EDITORIAL

Neal Flomenbaum, MD
EDITOR-IN-CHIEF

Medical Malpractice—With Malice Toward All

Responding to reader requests, *Emergency Medicine* began a new monthly column last August, entitled "Malpractice Counsel," with commentary by Associate Editor-in-Chief Frank Counselman, MD, and occasionally, me. Recently, a reader's e-mail expressing concern about the take-home message of a comment in the November issue prompted both an editorial discussion and some personal reflections on the subject of "med-mal."

The comment that the reader questioned emphasized the importance of a careful history, physical exam, and visual acuity test in diagnosing orbital fractures, and also noted that when such fractures are suspected, "CT scan is considered the gold standard for imaging." The reader felt that there was too much emphasis on obtaining radiographic studies, which would contribute to skyrocketing costs of care. Of the 16 cases discussed in "Malpractice Counsel" between August and December, seven cases involved radiographic imaging—five resulting in plaintiff decisions, two favoring the defendant. In these seven cases, radiographic studies had not been requested in four and were delayed in one, unobtainable in another, and incorrectly interpreted in still another. Although I am concerned about the possible radiation effects of unnecessary studies, I don't think *Emergency Medicine* readers will have difficulty interpreting the comments.

The reader also thought the case descriptions were too short to permit informed opinions about malpractice decisions, the majority of which nationwide favor the defendant physician and hospital. However, the *comments* are the focus of the column, not the decisions. The comments are intended to share rules of sound emergency practice and information about trends to help EPs reduce the number of cases they may become involved with—or, when a malpractice case is unavoidable, to increase the chances of a favorable outcome.

The comments thus far include such advice and counsel as "have a back up plan when you are attempting a difficult airway," "read and reconcile the nurse's triage notes with your own prior to discharging a patient," and "remember that frequent users of the ED are not immune to real disease." Observations include: "if an ED doesn't get triage right, nothing else [may] matter," "bad outcomes can occur despite appropriate medical care," and "increasingly, regulatory agencies and malpractice juries are holding emergency physicians and hospitals responsible for timely completion of diagnostic studies—particularly radiologic exams—regardless of how busy the ED may be. "

As for the personal reflections on the subject, I should mention that in 4 1/2 years and over 50 editorials, this is the first time I have even considered this subject. I've come to the following conclusions: malpractice cases are brought and decided for a variety of reasons, not all of which are based on truth and justice; bad medicine and bad results are not synonymous; and bad physicians are not necessarily identified by malpractice cases, while skilled and conscientious physicians are sometimes caught up in cases, at great personal cost. I have also concluded that expert witnesses should not be either "for the plaintiff" or "for the defense," and that the outcome of cases should not be based on the venue or the skills, resources, or fees of the attorneys. Unfortunately, I doubt that any of these conditions are likely to change in the near future.

"Malpractice Counsel" can be a valuable means of teaching emergency medicine—no less valuable when the cases are handled fairly and the trials are conducted honestly. EM