The Bare Truth

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No good deed goes unpunished – the case of the lost leg.

On November 22, 2003, the patient (an 89 y/o WM) was admitted to a south Florida hospital at 10 pm with a fever of 104 degrees. He was evaluated by the emergency room physician and noted to have what appeared to be an infected wound on the plantar aspect of his left foot. IV antibiotics were started on the orders of the patient's cardiologist.

After admission a variety of consulting opinions were obtained, to include an infectious disease specialist, our GALDI vascular surgeon, a cardiologist and radiologist. The afternoon after admission a doppler study reflected no popliteal flow but this was not communicated to anyone treating the patient.

It was decided the best course of action to save the patient's life was to perform an above the knee amputation of his left leg. The surgery was successful and recovery uneventful.

Was this a successful collaboration by multiple physicians to save a compromised patient's life? Wrong! The patient, funded and spearheaded by his physician son and family, sued all the treating physicians and the hospital for malpractice for wrongfully amputating the patient's left leg.

What went wrong?

An understanding of the patient's past medical history is important in understanding this case. Three years earlier (November, 2000), a south Florida vascular surgeon (VS) diagnosed the patient with bilateral popliteal aneurysms. Given his advanced age and co-morbid condition, he recommended no surgery for the aneurysms and, instead, suggested ultrasound checks of the aneurysms every six months to monitor any change (surgery was considered too risky) and sent a letter outlining his suggestions to the patient's son (himself an orthopedic surgeon), with a copy to the patient's treating VS in New York. (During litigation, both physicians acknowledged receiving the letter and agreeing with the findings and recommendations.)

The patient did not return to the south Florida VS for the next 3 years. Instead, he underwent evaluations every six months with his New York VS for a repaired iliac aneurysm. Unfortunately, however, the VS never performed an ultrasound of the patient's popliteal aneurysms (remember, though, he acknowledged receiving the letter suggesting biannual popliteal evaluations). The New York treating VS last evaluated the patient a month prior to his Emergency Department (ED) admission of November 22, 2003.

At 2:15 a.m. on November 23, 2003, the patient was admitted from the ED to the medical surgical floor of the hospital. The surgical floor nurse was unable to palpate pulses in either foot, despite the ED record which reflected pulses were palpated. This was the first indication of vascular compromise.

Later that morning the patient's cardiologist evaluated the patient and found him to be very ill and septic. He ordered a consult with an infectious disease (ID) specialist who saw the patient midday. The ID noted the patient to be septic with a wound infection and observed ischemic changes to his left lower extremity. He instituted an aggressive antibiotic regimen, cultured the wound and requested our GALDI vascular surgeon evaluate and workup the patient.

The patient's cardiologist ordered a doppler ultrasound which was negative for deep vein thrombosis. The ultrasound tech noted on the ultrasound worksheet that there was "a popliteal

aneurysm with no flow incidentally noted," and dropped the film and worksheet into the radiologist's box for routine review the next day. She did not tell anyone there was "no flow" noted.

The ID's recommendation for the vascular surgeon consult was not communicated to the cardiologist until early that evening. Our GALDI vascular surgeon was called to see the patient and responded within 3 hours. By then, ten hours had passed since the cardiologist noted "ischemic" changes in the patient's left leg.

Our GALDI vascular surgeon's evaluation reflected the patient "lost power" in his foot several days earlier and had signs of irreversible ischemia. He determined revascularization was unlikely and carried with it a very significant risk of death, infection or renal failure. The insured had an extensive conversation with the patient and his family regarding his condition and the fact he would lose his leg. He spoke with the cardiologist and told him of his recommendations. A heparin protocol was initiated to preserve any collateral circulation in an effort to save some limb length and prevent further embolization. IV hydration was ordered to optimize and preserve renal function in anticipation of a possible arteriogram to determine if thrombolytic therapy was an option.

On November 24th, the radiologist refused to perform an arteriogram because of the health risk to the patient. The best option at this time was to perform an above the knee amputation of the patient's left leg which was performed the following day by another surgeon.

Post amputation, the patient's son, himself a surgeon, complained that the leg should not have been amputated and the treating physicians should have attempted revascularization of the leg before deciding to amputate it.

The Lawsuit

The patient subsequently sued the hospital, our GALDI insured, and several of the other treating physicians. Our insured was sued on the theory that he should have attempted revascularization of the patient's leg when first seen. Our insured believed the leg was unsalvageable and any attempt to do so could lead to death.

The patient brought in his New York treating vascular surgeon to serve as his expert (his treating surgeon for over 10 years). On deposition the VS concurred with the treatment plan as outlined in the 2000 medical evaluation letter (which recommended 6 month ultrasounds of the popliteal artery). Additionally, the VS admitted that he never performed a popliteal ultrasound while treating the patient. He only monitored his earlier repair of the patient's iliac stent graft. His last ultrasound on the iliac stent repair was done 3 weeks prior to the south Florida November 22nd hospitalization. He also testified under oath that our GALDI insured could have revascularized the artery in 90 minutes. He was impeached on the stand when he admitted on the stand that he performed a less extensive surgical procedure on the patient's other leg a year earlier that took him 4 hours to complete.

Defense experts testified that the leg was irreversibly ischemic at the time of evaluation and the leg was unsalvageable. Medically, he was not a candidate for revascularization surgery.

The hospital settled prior to trial for a confidential amount. Our GALDI insured felt he did nothing wrong and was determined to have his day in court. He, along with the remaining codefendants, decided to go to trial.

The case was tried in the spring of 2011. After a three week trial, and a half day of deliberation, the jury returned a verdict of "no negligence" against our GALDI insured, along with all other remaining codefendants.

Notably, ten days after the defense verdict was returned, the 96 y/o patient (who appeared one day at trial and was subsequently hospitalized for the remainder) died.

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2011 Florida Legislative Update

The 2011 Legislative session was challenging in more ways than one. There were many legislative proposals introduced but only a few made it to the finish line. Physicians had hoped that a final version would include access to subsequent treating physicians, which current law prohibits, but this provision fell short of the line. HB479 did make it across the line and if approved by the Governor will become effective October 1, 2011. Some of the key provisions in the bill are:

Expert Witnesses:

It is going to cost out of state physicians $50 to be an expert witness in Florida litigation. Depending on their specialty, physicians have to apply and receive a certificate from one on the medical boards (Medicine, Osteopathic or Dentistry). The boards have 10 days to review the application and issue a certificate. The certificate allows the expert to sign an affidavit for a Notice of Intent, provide deposition testimony and live testimony at trial. If the applicant has provided deceptive or fraudulent expert witness testimony elsewhere, it is grounds to not issue a certificate. The Boards have the authority to discipline any expert witness (in state or certificate holder) who provides deceptive or fraudulent expert witness testimony. The certificate is good for 2 years.

Cataract Surgery – Informed Consent:

Cataract surgery is one of the most commonly performed surgeries in Florida. The various Boards of Medicine have been asked to come up with and adopt a standard informed consent form that sets forth the recognized specific risks related to cataract surgery. Once the form is properly completed, signed and witnessed, it becomes a rebuttable presumption that the doctor properly disclosed the risks of surgery to the patient.

Settlements:

Florida is one of the few remaining states where the insurance company can settle a claim without the physician's approval. This changed somewhat this year. Physicians can now enter into insurance contracts that give the physician the authority to approve or deny a settlement, provided the insurance company offers such a policy. Insurance companies are permitted but (more importantly, not required to provide a policy that allows the physician to say "no" to a settlement.

Medical Authorizations:

Now a defendant physician can get the plaintiff's protected health information. Section 766.1065, F.S., is created to require that any presuit notice in the medical negligence action must include an authorization for release of protected health information. If the release authorization does not accompany the presuit notice, then the presuit notice is considered void. If the plaintiff or their attorney revokes the authorization, the presuit notice and any tolling or postponements are deemed retroactively void from the date of issuance.

Team Physicians:

For years physicians were reluctant to serve as a volunteer team physician due to the potential exposure he/she encountered when treating an injured player(s). Section 768.135, F.S., was amended to extend immunity protections to volunteer team physicians for malpractice liability unless the medical care rendered was given in bad faith, with malicious purpose, or in a manner exhibiting wanton and willful disregard of human rights, safety, or property.

Medicaid Patients - Limitation of Medical Malpractice Damages:

There is another bill worth noting for those treating medicaid patients. CS/HB-7109 added subsection (6) to 766.118, F.S. This new subsection limits non-economic damages if a physician(s) is sued for medical malpractice for providing care to a medicaid patient. When more than one treating physician is involved in the treatment of a patient, the provision limits non-economic damages to no more than $300,000 per claimant, and limits liability for a single treating practitioner to no more than $200,000 in non-economic damages, unless the plaintiff pleads and proves that the practitioner(s) acted in a wrongful manner. The effective date of this new subsection is effective July 1, 2011 if the Governor signs the bill.

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