Medical Malpractice Trial, Part 1: The Events

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I recently spent 3 amazing weeks in a medical malpractice trial. Over the next few months, I would like to share the experience with you. Despite the fact that I practice law and have been an expert witness for more than 20 years, the experience opened my eyes and has definitely changed how I practice medicine in the urgent care setting.

I took copious notes during the trial and have access to all of the depositions and trial testimony, so I will do my best to make this series as factual as possible. That said, I will change the names of the defendants and plaintiffs; however, I will keep the names of the attorneys and expert witnesses in the case.

Case name: *John and Cathy Dalton v. Dr. Beth Ange and Responsive Emergency Medicine*

Decedent: Johnny Trey Dalton

Attorney for plaintiff: Bernard Elliot Greyson, MD, JD

Attorney for defendants: Cristy Chait, Esq.

Defendant's Disclosure

On February 5, 2012, Johnny Dalton was brought by his mother and sister to the emergency department (ED) at St. Jacob's Hospital at 2:00 a.m. He arrived ambulatory, stating that he had taken methadone pills. He was not sure of the amount; however, his family believed it was liquid methadone and that he took 80 to 90 mg.

His vitals on admission were as follows: blood pressure, 114/77 mm Hg; pulse, 75 beats/min; temperature, 37°C, respiratory rate, 11 breaths/min; oxygen saturation, 98% on room air. He was initially seen and evaluated by Dr. Bob Scott. The clinical nursing notes indicate that he had ingested 2 bottles of methadone, 30 mg each, while at a party. He also told the nurse he was suicidal.

On presentation, he was noted to be sleepy but able to answer questions and interact appropriately. The patient's chart notes that Dr. Scott was speaking with the patient and family at about 2:15 a.m. Laboratory tests were ordered, and all findings were within the normal range, including levels of aspirin and Tylenol. Johnny refused to submit a urine specimen for a urine toxicology screen. Suicide precautions were ordered. A sitter was with the patient reportedly from 2:37 a.m. until discharge. At 5:16 a.m., Dr. Scott ordered a psychiatric consult. At 5:19 a.m., the patient was noted to request water.

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The patient's care was assumed at 6:52 a.m. by Dr. Beth Ange, who is the chairperson of the Department of Emergency Medicine, and at about 7:30 a.m. by the day nurse. Symptoms, physical findings, and pending evaluations were reported to Dr. Ange. It was noted that the patient was resting quietly and was awake in no distress at about 7:30 a.m. Family members were at the bedside as well. The patient was noted to be sleeping at 9:10 a.m., with a respiratory rate of 14 breaths/min, unlabored breathing, and no acute distress.

At about 9:15 a.m., a psychiatric evaluation was done. According to the psychiatric report, the patient had been brought to the ED by emergency medical services after his mother called 911 because the patient looked "really pale and wasn't answering right." The patient was at a party and took some liquid methadone. He was told that they were like "Oxys." The patient denied any attempt to harm himself and reported that he just "wanted to get high."

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Both the mother and the patient stated that he had no history of making remarks with suicidal ideation or of ever attempting to harm himself. In addition, he reported a moderate history of abusing substances, and his mother agreed. He was recently seen at a behavioral health center and prescribed lorazepam. He was given lorazepam 4 days earlier for generalized anxiety disorder. He was not receiving any counseling.

He reported moderate depression over "lots of stuff." He had been arrested for domestic violence toward his family on October 4, 2011. In his substance abuse history, he reported marijuana use from age 17 to 18 years, opiate pain pills 1 or 2 times per month in the last 4 months, a one-time use of cocaine at age 18 years, and "pretty heavy binges" of dextromethorphan for approximately 1 year. He denied alcohol abuse.

The diagnosis was generalized anxiety disorder and opioid abuse. Depressive disorder was ruled out. The crisis worker noted that he was to be discharged home with his mother. At 9:33 a.m., he was given 4 mg of Zofran. At 9:45 a.m., the patient was observed to be vomiting into a trash can, and Dr. Ange was notified. A breakfast tray was provided to the patient at 9:50 a.m.

Dr. Ange confirmed with the patient that he was not suicidal at that time. At 11:25 a.m., it was noted that the patient's symptoms were improving. He was ordered discharged home in good condition and was to await a ride home. The intravenous line was removed at approximately 12:49 p.m. without incident. Discharge instructions and plans for follow-up care were reviewed. He was discharged home at 12:49 p.m. The discharge instructions included calling for an appointment as soon as possible with his physician, health maintenance organization, or clinic. He was to return to the ED if his symptoms worsened. He signed his own discharge instructions with very legible handwriting and walked out of the ED on his own.

The following day, approximately 22 hours after discharge from the ED and 35 hours after the reported ingestion, the fire department was contacted at 11:37 a.m. because Johnny was found not breathing. It was reported that he had last been seen 1 hour earlier. The fire department was reported to be on the scene at 11:41 a.m. Johnny was pronounced dead on the scene. Police were notified, and they searched the home, finding empty liquor bottles and 2 empty Ativan bottles in Johnny's room. The 90 Ativan pills he was prescribed 4 days before the methadone ingestion were gone.

An autopsy was performed. The pathology diagnosis was methadone intoxication. The toxicology report noted positive findings for methadone: 0.42 mg/L. His urine test findings were positive for methadone, methadone metabolite, and cocaine metabolite. He also had a high level of methadone in his stomach. A follow-up toxicology panel showed him to have relatively small amounts of Ativan in his blood and stomach. No blood alcohol content could be detected.

Legal Basis of Claim

The defendants violated the applicable standard of care while Johnny was in the ED by not admitting him to the hospital and by discharging him home after his presentation with an overdose of methadone and related symptoms.

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Commentary

The long and short of it is that methadone is a long-acting opioid, and the plaintiffs believe that Johnny's overdose 35 hours earlier was the cause of his death. Of particular importance in the medical record was Johnny's respiratory rate, his reported vomiting, whether he was in fact actually ambulatory, the lack of urine toxicology findings, and the way he looked in a photo that the family took of him at 2:30 a.m. on the day he presented to the ED.

The suit filed 15 months after Johnny's death named Dr. Ange, Responsive Emergency Medicine, and St. Jacob's Hospital as defendants.

In the next issue, I will discuss the relevant lessons for urgent care to be learned from preparation for the trial, including the expert witness's testimony, the family's testimony, and the motions filed by both sides. ■