Medical malpractice involving allegations of negligent failure to diagnose in emergency care

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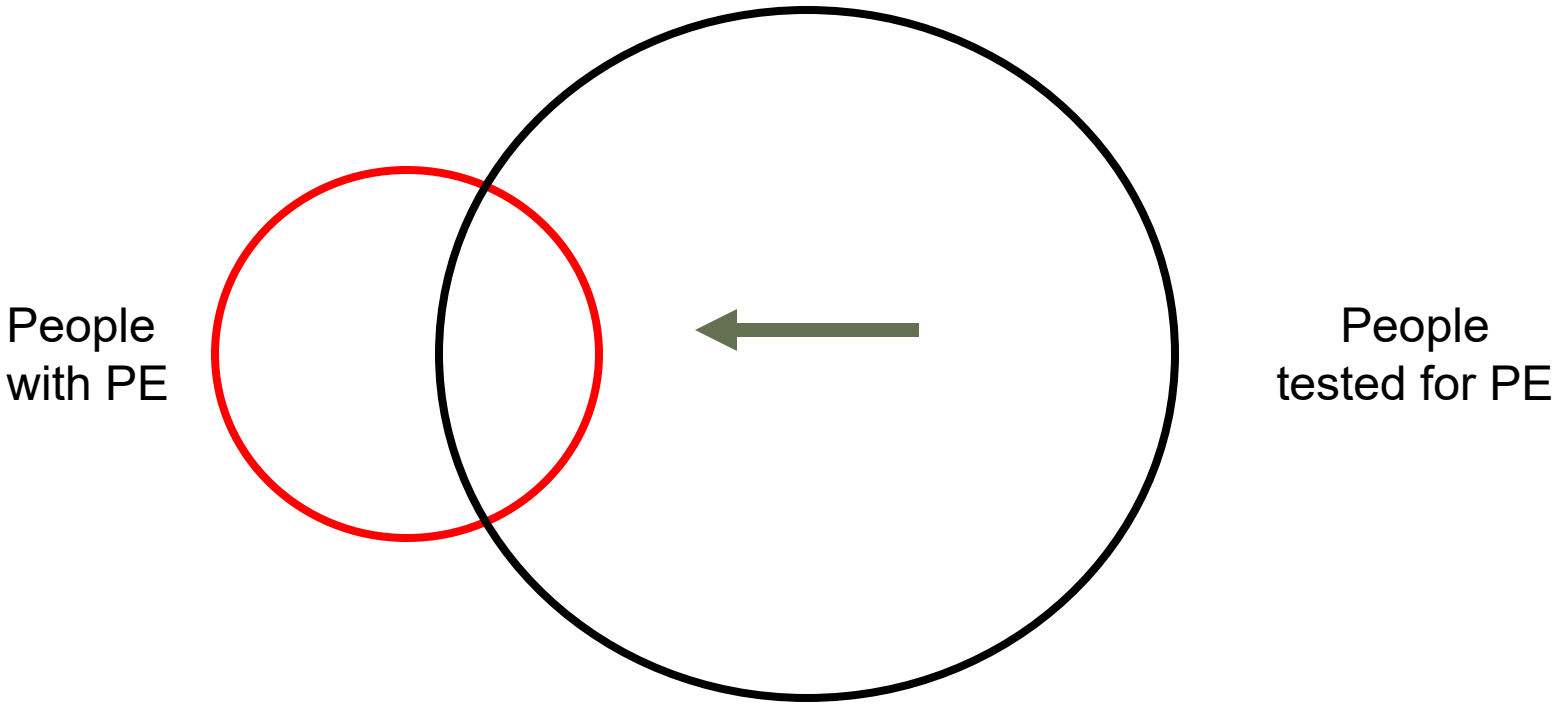

People
with PE
People
tested for PE

Instructions

We will do three cases.

I want you to decide if the patient had PE or not and were the actions negligent

If you see PHI that I failed to redact, please consider this confidential, and for teaching only and as protected information

Two parts to a verdict

Standard of care: Medical care that a reasonable and prudent physician would deliver under similar circumstances.

Causation: Did action or inaction by the defendent substantially contribute to the death or injury?

EMPATHY FAILURE LEADS TO NEGLIGENCE

“She was sitting there hyperventilating. He [the doctor] just kind of walked in the room and told her ‘you need to calm down’. He was writing in on his chart and talking to the nurse about getting a breathing treatment. He never even really looked at her.”

Deposition of a father of a patient who was discharged with PE and died, 2011

Q. Did you talk to him any further about how he was doing, how he was feeling?
A. Sure, several times.

Q. Tell me what you recall being said in that regard.
A. He just referred to--you know, he just referred to not--something's definitely wrong, you know, I mean, he just--breathing was off, he was dizzy, you know, he would get pale for a while and then you'd see a little color come back and see a little panic in his face and-–it was just discomfort.

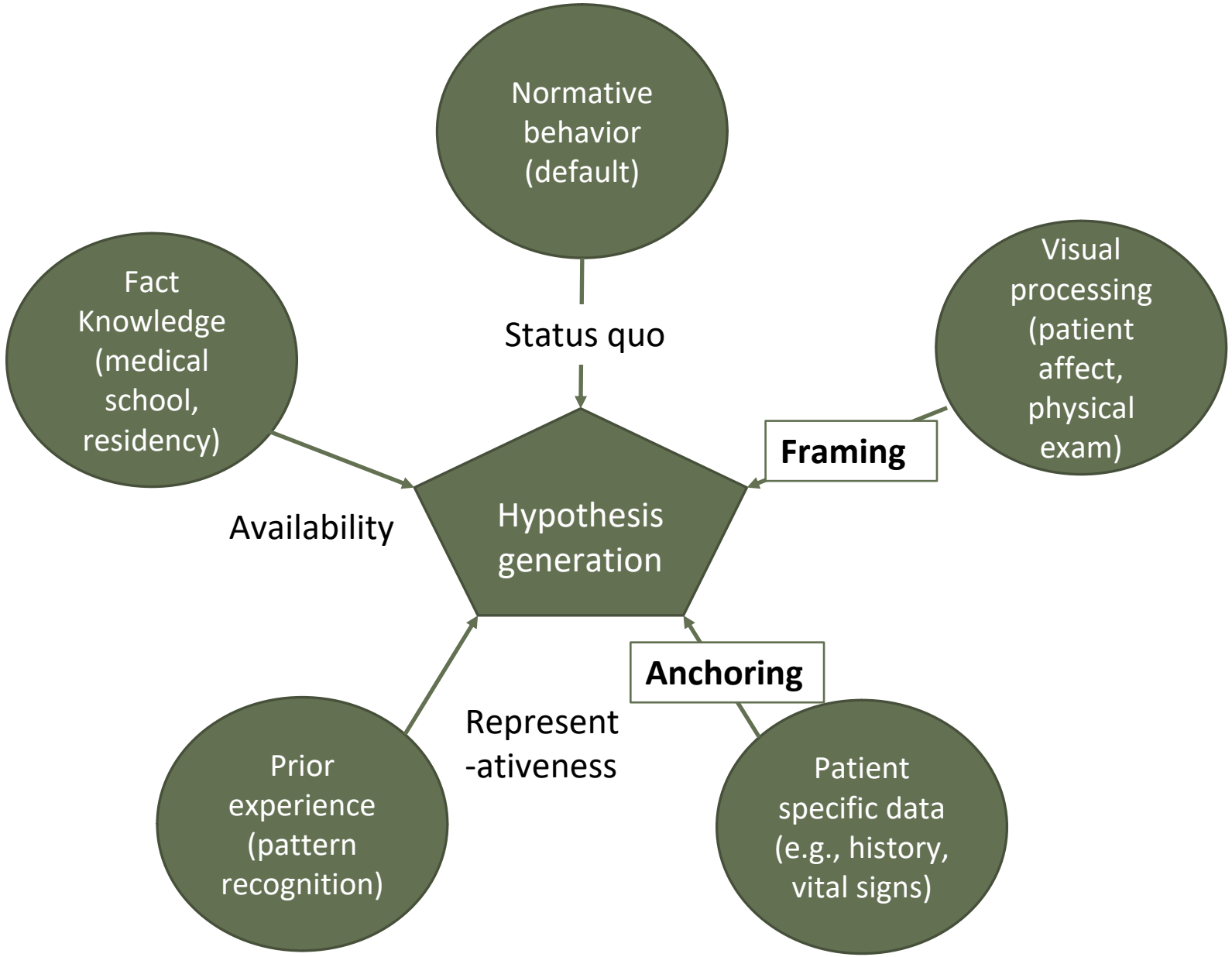
Q. Was there any change in his condition during the time that you were there?
A. Off and on. I mean, like I said, the breathing would get heavier and deeper and, you know, he'd turn one side to one side. You could see him getting pale and
sweating and -- you know, and then it would tone back down, you know, and –

Q. Tell me what you mean by "tone back down.“
A. I mean it is like he would go back to a non-panic state and his breathing would settle…

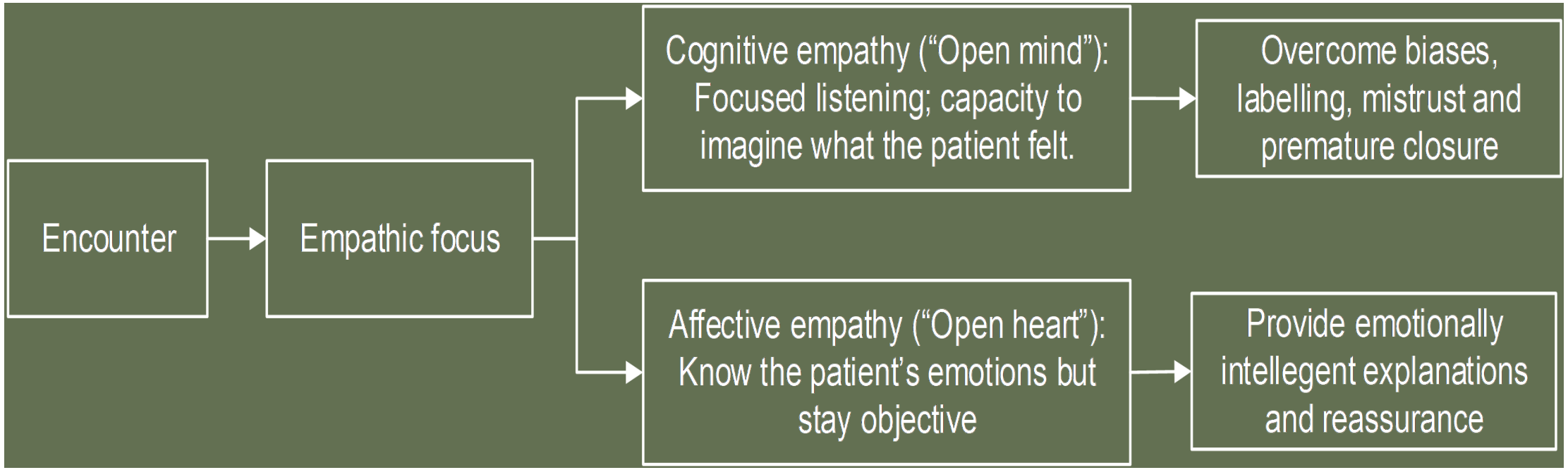
Empathy in parts

1. **Cognitive empathy**: Open mind; *life-saving*; capacity to understand what the patient experienced.
2. **Affective empathy**: Open heart; *soul-saving*; understanding what the patient feels.
3. Empathy is your individuality, it is not a competition; not an administrator's or researcher's metric. This is not patient satisfaction.

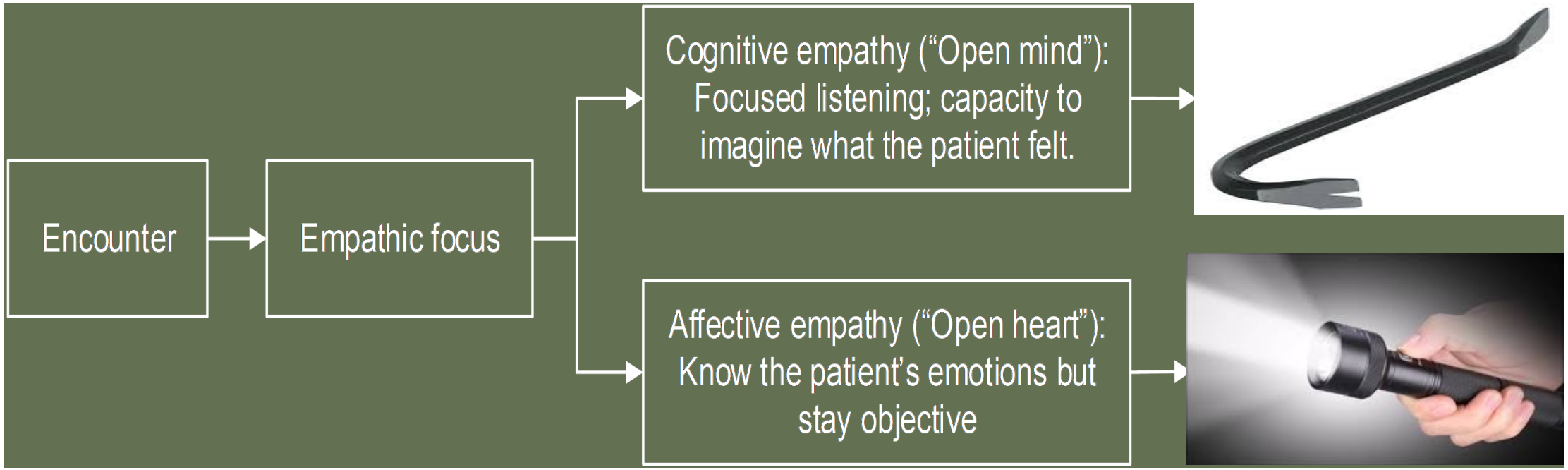
Biases in gestalt processing



DUAL EFFECT OF EMPATHY



DUAL EFFECT OF EMPATHY



DOOMSDAY: PLAINTIFF VERDICT

LICENSURE: The degree of charted empathy can sway state medical licensing boards

CASE #1

Complex comorbid conditions

ED Provider Notes Date of Service: 7/27/2015 4:57 PM

[redacted] MD

EMERGENCY MEDICINE ([redacted]

I was present for the initial triage evaluation and performed a medical screening exam on the patient and assisted in placement of initial orders and a brief evaluation.

Briefly, 31y/o F w/ hx ESRD (HD on M/W/F, missed today), DM, HTN and CHF who p/w c/o new onset nausea/vomiting/diarrhea, cough w/ productive sputum, subjective fever and chest tightness. Pt reports feeling weak w/ general malaise.

Labs, CXR and IV's ordered in triage.

Zofran and 250cc bolus given

History

Chief Complaint

Patient presents with

- Fever

Patient is a 31 y.o. female presenting with fever.

Fever

Associated symptoms: **cough**, **diarrhea**, **nausea** and **vomiting**

Associated symptoms: **no chest pain**, **no chills**, **no congestion**, **no dysuria**, **no headaches**, **no rhinorrhea** and **no sore throat**

31 y/o F PMH ESRD on HD (MWF), h/o ETOH abuse, CHF (EF 10-15% 1/15), HTN, poorly controlled DM, h/o DKA, frequent ED visits/admissions (most recently admitted to EDOU for 7/22-7/23 for dialysis catheter malfunction) presents with multiple complaints including cough, shortness of breath, abdominal pain, nausea, and vomiting. Reports cough with brownish sputum production, associated with shortness of breath and generalized weakness. Denies fever/chills. Also c/o chronic epigastric abdominal pain, associated with anorexia, nausea, vomiting, diarrhea. Last HD was Friday, had 3 out of 4 hours, unsure how much was removed. States she had to stop HD early because she had to take her daughter to a doctor's appointment. Missed HD today because she was not feeling well. Makes urine, denies change in amount of urine, dysuria, urgency, frequency, or flank pain. Reports compliance with her insulin, but did not take any today because she did not eat anything.

Denies ETOH - "I stopped in April"
Denies illicit drugs

Past Medical History

Diagnosis	Date
• Diabetes mellitus	
• CKD (chronic kidney disease)	
• ETOH abuse	
• HTN (hypertension)	
• CHF (congestive heart failure)	
• Preeclampsia	
• MRSA cellulitis	
• Type I (juvenile type) diabetes mellitus without mention of complication, uncontrolled	1/7/2015

History

Substance Use Topics

- Smoking status: Never Smoker
- Smokeless tobacco: Never Used
- Alcohol Use: No

Comment: Former drink. Drank > 1 pint per day for 3 years but stopped in June of 2014.

Review of Systems

Constitutional: Positive for fatigue. Negative for fever and chills.

HENT: Negative for congestion, rhinorrhea, sneezing, sore throat and trouble swallowing.

Respiratory: Positive for cough and shortness of breath. Negative for chest tightness.

Cardiovascular: Negative for chest pain.

Gastrointestinal: Positive for nausea, vomiting, abdominal pain and diarrhea.

Genitourinary: Negative for dysuria, urgency, frequency, flank pain, difficulty urinating and pelvic pain.

Neurological: Positive for weakness. Negative for numbness and headaches.

Physical Exam
BP 137/106 | Pulse 133 | Temp(Src) 99.4 °F (37.4 °C) (Rectal) | Resp 22 | Ht 5' 5" (1.651 m) | Wt 120 lb (54.432 kg) | BMI 19.97 kg/m2 | SpO2 97%

Physical Exam
Constitutional: She is oriented to person, place, and time. She appears well-developed and well-nourished.
HENT:
Head: Atraumatic.
Diminished breath sounds throughout. No crackles.
Eyes: EOM are normal.
Neck: Neck supple.
Cardiovascular: Normal rate, regular rhythm and normal heart sounds.

A: 31 y/o F PMH ESRD on HD (MWF), h/o ETOH abuse, CHF (EF 10-15% 1/15), HTN, poorly controlled DM, h/o DKA, frequent ED visits/admissions (most recently admitted to EDOU for 7/22-7/23 for dialysis catheter malfunction) presents with multiple complaints including cough, shortness of breath, and generalized weakness x 3 days. Also c/o chronic abdominal pain, nausea, and vomiting. Missed HD today. Rectal temp 99.4, tachycardic to 130s, received NS 250cc bolus in triage.

P:

- UPT
- U/A
- cbc, bmp, lfts, lipase, mg, lactate

- normal saline 500cc bolus
- CXR
- d/w Dr. [redacted]

ED Course

Lactate 2.8
WBC 5.6

Glucose 477
BUN 47 / Cr 6.97
Na 129
K 5.2 (slightly hemolyzed)
AG 17

CXR: Hazy focal opacity in the right upper lung which may be secondary to developing pneumonia, less likely aspiration.

In the setting of temp 99.4, tachycardia, lactate 2.8, CXR with PNA - concern for sepsis. Blood cultures sent, will give Zosyn, Vancomycin, and Azithromycin for HCAP.

22:20 patient signed out to resident MD [redacted] pending repeat BMP and lactate after fluid, admission for IV antibiotics for HCAP and renal for HD.

Q1: PE or NOT PE?

Q2: Deviation from standard of care?

Medical Outcome

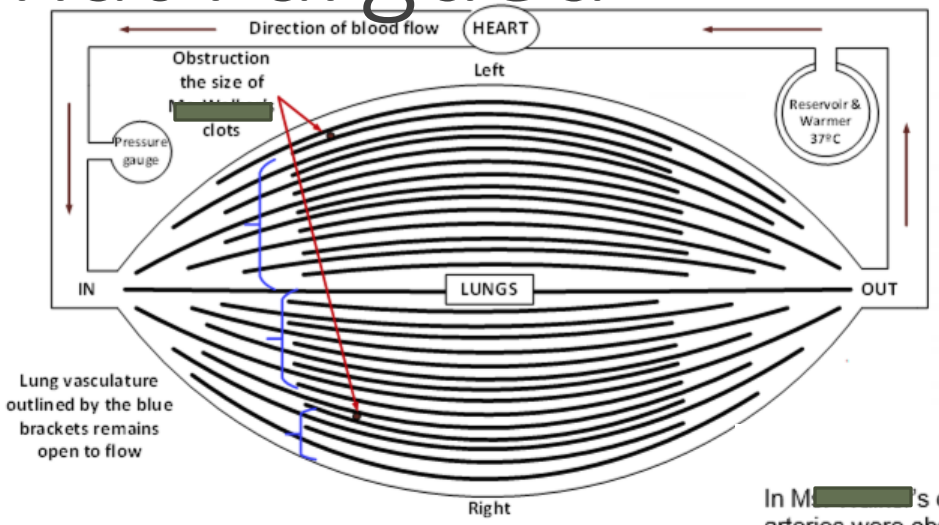
Admitted. Tx CHF, PNA.

Had Permacath exchange next day

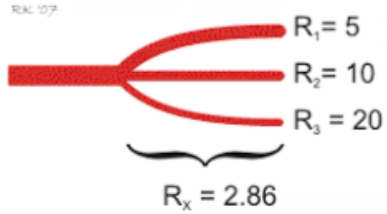
Arrests later that night

CTPA post arrest shows two subsegmental filling defects in each lung

What I argued



In M[redacted]'s case, even if two segmental pulmonary arteries were obstructed (but the actual case was less), this would amount to <5% total increase in resistance, and no measurable change in pressure in the right ventricle. The following diagram will enhance understanding of how trivial these clots were to M[redacted]s cardiac output:



$$R_X = \frac{1}{\frac{1}{R_1} + \frac{1}{R_2} + \frac{1}{R_3}}$$

Legal outcome

CASE SETTLED

Learning points

- Admitting patient to hospital ≠ off the hook
- Do not write contradictory statements on chart
- Team members often break the case
- In my sample, APPs are increasingly part of complex Medmal cases

CASE #2

Gastroenteritis in a 16 year old

MR#: M0461479	**Acct#: V008927196**	**DOB: 06/23/2000**
Age/Sex: 16/F	Location: ER	Admit Date:
Report #: 0715-0421	Dictating Provider: [redacted]	MD

Chief Complaint:
Chief Complaint: Gastrointestinal
Stated Complaint: VOMITING FOR OVER ONE WEEK
Time Seen by Provider: 07/15/16 14:54
History of Present Illness:
16-year-old female here with parents for evaluation due to nausea vomiting. According to her father she had nausea vomiting which started about 6 days ago. She has been having nausea and vomiting daily. Had seen her primary care provider was given prescription for Phenergan. Phenergan5 helps some she has been able to keep down some fluids but not very much. She does not have abdominal pain. Few days ago she had temperature 100.5°. She denies any pain. He has not had diarrhea. She had menstrual period which ended about a week ago. During her menstrual. She used about 4 to 5 pads per day. This is her normal menstrual cycle. No ongoing vaginal bleeding. No blood in the stool. She has had no cough or congestion. No recent travel. No known sick contacts.
History obtained from: patient, parent

PMH/PSH:
Patient History Reviewed: no significant past medical history
Past Surgical History: tonsillectomy
Additional Surgical History: ear tubes

Home Meds & Allergies:
Allergies/Adverse Reactions:

No Known Allergies Allergy (Verified 07/15/16 14:42)

Patient History Reviewed: no significant past medical history
Past Surgical History: tonsillectomy
Additional Surgical History: ear tubes

Home Meds & Allergies:
Allergies/Adverse Reactions:

No Known Allergies Allergy (Verified 07/15/16 14:42)

Medication List

Birth Control Pill 07/15/16 [History]

Social & Family History:

- Substance Abuse/Social Hx
Smoking Status: Never smoker

Review of Systems:
Constitutional: fever - Few days ago she had fever
ENT: No: nasal congestion
Respiratory: No: cough, difficulty breathing
Cardiovascular: No: chest pain
Gastrointestinal: nausea, vomiting. No: abdominal pain, diarrhea

Genitourinary: No: painful urination, vaginal discharge, vaginal bleeding
Musculoskeletal: No: neck pain, back pain
Neurological: No: headache
Integumentary: No: rash
10 systems reviewed: as above otherwise negative

Physical Exam:
Vital Signs:

	Temp	Pulse	Resp	BP	Pulse Ox
07/15/16 18:16		139 H		100/57 L	93
07/15/16 16:20	97.6 F	129 H	17	94/59 L	91
07/15/16 14:37	97.4 F	145 H	24 H	105/68	93

Constitutional: no acute distress
Eyes: normal sclera, PERRL, EOMI, Other - She has conjunctival pallor. no: scleral icterus
ENT: oropharynx appears normal, dry mucus membranes. no: nasal congestion, pharyngeal erythema, pharyngeal exudate
Respiratory: normal rate, lung sounds clear. no: respiratory distress, wheezing, rhonchi, rales
Cardiovascular: normal rate, regular rhythm, peripheral pulse(s) - Symmetric radial pulses. no: murmur, delayed capillary refill
Gastrointestinal: soft, bowel sounds present. no: tenderness, organomegaly, palpable mass, distention, hernia(s), rebound rigidity or guarding
Musculoskeletal: head/face atraumatic, extremities atraumatic, normal extremity ROM, extremities non-tender. no: pain with neck flexion, cervical spine tenderness, thoracic spine tenderness, lumbar spine tenderness
Integumentary: normal color, warm & dry. no: rash
Neurological: Other - She is awake and alert. Speech is clear. Mental status is appropriate. No confusion. Equal strength in all extremities.
Psychiatric: Other - She is anxious in appearance

Test Results:
Results: reviewed & interpreted by me to support final diagnosis
Lab Results:

Laboratory Results - last 24 hr

	07/15/16 16:51	07/15/16 17:00	07/15/16 17:48
WBC	10.3		
RBC	4.95		
Hgb	11.8 L		
Hct	35.9		
MCV	72.6 L		
MCH	23.9 L		
MCHC	32.9		
RDW	15.0 H		
Plt Count	304		
MPV	7.4		
Neutrophils %	71.3 H		
Lymphocytes %	23.0 L		

Monocytes %	5.0		
Eosinophils %	0.2 L		
Basophils %	0.5		
Neutrophils #	7.3 H		
Lymphocytes #	2.4		
Monocytes #	0.5		
Eosinophils #	0.0		
Basophils #	0.0		
Nucleated RBCs	0.00		
Nucleated RBCs/100 WBC	0.00		
Sodium	140		
Potassium	4.4		
Chloride	112 H		
Carbon Dioxide	20 L		
BUN	13		
Creatinine	0.8		
GFR Calculation	TNP		
Glucose	87		
POC Glucose			
Calcium	7.6 L		
Total Bilirubin	0.6		
AST	14 L		
ALT	13		
Alkaline Phosphatase	82		
Total Protein	6.5		
Albumin	2.7 L		
Globulin	3.8		
Albumin/Globulin Ratio	0.7 L		
Urine Color		Amber	
Urine Clarity		Cloudy	
Urine pH		5.0	
Ur Specific Gravity		1.025	
Urine Protein		30 mg/dl	

23-JUN-2000 (16 yr)
Female Caucasian

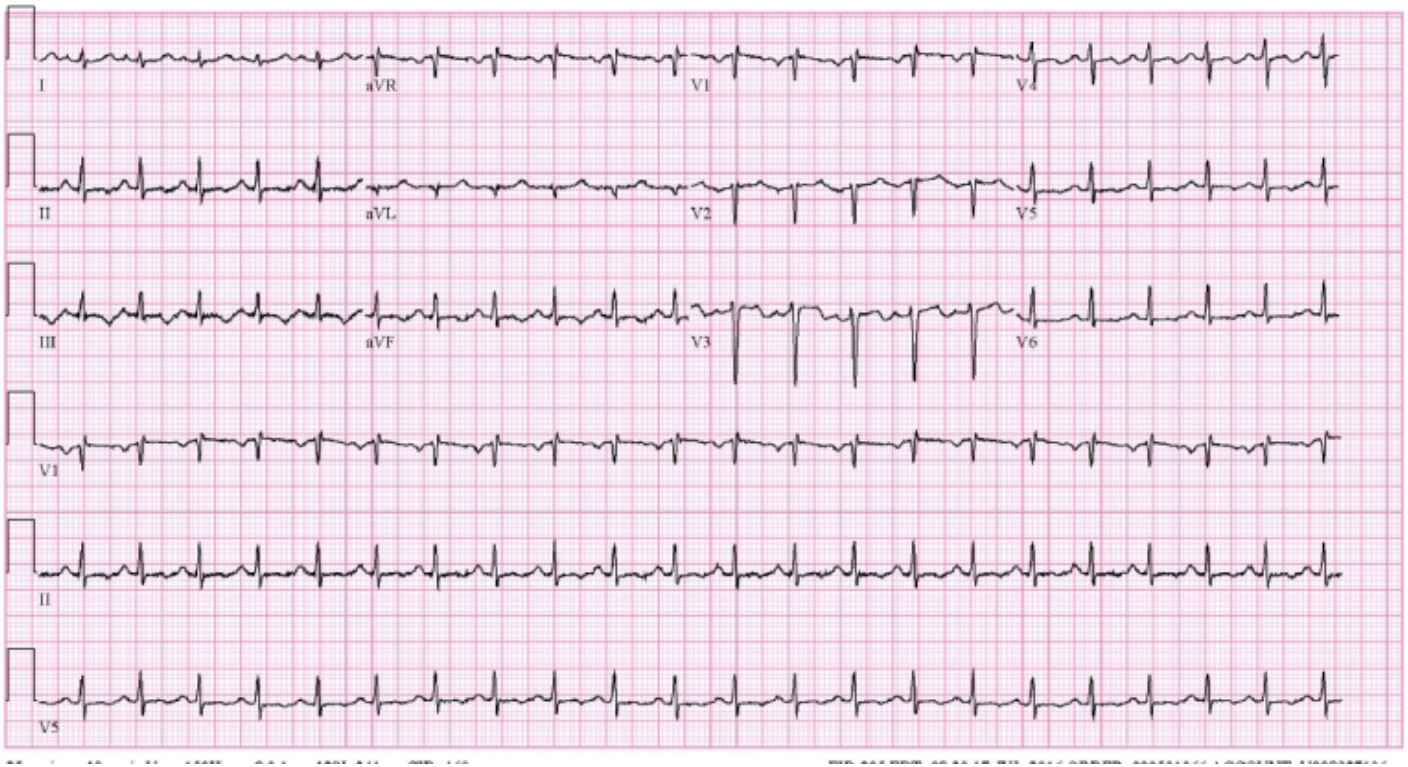
Room:
Loc:11

Vent. rate	132	BPM	Sinus tachycardia
PR interval	128	ms	T wave abnormality, consider inferolateral ischemia
QRS duration	74	ms	Abnormal ECG
QT/QTc	382/565	ms	No previous ECGs available
P-R-T axes	65 79	-16	Confirmed by BYRNES, M.D., LUKE (205) on 7/17/2016 8:20:11 AM

Technician: SAL
Test ind:SOB

Referred by: JOINES

Confirmed By: LUKE BYRNES, M.D.



Medical Decision Making:
16-year-old female here with nausea vomiting for about a week. No known exposure. She does have some conjunctival pallor. She is anxious in appearance. She is tachycardic but this is probably due to combination of anxiety and dehydration. She was given IV fluids. Was also given anxiolytics.

Labs reviewed. White blood cell count normal. She is mildly anemic with hemoglobin 11. BUN and creatinine are normal. No significant electrolyte abnormality. LFTs normal. Urinalysis not consistent with UTI. She is not pregnant.

She is still tachycardic after IV fluids. She was able to tolerate some oral fluids with Gatorade. Think her persistent tachycardia probably has something to anxiety. Had a long discussion with patient and her parents. Parents are comfortable taking her home. Will give prescription for Phenergan as they do have some Zofran at home but Phenergan seems to work better. I had spoken to Dr. David Berry who came to the ED and reviewed the case. Dr. David Berry did not feel patient needed to be admitted. Discussed with parents recommend she follow up with her primary care provider. If her symptoms worsen or she has inability to tolerate oral fluids should return to the emergency department. Parents are comfortable with this plan.

Disposition:

- Diagnosis & Disposition
Dehydration, Tachycardia

Nausea & vomiting
Qualifiers:
Vomiting type: unspecified **Vomiting Intractability:** non-intractable **Qualifier Code:** (R11.2)
Nausea with vomiting, unspecified
Home
Improved

- Prescriptions & Referrals
Promethazine [Phenergan (Promethazine) 25 mg tab*] 25 mg PO Q6HR/PRN PRN #30 tab
PRN Reason: Nausea/Vomiting
[redacted], MD [Active Physician] -

- Instructions
Drink plenty of fluids to prevent dehydration. Bland diet as discussed.

Please follow up with your doctor Monday.

Medical Decision Making:
16-year-old female here with nausea vomiting for about a week. No known exposure. She does have some conjunctival pallor. She is anxious in appearance. She is tachycardic but this is probably

Physical Exam:
Vital Signs:

	Temp	Pulse	Resp	BP	Pulse Ox
07/15/16 18:16		139 H		100/57 L	93
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Disposition:

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Improved

- Prescriptions & Referrals
Promethazine [Phenergan (Promethazine) 25 mg tab*] 25 mg PO Q6HR/PRN PRN #30 tab
PRN Reason: Nausea/Vomiting
LOPINA,BART, MD [Active Physician] -

- Instructions
Drink plenty of fluids to prevent dehydration. Bland diet as discussed.

Please follow up with your doctor Monday.

Q1: PE or NOT PE?

Q2: Deviation from standard of care?

Medical Outcome

Goes home, feels intermittently better and worse. Returns to FP office 3 days later with almost identical complaints and vital signs and sent home again.

FP doctor is good friend of family

History of Present Illness:
16-year-old female was brought in by EMS. According to their history patient had collapse. Patient had stopped breathing on arrival to the hospital they never had a good pulse on the patient. They were able to start an IV and was giving her some fluids. No other treatment rendered in the field. Patient could not provide any history. According to the family patient was seen in the ER 5 days ago. That visit was reviewed. Patient apparently had been given IV fluids she had had some continued vomiting. Today she ate a little. She was weak. Apparently while walking up stairs to go back to bed tonight she collapsed. According to family patient had some epigastric abdominal pain.

Teaching points

Teenagers can have PE

Don’t miss oral contraceptives

Don’t write things that don’t make sense

Use the D-dimer liberally in teens on OCPs with signs or symptoms of PE

CASE #3

Healthy 28 year old with mild breathing difficulty

Primary Visit Coverage

Payor	Plan
BCBS OUT OF AREA	BCBS OF VERMONT

Reason for Visit

Breathing Problem

Donnor for stem cell to sister on 10/8. Pt was placed on neupogen for 5 days therefater the collection of stem cells took 2 days. After donation short of breath, some chest pressure constricting breathing. Felt got better, therefater 2 weeks ago breathing getting difficult. Denies whezzing or cough. Took vitals at SCCA O2 sat 91%, pulse 100. Pt is currently taking care of sister at SCCA

Reason for Visit History

Diagnoses

Short of breath on exertion - Primary
ICD-10-CM: R06.02
ICD-9-CM: 786.05

Patient Referred By: No ref. provider found
Patient's PCP: No primary care provider on file.

Subjective:
Patient is a 28 year old male, here to discuss Breathing Problem
The following portions of the patient's history were reviewed with the patient and updated as appropriate: past surgical history, past social history and past family history.

HPI28 year old male comes in with shortness of breath, has felt short of breath since 10/8 - started after donating stem cells to sister (had received shot from SCCA) , started few days prior to starting cephalexin for buttock abscess, denies fever or chills, no cough, feels like breathing is getting worst; got CXR at SCCA and was told it was normal. Denies feeling anxious, able to sleep thru the night, can lay flat on back ; no leg swelling; no hx of asthma, wheezing in the past; earlier today o2 sat was 91% at SCCA, no new food; feels more short of breath going up stairs the last week

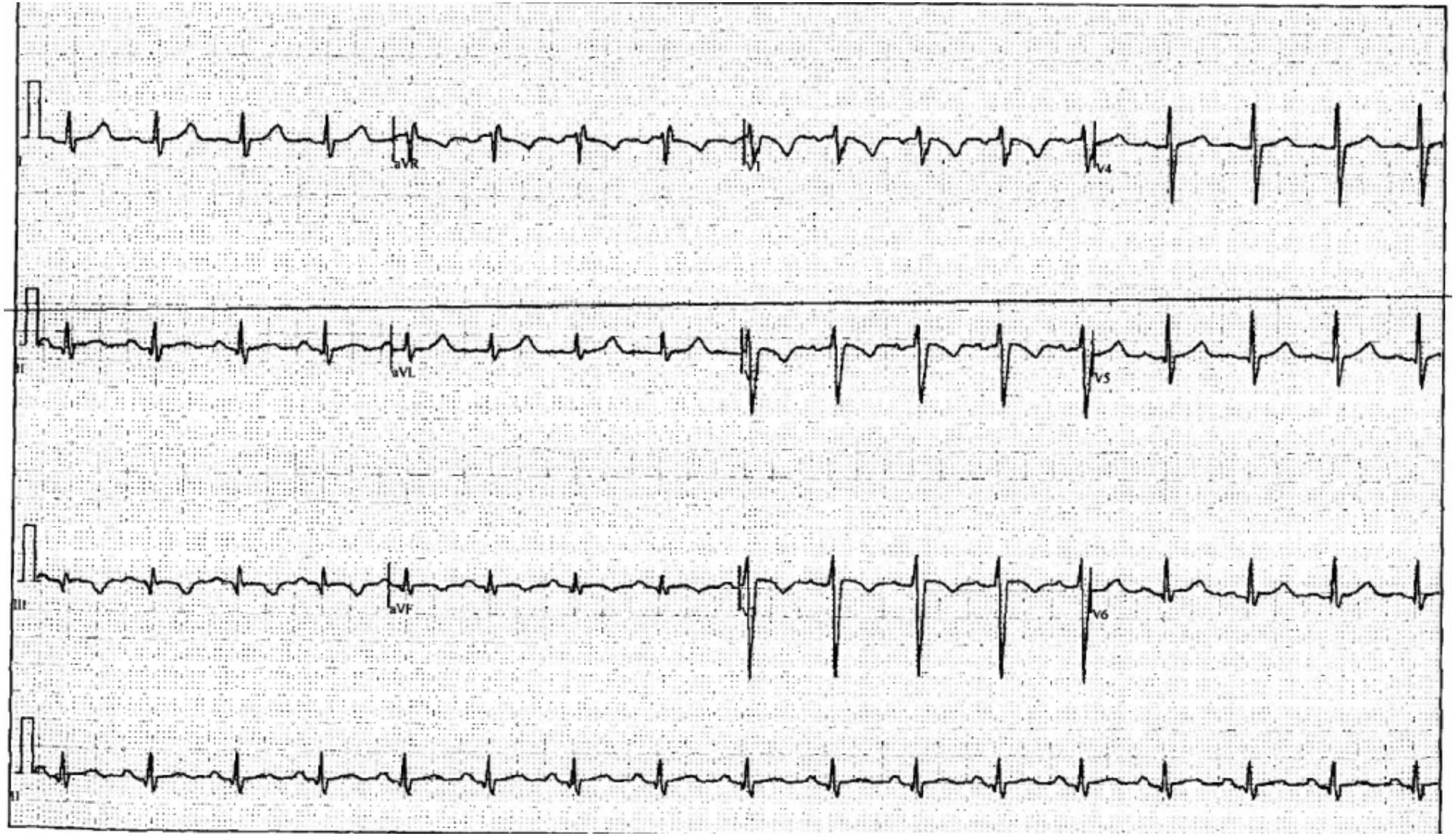
Review of Systems- no fever or chills ; was seen for abscess last week, was lanced

Objective:
Physical Exam
Constitutional: He appears well-developed and well-nourished. No distress.
HENT:
Head: Normocephalic and atraumatic.

Right Ear: External ear normal.
Nose: Nose normal.
Mouth/Throat: Oropharynx is clear and moist. No oropharyngeal exudate.
Eyes: Conjunctivae and EOM are normal. Pupils are equal, round, and reactive to light. Left eye exhibits no discharge. No scleral icterus.
Neck: Normal range of motion. Neck supple. No thyromegaly present.
Cardiovascular: Normal rate, regular rhythm and normal heart sounds.
Pulmonary/Chest: Effort normal and breath sounds normal. No respiratory distress. He has no wheezes. He has no rales.
Abdominal: Bowel sounds are normal. There is no tenderness. There is no rebound and no guarding.
Lymphadenopathy:
He has no cervical adenopathy.
Neurological: He is alert.
Skin: Skin is warm. He is not diaphoretic.
No swelling or redness around rectal area
Nursing note and vitals reviewed.
EKG- NSR, no acute ST or T wave change
Albuterol neb - improved air exchange, able to walk, O2 sat 94-97%; PEF 390

Assessment and Plan:
Diagnoses and associated orders for this visit:

Short of breath on exertion
- ECG ROUTINE ECG W/LEAST 12 LDS W/I&R
- Cancel: CBC, DIFF
- Cancel: COMPREHENSIVE METABOLIC PANEL
- albuterol 2.5 mg/3 mL (0.083%) Inhalation solution; Inhale 3 mL (2.5 mg) via nebulizer One time.
- CBC (HEMOGRAM); Future
- COMPREHENSIVE METABOLIC PANEL; Future


aVR
V1
V4
aVL
V5
aVF
V6

stop cephalexin 500 since infection is better, possibly allergy to it
Get blood test if breathing is not improved

Vital Signs - Last Recorded

BP	Pulse	Temp(Src)	Resp	Wt	SpO2
133/92	**104**	97.9 ?F (36.6 ?C) (Temporal)	18	**313 lb (141.976 kg)**	95%

mmHg

Encounter Messages Expand All Collapse All

No messages in this encounter

Allergies as of 10/26/[redacted] **Reviewed On: 10/26/[redacted]**

No Known Allergies

Ordered Medications

	Disp	Refills	Start	End
Albuterol Sulfate HFA (PROAIR HFA) 108 (90 BASE) MCG/ACT Inhalation Aero Soln	1 Inhaler	2	10/26/2015	

Q1: PE or NOT PE?

Q2: Deviation from standard of care?

The next day…

HISTORY OF PRESENT ILLNESS:
28-year-old man with history of depression and recent stem cell donation for his sister who is inpatient on SCCA for hematologic malignancy brought in by medics with CPR in progress.

The patient reportedly called 911 on his own from his residence with shortness of breath. On medic arrival, they found the patient clammy, diaphoretic, in severe respiratory distress with hypoxia and tachycardia. Prehospital EKG w/ sinus tach, right axis deviation, RBBB pattern, TWI in V1-V3, II, aVF. Shortly after arrival, the patient had a syncopal event and went into PEA arrest. He was intubated in the field by the medics. CPR was initiated, and the patient received a total of 30 minutes of CPR prior to arrival. On rhythm checks, the patient had persistent pulseless electrical activity without other rhythm. He received calcium prior to arrival. He arrives w/ CPR in progress, and is unable to provide further hx.

Legal outcome

Defense is “Up to date says no calf tenderness is 90% sensitive for ruling out PE”

And…allergy to Keflex

Causation: ***Dead man walking***

Jury decimated by COVID

Hung jury

Teaching points—case #3

You have to…you MUST know what pulmonary hypertension looks like on ECG

Ask about texting and Google

Do not say the patient has bronchospasm as a cause of dyspnea unless you have evidence of bronchospasm

Do not ever use *Up To Date* for anything

My advice

Dictate and **personalize** your notes: “show your work”, show **empathy**, use **logic**

Write out the truth: “I thought about PE (or ACS, or dissection, or SAH)…but decided not to test because….”

Plaintiff attorneys hate cognitive cases, but they take them when they see weakness to exploit