# MALPRACTICE COUNSEL

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

## Myocardial Infarction Missed in Young Man

A 25-year-old man went to an emergency health center in Connecticut with complaints of chest pain and numbness in his left arm. He was examined by an emergency physician, Dr A., who ordered an ECG. A cardiologist, Dr F., interpreted the ECG as depicting "atypical chest pain of musculoskeletal origin" and discharged the patient.

Three days later, the man began to feel dizzy and collapsed. He was pronounced dead at an ED. Autopsy revealed the cause of death to be an acute myocardial infarction (AMI) due to dissection of the anterior descending coronary artery.

The plaintiff claimed that Dr A. should have ordered a stat cardiology consult with testing for serial cardiac enzyme and troponin levels and should have admitted the decedent to the hospital. The plaintiff claimed that Dr F. failed to adequately treat a patient with an abnormal ECG. The plaintiff also claimed that the defendants improperly diagnosed and discharged the decedent. The defendants denied liability.

### Outcome

The case went to trial against Dr F. only. According to a published account, a defense verdict was returned.

### Comment

Unfortunately, this case raises more questions than answers. In addition to more information about the clinical presentation, we need a copy of the ECG to evaluate. It is also unclear how the cardiologist became involved; was he consulted?

The incidence of AMI in the young (usually defined as those younger than 45) is infrequent, but unfortunately not zero. Multiple cardiac risk factors, hypercoagulable states, abuse of cocaine, or congenital coronary anomalies are usually the cause when AMI occurs in a young person.

Coronary artery dissection, as in our patient, can occur spontaneously. It is reportedly more common in women than in men (especially in the peripartum period) and frequently involves the left anterior descending artery. These patients do not usually have a history of exertional symptoms. Treatment usually involves stenting and/or bypass grafting.

Patients with dissection of a coronary artery are incredibly difficult to diagnose and frequently have a bad outcome. **—FLC**

## Failure to Raise Bedrail Results in Death

In October 2006, an 84-year-old woman was transported from a nursing home to a hospital ED in Washington via a private ambulance staffed by two EMTs. The patient had congestive heart failure, atrial fibrillation, dementia, and urosepsis. On arrival at the hospital, the ambulance crew transported the woman from their gurney to a bed in the ED.

Several minutes later, she fell from the bed to the floor, striking her head. A rail on the side of the bed had been left down after the transfer. The woman sustained cerebral hemorrhage, nasal fracture, and facial lacerations and subsequently died.

The plaintiff claimed that the EMTs were negligent in failing to raise the rail on the bed after transferring the patient from the gurney. The ambulance company claimed that the transfer had been properly performed and that the decedent was in the care of hospital staff at the time of the fall. The defendant also claimed that any injuries sustained during the fall were not related to the patient's death.

### Outcome

According to published reports, a defense verdict was returned.

### Comment

This is a sad case for everyone involved. While the appropriate verdict (defense) was returned, we are reminded that health care providers should "first, do no harm." Everyone working in the ED—physicians, nurses, techs, volunteers, etc—should try to make it a habit to raise the bedrails on any patient who appears to be at risk for a fall.

ED beds are notoriously narrow and uncomfortable and elevated a few feet above very unforgiving floors. Thus, falls frequently result in significant injury to the patient.

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Falls are not an uncommon source of ED malpractice cases. We can keep them to a minimum if everyone is vigilant about "bedrails up." **—FLC**

## Sudden Collapse During Football Game

In February 2007, a 19-year-old man fell to the ground while playing touch football. He was transported to the ED of a university hospital in Philadelphia.

The first emergency physician to see him, Dr W., developed a differential diagnosis that included possible congenital defect of the heart, and cardiologist Dr K. was consulted. Dr K. did not come to the hospital to examine the patient.

Three and a half hours after arriving at the ED, the young man died as a result of a defect in his left coronary arteries that caused a lack of oxygenated blood flow to the heart muscle during exercise.

The plaintiff claimed that the decedent should have been sent immediately to the cath lab for stabilization and treatment. The defendant claimed that nothing more could have been done because this condition is not diagnosable in an ED within 3 hours of presentation. The defendant maintained that surgery to correct a heart defect requires extensive work-up, imaging, and planning, and that the proper plan for work-up was being created at the time the patient died. The defendant also maintained that the decedent had been evaluated by cardiologists on previous occasions, without the congenital defect being found.

### Outcome

According to a published account, a $3 million verdict was returned.

### Comment

Although the defense claimed that the presenting condition was not diagnosable in an ED within 3 hours and that the congenital coronary artery defect had not been identified during previous evaluations, the jury might have found these claims more credible had the defendant cardiologist come to the hospital to examine the patient before he died. Woody Allen's famous quote may be particularly applicable here: "80% of life is showing up." **—NF**

## Was Patient With Hemorrhage Neglected in the ED?

A 66-year-old man underwent a lithotripsy procedure for kidney stones. He had been taking warfarin due to a history of chronic atrial fibrillation and a transient ischemic attack.

Three days after the lithotripsy procedure, the man presented to an ED in Virginia with severe flank pain. CT of the abdomen revealed a large retroperitoneal hematoma and prominent perinephric and pararenal hemorrhages.

For nine hours, the patient remained on a gurney in the hallway of the ED, where, it was alleged, he was allowed to deteriorate until he was admitted to the ICU in critical condition. The man died the next day.

The plaintiff claimed that the defendants, an ED physician and the admitting urologist, failed to monitor and treat the active hemorrhage during that nine-hour period. The plaintiff contended that the defendants failed to order coagulation studies and did not respond to signs of escalating hemorrhagic shock. The plaintiff also contended that the defendants did not reverse the coagulopathy, control the bleeding, or seek timely consults from surgery and interventional radiology.

### Outcome

According to a published account, an $825,000 settlement was reached.

### Comment

The important issue here appears to be the plaintiff's claim that for nine hours the patient wasn't monitored or treated for the prominent hemorrhages identified on CT. Although the admitting urologist was named as a codefendant, during the time that an admitted patient remains in the ED, a jury will typically consider the emergency physician and ED staff at least partly responsible for providing the care—and for the outcome. **—NF**

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