Swift Justice: The Malpractice Case That Ended Almost as Soon as It Began

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Previous closed claim articles have highlighted cases resulting in a loss payment made by SVMIC. As a change of pace to start off the new year, this closed claim article discusses a case that went to trial and resulted in a defense verdict for a SVMIC-insured physician.

Marlon Stone, a 44-year-old male patient, had an episode of severe chest pain at his home during the evening hours of April 24. He considered having his wife drive him to the ER, but he changed his mind after the pain subsided. He made an appointment on April 25 to see Dr. Hall on April 26 at 3:00 PM. During the morning hours of April 26, Mr. Stone had another episode of severe chest pain. He presented to a walk-in clinic and was seen by a nurse practitioner. His medical history, noted by the provider, included one pack per day of tobacco use, a cough of one week duration, and history of GERD. At the time of the visit, Mr. Stone specifically denied chest pain sweats, chills, fever, sore throat, wheezing, myalgia, headache, nausea, vomiting, or shortness of breath. His exam showed normal

vital signs, no acute distress or other evidence of acute respiratory infection, and his ENT exam was also normal. Mr. Stone's chest exam was normal on auscultation without wheezing, rhonchi or rales. There was no stridor or cardiac abnormality during the exam. The nurse practitioner diagnosed the patient with sinusitis and instructed him to, "Call 911 or proceed to the nearest emergency department if you develop shortness of breath, chest pain, or other symptoms that concern you." Mr. Stone was instructed to follow up immediately if his symptoms worsened or if he developed new symptoms and was strongly advised to see Dr. Hall later that day. The nurse practitioner prescribed Augmentin Mucinex, Prednisone, and promethazine/dextromethorphan as cough syrup.

Mr. Stone presented to Dr. Hall's office at 3:00 PM later that day as scheduled. He related his principal complaint as GERD with associated esophageal burning that was improved with Prilosec. He stated the symptoms were associated with discomfort in the center of his chest radiating into his left arm and left neck that had started 3 days earlier. The pain lasted 5-10 minutes and improved with position change. He denied any other associated symptoms. His exam showed a relatively low systolic blood pressure, normal pulse, normal oxygen saturation, and that he was mildly overweight and in no distress. His HEENT, pulmonary, and cardiac exams were all normal except for clear nasal discharge consistent with the previously noted sinus condition. His cardiac exam noted a "normal rate, regular rhythm, and no murmurs." An EKG was normal in rate and rhythm and with no morphologic changes except for a computer description of "borderline left axis deviation." Dr. Hall's EKG assessment suggested there were no significant abnormalities. A "Total Risk Score" was deemed to be 0, suggesting that Dr. Hall considered cardiac disease, but a logical assessment of cardiac risk was not clinically apparent. Despite this negative assessment, Dr. Hall decided as a matter of caution to refer Mr. Stone to a cardiologist. Dr. Hall also recommended weight loss, diet, exercise, and abstinence of tobacco products.

Mr. Stone left Dr. Hall's office shortly before 4:00 PM and returned home. A 911 call was made by a delivery driver at 5:45 PM stating he found Mr. Stone on a couch, and he was cold to the touch. (The driver knocked on the patient's door and could see through a window that he was on a couch. When the patient did not respond to the knocking, the driver went in the house through the unlocked door.) The coroner ruled Mr. Stone had experienced a natural and sudden death and suspected a myocardial infarction.

Mr. Stone's estate filed suit against Dr. Hall and his group. The estate alleged that Dr. Hall should have sent Mr. Stone to the ER based on his presentation and examination at Dr. Hall's office rather than referring Mr. Stone to a cardiologist where he would be seen at a later date.

There were some facts in this case that worked in Dr. Hall's favor. Mr. Stone was only 44 years old, with his weight and smoking habit as the only risk factors, he had a negative formal cardiovascular risk assessment that was performed by Dr. Hall. Mr. Stone gave a positive history of GERD, which is responsive to Prilosec. He had no physical findings suggestive of cardiac disease, and his EKG was only marginally abnormal. Mr. Stone

showed no physical signs of cardiac disease during his exam, although he did have nasal congestion, suggesting either an allergic or infectious origin. With a negative cardiac risk assessment, Dr. Hall recommended a cardiac referral in order to fully rule out cardiovascular disease.

Unfortunately, there were some facts that worked against Dr. Hall as well. The historical findings of left arm and neck pain and mid chest symptoms that Mr. Stone related as beginning three days earlier caused Dr. Hall to consider possible cardiac disease. The estate's expert witness used this information to try to prove that Dr. Hall should have sent Mr. Stone to the ER rather than refer him to a cardiologist. Also, there was a significant delay in the transcription of the medical records which was used against Dr. Hall in order to question the truthfulness of the dictation. The delay was especially difficult in this fact pattern, because the transcription occurred after the patient was deceased. This type of scenario can cause a jury to question the truthfulness of a physician's testimony, making the physician appear less credible. Both the plaintiff and the defendant in medical malpractice cases are required to have expert witnesses who will testify at trial. If all of the expert witnesses appear credible, then a jury may rely upon the testimony of the defendant even more so than usual. If a jury considers a defendant's testimony to be less than credible for various reasons, such as a delay in transcribing a dictation, it could be a factor making it difficult for a jury to return a defense verdict for the physician.

The estate's attorney made a demand for damages to try to settle this case soon after the lawsuit was filed rather than go to trial. However, Dr. Hall was not interested in trying to settle this case, and expert reviews were supportive of Dr. Hall's care. The trial lasted a week, and the jury returned a defense verdict for Dr. Hall and his group just ten minutes after deliberations began. The estate chose not to file an appeal, and the file was closed without a loss payment being made.
