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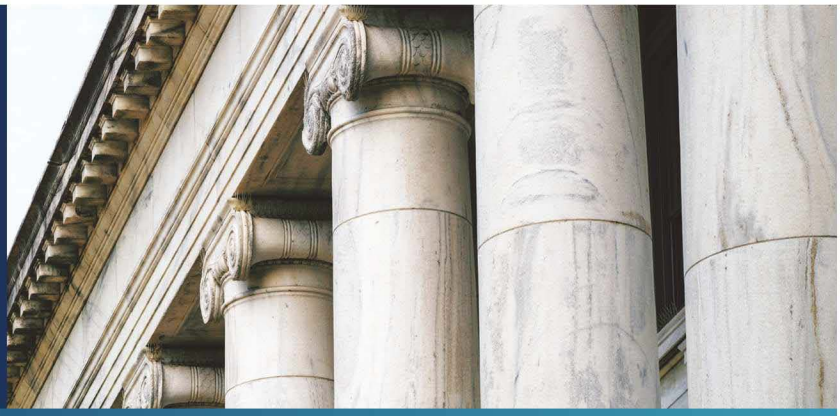
CASE REVIEW



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.

As previously discussed in the Spring 2017 issue of Dateline, *MLMIC Insurance Company is increasingly using summary judgment motions to successfully defend medical professional liability lawsuits commenced against its policyholders, thus precluding the need for a lengthy and expensive trial. The following is one such case.*

CASE STUDY I

Summary Judgment Granted to Internist after Patient Expires

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A 45-year-old self-employed male physical therapist called his internist to complain that he had experienced vomiting, incessant reflux, chest pain, burning, and nausea while on a recent two-week camping trip. The patient's medical history was significant for a diagnosis of Hodgkin's lymphoma at age fifteen. He had been successfully treated with chemotherapy and radiation. The patient also had a history of gastro-esophageal reflux disease, diabetes mellitus, and hypercholesterolemia. He advised his physician that during the camping trip, he had consumed more alcohol than was normal. The physician felt that the symptoms he reported were likely secondary to increased heartburn from drinking

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CASE STUDY II

Lost Medical Records Result in Severe Allergic Reaction

Brian Muller
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and, therefore, he adjusted the patient's GERD medication.

Five days later, the patient presented to the internist's office, where he was seen by a nurse practitioner. The patient again complained of chest pain with nausea, but had no symptoms of palpitations, diaphoresis, radiation of the pain, or shortness of breath. An EKG was performed showing an interval myocardial infarction with an ST segment elevation. The nurse practitioner promptly consulted the internist about the EKG. However, in the interim, the patient had already left the office. As a result of his concern about the EKG, which showed the patient had experienced a myocardial infarction within the past two weeks, the internist promptly referred the patient to be seen by a cardiologist. He requested that a stress echocardiogram be performed. However, he did not start the patient on a beta blocker and aspirin at that visit.

Three days later, the patient was seen by the cardiologist, who performed an echocardiogram. He decided not to proceed with the stress portion of the test. The echocardiogram indicated significant abnormal wall motion of the left ventricle, with an ejection fraction of approximately 25%. Further, the EKG showed malignant ventricular tachycardia, which required immediate hospitalization for monitoring. Despite these findings, the cardiologist did not send the patient to the hospital. He placed the patient on carvedilol and scheduled a cardiac catheterization for four days later.

That same evening, the patient became unresponsive and his wife contacted 911. Although the EMTs performed chest compressions en route to the hospital, the patient never responded and was pronounced dead on arrival. On autopsy, the cause of his death was determined to be a cardiac arrhythmia secondary to coronary artery disease.

The patient's spouse commenced a lawsuit naming the cardiologist and the cardiology group, as well as the internist, his nurse practitioner, and his group. The complaint generally alleged that the cardiologist failed to diagnose and/or ignored multiple signs of a recent or evolving myocardial infarction and failed to send the patient immediately to an emergency department or admit him directly to the hospital. The specific allegations against the internist and nurse practitioner were the failure to recognize the signs and symptoms of a myocardial infarction and the failure to emergently refer the patient to a cardiologist and/or the hospital. In response, the internist stated that although the patient complained of chest pain during his office visit, this pain did not radiate to his jaw or left shoulder. Nor did he have diaphoresis and dyspnea. Further, once the patient had an abnormal EKG in his office, the internist and nurse practitioner referred him promptly to the cardiologist for a stress echocardiogram.

The cardiologist's defense was that the patient was stable and asymptomatic. Therefore, he claimed that he appropriately treated him on an outpatient basis. He also claimed that scheduling the catherization for a later date was proper. Additionally, he alleged that even if the patient had a myocardial infarction prior to his cardiology appointment, the event was over and no longer constituted an emergency.

The care of both physicians and the nurse practitioner was reviewed by MLMIC experts in cardiology and internal medicine. The cardiology reviewer opined that the cardiologist should have sent the patient immediately to the hospital because both the echocardiogram and the EKG pointed to an acute or very recent cardiac event. The EKG also indicated polymorphic ventricular tachycardia with multiple episodes of couplets and triplets. The reviewer felt strongly that this rhythm should not have been left untreated.

When the case was reviewed by an outside expert in internal medicine, the expert fully supported the medical care provided by the internist and his nurse practitioner. He suggested that the prompt referral to a cardiologist was appropriate. This expert also stated the patient's later care by the cardiologist was an intervening cause of the patient's death that superseded all of the actions of the internist and the nurse practitioner. Therefore, he concluded that once the patient saw the cardiologist, the internist and nurse practitioner did not proximately cause the patient's death.

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Based upon this expert's opinion and affidavit, the defense counsel made a motion for summary judgment on behalf of the internist, his nurse practitioner, and their group. After reviewing the opposing expert opinions, the judge granted summary judgment in favor of the internist, his nurse practitioner, and his group, dismissing them from the lawsuit. Thus, only the cardiologist and his group remained as defendants.

Counsel for the plaintiff initially demanded $2.1 million to settle the lawsuit. This demand was based on the loss of the decedent's income, as well as that of his wife. She had been employed at her husband's physical therapy office as an office manager and biller. She also claimed a loss of spousal support and the loss of parental guidance of the decedent's minor child. This lawsuit was eventually settled for $1.4 million on behalf of the cardiologist and his group.

A Legal & Risk Management Analysis

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A motion for summary judgment means that a judgment is granted to the defendant where there is no basis for the lawsuit. A summary judgment motion must be made within 120 days after the note of issue is filed. A note of issue states that the case is ready for trial. The judge is then asked to determine whether there are any material questions of fact that would require resolution at a trial because one or more of the essential legal elements of a medical professional liability case are missing. The defendant must show that he/she did not depart from the standard of care and/or that any alleged departure did not proximately cause the patient's injuries.

The current trend in New York State reveals that defendants are being granted summary judgments in medical professional liability cases more frequently than in the past. Therefore, it is important for MLMIC policyholders to know that the MLMIC Claims staff is closely and continuously reviewing all lawsuits to determine whether a motion for summary judgment is indicated. If the case does meet the necessary criteria, MLMIC then retains an expert who will provide strong support for the defendant in an "expert" affidavit, which must be a part of the motion papers.

It is important to understand why the motion for summary judgment was granted in this case. To win a motion for summary judgment based on a lack of causation, a defendant must show that there is no connection between the treatment provided and the plaintiff's alleged injury. This must be substantiated by the affidavit of a defense expert. In this case, the patient's medical records and the opinion of the outside expert in internal medicine provided the necessary proof upon which this motion was based. The expert opined that the care of the co-defendant cardiologist was so deficient that it was a superseding intervening cause of the patient's death. This abrogated any deficits in care rendered by the internist and nurse practitioner. The expert dealt with the plaintiff's specific allegations and showed how they no longer were applicable once the patient saw the cardiologist.

Initially, when making this motion, a defendant has the burden to show that he/she is entitled to dismissal of the action. The judge may determine that the defendant has not met this burden and can deny the motion, even prior to reviewing the motion papers submitted by the plaintiff in opposition. However, if the defendant shows that he/she is entitled to make a motion for summary judgment, the judge must then carefully review the plaintiff's papers and, particularly, the plaintiff's expert's affidavit. The judge must determine whether the plaintiff has raised factual issues requiring a trial or, alternatively, whether the plaintiff's expert's affidavit is insufficient or conclusory, i.e. does not deal with the issues of the standard of care and causation, nor with the specific facts of the case. If the affidavit of the plaintiff's expert creates a question of fact that must be resolved by the jury, the defendant's motion will be denied. However, if the plaintiff is not able to overcome the defendant's arguments, the motion for summary judgment will be granted. The case is then dismissed without going to trial.

In this case, the summary judgment motion made by the defendants and the expert's affidavit withstood the plaintiff's opposition. The plaintiff's expert for this motion was unable to counter the facts, which showed that the intervening and superseding actions of the cardiologist proximately caused this patient's death. Therefore, both the defendant internist, the nurse practitioner, and his group were dismissed from the lawsuit before trial.

CASE STUDY II

Lost Medical Records Result in Severe Allergic Reaction

Brian Muller
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MLMIC Insurance Company

A 62-year-old female first presented to the MLMIC-insured physician for a urinary tract infection and was treated with Bactrim, a sulfa-based drug. She had a history of recurrent urinary tract infections, hypertension, hyperlipidemia and chronic mild kidney deficiency. After taking this medication, she developed widespread itching. She promptly contacted the practice to advise them of her reaction. A different physician in the practice then switched her antibiotic to ampicillin. She reported no further allergic reactions. The defense counsel could not confirm this initial allergic reaction, nor the change in antibiotic, at the time of the lawsuit because, approximately five years after she had this reaction, the patient's paper medical record was lost. A new record was generated for the patient. Incredibly, this new record was lost three years later. Again, a new record was generated for the patient. Over the course of the next few years, the patient was compliant and seen regularly for physical examinations and occasional sick visits, but never required treatment with antibiotics.

Thirteen years after the original allergic reaction, the patient presented with a possible urinary tract infection. A urine culture revealed the presence of E. coli. The physician prescribed Bactrim DS (double strength), one tablet twice a day. Pharmacy records indicated that the patient never filled this prescription. Over the next year and a half, the patient had seven more office visits. However, when the patient was next seen because of her history of urinary tract infections, the physician performed a routine urine culture. By then, the physician was using an electronic health record (EHR). The physician reviewed the patient's medical history and documented in the EHR, "I reviewed the patient's drug allergy history with her." However, he did not document any allergies to specific medications. Although she was asymptomatic, the patient's urine culture was reported as being positive for E. coli. The physician again prescribed Bactrim DS, one tablet twice a day. She was also advised to increase her fluid intake and drink cranberry juice. This time, the patient did fill the prescription and took the medication.

Thirteen years after the original allergic reaction, the patient presented with a possible urinary tract infection.

Four days later, the patient returned to the office complaining that she had developed blisters on her upper right arm, upper legs and buttocks after taking two doses of Bactrim. The physician documented the blistering, but also noted that she did not complain of shortness of breath, pain, swelling or any other symptoms of anaphylaxis. Additionally, she had no mucosal membrane involvement, which is a possible indicator of Stevens-Johnson syndrome (SJS). During this visit, a dermatologist, who was both a colleague and a patient of the practice, happened to be in the waiting room. He was asked to come in to the examination room to see the patient. The dermatologist quickly evaluated the patient and recommended treatment with Atarax, Biafine and Medrol to relieve her itching and swelling. Although he claimed that he too entertained the possibility of SJS, he also failed to make this diagnosis due to the lack of oral lesions. The patient's physician documented in the EHR that the blisters were merely secondary to a reaction to sulfa.

The next day, the physician called the patient to inquire about her reaction. She reported that she had no new complaints. However, two days later, she emergently returned to the office complaining of pain and difficulty sitting and lying down. The blisters were now weeping. His impression was a severe reaction to Bactrim. He sent the patient immediately to

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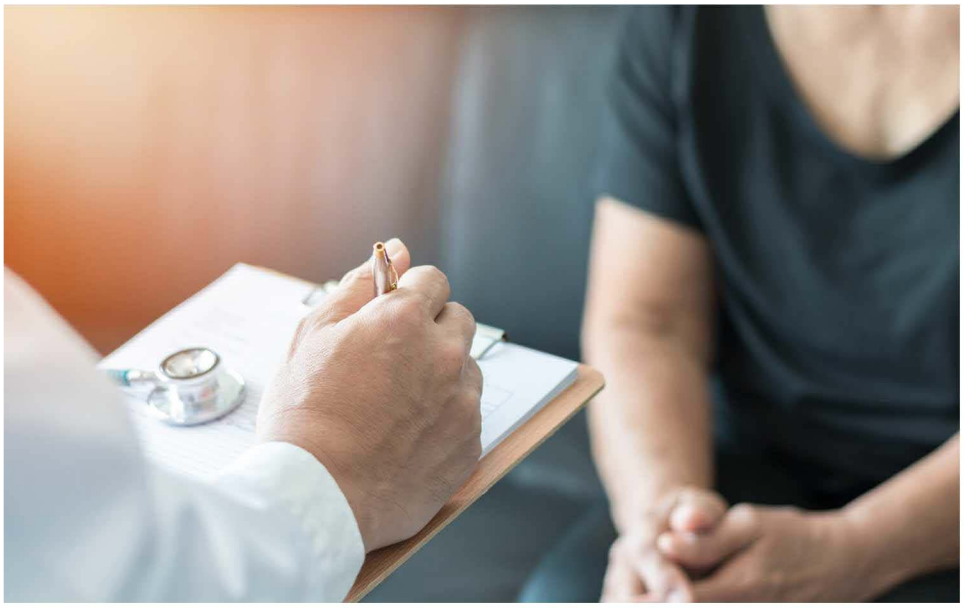
the emergency department of the nearby hospital. When she arrived, approximately 30-40% of her body was covered by blisters. She was promptly admitted to the hospital with a diagnosis of toxic epidermal necrolysis (TENS) vs. SJS. Because of the severity of the blistering, she was transferred from a medical unit to the burn unit. A biopsy ultimately confirmed the diagnosis of SJS. The patient was hospitalized for 34 days. During that time, she had multiple complications including a DVT, respiratory distress, line sepsis, microvascular ischemic changes, and mental status changes. At discharge, she had widespread hyperpigmentation, which resulted from the blisters.



The patient commenced a lawsuit against her physician, alleging that he should have been aware of the original allergic reaction she had to Bactrim many years prior. She alleged that her allergic reaction to Bactrim and the development of SJS was in part due to his poorly documented and lost records. In contrast, the patient was able to corroborate her previous allergic reaction to Bactrim by obtaining fourteen-year-old pharmacy records. She proved not only had she notified her physician, but that her medication was in fact changed due to this allergic reaction.

The care was reviewed by MLMIC experts. They noted that Bactrim, a sulfa-based drug, is a well-known cause of SJS. Therefore, the experts opined that there was no excuse that this allergy had not been continuously flagged in the patient's medical record. Further, the patient was asymptomatic at the time of the most recent diagnosis of a urinary tract infection. Therefore, the reviewers questioned whether Bactrim was even warranted to treat this infection. Although one reviewer questioned whether the patient was a reliable historian, it was felt that the patient could reasonably assume that the physician had that information in his records since she was unaware that he had twice lost her records.

The care was then reviewed by an outside expert in infectious disease. This expert opined that the case was clearly not defensible. He noted that Bactrim is high on the list of drugs which cause a severe reaction such as SJS. Therefore, since the patient had a reaction to Bactrim initially, the patient should not have received this drug again, unless it was an emergency and there were no other options. He further noted that it only takes one dose of Bactrim to cause such a severe reaction. The expert also opined that it would be impossible to defend a physician who lost a patient's record twice. He further criticized the physician's failure to document the patient's allergy to Bactrim/sulfa since the patient would likely testify at her deposition and at trial that she had developed a rash when first treated with Bactrim fourteen years ago, and the pharmacy records would confirm this prescription.

The infectious disease expert was also highly critical of using another patient to do a "sidewalk" consultation with this patient. Neither physician truly appreciated the severity of the reaction, although earlier hospitalization would not likely have stopped it. He also confirmed that the lack of mucous membrane involvement, which concerned both the patient's physician and the dermatologist, does not preclude this diagnosis. Finally, he was highly critical that an asymptomatic urinary tract infection was treated with antibiotics.

Aside from the many complications the patient had during her very long hospitalization, the patient's permanent damages consisted primarily of a cosmetic skin defect over much of her body. The expert stated that this patient was fortunate, since corneal scarring and blindness and/or vaginal and rectal pain are common permanent damages due to SJS.

Because of losing the patient's records twice, the lack of adequate documentation of her visits, the inappropriate use of Bactrim, an inappropriate dermatology consultation, and the very complex and prolonged hospitalization of this patient in the burn unit, all of the experts strongly advised prompt settlement of the lawsuit. Therefore, negotiations ensued early in the litigation and the lawsuit was settled for $862,500.

A Legal & Risk Management Analysis

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Stevens-Johnson Syndrome is an unusual but serious reaction to medications. A series of errors by the defendant physician led clearly to this reaction and made this lawsuit very difficult to defend. The entire case was significantly impacted by the loss of the patient's medical records not once, but twice. This allowed valuable information critical to the patient's history to be lost and it was never retrieved. Because the defendant could not provide a rational explanation for losing the record twice, the plaintiff's counsel could easily make the defendant look sloppy and uncaring. Arguably, that could then be applicable to the plaintiff's medical care as well. The defendant was unable to show that he had tried to recreate the information contained in the lost records from pharmacies, other physicians, or the patient herself. The patient was 67 years old when she had the initial reaction and was 78 when she developed Stevens-Johnson syndrome. Therefore, it would be unlikely that the patient could be faulted for either not recalling that reaction or assuming that the physician had documentation of the reaction in his records.

In general, there also was poor documentation of the patient's care and physical examinations. For instance, documentation of yearly physical examinations stated only that the examination results were unchanged. His notes failed to identify which parts of the body he examined. Further, even at the time of the final allergic reaction, which resulted in the patient's thirty-four-day admission, there is no documentation in the allergy section of the EHR of the reaction. Nor was there documentation of this reaction when the patient was seen one month after her hospitalization. When there is a consistent lack of documentation, the defense of a lawsuit is very difficult.

Of great concern to the MLMIC and outside experts who reviewed the case was the use of another patient in the office, who happened to be a dermatologist, to evaluate this patient. The defendant physician asked him to do a "curbside" consultation. This type of informal consultation creates a risk for the patient as well as the consulting physician. It also raises serious confidentiality issues. There was no doctor-patient relationship formally established by the dermatologist with this patient. Further, there is no proof that the dermatologist asked relevant questions of the patient with respect to medication allergies, as he would in a formal office consultation. He briefly examined her mouth and the blisters and then recommended symptomatic treatment. He should not have been asked to see the patient. In fact, because he did not document his examination and findings in a patient record, he put himself at risk not only to be sued but also to be in violation of professional misconduct laws. Further, this situation both disclosed the identity of the dermatologist as a patient of the defendant, as well as the identity of the plaintiff, without written authorization by either to do so, potentially breaching confidentiality laws. Fortunately, the patient suffered no further damage from the two-day delay in hospitalization due to the dermatologist's incorrect opinion.

The final legal issue in this case was whether the delay in sending the plaintiff to the emergency department when she first developed blisters increased the length of her hospitalization, the sequelae she experienced there and, thus, her damages. This was the basis for the plaintiff's argument for substantial damages. Fortunately, all of the expert reviewers concurred that a two-day delay would not have made a difference in the eventual outcome of the case.

Interestingly, the initial response of the MLMIC reviewers was to defend this lawsuit. This stance was justified in part by the demand by the plaintiff for the physician's entire MLMIC policy limits to settle this lawsuit. However, because of very negative reviews of the many deficits in the care of this patient by the outside infectious disease expert, defense of this case would have been very risky. Further, no other outside expert could be found to defend the care provided. Therefore, intensive and successful efforts were made to reach a settlement.

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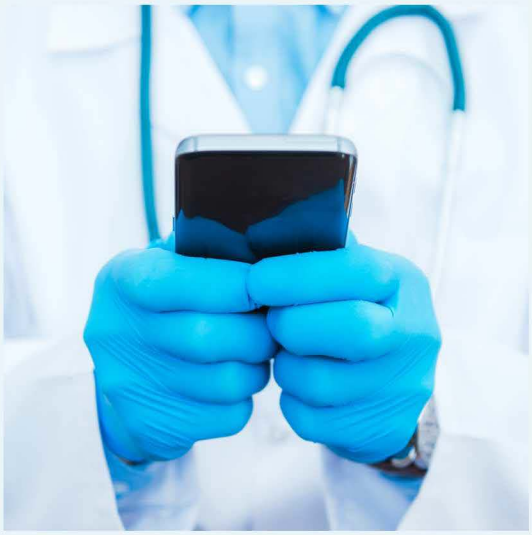

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These findings are a reminder of the importance of #NY's "One & Only Campaign" that promotes proper hand hygiene, dedication of multi-dose vials to only one patient when possible & adequate scrubbing of medication vial diaphragms. bit.ly/2VhJ6Ou

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