LEGAL REVIEW & COMMENTARY
EXPERT ANALYSIS OF RECENT LAWSUITS AND THEIR IMPACT ON HEALTHCARE RISK MANAGEMENT

Failure to diagnose infection causes toddler death and yields verdict of $1.72 million

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News: Plaintiffs' 3-month-old daughter was taken to the hospital with a high fever and elevated pulse rate. The emergency department (ED) physician diagnosed an ear infection and discharged the infant with a prescription for antibiotics. Three days later the girl's father found her cold and lethargic. He took her to a different hospital, where she was diagnosed with pneumococcal meningitis, hypoxic brain injury, and hydrocephalus, which required hospitalization for a month. After discharge, the girl lived for 20 more months, but she was constantly in and out of the hospital and eventually died from respiratory arrest, which the plaintiffs claimed was due to the originally undiagnosed meningitis infection. Plaintiffs sued the hospital and the ED physician, and they won a verdict of joint and several liability for $1.7 million.

Background: The plaintiffs' daughter was born as a full-term baby with no material health problems or birth defects. She enjoyed normal development for the first 15 weeks. On Dec. 16, 2007, the plaintiffs' daughter began to suffer from a high fever, and she went to the ED. The baby initially was observed by the nurse with abnormal vital signs of elevated pulse of 190 beats per minute, elevated respiratory rate of 33 breaths per minute, and a high temperature of 103 degrees. The ED physician noted that he reviewed the nurse records and documented a history of fever, but nothing else. He then conducted and reported a normal exam, but he circled the preprinted finding of "abnormal tympanic membranes." He did not describe any findings in either of the baby's ears, nor did he even indicate which ear he suspected to be infected. He diagnosed the baby with a middle ear infection but otherwise joked with the parents that she was essentially too healthy to be in the ED. He discharged the baby with an antibiotic prescription, with the instruction to the parents to follow up with their regular pediatrician on an "as-needed" basis.

Three days later, the baby's father found her lethargic, cool to touch, and very pale in her crib. The baby's pediatrician sent her to a different hospital immediately, where she was diagnosed with pneumococcal meningitis and a hypoxic brain injury and hydrocephalus, caused by her infection. After discharge a month later, the baby suffered constantly and eventually died just after her second birthday due to respiratory insufficiency.

Plaintiffs sued and contended that the hospital and the doctor were negligent because the doctor had failed to evaluate the likelihood of a serious bacterial infection and did not exclude the possibility of bacteremia and meningitis. Plaintiffs alleged that a reasonable doctor would have at least ordered a complete blood count and a urinalysis, which were not done, and that abnormal test results would have caused additional evaluation, resulting in a correct diagnosis. The plaintiffs alleged that the doctor should have followed up with the patient in person within 24-48 hours.

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The defense position was that neither the hospital nor the doctor were negligent because the doctor had acted within the proper standard of care given the facts before him at the time, especially evidence suggesting that the most likely ailment was a simple middle ear infection. The defense maintained that plaintiffs could not prove that their daughter was suffering from meningitis at the time of treatment, and that the baby contracted meningitis after leaving the ED.

The jury rejected the defense arguments and found for plaintiffs in the amount of $1.7 million, representing $860,000 for economic damages and $860,000 for the baby's pain and suffering.

What this means to you: This case is an unfortunate lesson in not being complacent when confronted by what might seem to be routine presenting symptoms. Many fussy babies who present with high fevers do have a simple ear infection, and one can speculate that this doctor made up his mind upon learning the symptoms. Certainly the fact that the doctor didn't specify why he concluded as he did or even indicate which ear was likely infected suggests that he believed this was a routine case that did not warrant further investigation. Thus, one lesson here is that each case must be analyzed with the idea that it could be the outlier. Care must be taken to rule out the unlikely, and conclusions even of the likely diagnosis must be documented with an eye toward having a solid record for use in defending against any subsequent litigation.

Another lesson is that what likely seemed a jovial comment at the time that the baby didn't belong in the ED likely looked horrible and probably was repeated for dramatic effect (with sarcasm) again and again by the plaintiffs' lawyers. In the context of treating patients, every spoken word might someday be repeated with a life of its own. While a physician can have a cheerful bedside manner, it does caution in favor of thinking twice before giving a stray comment.

Note in particular that sepsis often is overlooked in all age groups because older adults might be essentially asymptomatic while young infants, the most vulnerable, often have very high fevers from relatively common viral or bacterial infections. However, sepsis always must be ruled out on all patients presenting to an ED with symptoms. It has become a standard of care in most hospitals.

The emergency physician in this case picked the easy path toward a simple diagnosis and never looked back, even though the infant presented with the three most common signs of sepsis: high fever, rapid heart rate, and rapid respiratory rate. In addition to inadequate documentation of what he saw and where he saw it, he did not make any attempt to support his assumption with diagnostic tests. A simple white count, blood cultures, and a serum lactate should have been ordered.

More generally, there is no place in medicine for untested assumptions. Where there is uncertainty, there must be continued probing and questioning. A second or even a third opinion from an expert often can bring clarity and alleviate doubt. Had the physician ruled out sepsis, the defense's argument that the infant contracted meningitis after discharge might have been relevant.

A final issue in this case was the discharge instructions given to the parents. Prescribing antibiotics indicates that the patient was suspected of having a bacterial infection. Follow-up to ensure that the correct antibiotic has been prescribed and that the patient's condition is improving rather than deteriorating is critical. Telling the parents to follow-up with their pediatrician "as needed" rather than "within 24 hours" or some other very short timeframe could well have directly contributed to the death.

REFERENCE:

D.O. No. 09-9629 (Berks Cty. Ct. of Common Pleas, PA, June 14, 2013). ■

$21.9 M award in elective steroid injection procedure

News: The patient, a 54-year-old woman, suffered from chronic and severe back pain, and she sought treatment at a medical facility. Under the advice and direction of a physician, she underwent an elective epidural steroid injection (ESI) aimed at relieving pain. However, while sedated, the patient's airway became blocked, which resulted in oxygen deprivation for as long as 10 minutes. Multiple electronic monitors indicated that the patient was not breathing properly, but the physician continued the procedure despite these indications. Emergency assistance was not called for more than an hour, and the physician failed to report to a subsequent treating hospital that the patient was deprived of oxygen for several minutes. As a result of the oxygen deprivation, the patient suffered severe brain damage, and she died six years after the procedure from complications related to the brain injury. The patient's surviving spouse and estate brought suit. They

alleged that the physician and his employer, as well as the medical facility and lead nurse, were negligent. The defense claimed a sudden stroke or other unforeseeable cause was the source of injuries. The jury awarded the widower and estate $21.9 million in damages.

Background: The patient chose to undergo an elective ESI, which is a routine, minimally invasive procedure designed to relieve pain. The patient was given propofol, a sedative which the patient had taken twice without issue. However, during this procedure, the patient's airway became blocked, and the patient's blood-oxygen levels became critically low. Two electronic monitors indicated the dangerous condition the patient was in, and nurses and operating staff warned the physician that the patient was not breathing. The physician continued the procedure. The patient was deprived of oxygen for as long as 10 minutes. Beyond this oxygen deprivation, the patient's blood pressure had dramatically dropped, and there was no detection of a pulse.

Emergency assistance was not called for more than an hour, even with the patient's critical condition. The patient eventually was transported to a different nearby hospital, which attempted treatment. The physician in charge of the ESI, however, did not report to the subsequent hospital that the patient had been deprived of oxygen for several minutes. As a result of the oxygen deprivation and other issues with the procedure, the patient suffered severe brain damage. She was unable to move or communicate except for blinking her eyes for "yes" or "no." This condition persisted for six years until the patient died of complications related to the brain injury.

The patient's surviving spouse and estate brought suit against four parties involved with the procedure: the lead physician, the physician's employer, the medical facility, and the lead nurse at the medical facility. The widower and estate alleged that the physician incorrectly decided to continue the procedure given the patient's lack of breathing and other warning signs and that this decision caused the severe oxygen deprivation and resulting brain damage. The plaintiffs argued that the patient likely suffered an adverse reaction to the sedative, which led to hypoxia, or dangerously low blood-oxygen levels, within minutes of the procedure's start.

Testimony during trial revealed that the physician arrived late to the procedure and that he appeared to be "impaired," both of which were reported to be common occurrences. The physician reportedly was diagnosed with cancer in 2005 and was taking medication at the time of the procedure. The defense's primary contention was that the patient suffered a sudden stroke or that another unforeseeable event caused the injury. Based on the patient's two prior uses of propofol without any complications, the defense claimed that the physician could not have reasonably predicted a complication with the sedative. The plaintiffs challenged the credibility of the defense's expert, an anesthesiologist who was a friend and colleague of the lead physician, as the expert had no experience with ESI procedures. The jury found three of the four defendants liable: 50% for the physician, 30% for the first medical facility, 20% for the physician's employer, and no liability for the lead nurse. The jury awarded $21.9 million but did not award punitive damages.

What this means to you: The primary cause of liability in this case for the physician was inflexibility. The physician failed to heed signs that indicated that a change was required. Providers must be conscious of warning signs that might indicate that a procedure is not going normally or within acceptable bounds. Some deviation is likely acceptable, but ultimately the question with medical negligence becomes what would a reasonable physician have done in the same or similar circumstances. If there are minor warning signs that oxygen levels are low, but not to critical points, a reasonable physician might continue and watch the monitoring systems closely to determine whether or when to discontinue the procedure and instead stabilize the patient. This step might be particularly relevant to elective procedures such as ESI. The patient is not in an emergency situation in which halting the procedure itself might cause even more serious injury, so delaying treatment might be the best solution. In this case, the monitors as well as the OR staff and nurses trained to assess the patient's condition during the procedure all warned the physician that the patient was in respiratory distress.

A temporary drop in blood pressure might be tolerated for a short time by a relatively young and healthy patient. However, a compromised airway, whether caused by a blockage or the drug-induced depression of the patient's respiratory drive, is an emergency situation that must be immediately corrected. Resuscitation procedures were more important than continuing the epidural injection.

Federal and state laws require that a crash cart be within easy reach of the surgical team and that there are

individuals present who are trained to use it. The crash cart has emergency equipment including a defibrillator to correct lethal cardiac arrhythmias and supplies to intubate and mechanically ventilate the patient. Finally, once the physician realized that this patient's medical condition had deteriorated to a point beyond his ability to deal with it, the delay to get the patient to a higher level of care was very problematic, especially when complicated by his purposeful or unintentional failure to notify the receiving facility of the circumstances surrounding the patient's condition.

There is also a chain of command that most nurses are trained to use in the event that a physician is engaged in unsafe practices. Sometimes the very act of threatening to inform a person in authority is enough help the physician recognize and correct the dangerous situation, and physicians need to be trained to accept such situations gracefully. The facility staff members here likely should not have stopped with just the verbal warning to the physician, which might be why the facility also was found liable.

Another lesson from this case is be on time, and be physically and mentally prepared for an operation. We all inevitably have some time when we go to work with something else on our minds, and this situation is difficult to prevent. For providers, though, this circumstance might lead to a dangerous situation. A physician who is distracted might not be completely dedicated to the patient and, instead, might be thinking about a personal matter. This physician reportedly was distracted and might have been impaired, which raises more serious concerns as to the fitness of a physician to perform his responsibilities. Personal issues clouding judgment or distracting providers can cause serious, even fatal, injuries. Impairment, including narcotic impairment, results in seriously compromised decision-making and reflexes that can be disastrous in any medical context, but especially in a surgical procedure that is difficult even without unnecessary handicaps. Once again, the surgical team, upon recognizing a physician's possibly compromised physical or mental condition, had an opportunity to intervene and convince the physician to postpone the procedure. While canceling operations might not be viewed with favor, it is a far better option than attempting them while impaired or seriously distracted to a level that compromises a physician's decision-making or reflexes. Performing while impaired is a recipe for disaster and liability.

Expert witnesses are a critical element of almost all medical malpractice cases. Experts must be chosen wisely. An injured plaintiff, via his or her counsel, potentially will challenge the credibility of your experts, which makes choosing a likeable, believable, and credible witness all the more difficult. The physician chose a friend as his expert, and this friend didn't perform ESI (epidural) procedures. Both of these conditions created an easy target for the plaintiff's counsel to attack and point out to the jury that this expert might simply be trying to protect his physician friend, and with little actual knowledge as to the medical standard of care expected during ESI procedures. If the physician had looked outside his circle of friends for a third party who was familiar with the ESI standards used in this case, he might have had a better likelihood of persuading the jury that he met the appropriate level of care. Juries are invariably suspicious of experts who often can be seen as "hired guns," individuals paid to say what needs to be said on the stand and who are handsomely compensated for these words. Convincing the jury that your expert is honest and not simply spinning a smooth story is often critical to a successful defense, and working with counsel to choose the right expert for a particular case can be complicated. Also, it is critical to retain the right expert or experts as early in the case as possible so they can help shape discovery and pretrial efforts. They should not have to write an expert report or give expert testimony at deposition or trial without all of the necessary information.

Finally, legal treatments of punitive damages for medical malpractice vary by state, but the general requirement focuses on intentionality. Punitive damages seek to punish an offender for what is viewed as willful misconduct. It is a difficult burden to achieve for a plaintiff, particularly because medical malpractice focuses on negligent behavior rather than intentional behavior. Negligence does not require any intent to cause harm, but it relies upon an individual's duty to another which is breached and causes harm. However, if a plaintiff can prove that the care provider intentionally caused harm to the patient, then punitive damages might be warranted.

The jury initially stated that punitive damages were warranted, but awarded zero dollars. The attorneys for the patient and the defense speculated that this zero award was caused by the high compensatory award of nearly $22 million, thus perhaps the jury viewed the $22 million as sufficient.

REFERENCE:

State Court of Fulton County, GA. Case Number 10EV010621. Jan. 26, 2015. ■