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Don't get comfortable; Cover basics or kiss your assets goodbye

By **Rudy Bisciotti, JD,** Gilliland and Associates, Covington, KY. Commentary by **John C. Gilliland, II, JD**, Gilliland and Associates, Covington, KY.

In this month's ED Legal Letter, *our author has provided a variety of medical malpractice cases with relevance to us as emergency physicians. Some of these cases resulted in settlements prior to trial; others went to trial where juries rendered verdicts. In most of the cases, we have been provided with only limited facts. With that caveat in mind, in some of the cases where the jury returned a defense verdict, one can easily imagine another jury, with similar facts, finding for the plaintiff. The point being: Don't get too comfortable just because the physician prevailed in some of these cases; they easily might have turned out differently.*

Some of the lessons that these cases teach are the recurrent themes that all of us involved in emergency medicine risk management constantly stress: early scheduled follow-up evaluations can prevent disasters (e.g., patients with right lower quadrant pain); simple, clear discharge instructions which cannot be misinterpreted are essential; common problems occur commonly (e.g., pulmonary embolism [PE]); if the patient has right lower quadrant pain, always consider appendicitis and discuss the possibility with the patient (or parent in the case of a minor patient); if the patient has chest pain and is in the appropriate age group, consider acute myocardial infarction (AMI); remember that many ED malpractice disasters are vascular (e.g., PE, aortic dissection or aneurysm, subarachnoid hemorrhage); laboratory and x-ray follow-up must not be ignored; when a patient returns to the emergency department for an unscheduled recheck, that patient may be giving you an opportunity to remedy an earlier misdiagnosis; patients with possible AMI need "IV, O_2, monitor" right now, etc.

Case No. 1: Discharge Instructions Are Vital

On Oct. 27, 1995, a 50-year-old sales manager came to the emergency department of Santa Monica UCLA Medical Center complaining of constant, severe right-sided abdominal pain for the past 30 hours, associated with fever

and nausea. A nurse found right lower quadrant tenderness on palpation.[1] The defendant emergency physician had noted right upper quadrant tenderness on examination. The patient's white blood count was elevated (19,300) with a left shift. Other laboratory tests were negative.

After a lengthy wait for an abdominal ultrasound, the patient reported that his abdominal pain had resolved. The ultrasound was never done. The patient was discharged with a diagnosis of acute viral illness – "the flu." Before discharge, the emergency physician had a brief phone conference with the codefendant internist who was on-call for the patient's family physician, during which time the emergency physician advised the internist of the patient's emergency department evaluation.

Five days later, the patient was hospitalized and underwent surgery for what was found to be a perforated appendix with a large retroperitoneal abscess. One week later, the patient was found to have a significant wound infection that had caused his abdominal incision to open. A second surgery was required to explore and irrigate the wound. The patient's postoperative course was complicated, ending with the patient's death one month after admission.

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The plaintiff claimed that the patient had presented on his initial visit with classic symptoms of appendicitis and that the diagnosis was missed at that time by the emergency physician, who should have requested a surgical consultation. Incidentally, the emergency physician was only four months out of his residency. The codefendant on-call internist, it was claimed, should also have suspected acute appendicitis and, particularly with the elevated white blood count, should have suggested that the emergency physician obtain a surgical consultation. It was alleged that, had a surgical consultation been obtained at the time of the patient's first emergency department visit, the patient would have undergone an appendectomy prior to perforation. As a result, it was alleged that the post-operative complications sustained by the patient, which ultimately resulted in his death, could have been avoided.

The plaintiff further claimed that, at the conclusion of the patient's first emergency department visit, because of the patient's abdominal pain and elevated white blood count, the standard of care required the emergency physician to instruct the patient to return within 12 hours for a reevaluation. That is, even if it was not negligent to have discharged the patient at that time, given the circumstances, it was negligent not to arrange early reevaluation. The plaintiff claimed that, had the patient been instructed to return in 12 hours and had he been reevaluated at that time, appendicitis would have been diagnosed, and he would have undergone an appendectomy prior to perforation. As a result, he would have lived, despite an alleged misdiagnosis on his first visit.

Unfortunately, the patient relied on the initial diagnosis of "the flu" and did not return early enough for reevaluation, feeling he just had to get over it. The plaintiff claimed that the delay in diagnosis, because of the failure to make a proper diagnosis at the time of the initial emergency department evaluation and a failure to recommend appropriately prompt follow-up evaluation, allowed the patient's appendix to rupture. This led to the postoperative complications and, ultimately, to the patient's death.

The defense answered that the patient's presentation was atypical for acute appendicitis and, as a result, the emergency physician was not negligent in failing to make the diagnosis at the time of the first visit, if the patient indeed even had acute appendicitis at that time. When the patient's abdominal pain resolved during his stay in the emergency department, it was reasonable, according to the defense, for the physician to discharge

the patient with the discharge instructions he was given. According to the defense, the patient was responsible for the complications that ensued because he failed to follow the physician's instructions, which called for him to return to the emergency department if his symptoms recurred. In addition, the defense claimed that the patient was still medically salvageable when he was taken to surgery at the time of the wound infection, but the surgeon performed the wrong procedure and this was really the proximate cause of the deadly post-operative complications.

At trial, a jury verdict in favor of the defendant was returned.

Commentary: *This case presents, among other issues, that of comparative or contributory negligence. In comparative/contributory negligence (these are different names for essentially the same defense – which name is used depends on the state), the claim is that the plaintiff is responsible for some or all of the injury which resulted. This should, depending on how negligent the plaintiff was, in comparison to the defendant, either reduce or eliminate liability for the defendant. Comparative/contributory negligence is what is known as an affirmative defense and such defenses should always be asserted when the facts support such a defense. In this case, the alleged comparative/contributory negligence was the plaintiff's alleged failure to follow the physician's discharge instructions.*

Editor's note: *This case is an excellent example of the importance of discharge instructions. None of us can always correctly diagnose acute appendicitis in its early stages. In this case, there is certainly reason to believe that the patient had acute appendicitis at the time of his first emergency department visit. However, the physician was found not liable because he had instructed the patient to return if his symptoms recurred, and the patient failed to follow these instructions. Had he returned when his symptoms recurred, the jury believed the subsequent complications would have been avoided.*

While this physician prevailed based on discharge instructions (telling the patient to return if his symptoms recurred), the safer approach is to set a specific time for reevaluation of such patients. With suspected appendicitis, an interval of 8-12 hours is generally appropriate. The patient should be instructed to return to the emergency department for a reevaluation after a specific interval (e.g., 8-12 hours), no matter how he or she feels. Always instruct patients exactly: 1) where to go; 2) when to go; and 3) what should happen when they get there. Finally, always instruct patients to return to the emergency department immediately if their symptoms worsen or change (i.e., they develop a new symptom).

Case No. 2: ED Blood Cultures

The plaintiff, age 47 and unemployed, presented to the emergency department on May 3, 1991, complaining of back pain and a low grade fever.[2] While in the emergency department, blood cultures were drawn. The patient was admitted from the emergency department, and after 48 hours the blood cultures showed no growth. Following a three-day admission, the patient was discharged. Subsequent to the patient's discharge, the blood cultures were reported as positive. The laboratory technician testified at trial that she had contacted the patient's internal medicine physician's office to advise of the positive blood culture. The internist claimed that no such communication had been received. In any case, no one notified the patient of the positive blood culture over the next three days.

Following discharge, the patient developed sepsis. As a result of the septicemia, the patient's thoracic spine was seeded, causing osteomyelitis. This progressed to an epidural abscess that ultimately encroached on the spinal cord, resulting in paraplegia. By the time the diagnosis was made on May 31, 1991, the plaintiff was irreversibly paraplegic. It was the plaintiff's contention that, because the physicians did not respond promptly to the positive blood culture, he unnecessarily developed osteomyelitis and an epidural abscess which resulted in his paraplegia. Had he been called back to the hospital at the time the blood cultures were found to be positive, it was argued his paraplegia could or would have been avoided.

The defendant physicians unsuccessfully claimed that they were not advised of the positive blood culture and that osteomyelitis is an extremely rare and difficult diagnosis to make. At trial, the jury returned a verdict for the plaintiff in the amount of $1,141,000.

Commentary: *In a case like this, there is always the danger that codefendants will end up accusing each other of causing the patient's injury. The hospital will claim that the physicians were notified of the positive blood culture and were negligent in not responding to those results. The physicians will argue they never received the notification and, therefore, the hospital laboratory bears responsibility. This is always a good situation for the plaintiff (each defendant making the*

plaintiff's case against the other defendant) and a disaster for the defendants.

Editor's note: *Never discharge a patient from the emergency department, or admit a patient to the hospital, until all laboratory results have been returned and evaluated. If you must order a laboratory test that will not be, or cannot be, performed on a stat basis, it is essential that an appropriate follow-up system be in place. Even if the patient is admitted, and any adult patient sick enough to have blood cultures sent is sick enough for admission, the emergency department must have a laboratory follow-up system in place. In a case such as this, when the patient has already been discharged from the hospital, it is likely that the positive laboratory result will come back to the emergency department (since it was drawn in the emergency department), which will have the responsibility for contacting the patient and his or her physician.*

Case No. 3: Cases Aren't Just about Negligence

On Oct. 6, 1996, a 61-year-old director/actor with a long history of high blood pressure developed the sudden onset of chest and back pain, associated with leg numbness and weakness.[3] He went to a local hospital emergency department where he was seen by the defendant emergency physician. The physician ordered routine tests, an EKG, chest x-ray, urinalysis, and blood tests. A cardiology consult was not requested, and no imaging studies were ordered, other than the chest x-ray. The patient, unbeknownst to the emergency physician, unfortunately had a dissecting aortic aneurysm. The emergency physician discharged him with a diagnosis of "atypical chest pain." He arrested and died the next day.

The plaintiff contended that the defendant physician negligently failed to make the diagnosis of an aortic dissection, either by consulting a cardiologist, doing appropriate imaging studies, or admitting the patient to the hospital for further evaluation. As a result of the physician's failure to make the appropriate diagnosis, the dissection extended, finally rupturing and causing the death of the patient the day after the emergency department visit.

The physician defended his treatment of the patient, contending that the patient's presentation was not typical of a thoracic aortic dissection and the patient had been seen by his private physician the day following the emergency department visit, who also missed the diagnosis. The case was settled for $900,000.

Commentary: *In this type of case, where the facts may present a possible if not probable case of liability, it may become necessary to focus on the amount of damages that the plaintiff may be awarded. Where "wrongful death" is the claim asserted, close analysis of the respective state's wrongful death statute or law must be conducted to determine exactly what type and element of compensatory damage is recoverable.*

Editor's note: *It is important to remember that there are four elements to a malpractice case: duty (physician-patient relationship); negligence (breach of the standard of care); proximate cause (defendant's negligence must be a cause of the damages, and closely enough related to the damages that the defendant should be held liable); and actual damages (plaintiff must have suffered some compensable injury). In the case of emergency physicians, the first element (duty) is essentially a given, at least when the patient is in the emergency department. Importantly though, even if the second element (negligence) is present, the case is not necessarily lost. In defending a physician, there is no question that we would prefer to be able to make a credible argument that there was no negligence. This is, however, not always possible. While we do not like having to focus our defense primarily on the causation element, when the physician's treatment appears to have been clearly below the standard of care, we have little choice. Finally, if the plaintiff can establish the first three elements, we can still attempt to limit the available damages.*

Case No. 4: Leaving Against Medical Advice

This incident took place on June 24 and 25, 1988.[4] The infant decedent, a 2-year-old at the time, and his twin brother and 4-year-old sister, were left in the care of their grandmother while their parents were out of state. The grandmother believed the 4-year-old had ingested some of her medication, and at approximately 9:30 p.m. on June 24, 1988, she took her granddaughter to the hospital for evaluation. All three of the grandchildren came with her to the hospital, but only the 4-year-old was evaluated. After the hospital personnel took the child's history and observed her for about four hours without any apparent ill effects, the grandmother signed the child out against medical advice and brought her home.

Evidence indicated the physician informed the grandmother that the child could have complications, including cardiac arrest, and advised against signing

her out against medical advice. One hour after the grandmother left with the child, her laboratory results came back normal.

The grandmother claimed that at about 2:30 a.m. she became worried that her 2-year-old grandson was sick and also had possibly ingested some of her medication. He had vomited, was agitated, and was complaining of abdominal pain. She alleged that she took the child's pulse, called the hospital, and had a conversation with someone there. She returned to the hospital at 5 a.m. with all three children. They did not actually enter the hospital, but claimed that three nurses had checked her grandson in the parking lot and said that his pulse was fine. Three hours later, the infant was dead on arrival at another hospital from what was determined to be an overdose of Verapamil, the grandmother's blood pressure medicine.

The plaintiff claimed that the physician who initially saw the 4-year-old girl was negligent for allowing the grandmother to sign her out against medical advice, without considering the possibility that the twin boys might have ingested the medication and advising the grandmother of that possibility. The plaintiff claimed that it was a breach of the standard of care not to have evaluated all three children. The plaintiff also claimed that the resident physician had taken an inadequate history in the emergency department.

The emergency physician who treated the 4-year-old girl on June 24 countered that there was no physician-patient relationship established between him and the boy who eventually died, because the grandmother never requested that he be examined and the physician never evaluated the child. He testified that the grandmother only gave history related to her granddaughter, stating that she was the only grandchild who could have gotten into the medicine. Furthermore, the grandmother only presented her granddaughter for evaluation, not the two grandsons. He further contended that his evaluation and treatment of the girl was appropriate, in that the grandmother had induced vomiting before bringing her granddaughter to the hospital and she was observed over a four-hour time period. He testified that he had advised the grandmother not to sign the child out and maintained that he would only have been permitted to stop her from leaving with the child if the situation had been life-threatening, or if he suspected child abuse, neither of which applied in this case.

The hospital contended that its personnel took a complete and appropriate history and that when the grandson was observed in the parking lot by its personnel, that action did not constitute the initiation of treatment and that the grandmother was free to bring the child into the hospital at that time for treatment, but chose not to do so. At trial, the jury returned a verdict for the defense.

Commentary: *This case presents an interesting question of when the physician-patient relationship begins. Such an issue is fact-specific and should be analyzed on a case-by-case basis. The absence of a physician-patient relationship should be raised as a defense when, as in this case, the facts justify the assertion of such a defense.*

Editor's note: *This was undoubtedly a very difficult case for the emergency department personnel. If the grandmother had told the physician that the grandson might have ingested the medication, yet refused to bring the child into the department, the physician could have involved children's protective services, hospital security, and/or the police. Attempts to reach the parents should also have been made. This is easy enough to say in retrospect; it was not necessarily so easy to do at the time.*

Case No. 5: Saved by a Directed Verdict

In this case, the plaintiff claimed that the defendant physicians failed to diagnose the patient's allergic reaction to an antibiotic and, instead, increased the dose of the medication, resulting in the allergic reaction, toxic epidermal necrolysis, dramatically worsening. As a result, the 33-year-old patient died nine days later.[5]

The decedent, a cosmetology student, went to the hospital with cold symptoms, including a fever, on Jan. 9, 1992. She was discharged from the emergency department with a prescription for Augmentin. Within hours after taking the medication at home, she became nauseated and felt dramatically worse. She returned to the same hospital the next day for evaluation of her worsening symptoms. By the time she was examined by the defendant physicians in the emergency department, it was claimed she was exhibiting all the signs and symptoms of a serious allergic reaction to the medication.

She had a raised, bullous rash on her face, purulent discharge from her eyes, vaginal inflammation, and discharge, nausea, vomiting, and severe swelling of her face and pharynx. None of the defendant physi-

cians recognized that the patient was having an apparent allergic reaction to the antibiotic. Instead, they gave her a parenteral dose of another penicillin derivative, Unasyn.

Over the next 12 hours, the Unasyn was given three times, during which time the patient's condition deteriorated rapidly. She developed respiratory failure and required intubation and mechanical ventilation. The rash on her face progressed to widespread bullae and skin sloughing. Finally, after the patient had received, in total, 18 times the dose that had originally caused the allergic reaction, another physician recognized her problem as an allergic drug reaction and immediately stopped the Unasyn. The patient was changed at that time to an alternative, non-penicillin type, antibiotic.

Plaintiff contended that the patient's allergic reaction should have been diagnosed before she was given the intravenous Unasyn, since she had presented with the hallmark signs and symptoms of an allergic drug reaction, in particular the rash, inflammation of multiple mucosal membranes, and nausea and vomiting. Plaintiff claimed that the additional doses of intravenous Unasyn, which the patient received in the hospital, aggravated her allergic reaction and resulted in the massive skin loss. Toxic epidermal necrolysis (TEN) causes large areas of skin to slough and also causes erosions and inflammation of the body's internal mucosal linings and membranes, including those in the lungs and the gastrointestinal tract.

After two days of extensive skin loss, the doctors at the original hospital transferred the patient to the regional burn center for treatment by burn specialists. At the burn unit, the areas of skin loss were cleaned and covered with synthetic skin. She was mechanically ventilated and provided enteral feedings by nasogastric tube because she was unable to eat or drink. Despite the efforts of the staff at the burn center, the patient developed sepsis. This ultimately led to cardiac arrest and, nine days after the patient's original emergency department visit, she was dead at the age of 33.

The defense contended that the patient's TEN was not caused by any medication but, rather, was triggered by some unidentified infection which had precipitated the patient's illness before she ever presented to the emergency room or received any antibiotics. Plaintiffs emphasized in their case, however, that the hospital discharge summary and the records of the burn unit documented the opinion of the treating physicians that the plaintiff's TEN was caused by an allergic drug reaction.

At trial, the jury returned a verdict of $2,085,000 against two of the physicians who jointly made the decision to administer the Unasyn; however, the court directed a verdict in favor of the hospital.

Commentary: *A directed verdict is a verdict handed down by the court in cases where, after construing the evidence most strongly in favor of the nonmoving party, the court concludes that reasonable minds could come to but one conclusion, that a verdict in favor of the moving party is warranted. No jury assent to a directed verdict is necessary – the question is never sent to the jury. The decision rests with the court based upon the court's analysis of the evidence and how the court feels reasonable minds would interpret the evidence. In this case, the court ruled that, as a matter of law (i.e., not a decision for the jury), the hospital was not liable for the patient's death.*

Case No. 6: 'IV, O_2, and Monitor'

The patient, a 47-year-old female, arrived at the emergency department complaining of chest pain and other symptoms consistent with a cardiac problem.[6] She claimed that the nurse did an initial assessment but left her unattached to a cardiac monitor during the next hour. Plaintiffs contended at trial that, while the patient waited in the emergency department for the defendant nurse to return, her condition worsened, and she went into cardiac arrest and subsequently died.

The defendant physician settled before trial. The case proceeded against the emergency department nurse. The defendant nurse denied negligence and contended her actions were within the standard of care and she had followed the instructions of the doctor. At trial, the jury returned a verdict in favor of the defendant nurse.

Commentary: *This case involves the issue of a settling co-defendant. In such cases, it may be argued in some, if not most, states that the amount of that settlement should be set off against any eventual jury verdict rendered against the non-settling defendant, if any. Close analysis of each respective state's law and statutes should be conducted to determine the effect of a settling co-defendant upon any remaining defendants.*

Editor's note: *Once again, we have limited facts on which to offer an opinion here. Nonetheless, to prevail on a theory that it is not the standard of practice to immediately place a patient with chest*

pain on a monitor, is fortunate indeed. When teaching advanced cardiac life support, I know I always teach that chest pain patients should always be brought immediately back to a monitor room and the next step is "IV, O_2, monitor." Never one without the other two.

Case No. 7: Beware Return Visits

In December 1999, a 27-year-old sales clerk with Marfan's Syndrome, a genetic disorder which is associated with a high risk for aortic dissection, presented to the emergency department complaining of severe chest pain.[7] He was admitted for further testing and observation. After a night in the hospital, he was released the following day. He returned to the emergency department two days later complaining of the same symptoms. At this time he was not admitted, although his cardiologist was consulted by telephone. He was instructed to follow up with another cardiologist. After another two days, late in the day, he went to the cardiologist's office with the same complaint of severe crushing chest pain. Allegedly the cardiologist, told him he would be all right, gave him more pain medication, and sent him on his way. He died in the parking lot of a thoracic aortic dissection. The case was settled for $900,000.

Commentary: *This is a case where negligence and liability appear likely, and the plaintiff is young, making for the potential of large damages. In such a case, to avoid the risk of a huge jury verdict, settlement is likely.*

Editor's note: *Beware the patient who presents multiple times with the same complaint. This case reinforces two important risk management rules for emergency physicians. First, never trust the diagnosis made by the physicians who previously saw the patient. In this case, they all concluded that the patient was fine – he wasn't. Second, be careful when a patient returns a second time with the same complaint, and be especially careful if it is the third visit with the same complaint. There is going to be a reasonable chance that something was missed and, if it was, it will not look good if the patient has come back to see you a second or third time and you seemingly continue to ignore the problem. You don't have to admit every patient who returns a second or third time to the emergency department; you should, however, consider it.*

Case No. 8: Common Illnesses Occur Commonly

Plaintiff, an active 44-year-old waitress with no significant history of relevant diseases or problems, except a demonstrated fear of doctors (her mother had breast cancer), developed some flu-like weakness with a borderline tachycardia, for which she sought treatment from her private physician.[8] He examined her and prescribed a beta-blocker, Corgard, which she took initially as a 20-mg dose. She collapsed on a brisk walk with her husband some three hours later and, although there was no complete loss of consciousness, there was "near syncope." After evaluation, she was sent home to rest and eat.

Later that evening, she was sent by another physician to the emergency department at the hospital for observation. It was suggested that she receive a chest x-ray, have her sedimentation rate checked, and be given a general examination regarding her complaints of breathlessness and weakness. The chest x-ray was read as "normal" by the treating physician and by the radiologist the next morning. The sedimentation rate was normal and there was, in the opinion of the examining physician, no sign or symptom of pulmonary or other significant problems on examination. The patient denied having any shortness of breath. Her EKG and pulse oximetry were also normal.

The patient, through her husband, mentioned to the physician, as an afterthought at the end of the examination, that she had had some leg pain. This had been present earlier but was now resolved. She described it as a "charley horse" or cramp. Her legs were examined. However, because the physician did not consider this to be important, this examination was not noted on the patient's chart.

The patient was discharged home with instructions to see her private physician in the morning. She had elevated liver enzymes, and hepatitis was being considered and worked-up by her physician. She and her husband had eaten oysters in the past few days, and it was suspected she might have contracted hepatitis from them, although her husband had no symptoms. The patient remained weak, but continued to rest and felt better on resting. There were a total of three visits and three telephone calls to the private physician. On the ninth or 10th day of her course of treatment, she was taken to the hospital by ambulance, having developed severe respiratory problems. She had a pulmonary embolism and died.

Plaintiff alleged that defendants failed to appreci-

ate a Westermark's sign, present on her earlier chest x-ray obtained in the emergency department, a sign of pulmonary infarction. Defendants allegedly failed to take into account that the decedent's mother had a history of deep vein thrombosis (DVT), an aunt had had a pulmonary embolism, and that her father had a mesentery infarct secondary to heart disease, all indicating a hereditary propensity to clot. The defendants also allegedly ignored a history of general weakness, shortness of breath, and leg pain, all of which were suggestive of PE. It was claimed that, had she been properly treated with heparin, she would not have died.

Defendants countered that the x-ray was normal, as read by the treating physician and the radiologist, without a Westermark's sign or other evidence of PE; the signs and symptoms she exhibited were entirely consistent with a viral illness, a reaction to Corgard, or viral hepatitis. The defendants further contended that the leg pain was more consistent with a musculoskeletal etiology than with DVT. In any case, it was transient and had occurred during exercise.

The defense argued that the patient had been properly examined by the family practitioner as well as the emergency physician, and all relevant history, as well as signs and symptoms, were considered by both doctors at all times. The family history of DVT and PE was irrelevant because it did not establish the existence of one of the hereditary clotting factors necessary to suggest an autosomally dominant propensity for clotting (Protein C, Protein S, or Antithrombin III deficiency). It was argued that the DVT's and pulmonary embolism, as well as the mesenteric infarct, suffered by the patient's relatives were each the result of unique circumstances, not the result of a hereditary abnormality. In this case, the defense contended that the patient's presentation was atypical for DVT or pulmonary embolism and it was not unreasonable that the diagnosis might not have been made. That is, despite the fact that the physicians might have "missed" the diagnosis, their treatment of the patient was within the standard of care.

At trial, the jury returned a verdict in favor of the defendants.

Commentary: *The determination of a physician's standard of practice in any given case will require expert testimony. Furthermore, in cases where certain anticipated evidence may be thought to be irrelevant, or otherwise inadmissible, it is important to raise all such objections, prior to trial if possible. Relevant evidence is that which has a tendency to make the existence of a fact which is of consequence to the determination of the lawsuit more probable or less probable than it would be without the evidence. In some cases, however, even relevant evidence may be excluded if its value is substantially outweighed by the danger of unfair prejudice, confusion of the issues, or that it might mislead the jury. Evidence may also be excluded for many other reasons – privilege, hearsay, etc.*

Editor's note: *This is another case that might well have turned out the other way. Pulmonary embolism is both common, and commonly missed. Often we get away with missing pulmonary emboli as they are small and not followed by subsequent lethal emboli. A high index of suspicion for pulmonary embolism is always prudent. All emergency physicians should be familiar with the Prospective Investigation of Pulmonary Embolism Diagnosis (PIOPED) studies and their recommendations for the evaluation of patients with possible pulmonary embolism.*

Case No. 9: Saved by Discharge Instructions

On March 15, 1998, a 20-year-old woman presented to the defendant physician who was a board certified internist.[9] She complained of nausea, vomiting, and difficulty breathing over the previous several days. The defendant performed an EKG that revealed sinus tachycardia. It was alleged that, based on the EKG results, the defendant should have ordered an arterial blood gas and hospitalized the patient. The defendant contended that the patient was properly treated for her complaint of nausea, and that, since she was not in respiratory distress, an arterial blood gas was not indicated. The patient was scheduled for a return visit on March 24, and was told to call earlier if her complaints persisted. She did not return. On March 25, the patient's mother notified the defendant that her daughter would be traveling out of state to Georgia. The patient was in Georgia for several days, during which time she felt ill. On April 1, she was taken to the emergency department and administered Verapamil to lower her elevated blood pressure. She subsequently suffered a cardiac arrest and, as a result, suffered anoxic brain injury. She lapsed into a coma and was airlifted to the Tallahassee Medical Center where she remained unresponsive until her death on April 6, 1988.

Defendant was alleged to be liable for failing to order an arterial blood gas studies and failure to hospitalize the patient. Defendant contended that there

was no medical indication for such tests on March 15, 1988, and the patient never returned as instructed for further evaluation. At trial, the jury returned a verdict in favor of the defendant.

Commentary: *This case, like one discussed above, involves the issue of comparative or contributory negligence. This is an affirmative defense which, when applicable, can either preclude or reduce an award for the plaintiff, despite negligence on the part of the defendant. State statutes and laws differ as to the potential application and effect of the doctrine of comparative/contributory negligence at trial.*

Editor's note: *Always maintain a high index of suspicion for PE.*

Endnotes

1. Young v. Catena, No. SC044095, Cal., (L.A. County Super. Ct. November 1998).
2. McFarland v. Childress, No. 96-L-241, Va., (Winchester Circuit Court, August 1998).
3. Anonymous v. Anonymous, Cal., (L.A. County Super. Ct. 04-02-98).
4. VanSchoonhaven v. Childrens Hospital of Buffalo, No. 11987/88, N.Y., (Erie County Sup. Ct., March 1998).
5. Gunn v. Rodgers, No. 93-11-3330, Pa., (Philadelphia County Court of Common Pleas 1998).
6. Cooper v. Gerdt, No. 952-10205A, Mo., (St. Louis City Cir. Court 1998).
7. Correl v. Anonymous, Wash., (Pierce County Super. Ct., July 1998).
8. Johnson v. Cummings, No. 71-48-52, Cal., (San Diego County Super. Ct. March 1998).
9. McKay v. Etess, No. 19641/99, N.Y., (Queens Cty. Sup. Ct. Jamaica March 1999).

Plan geared at slashing medical errors by 50%

By **David L. Freedman, MD, JD, FAAEM**

In the November issue of *ED Legal Letter*, Pearl Schaikewitz provided an excellent review of errors in medicine and efforts to reduce the consequences of human error in medical practice.[1] Her article could not have been more timely. On Nov. 29, the Institute of Medicine (IOM) of the National Academy of Science published a press release summarizing the highlights of its in-depth report on the frequency of medical error and recommended strategies, including mandatory reporting requirements, to reduce these errors and their devastating consequences: To Err is Human: Building a Safer Health System.

According to the IOM, medical errors kill approximately 44,000-98,000 people in United States hospitals each year. Even if the lower estimate is correct, more people die each year as a result of medical errors than die from highway accidents, breast cancer, or AIDS. Medication errors in and out of hospitals, according to the IOM, account for more than 7,000 deaths per year.

The committee that wrote the report was of the opinion that "[t]he know-how exists to prevent many of these mistakes." In its summary statement, the committee set a goal of reducing the number of medical errors by at least 50% in the next five years: "We believe that with adequate leadership, attention, and resources, improvements can be made." According to the IOM, and as was discussed by Ms. Schaikewitz in her article, most medical errors are not the result of individual recklessness, rather they are the result of basic flaws in the way our health system is organized.

The IOM proposed a four-part plan to address the problem. First, the institute proposed a National Center for Patient Safety within the Department of Health and Human Services. It would be expected that such an agency would enhance medical safety as other safety agencies have done for other industries, e.g., the airline industry (Federal Aviation Administration and National Transportation Safety Board) and workplace safety (Occupational Safety and Health Administration).

Second, a nationwide mandatory public reporting system for medical errors ("the failure to complete a planned action as intended or the use of a wrong plan to achieve an aim") was recommended. In the case of errors that did not have serious consequences, the data should be kept confidential. In the case of "serious errors," the information would be public. Apparently, the IOM envisions a system whereby there would be mandatory reporting of "serious errors," but only voluntary reporting of other errors. Information obtained through the voluntary reporting system would remain confidential and would be used to develop error-reduction strategies.

Third, involvement of public and private purchasers (e.g., businesses buying coverage for their

employees) would be encouraged. If these purchasers make safety a priority, financial incentives can be created for health care organizations and providers to make the necessary changes. Currently, consumers rely on regulators and accrediting agencies to promote patient safety. While these regulators and agencies (e.g., Joint Commission on Accreditation for Healthcare Organizations [JCAHO]) do have some role in promoting patient safety, many believe they do not do enough. As we discussed in the October 1999 issue of *ED Legal Letter*, an evaluation of the effectiveness of JCAHO in policing the health care industry by the Office of Inspector General's Office of Evaluation and Inspection raised concerns about the adequacy of the current JCAHO accreditation system.

The IOM also suggested that the Food and Drug Administration should become more active in preventing medication errors, e.g., by working to eliminate similar-sounding drug names and confusing labels and packaging that contribute to medication errors.

Finally, health care organizations must create a "culture of safety." To do this, systems must be geared to prevent, detect, and minimize hazards and the likelihood of error. "Well-understood safety principles should be adopted, such as designing jobs and working conditions for safety; standardizing and simplifying equipment, supplies, and processes; and avoiding reliance on memory." As technologically advanced as modern health care is, in many ways we are way behind in safety technology.

If you call Domino's® for a pizza, they call you by name (Caller ID) and ask if you still live at, e.g., 111 Easy Street. When you give your order, they enter it directly into the computer. As anyone who orders pizza knows, this does not prevent errors. It does, however, markedly decrease their number. For starters, they have the correct name, correct address, and the correct order, assuming the person on the phone entered it correctly into the computer.

Contrast that with the common practice of patients being given illegible hand-written prescriptions and discharge instructions. There is simply no place for such dangerous practices in modern health care.

The IOM's report, the first in a series, is available from the National Academy Press (800-624-6242). The cost of the pre-publication report is $45 plus $4.50 shipping.

Endnote

1. "Preventing Death and Injury From Medical Errors Requires Dramatic, System-Wide Changes," Nov. 29, 1999.

Physician CME Questions

9. Discharge instructions should always specify:
   a. where to go for follow-up.
   b. when to follow-up.
   c. that patients should return to the emergency department if their symptoms worsen or if new symptoms develop.
   d. all of the above.

10. If a parent or guardian wants to leave the emergency department with a child against medical advice, and you have concerns about the safety of the child, options you should consider include:
    a. letting the parent or guardian leave with the child.
    b. contacting children's protective services.
    c. asking hospital counsel to schedule a guardianship hearing in probate court.
    d. none of the above

11. Contributory or comparative negligence is:
    a. an affirmative defense.
    b. an element of a malpractice evidence (i.e., must be proven by the plaintiff).
    c. both of the above.
    d. neither of the above.

12. The Institute of Medicine, in response to its findings regarding the frequency of medical error, has recommended:
    a. establishment of a federal agency to address patient safety.
    b. mandatory reporting of medical errors.
    c. involvement of public and private health care purchasers in improving patient safety.
    d. all of the above.

In Future Issues:

Practicing Procedures on Newly Deceased Patients