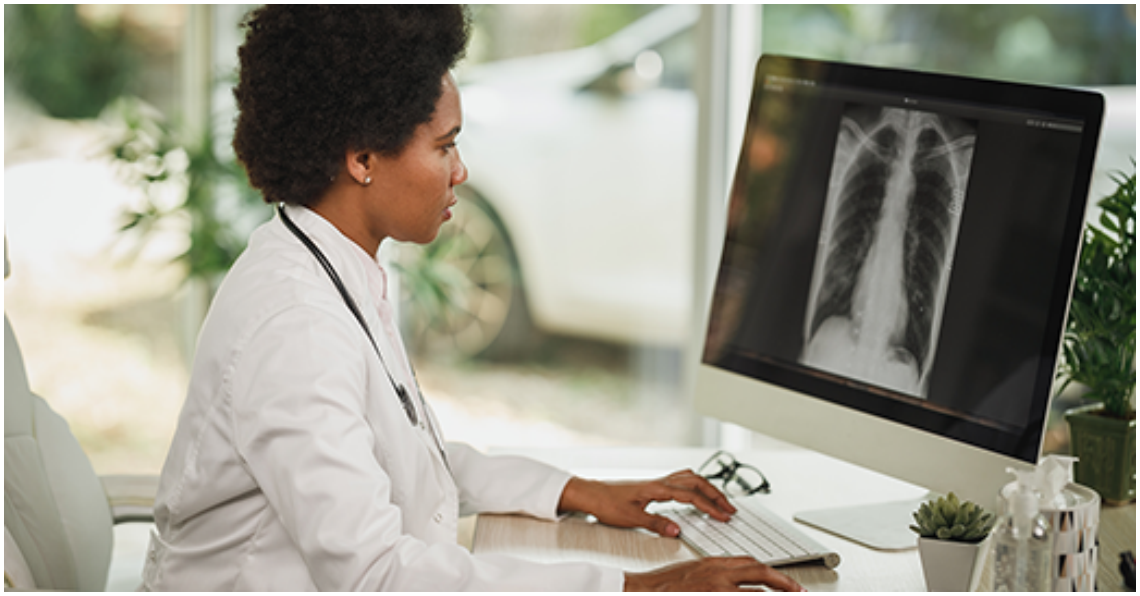
Seeing the Invisible



By John T. Ryman, JD

“Vision is the art of seeing what is invisible to others.” Jonathan Swift

Swift died in 1745, 150 years before Wilhelm Conrad Rontgen accidently discovered X-rays. So, of course, Swift was not talking about radiology, but when I saw this quote recently, it reminded me of this case.

Josh Able was a 14-year-old high school football star. Like many teenagers, Josh liked to relax with video games and junk food. After an evening of overindulging in snacks, Josh did not feel well when he awoke early the next morning.

Josh arrived with his mother at the emergency room shortly after 5:00 a.m. on April 17, 2020, with complaints of right lower quadrant pain, nausea, and vomiting. Josh’s appendix could not be visualized on an abdominal ultrasound. The abdominal exam by the Emergency Room (ER) physician was benign. However, Josh was transferred to a local children’s hospital with concern about possible appendicitis. When Josh arrived there mid-morning, his blood pressure and white blood count were elevated. He had a history of hypertension. Josh reported that he had been nauseous since the day before with persistent abdominal pain that migrated to his right lower quadrant. The ER physician ordered a Computed Tomography (CT) scan of the abdomen and pelvis with contrast. The

CT was interpreted by our insured, Dr. Baker. In his report, Dr. Baker noted that “the vermiform appendix is normal in appearance… no acute findings.” The ER physician, based on his physical exam and the report from Dr. Baker, gave Josh morphine and Zofran and discharged him in stable condition. Josh and his mother were instructed to immediately return to the ER for evaluation if he developed intractable pain, nausea, or vomiting.

On April 20, Josh went to a primary care clinic where he reported that symptoms including nausea, vomiting, and diarrhea had been ongoing for four days and had worsened. An abdominal X-ray was obtained with an impression of nonobstructive bowel gas. A blood test was ordered, and Josh was discharged. His mother received a phone call from the clinic the following morning advising her that, based on the blood test results, she should take Josh to the nearest ER.

At the ER, a CT scan with contrast showed that Josh had evidence of a ruptured appendix with multiple intraperitoneal abscesses. Josh was transferred by ambulance to a children’s hospital where an intraabdominal drain was placed. The drain was removed on April 26 prior to discharge. On May 1, Josh was readmitted with recurrent abdominal pain and fever. A new drain was inserted and remained until May 13. Josh underwent removal of his appendix on July 21. Thankfully, within a few months Josh had fully recovered and was playing football for his high school and ultimately went on to play college football.

Approximately one year after the medical care by Dr. Baker, Josh’s parents filed a lawsuit on his behalf against Dr. Baker and his group. The plaintiffs alleged that Dr. Baker failed to diagnose appendicitis, and that the failure caused injuries.

Dr. Baker’s defense team built a defense based on the theme that Dr. Baker’s interpretation of the CT scan was within the standard of care. Only with the benefit of hindsight could one possibly identify elements in the imaging that might be subtle indications of appendicitis. Defense attorneys for Dr. Baker retained two radiologists and two general surgeons who supported the defense theme. More specifically, the experts believed that Josh did not have appendicitis when he presented to the hospital on April 17, and thus surgical treatment was not indicated. The facts indicated that appendicitis probably developed on the 18th or 19th.

About four and a half years after Dr. Baker interpreted the CT scan, the case went to trial. Dr. Baker and his group were the only defendants. The plaintiff’s radiology expert supported the plaintiff’s theory that the findings on the April 17th CT were consistent with appendicitis, and that Dr. Baker should have reported those findings to the ER doctor. The plaintiff had emergency medicine and surgical experts who supported the assertion that if Dr. Baker had accurately identified the appendicitis, a surgical consult would have been oobtained,and surgery could have been performed to avoid the rupture and subsequent hospitalization.

The trial lasted six days. After hearing all the facts, the jury was asked to answer the essential question of, “Do you find the Defendants to be at fault?". After about 90 minutes of deliberations, the jury said “No”. There was no need for the jury to answer any other

questions. At trial the defense team and Dr. Baker successfully educated the jury on the facts. The jury understood that Dr. Baker met the standard of care and found that he was not responsible for any injuries to Josh.

It is generally accepted that the most important witness in a medical negligence trial is the physician defendant. In this case, Dr. Baker did a very good job defending his care by educating the jury. He showed the jury that the findings he allegedly missed on imaging were extremely subtle and inconclusive. The defense experts explained that the imaging was normal, and the alleged abnormal findings were only perceptible with benefit of hindsight. Dr. Baker did not “miss” anything.

The easy approach when encountering a lawsuit alleging that a “miss” by a radiologist caused injury is to think it is a simple case and one that should be settled. The harder approach is to dig into the details, and with the help of our insured doctor, defense counsel, and defense expert consultations, learn and understand the facts. Maybe it was simply a “miss”, or maybe not. In this case, we found that it was not a “miss”. Through a thoughtful, deliberate process, we learned that Dr. Baker met the standard of care. This process can be difficult and challenging. It is not an easy path for the doctor or the defense team. It requires competence, perseverance, and toughness. The process of litigation, including depositions and trial, is difficult for a doctor. In his book, Do Hard Things, Steve Magness said that “[r]real toughness is experiencing discomfort or distress, leaning in, paying attention, and creating space to take thoughtful action.” We are acutely aware of the challenges faced and impressed by the toughness Dr. Baker demonstrated in this case.

*Names of the parties have been changed.
