Tragic Outcomes Don’t Equal Bad Medicine

By John T. Ryman, JD

This case is a good example of circumstances we sometimes encounter where the outcome is tragic, although the medical care by our insured physician was appropriate and caused no harm. The magnitude of the injury fuels the pursuit of the lawsuit. A case like this will garner great sympathy for the patient from everyone involved, is a professional tragedy for the doctor, and creates significant anxiety about the risk of trial.

This patient’s outcome is unquestionably tragic. Eve* was a pregnant 22-year-old with a history of smoking and obesity as well as a family history of venous thrombosis. At 30 weeks' gestation she presented with placental abruption and fetal demise requiring an emergency cesarean section. On postoperative day five, she presented to the emergency department with chest pain and shortness of breath. On exam, a nurse and physician’s assistant both documented good pulses in all extremities. A chest CT angiogram was negative for pulmonary embolus. She was seen by her obstetrician and discharged. When she was seen in her obstetrician’s office the following day, Eve reported that her foot felt

like it was asleep. Her OB reported no lower extremity tenderness. If pulses were evaluated, it was not recorded. Two days later, Eve presented to the local emergency department complaining of left lower extremity pain. She was found to have 2+ pulses in her right foot and 1+ pulses in the left foot, with sensation and motor function. Her left lower extremity was cool despite good pulses in all extremities. There was discoloration on the plantar surface of her left foot. Eve was transferred to a higher-level facility. On presentation she was found to have a discolored left foot. Venous and arterial ultrasounds were negative for major vessel thrombosis. She was discharged but returned eight days later to the same hospital. At that time there were no pulses in her left foot. Our insured surgeon, Dr. Jones, was consulted. Since she had preserved motor function and sensation, and symptoms were not considered acute, Dr. Jones recommended intravenous anticoagulation with Heparin. The next morning Dr. Jones recommended arteriography and surgical intervention. Dr. Jones made an extensive attempt at removing arterial blood clots found throughout Eve's left leg but found no flow into the smaller arteries. Four days later he performed a below-the-knee amputation.

The patient filed suit against eight physicians alleging medical negligence. With respect to our insured, the plaintiff's experts were critical that Dr. Jones deviated from the standard of care by failing to use TPA as a first measure, that use of mechanical thrombectomy caused downstream embolization that made distal occlusions worse, and that Dr. Jones was not qualified and should have consulted an OB/GYN prior to further treatment.

The defense theme was that Dr. Jones considered administering TPA, but it was not appropriate to attempt given the timing and unresponsiveness to other interventions. Imaging showed that there was significant clotting that had been present for more than a week when Dr. Jones first saw the patient. During the procedure, Dr. Jones used a spider wire basket to catch embolization when he attempted to recanalize the proximal clot. He also used spot imaging during the procedure, before and after and found no evidence of downstream embolization. The unfortunate fact was that the patient's leg was not salvageable by the time she saw Dr. Jones and had not been salvageable for a significant period of time before his treatment. Of course, both the plaintiff and defendants had medical experts to support their positions.

It seemed that the medical care was appropriate, and the biggest risk was sympathy for the young plaintiff and the potential for a large verdict. The plaintiff would claim physical and emotional pain and suffering, and that the injury would limit her employment prospects. A juror would have to be pretty cold-blooded not to sympathize with this young woman.

The defense team obtained reviews of the care from multiple physician experts. The clear consensus was that Dr. Jones met the standard of care and exercised appropriate professional judgment. Further, by the time Dr. Jones was consulted there was nothing he could have done to prevent the unfortunate outcome. Dr. Jones was quite concerned about the case and at times waivered in his resolve to go to trial. His concerns were normal and common. However, his defense counsel helped him to choose the course of

proceeding through trial and defending his care. This turned out to be the right choice. We did not believe that this was a case of medical negligence by Dr. Jones and strongly supported him throughout the process. As part of our analysis, the case was reviewed and discussed thoroughly both in-house and with defense counsel. We were convinced that the care provided by Dr. Jones was appropriate and deserved to be defended, and further, that a jury would likely agree. Every case is unique, and they all involve risk, some more than others.

The case proceeded through a two-week trial. By the time the case was submitted to the jury for a decision only three defendants remained, including Dr. Jones. After two days of deliberations the jury had reached a verdict on two defendants but was at an impasse as to the third. The jurors presented a verdict in favor of Dr. Jones and one other defendant but were unable to reach a verdict as to the third defendant. The Court declared a mistrial. Defense counsel for Dr. Jones filed a Motion with the Court to enter judgment in favor of Dr. Jones notwithstanding the mistrial. The Court denied the Motion, and defense counsel subsequently filed a new Motion for judgment in favor of Dr. Jones, arguing that the jury found that Dr. Jones did not deviate from the standard of care, which is the threshold liability issue, and the jury's decision covered all issues against Dr. Jones. In response to this second Motion, the Court set aside the mistrial as to Dr. Jones and entered a defense verdict. Thus, the trial against Dr. Jones was successfully concluded.

As is often the case, the defendant doctor was the most important witness. Everyone else simply provided support. In his deposition and later at trial Dr. Jones was an excellent witness. He explained his medical decision-making in a simple and understandable way. He presented as a competent, caring physician, and a good teacher. In previous editions of this newsletter, we have addressed the challenges of a physician entering the courtroom arena. It is not an easy path. Dr. Jones entered, fought, and won.

Often, we have found, as we did in this example, that defending good medical care with a good doctor and experienced defense counsel is often a successful strategy. It is unfortunate that a tragic outcome will often lead to stressful litigation, but good medicine can be effectively defended through trial when the defendant physician and defense counsel work closely together, supported in their efforts by SVMIC.

*The names have been changed as a courtesy to the persons involved.
