50,000 immediately the surgeon is reimbursed."[6]

For most clinicians, the idea of deciding on a course of treatment because it will be lucrative is an alien concept. Good clinicians base treatment on the accepted medical standard, and cost factors are a distant consideration if one at all.

However, if your practice involves a procedure or intervention that is a particularly lucrative billable event, do your part to play mental "devil's advocate" and ensure that patients are genuinely in need of the treatment.

In some rare, bad (and usually highly publicized) cases, a procedure will be overused in a patently fraudulent way, which we all recognize is unethical and illegal. However, in other instances, a procedure may be overused because it is familiar and available. We've all heard the adage, "If all you have is a hammer, everything looks like a nail." This "cute" expression holds some truth about the risk for cognitive bias based on the over-reliance on a familiar remedy.[7] This particularly involves specialty practices that perform certain procedures frequently.

In this case, the plaintiff's nuclear stress test showed an ejection fraction of 50%, which the defendant decreased to 42%. That is substantially different than the first ejection fraction of 25% and the second of 30% in a 39-year-old patient without any clinical signs of congestive heart failure. Did the defendant's ability to offer an ICD color his appraisal of the patient's cardiac function?

In closing arguments to the jury, the plaintiff's attorney probably argued "this defendant behaved as if every human heart could be improved with a battery and wires." Examine your practice to be sure you aren't seeing nails where they don't exist—because tomorrow, they will be the nails in the coffin of your career.

One thing missing from this case summary—but available via court records—is that the plaintiff claimed she had wanted a second opinion but was told she couldn't have one: "I wanted a second opinion. And when I called [the defendant's] office and asked 'Could I have a second opinion,' his nurse answered the phone and said that if I did get a second opinion, then I couldn't come back."[8]

There are a few aspects to discuss here, one of which is the second malpractice trap: viewing second opinions as an enemy. Most clinicians realize they are actually your friend. However, some providers are threatened by second opinions. It is as if they roll out of bed in the morning and consult the mirror to ask, "Who is the top cardiologist of them all?" and need the validation of that voice saying, "You, Dr. Smith—why of course, you!"

To that I say, forget the mirror, you egotistical so-and-so. Snow White will help protect you, your career, and most importantly, your patient. Allow the second opinion. In fact, integrate an expectation of the them into your practice style, to disarm any feelings of awkwardness, confrontation, or defensiveness. Think of the benefits: If Snow White validates your opinion, you have much stronger case that a course of treatment was indicated. Conversely, if Snow White arrives at a different opinion, she may have seen something you did not, and/or it may also relieve pressure from the patient to take an action with which you were only borderline comfortable.

In cases I've worked on, I've seen some excellent surgeons who *require* a second opinion as a precondition to operating. This is particularly helpful when patient expectations are uncertain or there is a track record of unsuccessful interventions (eg, chronic back pain with multiple failed surgeries). Furthermore, a second opinion shows diligence, humility, and concern for the patient. It also gives you backup. As *Top Gun* taught us, there is no need to be a "maverick" when you can have a wingman.

As far as the alleged comment by the cardiologist's nurse: We don't know for certain if this actually happened—but if it did, it was unwarranted and foolish. Any jury would hear this and conclude the defendant (1) was an ass, (2) had something to hide, or (3) was guarding a profit source. Any way you slice it, this is bad for the patient and ultimately bad for the defendant. Make room in your practice for second opinions.

There was a legal fight regarding the admissibility of what the nurse had said. The defense filed a motion to prevent the plaintiff from telling the jury about the

nurse's statement, on the basis that the nurse's statement was inadmissible hearsay. The court denied the motion, ruling that the cardiologist's nurse was his agent and her words could be properly brought before the jury. The court found that the plaintiff relied on that statement in determining whether to have the ICD placed or obtain a second opinion.

This raises an interesting malpractice awareness point: If you are sued for malpractice, anything you had said to a patient, the patient's family, or your coworkers will be admissible in court as a "party admission," classified as either nonhearsay or a hearsay exception (assuming the statement was not made as part of a bona fide peer review, in which case it will likely be subject to peer review privilege). As seen in this case, this also applies to people acting as agents on your behalf. Be cautious of what you say and how you say it—and what your practice's representatives are saying as well.

Interestingly, the jury found for the plaintiff in the amount of $1.75 million, but they declined to award punitive damages, which are designed to punish defendants rather than compensate the plaintiff. In Arkansas, the standard for punitive damages is tough; the plaintiff must "prove by clear and convincing evidence that the defendant knew or ought to have known, that their conduct would naturally and probably result in injury or damage and that they continued the conduct with malice or in reckless disregard of the consequences from which malice may be inferred."[9] A similar standard exists in most states. Because there were no punitive damages, we can infer the jury did not think the defendant implanted the ICD (for profit) knowing it wasn't indicated.

IN SUMMARY

Consider foreseeable risks of practice interventions; be sure your practice is not on "autopilot," recommending a common procedure or intervention too frequently. Don't be threatened by second opinions; welcome them. And watch your words—as they say on every police procedural you've ever watched, they can be used against you. **CR**

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