COMMENTARY PROVIDED BY
Jeffrey L. Susman, MD

Biopsy, excision, or a referral could have avoided this million-dollar settlement.

Antibiotics fail to head off sepsis

SHORTNESS OF BREATH AND RIGHT-SIDED CHEST PAIN prompted a 45-year-old woman to go to the emergency department (ED) early one morning. She had a history of chronic lung problems with multiple diagnoses of pneumonia, pneumothorax, blebs, and bronchiectasis. The ED doctor diagnosed community-acquired pneumonia and admitted her for intravenous antibiotic treatment.

Late that afternoon the patient's condition deteriorated rapidly. She was transferred to the intensive care unit, where she died of septic shock caused by *Pseudomonas aeruginosa* 22 hours after she had arrived at the ED.

PLAINTIFF'S CLAIM The patient should have received broader-spectrum antibiotics.

THE DEFENSE The hospitalist who treated the woman as an inpatient claimed that the treatment she received was appropriate and that she probably would have died even if other antibiotics had been prescribed. The hospitalist also claimed that the nursing staff failed to notify her of the patient's low blood pressure readings until 10 hours after the initial evaluation. A nurse denied this claim, asserting that the hospitalist had been paged several times during the day. The discharge summary and nursing notes on the patient were missing.

VERDICT $5.28 million arbitration award.

COMMENT *It surprises me how often key portions of medical records go missing! Here, the absence of a discharge summary and nursing notes may well have contributed to a $5 million award.*

Change, and not for the better

AN ATYPICAL MOLE ON THE LEFT CALF was brought to the attention of a primary care physician by a 36-year-old man during a full physical. The mole was 1 × 1 cm; the patient reported that it had been changing. The mole's appearance didn't worry the physician, who described it in his notes as either a hemangioma or dermatofibroma. The doctor advised the patient to return in 6 months if he wanted the mole removed for cosmetic reasons.

Over the next 5 months, the patient noticed further changes in the mole and called the doctor's office. He was seen by a colleague of his physician, who immediately sent the patient for a biopsy and surgical consultation. The mole was removed and diagnosed as an ulcerating melanoma with downward growth.

Shortly thereafter, the patient underwent wide excision and lymph node dissection, which showed clear margins and no lymph node involvement. Twenty months later, a mass was found in the patient's liver. Biopsy diagnosed metastatic spread of the melanoma. The patient died 2 months later.

PLAINTIFF'S CLAIM The patient should have had a biopsy and received a surgical referral at the time of the physical examination when he first reported the mole.

THE DEFENSE Waiting for 6 months was appropriate because the mole didn't look like a melanoma when the patient first called it to the physician's attention. The melanoma had already metastasized at the time of the physical examination and the diagnostic delay didn't affect the outcome.

VERDICT $1 million Massachusetts settlement.

COMMENT *A changing mole should always raise concern. Biopsy, excision, or a referral could have avoided a million-dollar settlement.*

Failure to address persistent symptoms proves disastrous

PAIN IN THE BACK AND CHEST along with respiratory difficulty prompted a 49-year-old man to visit his physician. The physician told him to go to a hospital. The doctor who examined the patient at the hospital diagnosed muscle strain and prescribed muscle relaxants.

The following day, the patient returned to his physician complaining of continuing

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.

symptoms. The doctor sent him home. He died the next day of an aortic rupture caused by an undiagnosed dissection.

PLAINTIFF'S CLAIM The 2 physicians should have diagnosed the dissection, which would have permitted treatment and prevented death. The patient had been treated previously at the hospital, and his records should have raised suspicion of an aortic aneurysm. The hospital physician was a new hire and hadn't received proper training in the hospital's electronic records system. He should have ordered a computed tomography scan or cardiology consult. The patient's physician failed to address the ongoing symptoms. He should have hospitalized the patient at the time of the second visit.

THE DEFENSE The hospital physician claimed he had intended to contact the cardiologist who had treated the patient, but the patient couldn't remember the cardiologist's name. The patient's symptoms didn't suggest an aortic dissection, and the dissection occurred after the patient was discharged from the hospital.

VERDICT $3.4 million New York verdict against the hospital physician only.

COMMENT *Although the hoofbeats are usually horses, always remember the zebras (or should it be lions?), particularly when a patient returns repeatedly with ongoing symptoms.*

Controlled substances out of control

A WOMAN WITH CHRONIC MIGRAINES, anxiety problems, and nausea also had cardiomyopathy and chronic atrial fibrillation, which could be triggered by pain from her other ailments. She came under the care of a physician who prescribed a number of drugs, including meperidine, hydrocodone, tizanidine, diazepam, promethazine, alprazolam, and oxcarbazepine. The doctor prescribed injectable forms of certain medications after the patient told him her next-door neighbor was a nurse and could help administer the drugs.

Four years after coming under the doctor's care, the patient signed a Controlled Substance Agreement specifying that the physician would discontinue her as a patient if she got controlled substances from another doctor. (Evidence was later found that the patient was receiving prescriptions from other physicians.)

While under treatment by her doctor, the patient was hospitalized a number of times for medication overdoses. The record from one hospitalization reported that she had made angry, profanity-laced requests for meperidine and promethazine.

About 2 years after signing the Controlled Substance Agreement, the patient received prescriptions from her doctor for 210 doses of meperidine, 100 doses of promethazine, and 60 pills each of diazepam, alprazolam, and acetaminophen and hydrocodone. She filled the prescriptions at 2 pharmacies without objections from the pharmacists. She died of an accidental drug overdose the following month.

Postmortem blood testing showed high levels of meperidine and promethazine. The patient had apparently taken the equivalent of 11 "shots" of meperidine (5 times the maximum prescribed amount), probably by injecting herself through a peripherally inserted central catheter rather than by intramuscular injection, as prescribed.

PLAINTIFF'S CLAIM The patient's doctor was negligent in prescribing large amounts of controlled substances when he should have known that she was a drug seeker with a drug abuse problem. The pharmacies were negligent for filling the prescriptions without question.

THE DEFENSE The patient was solely responsible for her own death because she gave herself a large overdose.

VERDICT $500,000 Alabama verdict. The case against the pharmacies was dismissed.

COMMENT *Increasingly it is expected that physicians (and pharmacists) perform due diligence when prescribing opioids, including taking reasonable precautions against the drug-seeking patient.* **JFP**

For more on prescription drug abuse, see "Diagnosing and treating opioid dependence" on page 588.