WHAT'S THE VERDICT?

COMMENTARY PROVIDED BY
Jeffrey L. Susman, MD, Editor-in-Chief

"It's easy to postpone a face-to-face evaluation of a patient after a procedure. In this case, such a delay cost more than $1.8 million."

Bedside visit comes too late

A 22-YEAR-OLD MAN underwent a liver biopsy after being admitted to the hospital a week earlier with fever, chills, diarrhea, and general malaise. A number of specialists had seen him in the hospital because of abnormal laboratory studies, increasing fever, and a maculopapular rash over his trunk and face.

After the biopsy, the patient was dizzy and diaphoretic. His attending physician ordered hemoglobin and hematocrit levels, which were lower than earlier that day. Repeat testing showed a further decrease, prompting the physician to order 2 units of red blood cells.

Typing and cross-matching delayed the transfusion for several hours. Before it could be started, the patient was found unresponsive. When the attending physician came to the bedside, the patient had no palpable pulse. A code was called, but resuscitation efforts failed.

An autopsy found a small hole in the liver and 3500 mL of blood in the peritoneal cavity, as well as hepatitis with zonal and submassive necrosis, hemoperitoneum, and hypertrophy of the heart. An HIV test performed before the biopsy eventually came back positive.

PLAINTIFF'S CLAIM The attending physician and nurses were negligent in failing to respond to signs and symptoms of internal bleeding, including falling hematocrit and hemoglobin levels. The attending physician, who was at the hospital when the patient's condition deteriorated, should have gone to the bedside and taken steps to prevent his death.

THE DEFENSE The patient had been stable overnight; a bedside exam was unnecessary.

VERDICT $1,815,658 Texas verdict.

COMMENT *Considering the many demands on clinicians' time, it's easy to postpone a face-to-face evaluation of a patient after a procedure. In this case, such a delay cost more than $1.8 million. A laboratory test or nurses' notes are sometimes inadequate substitutes for a physician's evaluation.*

CONTINUED ON PAGE 232

CONTINUED FROM PAGE 220

The physician noted ventricular hypertrophy with pericardial effusion and mild aortic loop dilatation but, for the second time, didn't order tests to rule out aneurysm or dissection.

Failure to investigate suspicious symptoms ends badly

A MAN WITH SIGNS AND SYMPTOMS SUGGESTIVE OF AORTIC ANEURYSM/DISSECTION—including chest pain, pericardial effusion, aortic regurgitation, and aortic dilatation—saw his physician, but the doctor didn't order any tests, such as computed tomography (CT) with contrast, magnetic resonance imaging (MRI), or transesophageal echocardiogram (TEE).

Two weeks later, the 43-year-old patient returned to the physician, who noted left ventricular hypertrophy with pericardial effusion and mild aortic loop dilatation. Once again, the doctor didn't order tests to rule out aneurysm/dissection.

Three weeks after the second office visit, the patient collapsed and was taken by ambulance to a hospital, where he was pronounced dead. An autopsy indicated that the cause of death was cardiac tamponade resulting from an undiagnosed aortic dissection.

PLAINTIFF'S CLAIM The physician should have ordered a CT scan with contrast, an MRI, or a TEE, any of which would have confirmed an aortic aneurysm/dissection, mandating immediate admission to a hospital for surgery.

THE DEFENSE No information about the defense is available.

VERDICT $1 million Maryland settlement.

COMMENT *Although many common conditions will resolve spontaneously, it's hard to imagine temporizing in a patient with chest pain and presumed aortic dissection.*

Unrecognized spinal infection leads to paralysis

A 355-LB MAN WITH DIABETES AND SPINAL DISC DISEASE experienced a sharp pain between his shoulder blades after playing golf, followed by constant back pain radiating to his chest. He went to the emergency department (ED) the next day and was admitted to the hospital to rule out a heart attack.

During a week in the hospital, the patient was seen by several doctors and diagnosed with pneumonia and excessive myoglobin levels. A computed tomography (CT) scan of the thorax and abdomen showing fluid buildup in the lining around the lungs led to the pneumonia diagnosis. No definitive spinal view was available, however, because of a mixup between a secretary and a radiology technician.

When the patient saw the hospital attending physician (at the family practice group where she was a partner) after discharge from the hospital, he complained of shooting pain down his spine. The doctor prescribed muscle relaxants. Soon afterward, the patient developed difficulty walking and reported no bowel movements for 13 days.

Almost 2 weeks after discharge from the hospital, the patient broke his ankle. He told the paramedics who responded that he felt numb from his nipples to his feet. He was taken to a community hospital, where a doctor ordered another CT scan. The radiologist who read the scan failed to identify the serious spinal infection it indicated.

The patient was transferred back to the original hospital. No doctor saw him for 8 hours after transfer, by which time he was paralyzed from the chest down.

PLAINTIFF'S CLAIM The fluid buildup on the first CT scan was caused not by pneumonia but by an infection in the spinal discs that had spread to the vertebrae and surrounding tissue.

THE DEFENSE The attending physician denied at trial that the patient had told her about the shooting pains down his spine during the posthospitalization visit.

VERDICT $4.75 million Illinois verdict, preceded by more than $2.7 million in settlements with some of the doctors involved and the community hospital.

COMMENT *Careful follow-up of ED visits and coordinated care are essential to avoid large verdicts such as this one.* **JFP**

The cases in this column are selected by the editors of *The Journal of Family Practice* from *Medical Malpractice: Verdicts, Settlements & Experts,* with permission of the editor, Lewis Laska (www.verdictslaska.com). The information about the cases presented here is sometimes incomplete; pertinent details of a given situation may therefore be unavailable. Moreover, the cases may or may not have merit. Nevertheless, these cases represent the types of clinical situations that typically result in litigation.