

ED Legal Letter™

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Dodging the Bullet: Part II

A review and discussion of several close clinical encounters

By Adrian Amin, MD, Senior Resident, Department of Emergency Medicine, Medical College of Georgia, Augusta, and Larry Mellick, MD, MS, FAAP, FACEP, Professor of Emergency Medicine and Pediatrics, Department of Emergency Medicine, Medical College of Georgia, Augusta

The first “Dodging the Bullet” article was written and published in the September 2011 issue of *ED Legal Letter*. In the earlier article, as well as this article, a series of actual clinical cases are presented that could have turned out differently if the wrong management decision had been made. The goals of this article remain the same as the earlier one: to glean important points of educational and teaching value from each of the reported high risk cases; and to highlight the fact that clinical misadventures are often a single judgment call away from a potential tragedy. I am confident that every emergency medicine physician practicing could write their own case series of near misses. That’s simply the nature and reality of practicing medicine in the emergency department. And, as stated previously, our decision-making processes are often complicated, tenuous, and treacherous at times, and, consequently, the odds are not in our favor. Therefore, as stated previously, it is just a matter of time before the bullet finds its mark, and we can only hope that “harm is minimized, our documentation supports our decision making, and that the patient and his or her family are understanding and forgiving.”

Nebulous Nasal Congestion

An elderly man presented to the emergency department with complaints of nasal congestion. He had no difficulty breathing orally, but his lack of ability to breathe nasally was causing him concern. Upon examination, he had a systolic blood pressure of 93 mm Hg and a heart rate of 110 bpm. The patient was questioned regarding his low blood pressure,

and he stated that his blood pressure often fell at the lower end of normal. Upon review of available past records, his blood pressure was indeed found to be in alignment with previous findings.

The patient's known medical conditions were metastatic squamous cell carcinoma and asthma; however, at the time of presentation, he said he "felt fine." His physical examination was unremarkable. Upon gentle probing for additional symptoms, the patient mentioned a tendency to be claustrophobic and offered that his current symptoms might be explained by his anxiety.

Because the presentation was benign, preparations were begun for his discharge. However, after a last-minute discussion between the attending physician and resident, a decision was made to order a complete blood count (CBC). These test results demonstrated a WBC count of 26,000/mm³ along

Figure 1: Patient with nasal congestion



with a 3-gram drop in hemoglobin (7.5 g/dL). (See Figure 2.) A chest X-ray was ordered, which showed a large lung abscess. (See Figure 3.) The patient was started on piperacillin/tazobactam and vancomycin. Within a few hours of presentation, the patient's condition deteriorated and his systolic blood pressure dropped into the 60s and his heart rate increased to 130. He was promptly admitted into the MICU.

A chest radiograph demonstrated a 6 cm cavitary lesion that involved the superior segment of the left lower lobe, with air fluid level and surrounding airspace consolidation. Given its rapidity of development, this finding was consistent with necrotizing pneumonia. It was uncertain whether there was fistulous communication with the esophagus or adjacent bronchus. No additional pulmonary lesions were demonstrated, and there was a very small pleural fluid component evident.

Following admission, the abscess was drained using CT guidance. Manual aspiration yielded approximately 10 mL of frank pus. The tract was serially dilated and a 12 French drainage catheter was placed over the guide wire into the left upper lung abscess. The catheter was placed to waterseal

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Vice President / Group Publisher: Donald R. Johnston

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Managing Editor: Leslie Hamlin

Editor-in-Chief: Arthur R. Darse, MD, JD, FACEP

Contributing Editors: Larry B. Mellick, MD, MS, FAAP, FACEP, and Stacey Kusterbeck.

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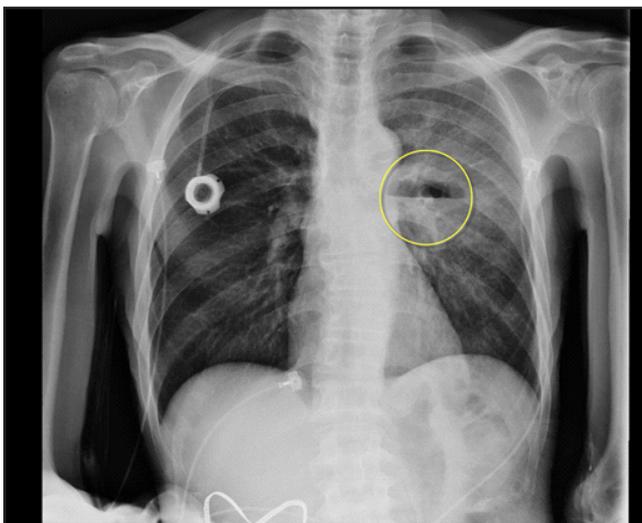
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Please contact **Leslie Hamlin, Managing Editor**, at leslie.hamlin@ahcmedia.com.

Figure 2: Laboratory testing showing an elevated white count and low hemoglobin

Hematology		
WBC	13.1	26.0
RBC	2.99	2.28
Hgb	10.3	* 7.5
Hct	29.7	21.9
MCV	99.4	* 96.2
MCH	34.4	32.9
MCHC	34.7	34.2
RDW	14.3	15.1
Platelet	481	932
MPV	6.3	6.3
Neut abs	11.1	23.9
Lymph abs	0.3	0.8
Mono abs	1.3	1.3
Eo abs	0.4	0.0
Baso abs	0.0	0.0
Blast abs	0.0	0.0
Anisocytosis		

Figure 3: Chest X-ray demonstrating large lung abscess



and secured at the skin entry site with a silk suture. No complications occurred.

Discussion

Emergency medicine physicians are often faced with seemingly insignificant symptoms that, on the surface, can appear to be unrelated. However, it is the clinical judgment and perhaps an unexplainable feeling or concern that may prompt physicians to dig deeper to ensure different aspects are considered. In many cases, it may be helpful to consider alternate options besides the obvious to determine if there really is a medical concern. In this case, the last-minute decision to perform a

CBC was integral to finding and draining a deep-seated, pus-filled abscess that had the potential to lead to an undesirable outcome.

Learning Points

- Never completely trust your own clinical judgment and diagnostic acumen.
- For vulnerable patients who are not overtly symptomatic, it is sometimes better to err on the side of caution and consider performing further testing or a diagnostic procedure to detect an underlying condition.

Hidden from View: Tibial Plateau Fracture

An adult male was transferred from an outside hospital for the evaluation of possible compartment syndrome after having his legs caught between several large trees that fell. His diagnosis was negative for compartment syndrome; however, he continued to have a painful gait, with the pain mostly in the posterior calf with ambulation. On palpation, he was tender on the medial and lateral proximal right tibia. (See Figure 4.) His plain films, including oblique views, showed no apparent fracture. (See Figure 5.) In a recent morbidity and mortality conference, there was a discussion of a similar case of a missed tibial fracture that was not visible on X-ray but was apparent on CT scan. Simply because there was a significant degree of similarity between the two cases, a CT scan was ordered of the proximal tibia. To our surprise, the CT scan demonstrated a tibial plateau fracture. (See Figure 6.) The patient's leg was splinted in the emergency department, and the fracture was subsequently treated by the orthopedic department by internal fixator placement and immobilization via a long leg splint. (See Figure 7.)

Discussion

Most fractures of the tibial plateau are readily diagnosed by conventional radiography. However, as in the case above, in the event that unremarkable findings are present in traditional radiography films, a CT scan should be considered to gain a clearer view of the articular surface of the tibia.

CT scans provide reconstruction of axial images into coronal and sagittal planes, which allow for localization of surgical landmarks as

Figure 4: Swollen, tender calf with evidence of bruising



Figure 5: Plain films of the knee that appear to be normal



Figure 6: CT scan demonstrating evidence of tibial plateau fracture



Figure 7: Splinting the fracture in the emergency department



well as fracture fragments. Since CT scans are generally able to depict all fractures, it is important that both coronal and sagittal reconstructions of axial data are incorporated to avoid false-negative errors that can occur when only axial imaging is used. For example, if a fracture predominates in the axial plane, it may be overlooked in the CT, leading to inaccurate diagnosis and subsequent treatment. Through the reconstruction of data into different planes, additional information such as articular depression and diastasis may be obtained easily.

Learning points

- Morbidity and mortality meetings allow physicians to learn from the clinical misadventures of others and enhance diagnostic acumen in seemingly cut-and-dry cases.
- In the event that traditional radiologic films show unremarkable results and the patient's findings are more consistent with a fracture, consider using more evolved technology such as CT scans to gain both coronal and sagittal planes for more detailed imaging of possible fracture sites.

Oral Cancer

For a second time in a week, a 55-year-old male presented to the emergency department for evaluation of tooth pain. He had been followed by a dentist for about six weeks, and the dentist had even pulled a tooth suspected of being the cause of the pain. (See *Figure 8*.) During the first emergency department visit, the patient was treated with pain medications and antibiotics for a suspected abscessed tooth and discharged home.

During the second emergency department visit, the resident who first evaluated the patient expressed concern that the patient was exhibiting drug-seeking behavior. However, a second and closer look revealed an ulcerated tongue lesion. (See *Figure 9*.)

The patient thought a sharp tooth was ulcerating his tongue and causing constant pain. However, the patient reported a 20-pack-per-year

history of smoking and daily alcohol consumption. A CT scan with contrast showed a lesion consistent with cancer of the tongue.

Otolaryngology (ENT) was consulted. The ENT team biopsied the lesion and arranged follow up. The patient subsequently underwent extensive surgery of the tongue and neck for squamous cell carcinoma of the left tongue and tonsil.

Discussion

Squamous cell carcinoma is the most common malignancy of the tongue. There are three growth patterns recognized, which include the ulcerative type seen in our patient. Tobacco use is strongly associated with oral cavity cancers, and tobacco use is documented in up to 90% of patients with oral cavity cancers. Alcohol consumption is also strongly associated with oral cavity cancers.

The bullet was dodged because the physicians did not anchor too early on the diagnosis. Early anchoring on a diagnosis is one of the reasons diagnostic misadventures occur.

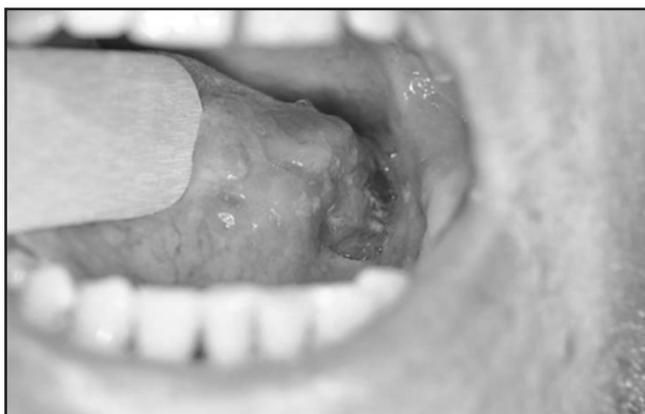
Nevertheless, six weeks of dental evaluations, an unnecessarily extracted tooth, and two visits to the emergency department took place before the diagnosis was made.

A YouTube video of this patient's presentation can be seen at the following link: <http://www.youtube.com/watch?v=GBDcnjN4TN0>.

Figure 8: Previously extracted tooth carried by the patient's wife



Figure 9: Ulcerated tongue lesion due to oral cancer



Learning Points

- Premature closure on the wrong diagnosis is a common cause of misdiagnosis in the practice of medicine.
- While drug-seeking behavior is commonly seen in the emergency department, it is critical that emergency physicians avoid becoming overly suspicious of patients who return for evaluation of painful conditions.

Every patient deserves a thorough evaluation of their complaint, no matter how frustrating their behavior or their frequency of visits to the emergency department.

The Diagnostic Challenge of Newborns

An 11-day-old infant was brought to the emergency department and presented with loose stools. The first-time mother stated that the baby “felt warm,” but there was no other documentation of fever. Upon examination, the baby was vigorous,

feeding appropriately, and afebrile with normal vital signs. The number of loose stools was consistent with normal newborn patterns. The patient was discharged. The attending physician instructed the mother to check the infant's temperature with a thermometer and to return if the temperature was greater than 100.4°F. Two days later, the infant returned to the emergency department with a fever. A septic work-up was initiated, but venous access was difficult.

Multiple intravenous (IV) line attempts resulted in only enough blood for a CBC and blood culture. A decision was made to proceed with a CSF tap, with plans to administer antibiotics intramuscularly immediately afterward. The results of the CSF were as follows: color: straw; clarity: slightly hazy; WBC: 1,025/mm³; RBC: 28/mm³; WBC differential: segmented neutrophils 28%; lymphocytes 49%, and monocytes 23%; protein: 236 mg/dL; glucose: 43 mg/dL; the Gram stain was negative. (See Figure 10.) However, the culture of the cerebrospinal fluid subsequently demonstrated growth of "rare *Listeria monocytogenes*."

Discussion

Listeria monocytogenes is a ubiquitous gram-positive, motile, rod-shaped bacterium. The principal route of acquisition of *Listeria* is through the ingestion of contaminated food products. It is not uncommon for pregnant women to carry *Listeria* asymptomatically in their GI tract or vagina. These maternal *Listeria* infections can result in chorioamnionitis, premature labor, spontaneous abortion, or stillbirth. Fetal infection can occur via transplacental transmission, but vertical transmission can also occur from mother to infant during passage through an infected birth canal. There are two clinical presentations of neonatal infections: early onset (< 5 days) and late onset (> 5 days). Early-onset neonatal listeriosis is usually associated with sepsis or meningitis. As was found with our patient, late-onset *Listeria* neonatal infections frequently present as life-threatening purulent meningitis.

The primary reason for performing a lumbar puncture on a febrile infant or child is to differentiate viral meningitis from bacterial meningitis. While viral meningitis significantly outnumbers bacterial meningitis by as much as 50:1, bacterial meningitis is significantly more common in newborns, hence the strong recommendation of a full sepsis work-up in febrile infants younger than 1 month of age.

Figure 10: Cloudy spinal fluid



In the event there is a limited amount of sample to perform laboratory tests, it is recommended to perform a Gram stain and culture, as Gram stains from bacterial meningitis are positive in approximately 70% of cases.

An important note to mention in this case is that the mother telephoned the pediatric emergency department requesting advice from a physician about her child. The emergency department clerk was overheard advising the patient's mother to contact her pediatrician. After hanging up, the clerk's response was, "Their 13-day-old baby had a fever and I told the mother to call their pediatrician." The temptation of non-medical personnel to give advice over the telephone is a recurrent issue, and in this case, could have delayed the return of this infant to the emergency department. Thankfully, this did not happen, and the child was brought to the emergency department in a timely manner.

Learning Points

Even though giving advice over the telephone is generally discouraged, there are certain situations when advice should be given. In this case,

an urgent request to bring a febrile neonate in for an emergent evaluation was mandatory to prevent any untoward outcomes.

Don't allow procedures to delay life-saving treatment. While it was difficult to obtain intravenous access on this infant, the precedence of performing a cerebrospinal fluid (CSF) tap and administering antibiotics was more important than continuing to attempt IV access.

Never underestimate the subtle presentations of sepsis in neonates. The patient was seen in the emergency department two days previously with signs of infection: felt warm, was spitting up, and had a change in stool pattern. Subtle, nonspecific, early signs such as these need to be rapidly evaluated in these young patients.

Deep Venous Thrombosis

A 61-year-old male presented to the emergency department for evaluation of posterior left knee pain that had been present for one week. The patient admitted to an event of mild trauma when he hit the knee on a step while bending it. As a construction worker, he described walking up and down stairs frequently. He also described the pain as predominantly on the posterior aspect of the left knee, with radiation of pain down the back of the calf. He also reported tingling and numbness.

The examination demonstrated a nearly normal examination of the left lower extremity. There was no swelling, erythema, or ecchymosis. (See *Figure 11*.) The only positive finding was tenderness with palpation of the left posterior medial knee.

Both the physician assistant and attending physician were suspicious that the patient's pain was caused by a Baker's cyst. An ultrasound of the left lower extremity was obtained to assess for the presence of a Baker's cyst. The possibility of a deep vein thrombosis was considered, but physical evidence for a deep vein thrombosis was nearly non-existent. Nevertheless, multiple color Doppler and grayscale images of the left lower extremity demonstrated extensive acute deep vein thrombosis within the left lower extremity. Acute deep vein thrombosis was noted in the superficial femoral, greater saphenous, popliteal, gastrocnemius, and lesser saphenous veins. The patient was treated as an outpatient with Lovenox® (enoxaparin sodium injection), and follow-up was arranged.

Discussion

The bullet dodged with this patient was an exami-

Figure 11: Relatively normal-appearing lower extremities despite a large DVT clot load



nation and history more consistent with a medical condition other than the life-threatening condition discovered. Deep vein thrombosis can be subtle in its presentation, and this patient had no risk factors except a vague history of trauma. Nevertheless, a failure to make the diagnosis of deep vein thrombosis in the patient could have resulted in a fatal outcome for this patient.

Learning Points

- Even though the practice of medicine has zero tolerance for diagnostic failures, and delays in diagnosing the complexity and variability of disease presentations make perfection impossible. Consequently, it is important to educate our patients that disease presentations are rarely classic and disease progression is sometimes required before a condition can be diagnosed.

Summary

This article highlighted a number of clinical scenarios in which misdiagnoses were barely averted. The goal is to help others avoid the similar near misses and traps in clinical decision making. Additionally, the authors hope to emphasize the uncontrolled environment and potential risks that occur when large numbers of undifferentiated patients present to the emergency department for evaluation.

Because physicians are humans prone to error, and disease processes frequently do not fit the classic description, clinical perfection is not always possible. Thankfully, most delays in diagnosis and timely management do not have serious conse-

quences. When they do, however, it is important to have documented the findings and thought processes well and to have maintained a positive relationship with the patient and his or her family. ■

Avoid These Clinical Disasters That Lead to Likely Lawsuit

Missed acute myocardial infarction (AMI) cases are usually top of mind when it comes to ED malpractice litigation, but other lesser-known clinical pitfalls also result in claims, warns **Martin Ogle**, MD, FACEP, senior partner and vice president of CEP America, an Emeryville, CA-based provider of acute care management and staffing solutions. “The only way to mitigate risk is to maintain an open mind in your differential diagnosis to things that are less common but potentially very dangerous,” he says. Here are some scenarios resulting in recent claims against emergency physicians (EPs):

- **Anticoagulated patients who suffered minor trauma.**

Patients with a head injury, or what appears to be a minor spine injury from a fall, have a much higher risk of dangerous or even fatal internal bleeding, which could result in an epidural hematoma and subsequent neurologic deficit, says Ogle.

“We have our own risk retention group that provides services for most of our EDs, and we have definitely seen a spike in those situations,” says Ogle. “The EP needs to be on heightened alert about identifying potentially life-threatening or neurologically damaging bleeding.”

Triage nurses must be sure the patient’s anticoagulated status is communicated to the EP, emphasizes **Michelle Myers Glower**, RN, MSN, a Wilmette, IL-based legal nurse expert and clinical nursing instructor at Loyola University Chicago.

“I have reviewed hundreds of medical records of falls, and I look for documentation on if the patient hit their head, whether they were anticoagulated, and that the CT of the head was ordered,” says Myers Glower.

Overlooking the critical piece of information that the patient is taking an anticoagulant can easily lead to a malpractice lawsuit against the ED, she warns. “Litigation comes when no one collects the history of anticoagulation or head injury and then no CT is ordered, resulting in an intracranial hemorrhage,” says Myers Glower.

- **Ingestion of foreign bodies in children.**

In the past, EPs have taken the approach that if an object had passed into the stomach, it would almost certainly find its way out without any intervention, says **Douglas S. Diekema**, MD, MPH, an attending physician in the ED at Seattle Children’s Hospital and director of education for the Treuman Katz Center for Pediatric Bioethics at Seattle (WA) Children’s Research Institute.

“But with ingestions of button batteries and small magnets, ED physicians have had to be much more careful in evaluating *what* has been ingested to assure that it doesn’t pose a risk,” he says. “These more dangerous ingestions require significantly more vigilance, and certainly pose a potential liability risk.”

EPs must be aware of the fact that some ingested metal objects represent a problem and may need to be removed, and they need to be able to recognize when they may be dealing with one of those objects on an X-ray, says Diekema.

“Finally, they need to involve the appropriate specialty — often a gastroenterologist or surgeon — when they have identified a button battery or magnet in the gastrointestinal tract, including the esophagus,” says Diekema.

- **Missed diagnosis of acute coronary syndrome (ACS).**

If a patient’s coronary arteries are stenotic, that patient may present to the ED with signs and symptoms suggestive of angina or an AMI. “If AMI is ruled out by serial EKGs and troponins, we still need to be thinking that the diagnosis could be ACS,” says **Bruce Wapen**, MD, an emergency physician with Mills-Peninsula Emergency Medical Associates in Burlingame, CA.

A patient’s chest pain might be caused by a narrowing of one or more coronary arteries that has not yet caused changes in the EKG or troponin levels, “and yet, the patient is a time bomb,” he explains.

If the EP strongly suspects ACS, Wapen says he or she should consult a cardiologist, who may want to take the patient for a stress echocardiogram contemporaneously with the ED visit. If it’s Saturday, the patient should be seen in the cardiologist’s office on Monday morning, with instructions to come back to the ED immediately for new or worsening symptoms, he says.

“Current guidelines say you don’t absolutely have to admit them to the hospital, but they do need a referral to a cardiologist for stress testing within 72-hours,” says Wapen.

- **Diabetic ketoacidosis (DKA) precipitated by an underlying stressor or infection.**

In one case reviewed by Wapen, a man presented to a university hospital ED with a sore throat and reported feeling weak and thirsty for several weeks. “The medical student sees the throat is bright red, but the ED attending says to do a *focused exam* and treat him for strep throat,” says Wapen. The patient died two days later of DKA. “This was the infection that tipped the scale and put a previously nondiabetic patient into a diabetic crisis,” he says. “The literature is full of examples of this.”

The lesson, says Wapen, is to listen carefully to the patient for clues that a serious malady may lurk behind a more obvious, minor problem, and do the testing to rule out the worst case scenario. “How hard would it have been to do a random blood sugar finger stick?” he asks.

• **Epidural abscesses and infections resulting in neurological deficits, paraplegia, and quadriplegia.**

“Historically, that’s generally been limited to patients with endocarditis or intravenous drug abuse,” says Ogle. “But we are seeing this more frequently in patients that don’t have those traditional risk factors.”

This could be due to more resilient antibiotic-resistant bacteria or an overall increase in immune deficiencies, says Ogle. He says that while it’s not realistic to perform a lumbar magnetic resonance imaging of the spine in every patient with low-grade fever and back pain, “EPs have to be cognizant that not all back pain is simple back pain. Of the 4 million patients we see a year, we now see a smattering of those cases. In years past, we virtually would never see a case like that.”

EPs need to be meticulous in their documentation in this situation, says Ogle, and confirmation of intact neurologic status is essential. “No explanation for a low-grade fever documented in the nursing notes, or lack of documentation of the presence of midline spine pain and/or tenderness, can create questions about the thoroughness of the ED encounter,” he says.

D. Jay Davis, Jr., JD, a partner at Young Clement Rivers in Charleston, SC, defended an EP in one case involving a patient who presented with back pain, fever, and some arm numbness after having recently fallen from his bunk. “Unfortunately, this patient was diagnosed with a fall and the abscess was missed. He eventually became paralyzed from T-9 down,” says Davis.

The patient had common explanations for symptoms of his back pain that were completely consistent with a musculoskeletal injury from a fall, notes Davis. “The doctor’s records looked

like he assumed the musculoskeletal injury was the cause. He did not demonstrate in his chart a thoughtful process that showed he was ruling out the more dangerous causes.”

The EP failed to adequately document a thorough neurological exam. “In this instance, the patient had a fever. The doctor, in essence, ignored this and assumed the back pain was associated with the likely cause of falling out of his bed,” says Davis.

While the EP treated the fever with acetaminophen, there was no follow up or evaluation noted in the chart. “The doctor simply worked-up the fall,” says Davis. “He did not work-up the fever with equal vigor. His history did not address it. His follow up did not address it.”

Davis says that a good neurological exam and better work-up of the fever would have avoided this lawsuit. “As I have told many clients, bad outcomes drive these cases. In this instance, it was clear in hindsight that the fever was a significant finding,” he says.

In ED misdiagnosis cases, there is almost always a small sign or symptom that gets lost because the case looks so much like hundreds of others, says Davis. “Careful evaluation of all sign or symptoms is the best defense to a misdiagnosis case. Pay attention to that one symptom that doesn’t seem to fit the story,” he says. ■

Sources

For more information, contact:

- D. Jay Davis, Jr., JD, Partner, Young Clement Rivers, Charleston, SC. Phone: (843) 720-5406. E-mail: jdavis@ycrlaw.com.
- Douglas S. Diekema, MD, MPH, Treuman Katz Center for Pediatric Bioethics, Seattle (WA) Children’s Research Institute. Phone: (206) 987-4346. E-mail: diek@u.washington.edu.
- Michelle Glower Myers, RN, MSN, Wilmette, IL. Phone: (312) 406-1239. E-mail: mmyersglower@aol.com.
- Martin Ogle, MD, FACEP, Vice President, CEP America, Emeryville, CA. Phone: (949) 461-5200. E-mail: MartinOgle@cep.com.
- Bruce Wapen, MD, Foster City, CA. Phone: (650) 577-8635. E-mail: Bdwapen@aol.com.

Undertriaged Elders Might Appear Ignored in Chart

Consider age at triage, or face possible suits

When researchers at University Hospital Basel in Switzerland set out to study triage of elderly patients in their ED, they were surprised to find that 22.5% were undertriaged, reports **Christian Nickel**, MD, one of the study's authors and an emergency physician (EP).

We were surprised that the rate of undertriage in elderly ED patients was that high in our setting," he says. Researchers evaluated 519 patient records for patients triaged using the Emergency Severity Index (ESI), and found undertriage in 117 cases. In 13 of the undertriaged patients, life-saving interventions were ultimately performed, including airway and breathing support and/or emergency medication.

Of the undertriaged cases, 25% involved patients with non-specific complaints such as generalized weakness. "The main pitfall was non-adherence to the triage algorithm," says Nickel. "Regular staff training of both ED physicians and triage nurses should focus on this issue. Triage performance should be regularly monitored."

See All Elders Promptly

Essentially, *any* complaint can be a life-threatening one in an older ED patient, emphasizes **Robert Suter**, DO, professor of emergency medicine at UT Southwestern Medical Center in Dallas, TX. "Any time you have an older patient come into your ED to be triaged, they really need to be taken very seriously," he says. "With advancing age, that becomes exponentially more true."

Suter says that there are no good evidence-based guidelines for when the triage level should increase based on a patient's age, but that it's reasonable for an ED to have a policy using a cutoff of 65 or 70 years old for when patients should be triaged in part based on their age, not triaged as non-urgent, and seen promptly ahead of other patients.

An older patient with seemingly benign symptoms might appear to suddenly decompensate due to age-related neurologic or cardiovascular changes or medications the patient is taking. "The patient might not be experiencing the same

intensity of symptoms that you would expect in a younger patient," explains Suter. "The patient may have hypertension, and now their dropping blood pressure makes their blood pressure appear normal instead of low. That could fool the triage person."

Suter notes that the largely subjective triage process used in most EDs is part of the problem. "It's still common for EDs to do unstructured triage based largely on the triage nurse's judgment of the complaint," he says. "Also, some triage systems in common use, such as ESI, actually were designed to predict resource utilization and not necessarily the dangerousness of the patient's complaint."

For this reason, Suter says EDs should consider establishing age older than 65 or 70 as a very important red flag that raises the triage level at least one notch, similar to the way a child 28 days of age or younger should be triaged as urgent or emergent regardless of the stated complaint. "Older patients should have their triage category adjusted up because of the higher likelihood that something bad will happen," he says.

Suter says he has seen a number of claims involving an older patient who presented to an ED with a seemingly benign complaint, waited for a long period to be seen, and then suddenly decompensated either in the waiting room or right after being brought back.

"While a medical reviewer may look at a case like this and see there were not necessarily any alarming symptoms or signs, it's very different for a layperson on a jury to understand why the ED didn't recognize that this older patient was about to die," says Suter.

When an older patient with a trivial complaint dies in the waiting room without having been seen by a physician, the average person will assume something wrong was done and there was a callous disregard for the patient's safety, says Suter. "It may have been unavoidable, but no one will ever accept that," he says.

If that same patient was brought back quickly, saw the EP, and the evaluation had begun, it would appear instead that the hospital and the EP were concerned about the patient and doing the right thing, he says. "For example, EPs are trained to have a very low threshold to do an EKG in an older patient," adds Suter. "If an EKG is obtained and appears normal, when something bad happens a half-hour later, you have that additional evidence that they appeared to be doing O.K. and the arrest couldn't have been predicted."

If the patient dies before being seen, the presumption within the legal system will be that the patient's life could have been saved if they had a more timely evaluation, says Suter. "That may not be the case, but it's a difficult charge to defend yourself against," he says. "It really puts you in a difficult position to deal with Monday morning quarterbacking."

Make Case Defensible

Kathy Dolan, RN, MSHA, CEN, CPHRM, senior risk management consultant at ProAssurance, a professional liability insurance carrier in Birmingham, AL, and former manager of an emergency department at a level II trauma center, regularly sees claims involving elderly patients in the ED alleging failure to recognize, missed diagnosis, inappropriate discharge, failure to refer, and failure to treat.

"Elderly patients are at risk for all of these things because of age, multiple medications, and multiple comorbidities. They can be very poor historians as well," says Dolan.

"Not going far enough" when obtaining a history from the elderly patient can make a case less defensible, according to Dolan. "Correct medication lists are difficult to obtain. Patients may think some symptoms aren't as important to mention," she says.

Failure to explain the physician's decision-making process is also a problem Dolan commonly sees in charts she reviews, such as charting why a head CT wasn't done. "We want to see a full circle," she says. For example, when abnormal test results return, documentation of notification to the patient and change in the treatment plan is important.

Dolan has reviewed several claims involving ED nurses failing to recognize and report a change in an older patient's status while undergoing testing in the ED. "These patients can be in the department for long periods of time. The EP goes in to provide discharge instructions, and finds the patient in dire condition," says Dolan. "Everyone is at risk if a lawsuit is filed and documentation doesn't support the patient's condition." ■

REFERENCE

1. Grossmann FF, Zumbrunn T, Frauchiger A, et al. At risk of undertriage? Testing the performance and accuracy of the Emergency Severity Index in older emergency department patients. *Ann Emerg Med* 2012; 60(3):317-325.

Sources

For more information, contact:

- **Kathy Dolan, RN, MSHA, CEN, CPHRM**, ProAssurance, Birmingham, AL. Phone: (319) 310-2249. E-mail: kdolan@proassurance.com.
- **Christian Nickel, MD**, Emergency Department, University Hospital Basel, Switzerland. E-mail: CNickel@uhbs.ch.
- **Robert Suter, DO**, Professor of Emergency Medicine, UT Southwestern Medical Center, Dallas, TX. Phone: (214) 648-4838. E-mail: robert.suter@utsouthwestern.edu.

CNE/CME OBJECTIVES

After completing this activity, participants will be able to:

1. Identify legal issues related to emergency medicine practice;
2. Explain how the legal issues related to emergency medicine practice affect nurses, physicians, legal counsel, management, and patients; and
3. Integrate practical solutions to reduce risk into daily practice. ■

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CNE/CME QUESTIONS

1. Which is recommended to reduce risks regarding epidural abscesses and infections in ED patients, according to **Martin Ogle**, MD, FACEP?
 - A. EPs should perform a lumbar magnetic resonance imaging of the spine in every patient with low-grade fever and back pain.
 - B. Lack of documentation of the presence of midline spine pain and/or tenderness is highly unlikely to create questions about the thoroughness of the ED encounter in the event a lawsuit is filed.
 - C. It is essential for EPs to document confirmation of the patient's intact neurologic status.
 - D. It is not advisable for EPs to document a thorough neurological exam to rule out epidural abscess in a patient with back pain who also reports a recent neck or back injury.
2. Which is recommended regarding ingestion of foreign bodies in children, according to **Douglas S. Diekema**, MD, MPH?
 - A. EPs should always take the approach that if an object has passed into the stomach, it will almost certainly find its way out without any intervention.
 - B. EPs must be much more careful in evaluating *what* has been ingested to assure that it doesn't pose a risk.
 - C. EPs can safely assume that ingested metal objects don't need to be removed.
 - D. It is not advisable for EPs to involve gastroenterologists or surgeons when they have identified a button battery or magnet in the gastrointestinal tract, including the esophagus.
3. Which is true regarding liability risks of undertriaged elders, according to **Robert Suter**, DO?
 - A. EPs should consider that almost no reported cases of undertriaged elders in the ED have involved patients with non-specific complaints such as generalized weakness.
 - B. EDs should ideally have a policy that elder patients be triaged in part based on their age, not triaged as non-urgent, and seen promptly ahead of other patients.
 - C. EPs should bear in mind that the fact that an older patient was brought back quickly and the evaluation started makes a case

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- less defensible in the event a bad outcome occurs, than if the same patient was still in the ED waiting room.
- D. EDs should not implement a policy to adjust the triage category of older patients.

Dear *ED Legal Letter* Subscriber:

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