



# The Bare Truth

Gulf Atlantic Legal Defense Insurance, Inc.

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## *The Bite of a Mosquito - A Case of Malaria*

Many physicians will go their entire career without ever seeing a case of malaria and treatment of malaria can be complicated as this case reflects.

The patient is a 22 y/o African-American female born in Ghana. Her father, a graduate of the University of Ghana medical school, is an OB/GYN, with an active practice in the northeast. She was living in south Florida and had just returned from a one month vacation in Ghana when she started to experience some physical complaints.

She presents to a south Florida hospital on February 14, 2004, with complaints of fever, chills and body aches for two weeks. She explained her father was a doctor and he had been treating her long distance for the last week. The Emergency Room physician made an initial diagnosis of malaria, possibly resistant *Falciparum Plaxmodium*. He knew certain malarias have resistance patterns and when the stain came back he immediately started her on 1 gram IM Cholroquine. He then contacted the on call Infectious Disease specialist, (Dr. A), who saw the patient in the ED.

The history the patient given to Dr. A was that she had just returned from a one month vacation in Ghana and had not taken the required amount of prophylaxis to avoid malaria. The working diagnosis was that she contracted malaria during her stay. Dr. A told the patient she had malaria and spoke with her father. Her physician father stated that he is an expert in malaria and had already spoken to the ER doctor, recommending she be started on small doses of Cholroquine. Dr.

A recommended she be treated with Quinine and Doxicycline because according to the CDC there is a strain of malaria resistant to Cholroquine in Ghana.

The father disagreed and said he was from Ghana and knew the resistant patterns from that area. Dr. A told the father that he would keep her on Cholroquine, however, after 24-48 hours if she did not show signs of improvement, he would switch to Quinine and Doxicycline. The father voiced no objections to this treatment plan. (It should be noted that throughout the patient's hospitalization, her father frequently conferred with the treating physicians on their treatment plan.)

On February 15th, during the early morning hours, Dr. A received a call from the radiologist and was informed the patient suffered a seizure while receiving a CT scan. The radiologist mentioned that she was foaming at the mouth and her tongue was bleeding. She was transferred to the ICU and immediately started on Quinine and Doxicycline. Dr. A saw the patient later that day and noted she had complaints of nausea,

headaches and fever, but was oriented to time and place.

The following day, the 16th, Dr. A turned the patient over to our GALDI Infectious Disease specialist. A review of her treatment was she had started a trial run of Cholroquine at the request of her father, but because her symptoms were not improving, her meds were changed to Quinine and Doxicycline. She deteriorated overnight and an IV of Quinidine had been started. That morning Our GALDI ID specialist took over treatment of the patient.

Our GALDI insured reviewed the chart and all the smears which had been completed over the weekend. He then saw the patient, signed off on the current meds, and noted she was confused but able to converse. She appeared very ill and was tachycardic. He requested additional blood work and another smear. Later that evening the patient seized, arrested, and became unresponsive and subsequently expired.

An autopsy was performed; however, the examiner, on deposition, conceded he made no effort to determine

### *Profile of one of GALDI's Panel Counsel*

*Falk, Waas, Hernandez, Cortina, Solomon & Bonner, PA., Ft. Lauderdale/Coral Gables*



*RoseMarie Antonacci-Pollick*, Partner. Admitted to FL Bar, 1985.

Undergraduate of Emory University BA, magna cum laude from University of Miami, 1982. JD, University of Miami, 1985.

Areas of Practice: Medical Negligence and DOH Administrative matters.

Professional Activities: Board of Directors, Greater Palm Beach County Juvenile Diabetes Research Foundation and National Lay Review Committee, Juvenile Diabetes Research Foundation.

(Cont.)

why she had cerebral edema and took no stains to document parasites in the blood stream or brain, or question why she had elevated levels of Cholroquine in her system (she had not received this drug for at least 48 hours prior to her death).

### "The Suit"

A Notice of Intent and suit was subsequently filed by the patient's father, as personal representative, against Dr. A, the hospital and our GALDI Infectious Disease specialist, alleging the doctors and nurses failed to monitor and control her dosages of IV Quinine and she eventually became Quinine-toxic and expired. Discovery ensued.

Plaintiff's 83 y/o pathology expert testified that her death was due to an undeliberate overdose of medications and based his testimony on the toxicology report. He acknowledged that Falciparum Plasmodium malaria was the most life-threatening type of malaria and even though there were parasites in the brain he insisted this was not a case of cerebral malaria.

Plaintiff's Infectious Disease expert was deposed and provided very favorable testimony to the defense of the case. It was his opinion that the patient's death was caused by Falciparum Plasmodium malaria and its complications, specifically cerebral edema. From his review of the case, it appeared that the local doctors were deferring to her father and his suggestions, only changing the treatment course when she began to deteriorate. He was also critical of the pre-hospitalization course of treatment by her father, saying he should have suspected malaria and gotten her to a hospital earlier. The correct treatment was Quinine Sulfate and Doxycycline because Chloroquine resistant strains of malaria are found in Ghana.

Favorable testimony was also gleaned from the plaintiff's Internal Medicine expert who felt the patient died because of

President's Letter

At Gulf Atlantic, we are proud of our heritage of helping physicians navigate through troubled times. Formed in the malpractice crisis of the 70's, and reinvented in the malpractice crisis of the early 2000's, the Gulf Atlantic team knows that one thing is certain in this world -- uncertainty.

Actually, physicians who carefully consider their liability exposure, who choose to make decisions alone whether to settle or defend the claim and who pay a judgment out of their own pockets, are self insurers. They are not unprotected, they've just chosen a different, and in many cases more efficient, method of financial protection against lawsuits--just as many Fortune 500 companies do.

When you, a colleague or your medical group decide to take the step to become a self insurer, Gulf Atlantic wants to help you do so effectively and efficiently. We think the key to any insurance operation, whether as a self insurer or as an insurance company, is the ability to mount a vigorous and effective defense.

A Gulf Atlantic Legal Defense insurance policy ensures that when the time comes, you'll be able to mount that defense. Gulf Atlantic's panel of attorneys includes most of the law firms in Florida specializing in medical malpractice defense. Ask a malpractice defense lawyer about us. Most will know of us, and we think all who do will say good things about us.

And with our new coverage options, you'll be better able to customize your legal defense policy to meet your needs. We now offer, in addition to our standard policy, which provides broad defense cost coverage with \$100,000 per claim and \$200,000 annual aggregate limits of liability, the following:

- ♦ Additional per claim and annual aggregate defense cost limits of liability in increments of \$25,000, up to an additional \$100,000.
- ♦ Separate group and corporate coverages. Corporate entities may choose shared limits or separate limits.
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quinine toxicity and low potassium which led to a fatal cardiac arrhythmia. This testimony was in conflict with the plaintiff's ID expert who believes the appropriate treatment was started too late to prevent cerebral involvement and this is what caused her death.

At this point the case was ripe for mediation. With the plaintiff's own experts critical of the patient's father's intervention in

her care and treatment, and the fact that the plaintiff's own experts were not exactly sure of her cause of death, the case was resolved by the parties. The hospital and Dr. A paid a small six figure settlement and our GALDI doctor was dismissed and paid nothing.

Length of Litigation: 5 years  
Cost of Litigation: \$80,014.69

# Helpful Deposition Hints

Getting noticed for a deposition can be a scary thing. Over the years the firm of McEwan, Martinez & Dukes in Orlando, FL, has put together some simple deposition “hints” to help doctors prepare.

1. Tell the truth. This is more than a copybook maxim; it is a rule of self-preservation for witnesses. Assume that the examining counsel is supporting himself on his professional ability and that this includes the ability to make a witness who is playing fast and loose with the truth very uncomfortable. Further, you can repeat a true story over and over, where if there is a deviation, it will come out sooner or later.
2. Think before you speak. Allow five full seconds to elapse before beginning to answer the question. This allows counsel to formulate objections and further allows you to think through what your answers are going to be. You should realize that when you testify you are dictating an important document.
3. Answer the question. The examiner is entitled to an answer to the question which he asks, but only to that question.
4. Do not volunteer information. You are not there to educate the examiner.
5. Do not answer a question you do not understand. It is up to the examiner to frame intelligible questions; if he cannot do it, do not help him. Do not explain to the examiner that the question is incomprehensible because he has misunderstood words of art in your profession. Do not help the examiner by saying “do you mean X or do you mean Y.” You will be asked both of these questions.
6. Talk in full, complete sentences. Unless it is a simple question, the question should not be answered yes or no. Beware of questions containing double negatives.
7. You only know what you have seen or heard. Questions are often phrased “do you know?” A question on deposition may legitimately call for something you do not know, but it must be so phrased. There is a difference between a question which asks do you know, and a question which asks whether you have any information bearing on a particular subject.
8. Do not guess. If you do not know or cannot recall something, say so. This rule becomes more important and more difficult to follow when the examiner is scoring points or making it appear to you that only an idiot does not know the answer to the questions.
9. Be as specific or as vague as your memory allows, but do not be put in a position contrary to your true recollection. If you are asked when something occurred and you remember that it occurred on January 15, state January 15. If, on the other hand, you cannot recall the exact date, state the approximate date and say that it is approximate.
10. Do not explain your thought process as to how you reached the answer to a question. In answering a question to which your answer depends on your recollection and other facts not called for by the question; do not refer to these other facts in explaining how you can answer the question. In other words, if you are asked when a conversation with Mr. Jones occurred, and you recall that it had to be in December because you met Mr. Smith after Mr. Jones and that was in January, do not explain this thought process to the examiner.
11. In testifying concerning conversations, make it clear whether you are paraphrasing or quoting directly.
12. In answering questions calling for a complicated series of events or extensive conversations, summarize these where possible. The examiner, if he is doing his job properly, will ask for all the details. It is always possible the examiner will accept your summary and not ask additional questions.
13. Never characterize your own testimony. “In all candor,” “honestly,” “I’m doing the best I can,” should never be used.
14. Avoid all adjectives and superlatives. “I never” or “I always” have a way of coming back to haunt you. There are times however, when such words are appropriate and the decision to use these terms should be discussed with your attorney prior to the deposition so there are no surprises when they come out.

*(Additional “hints” will follow in our next newsletter or you can read the entire article at [www.gulfatlantic.com](http://www.gulfatlantic.com))*



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