Breakdown in Procedures and Failure To Act by Medical Staff Proves Deadly

If all had gone according to hospital policy the night John G presented to a prominent South Florida hospital with sudden onset of chest pain that radiated to his back, hypertension, swelling in the chest cavity and a family history of aneurysms, medical experts would have given him an 85 percent to 95 percent chance of survival.

But that's not what happened in the fall of 1997 when John and Patricia, his wife of nearly 20 years, arrived at the hospital at 10 p.m.

$1.4 Million Settlement:

FAILURE TO FOLLOW HOSPITAL PROCEDURES CAUSES DELAY AND DEATH

What followed was a chain of events in which doctors and hospital staff failed this couple at every turn. From his initial arrival at 10:00 p.m. to the final pronouncement of his death the next morning at 11:00, John's aortic dissection was allowed to advance untreated for thirteen hours until his wife literally watched him needlessly die.

It all started correctly. The ER doctor ordered a CT scan to rule out an aortic dissection, but determined that John was allergic to the contrast dye necessary for imaging. Then, according to policy, the physicians notified the hospital's primary on-call radiologist who was serving two hospitals that night under a previously arranged contract. The radiologist ordered an MRI to be done immediately.

But instead of receiving John's MRI results to interpret, the radiologist never heard from the referring physicians again. Instead, the radiologic technologist, who was not a physician, called another doctor rather than calling the MRI technologist to come in and perform the study.

Thus began the breakdown in procedures, communications and standards of care that would ultimately cost John his life.

With no MRI technician en route, an entirely different radiologist was called to confer with the admitting physician. This secondary on-call radiologist was home in bed, sleeping, when the call came in asking for medical direction. This second radiologist, completely unaware that an MRI had already been ordered, or the primary on-call radiologist's availability to read it, decided after a consult with the admitting physician that John's condition could wait until the "early a.m."

This decision was contrary to all acceptable standards of care for these symptoms and the admitting hospital's own policies and procedures.

An aortic dissection is a tear in the inside wall of the aorta. Left untreated, the dissection or tear will advance until the aorta ruptures, causing immediate death. An aortic dissection is a surgical emergency, and the hospital that admitted John G didn't even have the capability to provide that surgery. No one ever told John G or his wife that he may have an aortic dissection, no one ever told them that an aortic dissection was life-threatening and required surgery, and no one ever told them that the hospital didn't have the capability to provide the treatment he needed, but that other area hospitals could.

It was now 1:10 a.m. By the time the MRI began at 8:10 a.m., it took roughly an hour and twenty minutes to diagnose John with the very same aortic dissection that the admitting physicians initially suspected and preliminarily diagnosed. But because the hospital didn't have the capability to provide the surgery to repair the dissection, it had to be performed at another hospital. This cost John and Patricia time they didn't have. At 11:05 that morning, while he waited to be transferred, John's aortic dissection ruptured. He died immediately.

In presenting the case, Patricia's attorneys, Lance Block and Jim Gustafson of Searcy Denney Scarola Barnhart and Shipley, argued that, "John died at a hospital that did not have the service capability to treat the dissection. John died after waiting some seven hours for a test that was to be performed on an emergency basis, and he died while awaiting transfer to a facility with the capability to treat his life-threatening condition, which required emergency surgical intervention. It is undisputed that, whenever there is a differential diagnosis of a dissection, the condition must be ruled out on an emergency basis. In John's case, the defendants failed to do that, and he died as a result."

After years of litigation, including the bankruptcy of an out-of-state insurer for one of the defendants that reduced the available recovery from that defendant to a mere $300,000, a final, total settlement was reached in the amount of $1.4 million. ■