

'Gross Negligence': A Slippery Slope for Dubious Expert Testimony

by William Sullivan, DO, JD on March 12, 2014

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Expert opinions eviscerate Georgia law enacted to protect emergency medical care

In an attempt to mitigate the high costs of medical malpractice insurance, decrease the number of multimillion dollar jury verdicts, and encourage physicians to provide medical care, some states have enacted laws to limit the liability of medical providers in medical malpractice cases. Capping noneconomic damages in medical malpractice cases is but one of the better-known methods that many states have utilized, but there are many others.

Another approach that some states have used to implement tort reform is to increase the standard of proof required to prove negligence in cases where physicians are required by law to provide care. In general, to win a medical malpractice case, a plaintiff must prove that a physician had a duty to treat the patient, that the physician breached the duty, and that the physician's breach of duty caused the patient to suffer damages. In most states, the standard for proving a "breach of duty" in a medical malpractice case is a simple negligence standard, meaning that a plaintiff must prove that a doctor violated the "standard of care" by failing to act as any other reasonable physician would act under similar circumstances.

In 2005, the Georgia legislature enacted a statute⁽¹⁾ requiring that any patients filing a medical malpractice claim based on EMTALA-related care must prove by "clear and convincing evidence" that the medical provider was grossly negligent. While the definitions of "gross negligence" vary from state to state, Georgia courts define "gross negligence" as being "equivalent to (the) failure to exercise even a slight degree of care" and "lack of the diligence that even careless men are accustomed to exercise."⁽²⁾

Using the definition provided by Georgia courts, in order to win a medical malpractice case in Georgia, a plaintiff must prove by "clear and convincing evidence" that a physician failed to provide even a "slight degree" of medical care or that the physician's medical care was less than "careless." In theory, these are high hurdles to overcome, and many trial judges will dismiss cases, as a matter of law, that fail to meet this standard of proof. However, after a recent Georgia Supreme Court case, the initial determination as to whether a physician's medical care was grossly negligent is now being left to the assertions of an expert witness. If an expert's assertions of gross negligence are made in a careless manner, those allegations may result in severe repercussions for defendant physicians.

Application to Legal Cases

Expert opinions were central to a recent Georgia case⁽³⁾ in which a 15 year old patient who was one week status post arthroscopic knee surgery went to the emergency department with complaints of left chest pain. The pain was worse when he laid flat. He had no fever or dyspnea and denied other complaints. In the emergency department, the patient had normal vital signs and "perfect" pulse oximetry. The physician performed a physical exam and ordered an EKG and a chest x-ray, both of

which were interpreted as being normal. The patient's pain resolved after receiving Toradol and he was sent home with a diagnosis of pleurisy and a prescription for Naprosyn. Two weeks later, the patient again developed chest pain and dyspnea. He was transported by ambulance back to the emergency department where he died from bilateral pulmonary emboli.

The patient's parents filed a medical malpractice lawsuit against the treating emergency physician and the emergency physician's group. The trial court dismissed the case for failing to meet the "gross negligence" standard of proof. An appellate court then affirmed the trial court's decision. The Georgia Supreme Court reviewed the case, including testimony from plaintiff experts Drs. Peter Rosen and Dr. Steven Gabaeff. According to the court opinions, Drs. Rosen and Gabaeff testified that the EKG showed "Q3T3" abnormalities and the chest x-ray demonstrated cardiomegaly – which were allegedly both suggestive of a pulmonary embolism. Dr. Rosen's opinion was based on his experience diagnosing "hundreds if not thousands" of pulmonary emboli in his career. Rosen and Gabaeff opined that the patient's symptoms "presented a classic case of pulmonary embolism" and that the diagnostic measures that the emergency physician took in response to those symptoms "did nothing to prove or disprove the presence" of a pulmonary embolism. While the treating physician believed that relief of pain from a pulmonary embolism would not occur with administration of Toradol, the experts called that reasoning "ridiculous." Both experts stated that the standard of care required the treating physician to obtain a CT scan in order to rule out a pulmonary embolism in the patient, and that failure to do so was "grossly improper, egregious, and contrary to well-known and fundamental medical principles." Given these expert opinions and other testimony in the case, the Georgia Supreme Court held that the treating physician's treatment may have been grossly negligent and that a jury would have to decide the issue.

Hindsight

Experts must be cognizant of the strong hindsight bias created by knowing the outcome of a patient's treatment and must strive to engage in prospective rather than retrospective review of a physician's care. These caveats are even more important when delineating between ordinary negligence and gross negligence. It is medically and ethically inappropriate for an expert to make an allegation of medical negligence that is in any way based on the patient's outcome.

It is abundantly clear that in this case the opinions of both experts were significantly influenced by hindsight bias. They repeatedly criticized the treating physician for failing to properly evaluate the patient for a "pulmonary embolism" even though that diagnosis was not known until two weeks after the patient had been discharged from the emergency department. In addition, they called the physician's clinical exclusion of pulmonary embolism in the patient "egregious" even though the patient's vital signs and oxygenation were normal, the alleged abnormalities found on x-ray and EKG were not predictive of pulmonary embolism, and the patient had a low pre-test probability for pulmonary embolism.

Pursuant to Georgia law, the standard to which the emergency physician was held in this case was a failure to provide even a "slight" degree of medical care to the patient. Had Drs. Rosen and Gabaeff focused their opinions upon the prospective evaluation of a 15 year old male with pleuritic chest pain, they would have realized the significant leap in logic it would take to allege that a history and physical examination, evaluation of oxygenation, evaluation of chest x-rays and EKG, administration of medications to treat symptoms, and subsequent re-evaluation of the patient all constituted less than "slight" care of this patient or were "less than careless."

The Fall Out

A finding of grossly negligent medical care has implications far beyond being found liable in a medical malpractice case. A determination that a physician engaged in grossly negligent medical care may affect that physician's ability to continue practicing medicine. Physician employment contracts often contain language allowing the physician to be immediately terminated for any actions that constitute a threat to the safety of patients. Failing to exercise "even a slight degree of care" in providing treatment to patients would certainly fit that definition. However, losing one's job may be the least of the physician's worries. A determination that a physician's care was grossly negligent may also cause a physician's malpractice coverage to be denied, may subject a physician to punitive damages, and may result in adverse actions against the physician's license.

Denial of Malpractice Coverage

Just as a homeowner's insurance policy may exclude certain types of damages from coverage, medical malpractice insurance companies also exclude certain actions from coverage. For example, medical malpractice insurance carriers generally deny coverage for criminal acts. Policy language may also exclude grossly negligent acts from coverage. One medical malpractice insurance company's policy reserves the right to deny defense or payment of damages for "any criminal, intentional, fraudulent, malicious, or reckless act or omission." Another medical malpractice policy reserves the right to cancel an insurance policy (and presumably deny coverage for) "discovery of willful or grossly negligent acts or omissions ... which materially increase the risks insured under this policy."

An allegation of grossly negligent care or a finding of grossly negligent care by a jury may be sufficient cause for an insurer to deny a physician's medical malpractice coverage, leaving the physician personally liable for all defense costs and judgments associated with the medical malpractice lawsuit.

Punitive Damages

In most states, medical malpractice defendants can be liable for punitive damages. While many of the states that allow punitive damages require that a defendant engage in acts demonstrating "willful misconduct," "malice," "fraud," or "outrageous conduct" before punitive damages can be imposed, some states allow punitive damages to be imposed with a finding of gross negligence. For example, under Florida statutes, a defendant may be held liable for punitive damages "if the trier of fact, based on clear and convincing evidence, finds that the defendant was personally guilty of intentional misconduct or gross negligence."⁽⁴⁾ Mississippi allows punitive damage awards for clear and convincing proof of "actual malice, gross negligence which evidences a willful, wanton or reckless disregard for the safety of others, [or] actual fraud." Even in Georgia, punitive damages may be awarded if "it is proven by clear and convincing evidence that the defendant's actions showed willful misconduct, malice, fraud, wantonness, oppression, or that entire want of care which would raise the presumption of conscious indifference to consequences."⁽⁵⁾

Punitive damage awards are paid out of the defendant's pocket.

Actions Against a Physician's Medical License

Every state has a Medical Practice Act which delineates how medical providers are to be licensed, monitored, and disciplined. If a state licensing board becomes aware that a physician's medical care has been adjudged grossly negligent, the Board is likely to take some action against the physician's medical license. For example, California statutes require the Division of Medical Quality to take action against any licensee who is charged with "unprofessional conduct" – the definition of which

includes “gross negligence.” (6) Illinois statutes allow revocation, suspension and “any other disciplinary action” against a physician’s license in addition to a fine of \$10,000 for each violation, when a physician engages in, among other things, “gross negligence in practice under this Act.” (7)

Like malpractice payments, adverse actions taken against a physician’s license are reported to the National Practitioner Databank and may trigger adverse actions by medical boards in any other states where the physician holds a medical license.

Conclusion

As medicolegal paradigms change, we must educate ourselves about how those new paradigms affect our practice and our liability. While legislative changes in the standard of proof for medical malpractice cases may help states retain emergency physicians and specialists who are willing to provide emergency medical care, allowing experts to provide illogical and inappropriate testimony regarding those standards defeats the intended purpose of the legislation and puts emergency physicians at considerable risk. Just as emergency physicians should have an interest in protecting our patients from inappropriate medical care, so too should we have an interest in protecting our colleagues from inappropriate medical testimony. Failing to address these issues benefits neither us nor our profession.

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References

1. OCGA § 51-1-29.5(c)
2. [Giemmo v. Cousineau, No. S09A1807 (March 15, 2010)]
3. <http://caselaw.findlaw.com/ga-court-of-appeals/1616486.html>, <http://caselaw.findlaw.com/ga-supreme-court/1649592.html>
4. Fla. Stat. 768.72(2)
5. O.C.G.A. § 51-12-5.1(b).
6. Cal. Code Section 2234 (b)
7. 225 ILCS 60/22(A)(4).

Case Files

Examples of Gross Negligence in Medical Malpractice

1 Surgeon was found liable for gross negligence after treating postoperative ileus with nasogastric suction and failing to monitor or replace electrolytes for three days. Patient later died from suspected electrolyte imbalance. Expert testimony played large part in court’s determination, as two experts both testified that omissions such as failing to administer electrolytes to a patient who

could not tolerate oral fluids and failure to review x-rays taken the night before the patient's death were "an extreme departure from the standard practice of medicine."

Gore v. Board of Medical Quality Assurance, 110 Cal. App. 3d 184 (Cal. 1980)

2 Doctors liable for grossly negligent care after administering 400 hours of supplemental oxygen to premature infant who later developed blindness from retrolental fibroplasia. Prior to event, AAP report was published warning of development of RLF in premature infants receiving supplemental oxygen and recommended regular ABG monitoring. At subsequent hospital pediatrics meeting, staff doctors warned that hospital would have "blind babies" if it did not obtain equipment to monitor neonatal blood gases. When plaintiff born as premature infant, hospital neither had proper equipment nor offered to transfer patient to hospital that did have proper equipment.

Birchfield v. Texarkana Memorial Hosp., 747 SW 2d 361 (Texas 1987)

3 Emergency department nurses were found liable for gross negligence for giving intravenous verapamil to patient suffering from ventricular tachycardia who refused cardioversion and whose rhythm had not responded to either lidocaine or bretylium. Cardiologist recommended giving Verapamil, but ACLS protocols noted that Verapamil is contraindicated in ventricular tachycardia, and nurses admitted knowing that there was an extreme risk in giving Verapamil. Patient suffered cardiac arrest shortly after receiving Verapamil and now has permanent brain damage. Emergency physician and cardiologist found not liable.

Columbia Medical Center of Las Colinas v. Bush, 122 S.W.3d 835 (Texas 2003)