MLMIC
Medical Liability Mutual Insurance Company

CASE REVIEW

A Review of Case Studies for MLMIC-Insured Physicians & Facilities

Summer 2015

The Loss of Chance Doctrine

The cases presented in this issue involve the legal doctrine of the "loss of chance." The plaintiffs in both cases alleged that the negligence of, and delay in diagnosis by, the treating physician was a "substantial factor" in causing their injuries. Expert testimony for the plaintiff will often state that plaintiff's chance of survival would have been better if diagnosed earlier, and they may even include a percentage improvement in the chance of survival if the malpractice had not occurred.

Under this doctrine, before the case is sent to the jury at the end of testimony, a plaintiff's lawyer will request that the court charge the jury to decide whether the plaintiff would have survived or not suffered the injuries claimed if he/she had received proper and timely treatment. Although courts in New York are not in complete agreement, they have generally held that in order to use the "loss of chance" doctrine, the plaintiff must prove that the malpractice deprived the plaintiff of a "substantial possibility" of recovering from the underlying ailment for which the plaintiff originally sought treatment. In all of these cases, the term "substantial possibility" is the key.[1,2,3,4] The application of "substantial possibility" in any given case is left up to jury interpretation.

If you are a MLMIC insured and have any questions not covered in the following cases, please do not hesitate to contact the attorneys at Fager Amsler & Keller, LLP by calling the office nearest you, or by utilizing the Contact Us feature on MLMIC.com.

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1. Kallenberg v. Beth Israel Hosp., N.Y.S. 2d 508 (1st Dep't 1974), aff'd, 337 N.E. 2d 128 (1975).
2. Candia v. Estepan, 734 N.Y.S. 2d 37 (1st Dep't 2001).
3. Cannizzo v. Wijeyasekaran, 689 N.Y.S. 2d 315 (4th Dep't 1999).
4. Kimball v. Scors, 399 N.Y.S. 2d 350 (3d Dep't 1977).

CASE STUDY #1

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A 41-year-old female was diagnosed with infiltrating duct cell carcinoma of the left breast. She underwent a left breast mastectomy, node dissection, and breast reconstruction in early December of 2009. Several days prior to the surgery, the patient met with two plastic surgeons to discuss having breast reconstruction immediately following the mastectomy. Several options were discussed with her, including an abdominal/TRAM flap procedure, a latissimus flap procedure, and a free flap procedure.

The patient was obese and a "social" smoker. Because of this, she was not an appropriate candidate for the TRAM flap procedure. Nevertheless, the patient "insisted" on having this particular type

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Case #1 *continued*

of reconstruction and the physicians agreed to perform this procedure. She was advised of the risks of this surgery, including infection, bleeding, scarring, asymmetry, wound healing complications, hernias, and the need for possible revision surgery. This discussion was documented in her medical record.

On the day of the procedure, the patient was once again advised of the risks that had been discussed in the office. She then signed a consent form. After the mastectomy was completed, the pathologist reported that the carcinoma was HER-2 positive poorly differentiated invasive ductal carcinoma. Despite knowing this, the plastic surgeon proceeded to perform a right breast reduction. He then reconstructed her left breast with a TRAM flap. The plastic surgery discharge note stated "wounds ok…some skin flap necrosis on the left side…treated with nitroglycerin."

The patient was discharged on pain medication and antibiotics. She continued to see both of the plastic surgeons regularly that month for her post-operative care. However, by the end of December, the TRAM flap had obvious necrosis. Two weeks later, the patient underwent debridement of the skin flap with a TRAM revision and was treated with a wound VAC. By February of 2010, although the wound was improved, it still had not completely healed. Finally, in May of 2010, the patient's oncologist ordered a wound culture, which was positive for MRSA. The patient was treated with IV antibiotics. Although the patient was originally scheduled to begin chemotherapy 6 weeks following the mastectomy, due to the wound infection, the initiation of chemotherapy was delayed for six months. In September of 2010, the patient went to see a different plastic surgeon at a large cancer center. This surgeon recommended that she wait until the wound healed before undergoing any further reconstruction.

In February of 2011, the patient underwent a latissimus flap breast reconstruction by her new plastic surgeon. However, the patient then began to show symptoms of osseous metastasis, including the spine. Finally, in October of 2011, she underwent a kyphoplasty and had palliative radiation therapy to her right hip.

Thereafter, the patient commenced a lawsuit against the general surgeon, both of the original plastic surgeons, and their professional entity. She alleged that they had failed to advise her of the risk that the reconstruction would fail and failed to diagnose and timely treat her post–operative infection. She also alleged they had inappropriately recommended the TRAM flap reconstruction to her because she was not a candidate for this type of procedure. She alleged further that during her post-operative care, they had failed to timely perform a culture and sensitivity of the wound drainage so they could properly treat her with antibiotics, debridement, drains, and surgery. Finally, she also alleged that they had failed to perform an adequate informed consent discussion pre-operatively.

The damages claimed included a severe infection with loss of the flap, and pain and suffering related to the additional corrective procedures (tissue expanders and implant surgery) she had to undergo as a result. The most significant of the damages claimed was a delay of six months in the initiation of chemotherapy, due to the infection, and ensuing treatment, therefore depriving her of her best chance of survival and increasing her risk of metastasis.

The expert reviewers retained on behalf of the defendants were critical of all of the treating physicians. They criticized the general surgeon for permitting immediate reconstruction to be performed after the mastectomy. They stated that her obesity and history of smoking increased the risk of complications which could, and in fact did, delay the onset of adjuvant therapy. This was felt to be a critical potential factor in the onset of her metastatic disease.

The plastic surgery experts criticized the use of a TRAM flap in an obese patient who also smoked. They also felt that the plastic surgeons appeared overly concerned with necrosis of the flap, for which she received topical Silvadene. However, they never docu-

mented that they had considered a possible infection at any time until the patient was febrile. This was confirmed by their failure to culture the wound throughout her entire course of treatment by them. Only at that point did they prescribe systemic antibiotics. As a result, the experts felt strongly that their failure to consider the presence of an infection and perform cultures were clear departures from the standard of care.

As a result of these numerous, serious deficiencies in the patient's care, and the resulting delay in the initiation of chemotherapy, the case was settled on behalf of the plastic surgeons for $1.7 million dollars. The general surgeon, named in the lawsuit but not a MLMIC insured, also participated in the settlement.

A Legal & Risk Management Perspective

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Several legal issues prompted the settlement of this case. The first was the need to perform an appropriate procedure with due consideration of the patient's medical history. Two specific risk factors made this patient an inappropriate candidate for an abdominal TRAM flap – she was obese and a smoker. Patients who are obese, and particularly those who smoke, often do not heal well after plastic surgery procedures. Since this patient potentially had metastatic disease, an abdominal TRAM flap should not have been offered as a viable option. The

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CASE STUDY #2

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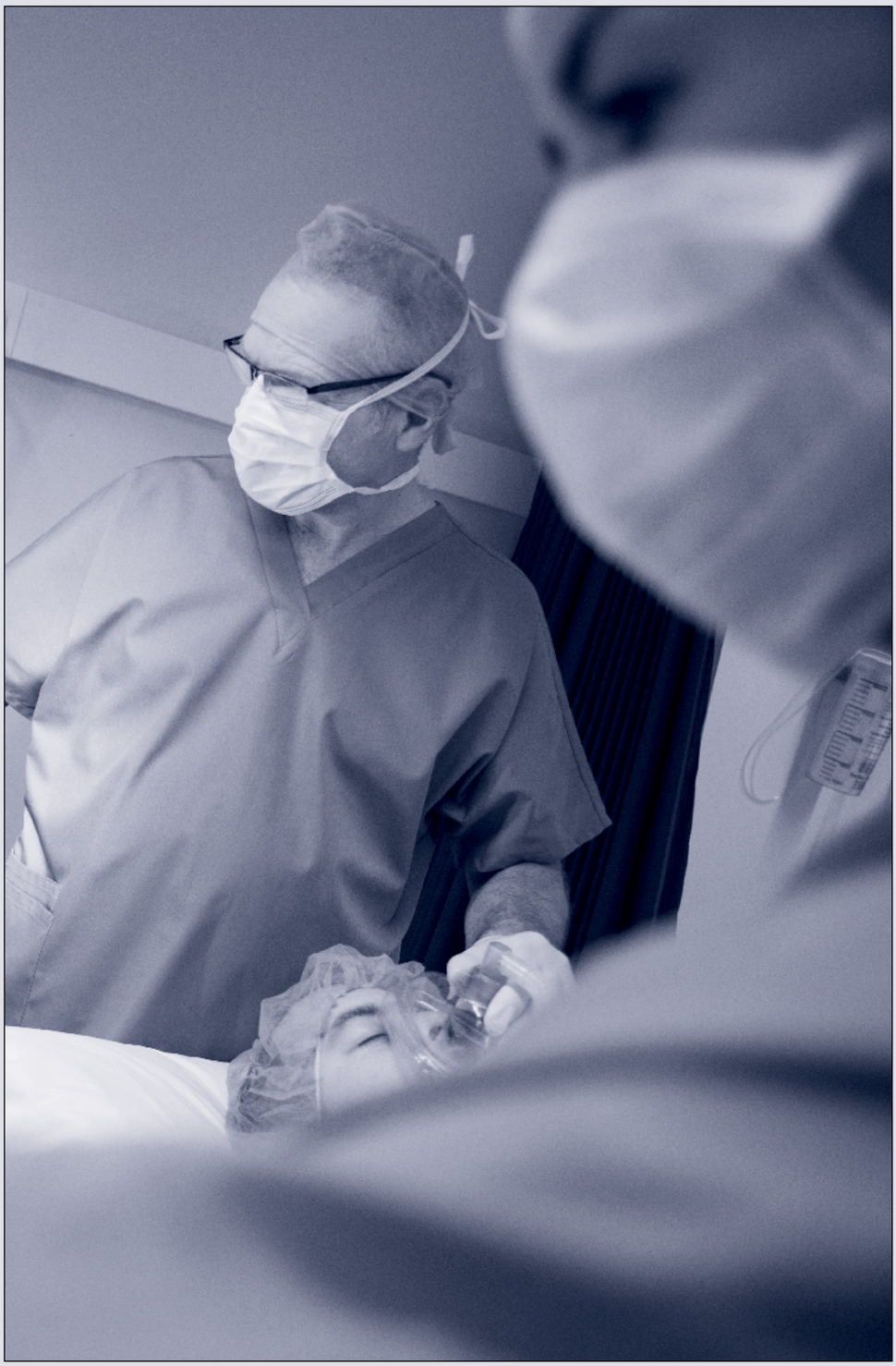
A 46-year-old male was referred by his primary care physician to an otolaryngologist (ENT). The patient was initially seen on November 15, 2006. He had a history of prior sinus surgery by another ENT in 2003. He also had GERD and had smoked for many years. The patient's current complaints were headaches, facial pain, dysphagia, and severe throat pain. Upon examination, the ENT observed nasal polyps, edema of the mucosa, and redness of the larynx. He prescribed antibiotics and scheduled a follow up visit.

On November 29, 2006, the patient returned to his office. He reported some improvement in his symptoms but continued to complain of dysphagia and throat pain. Upon examination, his larynx was still red and swollen. The ENT diagnosed esophagitis and possible GERD at this visit. He ordered an esophagram and prescribed Nexium for the patient.

The esophagram was interpreted by the radiologist as a right-sided hypopharyngeal diverticulum and thickened gastric folds. However, he could not exclude an infiltrating neoplasm, such as a lymphoma, and recommended clinical correlation to the ENT in his report.

Three days later, the patient returned complaining of severe facial pain from his cheek to his eye. An examination revealed nasal polyps which were blocking the patient's sinuses. The ENT ordered further radiologic studies at this visit.

On December 28, 2006, the patient underwent a CT scan of his sinuses. A different radiologist interpreted the scan



as polyps blocking the right maxillary sinus. Four days later, the ENT physician discussed with the patient performing surgical intervention to remove the blockage. On January 4, 2007, he performed endoscopic surgery to remove the polyps.

On January 10, 2007, the patient presented for his first post-operative visit. He reported some improvement in his symptoms. However, six weeks later, he returned to the ENT physician complaining of a severe sore throat, with pain radiating from his left ear for the past eight days. The ENT diagnosed pharyngitis with possible swollen lymph tissue and a possible mass. He prescribed steroids and antibiotics. One week later, the patient's symptoms had improved. However, during an endoscopic examination at that visit, the ENT physician had visualized two almond sized masses. Despite another week of steroids, the masses did not diminish in size. Therefore, he ordered an MRI.

On March 21, 2007, the patient underwent an MRI. This test confirmed the presence of a left oropharyngeal mass extending from the left hypopharynx to the left pyriform fossa. The radiologist not only stated in his report that a malignancy should be excluded, but also telephoned the ENT physician with his findings.

On April 4, 2007, the ENT biopsied the masses. The pathology results revealed stage IV moderately to poorly differentiated squamous cell carcinoma. Between April of 2007 and May of 2008, the patient underwent chemotherapy, radiation, insertion of a PEG tube due to his weight loss, and a left neck dissection. Despite this, the malignancy recurred, resulting in an additional left neck dissection, and pectoralis major flap reconstruction. On July 18, 2008, he was diagnosed with recurrent squamous cell carcinoma. He was scheduled for additional chemotherapy but further surgery was not recommended.

The patient then commenced a lawsuit against both the otolaryngologist and the radiologist, their corporation, and the hospital at which they practiced. He alleged that there had been an unreasonable delay in the diagnosis of oropharyngeal cancer, despite his complaints of severe facial pain, throat pain, and difficulty swallowing for more than five months. He claimed that the delay caused metastasis beyond his oropharynx and into the hypopharynx. This resulted in extensive surgical intervention and a decreased life expectancy. On March 23, 2009, the patient died. His estate added an action for wrongful death to the existing lawsuit.

This case was reviewed by experts in both otolaryngology and radiology. The ENT experts concluded that the otolaryngologist's care could not be defended. The patient's complaints had clearly warranted earlier, more definitive diagnostic and radiological testing. Further, with his history as a smoker, the nature of his symptoms, and the fact that he continued to complain that he obtained little to no relief from the prescribed treatment, the ENT should have strongly suspected a malignancy within the first few visits. These experts opined that the cancer was most likely present in November of 2006 and probably could have been easily visualized if the ENT had used a flexible laryngoscope to examine his throat. Further, the patient's symptoms were far too severe to justify the initial diagnosis of nasal polyps. An immediate biopsy should have been performed. A second ENT expert stated that if the diagnosis had first been made in November, 2006, the patient would not have needed chemotherapy and radiation, only surgery. Further, he opined that the patient may have required less invasive surgery than he endured and would have had a more positive response to the treatment, with a concomitantly longer life expectancy. Therefore, the reviewer felt there were serious departures from the standard of care.

Hampering the defense of this case further was an admission against interest by the ENT at his deposition. He admitted that the cancer most likely existed before his initial examination of the patient and acknowledged that if the patient had been diagnosed and treated earlier, a better outcome was likely.

Because MLMIC was unable to find an expert who was willing to defend his care, and as a result of the otolaryngologist's admissions against interest at his deposition, the case was settled only on behalf of the otolaryngologist. However, the fact that the patient's cancer had most likely metastasized prior to his initial visit to the ENT aided the settlement negotiations. The case was ultimately settled on behalf of only the ENT for $750,000.

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A Legal & Risk Management Perspective

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One of the key risk management issues in this case was the failure of the ENT to pay attention to the patient's history of smoking for many years and recognize the clear distinction between the symptoms he exhibited in 2003 and his current symptoms. He reported the symptoms were extreme and the pain unlike anything he had ever experienced. If the patient's history had been related by the ENT to the patient's present complaints, which did not resolve after the initial treatment, he might have been led to perform more definitive testing to rule out cancer within the first few visits. Therefore, from a risk management perspective, his failure to both link and document the link between past important "social history/behavior" which is associated with serious risks of disease with the patient's current symptoms created a problem for defending the ENT.

There was no documentation of how long the patient's symptoms had been present prior to the initial consultation with the ENT. Because he had not documented this history, at his deposition, he could not recall how long prior to the first consultation the patient had been symptomatic. This enabled the patient to claim that these were new symptoms which the ENT failed to properly diagnose.

Another risk management issue involved the diagnostic testing performed. The first radiologist who performed the esophagram stated in his interpretation that he could not exclude a neoplasm. Although he recommended "clinical correlation," he should have telephoned the ENT about this finding. The term "clinical correlation recommended" is very frequently used in reports of imaging studies and, unless a physician receives a call because there is suspicion of a neoplasm, the significance of this term is often missed or ignored. A call from the radiologist potentially could have saved the patient's life or mitigated his injuries. However, there was no documentation of such a call. Because of this, the patient was not diagnosed until after multiple visits with the ENT over several months. Therefore, through the application of the "loss of chance" doctrine, the patient claimed that the delay in diagnosis directly led to metastasis and resulted in greater disfigurement, pain and suffering, and a higher risk of death. If this case had gone to trial, this delay in diagnosis and treatment would have been used to justify the damages sought.

From a legal perspective, the ENT compromised his defense by making "admissions against interest" at his deposition by acknowledging that the cancer likely pre-existed his examination of the patient and, if diagnosed sooner, the outcome could have been altered. An admission against interest is defined as an admission of the truth of a key fact in dispute by a party, when that statement obviously is embarrassing, incriminating, or harmful to that person's pecuniary or personal interests. The statement is then allowed into evidence at trial because the person making the admission had no incentive to make such a damaging statement. This proves that the statement is reliable. Further, when such an admission is made at a deposition, it is being made under oath. Thus, it is very difficult to explain away such an admission at trial.

Finally, all of the experts who reviewed this case felt the ENT's care was not defensible. From a legal perspective, if the defense is unable to retain an expert who can effectively defend the care provided, and state that the standard of care was met, the need to settle the case becomes more imperative.

physician should have explained to her why she was not a good candidate and fully documented this discussion in her medical record. Although a patient, when given several options, can express her preferences to her physician, the physician should not agree to perform a procedure which is either contraindicated by the patient's condition or not in the patient's best interests, regardless of the patient's insistence on having that procedure. The responsibility for patient selection for a procedure lies with the physician, within his/her judgment and discretion, and not the patient. Thus, in retrospect, these physicians should have declined to perform this particular procedure in light of her obesity and history of smoking, instead of acceding to her demands.

The second legal issue causing a weakness in the defense was the fact that the surgeons performed the attempted reconstruction at the time of the mastectomy. Based on the pathology report, the surgeons were aware that the patient would need to start chemotherapy within six weeks of the mastectomy. Since performing the reconstruction, despite the results of the pathology studies, arguably was not in the patient's best interests, the patient's attorney could allege that this too was a departure from the standard of care. Further, he could allege that this decision may have been due to both patient pressure and, perhaps, the financial interests of the surgeons, both of which could inflame the jury.

The adequacy of the informed consent discussion was yet another risk management issue in this case. Although the risks discussed were documented in the patient's medical record, the risks did not include a potential delay in commencement of chemotherapy, if needed, nor a total failure of the procedure due to infection. In fact, the patient denied being advised of this and was able to claim a breach of informed consent.

Finally, when a wound persistently does not heal, infection must be considered and elimination of that possibility must be documented. Ironically, it was documented that the patient was told that infection was a known risk. However, the surgeons failed to recognize evidence or even consider the existence of an infection. Further, they failed to document that they had eliminated infection as a cause of the patient not healing well. According to the plastic surgery experts, this failure was a clear departure from the standard of care.

When obvious and serious departures from the standard of care result in a delay in critical treatment, it is difficult to find an expert to defend the case. An expert for the defense must not only be able to put forth a defense and clearly show that the standard of care was met, but must also be able to withstand intense cross examination by counsel for a sympathetic plaintiff who now has metastatic disease. In this case, finding such an expert to testify was not possible. Therefore, settlement was indicated.

Perhaps the most crucial allegation made against these physicians was the delay in the start of treatment of her cancer due to the wound infection. This delay allowed the plaintiff to seek damages for deprivation of a better chance for survival using the "loss of chance" doctrine. This doctrine was a strong factor in the need to attempt to negotiate a settlement due to a valid concern that the jury might be emotionally affected and choose to "punish" the physicians by rendering a large verdict in favor of the plaintiff. Therefore, when there is a lengthy delay in the diagnosis of cancer, the need to attempt to reach a settlement becomes clear. However, it is important to remember that a reasonable settlement cannot always be obtained pre-trial. Thus, at times, a case which is difficult to defend may go to trial before a settlement can be reached.

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