

the Reporter

EMERGENCY MEDICINE

ISSUES RELEVANT TO RISK MANAGEMENT

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The practice of emergency medicine and prudent risk management should be a forged partnership. Data regarding risks and claims of malpractice for the emergency physician include the following.¹

- One in four emergency physicians will be sued in his/her career.
- Most frequent causes of action include:
 - Failure to diagnose
 - Failure to properly treat
 - Failure to refer
 - Failure to inform

Liability risks in emergency medicine based on category of patient complaint rank as follows:

- Chest pain
- Pediatric fever
- Wounds and lacerations
- Fractures
- Headache
- Abdominal pain

The most common emergency medicine tort claims are:

- By number of claims, negligence in diagnosing and treating
 1. Fractures
 2. Lacerations/Foreign bodies
 3. Abdominal—appendicitis, ectopic pregnancy
- By indemnity paid, negligence in diagnosing and treating
 1. Heart disease
 2. Sepsis/Meningitis

The following case studies and analysis of each reflect events

that occurred in the emergency department with emphasis on key issues relevant to risk management. They are reprinted with the permission of the American College of Emergency Physicians.²

Case study: Return visits

A 32-year-old female with back pain presents to the emergency department of a metropolitan hospital at 10:00 PM. The emergency physician who examines her finds no neurologic abnormality and treats her for muscular strain with a muscle relaxant and codeine-containing analgesics. She is discharged to the care of her husband with instructions that include strict bed rest for three days and a follow up visit with a family practitioner.

Twelve hours later, her pain is somewhat worse, and she notes tingling in the buttocks bilaterally. She returns to the emergency department for reevaluation. During the registration process, the triage nurse criticizes the patient for not giving the medication a “chance to work.”

A different physician sees the patient and asks her about her symptoms. He reiterates that she needs bed rest and medication. Because he had observed the patient walking into the department, he decides not to perform specific neurologic testing. The patient is discharged again and instructed to rest in bed and take her medications.

Eight hours later, the patient loses control of her bladder and experiences tingling down both legs and difficulty walking. She is returned to the ED by ambulance, where neurologic evaluation indicates nerve compression. A myelogram reveals cauda equina syn-

drome secondary to a midline herniated disk. Neurosurgical consultation is obtained, but there is no surgical remedy. The patient is left with urinary incontinence, anesthesia in the buttocks and perineal area, and some mild leg weakness. The patient and her family immediately bring legal action against the hospital for failure to recognize her worsening neurologic condition.

Analysis

The validity of return visits to the ED has been carefully studied. Traditionally, ED personnel have believed that such patients are abusing or misusing the ED. This perception is incorrect. The return visit patient suffers from the fact that some diagnosis has already been made – a diagnosis that may be wrong in up to 25% of these patients. Even if the diagnosis is correct, the course of the patient's illness is not running as predicted. Perhaps the follow up instructions were not adequately explained to the patient. These facts, combined with the reality that getting into private physicians' offices may be difficult, constitute legitimate reasons for a patient to return to the ED.

From a risk management standpoint, the return visit to the emergency department is essentially the patient giving the hospital and the physicians a second chance to solve a problem. When these patients present, they should be seen as if they are completely new patients. Reassess the history, repeat the physical examination, and order any pertinent laboratory tests as if the patient is arriving for the first time. Do not be prejudiced by the initial visit and the initial diagnosis. To assume that the first evaluation revealed all problems is to deny the ever changing nature of diseases and many injuries.

Key points

- The patient who returns for a second visit or a patient who is transferred from another hospital should be considered, for evaluation purposes, to be a new patient.
- It is perfectly reasonable to refer to a patient's earlier records, but the physician is obligated to take an independent history and to perform a physical exam as if the patient were presenting with the symptoms for the first time.
- The physician is obligated to review previous test data and to repeat tests that may be relevant to the patient's care.
- The physician is obligated to review the entire treatment program on a return visit to make certain that the disease entity is progressing as expected and that the therapies recommended are adequate to meet the patient's current needs.

Case study: Change of shift

One-half hour before the end of shift, an emergency physician begins the workup of a patient who is a known alcoholic and frequent visitor to the emergency department. Initial evaluation reveals a patient who is intoxicated and somewhat belligerent. No other specific problems appear to exist, and the patient's only complaint is that his friends brought him to the emergency department because they thought he needed help. He does not view himself as needing medical attention.

Shortly after the examination, the patient falls asleep in the examining room. Vital signs at that time are normal. At the shift change, another emergency physician comes on duty and is told that the patient has already been evaluated. All that needs to be done, the first emergency physician says, is "wait for his blood alcohol level to drop and he wakes up, then you can discharge him."

Five hours later, when the patient wakes up and is ready to be discharged, the emergency physician orders a repeat blood alcohol test but does not reexamine him. He is discharged from the department. Four hours after discharge, the man is brought back by ambulance. He is in a coma and has right-sided weakness and a dilated left pupil. Despite rapid intervention, the patient dies as the result of a subdural hematoma. Both physicians are sued by the patient's family.

Analysis

Many physicians, risk managers, and attorneys consider change of shift to be an extremely dangerous time for patients. Normal vigilance is relaxed when a physician thinks a patient has already been evaluated properly by another physician. In this case, the patient suffered from the fact that no formal transfer of responsibility from one physician to the other took place, and no acknowledgement was given that the second physician had responsibility for the case and for reevaluating the patient. Subsequent examinations were not performed throughout the rest of the patient's stay, and he was discharged without any reevaluation.

The fundamental problem is that the second emergency physician accepted the initial diagnosis of alcohol intoxication at face value and did not reevaluate the patient prior to discharge. Certainly, intoxicated patients are notorious for having sustained other injuries. Because of this, they require reevaluation as the effects of alcohol are wearing off.

Change of shift lawsuits always involve several particularly thorny situations. First, two physicians are involved in this case, which may double the amount of insurance money the plaintiffs feel they should receive. Second, whenever two physicians are involved, the exact point at which one's responsibility ends and another's begins is often difficult to assess and may lead to bickering and in fighting among professionals. Such in-fighting only strengthens the plaintiff's case. The lack of documentation by the second emergency physician not only fails to support her contention that she had taken over the case, but also leaves all remembered findings or interactions in question.

Key points

- Change of shift should not result in a lower standard of care for the patient. If a physician for some reason cannot stay to complete the workup, proper transfer of responsibility and liability needs to occur.
- The incoming physician needs to reassess the patient completely, establish priorities, monitor the patient's progress, and reevaluate and instruct the patient at the time of discharge. To assume that any of these things have been done by the first physician is to court disaster.
- The physician who discharges a patient should be the physician of record and as such, will bear the

responsibility not only for the evaluation of the patient, but also for the reevaluations and the discharge program.

The transfer of responsibility at the change of shift should be an orderly, formal process so that no patient or family member is ever in doubt about who is in charge of the patient's care and who will direct further therapy.

Case study: Febrile children

An 8 week old boy is brought to the emergency department by his mother, who says that he has been fussy and eating poorly. The mother says the child is not taking as much formula as usual. He has been urinating and having bowel movements but just seems less interested in eating. The mother relates no trauma, and the child otherwise had been well.

Physical examination reveals an awake 8-week-old child in acute distress. Rectal temperature is 101.8°F, pulse rate 142, respiratory rate 28; no blood pressure is obtained. The child's head, ears, eyes, nose, and throat are remarkable only for fluid in the nose, but the fontanel appears concave. The child's neck is supple, lungs are clear, and the heart has a normal-sized rhythm without murmur. The abdomen is soft, non-tender, and non-distended. Genitalia appear normal. The skin is clear and somewhat dry with minimal tenting. Neurologically, the child has a normal startle response and can move all four extremities. No other parts of the neurologic examination are recorded.

Because it is late in the evening, the emergency physician decides to send the child home in the care of the mother, but on the off chance of an infection, he starts the child on oral ampicillin. The mother is instructed to contact her physician in the next few days if the child is not doing well. The mother and child return to the emergency department the following evening. The child is flaccid and has a bulging fontanel. At that time, a diagnosis of meningitis is confirmed, and the child is transferred to a hospital with a pediatric ICU. On discharge, the child is left with profound hearing deficit, decreased vision, and generalized increased spasticity.

Analysis

Although meningitis represents, at the most, only 5% of emergency medicine malpractice claims, it accounts for up to 17% of the medical liability dollars expended. Patients with a missed diagnosis of meningitis invariably have long hospitalizations and significant neurologic deficits that may require lifelong medical care. Certainly, earning capacity is decreased. The sympathy factor for such cases should never be underestimated.

In this case, several elements require emphasis. First, children are immunologically vulnerable during the first twelve weeks of life. An infected child less than twelve weeks of age may have an extremely difficult time generating the proper response to an invading organism. Classic findings, such as meningism and altered mental status, may be very deceptive in late findings. By the time the child has developed seizures and coma secondary to an infection, the process is already well on its way to causing significant neurologic impairment. Second, the mother's report of the

child's inability to eat was not challenged in the emergency department. A child who can eat and appears alert can usually be handled on an outpatient basis.

Over the past ten years, considerable efforts have been spent to analyze whether any laboratory tests are useful in the early diagnosis of the child with septicemia and meningitis. It has been repeatedly shown that the WBC count, the sedimentation rate, seroactive protein, the differential count, and serum electrolytes are useless. There is no better test to identify the child who requires workup than the physical examination conducted by an experienced physician. Because many of the factors required to diagnose meningitis are not present in extremely young children, those who are less than eight weeks of age, and some would argue twelve weeks, who are febrile or appear generally ill without specific focus of infection require a septic workup. Because extremely young children dehydrate rapidly in the face of infection, the ability to hold down fluids is critical.

Feeding the child in the emergency department not only helps reassure the parents, but also actually tests the ability of the child to function at home. Younger children may be fed bottles of electrolyte solution. In slightly older children, popsicles are an excellent indicator of the child's ability to feed. A child who will not take fluid in the department should be suspect for underlying illness. Children are much like adults, in that the diagnosis of gastroenteritis is a label often placed on patients who do not truly meet the criteria. Short-term follow-up is the only reasonable approach in the child who does not meet the criteria for admission.

In this case, the mother claimed to have called the pediatrician the next morning, but a visit was not scheduled until late that afternoon. Children must not be allowed to fall between the cracks in the system. A proper safety net with repeat examination within 6 to 12 hours goes a long way in reassuring parents and in detecting disease that may not be evident on the first emergency department visit.

Key points

- Infants less than 8 weeks of age with a fever require a septic workup.
- For children sent home, rapid follow-up either by a pediatrician or an emergency physician should be arranged.
- If meningitis is suspected, it must be treated immediately.
- If family circumstances could prevent the child from getting proper care, the physician should find some reason to admit the child.
- Feed the children in the emergency department. The child who will take a popsicle and ask for a second one is rarely severely ill.

Sources

1. Emergency Medicine and The Law, Risk Reduction Strategies That Tie It All Together, Rice, Matthew, MD, JD; 209.
2. Emergency Medicine Risk Management, 2nd edition, Henry, George, MD, FACEP & Sullivan, Daniel J., MD, JD, FACEP.

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PIAA Release

Senate Holds Hearing, Insurance Industry Experts Dispel Medical Malpractice Myths in D. C. Press Conference

Rockville, MD

February 12, 2003

Three insurance industry trade groups came together 2/11/2003 to set the record straight on the causes of the current medical malpractice crisis. The Physician Insurers Association of America (PIAA), the Insurance Information Institute (III), and the Alliance of American Insurers (AAI) presented statistical evidence that clearly places responsibility for the current medical liability and health care accessibility crisis on the shoulders of a dysfunctional tort system and its out-of-control costs. A series of exhibits showed the escalation of jury awards and settlements, the strength

of medical malpractice insurers' investment portfolios, and the rising costs to the health care system of the vast numbers of meritless malpractice cases that are filed every year. Stated Larry Smarr, PIAA President, "We realize that this is an emotional issue for many, including those for whom the services of doctors are increasingly unavailable. If the facts can get as much air time as the myths and soundbytes, I am confident we will find an effective solution to this national problem."

In addition, the group presented strong statistical support for caps on non-economic damages, showing the lower premiums paid by doctors in states with strong tort reforms already in place. For example, in

California, Kansas, and Colorado, caps on non-economic damages and other tort reform measures have resulted in a more stable and predictable insurance market, which has translated to lower premiums for physicians in those states.

Mr. Smarr also presented similar evidence at a Senate hearing on the medical liability crisis later in the afternoon. There he testified that from 1992 to 2001, the average claim payment amount has risen at a compound annual growth rate of 6.9 percent as compared to 2.6 percent for the CPIU.

A complete transcript of this press conference is available at www.thepiaa.org.