

Unprotected People #41

Pneumococcal Vaccine

Case closed: Pneumococcal vaccine may be everyone's responsibility

The following article was written by Ann Lofsky, M.D., and is used by permission of The Doctors Company (see www.thedoctors.com). The article tells a tale with two morals for health care professionals: one about the risks of pneumococcal disease for splenectomy patients, and one about the risk of any patient in need of immunization "falling through the cracks" of a multi-specialist team.

A patient with a serious medical condition is often treated by a number of physicians during the course of the illness. Determining which physician is primarily responsible for overseeing the patient's care may be difficult—even for the doctors themselves. If necessary treatment is omitted, it can become a difficult legal question as well.

A 38-year-old female noted a small mass on the left side of her neck, and a biopsy revealed mixed cellularity Hodgkin's disease. She was followed by a medical oncologist who referred her to our insured radiation oncologist, Dr. R. After obtaining a negative lymphangiogram, Dr. R. recommended a course of mantle irradiation. This was performed over a one-month period. The patient had excellent results, with shrinking of the neck mass, and she was classified as Hodgkin's stage IA-IIA in remission.

A CT scan of the pelvis was then ordered to confirm staging, and it revealed an enlarged uterus. Dr. R. referred the woman to a gynecologist, and a negative pregnancy test was obtained. Because of the possibility of Hodgkin's spread below the diaphragm, Dr. R. considered a course of radiation to the patient's spleen. Before beginning therapy, he consulted a prominent authority on Hodgkin's disease. The Hodgkin's authority expressed surprise that the patient had not been completely staged prior to irradiation and recommended an immediate staging laparotomy and splenectomy followed by additional radiation or chemotherapy as indicated by the surgi-

cal findings. Dr. R. phoned the woman's medical oncologist to discuss this plan.

The medical oncologist agreed with the proposed treatment and said he would provide the patient with a pneumococcal vaccine injection prior to surgery. Dr. R. informed the woman of the necessity of staging surgery and referred her to a general surgeon. When she expressed reluctance to undergo such an invasive procedure, he wrote to her, strongly advising she proceed. Surgery was performed and revealed Hodgkin's involvement of the spleen and periaortic lymph nodes. A medical oncologist prescribed a course of chemotherapy, and the patient has remained in remission since then.

One year after surgery, the patient presented to an emergency room complaining of chills. Her feet and hands were dusky and cold. She was ultimately diagnosed with pneumococcal sepsis, and disseminated intravascular coagulation and gangrene complicated her extensive hospital course. Treatment required bilateral below-the-knee amputations, partial amputation of eight fingers, and partial amputation of her nose. It was determined that she had never, in fact, received a prophylactic pneumococcal vaccine.

What Is The Applicable Standard Of Care?

Pneumococcal vaccine is routinely given to all persons at increased risk of serious pneumococcal infections, including those with immunosuppression, those age 65 or older, those living in high-risk social situations, and those with splenectomies. The vaccine has been shown to be 50 to 70 percent effective in preventing invasive pneumococcal infection in these patients, although the protection rate for patients with Hodgkin's disease may be lower. In a deposition, the patient's medical oncologist was forced to state that he had never before seen a patient who had undergone a splenectomy without first receiving the vaccine.

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Whose Responsibility Was It To Give The Vaccine?

All parties agreed that medical oncologists routinely provide injections of Pneumovax or Pnu-Imune prior to planned splenectomies. This oncologist argued that when he had last seen the patient, she had not yet agreed to surgery. He assumed he would see her again when she had decided, but he was next contacted after the procedure had been performed. He assumed someone else had provided the vaccine by this time. Further complicating matters was the fact that the patient changed medical oncologists after her surgery, and the original physician never saw her again.

Plaintiff experts contended that Dr. R. should have given the vaccine prior to beginning irradiation—the first immunosuppressive therapy given to this patient. Radiation oncologists argued this would not routinely be given by a radiologist, but Dr. R. could have referred the patient back to her medical oncologist for this purpose. The ultimate responsibility for oversight of a patient's care would fall to the primary physician, but in this case it was difficult to determine who that was.

Who Was Captain Of The Ship?

The plaintiff argued that our insured radiation oncologist had functioned in this case not only as a consultant but also as a primary director of the patient's care. In a handout given to his patients, Dr. R. describes himself as a valuable member of the treatment team, intricately involved in making diagnostic and therapeutic decisions. In fact, Dr. R. had ordered diagnostic studies, consulted with a medical expert, referred the patient to other physicians, and urged her to go forward with staging surgery—all functions usually assumed by the primary attending physician. The plaintiff's contention was that both Dr. R. and the medical oncologist were acting as "quarterbacks," and as such they had fumbled the ball on two occasions: first in failing to perform the staging laparotomy before initiating radiation therapy and second in neglecting to administer the pneumococcal vaccine.

The original treating oncologist conceded liability and settled out of the case for \$1 million. The surgeon,

admitting he never verified whether the vaccine had been provided, settled his case for \$500,000. Finally, the medical oncologist who directed chemotherapy after the staging surgery settled for an undisclosed sum, leaving only Dr. R. remaining as a defendant in this case.

What Is Joint And Several Liability?

Defense attorneys estimated that a jury might place 90 percent of the liability on the medical oncologist and surgeon, but Dr. R. could be found up to 10 percent responsible for this patient's injuries. The state of venue of this case follows the rule of joint and several liability. Under this doctrine, the plaintiff can opt to enforce the judgment against one of the defendants alone or all of them together. As long as any one of the defendants is found at least partially liable, that party is potentially on the hook for the entire amount of the judgment.

By all accounts this patient was an extremely sympathetic witness. Her injuries were very graphic and severe, yet she had struggled hard to overcome them and lead a normal life. She would continue to incur substantial medical and rehabilitation expenses, setting the stage for an astronomical jury verdict.

With the other parties to this lawsuit settled out, Dr. R. could potentially be left holding the bag alone for a multimillion-dollar award. Although it was possible this case could be defended on the medical issues alone, Dr. R. agreed to settle the case on his behalf for \$500,000.

Failure To Vaccinate May Inflame Juries

Malpractice cases for failure to provide pneumococcal vaccine are not uncommon and can involve serious patient injury or death. The fact that these outcomes could have been prevented by a simple, relatively low-risk vaccination can be inflammatory to juries. Experts in this case opined that every physician involved in this patient's care was in a position to review the records and realize that a potentially lifesaving intervention had been neglected. All physicians would be well advised to consider whether their patients qualify for pneumococcal vaccination.