MIEC

EMedicine Alert

A Loss Prevention Newsletter from MIEC

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Allegations in Emergency Medicine:

An Analysis of MIEC Claims History

INSIDE

EMedicine Alert
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MIEC has closed 1,171 emergency medicine claims and suits since 1977. A study of these cases revealed that 82% were closed with no indemnity paid to plaintiffs. In those cases in which indemnity monies were paid, the average indemnity was $180,800 per claim/suit, for a combined total in excess of $25 million. Cases in which indemnity monies were paid typically involved patients who died or suffered catastrophic and/or serious permanent injury such as stroke, extremity amputation, loss of a body part, paralysis, or brain damage. Defense costs were also substantial, averaging $19,400 per claim/suit and totaling $24,000,500.

MIEC wants to help you prevent allegations about your care, and to be well-defended if a patient claims you were negligent. This is the first in a series of newsletters specifically designed to aid emergency physicians in reducing their liability exposure. Some topics that will be covered include: defensible medical records; discharge instructions; communication with primary care physicians, specialists, and ancillary departments; temporary admitting orders; "boarding;" and shift changes.

We understand that many of the issues that arise are affected by factors that may be outside of emergency physicians' direct control. We hope you can use this information within your group, with personnel in the ED department, and with hospital administration to explore realistic solutions to shared liability risk.

Analysis of the top allegations revealed the usual suspects (*see Figure 1*), with "failure to diagnose myocardial infarction" at the top of the list. The standard of care does not require emergency physicians to be infallible (especially in the face of atypical presentation), and MIEC is often successful in defending against allegations of negligent failure to diagnose. If the exam and work-up are appropriate; if the physician's differential diagnosis and thought processes are clear; if communication among members of the health care team is effective; and if discharge instructions are clear, specific and consider contingencies, a plaintiff would be hard-pressed to prove a case of negligence. However, should a physician fail to make the appropriate diagnosis, a host of issues—some unrelated to the physician's clinical acumen—come into play that may compromise that physician's defense. Problems with documentation and/or communications with patients and members of the health care team often have a significant impact.

CASE STUDY: FAILURE TO DIAGNOSE MYOCARDIAL INFARCTION:

A 36-year-old male presented with a complaint of chest pain that had begun earlier in the day while he was walking. Per the nurse's notes, there was some associated shortness of breath and slight diaphoresis. The patient was noted to be a nonsmoker and was taking Lopid. The patient was well-developed, well-nourished and in no obvious distress. Temperature was 99.6, pulse was 89, respiratory rate was 16 and blood pressure was 147/95. On examination, his chest was clear to auscultation. There was a regular heart rate and rhythm and S1 and S2 were normal.

Dr. "A" placed the patient on a pulse oximeter, which showed 100% oxygenation on room air. Electrocardiogram, rhythm strip and chest X-ray were normal. Laboratory values were unremarkable, including a CPK of 157.

Dr. A determined that the patient's chest pain seemed to occur when he was lying flat. The patient was re-examined and remained stable. Dr. A diagnosed atypical chest pain, rule out esophageal reflux. He gave the patient Carafate and advised a bland diet. The patient was to followup with his primary care doctor and return to the ED if chest pain continued.

The patient saw his internist two days later. The medication was changed to Tagamet and a gallbladder ultrasound was ordered.

Three days later, the patient was seen in a different ED and a myocardial infarction was diagnosed. He underwent an angiogram and angioplasty approximately one month later.

The patient's lawsuit alleged that Dr. A failed to diagnose a myocardial infarction, and that as a result of the delay in his diagnosis, he suffered additional pain, has fear of a future heart attack, the need for future surgery and decreased life expectancy.

Note: Details of this case that do not affect the clinical presentation have been changed to preserve anonymity.

Most frequent allegations

Failure to diagnose/delay in diagnosis of:
Myocardial infarction, fractures, aortic aneurysm, impending stroke, appendicitis, testicular torsion, subarachnoid hemorrhage, meningitis, pulmonary embolism, sepsis

Negligent/improper treatment related to:
Intubation, sepsis/infection, pulmonary embolism, placement of central femoral line, respiratory arrest, psychiatric evaluation, hematoma

Negligent prescribing

Figure 1

DOCUMENTATION ISSUES COMPROMISE DEFENSE

Lack of adequate history - Although the patient arrived in the ED via paramedic transport and was given nitroglycerine by the paramedics, this information was not documented by the nurse or by the physician. According to Dr. A, the nurse is responsible for conveying such information. The doctor did not specifically recall if the nurse informed him of the patient's mode of arrival, or if he considered the mode of arrival and administration of nitroglycerine in his diagnosis. Regardless of the nurse's responsibility, Dr. A would have been better served to obtain and/or document this information in the chart rather than giving the appearance that he treated the patient without knowing *how* the patient arrived and what, if any, treatment had already been given.

During the course of the claim, it was also discovered that the patient's father had died of a heart attack and that the patient himself had a history of chest pain and was being worked up by a cardiologist. The records are silent on these issues and would seem to imply that the patient was not asked about his family and medical history.

Lack of detail in physical exam -With a presentation of chest symptoms, it is optimal for patient safety and to a doctor's defense to document the nature and character of the symptoms (pressure, burning, sharp, dull, etc.) and precipitating, exacerbating or mitigating factors (exertion, motion, position, eating, breathing). The documentation in this case did not describe the nature of the patient's symptoms with enough detail to definitively support the doctor's impression that the patient's pain was not cardiac in nature.

Unexplained inconsistencies between doctor and nurse's notes -The patient was noted by the nurse to be short of breath and to have slight diaphoresis, but the doctor's notes stated "associated symptoms denied" in the context of cardiac problems. As the patient's pain wasn't constant and improved upon administration of nitroglycerine, it was thought by the peer review committee that the patient was likely not experiencing an MI at the time of the ED visit. Although the committee found this doctor's care and treatment to be within the standard of care, documentation problems impaired the doctor's defense and the case was settled. Fortunately for the patient, the alleged delay in diagnosis did not result in serious injury or death; in turn, the settlement was in the low range.

Doctors win the vast majority of medical negligence trials. By and large, juries have respect for the medical profession and understand the difficult circumstances in which emergency physicians must provide care. Juries often forgive a doctor who misses a diagnosis so long as that doctor has reasonable skills and tries his or her best; what they do not forgive is the appearance of apathy or hostility. Failing to note the family history of a patient with chest pain is damaging enough on its own, but this case is typical in that several – some seemingly minor – documentation and communication issues combined to paint an overall picture of carelessness; a picture that would be difficult to rationalize to a jury.