Closed Claim Review: The Will to Win

By Tim Behan, JD

The prospect of being sued is unnerving at best, terrifying at worst. Although I don't know this from personal experience, I have talked to hundreds of our providers when they have called to report a lawsuit that has been filed against them. Thus, I know the range of emotions that most of the readers of this article, who have been through a medical malpractice lawsuit, experience. Any concern is only exacerbated when the patient has suffered a catastrophic injury or there has been a loss of life. Even if that is not the case, the stress is real. That is the negative part of this article. The positive part is that what seem like worst case scenarios can turn out to be wins. Any provider who has been through a lawsuit with us knows that they are assigned an excellent defense lawyer and have the full backing of the SVMIC claims team to navigate your way through the process. But that is only two thirds of what is needed to be successful regardless of how success is defined. The last third of the equation is you, the reader. And what is needed from you is the will to win.

In giving lectures or presentations, I have found that what providers love the most are war stories. Particularly when there is a positive ending. I am going to write about three cases

that were dangerous and complicated. All three resulted in defense verdicts due to the defendant providers believing in their care, themselves, and being invested in the process with their defense lawyers. The first involved a case out of Kentucky with a 55-year-old female who cleaned horse stables. She presented to the ED with paraspinal tenderness in the left mid-back area along with point tenderness over the paraspinal muscles. She was treated and released with medications for pain and muscle spasms. This was the beginning of a tortuous yearlong course. The ending of the medical story is that the patient developed an infection that seeded in her spine, diskitis. The diskitis finally became angry and ate away the spinal column leading to paraplegia. The basis of the lawsuit involved the multitude of visits to her primary care physician and the local ED for an array of medical issues. Essentially, she went through a year of treatment with various providers for various issues but during this time the diskitis was never completely addressed with curative long-term IV antibiotics. Instead, the patient received occasional oral antibiotics that had the effect of slowing but not eliminating the spinal infection. But the patient's PCP informed her that she had diskitis. This physician had even offered to pay her travel expenses to Louisville to allow treatment for this condition. But the patient refused. Then, she repeatedly presented to the ED but never disclosed that she had diskitis. The patient allowed this condition to go untreated and became paralyzed. The lawsuit was filed against her PCP, the ED physicians, the surgeon who removed the abscess, and a hospitalist who had cared for the patient. These five physicians were adamant that they had provided great care based on the information they had available to them in real time. They never wavered on their desire to have their day in court to defend their care. Their confidence and resolve, along with excellent expert support, made the decision easy to take this case to trial despite the potential for a large verdict due to the patient's paraplegia. After six days of trial, the jury unanimously agreed that none of the physicians had deviated from the standard of care and returned with a defense verdict for all.

There are moments in our history when the resolve to keep fighting can be tested by the passage of time. Well over a decade ago, a 25-year-old male presented to a suburban Alabama ED and reported having sharp chest pain, radiating to the left arm as a tingling sensation, and sweating that started when he became upset at work. During triage, he reported that the pain was gone. After taking a history, performing a physical examination, and reviewing an EKG, our emergency room provider diagnosed the patient with "CP [Chest Pain] – Resolved." Our provider instructed the patient on medications to take and told him to follow-up with his primary care provider. The patient was found deceased at home the next morning by a relative. The autopsy report listed coronary atherosclerosis as the cause of death with no acute MI seen, and no complete arterial occlusion or PE seen. Suit was filed and the allegations against our provider were failure to properly evaluate, diagnose and/or treat the patient's underlying heart disease, misinterpreting the EKG, failure to perform a medical screening exam, and failure to stabilize the patient before discharge. To counter these allegations, our defense lawyers obtained expert opinions from five very credible experts. The first said that the patient was an "unusual host" due to his young age as well as his presentation. Because of these elements, the slightly abnormal EKG was not concerning. He too would have discharged the patient. Our next expert supported the evaluation and discharge, saying the patient was unlikely to have

survived the event even if he had been hospitalized. Our third concurred with our second expert and added that even if the patient had been kept for enzymes and scheduled for a stress test the following morning, he would not have survived. Our expert cardiovascular pathologist believed the patient died from a fatal arrhythmia caused by stenosis and ischemia. Our fifth expert believed our provider had no reason to suspect CAD in a patient of this age and physical condition. Trial dates were set and continued multiple times. The litigation bogged down for other various reasons. And then a pandemic hit further delaying the trial. What was consistent during this time, however, were demands by opposing counsel to settle the case. But each time, our provider said no. We fully supported that decision each time. Finally, the trial took place. It lasted two weeks. It was emotional when the family members testified. Two jurors sobbed during the mother's testimony. Our experts performed at peak level as did our provider while on the stand. On the tenth day the jury got the case to decide. It only took them an hour to give a unanimous defense verdict for our ED provider.

A few years ago, in a small town in Arkansas, an 85-year-old male was admitted to the hospital after being diagnosed with flu. He was stabilized and appeared to be doing well. But late in the evening, he had an acute event. His heart rate was in the 150s, his oxygen saturations were in the 60s, and he was unresponsive and struggling to breathe. The RRT was called. One of the members of that team was our insured nurse practitioner assigned to the ICU that night. She, as well as nurses and two hospitalists, quickly arrived to the room. Based on the circumstances, all the providers agreed they needed to intubate him before taking him anywhere. Our NP covered her standard pre-intubation checklist and prepared to intubate him. She tilted his head and lifted his chin. In doing so, she realized his neck was very stiff. There was not any flexion in his neck, even when they removed the pillow from under his head. He had no range of motion in his neck. She gave etomidate to relax the patient and make it easier to manipulate his stiff neck and allow her to more easily achieve the airway. She asked for the glidescope. As she was working with the glidescope and starting the intubation, she heard a pop. It happened when she was lifting the chin. Immediately when the neck popped, it flexed with the tension alleviated, and she was able to secure an airway. The patient's O2 sats immediately increased and the patient was taken for testing as to the cause of the acute event. A few weeks later the patient succumbed to his flu and passed away. To our surprise, a lawsuit was filed alleging that our NP broke the patient's neck during the intubation causing the patient's death. The allegations were that she should not have intubated him because they could have kept bagging him and transported him to a more controlled setting to get the intubation done; she should have waited for the EM MD to come to the room to assist with the intubation; and/or when she started prepping the patient for intubation and recognized a stiff neck/no neck ROM, she should have abandoned the intubation or changed technique. What was discovered after the intubation was that the patient had a condition known as diffuse idiopathic skeletal hyperostosis (DISH). This was unknown to anyone at the time of the intubation. We quickly developed strong expert support that immediate intubation was required, or the patient would have passed away. The allegation of waiting for the ED physician to arrive was easily refuted as that provider was treating another emergency at the time. But most importantly, we had proof that our NP was by far the most qualified

available provider to perform the intubation as she had performed over 300 of them prior to this event. No other available provider had ever intubated a patient. As the trial date approached, opposing counsel made a settlement demand on our NP. Her defense lawyer was duty bound to tell her of the demand even though we all agreed that this case needed to be tried. Emboldened by the strong defense that had been built, our NP replied that she had no desire to settle the case because “I did not do anything wrong.” We completely agreed as did the jury. It only took them an hour and half after a five-day trial to render a unanimous defense verdict in her favor.

These three cases are but a small sample size of the defense verdicts we have had over the years. But all three exemplify that even when the medicine is complicated, the facts are contested, and the outcomes are devastating, trials can be and have been won. The common thread through these three cases, and all the others, is the providers’ belief in themselves and being an advocate for their care with the aid of defense counsel and SVMIC. It takes a team effort to prevail in these cases. But more to the point, what impresses juries and ultimately carries the day is the defendant provider and how they perform at their deposition and at trial. When there is a will to win, there is a likelihood of success. I know because I saw it firsthand in all three of these cases.

The contents of The Sentinel are intended for educational/informational purposes only and do not constitute legal advice. Policyholders are urged to consult with their personal attorney for legal advice, as specific legal requirements may vary from state to state and/or change over time.