MALPRACTICE COUNSEL

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Failure to Perform CT Scan and Diagnose Skull Fracture

A 35-year-old man fell at home, resulting in a significant laceration to the top of his head. He went to the ED and was evaluated by an emergency physician, Dr. G, who diagnosed him with a closed head injury. The patient was released several hours after his arrival.

The next day, during the evening, the man returned to the hospital with neurologic problems. A different emergency physician at the hospital ordered CT, which revealed a depressed skull fracture. The patient was transferred to another hospital, where he underwent an emergency craniotomy. He continues to experience seizures and significant neurologic deficit.

The plaintiff claimed that his continuing difficulties were due to a delay in diagnosing the fracture by Dr. G. The plaintiff maintained that Dr. G should have ordered a CT scan or obtained a neurologic consult. Dr. G claimed that his diagnosis was reasonable and that any delay in diagnosing the fracture did not change the outcome for the plaintiff.

Outcome

According to Tennessee Jury Verdict Reporter, a defense verdict was returned.

Comment

Unfortunately, we do not know anything about this patient's presenting signs or symptoms at his initial ED visit, other than a scalp laceration. Just because someone has trauma to the head and a scalp laceration does not mean he needs CT. First, what is the patient's Glasgow Coma Scale (GCS) score? An adult with a GCS score of 15 and only mild head trauma does not usually need CT of the head; the risk for a neurosurgical intervention is less than 1% in such patients.

Two evidence-based decision rules to help determine the need for head CT in a trauma patient are the Canadian CT Head rule and the New Orleans Criteria. Both have been validated in prospective studies and are excellent for detection of patients requiring neurosurgical intervention. For the Canadian rule, the presence of any one of the following indicates the need for head CT: a GCS score of less than 15 at two hours post-injury; suspected open or depressed skull fracture; any sign of basilar skull fracture; more than one episode of vomiting; retrograde amnesia greater than 30 minutes; dangerous mechanism; or age 65 or older. For the New Orleans Criteria, any one of the following would indicate a need for CT of the head: headache; vomiting; age older than 60; intoxication; persistent anterograde amnesia; evidence of trauma above the clavicles; or seizure. It is important to note that these rules apply only to adult patients and should not be used in children or in patients who are taking anticoagulants. **FLC**

Failure to Call Cardiologist for Man With Chest Pain

In January, a man visited a Virginia ED with complaints of chest pain. He was seen by an emergency physician, Dr. S, and admitted to the hospital under the care of Dr. P. The plaintiff underwent serial ECG and cardiac-marker laboratory testing, all of which returned normal results. Dr. P discharged him after two days.

The day after discharge, the man returned in the evening with chest pain. He was again seen by Dr. S. Repeat ECG and cardiac-marker laboratory tests were obtained, with normal results. The plaintiff was then discharged and told to keep his appointment for a stress test later in the morning. The stress test was completed. That evening, the plaintiff returned to the ED and was treated for a myocardial infarction.

The plaintiff claimed that at the time of the second ED visit, Dr. S should have called Dr. P or a cardiologist, who might have ordered beta-blockers, anticoagulants, and other medications, as well as angiography and cardiac intervention. The plaintiff maintained that this treatment would have prevented the heart attack.

The defendant maintained that the plaintiff had had

five negative laboratory tests and four normal ECGs and reported no pain after receiving a gastrointestinal cocktail, making it appropriate to discharge him for the scheduled stress test. The defendant also claimed that if a cardiologist had been called, it would not have changed the outcome, as a cardiologist would have ordered a stress test and would not have performed angiography or cardiac intervention.

Outcome

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

Comment

When a patient returns to an ED with the same complaint only a short time after a thorough "negative" exam, it is often difficult to approach the problem again with the same vigor and objectivity. In this case, though, the thoroughness of both exams and the documentation of normal and negative test results undoubtedly contributed to a defense verdict. **NF**

Perforation of Small Intestine

A 79-year-old woman presented to a gastroenterologist with symptoms of gallstones. An endoscopic retrograde cholangiopancreatography (ERCP) was performed, during which a gallstone was removed from the common bile duct. During the procedure, the gastroenterologist perforated the small intestine, although this was not recognized at the time.

The next day, the woman's daughter called the gastroenterologist to report that her mother was experiencing discomfort and pain, for which pain medication was prescribed. Twelve hours later, the patient was taken to an ED by ambulance with significant abdominal pain and discomfort. She was seen by an emergency physician, who scheduled a surgical consult and a CT scan for the next morning.

By morning, she was so distressed that a CT scan followed by emergency surgery was immediately performed. The woman died that day from overwhelming sepsis.

The plaintiff argued that the failure to appreciate the severity of the postoperative pain was negligent and that the gastroenterologist should have seen the plaintiff immediately and ordered CT. The plaintiff also claimed that the emergency physician should have ordered an immediate CT scan. The plaintiff maintained that earlier CT would have revealed the perforation and allowed for a timely surgical repair.

The gastroenterologist claimed that pain medication was the proper first mode of treatment for postoperative pain. The emergency physician claimed that the decedent's condition at the time of presentation to the ED did not warrant an immediate CT scan. He also claimed that the woman had little chance of survival at that time.

Outcome

According to a published account, a $200,000 verdict was returned against the emergency physician, with the jury finding that his actions resulted in a 20% reduction in the decedent's chance of survival. The gastroenterologist was found not at fault. The plaintiff received a net award of $40,000.

Comment

The emergency physician involved in this case seems to have been concerned about a bowel perforation, given the fact that he asked for a surgical consult. If a patient presents with an acute abdomen (eg, rigid abdomen, voluntary guarding, rebound), fluid resuscitation and immediate surgical consult are the best initial strategies, not necessarily an imaging study. It is unclear, however, if the surgeon evaluated this patient prior to her deterioration the next morning. We need to make clear to our consultants the seriousness of the clinical situation and how promptly we expect them to see the patient.

As emergency physicians, we need to consider procedural complications (eg, vessel injury, perforation) in the

differential diagnosis any time a patient presents with a serious complaint, such as syncope or pain, in close proximity to an invasive procedure. **FLC**

Alleged Violation of EMTALA

A 52-year-old man with a 25-year history of severe drug and alcohol addiction went to a Georgia hospital's ED. The hospital staff wanted him removed due to perceived malingering and narcotic-seeking behavior. Security was called to escort him outside the hospital in a wheelchair.

The man fell out of the wheelchair and for 20 minutes was recorded on surveillance cameras stumbling around outside as security stood nearby. He then fell and struck his head on the concrete sidewalk.

ED and security personnel refused to allow him to be brought back into the hospital. He was transferred by EMTs to a nearby public hospital, where he underwent surgery for devastating brain injuries. He died several days later.

The plaintiff alleged violation of Federal EMTALA laws. The defendant claimed that the decedent was intoxicated and caused his own death by falling. The defendant also argued that the fall occurred off hospital premises, so EMTALA did not apply.

Outcome

The extent of damages was limited by the fact that the decedent, despite having a PhD, could not stay sober or employed for long periods of time. A $250,000 settlement was reached.

Comment

Plaintiffs' attorneys sometimes claim EMTALA violations to help obtain inexpensive discovery or higher awards—especially in states that limit the monetary amount of malpractice judgments. But an EMTALA claim does not seem unreasonable when a hospital ejects a patient for "malingering and narcotic-seeking behavior," afterward captures his stumbling and head trauma outside on video cameras while security bars his return, and then claims that he caused his own death due to intoxication. (They probably also meet the legal explanation of "chutzpah"—a child who kills both his parents and then asks the court for mercy because he is an orphan). **NF**

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