

Medical Malpractice: Survival Strategies for Physicians—Part 3

Three cases illustrate important legal principles.

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This article is the third of four parts.

Part I of this series presented an introduction to basic nomenclature and concepts pertinent to medical malpractice law. Part II continued with an examination of the four elements that underlie any malpractice action: duty; breach of duty; causation; and damages. This part offers case studies of several instances of aortic dissection that resulted in malpractice actions being brought against physicians and analyzes the results as a way to illuminate the way the legal system works.

Because ordinary negligence is carelessness, and because all humans are careless, it is impossible to prevent or defend against all human error. This premise indicates that it is impossible to practice medicine without error. Given the complex nature of medical/surgical innovations that we use when attempting to treat advanced disease processes, it is an illusion to believe that we can practice medicine error-free.

Careful studies of human error, and specifically errors in medical practice, point out that the source of most medical errors is not a lack of personal concern or care, skill, or training, but a systemic system's failure, mostly out of the control of the physician. Most med-



ical errors cannot be eliminated by the personal tenacity and determined effort of an individual physician. As essential as professional integrity and training are to excellent medical practice, those qualities will not solve the ongoing problem of medical errors.^{1,2}

Circumventing Medical Errors

Circumventing medical error requires objective, thoughtful restructuring of how we practice medicine. Systems analysts counsel hospitals that incident report committees and peer review committees must proactively build in safety measures to help physicians practice standard-of-care medicine. Atul Gawande has written two excellent books: *Better* and *Checklist Manifesto: How to Get Things Right* that detail how physicians and systems can minimize the potential for medical errors. These deep intellectual explorations of how physicians can attempt to combat medical missteps are illumi-

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A number of strategies for avoiding errors, surviving allegations of negligence, and limiting liability have been proposed. The medical and legal literature is voluminous on this topic, but there are no fail-safe strategies or schemes to avoid medical errors or limit liability. Two things are important for physicians to consider: (1) how physicians can prevent medical errors; and (2) how physicians survive alleged negligence and an ensuing medical malpractice lawsuit.

nating. Avoiding adverse events, with or without fault, is our best defense, our best survival strategy.^{3,4}

Surviving Allegations of Negligence

When there is an allegation of negligence, physicians must seek excellent legal and personal counseling. If you have a choice, select your malpractice carrier based on the defense counsel panel's expertise in medical negligence law. Although it is an ele-

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ment that should be carefully considered, the most overlooked, ignored, and discounted injury of a medical malpractice lawsuit is the emotional injury to the physician.

Physicians tend to blame themselves for bad outcomes that may not be their fault. In addition, the isolation and shame that accompanies a medical malpractice suit may affect a physician's professional and personal life.

All state medical societies have committees that guarantee and pledge to provide private confidential counseling for the emotional devastation of a medical malpractice lawsuit. Surveys and follow-up have demonstrated that providing counseling to distressed physicians can be life-saving. But it is also documented that there is under-utilization of this resource by most physicians impacted by a medical malpractice lawsuit.^{3,4}

Aortic Dissection and the Potential for Charges of Medical Negligence

The untimely death of John Ritter brought aortic dissection into the national spotlight. If the patient's symp-

tom night, and the emergency physician had just come on duty. One of the first patients she saw was a woman in her 50s who had come to the ED with a complaint of chest pain. The patient complained of severe pain in her anterior chest and the interscapular area. The pain radiated into her upper left arm and into the neck.

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The pain was dull in nature, and she described it as "exactly like when I had my heart attack." She denied any "ripping" or "tearing" character to the pain.

Her electrocardiogram (ECG) was suspicious for acute myocardial infarction (AMI) with ST-segment elevations in the inferior leads. Although there definitely appeared to be ST-segment deviations, they were relatively minor and not clearly diagnostic of inferior injury. Her blood pressure was elevated (190/100). She was given sublingual nitroglycerin

and ratory studies drawn, IV lines started, medication mixed, and consent obtained—and the physician and nurses were anxious to proceed, because there had already been a significant delay while waiting for the chest x-ray.

Because the ECG did not clearly fall within the hospital's proto-

col criteria for thrombolytic therapy, the physician consulted with the cardiologist on call. The emergency physician faxed the ECG to the cardiologist. He agreed that, while the ECG was not clearly diagnostic of an injury pattern, in the face of the patient's known previous AMI, clinical presentation (pain "just like when I had my heart attack"), and abnormal ECG suggestive of AMI, thrombolytic therapy was indicated. The only thing holding up the thrombolytic therapy was the chest x-ray. The patient's pain was not responding to intravenous morphine and nitroglycerine.

Finally, the chest x-ray was done. The thrombolytic medication was mixed and at the bedside ready to be given when the x-ray was brought in. It should come as no surprise after this build-up that the chest x-ray was abnormal—it showed a markedly widened mediastinum. There was nothing subtle about the chest x-ray, which was strongly suggestive of aortic dissection.

The emergency physician called the cardiologist, who came in. A transthoracic echocardiogram revealed the presence of aortic dissection. The patient was helicoptered to the nearest tertiary care hospital for surgical repair of the dissection.

This story highlights the fact that the clinical diagnosis of aortic dissection is not always obvious, and aortic dissection can easily be confused with AMI. While sudden "tearing" chest pain that radiates to the back is the classic presentation of aortic dissection, many patients with aortic dissection do not have such a pre-

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The untimely death of John Ritter brought aortic dissection into the national spotlight.

tom may indicate aortic dissection, the physician must be suspicious—or run the risk that the pathologist will make the diagnosis at autopsy. Physicians must have a solid knowledge base of the different aortopathies and the potential for dissection.⁵ The following sections present three case studies that illustrate the kinds of circumstances in which lawsuits may be brought against the physician. *Although the cases discussed here all involve aortic dissection, the legal principles discussed are of general applicability.*

Case Studies

Case 1: Circumstances That Carry the Potential for Medical Negligence Allegations

It was Friday in the emergency department (ED), approaching mid-

and IV morphine sulfate. Her blood pressure came down (160/90), but her pain continued. Laboratory studies were sent, and a portable chest x-ray was ordered. Both the laboratory results and the chest x-ray were delayed because it was a typically busy shift on a weekend, and the department was literally overflowing with patients. Radiology, in particular, was especially slow because of multiple traumas that required a large number of x-rays.

The patient's pain continued, and she was given additional morphine sulfate and was started on a nitroglycerin drip. Still, her pain did not improve. The hospital did not have a catheterization laboratory. The physician on call decided to proceed with thrombolytic therapy. Everything was ready for thrombolytic therapy—labo-

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sentation. The diagnosis is further complicated by the fact that a patient with aortic dissection might also, as a consequence of the dissection, have a myocardial infarction.

It is natural to relax when you have confirmed the diagnosis that you had suspected clinically (myocardial infarction in a patient with chest pain). After all, you only expect a patient to have one problem at a time. However, in a patient with aortic dissection, an intimal flap may obstruct a coronary artery and lead to AMI. In such cases, missing the primary cause of the AMI and administering thrombolytic therapy would be catastrophic.

The consequence of giving thrombolytic therapy to a patient you thought only had an AMI, but who

nosed until autopsy. A diagnostic rate of 72% represents some improvement over the past decade, but given the consequences of missed aortic dissection, that clearly remains much too low.

The solution is to increase our index of suspicion when dealing with patients with chest pain and to learn to identify the sometimes very subtle clues of aortic dissection. The low rate of correct diagnosis is all the more worrisome given that: “(1) thoracic aortic dissection is the most common lethal disease affecting the aorta, and is two to three times as common as abdominal aortic aneurysm (AAA) rupture; (2) the absolute incidence by autopsy studies has risen two—to fourfold in the last 30 years; and (3) the mortality is as high as 1% to 2% per hour in untreated patients.”⁷

More than 90% of patients with aortic dissection experience sudden, severe chest pain.⁸

actually had aortic dissection, either alone or associated with AMI, is quite likely to be that patient's death. Fortunately, the physician in this case was able to resist the strong urge to give thrombolytic therapy, despite the pressure to provide therapy to all AMIs as quickly as possible (“time is muscle”), and she waited for the patient's chest x-ray to be done.

Fortunately, the physician was able to make the diagnosis of aortic dissection because the screening chest x-ray was markedly abnormal; and because of the x-ray findings, the physician was able to make a presumptive diagnosis of aortic dissection, confirmed by a definitive diagnostic test (echocardiography). In some cases, the x-ray findings will be highly suggestive of aortic dissection. Chest x-ray findings often are, however, much more subtle, and aortic dissection is a diagnosis that is missed with alarming regularity.

In a study of 236 patients with documented aortic dissection, only 72% of clinicians initially suspected aortic dissection.⁶ An alarming 28% of patients were not correctly diag-

Aortic dissection occurs when blood enters the media of the aorta (the middle layer), usually because of a tear in the intima (the inner lining of the aorta), and splits the wall of the aorta longitudinally. This creates a false lumen in the wall of the aorta that may extend proximally, distally, or in both directions. This extension of the false lumen may lead to decreased flow to, or obstruction of, the various branches of the aorta. This, in turn, leads to many of the secondary symptoms of aortic dissection⁸ (neurologic symptoms due to decreased flow through the carotids).

More than 90% of patients with aortic dissection experience sudden, severe chest pain.⁸ Although the classic description of aortic dissection pain is “ripping” or “tearing,” at least one study has shown this type of pain to be relatively rare.⁹

By contrast to the case just discussed, cases 2 and 3 involve aortic dissections that were allegedly missed. These cases provide lessons that will be useful in avoiding the risk of missed aortic dissection. They also provide reinforcing examples of

some of the legal and risk management principles that have been discussed earlier.

Case 2: Liability Requires Causation

In the case *Carmen C. Gomez v. Tri City Community Hospital, Ltd. d/b/a Tri-City Community Hospital* (4 S.W.3d

281 (Texas App. 1999), the Court of Appeals of Texas dealt with the issue of causation in a case involving a patient who died of aortic dissection. Recall that in order to prevail in a medical malpractice action, a plaintiff must prove all the following elements:

- Duty: requires the establishment of a physician-patient relationship;
- Negligence: requires breach of the applicable standard of care;
- Standard of care must have a nexus to the patient's harm; and
- Damages: requires that the plaintiff must have suffered a compensable injury.

The patient was brought by ambulance to the ED at Tri

City Community Hospital Jourdanton, Texas, with a complaint of back pain. He was admitted for observation and released the following day. At the time of his release, he was still complaining of back pain. The patient returned to the hospital the following day with a complaint of continuing back pain and an inability to stand up. In addition, he now complained of not having had a bowel movement for the past four days. He was admitted to the hospital. A chest x-ray done in the course of his evaluation revealed a “significantly widened mediastinum,” and “an increase in the size of the cardiac silhouette.”

Two days after the second admission, a radiologist reviewed the chest x-ray and dictated his report. In addition to the report of his findings, as indicated above, the radiologist stated that: “In the setting of back pain, consideration should be given for aortic dissection.” The report also contained a note that: “Ward [was] notified.”

The patient's condition deteriorated, and he was transferred by helicopter to a tertiary care center. A CT

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scan performed there revealed that the patient was suffering from a

Type 1 aortic dissection of the thoracic aorta. He was taken to the operating room emergently, where it was confirmed that he had a thoracic aorta dissection. The dissection was repaired with a synthetic graft, and the patient was determined to be “fairly stable following the surgery.”

The following day, the patient suffered pericardial tamponade, and the emergency surgery notes revealed “the patient suffered pericardial tamponade, and emergency surgery revealed a new bleeding site into the pericardium and abundant blood in the left chest.” The patient arrested, and resuscitative efforts were unsuccessful.

The plaintiffs sued Tri City Community Hospital and the emergency physician who had treated the deceased. The plaintiffs settled with the emergency room physician, and the lawsuit proceeded against the hospital. Prior to trial, the hospital moved for summary judgment, and the trial court granted a no-evidence summary judgment on a finding that the plaintiffs had failed to introduce any evidence of causation. That is, while the hospital may have been negligent in its treatment of the patient, and the patient had obviously suffered damages (death), the plaintiffs had failed to introduce any evidence that sufficiently linked negligent acts of the hospital to the patient’s death. The judge, therefore, refused to allow the case to proceed to trial. The plaintiffs appealed this ruling to the Court of Appeals of Texas.

It is important to understand how difficult it can be for a defendant to prevail on a motion for summary judgment. Short of getting a plaintiff to drop a lawsuit, summary judgment is the next best alternative. In a motion for summary judgment, the moving party (usually the defendant) argues that there is no issue of fact for a jury to consider and that the court should, as a matter of law, dismiss the case. In considering such a motion, the judge is obligated to look at all the evidence in the light most favorable to the opposing party (in

this case, the plaintiffs) and to grant the motion only if a reasonable jury could not find for the non-moving party.

On appeal, the appeals court instructed the jury to “look at the evidence in a light most favorable to the [party] against whom the summary judgment was rendered, disregarding all contrary evidence and inferences.” This obviously gives the appellant (the plaintiffs in our case) a huge advantage in the court’s weighing of the evidence.

With the entire benefit of the doubt in the plaintiff’s favor, the plaintiff should prevail if he can introduce any evidence that a juror might construe as establishing his case.

Exactly how much evidence is necessary for a plaintiff to bring for-

ward the requisite “more than a scintilla” of evidence.

The plaintiffs had introduced evidence, in the form of their expert’s affidavit, that, had the diagnosis been made on the day of admission, and the patient been taken to surgery at that time, he would have had a greater chance of survival. It was clear from the medical record that the x-ray was not read until two days after the deceased’s admission.

According to the court, there was sufficient evidence for reasonable people to conclude that, had the report of the chest x-ray been provided to the patient’s doctors on the day it was performed, the correct diagnosis would have been suspected at that time. Based upon the medical record and the plaintiffs’ expert witness’ affidavit, there was evidence

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ward in order to survive a summary judgment motion? Not much in this case. The court instructed the jury:

“A no-evidence summary judgment is improperly granted [i.e., the trial court should be reversed] if the respondent [plaintiff in our case] brings forth more than a scintilla of probative evidence to raise a genuine issue of material fact.”

The court went on to define “more than a scintilla” as any evidence that “rises to a level that would enable reasonable and fair-minded people [the jurors] to differ in their conclusions.” That is, if the plaintiffs had introduced any evidence that, if viewed in a light most favorable to the plaintiffs, would be sufficient for reasonable people on a jury to differ in their conclusion, the case should have been allowed to proceed to trial. Having restated the accepted rule for consideration of the appeal, the court proceeded to search

that there was a breach of the standard of care—the failure to read and communicate the results of the chest x-ray on the day of admission.

The court subsequently was able to link the negligent act and injury (i.e., establish proximate causation) from the evidence by making the following inferences:

- Had the physicians received the report on the day of admission, they would have considered the correct diagnosis; and
- Had the diagnosis been made on that day, the surgery would have been elective (the rupture likely did not occur until two days later when the patient’s condition suddenly deteriorated).

In addition, there was evidence that the patient would have had a greater chance of surviving had he been taken to the operating room on the day of admission. The grant of

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summary judgment for the trial court was reversed, and the case was remanded for trial.

Commentary: If the facts of the case make it difficult to defend the alleged breach of the standard of care, the case is not lost. The plaintiff also must prove that the breach of the standard of care proximately caused the patient’s injury.

Case 3: The “Rule Out Acute Myocardial Infarction” Patient

In the case of *Mindy Sommers v. Dr. Lisa Friedman and Wisconsin Patients Compensation Fund* (493 N.W.2d 393 (Wisc. App. 1992)), J. Sommers, the husband of the plaintiff Mindy Sommers was admitted to St. Mary’s Hospital in Madison, Wisconsin, after complaining of the sudden onset of chest pain. Dr. Lisa Friedman, a member of the St. Mary’s medical staff, became his primary

treating physician. After conducting initial tests, Dr. Friedman concluded that Mindy Sommers’ husband had not suffered an acute myocardial infarction. Dr. Friedman was, however, unable to diagnose the cause of his pain. She consulted with other physicians, including a cardiologist, and

Sommers, providing him with copies of all his medical records and urging him to see a physician upon return to his home in Arizona. Unfortunately, Mr. Sommers died a few hours later as a result of an aortic dissection.

Mindy Sommers sued Dr. Friedman and alleged that she was negli-

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further tests were performed, including an ECG, treadmill/stress test, and an upper gastrointestinal series, all of which were normal.

Following those consultations and the completion of the ancillary tests, Dr. Friedman informed Mr. Sommers and his wife that “heart attack, angina, and gastrointestinal problems had been ruled out as causes of his pain”. Dr. Friedman discharged Mr.

gent in failing to diagnose and treat her husband’s aortic dissection. After six days of testimony, the jury found Dr. Friedman not liable. The plaintiff appealed. Among the issues raised on appeal was the trial court’s admission of the testimony of three physicians, two residents, and a cardiologist, who testified that they, too, had examined Mr. Sommers and had

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taken his history and reached the same conclusions as Dr. Friedman. That is, they had not suspected aortic dissection either.

Plaintiff's counsel objected to the admission of this testimony on the grounds that it was not relevant and was highly prejudicial in that it "did not bear upon whether Dr. F exercised the applicable standard of care and skill, but merely provides [her] an escape from responsibility based

The trial court agreed with plaintiffs' counsel that there was "potential for misuse of this evidence by the jury to conclude that [because] these other doctors did not make the appropriate diagnosis either, that [fact] might be taken as a basis to relieve Dr. F of her responsibility to exercise the requisite standard of care."

The court then undertook a balancing of the probative value of the evidence, relative to its relevant purposes, versus its improper possible prejudicial effect. The trial court had

the rule-out protocol's criteria) creates a risk of sending home patients who did not have AMI, but had other serious diagnoses (e.g., aortic dissection and pulmonary embolism).

Conclusion

This part of our four-part series has presented several real-life examples of how medical negligence law may be applied. PM

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When making this decision, it is crucial not to focus narrowly on whether AMI has been ruled in or out.

upon the understandable reaction by the jury that if [other] doctors failed to diagnose the ailment, then Dr. F, by default, must have met the standard of care."

Regarding the admission of evidence. The basic rule is that evidence will generally be admitted if it is "relevant," that is, any "evidence having any tendency to make the existence of any fact that is of consequence to the determination of the action more probable or less probable than it would be without the evidence."

However, evidence will be excluded, even if relevant, if it is "prejudicial": It is prejudicial "if it has a tendency to influence the outcome [of the case] by improper means or if it appeals to the jury's sympathies, arouses its sense of horror, provokes its instinct to punish, or otherwise causes a jury to base its decision on something other than the established propositions in the case." The trial court had ruled that the testimony of the other doctors "was relevant to the degree to which Dr. F considered all of the medical information available to her when she diagnosed and treated JS." In addition, the testimony of the doctors was relevant to the defense's assertion that "an aortic dissection is a relatively obscure illness." According to the trial court, the testimony, therefore, was relevant, and the appeals court agreed.

concluded that a limiting instruction would sufficiently reduce the possibility of prejudice and had admitted the evidence. The trial court's limiting instruction was as follows:

"With regard to diagnoses and opinions received from other treating physicians, you may consider that testimony as it relates to the quality of medical care actually given to JS, but you are instructed that Dr. LF is obligated to provide medical care consistent with the standard of care just described irrespective of the opinions of other treating doctors."

The appeals court agreed that this limiting instruction had been sufficient to avoid the possible misuse of the testimony by the jury and affirmed the decision.

Commentary: We admit thousands of patients to dedicated chest pain units to "rule out heart attack," where relatively rigid protocols are followed to rule out heart attack (e.g., serial cardiac enzymes, monitoring, and stress testing). Often, it is emergency physicians who staff those units and make the ultimate decision whether to admit or discharge the patient. When making this decision, it is crucial not to focus narrowly on whether AMI has been ruled in or out. A narrow focus on AMI (and unstable angina) as the only possible diagnosis (patients are essentially automatically discharged from the chest pain unit if they fulfill



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