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CASE REVIEW

A detailed look at New York-specific medical professional liability cases

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The attorneys at Fager Amsler Keller & Schoppmann, LLP are available during normal business hours to assist MLMIC insureds with a wide range of legal services, including, but not limited to, advisory opinions concerning healthcare liability issues, liability litigation activities, lecture programs, and consulting services.

CASE STUDY I

Gastroenterologist and Hospital Absolved after Disastrous Outcome

Keith Vaverchak
Claims Unit Supervisor
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ED Visit

A 70-year-old man was found face down and unconscious on the street. When the police arrived and aroused him, he punched one of the officers. The man had a history of being convicted for DWI and was serving a five-year term of probation. He was brought to the ED of a nearby hospital. His blood alcohol level was .457. A CT scan showed no intracranial bleeding.

A MLMIC-insured gastroenterologist was called in consultation by the ED physician due to the patient's decreased hematocrit and hemoglobin, and a finding of occult fecal blood. The gastroenterologist's assessment was that the patient had alcoholic gastritis. He recommended that the patient undergo a colonoscopy after

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CASE STUDY II

Poor Communication Regarding Medication Management Results in Patient Death

Mark Collins
Claims Unit Manager
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Early Treatment

In 2003, a MLMIC-insured cardiologist treated a 65-year-old widower who had severe mitral valve regurgitation with normal LV function, as well as hypertension. Over the course of the next two years, the patient's ejection fraction decreased to 30-40%.

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completing alcohol rehabilitation. He planned to follow the patient after discharge as an outpatient.

Follow-up Testing

Several weeks later, the gastroenterologist saw the patient. The patient advised him that he "hated doctors and hospitals." He reported that his rectal bleeding had persisted since his discharge from the emergency department. He stated he had never had a colonoscopy but expressed concern that he might have colon cancer and was willing to undergo one. The physician advised him of the risks of a colonoscopy. The consent discussion included the risks of death, bleeding, perforation, the need for surgical repair, and a colostomy. The patient then consented to undergo a colonoscopy.

The colonoscopy revealed diverticulosis in the sigmoid and descending colons, as well as vascular friability and angiodysplasia in the cecum. The gastroenterologist used an argon plasma coagulator (APC) to cauterize the sites of angiodysplasia. The patient's colon was otherwise normal. There were no apparent complications.

When the patient was taken to the recovery room at 9:30 a.m., the physician wrote orders to discharge the patient when the appropriate discharge criteria were met. However, when the gastroenterologist saw the patient again briefly at 10:30 a.m., he told the patient to wait for him to return to discuss the results of the colonoscopy. He then gave these same verbal orders to three of the recovery room nurses.

At 12:15 p.m., the gastroenterologist returned to the unit and found that this patient had already left the facility. The nurse manager of the unit explained that he was discharged because of the written order that all discharge criteria had been met. Further, the patient had

demanded to leave the hospital. He had executed an AMA form and left, despite being advised he should remain to speak to his physician. Unfortunately, on the AMA form, the patient's signature was neither witnessed, timed nor dated.

Patient Expires

At 5:30 p.m., the gastroenterologist received a message from his answering service to call the patient or his daughter. He returned the call within ten minutes and the plaintiff's daughter reported that her father was "gassy." The physician advised the daughter that her father either had retained air in his colon, or he could have a perforation. He asked whether her father was in pain. The physician claimed that she denied this. During a deposition, the physician stated that he told the daughter to take her father to the ED promptly to be evaluated and to have an abdominal x-ray. The gastroenterologist also claimed the patient spoke to him during that call, and claimed the patient denied having any problems other than passing gas. The patient also was told by the physician to go to the ED or call 911 if his discomfort became worse. Finally, the physician advised the patient's daughter that he would check on her father later that evening.

At 7:30 p.m. that same evening, the physician called the patient. The patient was upset by his call and asked, "why are you calling me again?" The gastroenterologist told the patient that he had promised his daughter that he would follow up with him. He again told the patient that if he was still having gas or any other pain, he had to be evaluated in the ED. The patient allegedly told him to "stop bothering me" and abruptly hung up the telephone.

When his daughter's calls to the patient went unanswered the next day, she went to his home and found him dead. An autopsy revealed a perforation of the ascending colon, 2 inches from the ileocecal valve, with evidence of peritonitis, and fecal soilage of the peritoneal cavity. The primary cause of death was determined to be acute peritonitis with perforation of the colon "due to a colonoscopy with an argon plasma coagulator (APC)."

Lawsuit and Trial

The patient's daughter then commenced a lawsuit against both the gastroenterologist and the hospital. MLMIC experts in internal medicine and gastroenterology reviewed the patient's records. They opined that there were clear indications to perform the colonoscopy. Although the GI expert had some concerns about the use of the APC, including the lack of documentation of the wattage

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used and the number of pulses delivered, he opined that the insured should be vigorously defended as he was experienced in using this device.

The expert in internal medicine expressed concern about the telephone conversations that the gastroenterologist had with both the patient and the daughter, since his written documentation of these calls was untimed and undated. He questioned whether a jury would believe that this documentation was made prior to the decedent's death. However, an outside expert gastroenterologist retained by defense counsel believed that all aspects of the insured physician's treatment met the standard of care.

The Trial

In February 2015, this case went to trial. The plaintiff demanded $300,000 to settle the lawsuit. Prior to jury selection, the judge ruled that he would not permit the AMA form to be entered into evidence. He also would not permit the defense to discuss the patient's alcoholism or prior DWI conviction. Finally, the judge would not permit the defendant physician to testify regarding the substance of his second telephone conversation with the decedent, based upon what is called the "Dead Man's Statute."

The plaintiff's counsel focused her case on the decedent's discharge from the facility. Throughout the trial, the judge ruled in favor of the plaintiff's attorney on any objections made by defense counsel. The defendant testified that if the decedent had not left the hospital before speaking with him, the perforation would likely have been diagnosed, and this would have increased his chances of survival. Fortunately, the defense counsel was still able to introduce the AMA form into evidence, by having the nurse manager of the post-procedure unit read the chart into the court record, without any objection from the plaintiff's counsel. However, the judge did instruct the jury that the AMA form was not a valid release under the law. He further ruled that this form did not absolve the hospital from liability.

The plaintiff's expert admitted that not only was the colonoscopy procedure indicated, but that perforations are known complications of this procedure that can occur in the absence of negligence. This expert also did not criticize the technique used by defendant. However, he did testify that the defendant clearly deviated from the standard of care by giving verbal rather than written orders to the nursing staff to keep the patient in the unit until the defendant returned. The expert also testified that the defendant physician failed to evaluate the decedent prior to his discharge and failed to refer the decedent to the ED after he was home. Finally, he testified that by advising the decedent's daughter to allow the decedent to eat, the defendant had caused the decedent's death.

At the end of the plaintiff's case, the defense counsel moved to dismiss the lawsuit based upon the failure of the plaintiff to prove causation.

The plaintiff testified about the telephone call with the defendant the day before her father died. She had a significantly different recollection of the content of that call than the physician. She testified that she told the defendant that her father was in severe pain, had pressure in his stomach, and was diaphoretic. According to her testimony, she claimed the defendant told her that "it might be a good idea to give her father something to eat or drink." Apparently, she then gave him fluids and food. She further denied that she was ever told by the defendant to take him to the ED. Finally, she insisted that decedent did not speak with the physician while she was present.

At the end of the plaintiff's case, the defense counsel moved to dismiss the lawsuit based upon the failure of the plaintiff to prove causation. He stated that the plaintiff's expert only offered his opinion on alleged departures from the standard of care but did not link them causally to decedent's death. As a result, the trial court dismissed the lawsuit.

Appeal and Reversal

The plaintiff's counsel appealed the dismissal. The New York State Supreme Court, Appellate Division, 4th Dept., reversed the trial court's dismissal and ordered a new trial. The Court found that the defendant's actions "substantially diminished the decedent's chance of surviving the bowel perforation and subsequent infection." The defense counsel then appealed the dismissal to the New York State Court of Appeals. However, the motion to appeal this decision was denied. The lawsuit was then re-tried in 2018 before a different judge.

The second trial ended in a defense verdict in favor of the defendant gastroenterologist. Further, although the jury did find negligence on the part of the hospital, they did not find that the facility proximately caused the decedent to die. Therefore, no damages were awarded to the plaintiff.

CASE STUDY I

A Legal & Risk Management Analysis

Donnaline Richman, Esq.
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Counsel to MLMIC Insurance Company

Informed Consent

While the defendant eventually prevailed, this case presented a multitude of legal and risk management issues. The first issue identified in this case was an alleged lack of informed consent. The patient signed only an informed consent form from the hospital that did not specifically delineate the risks of a colonoscopy. Fortunately, the risk of perforation is a well-known and common complication of a colonoscopy. Therefore, the physician can testify that it is his regular practice to advise the patient of the risks, benefits and alternatives to a colonoscopy, including a few of the most severe and the most common risks. When having an informed consent discussion, the risks of the alternatives, including no treatment, must also be discussed. The gastroenterologist, however, did document that he had an informed consent discussion with the patient in his office notes. He stated he explained what the procedure entailed as well as providing the risks and benefits of the procedure.

Evidence Excluded

Another problem that arose was the validity of the AMA (leaving against medical advice) form. Although the patient signed this form before leaving the facility, the signature was not witnessed, timed or dated. At the first trial, the judge excluded this form from being admitted as evidence based on the Dead Man's Statute (New York State CPLR § 4519). This statute provides that under certain circumstances, an interested witness can not testify against a decedent about conversations held with the decedent. However, if the form had been properly dated, timed, and authenticated, it could have been introduced as a part of the medical record and entered as evidence as a valid declaration against the decedent's interests. Instead, the counsel for the defendant was permitted only to use the telephone records of the defendant physician, which would provide evidence of the calls he made to the decedent. In fact, during the first trial, the judge appeared to give the plaintiff's counsel every advantage, not only by not admitting the AMA form into evidence, but also by excluding evidence of the decedent's alcoholism and felony DWI conviction. He ruled that this information could only be used to determine the decedent's life expectancy and damages.

Testimony

The plaintiff's expert testified primarily about the fact that the defendant should have issued written orders to the nursing staff, rather than giving them verbal orders to have the patient remain on the unit until the defendant returned. The expert testified that this was a breach of the standard of care. While a written order is preferable, verbal orders are legally acceptable. However, the defense was able to counter a weakness in this case that the verbal orders contradicted and superseded the prior written order permitting discharge after appropriate recovery criteria were met. Written orders, other than standing orders for post-procedure care, are not commonly issued in many post-procedure units. Further, verbal orders are permissible pursuant to 10 NYCRR § 405.10(c)(8), the regulation that governs hospitals. They are to be used sparingly and authenticated by the physician within the time frame required by the hospital. Therefore, this expert's testimony about verbal orders was easily contested.

What was of concern was that some of the documentation by the RNs was confusing. At least one note stated that the patient was complaining of gas 8/10 and abdominal pressure. This made little sense. If the 8/10 was intended to reflect the patient's level of pain, the patient was not appropriate for discharge. Regardless, this patient was discharged by the nursing staff without first calling the physician. According to the head nurse, the patient allegedly met the discharge criteria as the written order had required. Thus, he was discharged despite a serious inconsistency between nursing documentation and discharge criteria. Because this patient had previously expressed very negative feelings about hospitals and doctors, it was most likely that he insisted on leaving the facility at the first opportunity, despite the physician's request that he remain. Finally, as noted, the patient had signed an AMA form, which clearly indicated he was going to leave regardless of whether he met discharge criteria.

Directed Verdict

Despite the latitude the judge initially permitted to the plaintiff's counsel during the trial, the defense counsel moved at the end of the plaintiff's case for a directed verdict (NYS CPLR § 4401) in favor of defendant.

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This motion is made when a plaintiff has provided insufficient evidence to sustain a verdict after presenting their case. It requires that the judge consider the evidence the plaintiff has presented and, even when viewed in the most favorable light to the plaintiff, giving him or her the benefit of every inference, not find a rational basis to find in favor of the plaintiff. The judge granted this motion and dismissed the lawsuit against the defendant.

Appeal and Retrial

The plaintiff then appealed this decision to the New York State Supreme Court Appellate Division, 4th Department. The Appellate Court ruled against the defendant and stated that the plaintiff did present legally sufficient evidence to require a new trial. The defense counsel then made a motion to appeal this decision to the New York State Court of Appeals. This motion was denied. Therefore, the lawsuit was re-tried before a different judge. This judge did not disallow the defendant's evidence, including the AMA form, as the original judge did.

As often occurs in a lawsuit, there were serious weaknesses in the medical record documentation. For instance, the defendant's documentation of his telephone calls made to the plaintiff's home was generally good. However, it did not contain the times or dates of the calls. Therefore, they were open to allegations of being written after the decedent's death. Fortunately, the plaintiff did not do so. In addition, the plaintiff's testimony was not at all credible. She testified that the defendant advised her to give the decedent food and drink while simultaneously claiming that he was in severe abdominal pain and diaphoretic, yet she did not take him to the hospital. This testimony was rebutted by the defendant's expert, who advised that a skilled gastroenterologist, such as the defendant, would not have advised a patient in severe pain to eat and would, as standard practice, advise the patient to be promptly taken to or go to the emergency department.

Finally, the decedent's autopsy report was admitted into evidence. The plaintiff focused her case on the autopsy's primary finding that perforation of the colon and peritonitis caused the patient's death. However, the defense counsel was able to show that there were secondary findings of severe CAD with 90% stenosis, hypertension, and a pulmonary embolus, all of which could well have cause decedent's death. These diagnoses created serious doubt that the defendant's care caused the patient's death.

At the end of the trial, the jury found in favor of the defendant. Additionally, the jury found that there was no proximate cause that the hospital contributed to the patient's death by its actions, so no damages were awarded to the plaintiff from the facility.

CASE STUDY II

Poor Communication Regarding Medication Management Results in Patient Death *continued from page 1*

In 2005, the patient underwent mechanical mitral valve replacement surgery. He then experienced several episodes of congestive heart failure and atrial fibrillation, requiring two admissions to the hospital. When his ejection fraction dropped to 15%, an automatic implantable cardioverter-defibrillator was inserted. Because of the valve replacement, the patient was placed on long-term anticoagulation (Coumadin) by his cardiovascular surgeon. One month later, the cardiologist took over maintenance of the anticoagulation. He monitored the patient's INR level monthly. The results of the INR levels enabled the cardiologist to determine whether to adjust the dosage of Coumadin. After he reviewed the results, he had his staff contact the patient to tell him whether to increase, decrease, discontinue, or maintain the Coumadin dosage at the same level. The patient primarily spoke Spanish. Therefore, a staff member fluent in Spanish called him with these instructions. If the patient's INR was too high, he was advised to not take the Coumadin for a defined period of time and then restart it. After he resumed the medication, he was to repeat the INR. Unfortunately, the cardiologist's office records failed to document both the current Coumadin dosage and any adjustments made after reviewing the patient's blood work. Until 2011, the patient's INR levels remained therapeutic.

Recent Care

In November of 2011, the now 73-year-old patient's INR was 3.87. He was seen one week later for a routine checkup by the cardiologist. At that visit, he had no complaints of chest pain or shortness of breath. The examination of his heart

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and lungs was normal. However, once again, the physician failed to document the patient's current dosage of Coumadin, the results of the patient's most recent INR level, or whether he had prescribed any other medications for this patient.

The following day, the patient's prescription for Coumadin was renewed by a covering physician. One week later, the patient's INR was 4.65. When this test result was received and reviewed, the designated staff member was told to promptly call the patient and advise him to discontinue the Coumadin for three to four days and then have another INR performed. These instructions were not documented in the patient's medical record.

Shortly thereafter, the patient experienced hematuria. He went to a nearby hospital emergency department where his cardiologist was not an attending. Thus, his cardiologist was neither informed of the patient's visit nor contacted by the emergency department physician. The patient claimed he was advised to stop taking his Coumadin, which he did. By December 13, 2011, the patient's INR level was 1.56. The cardiologist was promptly informed of this. Allegedly, the patient was told to promptly resume the Coumadin. However, once again, these instructions and the telephone call by the staff were not documented.

One week later, the patient's INR was 1.10. The cardiologist was not advised of these results. He then left for vacation until the end of December. The covering physician also was not informed of this panic value by the cardiologist's office staff. When the cardiologist returned to the office on December 27, he, too, was not informed of this INR.

On January 3, 2012, the patient was taken to the ED of a local hospital. He had slurred speech and left-sided weakness/paralysis. A brain CT scan confirmed that he had an infarct and he was admitted to the stroke unit. His INR was found to be 1.5. A subsequent CT scan revealed an acute ischemic infarct in the right MCA and ACA distribution, with a 7mm midline shift but no intracranial hemorrhage. The patient had left-sided paralysis and could not open his eyes, eat, or drink. He mumbled and tapped his head to indicate pain. Because he could not eat solid food, the placement of a feeding tube was recommended to his family. They refused to consent to this procedure. A Do Not Resuscitate order was then issued. Over the next 24 hours, the patient developed pulmonary congestion, renal insufficiency, and hyperkalemia. Three days later, he died.

The covering physician also was not informed of this panic value by the cardiologist's office...

Lawsuit Filed

The daughter of the deceased commenced a lawsuit against the cardiologist. She alleged that from November 2011 on, he negligently failed to properly monitor and respond to the decedent's INR levels, mismanaged his anticoagulation, and failed to act promptly to review the test results and inform the patient that he had a dangerously low INR. Thus, the patient was permitted to have a sub-therapeutic INR for a prolonged period of time, which led to the stroke. The daughter also alleged that the cardiologist failed to timely reinstate the patient's Coumadin, thus permitting the decedent's condition to deteriorate, resulting in a fatal embolic stroke. The complaint demanded monetary damages for the decedent's pain and suffering, the loss of services by his wife of seven years, and the loss of guidance, counseling and companionship on behalf of his three adult children.

Expert Review

The care was reviewed by a MLMIC expert in internal medicine. He concluded that there were serious difficulties in defending this case due to the lack of documentation of the decedent's INR levels, the dosages of Coumadin he prescribed, and the specific instructions relayed to the patient. These deficiencies in documentation made it difficult to determine whether and when the insured became aware of the decedent's INR of 4.65, which resulted in hematuria and a visit to the emergency department. Further, the medical record did not reflect when or whether the patient was advised to resume the Coumadin. Because of his failure to document these critical values and his instructions to the patient during the pivotal time period in mid to late December 2011, the expert opined that the standard of care was not met. Further, the reviewer concluded that because there was no documentation of the physician's awareness of an INR of 1.10, nor documentation that the decedent had resumed the Coumadin, his inaction resulted in a CVA and the death of this patient.

At the plaintiff's deposition, she testified that she had accompanied the decedent to the defendant physician's office seven or eight times. She also testified that, although his office staff had called her several times to relay instructions to the decedent to stop taking Coumadin, she was never told when he was to

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resume this medication. She further testified that, while the family was together for the Christmas holidays, her stepmother informed her that the decedent had been instructed to discontinue the Coumadin but was not told when to resume it.

Settlement

Because of the highly negative reviews by the MLMIC experts, settlement negotiations were undertaken even before the deposition of the defendant cardiologist. Counsel for the defendant had reported to the MLMIC claims staff that a probable jury verdict would likely approach the limits of his $1.3M policy. The settlement value of this lawsuit was estimated to be in the mid-six figures. Because of the decedent's age and co-morbidities, defense counsel was able to settle this lawsuit on behalf of the insured cardiologist for $450,000.

CASE STUDY II

A Legal & Risk Management Analysis

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Fager Amsler Keller & Schoppmann, LLP
Counsel to MLMIC Insurance Company

There was a global failure to properly and consistently communicate with the decedent and fully document his care. The failure to respond to his INRs and timely adjust his dosages of Coumadin resulted in decedent's demise. It also resulted in a substantial settlement paid on behalf of the defendant cardiologist.

Over an 11-year period of care by the cardiologist, the INR laboratory results were contained in the decedent's medical record. This does confirm that his INR was regularly monitored. However, there was little to no documentation about any advice the decedent was given about how and when to adjust his Coumadin dosage. Nor was there confirmation that he understood the significance of changes to his INR.

An LEP Patient

If this case had proceeded to deposition or trial, one of the issues

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on which the plaintiff's counsel could have focused was whether it was appropriate for an unlicensed staff member to translate and convey critical medical information. Merely speaking Spanish does not necessarily mean that the staff person should provide medical advice and critical information to a patient of limited English proficiency (LEP). In this case, it was crucial that the decedent understand the importance of the relevant medical issues. However, there was no written confirmation that the decedent understood the directions he was given. LEP patients who receive federal funding for healthcare, i.e. Medicare, must have access to a translator who is competent in medical terminology and information. Therefore, translation of the risks of Coumadin, and confirmation that decedent understood that information, could easily be challenged. The decedent and his daughter needed to understand that after his INR was checked, the physician should have advised him to adjust his Coumadin dosage. If he was not contacted, he should have been advised to promptly contact the cardiologist.

When the patient's INR reached 3.87, there was no documentation that a call was made to the decedent to adjust his Coumadin dosage. Nor was there evidence that the defendant was even made aware of this elevated INR by his staff. This lapse was compounded by the renewal of the decedent's Coumadin prescription by another physician, without first checking the most recent INR. Finally, when the decedent's INR continued to rise, the defendant apparently did adjust the Coumadin dosage. However, again, there was no documentation of this communication. It appeared that the decedent was not told for how long a time his Coumadin should be decreased nor when to have his INR re-checked.

From this point on, there were a series of disastrous events. The decedent experienced hematuria and went to an emergency department. He was advised to completely discontinue Coumadin. The defendant claimed that he was not advised of this emergency department visit. The decedent's next INR was 1.56. There was no documentation that the defendant provided any instructions to the decedent, nor that he was notified both before and after his vacation that the decedent's INR was 1.10. Further, he apparently failed to review any test results he received or contact the decedent or his daughter. Thereafter, the decedent had a terminal CVA and died.

Testimony

MLMIC experts reviewed the defendant's records over the entire 11-year period he treated the decedent. They opined that the defendant substantially failed to document any alleged communications with the decedent and that this failure directly led to decedent's demise. Their reviews were extremely negative. The reviewers concluded that the defendant clearly failed to meet the standard of care throughout all eleven years of patient care. The defense counsel was highly concerned about the negativity of the expert reviews and the lack of defensibility of the defendant's actions. Thus, the defense counsel immediately began settlement negotiations prior to defendant's deposition. There was serious concern that the defendant's testimony at deposition would substantially lack credibility because there was no documentation to substantiate his actions. Fortunately, given the facts of this case, the defense was able to negotiate a settlement of $450,000 on behalf of the cardiologist.

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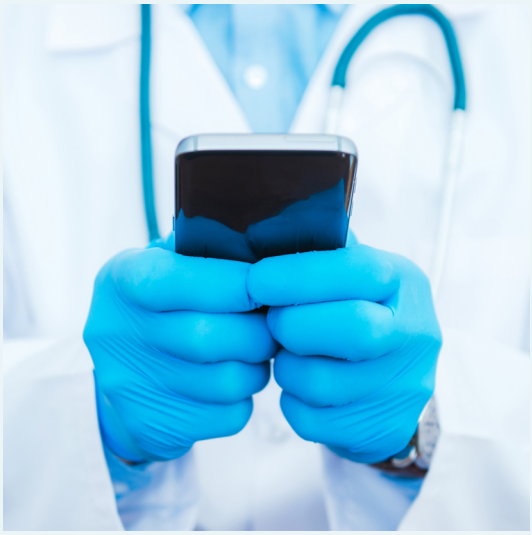

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