# ED Legal Letter™

*The Essential Monthly Guide to Emergency Medicine Malpractice Prevention and Risk Management*

From the publishers of *Emergency Medicine Reports* and *ED Management*

AHC Media



**How Much Time Did EP Spend with Patient? EMR Can Mislead. . . . . . 65**


**EDLL Reader Survey Now Online**

**This year, we're going digital with our annual *ED Legal Letter* reader survey — and giving away a free publication to subscribers who take it. To participate, go to the Web address at the bottom of this message and enter your responses. When you're done, you'll receive a PDF of our new 57-page publication, *2012 Healthcare Salary Survey & Career Guide*.**

**Thanks in advance for sharing your thoughts about *ED Legal Letter* and how we might better meet your needs as a subscriber.**

**Here's the Web address for the survey: https://www.surveymonkey.com/s/EDLsurvey2013**


**Financial Disclosure:** The following individuals disclose that they have no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study: Arthur R. Derse, MD, JD, FACEP (Physician Editor), Director and Professor, Center for Bioethics and Medical Humanities, Institute for Health and Society, Medical College of Wisconsin, Milwaukee, WI; Gregory Moore, MD, JD, Emergency Medicine Residency, Madigan Army Medical Center, Tacoma, WA (Writer); Gregory Pittman, MD, Emergency Medicine Residency, Madigan Army Medical Center, (Writer); Marilyn R. Geninatti, MD, FAAEM, FACC, CWS, Paradise Valley, AZ (writer); Stacey Kusterbeck (Contributing Editor); Shelly Morrow Mark (Executive Editor); and Leslie Hamlin (Managing Editor). Kay Ball RN, PhD, CNOR, FAAN, Consultant/ Educator, K&D Medical Inc., Lewis Center, OH (Nurse Planner) is a speaker for AORN and a stockholder for STERIS, Inc.

**June 2013**
**Vol. 24 • No. 6• Pages 61-72**


## Pulmonary Embolism in the Emergency Department: Legal Cases and Clinical Caveats


*By Gregory Pittman, MD, Emergency Medicine Residency, Madigan Army Medical Center, Tacoma, WA, Gregory Moore, MD, JD, Emergency Medicine Residency, Madigan Army Medical Center, Tacoma, WA, Marilyn R. Geninatti, MD, FAAEM, FACC, CWS, Paradise Valley, AZ*


Pulmonary embolism (PE) is not an uncommon disease, and is easily misdiagnosed, resulting in litigation against emergency department (ED) physicians. This article will use legal cases to illustrate medical caveats regarding PE.

### The Presentation of Thrombotic Pulmonary Embolism

In the *Estate of Chambers v. Quinones*, a 41-year-old New Jersey man presented to the ED after two episodes of fainting. Upon arrival, he was noted to have hypoxia, tachypnea, and signs of heart strain. He had a history of hypertension and had recently taken two four-hour plane flights. The patient was initially evaluated by the ED physician, and then 12 hours later by the family practice attending. The man died of PE, and his decedents sued claiming prompt PE testing was needed. The defendant claimed that fainting is not a common presentation for PE and that two plane rides of four hours is usually not long enough to cause a PE. A settlement was reached for $975,000, of which $400,000 was contributed by the ED physician and $500,000 by the admitting physician.[1]

The classic presentation of PE is pleuritic chest pain, shortness of breath, and hypoxia, but may also include tachypnea, tachycardia, hypotension, syncope, hemoptysis, right heart strain, or, in the worst case, cardiovascular collapse. Not all patients will present with all of these symptoms, and many are nonspecific, as there is no reliable single symptom. It is imperative, however, for the ED physician to investigate further when one or more of these factors are present. The following cases emphasize the challenging and vague presentation of this disease and why it is often referred to as the great masquerader.


**NOW AVAILABLE ONLINE! Go to www.ahcmedia.com/online.html. Call (800) 688-2421 for details.**

In the *Estate of Jabari Rhodes v. Dr. Khalid Malik*, *Dr. Ahmed Raziuddin, and Weiss Memorial Hospital*, a 29-year-old man presented to the emergency department lightheaded and dizzy after collapsing briefly prior to arrival. He was responsive when paramedics arrived and transported him to the ED. The first physician to see the patient ordered a head CT, chest X-ray, drug screen, and an EKG. The first physician's shift ended 30 minutes after the patient's arrival and his care was signed out to the oncoming physician. The CT of the head was negative, along with an unremarkable chest X-ray, drug screen, and EKG. The oncoming physician ordered no further testing, and the patient was discharged home with a diagnosis of possible seizure and advised to follow-up with his doctor for an outpatient EEG. Later that same day, the patient collapsed again at home, and paramedics were called. An hour later, he was pronounced dead. The autopsy revealed a PE to be the cause of death from a deep vein thrombosis (DVT) behind his right knee.

The decedent's family claimed a D-dimer and CT-PA should have been performed. The defense stated that the symptoms did not indicate PE and that the patient would have died even with a correct diagnosis. A jury verdict was returned for $2,757,209 for the plaintiff against the oncoming physician, while the off-going physician, who was originally caring for the patient, was found not to be at fault. The hospital settled pre-trial for $185,000.[2]

Another case of missed diagnosis is reported from Maryland in the *Estate of Derek Pastor v. Patrick Daly, MD, and Rointan Farahifar, MD*, in which a 28-year-old man with fever, nonproductive cough, and dizziness presented to the ED. Upon arrival, he was noted to be tachycardic, hypoxic, and weak, with noted shortness of breath. The differential included PE, congestive heart failure, and pneumonia. After initial work-up with EKG, chest X-ray, and labs, however, the patient was diagnosed with pneumonia and renal insufficiency and admitted before being transferred to another hospital. Upon arrival to the receiving hospital, no physician evaluation was performed, and five hours later, he collapsed. The decedent died 1.5 hours later. An autopsy confirmed PE as the cause of death.

The decedent's survivors alleged negligence in failing to diagnose or treat PE. The defendants claimed there was no negligence and that heparin would not have prevented the patient's death. A verdict was returned for $6.1 million.[3]

ED physicians should have PE high on their differential diagnosis because mortality without treatment is as high as 30%. This significantly high mortality results in large settlements and judgments when undiagnosed. While common symptoms in PE are dyspnea (73%), pleuritic pain (44%), cough (34%), or calf or thigh pain or swelling (44/41%),[4] syncope can be the presenting symptom in 14% of patients.[5] Fever may be present in up to 43% of patients and, when present with pulmonary consolidation, can be misdiagnosed as pneumonia. Beware of atypical presentations.

## Risk Factors in the Evaluation for Pulmonary Embolism

A recent case from Massachusetts exhibiting multiple PE risk factors demonstrates the impor-

**ED Legal Letter**™, ISSN 1087-7347, is published monthly by AHC Media, 3525 Piedmont Road N.E., Bldg. 6, Suite 400, Atlanta, GA 30305. Periodicals Postage Paid at Atlanta, GA 30304 and at additional mailing offices.

**POSTMASTER**: Send address changes to ED Legal Letter, P.O. Box 105109, Atlanta, GA 30348.

Subscriber Information: Customer Service: (800) 688-2421. Customer Service E-Mail Address: customerservice@ahcmedia.com. Editorial E-Mail Address: leslie.hamlin@ahcmedia.com. World Wide Web: http://www.ahcmedia.com. Subscription Prices: United States: $499 per year. Add $17.95 for shipping & handling. Multiple Copies: Discounts are available for group subscriptions, multiple copies, site-licenses or electronic distribution. For pricing information, call Tria Kreutzer at 404-262-5482. Canada: $529 per year plus GST. Elsewhere: $529 per year. Back issues: $83. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue's date. GST Registration Number: R128870672.

AHC Media is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

AHC Media designates this enduring material for a maximum of 18 *AMA PRA Category 1 Credits*™. Physicians should claim only credit commensurate with the extent of their participation in the activity.

Approved by the American College of Emergency Physicians for a maximum of 18.00 hour(s) of ACEP Category I credit.

AHC Media is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

This activity has been approved for 15 nursing contact hours using a 60-minute contact hour.

Provider approved by the California Board of Registered Nursing, Provider #14749, for 15 Contact Hours.

This activity is intended for emergency physicians and nurses. It is in effect for 36 months from the date of the publication.

Opinions expressed are not necessarily those of this publication, the executive editor, or the editorial board. Mention of products or services does not constitute endorsement. Clinical, legal, tax, and other comments are offered for general guidance only; professional counsel should be sought in specific situations.

Vice President / Group Publisher: Donald R. Johnston
Executive Editor: Shelly Morrow Mark
Managing Editor: Leslie Hamlin
Editor-in-Chief: Arthur R. Derse, MD, JD, FACEP
Contributing Editor: Stacey Kusterbeck.

Copyright© 2013 by AHC Media. All rights reserved. No part of this newsletter may be reproduced in any form or incorporated into any information-retrieval system without the written permission of the copyright owner.

AHC Media

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

tance of recognizing common PE associations. In the *Estate of Anonymous 32-year-old Woman v. Anonymous Emergency Room Physician and Anonymous Nurse Practitioner*, a 32-year-old woman was seen in the ED for shortness of breath and calf pain soon after having recent gynecological surgery and using Provera. The ED physician ordered ultrasounds of both legs, chest X-ray, lung scan, and D-dimer. The results showed a normal chest X-ray, a low-probability lung perfusion study, and negative ultrasounds of the lower extremities; however, the D-dimer was elevated. The patient was discharged with a diagnosis of leg edema and dyspnea, and she was advised to follow-up with her primary provider.

Two weeks later, after having multiple episodes of collapsing without loss of consciousness, increasing shortness of breath, and lethargy, the patient saw her nurse practitioner (NP). At that visit, she was noted to be diaphoretic, pale, and tachycardic. After basic laboratory tests and a chest X-ray were negative, the patient was discharged from the clinic and advised to follow-up four days later.

Two days later, she was taken to the hospital by ambulance after collapsing at home. A CT scan of the chest was ordered, but the woman died about 90 minutes later. An autopsy confirmed saddle PE as the cause of death. The decedents claimed CT angiography should have been performed at the initial visit and that she had classic signs and symptoms of PE at her clinic visit. A $2 million settlement was reached with all defendants but the nurse practitioner.[6]

Many risk factors increase the likelihood of developing PE and should prompt further inquiry into the cause of even vague or nonspecific symptoms. By far, the most common association with PE is the presence of DVT, which occurs in more than 50% of cases. Other common risk factors include immobilization, surgery in the last three months, malignancy, pregnancy, exogenous hormone usage, trauma, and heavy cigarette smoking.[4] Failure to recognize these risk factors exposes the ED physician to liability.

Two cases further illustrate the importance of early diagnosis in PE. In the *Estate of Kenneth Mathiasen v. Albany Medical Center and Donald Jeanmonod, MD*, a 53-year-old man with a history of atrial fibrillation fell, fractured his leg, and was transported to the hospital, where he received a cast. He was discharged and advised to stay immobile.

Two days later, he had an episode of syncope, atrial fibrillation, shortness of breath, seizure-like activity, and profuse sweating, which prompted transfer to the hospital by ambulance. His symptoms and atrial fibrillation resolved at the time of hospital admission. An EKG showed no signs of ischemia; however, soon after, his oxygen saturation dropped into the low 90s and he was placed on supplemental oxygen. A chest X-ray was originally read as negative, but later over-read by the radiologist as being suggestive of PE; however, this was not conveyed to the ED staff. The ED physician ordered a CT-PA based on symptoms, but it was not performed until three hours later. The CT scan showed PEs of the bilateral pulmonary arteries. The radiology read was not performed until one hour later, which coincided with the time the patient suffered a fatal cardiac arrest.

The plaintiff claimed that prompt testing should have been performed to diagnose PE and heparin should have been started before confirmation of the diagnosis. The defendants claimed that the actions taken were proper and that the size of the PE left no chance for survival. A $1 million settlement was reached.[7]

In the *Estate of Anonymous 40-year-old Man v. Anonymous Physicians* in Virginia demonstrated a similar presentation and outcome. A 40-year-old man fractured his tibia in an accident involving a tree. He was seen in the ED and referred to an orthopedist. Over the next several days, he developed chest pain and shortness of breath. His primary care physician diagnosed him with pneumonia and admitted him to the hospital for observation. On the second day of admission, a duplex ultrasound revealed a deep venous thrombosis, and anticoagulation was started. Laboratory tests revealed worsening renal function; therefore, CT of the chest could not be performed. The patient continued to worsen and a lung biopsy was ordered. In anticipation, anticoagulation was stopped. Due to worsening renal function, the decision was made to start dialysis, and surgery was postponed; however, heparin was not restarted. The patient suffered a PE prior to surgery and died.

The plaintiffs claimed there was an inadequate diagnostic evaluation. Also, they claimed that a lung biopsy was not indicated and heparin should have been promptly restarted. The defendants claimed there was no evidence of premonitory PE, even at autopsy, and that the decedent was suffering from pneumonia and multiorgan

system failure, which would have resulted in his death regardless of the PE. They also claimed that the PE came from the site of the dialysis catheter insertion, not the previously diagnosed DVT. A $1.7 million settlement was ultimately reached.[8]

Risk factors should be acknowledged in assessing the likelihood of PE. When suspicion is raised for PE, many different approaches exist for further evaluation. For low-risk patients, the PERC criteria is a validated tool for excluding PE and includes many of the common risk factors to exclude higher-risk patients. If a patient fulfills the PERC criteria, there is less than a 1% chance of the patient having a PE[9]; however, if a patient does not meet the PERC criteria, the modified Wells criteria may be used to further stratify patients based on PE risk and guide further work-up.

The modified Wells criteria are a scoring system that can stratify patients into high and low risk based on historical factors. Patients deemed to be low risk may undergo D-dimer testing. If the D-dimer is negative in a low-risk patient, no further evaluation is required; however, if the D-dimer is elevated or the patient is considered high risk, further evaluation is required using either CT-PA or ventilation-perfusion (V/Q) scan.[10] A negative CT-PA effectively excludes PE; however, a low probability or intermediate probability V/Q scan is not sufficient to exclude a PE and will require a CT-PA to confidently diagnose or exclude PE.

## EKG in Pulmonary Embolus

A 35-year-old man was seen in an emergency department about 10 days after being hospitalized for diverticulitis and two months after knee surgery. He had complaints of shortness of breath, chest pain, and palpitations. The emergency physician ordered an EKG and interpreted it as normal. The patient was sent out with a diagnosis of a panic attack. He was prescribed Ativan and given a referral to a psychiatrist to see in consult. The psychiatrist believed the patient had a medical condition and advised him to seek medical attention promptly with his own doctor or to go to another emergency room. The patient saw his family doctor, who sent him to a nearby hospital as a direct admit, suspecting angina as a diagnosis. There, the patient waited 12 hours to be seen by the admitting physician. He had increased pain and leg swelling during that time. The admitting physician then consulted a cardiologist, who made the diagnosis of a PE and evacuated the patient to another hospital. The patient died eight hours later.

A lawsuit was filed by the decedent's wife claiming that the EKG was misread, the patient was incorrectly diagnosed as having a panic attack, and that a diagnosis of PE should have been entertained and excluded. The plaintiff pointed out that the symptom complex of tachycardia, shortness of breath, and an abnormal EKG (along with a post-operative status) should have led to an evaluation for PE. The defendants argued that the diagnosis of a panic attack was within the standard of care. At trial, the jury found for the plaintiff and awarded her $1.264 million. The original ED physician was responsible for 35% of the award.[11]

The abnormal findings on the EKG in acute PE are neither sensitive nor specific for this diagnosis. Rather, the EKG is used most commonly to exclude other causes of chest pain such as myocardial ischemia, myocardial infarct, or pericarditis.[12] The EKG may be normal in up to 20% of cases, although sinus tachycardia and nonspecific ST-T wave changes are two of the most commonly cited findings.[13] A rightward shift of the frontal plane axis along with T-wave inversions (the classic S1 Q3 T3 pattern), new right ventricular conduction delay (incomplete or complete right bundle branch block), asymmetric T-wave inversions in the precordial leads, and a late transition of the R to S ratio in the precordial leads (signifying clockwise or rightward shift in the horizontal plane) all suggest right heart strain with volume and/or pressure overload. These acute cor pulmonale EKG findings may occur in many disease states in which the right heart is stressed. Likewise, atrial arrhythmias (atrial fibrillation and flutter) may occur due to hypoxia and stretch on the right atrium.[14] Recently, the finding of simultaneous T-wave inversions in both the inferior and the anterior leads has been shown to be specific for pulmonary embolism; yet, the incidence of this finding is rare at 4-11%.[15]

## Pulmonary Embolism Treatment

Once the diagnosis of PE is made, initiation of prompt and adequate anticoagulation should be administered to care for the patient and avoid litigation. The initiation of treatment decreases the mortality from 30% to 3-8%.[16] The case of *Curry v. Jewish Hospital* demonstrates anticoagulation as the standard of care in PE. A morbidly

obese Kentucky man with a history of PE three years prior was diagnosed with a new PE in the ED. He was started on heparin in consultation with his primary care physician, which is the same treatment he had undergone previously. The following day, the man died of a cardiac event. His decedents sued the hospital claiming the dosage of heparin administered was not therapeutic. The hospital claimed that the dosage was proper and that a higher dosage would have carried a higher risk due to the decedent's recent vasectomy. In addition, they claimed the decedent had a week of symptoms prior to seeking care. A defense trial verdict was returned.[17]

New data are showing that not all patients require hospital admission after diagnosis of acute PE; however, all patients do require a period of observation, education on the usage of outpatient medications, and very close follow-up.[18] ■

## Summary

By increasing awareness of atypical presentations, risk factor assessment, diagnostic modalities, and prompt treatment, liability in PE cases may be decreased.

REFERENCES


1. *Estate of Chambers v. Dr. Ariel Quinones*, Union county (NJ) Superior Court. No. V26N10 Oct. 2010.
2. *Estate of Jabari Rhodes, deceased v. Dr. Khalid Malik, Dr. Ahmed Raziuddin, Weiss Memorial Hospital*. Cook County (IL) Circuit Court, Case No. 06l-5467.
3. *Aubrey Pastor, indiv. and as PR of the Estate of Derek Pastor and Cesar Pastor v. Patrick Daly, MD and Rointan Farahifar, MD* Prince George's County (MD) Circuit Court, Case No. CAL0-39966.
4. Stein PD, et al. Clinical characteristics of patients with acute pulmonary embolism: Data from PIOPED II. *Am J Med* 2007;120(10):871.
5. Blinder RA, Coleman RE. Evaluations of pulmonary embolism. *Radiol Clin North Am* 1985;23:392.
6. *Estate of Anonymous Thirty-two-year-old Woman v. Anonymous Emergency Room Physician and Anonymous Nurse Practitioner*, unknown Massachusetts venue, No. V27N4. April 2011.
7. *Maryann Mathiasen, as Executor of the Estate of Kenneth Mathiasen, etc. v. Albany Medical Center and Donal Jeanmonod, MD*. Nassau County (NY) Supreme Court, Case No. 10235/06.
8. *Estate of Anonymous Forty-year-old Man v. Anonymous Physicians*. Unknown Virginia venue. V27N11.
9. Kline JA, Et al. Prospective multicenter evaluations of the pulmonary embolism rule-out criteria. *J Thromb Haemost* 2008;6(5):772.
10. Van Belle A, et al. Effectiveness of managing suspected pulmonary embolism using and algorithm combining clinical probability, D-dimer testing, and computed tomography. *JAMA* 2006;295(2):1721.
11. *Patricia Kilburn v. Aliquippa Community Hospital, Ganapathi Moka, MD, James Tatum, MD, et al*. Beaver County (PA) Court of Common Pleas, Case No. 12340-2005.
12. Goldhaber S. *Braunwald's Heart Disease: A Textbook of Cardiovascular Medicine*. 2008:1868.
13. Stein PD, et al. Clinical characteristics of patients with acute pulmonary embolism. *Am J Cardiol* 1991; 68:1723.
14. Todd K, Simpson CS, Redfearn DP, et al. ECG diagnosis of pulmonary embolism when conventional imaging cannot be used: A case report and review of the literature. *Indian Pacing Electrophysiol J* 2009;5:268-275.
15. Wittig MD, Mattu A, Rogers R, Halvorson C. Simultaneous T-wave inversions in the anterior and inferior leads: An uncommon sign of pulmonary embolism. *J Emerg Med* 2011;7:228-235.
16. Goldhaber SZ, Visani L, De Rosa M. Acute pulmonary embolism: Clinical outcomes in the International Cooperative Pulmonary Embolism Registry (ICOPER). *Lancet* 1999;353(9162):1386.
17. *Curry v. Jewish Hospital Shelbyville*. Shelby County (KY) Circuit Court, Case No. 07-0481.
18. Erkens PM, et al. Safety of outpatient treatment in acute pulmonary embolism. *J Thromb Haemost* 2010; 8(11):2412.


# How Much Time Did EP Spend with Patient? EMR Can Mislead

*Time-stamping being used in malpractice suits*

In the course of medical malpractice litigation, the plaintiff attorney claimed the emergency physician (EP) didn't see a patient with respiratory failure until 15 minutes after arrival. This was what the electronic medical record's (EMR) time stamp showed, but it wasn't the case.

"The EP did a nice job of putting in his notes, 'I was immediately informed of the patient's arrival and saw the patient as soon as they were in a room,'" says **Charles Emerman**, MD, professor and chairman of the Department of

Emergency Medicine at MetroHealth Medical Center/Case Western Reserve University in Cleveland, OH. The case was resolved in favor of the defense.

Time-stamped EMR entries sometimes give misleading information about how much time an EP actually spent with the patient. "EPs don't realize there is a whole audit trail with EMRs, but the lawyers know all about this, and they're going to be looking for it," Emerman says.

**Bruce H. Nagel**, Esq., a partner with Nagel Rice in Roseland, NJ, says his firm routinely asks for the number of patients seen during a particular ED shift, and cross references this information with computerized time stamps.

"Oftentimes, we can show that the emergency physician spent literally a few minutes with a patient on a very busy night," he says. "That, in my view, is a very persuasive thing to argue with a jury — that the doctor was running from room to room and didn't spend enough time on the history and exam."

MetroHealth's ED recently discovered that the time span from when a critical care trauma patient arrives until the EP signs into the computer is between 10 and 15 minutes. "It gives the appearance that a critical trauma patient was unattended to for that time," Emerman says. "In reality, we are in the room — we are just not in the computer."

In many EMRs, time stamps can be adjusted to reflect the fact that the EP was in the room at the same time the patient arrived. The computer's audit trail would show the time was changed, so if a lawsuit occurs, the EP would likely be asked about this in his or her deposition. "You would hope that the truthful answer would be, 'I wanted the record to reflect what actually occurred,'" says Emerman.

If the EMR's time stamp contradicts what the EP claims, "it becomes an issue of credibility before the jury," says Emerman. "If the EP says, 'I saw this patient immediately,' and the plaintiff attorney shows the jury the computer time stamp that implies there was a delay, the jury might believe the doctor, or they might believe the computer."

Here are questions EP defendants are likely to be asked about their workload during medical malpractice litigation by plaintiff attorneys:

• **What is your staffing pattern? How many EPs were in the ED when this patient arrived?**

If the EP indicates that a change in the ED's staffing was made recently, it brings up the questions, "Why did you change? Was it a result of this case?" "Most defense lawyers would object to any discussion of remedial actions taken after the incident case being introduced as evidence, but that's a fight between the lawyers," says Emerman.

The only issue the EP has to address on the stand is whether the staffing was adequate for care of the particular patient. "Statements during deposition that the ED didn't have enough nurses or physicians are unlikely to help the EP," says Emerman. "If those were concerns, this should be discussed with defense counsel prior to the deposition."

• **How much time did you spend with this patient?**

"Except for critical care time, I don't know very many emergency physicians who time themselves going in and out," says Emerman. "If you don't know for sure how much time you spent with the patient, guessing is a bad idea."

The plaintiff attorney might point out that nursing documentation in the EMR indicates the EP saw the patient at 12:03 and wrote orders at 12:06, for instance, and use those time-stamped entries to claim the EP spent only three minutes with the patient.

To refute this claim, the EP would then need to explain how the EMR works — that the time the EP signed on isn't necessarily when he or she went in to see the patient, and that nurses might have documented that the EP was in with the patient at a later point in time, when they had time to do so.

In another recent malpractice case, the family claimed the EP spent less than a minute with the patient. "The EP responded, 'I take as long as I need. I don't think it was only 30 seconds, but I don't time myself going in and out,'" says Emerman. "Guessing is a bad idea, but you should give the most truthful answer that you can."

The patient's perception of how much time the EP spent might be incorrect, and doesn't take into account the time the resident spent obtaining a thorough history and performing an evaluation, or the time the EP spent discussing the case with the resident, nurses, or consultants, or looking at X-rays.

"A physician serving as an attending physician may need to explain that process in a teaching hospital, and that the attending physician comes

into the room with a fairly thorough familiarity of what has already been found by the resident," adds Emerman.

• **How many patients were you caring for at the time the plaintiff was in the ED?**

Plaintiff attorneys typically request a log of ED arrivals, and will know how many patients were in the ED when the plaintiff arrived. They will probably find out which patients saw which EP, and possibly obtain chief complaints with names redacted, says Emerman. In deposition, the EP might be asked, "Here are all the patients you saw that day. Is that unusual? Is that a reasonable workload for you?"

"Obviously, 20 patients with minor complaints is a different workload than 10 patients with critical illnesses or injuries," says Emerman. "It still doesn't tell the lawyer whether the EP was overwhelmed. It only tells them how many people you saw over the course of your shift."

In another recent case, the EP testified that "I had another patient who appeared to be more critically ill, given what I knew about the patient, so I had to direct my attention to them."

"That case was settled before trial," says Emerman. "You would hope that juries would understand that two critical care patients might come in the ED at the same time and the EP has to care for both of them" — but this isn't necessarily the case.

If an EP states that the patient didn't receive their full attention because the EP was overwhelmed, "it's not likely to be an excuse that is going to work — because the next question is, 'If you were overwhelmed, why didn't you call someone in to help you?'" says Emerman. ■

### Sources

For more information, contact:

- Charles Emerman, MD, Professor and Chairman, Department of Emergency Medicine, MetroHealth Medical Center/Case Western Reserve University, Cleveland, OH. Phone: (216) 778-3577. E-mail: cemerman@metrohealth.org.
- Bruce H. Nagel, Esq., Nagel Rice, LLP, Roseland, NJ. Phone: (973) 618-0400. Fax: (973) 618-9194. E-mail: bnagel@nagelrice.com.

# Patient Has Explanation for Symptoms? Probe Further!

*Inadequate history is factor in many lawsuits*

After a 50-year-old man told an emergency physician (EP) that he thought his upper back pain was a result of using a pull crank to start his mower, the EP did a brief musculoskeletal history and physical exam focused on the patient's back pain, and discharged him with anti-inflammatory medication.

"A few hours later, the patient presented again with back pain, and now chest pain. He was diagnosed with a significant myocardial infarction, and survived a stormy hospital course," says **John Davenport**, MD, JD, physician risk manager of a California-based HMO.

The patient sued the EP for misdiagnosis of his myocardial infarction. "Trial testimony focused on the patient's age, the actions which precipitated his symptoms, and the fact that myocardial infarctions sometimes present with arm, upper back, and shoulder pain," reports Davenport.

The EP testified that he had considered the possibility of cardiovascular causes, but the chart didn't support this. "Fault was found with the paucity of documentation around possible cardiovascular causes and the lack of a heart examination," says Davenport. "The verdict was for more than $500,000."

## EPs Might Be Misled

Failure to obtain an appropriate history is the underlying reason for many ED medical malpractice lawsuits, according to **Kevin Klauer**, DO, EJD, chief medical officer at Canton, OH-based Emergency Medicine Physicians.

"Our best diagnostic information often comes from the people who are least equipped to provide it," says Klauer. Patients often communicate poorly because they don't feel well or because of language or educational barriers.

"People communicate their symptoms in different ways," says Klauer. "If you take that at face value and don't probe further to make sure they don't have something bad, that wouldn't be negligence in itself — but it might be a stepping stone to a bad outcome and a lawsuit."

Inadequate history frequently results in allegations of wrongful death, failure to diagnose, or delay in definitive management, for instance. "Why did you miss the diagnosis of subarachnoid hemorrhage? Because you didn't have a critical piece of information — but you didn't ask more questions because you thought the headache was a sinus infection," Klauer says.

Consider these risk-reduction practices for EPs:

**• Clearly document pertinent negatives.**

A simple entry in the chart stating that the patient had no cardiovascular history and denied chest pain or shortness of breath would have given the EP a much better chance at prevailing in the above lawsuit, says Davenport, and would have provided evidence that the EP had indeed considered the heart in his evaluation.

**• Remember that patients sometimes minimize symptoms.**

"Some patients are afraid of serious diagnoses that they themselves suspect, and minimize their own symptoms out of fear," says Davenport.

An elderly female was brought to the ED by a neighbor who witnessed the patient's fall injury, but the patient stated she had simply slipped on a wrinkled doormat and felt fine. After a brief assessment, she was discharged home.

"The next day the patient was found by family with hemiplegia. She stated that she had been having balance and strength problems for several days, which eventuated in a stroke," says Davenport. "The patient sued, and the defendant EP was found liable for a substantial amount."

Davenport says the EP's best defense is an awareness of the patient's possible denial of illness, and a high index of suspicion for serious causes of purportedly minor symptoms.

"In this case, the ER doc never really asked the appropriate questions because he was busy, and initially set to expect a minor condition by her first comments," he says.

**• Ask people who accompany the patient to describe the symptoms and signs as they saw them.**

In the above case, the neighbor stated at trial that when she tried to help the patient up after her fall, she seemed unstable and unable to use her right leg for a while. "This information might have aided the ER physician in coming to the correct diagnosis," Davenport says.

**• Don't be misled by explanations offered by the patient.**

A patient's plausible-sounding explanation is often the "path of least resistance" for the EP, adds Klauer. "'Oh, your chest pain is indigestion? Well, thank goodness — that makes it easy for me.' It's less effort and less testing."

In a recent claim alleging misdiagnosis of subarachnoid hemorrhage, the patient initially told the EP she thought her headache was due to sinuses.

"There was a good history and good evaluation. But if we remove that information — the patient explaining away her symptoms — the EP would have potentially made a different decision," says Klauer.

When patients offer an explanation for their symptoms, the EP should "receive the information in a black and white manner," Klauer says. "When the patient reports chest pain, at that point I'm not interested in how they explain it away. It's human nature to minimize our symptoms. That is oftentimes the root of why we go down the wrong path."

Klauer points to the case of the playwright Jonathan Larsen, who reported chest pain during two ED visits before he died of an aortic dissection. When he first presented to the ED, he mentioned that he'd eaten a bad turkey sandwich.

"The EP decided he had food poisoning, despite the fact that he had no diarrhea and no vomiting," says Klauer. During the second ED visit, he was diagnosed with a viral syndrome.

The family's lawsuit demanded $250 million in damages, with an undisclosed settlement. Klauer says it's likely that the patient's explanation of his symptoms distracted the EPs involved from the patient's chest pain.

Aortic dissection is a difficult diagnosis to make, and most of the time it's missed on the first visit, he acknowledges. "But is it possible to make it? Yes," says Klauer. "When someone gives us a piece of information that explains away their symptoms, sometimes the brain shuts off. But one should avoid the temptation to explain away chest pain, even if it's convenient to do so."

**• Ask what you could be missing when patients report headache, dizziness, or chest pain.**

EPs have less time due to higher-acuity patients and increased volume, but have to avoid saying, "I know the answer so I'm not going to ask for more data," says Klauer.

"A lot of people spend time on things that don't really bring value to the visit," he says. "But communicating with the patient on a critical element on potentially life-threatening or

injury-causing diseases that we could miss is *always* a worthwhile time expenditure."

Klauer says to "always document and always function looking for the bad thing. Ask yourself, What is it I could miss? If it's a subarachnoid hemorrhage, talk about it and ask questions about it." *(See related story on misdiagnosis of cauda equina syndrome, p. 69.)*

Klauer advises asking patients questions such as "What else have you not told me that I didn't ask you about?" "Do you have any other symptoms that I haven't asked you?" or "Are you sure this pain isn't different somehow than your migraine pain?"

"Those questions are sometimes impossible to drag out of your mouth when you have six other patients to see," he acknowledges. "We are so busy, and oftentimes overwhelmed, that we don't want the answers. They create more work for us if we find them. They force you to stay longer at the bedside and to work even harder than you already are."

Klauer says EPs should set out to prove to themselves that nothing serious is happening. "You may think you have a beautiful plan for intestinal cramping because you think it's intestinal flu. The problem with that plan is, it doesn't work for appendicitis," he says.

• **Remember that patients may intentionally omit information.**

After a patient who had come in for an occupational health evaluation became agitated, he was seen by the EP, who sedated and intubated the patient. The patient hid the fact that he had drunk a large amount of water to dilute his urine in order to conceal drug use, which dropped his sodium levels, and the patient died as a result.

The EP was alleged to be negligent because of the route and dose of the sedating medicine. "The person who caused the initial problem — the agitation and the mental status change — was the patient, by drinking the water, of course," Klauer says. "Nonetheless, there was such large potential exposure, that midtrial there was a settlement for the plaintiff for $225,000."

In this case, a critical piece of information was not inadvertently, but *intentionally,* omitted by the patient, "but when there is a bad outcome, things can get complicated," says Klauer.

EPs should *expect* to get inaccurate information regarding substance abuse, overdoses, and sexual history, for instance. "We know that people who intentionally overdose often have coingestions and they don't disclose them," says Klauer. "If you take that at face value and don't investigate for additional toxins, you absolutely will be liable for that mistake." ■

## Sources

For more information, contact:

- **John Davenport**, MD, JD, Irvine, CA. Phone: (714) 644-4135. E-mail: john.y.davenport@kp.org.
- **Charles R. Grassie**, MD, JD. E-mail: cgrassie@epmgpc.com.
- **Kevin Klauer**, DO, EJD, Chief Medical Officer, Emergency Medicine Physicians, Canton, OH. E-mail: kklauer@emp.com.

# This Misdiagnosis Is "Plaintiff's Dream Case"

*Show cauda equina syndrome was considered*

As **Kevin Klauer**, DO, EJD, chief medical officer at Canton, OH-based Emergency Medicine Physicians, was examining a woman who presented to the ED with back pain, she informed him that she'd frequently had it before. When he probed further, she stated that the pain down the lower back was a little worse than usual, but didn't offer much additional information.

"I went through all of the questions I go through to screen for cauda equina syndrome, and everything was negative," he says. Klauer then asked the patient and the family, "Is there anything else that I didn't ask that you need to tell me?" The woman's daughter said, "Mom, why didn't you tell him about the trouble you are having urinating?"

"This lady got an MRI, she had cauda equina syndrome, and she had her spinal cord decompressed within hours of her presentation ," says Klauer. "She wanted it be a simple back strain, and she omitted a piece of history that she didn't know was critical, which could have caused her permanent bladder dysfunction, permanent weakness in the leg, or other complications."

Klauer says that if the daughter hadn't given

this piece of information, he would have missed the diagnosis. "And is any jury in the world going to blame her?" he asks. "Though infrequent, this is a scary, dangerous diagnosis that is frequently missed until the neurological deficits are permanent."

**Charles R. Grassie**, MD, JD, former vice president of risk management and CEO of Emergency Physicians Medical Group in Ann Arbor, MI, says missed cauda equina syndrome is "a plaintiff's dream case. It is not as frequent as missed myocardial infarction, but these are usually huge-dollar cases."

Patients might be incontinent, impotent, or paralyzed as a result. "It doesn't kill the patient, but it maims them for life, and could be potentially avoided if treated," says Grassie. "It's an emotional case because of the nature of the damages and because if it's taken care of timely, it might be prevented."

EPs should be clear that cauda equina syndrome was considered for every back pain patient they see, advises Klauer. "Document, 'There are no signs of cauda equina.' That's all you have to say," he says.

For any patient who reports chronic back pain, document whether he or she has any bladder incontinence or retention. "Do this each and every time, even if you just saw them half an hour before," says Grassie. "If they go home and they then have that problem, your documentation shows that they didn't have it at the time you saw them."

Diagnosing cauda equina syndrome requires a level of testing that's a little more difficult in the average ED, notes Grassie. "EPs sometimes have a fear of crying wolf. It requires pulling the trigger and getting an MRI," he says. "It might mean you have to go through the difficulty of transferring the patient."

In some cases, Grassie says the diagnosis is missed because patients are frequent ED visitors. "Frequently, patients with chronic pain are treated rudely and maybe even abusively in the ED. So the patient is angry to begin with, and this time, comes in with something catastrophic," he says.

Grassie says that EPs should treat everybody, even full-blown addicts, with respect and acknowledge their own biases. The EP doesn't have to prescribe narcotics for an addict, but should nevertheless treat him or her professionally. "Addiction is just another diagnosis," says Grassie. "Everybody working in EDs develops certain categories of patients that they dread. If you recognize your biases before you walk in the room, it helps you to put those biases aside." ■

# Chart Statements Made During Consult: It Will Help Defense

*Documentation can decrease EP's exposure*

When a 37-year-old pregnant woman presented to an ED with right upper quadrant pain, nausea, vomiting, and diarrhea, communication between the emergency physician (EP) and the patient's obstetrician became a key issue in the ensuing malpractice litigation.

The EP recommended admission to the medical floor to exclude gastroenteritis, but preeclampsia was not included in her differential diagnosis. "Though there was no reported complaint of headache, her husband claimed that patient complained to nursing personnel of severe headache in the ED," says Janice M. Ginley, assistant claims manager for MIEC, an Oakland, CA-based malpractice carrier.

The EP contacted the patient's obstetrician, who agreed with admission to a medical floor vs. labor and delivery despite the patient being in her third trimester of pregnancy.

"There was a question of how effective the communication was by the ED physician to the obstetrician," says Ginley. "There was no concern conveyed regarding preeclampsia."

The EP did not report an increase in blood pressure or elevated liver enzymes to the patient's obstetrician because the transferring nurses advised her that they would do so and because the obstetrician didn't seem very concerned about the findings in the earlier phone discussion. After admission to the medical floor, the patient's blood pressure climbed to 202/98.

"The obstetrician was contacted, who recommended no further action," says Ginley. When the patient became less responsive and had trouble moving her left side, an internist ordered a stat CT that revealed moderate to large right parietal hemorrhage with edema and moderate mass effect with effacement of the ventricles. "The neurologist diagnosed HELLP syndrome. However, the patient

deteriorated and she and the fetus expired," says Ginley.

The patient's husband filed a lawsuit alleging significant delay in diagnosis and treatment, and alleged that earlier diagnosis and treatment with magnesium sulfate and earlier cesarean delivery would have resulted in survival for mother and fetus.

"The defendants included the ED physician, the hospital, and the obstetrician," says Ginley. "There was general support for the management by the ED physician, though there was criticism concerning lack of preeclampsia in her differential and that she should have communicated more effectively with the obstetrician." The plaintiff's experts testified that even if the EP didn't recognize the more exotic HELLP diagnosis, she should have been more concerned about preeclampsia and should have communicated the abnormal findings to the obstetrician.

The plaintiff claimed that while the EP might not have reported all the findings to the obstetrician, she contributed to the delay in diagnosis by failing to ask the right questions. The EP claimed she relied on the expertise of the obstetrician, which is why he was contacted. "The ED physician settled the lawsuit in the mid-six-figure range. The hospital settled in the low six figures," says Ginley. The obstetrician took the case to trial and was found 40% negligent, for a $2.4 million verdict.

The EP's lack of knowledge of hospital policies and procedures related to patients in the advanced stages of pregnancy were detrimental to the management of the patient and negatively impacted the outcome, says Ginley.

In addition, the EP's documentation regarding her communication with the obstetrician was poor. This enabled the obstetrician to deflect responsibility and deny the extent of reporting, thereby putting increased exposure on the shoulders of the EP.

"Had her documentation been more complete, her ability to rely on the direction of the consulting obstetrician — who arguably, as the specialist, had greater knowledge — would have created a stronger defense," says Ginley. ■

## Source

For more information, contact:

- Janice M. Ginley, Assistant Claims Manager, MIEC, Oakland, CA. Phone: (510) 596-4936. E-mail: janiceg@miec.com.

**To reproduce any part of this newsletter for promotional purposes, please contact:**
*Stephen Vance*
**Phone:** (800) 688-2421, ext. 5511
**Email:** stephen.vance@ahcmedia.com

**To obtain information and pricing on group discounts, multiple copies, site-licenses, or electronic distribution please contact:**
*Tria Kreutzer*
**Phone:** (800) 688-2421, ext. 5482
**Email:** tria.kreutzer@ahcmedia.com

**To reproduce any part of AHC newsletters for educational purposes, please contact:**
*The Copyright Clearance Center* for permission
**Email:** info@copyright.com
**Phone:** (978) 750-8400

## 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. ■

## CNE/CME INSTRUCTIONS

**HERE ARE THE STEPS YOU NEED TO TAKE TO EARN CREDIT FOR THIS ACTIVITY:**

1. Read and study the activity, using the provided references for further research.
2. Log on to **www.cmecity.com** to take a post-test; tests can be taken after each issue or collectively at the end of the semester. *First-time users will have to register on the site using the 8-digit subscriber number printed on their mailing label, invoice, or renewal notice.*
3. Pass the online tests with a score of 100%; you will be allowed to answer the questions as many times as needed to achieve a score of 100%.
4. After successfully completing the last test of the semester, your browser will be automatically directed to the activity evaluation form, which you will submit online.
5. Once the evaluation is received, a credit letter will be sent to you. ■

# CNE/CME QUESTIONS

1. Which is true regarding electronic medical records (EMRs) and medical malpractice litigation?
   A. If the EMR inaccurately indicates a delay in a case when, in reality, the EP saw the patient immediately, this cannot be introduced as evidence in court.
   B. EPs should not correct time-stamped data under any circumstances.
   C. EPs might need to provide an explanation as to why an EMR's time stamp was inaccurate.
   D. The fact that an EP adjusted the EMR's time stamp to reflect reality is not admissible, as long as the corrected information is accurate.

2. Which is recommended for EPs to avoid lawsuits stemming from an inadequate history?
   A. EPs should always expect to get accurate information regarding substance abuse, overdoses, and sexual history.
   B. EPs should clearly document pertinent negatives.
   C. EPs should remember that patients are much more likely to exaggerate symptoms than they are to minimize symptoms.
   D. EPs should avoid asking people who accompany the patient to describe the symptoms and signs as they saw them.

3. Which is true regarding diagnosis of cauda equina syndrome in the ED?
   A. It is not necessary for EPs to document whether this diagnosis was considered if a back pain patient was seen for the same complaint within the previous 24 hours.
   B. For any patient who reports chronic back pain, EPs should document whether the patient has any bladder incontinence or retention.
   C. It is not advisable for EPs to document that cauda equina syndrome was considered for every back pain patient they see.
   D. It is not sufficient for EPs to document "There are no signs of cauda equina."


## Editorial Advisory Board

Physician Editor
Arthur R. Derse, MD, JD, FACEP
Director and Professor, Center for Bioethics and Medical Humanities, Institute for Health and Society, Medical College of Wisconsin, Milwaukee, WI

EDITORIAL BOARD

Kay Ball, RN, PhD, CNOR, FAAN
Consultant/Educator, K&D Medical Inc., Lewis Center, OH

Sue A. Behrens, APRN, BC
Director of Emergency/ ECU/ Trauma Services, OSF Saint Francis Medical Center, Peoria, IL

Robert A. Bitterman, MD JD FACEP
President, Bitterman Health Law Consulting Group, Inc., Harbor Springs, MI

Eric T. Boie, MD, FAAEM
Vice Chair and Clinical Practice Chair, Department of Emergency Medicine, Mayo Clinic; Assistant Professor of Emergency Medicine, Mayo Graduate School of Medicine, Rochester, MN

James Hubler, MD, JD, FCLM, FAAEM, FACEP, Clinical Assistant Professor of Surgery, Department of Emergency Medicine, University of Illinois College of Medicine at Peoria; OSF Saint Francis Medical Center, Peoria, IL

Kevin Klauer, MD, Chief Medical Officer, Emergency Medicine Physicians, Canton, OH

Jonathan D. Lawrence, MD, JD, FACEP
Emergency Physician, St. Mary Medical Center, Long Beach, CA
Assistant Professor of Medicine, Department of Emergency Medicine, Harbor/UCLA Medical Center, Torrance, CA

Larry B. Mellick, MD, MS, FAAP, FACEP
Professor of Emergency Medicine, Professor of Pediatrics, Department of Emergency Medicine, Georgia Regents University, Augusta

Gregory P. Moore MD, JD
Attending Physician, Emergency Medicine Residency, Madigan Army Medical Center, Tacoma, WA

Richard J. Pawl, MD, JD, FACEP
Associate Professor of Emergency Medicine, Medical College of Georgia, Augusta

William Sullivan, DO, JD, FACEP, FCLM
Director of Emergency Services, St. Margaret's Hospital, Spring Valley, IL; Clinical Instructor, Department of Emergency Medicine Midwestern University, Downers Grove, IL; Clinical Assistant Professor, Department of Emergency Medicine, University of Illinois, Chicago; Sullivan Law Office, Frankfort, IL