MALPRACTICE IN THE EMERGENCY ROOM

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Holding an emergency room (ER) team responsible for preventable errors is difficult and nearly impossible. Tragedies such as the bombing that occurred recently in Boston justifiably paint emergency room teams as heroes who provide life-saving assistance when required. However, medical errors committed by emergency room physicians and nurses can result in patient loss of life or limb. Despite what may appear to be clear evidence of medical malpractice, plaintiff verdicts in ER cases remain notoriously difficult to obtain. To prevail, malpractice attorneys must understand the medicine, medical rules, diagnostic pitfalls, how ERs operate, and how these cases are defended. As a medical malpractice attorney, your role in protecting and promoting individual patient health and safety is essential.

In a study of closed malpractice claims from the Physician Insurers Association of America (PIAA), a trade association whose insurance carriers insure more than 60 percent of U.S. physicians, errors in diagnosis were identified as the “primary misadventure” in 37 percent of ER claims, representing 46 percent of all paid claims in the PIAA database. Malpractice in the ER is a substantial contributor to preventable patient injury and its attendant costs.

I. Worst First

The cardinal rule in the ER is that life- and limb-threatening problems must be ruled out first. This “worst first” rule is contained in virtually every ER textbook. ER physicians are taught to think the worst and rule out life or limb threats first, then other serious diseases consistent with

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2 Terrence W. Brown et al., An Epidemiologic Study of Closed Emergency Department Malpractice Claims in a National Database of Physician Malpractice Insurers, 17 ACAD. EMERGENCY MED. 553 (May 2010).
patient complaints, and work to exclude these before accepting less serious, plausible potential diagnoses. Failing to follow the worst first rule may result in missed or delayed treatment, with catastrophic consequences for the patient. For example, failure to properly evaluate a patient who has symptoms of a cardiac condition—such as heart attack or stroke—can result in death or life-altering injuries.

II. Advanced Cardiovascular Life Support and Advanced Trauma Life Support

Hospitals often mandate the approach their ER teams must use for patients with signs or symptoms of a cardiac condition, by way of hospital policies and procedures which sometimes include treatment algorithms. Evaluate these carefully, because they may deviate from generally accepted guidelines, such as those found in the advanced cardiovascular life support (ACLS) manual from the American Heart Association (AHA). The ACLS manual contains several sets of algorithms establishing a standardized approach to a variety of cardiac problems in the ER setting. Failure to properly evaluate a patient who presents with symptoms which may be explained by a cardiac condition, such as a myocardial infarction, stroke, or aortic or thoracic dissection, can result in patient death or life-altering brain or other injuries.

One of the best resources in evaluating whether a hospital’s ER care meets the minimum standard is the advanced trauma life support (ATLS) manual from the American College of Surgeons. ATLS seeks to prevent patients from suffering preventable consequences of trauma due to the hospital’s lack of a uniform response. In 1976, an orthopedic surgeon piloted a plane that carried his family and crashed in a Nebraska cornfield. He had serious injuries, and three of his kids were in critical condition. At the hospital, they all received substandard care. The surgeon realized that he had given better care in the field with limited resources than trained doctors and nurses at the hospital. This led to the first ATLS course that combined lectures, skill demonstrations, and practical lab experiences. ATLS seeks to prevent patients from suffering preventable trauma sequelae due to a lack of a uniform response. The ATLS manual is accepted as the standard of care in the immediate post-trauma period. ER doctors and nurses are commonly ACLS and ATLS certified, so utilizing these resources for questioning can be extremely valuable.

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III. Emergency Medical Treatment and Active Labor Act

Another valuable resource, and one of the most frequently overlooked tools available, is the Emergency Medical Treatment and Active Labor Act (EMTALA), also known as the patient anti-dumping law. Many lawyers are not aware that this act protects both insured and uninsured patients and requires that any patient who arrives at the hospital for an ER evaluation must be given an adequate medical screening and may not be discharged in an unstable condition, once it is determined that an emergency medical condition exists.

With regard to EMTALA “screening” claims, 42 U.S.C. § 1395(dd)(a) provides:

In the case of a hospital that has a hospital emergency department, if any individual (whether or not eligible for benefits under this subchapter) comes to the emergency department and a request is made on the individual’s behalf for examination or treatment for a medical condition, the hospital must provide for an appropriate medical screening examination within the capability of the hospital’s emergency department, to determine whether or not an emergency medical condition (within the meaning of subsection (e)(1) of this section) exists.

EMTALA’s screening requirement is not a standard of care issue and imposes strict liability on hospitals that fail to comply. Hospitals also must apply uniform screening procedures to all patients coming to the ER with similar symptoms, regardless of their ability to pay. To a hospital defending against a screening claim, a proven violation of this requirement is devastating. EMTALA also provides strict liability for discharging a patient in an unstable condition. EMTALA is one of the most frequently overlooked tools available to the medical malpractice attorney. There is an EMTALA litigation packet available through AAJ.

IV. Common Diagnostic Errors

ER malpractice often involves diagnostic errors. Some diagnostic errors (or pitfalls) in the ER are so common that medical journal articles are devoted to identifying their frequency and the reason for the errors to educate the medical community and reduce such errors, thereby

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7 See, e.g., St. Anthony Hosp. v. U.S. Dep’t of Health & Human Serv., 309 F.3d 680, 706 (10th Cir. 2002) (citing Abercrombie v. Osteopathic Hosp. Founders Ass’n, 950 F.2d 676, 681 (10th Cir. 1991)).

8 42 U.S.C. § 1395(dd); see also Phillips v Hillcrest Med. Ctr., 244 F.3d 790, 796-97 (10th Cir. 2001), cert. denied, 535 U.S. 905 (2002).

preventing patient injury and death. It is not uncommon for an ER physician to miss a diagnosis when a patient doesn’t have what is considered to be a “classic presentation.” You must become familiar with the specific medical condition in question and be able to identify the classic and atypical signs and symptoms that the ER team should have been aware of in evaluating the patient.

**Pulmonary Embolism**

For example, more than 50 percent of pulmonary embolisms (400,000 patients annually) are misdiagnosed with pneumonia, chronic lung disease, or another ailment, and 100,000 to 120,000 of these people die, with up to 70 percent of the pulmonary embolisms being diagnosed postmortem.\(^\text{10}\)

**Abdominal Aortic Aneurysm**

The ER “miss” rate for ruptured abdominal aortic aneurysms is 30 percent, due to absence of the “classic triad” of pain, hypotension, and a mass that pulsates as the heart attempts to pump blood through the vessel. More than 50 percent of patients with ruptured abdominal aortic aneurysms do not have this classic presentation.\(^\text{11}\)

**Bacterial Meningitis**

Up to 25 percent of bacterial meningitis cases are initially missed in the ER because the classic triad of symptoms (fever, neck stiffness, and altered mental status) is not present, and the ER team fails to appreciate its variable clinical manifestations, including patients presenting with no or mild headache, slow onset of symptoms, no fever, and no neck stiffness.\(^\text{12}\)

**Stroke**

Also, 14 percent of strokes are initially misdiagnosed for various reasons, such as failure to adhere to the AHA and American Stroke Association’s established stroke management

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guidelines, timely refer the patient to a stroke care team, take an adequate patient history, order and correctly interpret tests, and obtain appropriate consultation.13

Aortic Dissection

Failure to diagnose traumatic aortic dissection due to deceleration injuries—a cardiac injury that can result from sudden impact, such as vehicular collisions and falls from great heights—is another problem. This condition can occur when the stabilizing portion of an organ ceases forward motion while the movable body part continues to move forward.14 For immediate survivors, salvage is frequently possible if aortic rupture is identified and treated early. Many of the surviving patients die in the hospital, however, when they are left untreated. Specific signs and symptoms are frequently absent. Up to 30 percent of patients with aortic dissection are initially thought to have other conditions, and the ER team should always consider this in the differential diagnosis with acute chest, back, or abdominal pain.15 A high index of suspicion with history of decelerating force and characteristic radiologic findings, such as a widened mediastinum, followed by arteriography, are the means of making the appropriate diagnosis. The Trauma Nursing Core Course (TNCC) manual, like the ATLS manual for physicians, dedicates an entire chapter to rapid deceleration trauma and the injuries which are foreseeable in these types of incidents. In the course of evaluating patients with chest pain, the ER team should adopt the philosophy of “aortic dissection until proven otherwise” so this diagnosis is never missed.16

Subarachnoid Hemorrhage

Atypical presentations for subarachnoid hemorrhage are between 25 and 50 percent,17 and five percent of subarachnoid hemorrhage is missed in the ER due to failure to consider the full spectrum of possible symptoms, follow algorithmic workup, and understand the limitations of

16 ERIC J. TOPOL, TEXTBOOK OF CARDIOVASCULAR MEDICINE (Lippincott, Williams & Wilkins, 3d. ed. 2007).
testing. This condition can be missed because the patient doesn’t have the worst headache of his or her life.

**Myocardial Infarction**

Up to eight percent of acute myocardial infarctions (MIs) are missed each year in ERs across the United States, due to factors such as failure to take an appropriate history, misinterpretation of an EKG, and inadequate physician training and experience. Forty-two percent of women with myocardial infarction and approximately 31 percent of men with myocardial infarction do not have chest pain, yet doctors often fail to diagnose this condition because the patient doesn’t have crushing chest pain radiating to the left arm.

**Epidural Abscess**

Even though most patients do not present with the “classic triad” of fever, spine pain, and neurologic deficit, many ER physicians still wait until a patient develops neurologic deficits before performing testing for spinal epidural abscess. This has resulted in many patients ending up with irreversible neurologic deficits that were preventable. It has been recognized by the medical community since at least 2004 that a patient’s erythrocyte sedimentation rate (ESR) is better at identifying patients at risk of developing neurologic deficits before they are present and irreversible. Early intervention improves patient outcome, yet up to 50 percent of all cases are misdiagnosed or have delayed diagnosis.

**V. Tips**

In a situation involving a missed myocardial infarction diagnosis, one of the best questions to ask both plaintiff and defense experts is, “Would it be safe and appropriate for a physician to evaluate a patient who may be having a heart attack if the only presentation he or she was aware

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of was crushing chest pain radiating to the left arm?” The answer your expert will give, and the answer the defense expert should give, is “no.”

The same holds true for questions concerning all “classic” signs and symptoms. You must be prepared to prove that atypical presentations are not unforeseeable. To do so, you should be armed with supporting medical literature, preferably in the form of textbooks and medical journal articles. Jurors tend to rely heavily on medical textbooks and literature in these cases, especially when faced with competing medical expert testimony that they may not understand.

Each case requires a well-thought-out, case-specific written discovery plan. You must obtain a copy of the original hospital medical chart and review it carefully. Hospital records are frequently transmitted to subsequent treating physicians, along with radiologic imaging and interpretation. When medical care is called into question as a result of a medical malpractice lawsuit, it is not unusual for imaging studies to then disappear. Records may be altered, which can devastate a patient’s case if not uncovered. In requesting medical records from a subsequent treating physician, make sure to obtain the physician’s own records and any other provider records in the file, especially from the hospital where the patient received ER and inpatient care.

Obtaining a subsequent hospital’s records and comparing them carefully with the first hospital’s records may also reveal alterations. In addition, electronic medical record discovery warrants familiarity with how the hospital’s system tracks medical record access, changes, and deletions.23

VI. Defenses

Patient’s Own Fault

Early on, you must identify potential challenges and common defenses, and plan for how to deal with each roadblock that arises throughout litigation and during trial. A common defense argument is that the medical problem or injury that sent the patient to the ER in the first place was the patient’s own fault. However, some state supreme courts have held that a defense of patient contributory negligence does not apply when the patient’s conduct simply provided the occasion for ER care and treatment, which was later the subject of a malpractice claim.24 An ER patient who suffered internal injuries when he attempted to jump a moving car on his skateboard is an example. Sample questions to ask an ER physician at a deposition include: “Doctor, is the care that you provide to the driver of a car who ran into a brick wall any different from the care you provide to his or her passenger, who was asleep at the time of the collision?”


you make a medical mistake and your patient suffers a preventable injury as a result of your care, do you blame the patient for doing or not doing something that necessitated your emergency medical services in the first place?”

**Hindsight Bias**

One of the most common defenses is “hindsight bias,” or the “Monday morning quarterback” defense. The defense claims that now that the outcome is known, it is easy to say what signs and symptoms should have been recognized in the ER and what treatment should have been provided to the patient. It seemingly provides the justification for jurors to ignore evidence of substandard care and return defense verdicts. To avoid this defense, identify as much medical evidence in support of your argument as possible, including treatment algorithms, medical textbook references, hospital protocols, and prominent medical literature warning ER physicians of the signs and symptoms that are red flags for your client’s improperly diagnosed or treated medical condition. The more substantial the quality and volume of textbook and literature support, the less the defense can argue that an ER physician would be expected to recognize your client’s medical condition only with 20/20 hindsight.

**Benign Explanation**

Another frequent argument is that the patient’s signs and symptoms were consistent with a “benign explanation.” The best way of dealing with this issue is to simply confront the ER physician and defense experts during depositions. Ask for all the potential explanations for your client’s medical signs and symptoms. While one or more explanations may be benign (such as indigestion), others will not be. Then, you can argue that the physician should have employed the worst first rule.

**Judgment Call**

Defense attorneys also may argue that the ER physician was exercising his or her judgment, so he or she should not be held liable. However, just because something may be a judgment call does not mean that the call is correct and within the standard of care. If a physician doesn’t consider all the medical evidence or fails to recognize an atypical presentation, the judgment call can be wrong, and a medical error can occur. When this defense comes up at trial, remind the jury that it exercises its judgment when it returns a verdict, and failure to consider all the evidence can result in an incorrect judgment.

**Nurses Aren’t Physicians**

ER nurses are not physicians and, therefore, the defense usually claims that it is never the ER nurse’s fault. This is untrue, because ER nurses have their own professional duties to patients. As patient advocates, ER nurses are crucial to ensuring that patients do not slip through the cracks, errors are not made, and patients are not discharged with life-threatening problems. While physicians routinely spend just minutes with patients, nurses spend the majority of their
time with patients. Nurses are likely to be the first ones to observe clinical red flags, such as abnormal vital signs (elevated heart rate, elevated respiratory rate, or abnormal temperature, for example). Often described as a physician’s “eyes and ears,” a nurse’s role is vital to patient health and safety. When a nurse disagrees with a physician’s order, he or she has a duty to address the concern with the physician and, if the concern persists, to report the issue up the chain of command until the concern is appropriately addressed. ER nurses have a duty not to discharge a patient, despite a physician’s order, when they believe it is not safe to do so. The American Nurses Association (ANA) code of ethics requires nurses to safeguard patients whenever patient health or safety could be affected by anyone’s incompetent or unethical practice, including that of physicians. After pointing out to a jury the nurse’s crucial role in ensuring patient safety, it is easier to explain that the nurse’s role in making sure errors don’t occur is not limited to medication administration.

Not Probable

You must be ready to address probability and the legal standard of proof. Defense counsel may attempt to defend a failure-to-diagnose heart attack case by telling the jury that it was not probable (more than 50 percent likely) that the patient’s chest pain was due to a heart attack, so there was no reason to perform any diagnostic tests. While only 13 percent of ER visits for chest pain result in a diagnosis of acute coronary syndrome (heart attack or unstable angina), this does not mean that an ER patient with chest pain should be ignored because it is not probable. The best way to address this is to use emergency medicine textbooks, the hospital’s policies and procedures, and your experts to explain why life-threatening medical conditions must be ruled out, even if there is a more likely non-life-threatening explanation. It is also valuable to address this in voir dire by asking if anyone has ever felt a breast lump or chest pain and gone in for a medical evaluation. If the doctor said there is less than a 50 percent chance that it is cancer or a heart attack, would you still want (and need) to know the answer?

Preexisting Medical Conditions

Beginning with voir dire, defense counsel will argue that the plaintiff’s preexisting medical conditions and behaviors—such as obesity, smoking, and recreational marijuana usage—predisposed him or her to a cardiac problem or other medical condition. Consider voir dire questions such as, “How many of you could not hold the ER physician responsible for injuries to Mr. Jones because he was a smoker or obese?” Your client’s failure to follow ER discharge instructions to follow up with his or her physician leads to questions such as, “In this case you will learn Mr. Jones did not follow up with his physician in three days as instructed. How many


jurors simply could not hold the defendant ER doctor responsible for breaking a medical rule, which would have led to a diagnosis and treatment before discharge from the ER and prevention of this injury?"

_Doctor as Hero_

One of the most overlooked defenses is the presentation of the ER physician as a hero. You can point out how much the defendant ER physician charged for the time spent evaluating the patient (usually five to 20 minutes), multiplied by the number of patients seen during a regular shift. In the jurors’ minds, spending so little time with a patient and charging $1,000 or more may reduce the ER physician from a hero to someone simply providing a service for money.

_Plaintiff Undeserving_

Just as the defense attorney will attempt to elevate the ER physician to the position of hero, the attorney will also attempt to paint the plaintiff in a negative light. Do not be surprised if the plaintiff’s social media accounts (such as Facebook and Twitter) are introduced into evidence. On the day the plaintiff officially retains you, advise him or her to close all such accounts or at least make them private, as well as to refrain from discussing the subject of the lawsuit with anyone other than you and his or her spouse. Early in the case, you should pull every record available on your client (such as divorce, bankruptcy, criminal, credit, and driving records) so that there are no surprises at trial. A client’s unwary use of social media and seemingly harmless conversations with friends, coworkers, and acquaintances only increases the chances that the defense will zero in on potentially negative information.

_VII. Conclusion_

Malpractice attorneys are a vital part of a community safety net to ensure that when medical errors occur in the ER and result in patient injury or death, the errors are identified and the responsible ER physicians, nurses, and hospitals are held accountable. Holding health care providers responsible for substandard ER care will help prevent future medical errors.