# >> MALPRACTICE COUNSEL

Commentary by
**Francis L. Counselman, MD**
ASSOCIATE EDITOR-IN-CHIEF

**Neal E. Flomenbaum, MD**
EDITOR-IN-CHIEF

## Failure to Provide EpiPen After Reaction to Bee Stings

A 40-year-old man was taken to a hospital after a neighbor found him unconscious near his lawn mower with a swarm of bees around him. The neighbor claimed that she told the emergency physician and a nurse that she believed the man had been stung. The physician did not remember being told, but the nurse did. The information, however, was not noted in the medical chart. An internist who treated the man in the intensive care unit allegedly told the man's wife that bee stings had been ruled out when she asked whether there were any signs of them. The internist also claimed he told her that the emergency physician's diagnosis was heat stroke, but he believed that the patient had a seizure disorder. The patient was sent home after electroencephalography and CT tests for a seizure disorder were negative. Later that season, the man's wife allegedly saw him get stung by bees. He was rushed to a hospital again, but he died. The plaintiff claimed that the physicians should have provided the decedent with an EpiPen to slow swelling and allow enough time to reach a hospital.

### Outcome

A $1 million/$700,000 high-low agreement was reached with the emergency physician during jury deliberations. The internist had settled for a confidential amount during trial.

### Comment

This is a tough case, given the unclear etiology of the patient's syncopal episode. Taking a more careful history and noting the neighbor's comments in the chart could have helped establish the correct diagnosis. Patients who are treated for a serious allergic reaction or anaphylaxis and have a chance of a recurrent episode, such as from a subsequent hymenoptera sting, should be prescribed an epinephrine auto-injector. Note, however, that patients being treated with a β-blocker for hypertension should be switched to a different class of antihypertensive before they are prescribed epinephrine, to avoid a potential drug interaction. **FLC**

## Improper Intubation, Monitoring Blamed for Man's Death

The patient, age 62, was brought by ambulance to a hospital's ED in August 2007 with complaints of shortness of breath that had increasingly worsened over the previous several days. He was morbidly obese and had a history of respiratory problems, including hypoventilation syndrome, obstructive sleep apnea, and chronic obstructive pulmonary disease. He had required intubation on two previous occasions in less than 1 year. The decedent experienced respiratory arrest in the ED and suffered severe anoxic insult to his brain. He died several weeks later. The plaintiffs claimed that ED personnel failed to properly treat the decedent's low oxygen saturations, first by placing the endotracheal tube (ETT) in the esophagus when intubating the patient and then by failing to properly monitor the oxygen saturation after intubation. The plaintiffs also claimed that when the decedent suffered cardiac and respiratory arrest due to low oxygen saturation, the defendant's personnel failed to attempt re-intubation. The plaintiffs maintained that proper monitoring would have revealed the esophageal intubation and allowed for proper intubation before arrest. The defendant claimed that proper intubation was confirmed and that, despite any records of oxygen saturation after intubation, the decedent's oxygen saturations were in excess of 90%.

### Outcome

According to a published account, a $267,328 arbitration award was given.

### Comment

The difficult airway is every emergency physician's worst nightmare. It is important to have a backup plan (ie, bougie, intubating laryngeal

mask airway) for situations in which your preferred method of intubation proves unsuccessful. Also, when verifying ETT placement, you need to use methods that are more reliable than chest auscultation and visualization of vapor in the ETT. It is best to confirm placement with use of capnography or an end-tidal carbon dioxide detector. **FLC**

## Undetected Ascending Aortic Dissection Blamed for Death

A man presented to an ED with complaints of a sore throat, ear pain, back pain, and chest pain. The plaintiff was examined by an emergency physician, who initiated a workup that included blood work, electrocardiogram, and urinalysis. All of these were determined to be normal. The patient reported to the physician that he had recently been exposed to strep throat by a family member. He was diagnosed with an allergic reaction ear infection and sore throat and was prescribed antibiotics and an anti-inflammatory medication prior to being discharged. Within 24 hours of discharge, the man died at home. An autopsy revealed that his death was due to an ascending aortic dissection that extended to his lower abdomen. The plaintiff alleged negligence in the failure to properly diagnose the decedent's problem. The hospital settled for an undisclosed amount prior to trial. The plaintiff claimed that the decedent had complained of worsening chest pain, which should have caused the defendant physician to order a chest radiograph. The defendant claimed that the decedent reported his chest pain to a triage nurse, but not to her. The defendant also claimed that the aortic dissection was not present when the decedent was treated at the ED, and further maintained that even if the dissection was present, it would have been too small at the time to be diagnosed.

### Outcome

According to a published account, a defense verdict was returned.

### Comment

Although the jury returned a defense verdict in this case, seasoned emergency physicians know that if you don't read and reconcile the nurse's triage notes with your own prior to discharging a patient—even to note a difference in findings—you will one day be reading one of these notes from a six-foot easel in front of a jury. **NF**

## Delayed Diagnosis of Subdural Hematoma After Car Accident

The plaintiff, now age 72, suffered cuts to her forehead, upper eyelid, and lip and a fractured clavicle in a February 2002 vehicle collision. She was treated at an academic medical center by the defendant. The plaintiff was released from the hospital but experienced dizziness within a few hours and then lost consciousness. She was diagnosed with a subdural hematoma, which required surgery and left her with neurologic deficits as well as impaired her ability to walk unaided. The plaintiff claimed that if the hematoma had been diagnosed by CT immediately after the accident and treated, the effects would have been mitigated. The plaintiff additionally claimed that she and her daughter were not instructed to return to the hospital immediately if she became dizzy. The daughter assumed that the dizziness was due to the pain medication prescribed. The defendant claimed that the plaintiff's symptoms in the emergency department did not mandate a CT scan.

### Outcome

According to a published account, a $3.35 million settlement was reached.

### Comment

In recent months, we have all become more aware of the hazards posed by radiation exposure from excessive CT scans, but a force sufficient to fracture a clavicle, accompanied by head, facial, and soft tissue injuries, should mandate a thorough search for a more significant head injury as well as cervical spine injuries. **NF**