

# EMERGENCY ROOM MALPRACTICE

## WHO NEEDS A DIAGNOSIS?

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Bill Liebbe is a scuba diver who somehow obtained his law degree from SMU in 1980. To support his nitrogen addiction, Bill has made it a habit of suing doctors, hospitals and their insurance companies when they need it bad enough. Sometimes, this helps pay for his and his wife's scuba seminars in Belize.

Bill has been Board Certified in Personal Injury Trial Law since 1987. He is a sustaining member of ATLA, a fellowship member of TTLA and President-Elect of the Dallas Trial Lawyers' Association.



“First, tell me what your attorney thinks you’ve got.”

NATIONAL ENQUIRER

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## WHO NEEDS A DIAGNOSIS?

### I. Introduction

The scenario: The patient goes to the emergency room with a specific complaint. After examining the patient and perhaps running a few tests, a diagnosis of a non-life-threatening condition is made and the patient is sent home with instructions to follow-up with his or her private doctor. Within a few hours or so, the patient collapses and dies. The autopsy reveals the patient's complaints were due to a serious underlying medical condition that was missed by the emergency room doctor. Your consultant informs you that the history, signs, symptoms and test results support the diagnosis made and therefore the defendant was not negligent. Don't get rid of the case, get rid of the consultant, because the negligence may not be the misdiagnosis.

### II. Decision Making in the Emergency Department

The role of the E.R. physician differs from the role of the family practitioner, internal medical specialist or other clinical specialist. The major differences lie in the approach to the patient and the decision making process.

In the conventional clinical setting, the patient makes an appointment to see the doctor in the office. Ideally, a comprehensive history, physical examination and routine laboratory studies are obtained. A "problem list" or differential diagnosis is made. A plan of further testing and treatment is developed and over the course of days to weeks, the diagnosis is ultimately made. This "comprehensive" and "ideal" approach to patient care is not appropriate for the emergency room.



In the emergency department, every patient must be presumed to have an emergent condition. While it may be appropriate in the office setting for the physician to ask himself/herself, "What is the most likely cause of the complaint?," the emergency room physician must ask himself or herself, "What is the life threat?"

The most urgent and therefore immediate life-threatening conditions will involve the ABC's – Airway, Breathing and Circulation. The three components necessary to quickly identify the urgent and immediate life threat are:

1. the chief complaint;
2. a complete and accurate set of vital signs in the field and in the emergency department;
3. and the opportunity to visualize, auscultate and touch the patient.

The chief complaint is obtained from the patient, family members, observers, EMTs or others at the scene and will immediately help categorize the general type of problem (e.g., respiratory, trauma, cardiac, etc.).

THE DUPLEX

By Glenn McCoy



Vital signs (blood pressure, pulse and respiratory rate) may be used in the emergency room in two distinct ways. First, the physician must determine whether the vital signs are "normal" or "abnormal" for the particular patient. There are no "normal" vital signs for all adult patients. For example, a well conditioned, young athlete should have a resting heart rate in the 40-50 range. If he or she is a trauma victim with a pulse of 80, the patient must be presumed to have significant blood loss and an immediate evaluation for internal bleeding is required. Second, comparison of vital signs taken by the paramedics and vital signs upon arrival in the emergency department may give important clues to an underlying life-threatening condition. For example, a patient's blood pressure is 80 systolic with a pulse of 120 upon arrival of the ambulance. He receives I.V. fluids en route. He has "normal" vital signs upon arrival to the emergency department. If the emergency room physician failed to compare the vital signs and take into account the effects of fluid resuscitation, the patient may erroneously be presumed to have been "stable" upon arrival and evidence of internal bleeding overlooked.

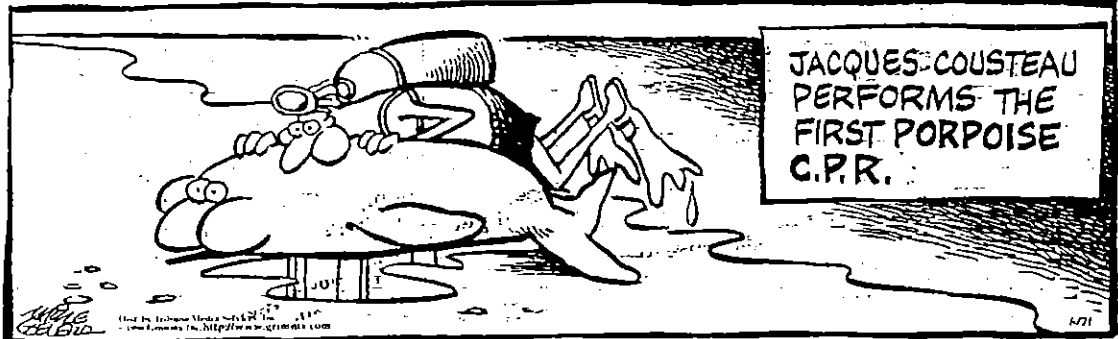
Finally, visualizing, auscultating and touching the patient may be the only way to recognize an immediate life-threatening condition. For example, touching the skin is important to evaluate for shock. Auscultation (listening with a stethoscope) may provide the only clues to certain life-threatening conditions such as bronchial constriction or tension pneumothorax.

If an immediate life-threatening condition -- problems with airway, breathing or circulation -- are identified, these problems must be addressed immediately before any other evaluation or test is performed.

## VARIETY

MOTHER GOOSE & GRIMM

By Mike Peters



CROCK

By Bill Rechin and Don Wilder

Once the emergent life-threatening condition has been ruled out or stabilized, the approach to the patient and the decision making process continues to have major differences in the emergency department as compared to the clinical office setting.

Differential diagnosis -- in the office setting, the differential diagnosis most often begins with the underlying condition that is most likely. In the emergency department, the differential diagnosis formulated must begin with the most serious condition possible to explain the patient's presentation. Although the emergency room physician will be "right" most of the time if the differential diagnosis begins with the most common or statistically most probable condition to explain the chief complaint, this practice may result in overlooking a more serious although uncommon problem. Emergency room physicians must therefore have a degree of "healthy paranoia" and eliminate the most serious condition, albeit rare, before arriving at a generally more common diagnosis.

The most important thing to remember however is that the role of the emergency room physician is not to always make a diagnosis of an underlying life-threatening condition, but to rule it out. Unfortunately, the diagnostic tests available in an emergency department do not always have the sensitivity or specificity to "rule out" an emerging life-threatening condition. Failure to appreciate the lack of specificity or sensitivity of a diagnostic test to rule out a serious and emerging life-threatening condition, often results in medical negligence in the emergency

department. In other words, if the chief complaint, history and physical examination suggests a serious and emergent life-threatening condition that cannot be ruled out with the diagnostic testing available in the emergency department, the decision, to discharge or call a specialist for admission, becomes critical.

The decision to recommend hospitalization: if the emergency room physician suspects a serious emergent underlying condition that is potentially life-threatening, he or she must consider the following:

1. Is there a medical need that can be fulfilled only by hospitalization? For example, does the patient need cardiac monitoring to rule out myocardial infarction? If so, admission is required.
2. Can the patient be safely discharged home? For example, if the patient has sustained head trauma, signs and symptoms of cerebral hemorrhage may not be apparent immediately and the patient needs to follow head trauma precautions at home. If the patient lives alone, he or she cannot be safely discharged.
3. Emergency room physicians often make the fatal mistake of being "ninety-five percent" certain of a benign condition and so inform the patient of his or her diagnosis. The patient is likely to ignore continuing and perhaps worsening symptoms and therefore not return for further medical evaluation.

Finally, the prudent emergency room physician examining a patient whose chief complaint is similar to a chronic condition will always ask: What's different now!



Carlton falls for the old rubber-scalpel gag.

*The*  
**FAR SIDE**

NOVEMBER

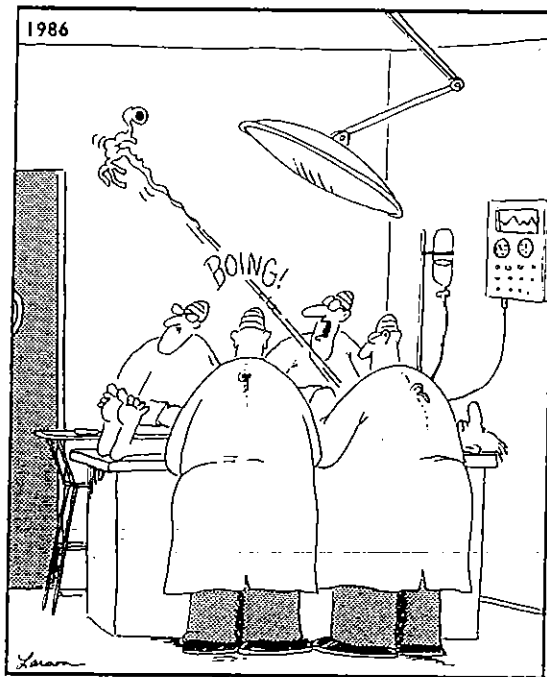
23 & 24

SATURDAY & SUNDAY

### III. Chest Pain

Chest pain is a common reason a patient presents to the emergency room. The etiology of chest pain, however, is often very difficult to determine in the emergency department because:

1. The severity of the pain is often unrelated to its life-threatening potential;
2. Various disease processes in a variety of organs may result in chest pain;
3. Physical findings, laboratory tests, and x-rays are often unavailable or nondiagnostic in the emergency room;



"Whoa! Watch where that thing lands—we'll probably need it."

The  
**FAR SIDE**  
November  
**15**  
WEDNESDAY

4. The location of the pain perceived does not often correspond with its source; and
5. There may be more than one disease process present.

Location of the pain is not diagnostic -- ever. Somatic fibers from the skin enter the spinal cord at a single level resulting in sharp, localized pain. These fibers are numerous.

Visceral fibers from organs in the chest and upper abdomen enter the spinal cord at multiple levels from T1--T6. The pain is usually dull, aching, and poorly localized. Visceral fibers from internal organs are less numerous than somatic fibers. Connections between visceral and somatic fibers may result in visceral (organ) pain being perceived as originating from somatic locations. This is why, for example, angina or "heart pain" may only be perceived as shoulder or arm pain.

There are at least six life threatening causes of acute chest pain that, if suspected by the emergency room physician, must be ruled out: They are -- myocardial infarction, unstable angina, aortic dissection, esophageal rupture, pneumothorax and pulmonary embolism.

Suspicion of one or more of these life threatening conditions arises from the chief complaint, history and physical evaluation.

Evaluation of chest pain should include such factors as: location, quality, onset, duration of associated symptoms, and pattern of radiation. Precipitating factors such as inspiration, movement, exertion, should also be inquired about. Determination of the origin of the pain may also be delineated through such relieving factors such as antacids, nitroglycerin, rest, or body position. While none of these factors are diagnostic, the classic patterns of chest pain are set forth in Table A appended to this paper.

Risk factors associated with ischemic heart disease: The emergency room physician must inquire and should document information concerning risk factors for heart disease. The risk factors are: age greater than 40, male sex, family history, cigarette smoking, hypertension, high cholesterol and diabetes.

Vital signs may be helpful and provide valuable information. For example, a blood pressure difference between the left and right arm of greater than 20mm Hg or a reduction or loss of lower extremity pulses is suggestive of a dissecting aortic aneurism. An elevated temperature accompanied by chest pain indicates an infectious or inflammatory process such as pneumonia or pericarditis. Rapid breathing may be due to hypoxia caused by pulmonary emboli.

It is important to remember that a single "normal" EKG does not rule out myocardial infarction. If the history and chief complaint are suggestive of myocardial infarction, serial EKGs are required because up to 20% of patients who are later diagnosed as having an acute myocardial infarction will initially have a normal EKG. In addition, changes on EKGs are different during the early stages of myocardial infarction, as compared to later EKGs. If the EKG shows early myocardial infarction and thrombolytic agents are not immediately administered, the patient may have unnecessarily suffered myocardial injury and damage that was avoidable.

Cardiac enzymes are not useful in the emergency department to rule out myocardial infarction, for two reasons: First, creatine kinase elevations do not occur until 4 to 6 hours following the onset of infarction. Lactic Dehydrogenase (LDH) and serum glutamate



oxaloacetate transaminase (SGOT) elevations occur even later. Secondly, the patient may have pre-infarction angina.

Some physicians believe that if the chest pain is relieved by treatment that typically resolves gastrointestinal problems, then the response to the treatment confirms the diagnosis. The problem here is two-fold. First, while a "GI cocktail" consisting of lidocaine and an antacid will frequently resolve esophageal pain, it also relieves angina in 10% of the patients. Secondly, since angina has a duration of five to 15 minutes, one must ask whether the pain was relieved because of the GI cocktail or because the angina resolved.

The factors most commonly associated with the discharge of a patient with chest pain due to acute myocardial infarction or unstable angina are:

1. Younger age group of patients
2. Female sex
3. Incorrect interpretation of the EKG
4. Failure to recognize atypical presentations
5. Hesitance to admit patients with vague symptoms
6. Reliance on negative lab and EKGs
7. Insufficient experience and training.

**Conclusion:**

In evaluating a potential emergency room malpractice case, do not concede defeat simply because the diagnosis made was "reasonable" under the circumstances. The better case may be the failure to rule out a serious life threatening condition.

In an emergency room malpractice case we recently settled, a 57-year old woman went to the emergency room complaining of chest pain. A single EKG revealed no myocardial injury. She was sent home with a diagnosis of gastritis. She died a few hours later as a result of myocardial infarction. A portion of the defendant doctor's deposition was as follows:

Q: I take it you considered myocardial infarction or myocardial ischemia since you ordered an EKG?

A: Yes.

Q: How confident -- how certain were you that she had gastritis?

A: I was about 95% certain it was gastritis.

Q: Was the other 5% heart?

A: Yes.

Q: Do you fly on airplanes?

A: Yes.

Q: Would you get on an airplane knowing that there was a one in twenty chance of it crashing?

A: No.

Q: Then why did you let this lady walk out of your emergency room knowing that there was a one in twenty chance she could suddenly die of a heart attack?

A: Sometimes, we doctors have to accept the risk of being wrong.



The  
**FAR SIDE**  
March  
**28**  
TUESDAY

"Mr. Liebke, may I be excused? My brain is full!"

**TABLE A**

*Classic Patterns of Chest Pain*

ETIOLOGY	QUALITY	LOCATION	RADIATION	DURATION	ASSOC. SYMPTOMS	ONSET
Myocardial infarction	visceral	retrosternal	neck, jaw, shoulder, arm	>15 min	nausea vomiting diaphoresis dyspnea	variable
Angina	visceral	retrosternal	neck, jaw, shoulder, arm	5-15 min	nausea diaphoresis dyspnea	gradual
Aortic dissection	severe	retrosternal	interscapular tearing	constant	nausea dyspnea diaphoresis	sudden
Pulmonary embolism	pleuritic	lateral	—	constant	dyspnea apprehension	sudden
Pneumothorax	pleuritic	lateral	neck, back	constant	dyspnea	sudden
Pericarditis	sharp stabbing	retrosternal	back, neck, shoulder, arm	constant	dyspnea dysphagia	variable
Esophageal rupture	boring	retrosternal epigastric	post thorax	constant	diaphoresis dyspnea (late)	sudden
Esophagitis	aching boring	retrosternal	interscapular jaws, neck, shoulder	min-hours	dysphagia	variable
Esophageal spasm	visceral	retrosternal	interscapular	min-hours	dysphagia	variable
Musculo-skeletal	sharp aching superficial	localized	—	variable	dyspnea	variable