



CASE STUDY

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A physician cannot hide behind the fact that he was only “on call.”

Overview of Facts:

A 31-year old male visited the ER on several occasions within a two week span of time. On the first ER visit he was admitted to the hospital and diagnosed with intracranial bleeding and uncontrolled hypertension. The patient was released from the hospital after six days. The patient went back to the ER complaining of left leg pain, stating that he was just released from the hospital two days prior for a stroke and had some residual hemiparesis in his left leg. The patient was discharged the same day with a prescription for Demerol for the leg pain. The patient returned to the ER every day for the next three days complaining of left leg and back pain. Ultrasonography of the lower extremities was normal. He stated that the pain medication was not helping. On the third ER visit the patient was readmitted to the hospital by his treating physician for additional testing. This time ultrasonography showed deep vein thrombosis.

On the final admission the admitting physician indicated his plan was to admit the patient for pain control, hydration and cardiology consult. He “planned to discuss the possibility of thrombolysis or heparin administration with a consulting physician.” Due to complaints of shortness of breath, a CT scan of the thorax was ordered stat at 10am. The CT scan was not completed until after 3pm. The STAT CT scan of the thorax documented multiple pulmonary emboli.

The on call physician was contacted at 6:30pm and informed of the CT thorax results. He gave orders to transfer the patient to ICU and to consult a neurologist to see if anticoagulation therapy was possible in light of the patient’s previous stroke. At 9:30pm the on call physician called back and gave additional orders including the administration of Lovenox, if approved by the neurologist. Orders were also given to obtain a signed consent for a placement of an IVC filter the following morning. The neurologist ordered a stat CT of the brain, and if it showed no new bleeding, anticoagulation was approved. At 11:30pm the on call physician was contacted and advised the CT indicated no new bleeding, only an old hematoma. The on call physician was also advised that the patient refused to take Lovenox “given his past history of cerebral bleeds.” No further action was taken by the on call physician. The patient began experiencing cardiopulmonary arrest and coded at 1:30am.

Lawsuit Filed

A lawsuit was filed naming as defendants the Hospital and the on call physician. The primary allegations against the hospital related to the delay in performing the CT scan of the thorax as well as the delay in contacting the physician with the CT results.

The allegations against the on call physician were:

1. Failure to provide timely medical care and treatment to Decedent when he knew the Decedent had deep vein thrombosis and pulmonary emboli.
2. Failure to order a blood thinner to prevent further blood clot formation.
3. Asking the hospital staff by phone to obtain consent for the insertion of an inferior vena cava filter instead of timely inserting the filter.
4. Failing to see the Decedent in person, but instead advising hospital staff by telephone of the actions to be taken when he knew the Decedent had deep vein thrombosis and pulmonary emboli and knew (or should have known) that the Decedent’s condition required immediate medical care and treatment.

Liability Concerns:

Plaintiff's experts were critical of the on call physician. He did not visit the Decedent when called by the hospital but rather issued verbal orders over the telephone. Both Plaintiff's and defense experts were of the opinion that once the on call physician received a telephone call from the nurses, he had an obligation to treat the Decedent. Plaintiff's expert argued that if the on call physician had come to the hospital to care for the patient he could have explained the need for Lovenox, rather than leaving such an important discussion to the nurse, and perhaps persuaded the patient to take the drug, and if not, then to proceed immediately with placement of the IVC filter, rather than waiting until the next day, knowing the patient had bilateral pulmonary emboli.

Defense and Risk Management Concerns:

1. The on call physician took the position, **despite preparation to the contrary**, that he was not a "consulting physician." In his deposition he stated that he had not been consulted but was "on call." He further stated, "I believe a doctor should have been closely monitoring the care and condition of the patient because he had bleeding in his brain, blood clots in his leg, and blood clots in his lungs." He further stated that "if I had been 'consulted' I would have gone and seen the patient."
2. Failure to communicate with the Decedent's family.
The treating physician asked the on call physician if he would like to talk to the family to explain what had happened. The on call physician declined to talk to the family because "I was not sure what that would accomplish when my whole interaction with the patient was five or six hours and I had never seen the patient and taken care of him. I was taking care of the patient when I was called on the telephone. I had no patient-physician relationship other than what was described on the phone messages to me. I was not consulted on his care. I entered orders on call." The family was told by the treating physician that "the on call physician was in charge of the patient at the time of the death."

Disposition:

The Hospital filed a Motion for Summary Judgment based upon the fact that the Plaintiff's expert did not have the qualifications to render any opinions against the hospital, nor to opine as to any alleged delay performing a stat CT scan of the thorax with pulmonary embolism protocol. Thus, our Insured became the sole defendant in this case.

There was a potential sympathy factor which was of great concern to us; particularly in the jurisdiction that this case was in. The deceased left behind a young widow and two children who were ages two and five months at the time of his death.

It was difficult to find an expert witness to support the on call physician. The on call physician indicated in deposition that "had he been 'consulted' he would have visited the Decedent." This statement would not play well before a jury. He cannot hide behind the fact that he was only "on call."

Accordingly, the case was settled out of court substantially below our policy limits.

In summary, it is obvious that this case may have had a different result if the on call physician had gone to the hospital rather than being "on call" via phone only. If so, he would have had an opportunity to meet and bond with the family. The fact that he did not meet with the family afterwards was also of concern. This doctor took the position that he only treated the patient for five or six hours and that he did not have a physician patient relationship with the deceased. Thus, he did not see a need to meet with the family. Instead, he let the treating physician meet with and console the family. The family was told by the treating physician that "the on call physician was in charge of the patient at the time of the death." As a result, the on call physician was the only physician sued. One question will go unanswered: If the on call physician had met with the family and developed a rapport with the family, would he have been sued...or, would he then have been the sole defendant?