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Warning: Appendicitis is common and commonly missed

By **David L. Freedman, MD, JD, FAAEM**, Attorney at Law, Miller, Canfield, Paddock & Stone PLC, Ann Arbor, MI

Abdominal pain is one of the most frequent complaints of patients presenting to emergency departments (EDs) for evaluation. Annually, approximately 5 million patients present to EDs in the United States for evaluation of abdominal pain, accounting for 5%-10% of all ED visits in some areas.¹ While most of these patients end up not having appendicitis, the emergency physician should at least consider appendicitis in nearly every patient who presents to the ED with abdominal pain. Appendicitis is a relatively common complaint, with a reported incidence of approximately one case per 1,000 people per year.²

Appendicitis is common and commonly missed. As many as 30% of patients with proven appendicitis are misdiagnosed and discharged by a physician before the correct diagnosis is made.³ As a result, missed appendicitis is a very significant risk-management issue in emergency medicine. The misdiagnosis of appendicitis is the fifth-leading cause of successful litigation against emergency physicians and accounts for 15% of all dollars paid in ED malpractice claims.⁴

The average layperson (i.e., jury member) has no idea how difficult it can be to make an accurate diagnosis of appendicitis, particularly in its early stages. Many people believe that there is an "appendicitis test" that can be administered that will reliably rule out the diagnosis of appendicitis. This perception is undoubtedly reinforced by physicians who overly rely on normal white blood counts (WBC) in ruling out appendicitis, leading to the misconception that the WBC is "the appendicitis test."

Appendicitis is a problematic diagnosis to miss for a number of reasons. Most importantly, a delayed diagnosis can lead to a significant increase in morbidity and even mortality. In defending a "missed appendicitis" case, we often face an uphill battle from the start in defending the case for two reasons. First, patients will relatively frequently present to the ED with a chief complaint of: "I think I've got appendicitis." Most, of course, do not and are sent home after

evaluation. Some of these patients who are sent home, however, actually did have appendicitis when they were first seen. A layperson on the jury likely will have concerns about the clinical acumen of the physician, having “missed” the diagnosis when even the patient knew he had appendicitis. Our arguments about how difficult it can be to make a diagnosis in “early appendicitis” will necessarily be a bit strained and might have limited effectiveness when the patient seemed not to have had any problem with making the diagnosis, despite the early stage of the illness.

Second, most laypersons believe that the diagnosis and treatment of appendicitis is entirely routine. That is, they believe the presentation, diagnosis, treatment, and recovery in appendicitis are, as a rule, uncomplicated. This fosters a layperson’s impression that any problem in the diagnosis, surgical, or post-surgical course of a patient with appendicitis means something went wrong (i.e., the physician missed something or did something wrong). In effect, despite our argument (supported by the judge’s instructions) that the plaintiff has the burden of proving that the standard of care was breached, there is at least some

degree of burden-shifting in the minds of the jury such that the physician who “missed” the diagnosis of appendicitis is “guilty” until proven otherwise.

***Davis v. Immediate Medical Services Inc. et al.*⁵**

Albert Davis began experiencing pain in his right lower abdomen on April 7, 1991, and in response to her husband’s complaints, Evelyn Davis “consulted a medical book at home.” After reading the book, Mrs. Davis thought that her husband’s symptoms were caused by appendicitis, and she took her husband to Immediate Medical Services, a local “emergency care facility.” The Davises told the examining physician, Dr. Barbara Guarnieri, that they were suspicious that the problem was appendicitis. Mr. Davis was examined by Dr. Guarnieri, who “took a history and performed a number of tests.” Following her examination, Dr. Guarnieri diagnosed a urinary tract infection, a condition that Mr. Davis had said he had suffered from a few years earlier. Dr. Guarnieri prescribed antibiotics and “told Mr. Davis that he should consult his own physician if he did not feel better *in a couple of days.*”⁶

Although Mr. Davis took the prescribed medication, his illness continued. Two days later his wife took him to Alliance Community Hospital (Alliance) on April 9. At Alliance, “Mr. Davis told Dr. Serri [the treating physician] that he was experiencing lower abdominal pain which had not subsided, and *again expressed his concern that it was appendicitis.*”⁷ Dr. Serri examined Mr. Davis, ordered additional tests, and eventually diagnosed “abdominal pain with an uncertain cause.” He advised that the course of antibiotics be completed and gave Mr. Davis a prescription for a pain medication. Dr. Serri also spoke to Mr. Davis’ family physician and told Mr. Davis to schedule a follow-up appointment with his family physician.

On April 15 (eight days after the first visit to the ED), Mr. Davis saw his family physician, William Eichner, at a scheduled appointment. At that time, Mr. Davis reported that he felt better but had experienced some cramping over the previous weekend. Dr. Eichner concluded that Mr. Davis had a urinary tract infection with resolved symptoms of gastroenteritis. Dr. Eichner prescribed a medication for stomach discomfort and scheduled Mr. Davis for a follow-up visit *two weeks later.*⁸

Eight days later, on April 23, Mr. Davis returned to the ED at Alliance with severe pain and breathing difficulties. Dr. Serri, the physician he had seen the

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Questions & Comments

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first time he came to Alliance, re-examined him. This time, Mrs. Davis requested that Dr. Serri contact her physician, Duane Kuentz. Dr. Kuentz came to the hospital, examined Mr. Davis and determined that he was suffering from multiple abdominal abscesses, perhaps from a ruptured appendix. He consulted a general surgeon, who recommended that Mr. Davis be taken to the operating room the following day after he had been stabilized.

The following day, an exploratory laparotomy was performed, and the surgeon discovered and drained the abscesses and removed the ruptured appendix. Despite surviving the surgery, Mr. Davis succumbed to the infection that had resulted from his ruptured appendix and died the following day.

A medical malpractice lawsuit was filed by Mrs. Davis as administrator of her husband's estate against multiple defendants. A jury eventually returned verdicts in favor of all the defendants except Dr. Eichner, the family doctor, who was found liable in the amount of \$643,000. A number of issues were appealed, and the case eventually reached the Supreme Court of Ohio. One of the issues on appeal is notable, particularly in light of our recent article on the use of expert witnesses (*ED Legal Letter*, November 2000). Dr. Guarnieri had called Dr. Bruce Janiak as an expert witness on her behalf. Dr. Janiak, it turned out, was insured by the same company, Physician's Insurance Exchange Company (PIE), that also insured some of the defendants in the case, specifically EM Care, the employer of Dr. Serri. The trial court refused to allow the plaintiff to cross-examine Dr. Janiak concerning this commonality of insurance for the purpose of demonstrating potential bias on the part of Dr. Janiak. The Supreme Court of Ohio eventually held that this was reversible error and reversed the judgments in favor of the remaining defendants in the case and remanded the cases for new trials, including a new trial for Dr. Guarnieri, even though he was not insured by PIE.

Commentary: *Never forget that patients and/or their families can be right. This case is a perfect example of the situation described in the introduction to this article in which a patient, or family member, has made the correct diagnosis and the physician (here, physicians) missed it. As a result, the defense has to overcome a significant initial hurdle in explaining how the physicians missed the diagnosis when the patient's wife was able to make the correct diagnosis after simply consulting her home health manual. The*

vast majority of patients who present to the ED thinking that they have appendicitis are, of course, incorrect. The jury, however, likely will be focused much more narrowly on the specific case before them in which the patient got it right and will not be particularly interested in excuses about how the vast majority of patients who think they have appendicitis are wrong. The jury likely will be impressed that the patient (in the case of Mr. Davis, the now deceased patient) in this case was right. The important lesson to be learned from this case is not, of course, to blindly rely on a patient's self-diagnosis, but rather to appropriately respond to that self-diagnosis by discussing with the patient your reasons for disagreeing, acknowledging that you could be wrong, and arranging very close follow-up for re-evaluation. The latter two points are particularly important in appendicitis where we frequently send patients home without definitively ruling out appendicitis. Sending a patient home who might have appendicitis to get rechecked if not "better in a couple of days" is not acceptable.

We also see in this case the apparent problem (a problem we have emphasized with regularity in *ED Legal Letter*) of relying on a previous physician's assessment. It seems that at least part of the problem in this case may have been that Mr. Davis was labeled as having a urinary tract infection, not appendicitis, at his first visit and then, on subsequent visits, the physicians might have failed to make a fully independent assessment of his problem, their evaluation being overly influenced by a previous physician's diagnosis.

Finally, this case demonstrates the importance of very carefully evaluating all the experts in your case, including those experts that will be used by your co-defendants. It may be that a jury would not find an expert's commonality of insurance with a co-defendant to be a sufficient reason to discredit the expert's testimony, but why take the chance?

The White Blood Cell Count

It is, in large part, physicians' frequent overreliance on the WBC in conjunction with the evaluation of patients with possible appendicitis that fosters the misconception among the public, and some physicians, that there is an "appendicitis test" and that the WBC is that test. It is not. There is no laboratory test that can accurately rule in or rule out the diagnosis of appendicitis. That is not to say that some laboratory tests (e.g., the WBC with differential) might not be helpful

to some extent in some clinical circumstances. Despite the fact that appendicitis is a clinical diagnosis, not a laboratory diagnosis, it is still common for the surgeon, in response to a request to provide a surgical consultation, to first ask what the WBC is and, if it is not back, to ask the emergency physician to call him or her back when it is, as if a normal WBC will eliminate the necessity for the consultation. Fortunately, even the surgical literature is acknowledging the fact that the WBC is not essential in the diagnosis of appendicitis or even the decision to operate.⁹

While it is true that approximately 75% of patients with acute appendicitis have an elevated WBC,¹⁰ an elevated WBC is extremely nonspecific and can be present in association with many benign abdominal conditions.¹¹ While it is true that patients with normal WBCs and normal differentials are unlikely to have appendicitis, as many as 4%-11% of patients with acute appendicitis will have a normal WBC and differential.¹² It is, therefore, certain folly to rely on such normal values to definitively rule out acute appendicitis.

Appendicitis in Women: *McKersie v. Barnes*¹³

The diagnosis of appendicitis in women is a particular problem for two primary reasons: 1) the differential is broader and more confusing than in men (*e.g.*, ectopic pregnancy, ovarian cyst, endometriosis, pelvic inflammatory disease); and 2) perforation can result in all of the complications seen in men, as well as possible infertility problems, including loss of an ovary and fallopian tube.

Sara McKersie, a 29-year-old mother of one, visited her internist, John Grant, on June 13, 1986, with complaints of abdominal pain, vomiting, diarrhea, nausea, and fever. Dr. Grant examined her and diagnosed her as having gastroenteritis or possibly appendicitis. Dr. Grant advised that she go to the hospital for further evaluation, but she declined.

Later that evening, Ms. McKersie's pain increased, and she called Dr. Grant, who again advised her to go to the ED. Dr. Grant called the ED at Barnes Hospital (Barnes) "to let the staff know plaintiff was coming in with possible appendicitis," and Ms. McKersie arrived at the ED at approximately 11 p.m.

About 1:50 a.m. on June 14, Dr. Richard Johnston, an ED intern, examined Ms. McKersie. Dr. Johnston realized appendicitis was a primary concern and conducted "pelvic and rectal examinations, took an X-ray,

and performed blood tests." Dr. Johnston noted that Ms. McKersie complained of "constant pain in her abdomen, localized in the right lower quadrant (where the appendix is located), fever, nausea, vomiting, diarrhea, and loss of appetite." In addition, Dr. Johnston also noted that Ms. McKersie also exhibited "tenderness in the lower right abdominal quadrant deep in the pelvis, a mass on her right ovary, and an abnormally high white blood cell count of 13,200." The court noted that "all of the above are symptoms of appendicitis." Despite this, in the diagnosis section of the chart, Dr. Johnston wrote that Ms. McKersie had "gastroenteritis, and a possible luteal (ovarian) cyst."

After examining Ms. McKersie, Dr. Johnston had consulted by telephone with a gynecology resident who, after hearing Dr. Johnston's summary of the case, agreed that Ms. McKersie had an ovarian cyst. Dr. Johnston also called Dr. Grant and told him of his patient's symptoms. Dr. Grant then agreed with the discharge of his patient. At discharge, Dr. Johnston told Ms. McKersie that "she did not have appendicitis and was not going to need surgery" and that she "either had a severe case of the flu (gastroenteritis) or an ovarian cyst."¹⁴ Ms. McKersie was discharged at approximately 3 a.m.

Dr. Grant testified at his deposition that Dr. Johnston had neglected to tell him that he (Johnston) was an intern who had never diagnosed appendicitis before, nor did he tell Dr. Grant of Ms. McKersie's abnormally high WBC.¹⁵ Dr. Grant also testified that, had he known of the elevated WBC, it would have raised a "red flag" and he would have done things differently.¹⁶ He also testified that, had he know that Dr. Johnston was an intern, he would have requested that a senior resident see the patient, or he would have come in himself to see his patient.

Later that morning, Ms. McKersie called Dr. Grant (as instructed by Dr. Johnston at the time of her discharge), and Dr. Grant told her to follow Dr. Johnston's instructions. Ms. McKersie contacted her gynecologist, Dr. Durel, who, believing her problem to be a cyst, recommended bed rest. On June 19, Ms. McKersie experienced a "vaginal discharge of a yellowish-green hue and foul odor."¹⁷ She went to see Dr. Durel, who examined her and found a mass on her right ovary. Dr. Durel admitted her to the hospital, and an ultrasound was performed. For the next several days, Ms. McKersie was treated with intravenous antibiotics at the hospital. Finally, on June 23, exploratory surgery was performed, at which

time it was discovered that Ms. McKersie's appendix had ruptured. Pus had spread into the pelvis and completely infected Ms. McKersie's right ovary and fallopian tube and, as a result, both had to be removed, along with her appendix.

Ms. McKersie filed a medical malpractice lawsuit against Barnes alleging that Dr. Johnston was negligent in failing to properly diagnose her appendicitis and this negligence was the cause of the eventual rupture of her appendix and loss of her ovary and fallopian tube. After a five-day jury trial, the jury returned a verdict against Barnes awarding Ms. McKersie \$624,000 in damages, itemized as \$314,000 in past noneconomic damages and \$310,000 in future noneconomic damages. The trial court reduced the award to \$474,000. On appeal, the judgment was affirmed.

Commentary: *Dr. Johnston started out doing all the right things, including putting appendicitis at the top of (or at least high on) his differential diagnosis list. He collected all the right information (although there was no mention of a pregnancy test in the case report). But then, despite strong evidence in support of appendicitis, he made the incorrect diagnosis. At this point, the correct diagnosis may not necessarily have been "acute appendicitis." A better diagnosis would have been "abdominal pain of uncertain cause/possible appendicitis."*

This is a case that probably never should have happened. The patient's physician alerted the ED that his patient was coming in with possible appendicitis, and the patient arrived with what appears to have been classic signs and symptoms of appendicitis. Unfortunately, the case went bad: 1) Dr. Johnston was inexperienced and not sufficiently supervised; 2) the gynecology resident relied on the presentation of an inexperienced intern rather than actually examining the patient; and 3) Dr. Johnston apparently failed to provide all relevant facts to Dr. Grant and/or Dr. Grant failed to ask the right questions.

The Urinalysis: *Holder v Caselton*¹⁸

On June 23, 1991, Richard Holder went to the ED at Boyd Hospital in Carrollton, IL, with a complaint of "sudden onset of epigastric pain." He was examined by Dr. Jude Caselton who, believing that Mr. Holder might have acute gastritis, gave him pain medication and told him to return if his pain did not subside. On June 25, Mr. Holder returned to the ED, now "complaining of right lower quadrant abdominal

pain, lack of appetite, and slight nausea." Dr. Caselton examined Mr. Holder and found that he had "diffused [sic] abdominal tenderness, mainly in the right lower quadrant."¹⁹ Dr. Caselton admitted Mr. Holder and ordered laboratory tests, including a complete blood count and a urinalysis.

On admission, Mr. Holder's WBC was elevated, and his urine was "loaded with red blood cells."²⁰ Mr. Holder had a long history of urinary tract problems, including kidney stones and hematuria. He also had previously complained of pain in his right flank and right abdomen. Dr. Caselton suspected a kidney stone and intended to observe Mr. Holder for "acute abdomen with early acute appendicitis."²¹ During his entire hospital stay, Mr. Holder continued to have hematuria.

On June 26, Mr. Holder was examined by a general surgeon, Dr. Jose Parcon, who found that Mr. Holder had pain over both lower quadrants. An intravenous pyelogram showed no obstruction, and Mr. Holder's WBC remained elevated. At the time he examined Mr. Holder, Dr. Parcon believed that immediate surgery was not indicated, and Dr. Caselton concurred in this opinion.

On June 27, Dr. Caselton examined Mr. Holder and found no tenderness or rigidity in the abdomen and, on June 28, Mr. Holder's WBC had decreased to normal. On June 29, Mr. Holder's WBC was still normal, and Dr. Caselton thought that his patient seemed better and that his abdomen was soft and less tender. The nurses strained Mr. Holder's urine and found a "black prickly stone."²² Late in the evening on June 29, Mr. Holder began deteriorating, "complaining of lower right-quadrant pain and voiding dark-brown and stained urine. He also had decreased blood pressure."²³

On the morning of June 30, Mr. Holder complained of severe abdominal pain and had rapid respirations. During the afternoon of June 30, Mr. Holder denied any pain, and Dr. Caselton thought Mr. Holder had "renal colic and a decompressing belly that was 'throwing off' pulmonary emboli."²⁴ On July 1, Dr. Caselton ordered Mr. Holder transferred to Jacksonville to be seen by a specialist. Mr. Holder died en route, and an autopsy revealed that his cause of death was "peritonitis from a bacterial infection caused by a ruptured acute appendix."²⁵

A medical malpractice lawsuit was filed by Mr. Holder's estate against Drs. Caselton and Parcon, alleging that the defendants failed to diagnose and treat Mr. Holder's acute appendicitis and sepsis. A jury returned a verdict for the defendants, and this

verdict was affirmed on appeal.

Commentary: *The defendants prevailed in this lawsuit, although a different jury might have reached an opposite verdict. It appears that the physicians focused too narrowly on the patient's hematuria. The hematuria, along with Mr. Holder's history of kidney stones, certainly made it reasonable to include renal colic in the differential, perhaps even high on the differential. The hematuria would not, however, be reason to not keep appendicitis high on the differential, if not at the top, especially with a presentation on June 25 that certainly seems to suggest appendicitis — right-lower quadrant pain, anorexia, nausea, and diffuse abdominal tenderness that was worst in the right lower quadrant.*

While it is possible that Mr. Holder had both renal colic (which was causing his hematuria) and appendicitis, there was no objective evidence to suggest renal colic, other than the hematuria — his intravenous pyelogram and autopsy were negative for stones. That does not mean that he did not have a stone, but, other than the hematuria, there was no objective evidence of a stone. On the other hand, it was ultimately proven that he had a ruptured appendix and that was certainly an adequate explanation for his right-sided abdominal pain. In the final analysis, it really does not matter whether there was a concurrent stone or not — Mr. Holder had autopsy-proven ruptured appendicitis.

Physicians also should not be unduly distracted by a finding of WBCs or bacteria in the urine. If the appendix is in contact with the ureter, the urinalysis can mimic the urinalysis of a urinary tract infection. Up to 30% of patients with documented appendicitis will have more than five white blood cells per high-power field.²⁶

When discussing being misled by hematuria, mention must be made of the even more serious problem that can be misdiagnosed as renal colic: abdominal aortic aneurysm (AAA). A brief digression with a few cautionary comments is therefore in order. First, if you are going to make the diagnosis of renal colic and your patient is in the age range where AAA should be seriously considered, at least think about — if not rule out — AAA. Obviously, a history of multiple renal calculi does not rule out AAA. Do not allow yourself to ignore the possibility of AAA based upon hematuria and a history of renal colic. Second, if you are tempted to make the diagnosis of renal colic in the face of bilateral flank pain, think again (and again, as many

times as necessary, until you have definitively ruled out AAA). Patients certainly can develop stones in both kidneys, but it would be highly unlikely to have simultaneous, bilateral renal colic.

The Rectal Examination: *Shea v. Izsak*²⁷

Some cases alleging the failure to diagnose appendicitis have been based specifically upon the failure to do a rectal examination. While many experts would now agree that it is not necessary to do a rectal examination on all patients with possible appendicitis, classic surgical teaching has been that a rectal examination is part of the proper evaluation of all patients with abdominal pain. The following is an interesting case in which the failure to do a rectal exam was at issue.

On Jan. 4, 1997, Trisha Shea came to the Toledo (OH) Hospital ED with complaints of diffuse abdominal pain, vomiting, and diarrhea. She was seen by Dr. Eugene Izsak, the emergency physician on duty at the hospital. According to the court, Dr. Izsak “examined Miss Shea’s mucous membranes, lips, lungs, and heart, and papitated [sic] her abdomen.”²⁸ On examination of her abdomen, Dr. Izsak concluded that she had no tenderness in the area of her appendix.

Dr. Izsak made a provisional diagnosis of gastroenteritis with mild dehydration and treated Miss Shea with intravenous fluids and promethazine. Miss Shea remained in the ED for four hours while receiving the fluids and, during that time, was observed by Dr. Izsak. She was then discharged with instructions to seek further evaluation for any persistent vomiting or high fever.

Two days later, Miss Shea was admitted to St. Luke’s Hospital in Toledo, and was treated for a ruptured appendix. Miss Shea subsequently filed a malpractice lawsuit alleging that Dr. Izsak was negligent in failing to diagnose her appendicitis when he saw her on Jan. 4. The only omission that the plaintiff specified with respect to Dr. Izsak’s evaluation of her was that he had not performed a rectal examination.

The plaintiff’s own expert witnesses provided little, if any, support for the contention that Dr. Izsak’s failure to do a rectal examination constituted a breach of the standard of care. However, Dr. Izsak himself had authored a chapter (“Approach to Abdominal Pain”) in *Pediatric Emergency Medicine*, published by A.B. Saunders Co. in 1992, in which he stated that “[a] rectal exam should be included in all evaluations of

abdominal pain.” Fortunately for Dr. Izsak, this failed to convince the court that Dr. Izsak’s failure to do a rectal examination constituted a breach of the standard of care because the court found that: 1) the chapter did not, itself, establish that the standard of care in 1992 was to do a rectal examination on all patients with abdominal pain; 2) the standard of care at issue was for 1997, not 1992; 3) “an article in *Emergency Medical*, November 1998 . . . cite[d] several studies which indicate that rectal exams are not helpful in diagnosing appendicitis; and 4) plaintiff’s own expert testified that he often did not use a rectal exam to diagnose appendicitis. A motion for summary judgment for the defendants, the hospital and Dr. Izsak, was granted, and the case was dismissed against all defendants.

Commentary: *As a defendant, it is crucial to assist your attorney by bringing any potentially damaging evidence to the attention of your attorney, including articles that you may have written that could undermine your case. In this case, Dr. Izsak apparently did so, and his attorneys were able to appropriately respond to and counter Dr. Izsak’s 1992 article.*

While there is certainly literature support for the contention that a rectal examination is not necessary for the diagnosis of appendicitis, a plaintiff still likely will be able to find an expert who will testify that a rectal examination should be done in all patients with possible appendicitis. An additional benefit of a rectal examination (not to the patient) is that documentation of a rectal examination is evidence of the thoroughness of the physician’s evaluation of the patient.

Atypical Presentations: *Clelland v Haas*²⁹

Brenda Clelland went to the ED at St. Tammany Parish Hospital on the morning of Friday, Oct. 13, 1995, with a complaint of “sudden onset of severe mid-abdominal pain.” According to the triage nurse, Ms. Clelland complained of nausea, but had no vomiting or diarrhea. She did complain that her pain worsened when her car went over bumps in the road on the way to the hospital. Dr. Michael Haas, the emergency physician, noted in his history that Ms. Clelland was not complaining of any nausea and was describing her pain as “general lower-abdominal pain.” Ms. Clelland’s vital signs were normal, and Dr. Haas’ examination revealed she had no rebound tenderness or rigidity of her abdomen. Her WBC was 14,000.

Dr. Haas ordered a pelvic ultrasound to “reveal any uterine or other female organ problems in

addition to any abdominal problems.” At some point, Ms. Clelland was given an injection of ketorolac. The ultrasound was interpreted as showing “a pocket of fluid in the posterior cul-de-sac,” which the interpreting physician attributed to a ruptured ovarian cyst. It also was noted that cysts previously had been identified in Ms. Clelland’s left ovary and there were currently none.

Ms. Clelland’s pain subsided within two hours of her ED admission. It was Dr. Haas’ impression that Ms. Clelland probably was suffering from a ruptured ovarian cyst. He discharged her with prescriptions for an analgesic and an antibiotic and instructions to follow up with her private doctor on the following Monday, *three days later*. Dr. Haas contended that he verbally told Ms. Clelland to return to the ED or call her doctor if her symptoms returned or worsened. This, however, was not supported by the written discharge instructions.

On Saturday, Ms. Clelland felt somewhat better, but early Sunday morning, she awoke with “a high fever, diarrhea, nausea, and intense pain in her lower-right abdomen.” She returned to the ED and was examined by a different physician, Dr. Joan Curtis. Dr. Curtis diagnosed appendicitis and consulted a surgeon, who subsequently removed Ms. Clelland’s ruptured appendix. Several complications followed the appendectomy that Ms. Clelland contended were related to the ruptured appendix.

Ms. Clelland filed suit against Dr. Haas and, at the conclusion of a jury trial, the jury returned a verdict in Dr. Haas’ favor. This verdict subsequently was upheld on appeal by the Court of Appeal of Louisiana.

Commentary: *While Dr. Haas prevailed in this lawsuit, the claim that the plaintiff had the best chance of proving (breach of the standard of care with respect to the discharge instructions provided), could have been pre-empted if Dr. Haas had written all of his discharge instructions, particularly the instruction to return to the ED if her symptoms worsened. While this jury believed that Dr. Haas had provided this discharge instruction verbally, and therefore returned a verdict for Dr. Haas, another jury might have decided otherwise.*

Ms. Clelland’s presentation was not classic in that she had a sudden onset of severe pain, and it was understandable that Dr. Haas probably felt this onset was more consistent with a ruptured ovarian cyst. It is crucial, however, to remember that “atypical” presentations of appendicitis are typical. The

emergency physician must constantly guard against focusing exclusively on a diagnosis suggested by the patient's initial presentation.

The Benefits of a Well-Documented Record

Gonzalez v. United States.³⁰ Eighteen-year-old Jose Gonzalez began experiencing abdominal pain on the morning of May 27, 1982. The pain got worse as the day progressed and did not improve after he took two Pepto Bismol tablets. Mr. Gonzalez went to work, completed the entire evening shift, came home, and went to bed. At approximately 4 a.m., he awoke with severe pain, and his mother drove him to the ED at William Beaumont Army Medical Center, where he arrived at approximately 4:50 a.m. on May 28.

At that time, Mr. Gonzalez gave a history of abdominal pain since 9 a.m. the previous day, and he said it was particularly severe in the right lower quadrant. He complained that the pain was made worse by eating, and that nothing he had tried had improved the pain. He also stated that he had not had any nausea, diarrhea, or vomiting.

He was evaluated by Dr. Edwina Popeck, the ED physician who, after conducting a “complete physical examination,” ruled out appendicitis and made a diagnosis of gastritis. She discharged Mr. Gonzalez with advice to take analgesics for the pain and to “return to the emergency room if the pain worsened during the day.”³¹ Mr. Gonzalez was discharged at approximately 6:15 a.m.

During the day of May 28, Mr. Gonzalez rested at home, and the pain continued without any significant change. At about 4 p.m., Mr. Gonzalez advised his mother that the pain had worsened. Mrs. Gonzalez telephoned the ED at William Beaumont and was instructed to bring Mr. Gonzalez back to the hospital. After his father was located, Mr. Gonzalez was brought back to the hospital by his parents, arriving at approximately 9:15 p.m.

Mrs. Gonzalez brought Mr. Gonzalez into the ED and informed the clerk that she had been instructed by the hospital to return Mr. Gonzalez to the ED. He was told to go to the records office, obtain his medical record, and then return to the ED. By the time Mrs. Gonzalez returned from the records office with her son, Mr. Gonzalez' pain had increased and he was unable to walk. They then waited approximately an hour and 15 minutes without being seen by any ED personnel. When Mrs. Gonzalez inquired at

approximately 10:30 p.m. as to when her son would be seen, she was told that “the doctors were all busy, and that quicker service might be obtained by going to another hospital.”³²

Mrs. Gonzalez then took her son to Sierra Medical Center, a private hospital in El Paso, TX, approximately 15 minutes from William Beaumont. Mr. Gonzalez was seen in the ED at approximately 10:45 p.m., and a diagnosis of probable ruptured appendicitis was made. He was taken promptly to the operating room, and the surgeon found a ruptured appendix with associated peritonitis. Mr. Gonzalez was hospitalized for 13 days, but recovered well except for a wound abscess that had to be drained. The surgeon, Dr. Ruben Ramirez, later opined that no permanent disability was anticipated.

Mr. Gonzalez filed a claim of malpractice alleging: 1) Dr. Popeck was negligent in failing to diagnose appendicitis when he was first seen in the ED on May 28; and 2) William Beaumont was negligent in not admitting him for surgery at the time of his second visit to the hospital at 9:15 p.m. on May 28. After a nonjury trial, the court found that Dr. Popeck had not been negligent in her treatment of Mr. Gonzalez, but that William Beaumont breached the standard of care in its treatment of Jose at the time of his second visit, and that this breach of the standard was the proximate cause of damages to Mr. Gonzalez (pain and suffering, and the expense of medical treatment at the private hospital). A judgment of \$13,105.50 was entered in favor of Jose (\$2,500 for pain and suffering and \$10,605.50 for the medical expenses).

Commentary: *Few would argue that, under these facts, William Beaumont had improperly “constructively discharged” Mr. Gonzalez and that the hospital had breached the standard of care at the time of Jose’s second visit to the hospital. Whenever there is an unscheduled return visit to your ED, view this as an opportunity to correct a possible earlier error. Take the opportunity to impress the patient with how much you care and to put your “spin” on why the diagnosis was not made at the time of the earlier visit. “Bend over backward” for the patient and explain that, at the time of the first visit, it was simply too early in the course of the disease to make the diagnosis.*

There is little doubt, if any, that Mr. Gonzalez had at least early appendicitis when seen by Dr. Popeck on May 28 and that she “missed” the diagnosis. Why did the plaintiff not prevail in his action against her? Because, despite the fact that Dr. Popeck did

not make the diagnosis, she: 1) did not breach the standard of care because the court was impressed that she had performed a “complete physical examination in an effort to diagnose the Plaintiff’s condition;”³³ 2) she had provided appropriate instructions for close follow-up; and 3) she had carefully documented all of this in the patient’s medical record. In short, she did everything right.

It is not possible to correctly diagnose every case of early appendicitis, and the failure to do so does not itself establish a breach of the standard of care. In this case, the court was clearly impressed that Dr. Popeck had done everything necessary to evaluate Mr. Gonzalez, no doubt also impressing the court that she cared about her patient. The court listed at length the extent of the evaluation performed by Dr. Popeck, including, in particular, the following: normal vital signs; a complete physical examination including observations that there was no pain with walking or jumping, bowel sounds were present, “leg manipulation tests” were negative, tenderness was confined to the right-upper quadrant, and a rectal examination was negative; abdominal X-rays that were negative; and a WBC of 16,600, apparently with a normal differential. Because all of this was done by Dr. Popeck and documented in the record, the court concluded that she had done everything necessary to evaluate Mr. Gonzalez and, therefore, her decision to discharge him under close follow-up was reasonable.

On discharge, Dr. Popeck advised Mr. Gonzalez to “return to the emergency room if the pain worsened during the day.” Her follow-up advice was clear and provided an appropriate follow-up interval. The only suggestion that can be made to improve upon those instructions is that, if there is any real suspicion of appendicitis, you should tell not only the patient to return if worse or if any new symptoms develop, but you also should schedule the patient to return to the ED for re-examination in four to eight hours. A scheduled recheck will detect the progression of disease in an unreasonably stoic individual who might not feel that his or her symptoms are sufficiently “worse” to return for a recheck.

ACEP Clinical Policy

It has been estimated that as many as 20,000 practice guidelines have been developed by more than 500 specialty societies and organizations.³⁴ Obviously, no physician can, or should, follow (or even be aware) of

every practice guideline. That being said, there are some guidelines that represent such wide-based consensus that they generally should be followed, absent a specific reason for deviation from the guideline [e.g., *the Advanced Cardiac Life Support Standards* from the Dallas-based American Heart Association’s (AHA)]. Emergency physicians should be familiar with the various clinical policies promulgated by the Irving, TX-based American College of Emergency Physicians (ACEP). One of those policies is relevant to the evaluation of appendicitis: *Clinical Policy: Critical Issues for the Initial Evaluation and Management of Patients Presenting With a Chief Complaint of Nontraumatic Acute Abdominal Pain*.³⁵ This policy, which expands on a previous *Clinical Policy for the Initial Approach to Patients Presenting With a Chief Complaint of Nontraumatic Acute Abdominal Pain* that was published in 1994, was approved by the ACEP Board of Directors on June 7, 2000.

Unlike the AHA *Advanced Cardiac Life Support Guidelines*, for example, the ACEP clinical policy does not provide an algorithm for the evaluation and treatment of patients. Rather, it presents important research on relevant critical issues and makes recommendations, whenever possible, based on scientific research, as opposed to based simply on the consensus of an expert panel. The policy was drafted based upon an extensive evaluation of the literature, principally articles published between January 1990 and January 1999. Members of the policy subcommittee reviewed the articles and scored them for strength of evidence. Strength of recommendation was then made according to the following criteria:

- **Evidence-based standards.** Generally accepted principles for patient management that reflect a high degree of clinical certainty.
- **Guidelines.** Recommendations for patient management that might identify a particular strategy or range of management strategies that reflect moderate clinical certainty.
- **Options.** Other strategies for patient management based on preliminary, inconclusive, or conflicting evidence or, in the absence of any published literature, based on panel consensus.³⁶

It should be noted that there were important exclusions from the policy: children, patients with known antecedent trauma, and patients in the last trimester of pregnancy or the first month postpartum.

Appendicitis Risk Management Strategies

1. Unless you know with certainty that your patient already has had his or her appendix removed, consider appendicitis in any patient with abdominal pain.
2. Listen to and talk to your patients. You face an uphill credibility battle if the record is clear that the patients (or the patients' family) told you that they thought it was appendicitis, and you seemingly ignored them and proceeded to "miss" the diagnosis.
3. Not all patients with possible appendicitis will be taken directly to surgery; many will not even be admitted. Close follow-up is essential in patients you send home with possible appendicitis. Always arrange close follow-up, which will usually mean follow-up in a matter of hours, not days.
4. A surprised patient is more likely to be a litigious patient. If there is any chance whatsoever that the patient with abdominal pain that you are sending home might have appendicitis, discuss this with the patient. In particular, you should educate the patient and family that the diagnosis of early appendicitis can be extremely difficult and that there is, unfortunately, no definitive test to rule out appendicitis. You will not get a CT scan on every patient who might have appendicitis.
5. Do not rule out appendicitis based upon a normal white blood count (WBC) and differential.
6. Do not let your surgical consultant refuse to see your patient or rule out appendicitis based on a normal WBC.
7. Be particularly careful in ruling out appendicitis in high-risk settings: the very young, the elderly, and women who are pregnant.
8. Do not rely on the latest combination of laboratory tests touted to allow appendicitis to be ruled out unless such practice is widely confirmed and becomes the standard of care. For example, the "triple test" consisting of WBC, differential, and C-reactive protein reportedly has a negative predictive value of near 100%. While combinations of tests such as this might someday yield an "appendicitis test," we are not there yet.
9. Remember that "atypical" presentations of appendicitis are common.
10. Discharge instructions for all patients should always be detailed and written. All discharge instructions should include a statement similar to: "Return to the ED immediately if your symptoms recur, you develop any new symptoms, or you are worse in any way. Call your family doctor tomorrow [in some cases, e.g., appendicitis, you will arrange closer follow-up] to advise as to how you are doing." If you believe there is any real chance of appendicitis, schedule a recheck in the ED for four to eight hours after discharge, depending on the clinical circumstance.
11. Cervical-motion tenderness is not diagnostic of pelvic inflammatory disease and is entirely consistent with appendicitis, particularly once it has progressed to the point at which peritoneal signs are present.
12. If you keep a patient in the department for observation, you should serially examine the patient and document the results of those examinations, including the patient's symptoms at each interval. Most importantly, carefully document the patient's symptoms and examination just prior to discharge.
13. If you give narcotics or other analgesics to patients with abdominal pain (and this is often appropriate), do so judiciously (i.e., small intravenous doses). It is always a good idea to know your surgical consultants' thoughts on this as well so as to avoid confrontations that might occur when the surgeon arrives to see the patient and is upset that the patient is now entirely comfortable after narcotics have been given.
14. If you want to make the diagnosis of "gastroenteritis," the patient should have vomiting (at least nausea) and diarrhea. If the patient does not, rethink your diagnosis. The more appropriate diagnosis often will be "abdominal pain of uncertain etiology." And when this diagnosis is made, you must appropriately counsel the patient regarding the possibility of appendicitis.
15. Never let your surgical consultant intimidate you. Get a surgical consultation as often as you think it is necessary, which, in the case of possible appendicitis, should be often.
16. If you have a concern about whether the patient will, or can, return for necessary follow-up, admit the patient, or keep the patient in the ED for observation.
17. Understand and agree as a department on the usefulness and role of imaging studies (CT scan and ultrasound) at your facility. While published studies of the sensitivity and specificity of these modalities provide useful information, it is important to know how good your imaging technicians and radiologists are, in particular with respect to ultrasound where there is such a degree of operator variability.

It is recommended that all emergency physicians familiarize themselves with the policy, understanding that the state of knowledge in medicine is in a constant state of change and certain modifications of any static clinical policy (ACEP clinical policies are scheduled for revision every three years) might be necessary. Deviations from well-accepted algorithms or clinical

policies, however, should be made based only upon sound clinical judgment, as consensus guidelines might be cited as evidence of the standard of care.

In diagnosing undifferentiated abdominal pain (UDAP), it is recommended that such patients "should have a diagnosis of UDAP rather than given a more specific diagnosis unsupported by history, physical, or

laboratory findings.”³⁷ By acknowledging that a definitive diagnosis has not been made and, therefore, a significant problem might exist (e.g., acute appendicitis), the physician is more likely to arrange appropriate close follow-up. This also prompts the physician to explain to the patient that he or she might have, for example, early appendicitis and should return for evaluation in a specific number of hours or, if worse, before then. If, on the other hand, the physician labels what really was UDAP as, for example, gastroenteritis, it is too easy for the physician to not advise appropriately early follow-up. In addition, using UDAP as a diagnosis avoids the surprised patient (who is always a risk management problem): “But the ER doctor told me it was just the stomach flu.”

The clinical policy recommends that physicians should “not restrict the differential diagnosis solely by the location of the pain.”³⁸ This is certainly relevant to the patient with possible appendicitis. While most patients with acute appendicitis will have right lower-quadrant pain (although many do not have a good history of migration to the right lower quadrant), the absence of right lower quadrant pain does *not* rule out the possibility of appendicitis. This is, of course, particularly the case in the later stages of pregnancy where the appendix is moved far cephalad from its usual right lower quadrant position (by the eighth month of gestation, the appendix is virtually subcostal in location).

The clinical policy reviews the state of the art with respect to the various imaging modalities and laboratory tests in the diagnosis of acute appendicitis (as of June 7, 2000). According to the policy: “CT [computerized tomography] scanning has emerged as the imaging modality of choice in most patients with suspected appendicitis in whom an imaging study is indicated. Sensitivity approaching 100% and specificity of 95%-98% are reported from one university group. Similar results have been reported in a community hospital setting.³⁹ It is not, of course, the recommendation, at this time, that all patients with suspected appendicitis be evaluated by CT scan. The policy also reports that, for ultrasound, the best reported sensitivity is 93%, and the best reported specificity is 91%.⁴⁰ Ultrasound is, however, very much dependent on operator experience and expertise.

Conclusion

Appendicitis is a difficult diagnosis that is easily missed in its early stages and in high-risk patients (the

very young, the elderly, and pregnant women). Until we have an accepted test to rule out appendicitis (perhaps the CT scan will be that test), the diagnosis is clinical and a high index of suspicion is well-advised. No patient with UDAP who still has his or her appendix should be discharged without a discussion of the possibility of appendicitis and with specific instructions for close follow-up (i.e., within hours, not days). Risk management strategies summarizing the content of this article may be found in table on p. 58.

Endnotes

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20. *Id.* at 683.
21. *Id.*
22. *Id.*
23. *Id.*
24. *Id.*
25. *Id.*
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27. 1999 U.S. Dist. LEXIS 4532 (N.D. Ohio 1999).
28. *Id.* at *1.
29. 2000 La. App. LEXIS 3572 (2000).
30. 600 F.Supp 1390 (W.D.Tx 1985).

31. *Id.* at 1392.
32. *Id.* at 1393.
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34. Leone A. Medical practice guidelines are useful tools in litigation. *Med Malpractice* 1993; 10:1.
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37. *Id.* at 408.
38. *Id.* at 409.
39. *Id.* at 414.
40. *Id.*

CE/CME Questions

1. Appropriate outpatient follow-up for a patient discharged from the ED with possible appendicitis should be in:
 - A. hours.
 - B. one day.
 - C. 2-3 days.
 - D. None of the above
2. Your chances of prevailing in a malpractice lawsuit alleging the failure to diagnose appendicitis will be enhanced by:
 - A. a meticulously documented complete history and physical examination.
 - B. well-documented discharge instructions providing for close follow-up.
 - C. use of surgical consultation when appropriate.
 - D. All of the above
3. Which of the following, if any, is essential in every patient presenting with a complaint of abdominal pain?
 - A. CBC
 - B. CT scan
 - C. ultrasound
 - D. None of the above
4. Patients who create a high risk for missing the diagnosis of appendicitis include:
 - A. pregnant women.
 - B. the very young.
 - C. the elderly.
 - D. All of the above

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