Your Adversary in a Lawsuit: It's Not Always the Plaintiff

By William "Mike" J. Johnson, JD

Debbie[i], a woman in her fifties, presented to the emergency department on a Saturday with left chest pain, left arm numbness, shortness of breath, nausea and vomiting; she had been experiencing vomiting for two days. The ED physician, Dr. Smith, noticed that she had slightly elevated blood pressure and that she was short of breath. An EKG was abnormal, with changes consistent with myocardial infarction and/or ischemia. Her cardiac enzymes were normal on the initial and repeat test, but a chest x-ray showed changes consistent with cardiomegaly. A second EKG showed the same abnormalities present on the first EKG. Debbie had a family history of hypertension and heart disease. The on-call cardiologist, Dr. Jones, recommended that Debbie come to her office within two days for a nuclear medicine stress test and recommended that she take aspirin daily. The cardiologist did not come to the hospital to examine Debbie. Debbie was instructed to see the cardiologist on Monday; however, she changed the scheduled appointment from Monday to Tuesday. She died of an acute myocardial infarction on Tuesday before making it to the appointment with Dr. Jones.

A lawsuit was filed by Debbie's husband against the emergency department physician, alleging that he failed to properly diagnose and treat Debbie, causing her death. The ED physician alleged comparative fault against the on-call cardiologist, contending that he had consulted with her on the patient's condition (including sharing the EKG results) and that the cardiologist recommended that Debbie be sent home and instructed to follow-up in her office. Subsequently, Debbie's husband amended his complaint to add the cardiologist to the lawsuit alleging that she should not have discharged Debbie, the stress test should not have been delayed, and she failed to correctly diagnose and treat Debbie.

Dr. Smith, the ED physician, contended that he told the cardiologist, Dr. Jones, that the EKG was abnormal. The cardiologist did not ask that the EKG be faxed to her and asserted that while she did not remember the conversation, if she had been told the patient had an abnormal EKG, she would not have recommended that Debbie be discharged. There was no documentation of the conversation between the two physicians.

Neither policyholder wanted to consider settlement, so the case proceeded to a trial that lasted for seven days. The plaintiff presented only one expert witness, an ED physician, who addressed the standard of care and causation. He testified that an ED physician should not have allowed the patient to be discharged from the emergency department, but should have instead taken whatever steps were necessary to make sure the patient was admitted or at the least should have demanded that the cardiologist make an in-person examination. This expert witness was not particularly strong or impressive.

Ironically, the defendant physicians arrayed multiple experts to testify against each other, and these experts were stronger witnesses than the plaintiff's expert (and helped the plaintiff's case). The defendant ED physician presented one ED expert and two cardiology experts along with his own testimony. One cardiology expert testified that Dr. Jones, the cardiologist, was required by the standard of care to personally review the EKG or go to the hospital to see the patient. Dr. Smith's other cardiology expert testified that Dr. Smith was within the standard of care by discharging the patient after consulting with Dr. Jones. Dr. Smith was a

good witness on his own behalf.

Dr. Jones presented two ED experts against Dr. Smith in addition to her own testimony. One ED expert testified that Dr. Smith should have admitted the patient or asked Dr. Jones to come to the hospital to see the patient. Dr. Jones' other ED expert was also critical of Dr. Smith. Dr. Jones' testimony was not very compelling due largely to the fact that she did not remember the call from Dr. Smith.

The plaintiff in this case had his work largely done for him as each physician introduced testimony against the other. "Finger-pointing" further created the danger that confidence in one or both physicians would be eroded such that a jury could be angered or that the jury would find against both physicians. Ultimately, a jury awarded a substantial verdict against only Dr. Jones, the cardiologist, but did not find against the ED physician.

Expert reviewers had concerns about the care of both physicians. They had increased risk due to the fact that one physician was not physically present and the patient's condition and treatment was being relayed and coordinated by phone. If Debbie's EKG had been faxed to the cardiologist, there would have been less room for error or misinterpretation. Thorough and careful documentation by both physicians would have been helpful, particularly to the cardiologist who did not remember the conversation concerning Debbie's condition and discharge. It can be expected that a jury will give more weight to the testimony of a physician who testifies unequivocally and emphatically as to his/her treatment than one whose memory is not as clear and whose thought process was not documented.

When a medical malpractice lawsuit involves more than one physician, challenging dynamics can result which increase the complexity of defending the case and the exposure for all involved. Lawsuits are not static and include many variables. The prospects of each party may change as the case progresses through discovery. For example, the risk of going to trial may increase or decrease and opportunities for resolution may become more or less favorable or not materialize at all. Unfortunately, hindsight is 20/20 in these cases. And it may be even sharper than 20/20 when a fellow provider casts blame.

[i] Names have been changed
