WHAT'S THE VERDICT?
Medical judgments and settlements

COMMENTARY PROVIDED BY
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Inadequate follow-up ends in a kidney transplant

SMALL AMOUNTS OF PROTEIN AND BLOOD appeared in urine samples obtained during routine screenings of a 34-year-old man by his primary care physician. The doctor never told the patient about the proteinuria and reassured him that the presence of blood was normal for some adults and nothing to worry about.

The physician requested a urology consult on 1 occasion, but no cause was found for the blood and protein in the urine. After a further work-up, the primary care physician concluded that it was benign. The urologist maintained that it wasn't his job to do a workup for kidney disease or proteinuria; a kidney specialist would normally do such a work-up.

The blood and protein in the patient's urine increased during subsequent years. The primary care physician didn't order additional testing or consult a kidney specialist.

At a routine physical exam 5 years after the initial finding of proteinuria and hematuria, the patient's blood and urine screening tests were grossly abnormal; he had anemia and kidney failure and needed immediate hospitalization. The primary care physician didn't tell the patient about the abnormal test results because he didn't see them—a lapse he blamed on a system error and office staff.

Several weeks after his latest doctor visit, the patient became acutely ill. His kidneys stopped functioning, and he went into hypertensive crisis. He was hospitalized and IgA nephropathy was diagnosed. His kidneys never recovered. The patient was placed on hemodialysis and received a kidney transplant 6 months later.

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The cases in this column are selected by the editors of *The Journal of Family Practice* from *Medical Malpractice: Verdicts, Settlements & Experts*, with permission of the editor, Lewis Laska (www.verdictslaska.com). The information about the cases presented here is sometimes incomplete; pertinent details of a given situation may therefore be unavailable. Moreover, the cases may or may not have merit. Nevertheless, these cases represent the types of clinical situations that typically result in litigation.

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PLAINTIFF'S CLAIM Although IgA nephropathy has no known cause or cure, it can be treated with diet modification, lifestyle change, blood pressure control, and medication. With proper diagnosis and treatment, the patient would have retained kidney function for another 2½ years or more.

DOCTORS' DEFENSE Earlier diagnosis would have prolonged kidney function for only about 6 months.

VERDICT $400,000 Massachusetts settlement.

COMMENT *Blaming a bad outcome on "a system error and office staff" is unlikely to be a winning defense in a court of law.*

Teenager dies of undiagnosed pneumonia

A 16-YEAR-OLD GIRL was taken to the emergency room with diarrhea, fever, a nonproductive cough, chest pain, and rhinorrhea. The pediatrician and nurse who examined her found no abnormalities of the lungs, respiration, or oxygenation. A viral syndrome and/or infection of the upper respiratory tract was diagnosed. The girl was discharged with instructions to see her primary physician and return to the ER if her condition worsened.

The patient saw her pediatrician 3 days later after becoming increasingly weak. The pediatrician noted abnormalities in her respiration. He diagnosed a virus but prescribed antibiotics, and told the girl to return if her condition became worse. The girl didn't return and died 3 days later. Her death was attributed to pneumonia.

PLAINTIFF'S CLAIM The pediatrician and nurse in the ER should have diagnosed pneumonia. The differential diagnosis in the ER should have included pneumonia, and the patient shouldn't have been released until pneumonia had been ruled out. The patient's pediatrician should have given IV antibiotics and ordered a chest radiograph and white blood cell count.

DOCTORS' DEFENSE The patient's symptoms were characteristic of a viral infection and not typical of a bacterial infection. The pneumonia originated after the patient was last seen and was an aggressive form.

VERDICT $3.9 million New York verdict reduced to $500,000 under a high/low agreement.

COMMENT *Our worst nightmare: treating a patient appropriately by withholding antibiotics (in the case of the emergency room staff) followed by a catastrophic outcome. This case is a great example of why we practice defensive medicine and what's wrong with our tort system.*

The nurse practitioner consulted the physician twice during the visit, but the doctor never examined the patient.

Serious symptoms and history fail to prompt stroke work-up

A MAN WITH DIABETES AND HYPERTENSION went to his primary care physician's office complaining of right-sided headache, dizziness, some weakness and tingling on his left side, and difficulty picking up his left foot. The 56-year-old patient was seen by a nurse practitioner. The nurse consulted the physician twice during the visit, but the physician didn't examine the patient personally.

An electrocardiogram was performed. The nurse found no neurologic indications of a transient ischemic attack. The patient was sent home with prescriptions for aspirin and atenolol and instructions to return in a week.

The patient's condition deteriorated, and he went to the emergency department, where he was treated for a stroke. The symptoms progressed, however, leading to significant physical and cognitive disabilities.

PLAINTIFF'S CLAIM The physician and nurse practitioner failed to appreciate the patient's risk of a stroke and recognize that his symptoms suggested a serious neurologic event. Immediate referral to an ED for a stroke work-up and treatment would have prevented progression of the stroke and the resulting disabilities. The physician should have evaluated the patient personally. The patient had not received proper treatment for hypertension, diabetes, and high cholesterol for many years before the stroke.

THE DEFENSE The treatment given was proper; earlier admission wouldn't have made a difference.

VERDICT $750,000 Massachusetts settlement.

COMMENT *Supervision of midlevel employees carries its own risks. When in doubt, see the patient!*