A Case of Retrospective Clarity

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There is not a day that goes by without an emergency or some type of accident. These scenarios are what make emergency medicine necessary. The American College of Emergency Physicians defines emergency medicine as “the medical specialty dedicated to the diagnosis and treatment of unforeseen illness and injury…[e]mergency medicine encompasses planning, oversight, and medical direction for community emergency medical response, medical control, and disaster preparedness.”[1] The fast-paced nature of emergency medicine forces emergency physicians to make quick decisions and take decisive action based on limited information in order to do what is best for a patient they’ve just met.” These challenges inherently increase liability. In fact, 1 out of every 14 emergency physicians get sued each year. [2] How can liability be reduced? Our claim review touches on the pitfalls of practicing medicine in this environment and the important role thorough documentation can play in combating potential liability.

This claim involves the treatment of a 20-year-old female, Amelia Thomas[3], who presented to the emergency department via EMS. EMS was called when it was reported that emergency services were needed to treat a young woman who was exhibiting

abnormal behavior at a party. The EMS notes were an important aspect of the case as an EMS responder documented that the patient was compliant with care and assisted EMS with her treatment. Documentation noted that the patient remained alert, but non-verbal during transport. All four of the patient's extremities were evaluated for strength and abnormal movement, and no abnormalities were found. Particularly due to the drug paraphernalia found at the scene, an initial diagnosis of drug intoxication was given. When the patient presented to the emergency department Dr. Strobl, our insured emergency physician, provided care. He documented that the patient was uncooperative. He specifically noted that the patient was able to move all her extremities. Most importantly, he noted that her neurological exam was limited due to Amelia's lack of cooperation. Her musculoskeletal assessment was within normal range for motion and strength. Dr. Strobl observed the patient giving nonverbal answers to questions asked. She would shake her head yes or no. Labs were taken, and the urine drug screen was positive for marijuana. A chest x-ray was negative for an acute cardiopulmonary process. The patient was discharged later that night. On discharge, Dr. Strobl documented that the patient's mental status had improved, and that Amelia's condition was unchanged. The thought was that Amelia's symptoms were the result of recreational drug use. The discharge diagnosis was marijuana use, with a differential diagnosis of confusion, alcohol intoxication, and drug abuse.

A few days following discharge, Amelia's mother called EMS due to her daughter's altered mental status. She stated to EMS that her daughter was recently sent home from the hospital with the same signs and symptoms (altered mental status and inability to ambulate) as they were presently seeing. EMS noted that the patient was able to move her left side and while she was trying to speak, nothing came out. The patient was awake and alert, but non-verbal initially. This eventually improved in transport, and Amelia became verbally responsive while in the ambulance. She responded to her name and advised that she did not know the answers to the other questions used to assess her orientation. Her speech was slurred. It was unknown how long this had been occurring because she had been non-verbal around her family. EMS noted that the patient had slurred speech and right-sided weakness for the past 48 hours.

She was seen by an ER physician. His neurological exam revealed that her right side was flaccid, her speech was slurred, and she was disoriented. She appeared moderately confused, but she answered some questions appropriately. Her ROM of her right side was limited. She admitted to smoking "weed." A CT scan revealed a significant abnormality (stroke vs. mass). The impression of the CT scan report was that her findings could represent vasogenic edema secondary to underlying parenchymal brain lesions with etiologies including brain ischemia or an infarction.

Amelia was then transferred to another facility. Her H & P noted that she was aphasic. This time when she was asked questions, she had a challenging time differentiating between yes and no. She also had difficulty understanding and following simple commands. An exam revealed dense right facial paralysis, and she was not able to understand the instruction to stick out her tongue. She had dense right flaccid hemiplegia,

but she seemed to have sensory perception on the right because she grimaced when her right lower extremity was touched. An MRI showed that the patient had a large acute left MCA territory infarct and moderate surrounding edema. Findings of a transthoracic echocardiogram found that the patient had a mitral valve echogenic shadow that was suspicious for vegetation. Neurology noted right hemiparesis, aphasia, and hypersomnolence. Amelia underwent another CT scan, which revealed that she had suffered a left middle cerebral artery stroke. Cardiology was consulted and included a differential diagnosis of endocarditis versus a mass that was likely due to stroke. Amelia remained an inpatient for three weeks and then went on to rehab.

A lawsuit was filed by the patient, alleging that the care provided by Dr. Strobl, his practice, and the hospital did not comply with the standard of care. The primary allegations against Dr. Strobl were failure to timely recognize symptoms of a stroke; failure to perform a stroke assessment; failure to timely perform a neurological exam; failure to obtain a CT scan; failure to timely administer treatment for acute ischemic stroke; and discharging Amelia Thomas in an unstable condition.

The alleged damages were high in this suit because the patient sought compensation for her disfigurement, loss of capacity for the enjoyment of life, pain and suffering, medical expenses, loss of earning capacity, lost wages, and mental anguish. The amount of economic damages alone were especially high given the young age of the patient and a long life expectancy, the expensive life care plan, and the permanent injury she sustained. The monetary demands from the patient's attorney removed the possibility of settling the matter as they were well over the amount of Dr. Strobl's policy limits.

The case had many hurdles from a defensibility perspective.

The first was the perception of an unintentional or unconscious bias as a result of the patient presenting as a drug user which the plaintiff argued had an impact on the care provided by our insured physician. This was an easy argument to make given, at first glance, this case could appear to demonstrate a physician who failed to thoroughly investigate symptoms relative to a stroke in a young person as it is an uncommon event, and assumed it was due to drug intoxication because of the presence of drugs in her urinalysis and the EMS record. This narrative was the first thing argued to the jury in opening statements. Plaintiff's counsel pushed the idea that our physician was very busy, and he assumed the patient was a drug addict, so he put little effort into investigating the cause of the symptoms, basing his diagnosis on the obvious choice of drug intoxication as the cause of her condition.

Another big hurdle was inconsistencies in the records due to the overall lack of documentation. Documentation from EMS stated that the patient was awake and compliant. She was trying to assist EMS but was non-verbal. Dr. Strobl admitted he failed to change the template default for documentation in his H & P, which described the patient as cooperative with normal judgment. It wasn't until Dr. Strobl testified during the trial that he specifically recalled she was noncompliant by pulling off the monitor leads and pushing the nurses' hands away. This was also consistent with the nurses' testimony. This missing

language, if it had been noted in the record, would have gone a long way in explaining that Amelia could move her extremities when Dr. Strobl examined her and would have supported his drug intoxication diagnosis. Documentation helps support the veracity of testimony, leaving little doubt for a jury. He testified that, as he documented, her musculoskeletal assessment was normal.

Another point that the patient's attorney used against Dr. Strobl was the incomplete neurological exam. The medical record documented that neurological exam was limited due to the patient's lack of cooperation. He testified that he observed Amelia Thomas making fists but did not document this. In his testimony, he agreed that the inability to move one side of the body can be a stroke sign, but this is not something that he saw when the patient was in the ER. Dr. Strobl asserted that the patient appeared to be choosing when to respond and that her presentation appeared to be more of a refusal to speak than an indication that she could not speak.

Lastly, documentation was an issue in refuting the allegation of discharging an unstable patient. On this point, the plaintiff's attorney questioned the mother on the stand about her allegation that she had to physically drag her daughter out of the ER. She testified that the patient was unable to walk and was in the same condition as she was when she presented. Dr. Strobl re-examined the patient before discharge. However, his note was short and noted only that the patient's condition was unchanged, but with mental status improvement. No elaboration was made, and there was no documentation as to what he observed or their interaction. Again, Dr. Strobl's testimony was needed to make clear that Amelia Thomas was answering yes and no questions with a clear speech pattern. If he had elaborated on his note indicating that the patient was not speaking before and then began speaking at discharge, this information would have been helpful when defending the alleged failure to diagnose a stroke. Additionally, Dr. Strobl did not document his interaction with Amelia's mother. He testified that, at discharge, she agreed that her daughter was improving and signed the discharge instructions. This testimony painted a very different picture than what was presented by the medical records alone. The testimonial inconsistencies along with the scant documentation made the case challenging to defend because it created a "he said/she said" scenario and forced the parties' credibility to come into question.

Despite these hurdles, Dr. Strobl's presentation on the stand, and his credibility, helped his defense. He was able to fully explain his clinical thought process and observations, filling in the gaps his documentation left at the time of treatment. Without Dr. Strobl's persuasive testimony at trial, along with the skills of his talented counsel, this case could have been lost. Fortunately for Dr. Strobl, the jury found that there was no breach in the standard of care and rendered a defense verdict.

By its nature, emergency medicine calls for fast paced care and quick cognitive agility. Even though time may be short, documenting clinical observations and analysis ensures retrospective clarity. Perhaps with more thorough documentation on the front end, this lawsuit may not have been filed.

Some best practice takeaways:

Translate clinical thoughts and observations to the record that paint a picture of the patient's condition so you can clarify medical decision making. Although you may have time pressures, it benefits you to document well. Any change in the patient's treatment or additional information provided by family or friends should be included.

Be aware of EHR templates. Make sure findings make sense in the context of the visit. Check for inconsistencies.

Consider a re-examination of a patient at discharge. When preparing a discharge summary, it is helpful to be specific in diagnosis and observations. Include relevant information provided by a family member.

[1] American College of Emergency Physicians. Jan. 2021.Definition of Emergency Medicine. Retrieved from http://www.acep.org/patient-care/policy-statements/definition-of-emergency-medicine

[2] Aya Itani, MD, MPH; Cedric Dark, MD, MPH, FACEP. Emergency Medicine Advocacy Handbook. Retrieved from http://www.emra.org/books/advocacy-handbook/liability-reform/

[3] The name of the physician and patient information have been altered.