Case #1

72 year old WM

Past Medical History
- Hypertension
- Coronary Artery Disease
- Atrial Fibrillation
- Renal Insufficiency

Medications
- ACE, Beta Blocker, Statin
- Coumadin
  - Co-managed by internist and cardiologist
  - Poor compliance (frequently missed PT/INR and office visits)
  - During preceding two years, INR varied between 1.4 and 7.8. (Therapeutic Range 2.0 - 3.0)
- Social History – Patient's son is a physician who lives out of state

Case #1

April 2005

- Admitted to hospital for altered mental status
- INR 6.3 on admission, BUN 45
- CT of head – No bleed, encephalomalacia
- Mental status gradually improved (? metabolic)
- INR 2.4 on discharge
- The internist spoke with patient's son regarding overall prognosis and need for better compliance.

Case #1

May 2005 – September 2005

- Continued difficulty with Coumadin management. INR variable between 1.7 and 5.5.
- Cardiologist and internist both spoke with son regarding noncompliance and risks.
- Conversations with patient and son documented by both physicians.

Case #1

September 2005

- Admitted with flank pain, hematuria
- INR 2.7
- IVP – negative for pathology
- Hematuria clears on second hospital day
- Cystoscopy negative for pathology

Case #1

- Seen by cardiologist
- Post-cystoscopy - Lovenox started
- Coumadin subsequently restarted
- Pre-discharge INR 1.4
- Verbal and written instructions were given regarding Lovenox and Coumadin
  - Obtain a PT/INR in one week
  - Call for follow-up appointment with cardiologist in 10 days
  - Cardiologist spoke with son regarding overall care

Case #1

- Discharged on September 9, 2005
- Did not keep appointment for PT/INR on September 16
- Did not keep appointment with cardiologist on September 19.
- September 21 – Patient brought to ER by ambulance with altered mental status. PT/INR 9.8. Head CT – subdural hematoma, increased ICP.
- September 22, 2005 - Patient died from brainstem herniation

Case #1 – Lawsuit Allegations

A lawsuit was filed against the cardiologist and the Urologist alleging:

- The Coumadin should have been discontinued
- Failure to maintain therapeutic range on the Coumadin
- The patient was prematurely discharged from the hospital (as INR was not therapeutic)
- The post-procedure and post-discharge anticoagulation regimen was excessive
- Failure to establish strict follow-up after discharge
- The cystoscopy was not indicated
- Lack of informed consent for the cystoscopy
- Lack of informed consent for the Coumadin
- Failure to warn patient of the increased risk of bleeding

Case #1 – Disposition

- The plaintiff failed to produce expert testimony supporting the allegations against the urologist and he was dismissed from the case.
- The case against the cardiologist went to trial.

Case #1

- The plaintiff's expert was a reputable cardiologist who had published several papers on Coumadin use in Atrial Fibrillation.
- He had testified as an expert witness only one time previously (4 years earlier and for the defense).

Case #1

- The plaintiff's expert testified that that Coumadin should have been discontinued when it became clear that it could not be safely managed.
- He also testified that the Coumadin was not adequately monitored.
- He was well-spoken and very credible.
- The defense did not cross-examine the plaintiff's expert.

Case #1

- The jury was unable to reach a verdict and the case ended in a mistrial.
- A new trial was scheduled.
- The parties subsequently agreed to settle the case and a payment of $65,000 was made on behalf of the cardiologist.

Case #1 – Medical-Legal Summary

RISK FACTORS

Coumadin

Noncompliance

Physician Family Member

Case #1

POINTERS

Co-management

Deference to Protocol/Guideline

Weighing the Risk/Benefit Ratio

Case #1

OUTCOME

Good

$92,500

Case #2

71-yr-old AAM

- PMH
  - HTN
  - Right nephrectomy (knife wound)
  - Bipolar disorder
- Initial Presentation
  - December 17, 2006, presented to ED with abdominal pain, nausea and vomiting of two days duration.
- Physical Exam
  - BP 116/72
  - Moderate obesity
  - Moderate, diffuse abdominal tenderness, no mass, BS present
  - Harsh systolic murmur
- Creatinine 5.3
  - KUB - air-fluid levels, ? Dilated loops of bowel
  - Urinalysis – unremarkable
  - CXR - tortuosity and dilatation of the aorta; chest CT suggested

Case #2

- 9 PM patient seen by surgical intern
- NG tube placed to suction
- Admitted to surgery, ? SBO, renal failure

Case #2

The following day (12/18/06)

- 8 AM - less abdominal pain
- 9 AM - CXR unchanged, KUB unremarkable
- 1 PM - ECG HR 100; sinus rhythmn
- 3 PM - Pt c/o dyspnea, 2L nasal cannula, renal consult ordered
- 4 PM - Renal sonogram normal L kidney, absent R kidney
- 5 PM CXR - unchanged
- 6 PM - Cardiology Consult ordered
- 7 PM - Transthoracic echocardiogram: LV thickening, mild aortic regurgitation
- 10 PM - cardiologist saw patient
  - Less dyspnea
  - Chest CT ordered for AM

Case #2

December 19, 2006

- 1 AM - BP 100/54 and O2 sat 95% (2L O2)
- 4 AM - BP 94/50
- 8 AM, SBP 80, O2 sat 90% (Face Mask O2)
- Unable to go for Chest CT
- 9 AM Patient transferred to ICU
- 10:30 AM Patient died

Case #2

Autopsy revealed that the patient died from a complete dissection of the aorta extending to the aortic bifurcation and involving the renal arteries.

Case #2 – Lawsuit Allegations

A lawsuit was filed against the three surgeons who saw the patient , the surgeons' practice (P.C.), two residents, the cardiologist, the radiologist, and the hospital alleging:

- Failure to obtain chest CT or TEE
- Delay in diagnosis of the aortic dissection.
- Misdiagnosis of the patient's abdominal pain
- Failure to obtain CT surgery consult.
- Failure to properly supervise the residents
- Failure to properly interpret the CXR
- Failure to properly interpret the echocardiogram
- Failure to obtain the patient's informed consent

Case #2 – Disposition

- The plaintiff produced credible expert testimony as to the various allegations.
- The case was settled on behalf of the Professional Corporation which employed the surgeons for $360,000.
- The hospital (which employed the residents and the radiologist) settled for an undisclosed sum.
- All of the physicians were released without a payment being made on their behalf.

Case #2 – Medical-Legal Summary

RISK FACTORS

Sunday Night Admission

Renal Failure Admitted to Surgery

Case #2

POINTERS

"Why is this guy on my service?"

"What are we doing for this guy?"

Move the Diagnostic Process Forward

Case #2

OUTCOME

Not So Good

Delay in Diagnosis

Avoided NPDB

Case #3

48 yr old white man

- No significant PMH
- Smokes 1 PPD
- September 2003 - Seen by PCP for abdominal pain of several months duration
- Pain described as upper abdominal, “aching” and intermittent

Social History
- President of a local bank
- Married, 3 children (14, 11, 9 yrs)

- PE unremarkable, hemoccult negative
- CBC – normal
- Referred to GI for EGD

Case #3

- October 2003
- Patient seen pre-EGD in endoscopy suite by Physician Assistant from gastroenterologist’s office
- Brief H & P - unremarkable
- Informed consent obtained
- EGD performed by gastroenterologist
- No significant pathology
- Report sent to PCP

Case #3

December 2003 - January 2004
- Visits to PCP
- Pain somewhat improved with Prilosec
- Upper GI – no significant abnormality

May 2004
- Visit to PCP
- Pain persists, 10 lb weight loss
- CT – pancreatic mass
- Diagnosed as pancreatic cancer
- Undergoes radiation treatment

September 2005
- Patient dies of his disease (at age 49)

Case #3 – Lawsuit Allegations

A lawsuit was filed against the gastroenterologist, the PCP and the radiologist alleging:

- Improper interpretation of the UGI
- Improper performance of the EGD
- Delay in diagnosis of the pancreatic cancer
- Failure to perform a thorough History and Physical
- Failure to obtain the CT scan in a timely manner
- Lack of informed consent
- Failure to consider the patient’s risk factors for pancreatic cancer.
- Failure of the radiologist and gastroenterologist to directly discuss the results of the Upper GI and EGD with the PCP.

Case #3 – Disposition

- The plaintiff attorney who initially handled the case left the law firm and the case was neglected. The plaintiff failed to respond to the defendant's requests for documents and several court imposed deadlines were not met.
- After no activity for 14 months, the defendants moved for dismissal.
- The court denied the defendant's motion, allowed the law firm to assign new counsel, and issued a new timeline for conducting discovery.

Case #3

- The case proceeded through discovery. The defendants made several, unsuccessful attempts to limit the nature and scope of the evidence which could be introduced at trial.
- Due to the unfriendly venue and high sympathy factor, the case was settled prior to trial on behalf of the PCP ($540,000), the gastroenterologist ($420,000), and the radiologist ($90,000).

Case #3 – Medical-Legal Summary

RISK FACTORS

Perfect Plaintiff

Procedure with an Unfamiliar Patient

"Stealing" the Patient

Case #3

POINTERS

Make Good Use of Your "Gut Feeling"

Take Care of the Patient

Pick up the Phone

Case #3

OUTCOME

Not Good

Ideal Plaintiff

Bad Result

Unfriendly Venue