Cardiac Symptoms Ignored, Woman Dies

On Aug. 19, 1999, Mrs. B went to her local hospital with chest pain and a reported family history of premature coronary artery disease. She told the emergency room physician that she had been having upper chest and shoulder pain for approximately five days. The ER doctor diagnosed chest pain and the need to rule out angina. He then contacted Dr. C, a general physician who had previously treated Mrs. B. Dr. C gave orders to admit Mrs. B.

At 7:36 a.m., an EKG was completed in the emergency room. The computer interpreted the study as abnormal, and Mrs. B's admitting diagnoses included chronic hypertension, chest pain, and the need to rule out coronary artery disease/angina.

Mrs. B was admitted to the telemetry floor at approximately 9:30 a.m. Cardiologist A examined Mrs. B and reviewed the EKG and documented chest pain/possible angina, obesity, adult onset diabetes, and hypertensive cardiovascular disease. His plan included the use of aspirin and other drugs to thin Mrs. B's blood, and he ordered a Troponin test, used to measure an enzyme level that rises in patients having heart attacks. Cardiologist A also ordered additional testing to take place in the morning, including a stress test, and repeat EKG and Troponin studies. Mrs. B continued to complain of chest pain throughout that day and into the evening hours.

The following morning, a repeat EKG demonstrated new abnormalities. Mrs. B also underwent the exercise portion of the stress test ordered by Cardiologist A. Mrs. B was unable to exercise for even three minutes before the test was discontinued due to her "fatigability." By 1:42 p.m., with her Troponin level still elevated, Mrs. B began complaining of chest pain. She was given nitroglycerine, which relieved her pain.

Experts testified that an emergency catheterization would have saved Mrs. B's life, and the stress tests should never have been performed.

Despite obvious signs that Mrs. B was developing an infarction, Cardiologist A resumed the exercise testing of Mrs. B the next day, August 21. Throughout the day, Mrs. B continued to complain of chest pain, and nitroglycerin continued to be administered to relieve the pain. Dr. C visited Mrs. B around 4:00 p.m., and he too noted her complaints of pain. By 5:30 p.m., Cardiologist A's partner, Cardiologist B, was notified. Cardiologist B ordered medications over the telephone for stomach upset, but did not treat Mrs. B's ongoing pain as a cardiac emergency.

Just before midnight, Cardiologist B was called concerning an episode of rapid heartbeat, nausea, and a small amount of vomiting. Cardiologist B ordered another EKG, which showed additional adverse changes, and Cardiologist B ordered Compazine. On Aug. 22, 1999, at 2:10 a.m., Mrs. B was found sitting up in her bed, unresponsive, and was pronounced dead.

Following Mrs. B's death, her husband of 31 years hired attorneys Chris Searcy and Karen Terry. Suit was brought against Dr. C, Cardiologist A, Cardiologist B, and the hospital. Experts hired by the plaintiff testified that an emergency catheterization would have saved Mrs. B's life. Furthermore, the stress tests should never have been performed.

Initially, the defendants collectively denied responsibility for Mrs. B's death, arguing that the Bs had refused a recommended catheterization. The medical records, however, did not support the allegation. No mention of the recommended life-saving measure, much less the fact that it was allegedly refused, was recorded. Eventually, the defendants began blaming each other for Mrs. B's death. The cardiologists argued that the general physician had failed to communicate the seriousness of the cardiac symptoms

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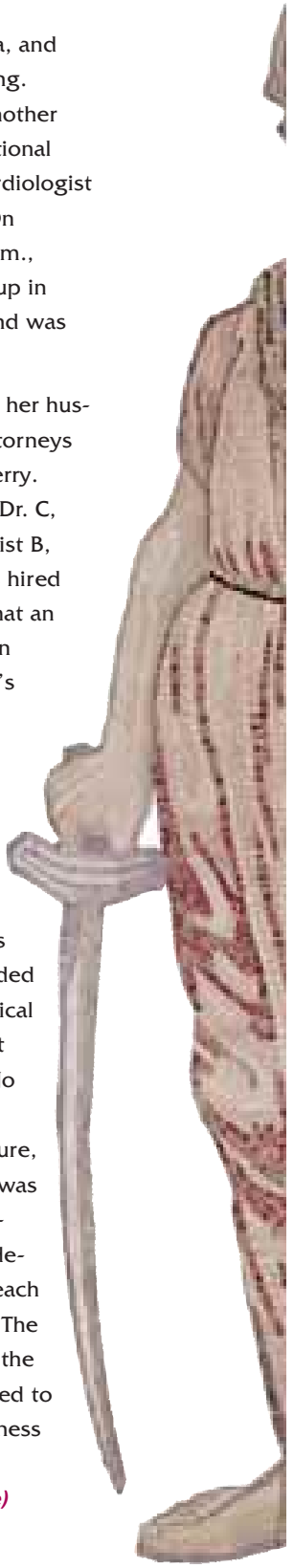

Decisions...Decisions...Decisions...

and test results, while the general physician blamed the cardiologists for failing to treat a patient who was obviously undergoing a serious cardiac event.

Ms. Terry settled the majority of the case with the hospital and the two cardiologists during mediation for a total of $700,000. Subsequently, Dr. C paid an additional $100,000 to resolve the remainder of the case. ■

Despite Numerous Doctor Visits, Man Diagnosed with Cancer

Mr. K, age 53, first established Dr. G as his primary care physician on Jan. 26, 1994. During Mr. K's third visit to Dr. G, which occurred on April 10, 1996, Mr. K underwent a prostrate-specific antigen (PSA) test. The result from the test was 2.4, which was within the normal range.

Mr. K visited Dr. G's office for treatment of various illnesses a total of seven times in 1997, although no physical examinations, PSA tests, or digital rectal exams were performed during that year. A similar scenario followed in 1998, as Mr. K visited Dr. G's office a total of ten times without ever having physical exams, PSA tests, or digital rectal exams performed.

On Sept. 20, 1999, during his fourth visit to Dr. G that year, a PSA test performed by the doctor revealed a level of 8.9, which exceeded the range deemed normal. A follow-up PSA test done on Nov. 12, 1999, revealed that the level had elevated to 16.4. As a consequence of the second lab value, Mr. Khan was referred for an exam with a urologist, which occurred on Dec. 2, 1999. By then, a CT scan showed the presence of metastatic carcinoma in Mr. G's prostate and thoracic spine. Aggressive treatment with radiation and chemotherapy was initiated, but the cancer continued to metastasize down to Mr. K's lumbar and sacral spine.

Believing that his cancer should have been detected long ago, Mr. K hired Dick Slawson of the law firm of Slawson, Cunningham, Whalen and Smith in Palm Beach Gardens, who in turn referred Mr. K to attorney Greg Barnhart. Mr. Barnhart investigated the claim, and in November 2001, placed Dr. G on notice of Mr. K's claim for medical negligence. Under guidelines mandated by the medical malpractice statute in Florida, that notice letter commenced a 90-day pre-suit investigation period, during which the opposing parties examined pertinent records, consulted with experts, and discussed the merits of the claim.

A follow-up PSA test done on Nov. 12, 1999, revealed that Mr. K's level had elevated to 16.4.

Prior to the expiration of the pre-suit investigation period, and therefore prior to the filing of a formal lawsuit against Dr. G, Mr. Barnhart successfully negotiated an $875,000 settlement on Mr. K's behalf with Dr. G's malpractice insurance carrier. The settlement proceeds will afford Mr. and Mrs. K some measure of comfort as Mr. K battles the effects of this dreaded, yet preventable, disease. ■