

Commentary by Francis L. Counselman, MD, Associate Editor-In-Chief | Neal E. Flomenbaum, MD, Editor-In-Chief

Was Diabetic Patient Discharged Too Soon?

In September 2000, a 52-year-old diabetic woman was found unconscious in her home by her daughter. She had taken her evening insulin, consumed alcohol, and not eaten. En route to the hospital, EMT personnel gave her a 1-mg shot of glucagon, which revived the woman immediately. She was awake, alert, and oriented on arrival in the ED.

Dr. A. evaluated the patient and ordered laboratory tests, as well as IV dextrose and a meal. The woman's glucose level in the ED was measured at 107 mg/dL and 136 mg/dL. Lab results were normal except for an elevated blood alcohol level. The patient was talking, thinking, and functioning normally and was discharged home.

The woman informed Dr. A. that her daughter would pick her up. However, the daughter did not pick up her mother that night, and the patient remained in the waiting area of the ED all night, repeatedly calling her daughter. She was found unconscious the next morning in a remote corner of the waiting area. She remained in a coma until her death three months later.

The plaintiff claimed that the discharge was improper and that the decedent suffered recurrent hypoglycemia overnight, resulting in profound brain damage and death. The defendant claimed that the decedent suffered an alcohol withdrawal seizure, not a hypoglycemic event.

Outcome

A defense verdict was returned. This was the second trial of this case; the first also resulted in a defense verdict.

Comment

Unfortunately, there are a couple of important unknowns in this case. First, what type of insulin did the patient use that evening: regular, NPH, etc? This is important because of the variable peak time and duration of action with different types of insulin. Regular insulin typically peaks in two to four hours and has a six- to 10-hour duration of action, while NPH peaks in four to eight hours and lasts 10 to 20 hours.

Also, had there been any recent change in the patient's insulin dose? We commonly see patients with hypoglycemia in the ED following a recent increase in their insulin dose by their primary care provider. Since insulin is eliminated by the kidneys, it is important to check renal function. It is not rare for new-onset renal failure in a diabetic patient to present as hypoglycemia.

Finally, how long was the patient observed in the ED? These are patients for whom you do not want to make a hasty disposition. It is better to let them eat and warm up (mild hypothermia is commonly seen in hypoglycemia), and observe them for some time and recheck the blood sugar.

From all accounts, it sounds like this patient was stable and safe for discharge. The emergency physician cannot be held responsible for the irresponsible actions of a patient's family members. **FLC**

Man Given Morphine for Pain

In December 2007, a 43-year-old man was taken to a hospital ED with complaints of intense abdominal pain, vomiting, and bloody urine by his wife, who then returned home.

The patient was diagnosed with a kidney stone. The initial treatment included 4 mg of IV morphine plus ketorolac for pain. Two hours after receiving pain medication, the man was discharged and advised that the kidney stone would pass in time. He called his wife to pick him up.

After paying, the patient walked out of the hospital. While walking on the sidewalk, about 200 to 300 yards from the hospital's doors, he thought he saw his wife and attempted to cross the road to meet her vehicle. While crossing, he stepped over a median divider and fell 15 to 30 feet into a dry washbed below. The lanes of travel were actually divided lanes of traffic on a bridge spanning a wash. The plaintiff suffered spinal injuries in the fall and is now a T-8 paraplegic.

The plaintiff alleged negligence in discharging him prior to the arrival of his transportation. The plaintiff claimed that he was impaired due to the pain medication and that the discharge plan should have included safe transportation from the hospital.

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The defendant denied that the plaintiff was impaired at the time of discharge, because the morphine had already been processed. It was also claimed that the hospital only had a duty to have a discharge plan in place, not to see that the discharge plan was carried out.

Outcome

The case was bifurcated, and the jury returned a verdict in the liability portion in favor of the plaintiff.

Comment

When is it safe to discharge a patient after you have administered pain meds or procedural sedation in the ED? And how long after discharge is an emergency physician responsible for a patient's well-being? These

are difficult questions to answer, but not uncommon causes of malpractice suits.

Guidelines established for elective procedures are not always applicable to the ED setting, and therefore an extra cautious approach in the ED is warranted. This is particularly important if the patient is not accompanied by a responsible adult.

Keeping such patients longer in the ED, meticulously documenting a stable condition upon discharge, and providing clear discharge instructions all help reduce your malpractice exposure. **NF**

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