Playing the Telephone Game: Can the Correct Diagnosis Win in the End?

By Kathleen W. Smith, JD

Do you remember playing the telephone game as a child? This is the game where the first player selects a word to whisper to the next player, and so on and so forth, until you see whether the final player ends up with the same word. The game challenges its players to listen carefully and make accurate identifications – did you hear the correct word to pass along, or did you misunderstand the word spoken to you and pass along an inaccurate word? In this closed claim, our "telephone game" began with our physician's accurate evaluation and diagnosis of his patient's condition. The "telephone game" was interrupted by one unsupported, unsubstantiated diagnosis appearing on a single medical record. The patient's lawyer seized upon that diagnosis, built a case around it, supported the theory with expert proof, and ultimately argued the theory to a jury. To win his case, our doctor was called upon to disprove the plaintiff's theory and convince the jury that his

explanation was accurate and true. Spoiler alert: he did just that!

Mr. Martin*, 95 years old, unfortunately fell at his home and broke his hip. After undergoing an uneventful surgical repair and subsequent hospitalization, Mr. Martin was transferred to the Subacute Care Unit of the hospital for rehabilitation and further care. Dr. Jones was his attending physician during his stay in the Subacute Care Unit. As is common with a patient his age, Mr. Martin had many pre-existing comorbidities, including an extensive history of bilateral lower extremity peripheral artery disease and peripheral vascular disease with prior right and left femoral bypass grafting. On Admission Day 1, Mr. Martin complained of left calf tenderness. Suspecting a blood clot, Dr. Jones ordered a venous Doppler ultrasound. This was negative for DVT. Some mild color changes were noted in his left foot over the next several days, but the tenderness resolved, and Mr. Martin was otherwise stable and progressing with his rehabilitation.

On Admission Day 8, however, Mr. Martin complained of significant pain in his left calf and marked color changes were noted in his left leg. Recognizing the sudden change in Mr. Martin's condition and cognizant of his medical history, Dr. Jones ordered a stat arterial Doppler ultrasound. This imaging revealed a complete occlusion in the patient's left femoral artery up to the popliteal bypass graft. After receiving this report, Dr. Jones emergently transferred Mr. Martin back to the hospital for further care from a vascular surgeon. The surgeon determined that Mr. Martin's left leg could not be salvaged, and a left above knee amputation was performed.

Oddly, and without any context or further explanation, the surgeon who performed the amputation documented in the Operative Report that the Pre- and Post-Procedure Diagnoses were "compartment syndrome left lower leg with ischemia noted x 2 weeks." Nothing in the medical record supported this diagnosis. In fact, the medical records from both the Subacute Care Unit and the initial admission directly contradicted compartment syndrome as an accurate diagnosis. Mr. Martin experienced a distinct change in his condition on the morning of Admission Day 8. Femoral artery occlusion was seen on stat ultrasound. The pathology from the amputation surgery confirmed an acute thrombosis with no evidence of widespread tissue necrosis. Instead of suggesting compartment syndrome as the cause, the clinical presentation, imaging, and pathology were instead consistent with the sudden development of a catastrophic occlusion that caused a rapid decline in the condition of the left leg.

In the lawsuit that followed, however, the plaintiff alleged that Dr. Jones failed to recognize, diagnose, and timely treat Mr. Martin's developing compartment syndrome, causing the need for amputation. The plaintiff's lawyer secured an expert who supported this theory. The plaintiff's expert testified at trial that a compartment syndrome was missed by Dr. Jones and was the cause of the amputation.

In defense of his care, Dr. Jones denied Mr. Martin ever actually had a compartment syndrome. Instead, Dr. Jones explained Mr. Martin's long history of peripheral vascular and artery disease. Mr. Martin experienced a sudden catastrophic event related to this pre-existing condition. Dr. Jones demonstrated how he promptly responded to this

emergency by ordering the appropriate diagnostic test and then transferring the patient emergently to the hospital for further care. Two defense expert witnesses who testified at trial were fully supportive of Dr. Jones' diagnosis and decision-making. Further, the defense experts also denied the existence of compartment syndrome.

During the trial, the jury was presented with two competing causation theories. Both theories were supported by physician expert witnesses. It was up to the jury to determine which theory to believe. At the end of the four-day trial, the jury agreed with Dr. Jones' explanation of what happened and returned a defense verdict in his favor.

To prevail in the telephone game, the players need to listen carefully. The same is expected of our treating physicians. Inattentiveness, even just one imprecise or assumed diagnosis in a medical record, can cause significant subsequent trouble. Here, it served as the foundation upon which the plaintiff built his lawsuit. However, Dr. Jones never doubted his opinion on causation, even in the face of the plaintiff's competing theory supported by an adverse physician expert. Always confident in his diagnosis, care, and treatment of Mr. Martin, Dr. Jones patiently waited for the litigation process to work its way through trial. And, like the winning team in the telephone game, Dr. Jones prevailed at trial with a jury who was equally patiently listening to the two competing theories of what happened, weighing them, and choosing the correct one.

*Names have been changed.
