AMERICAN COLLEGE OF EMERGENCY PHYSICIANS
SCIENTIFIC ASSEMBLY
1999

Advanced Risk Management: How to Avoid Being Sued

Malpractice claims and awards continue to rise in our specialty. Malpractice literature will be reviewed, with the recent trends in awards and risks identified. The presenter will describe approaches to lessen this risk, including practice patterns and interpersonal behaviors that are effective. Strategies for effective risk management while under pressure to reduce costs in the health care environment will be outlined.

- List the areas and behaviors associated with the greatest malpractice risk, the greatest number of claims, and the highest awards in emergency medicine.
- List approaches to effectively manage malpractice risk in emergency medicine.
- Discuss strategies to reduce malpractice risk while also lowering cost.

MO-43
Monday, October 11, 1999
3:00 PM - 4:55 PM
Room # N250
Las Vegas Convention Center

FACULTY

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Emergency Medicine Advanced Risk Management

Instructor:
Daniel J. Sullivan, MD, JD, FACEP

Abdominal Pain

Abdominal Pain

- Consider all the high risk clinical entities:
  - Myocardial infarction
  - Ectopic Pregnancy
  - Appendicitis
  - AAA
  - Testicular Torsion

Abdominal Pain

*Textbook history and physical examination focused on those clinical entities.

- Key:
  - Observation and re-examination
  - The lawsuit-stopper: Follow up instructions.

Abdominal Aortic Aneurysm

Abdominal Aortic Aneurysm - Litigation Overview

- The Legal Fiction

*Inadequate History or Risk Analysis

- AAA presents as flank pain or LLQ pain
- Complaint and Sign Integration

Abdominal Aortic Aneurysm - Litigation Overview

- **Syncope**
- *Imaging Study Issues
- *Patient Management Post Diagnosis

FTD Abdominal Aortic Aneurysm: Case Review

- 63 Y.O. male with abdominal pain, lightheaded and diaphoretic during BM.
- In tbe ED, BP 104/54 with tenderness in the LLQ. Dr. Diverticulitis and discharged.

FTD Abdominal Aortic Aneurysm: Case Review

- A 68 y. o. male entered the ED with complaints of Severe pain in abdomen and back, extending to left flank. LLQ tenderness.
- Discharged with ureteral colic.
- Developed paraplegia from AAA. 1.3 million.

AAA - Delayed or Improper Management

- 73 y.o. with abdominal pain and low back pain with a history of lightheadedness and diaphoresis and BP 90/50 in the ED and blue toes.
- ED physician makes the diagnosis but surgery delayed for five hours.
- Patient death. 1.7 million.

FTD AAA - Key Points

Know when to put AAA in the Differential Diagnosis.

- Suspect AAA in every elderly patient with
  - -Abdominal pain
  - – Back pain
  - – Syncope
  - – Change in LOC
  - -Pain in testicle or flank

Create a Record

*Physical examination

-Textbook abdominal examination

-Make the chart reflect your search for AAA

*Abdominal exam -No pulsatile mass

*Femoral pulses 2 + and equal

- LLQ no mass or tenderness

- Know Your Limitations
- Complaint and Sign Integration
- Believe the patient's description of events.

Department Recommendations

*Triage and ED staff must recognize the 'seconds to minutes emergencies.

- Quality improvement on abdominal pain charts.

Admission Orders

Admission Orders

- Does writing admission orders increase the risk of exposure to liability?
- ACEP's Position

-No ambiguity about patient responsibility

– EP is responsible for what occurs in the ED

– The EP should not be compelled to write orders which extend or appear to extend control and responsibility of the patient to tbr inpatient setting

Admission Orders

- Reality Check

*Strategy for Writing Orders

– Get the PMD to give telephone orders to you or the RN

-Time limits on EP orders

– No EP order writing for critical care patients

Admission Orders

- Strategy for Writing Orders (cont.)
  - -Limit the types of orders the EP can write
  - Medical Staff Bylaws statement on patient responsibility
  - ED rules and regs: "EP may write orders as a courtesy to the PMD"

Against Medical Advice

Against Medical Advice

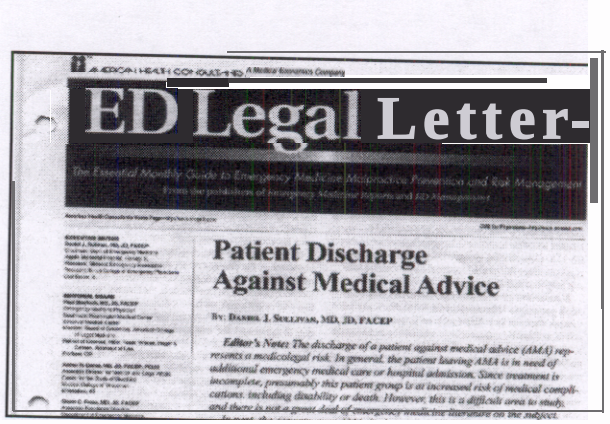
- Do not let the patient's decision affect your duty to provide the best care possible
- Take all steps to provide treatment and follow-up to the best of your ability, under the circumstances
- Document your efforts

Against Medical Advice

- Document functional competence.
- Explain the life or limb threat very carefully nod document the informed refusal.
- Have a second person witness and document the refusal.
- Provide the patient with the opportunity to change his or her mind.

Against Medical Advice

- Beware AMA in the patient with head trauma or EtOH.
- AMA is a process, not a form!
- AMA, properly done, will win a lawsuit.


ED Legal Letter-

The Essential Monthly Guide to Emergency Medicine Malpractice Prevention and Risk Management

Patient Discharge Against Medical Advice

By: Dannis J. Sullivan, MD, JD, FACEP

Editor's Note: The discharge of a patient against medical advice (AMA) represents a medicolegal risk. In general, the patient leaving AMA is in need of additional emergency medical care or hospital admission. Since treatment is incomplete, presumably this patient group is at increased risk of medical complications, including disability or death. However, this is a difficult area to study, and there is not a great deal of emergency medicine literature on the subject.

AIDS - HIV

AIDS - HIV

*Consider common law and statutory obligation to contact third parties at risk

- Prophylaxis standard of care
- Create department needle stick and exposure policy

EtOH

RED FLAG!

*Alcohol intoxication is a red flag.

- Key Points:
  - Don't delay the H & P in the intoxicated patient.
  - -Be aware of the high risk of head trauma nod spinal injury.

Allied Health Professionals

Allied Health Professionals

- Used with increasing frequency, sometimes inappropriately

*Malpractice Experience - Unknown

- Issues:
  - -Protocols
  - -Supervision

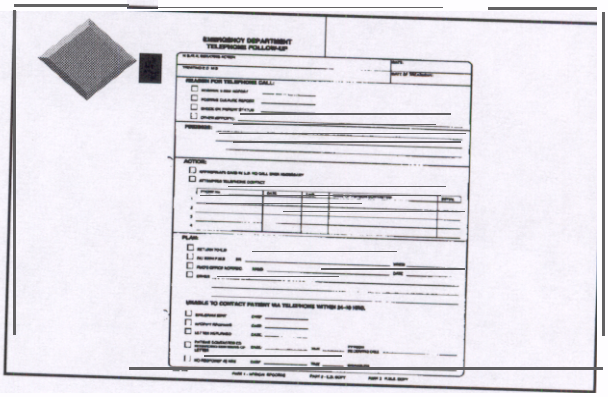
Amended X-Ray and Lab Follow-Up

Amended X-Ray

- For various reasons, emergency physicians misread x-rays.
- Amended x-ray systems can have a clinical impact.
- This system is protective.
- Make sure the system works well!

Lab Follow-Up

- Certain labs need a follow up (e.g., blood cultures)
- Patient and PMD contact should be timely
- Result and action taken must get into the medical record
- Recommendation: Use a form for F/U on x-rays, labs, etc.



The Failure to Diagnose Appendicitis

Litigation Overview

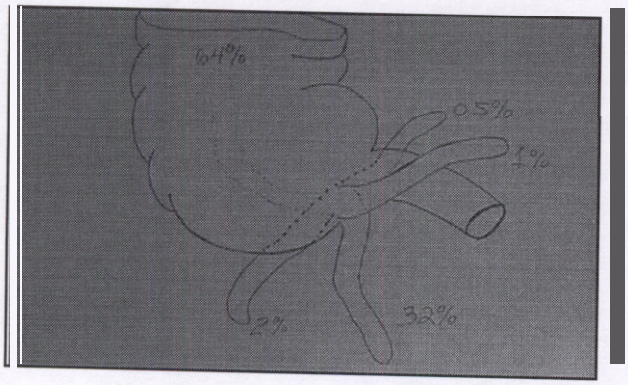
- The Atypical Case
- Recurrent Appendicitis
- The Lab Causes a Delay
- *Misdiagnosis of Gastroenteritis

Litigation Overview

- **Inadequate** Physical Examination
- **Observation and Re-Examination**
- **Narcotics** Mask the Pain
- *Inadequate Discharge Planning

Why is This Diagnosis Missed?

- *Appendicitis often has the clinical appearance of **gastroenteritis**
- **The** position of the appendix relative to the **cecum**



Why is This Diagnosis Missed?

- The physician's lack of familiarity with recurrent appendicitis
- The failure to observe and evaluate the patient's condition **over** a period of time.
- Diagnosis **can** be very difficult in the very young, the very old and in pregnant women.

Why is This Diagnosis Missed?

- **It** is very difficult to differentiate between appendicitis and PID.
- **In** some cases the diagnosis simply can't be made.

FTD Appendicitis - Recommendations

- **Complete,** textbook abdominal **examination,** including:
  - -genitalia
  - – pelvic
  - – rectal
- **Re-examination** of all cases of abdominal pain

FTD Appendicitis - Recommendations

*Document **wellness**
- -No pain
- –**Benign** re-examination
- -Taking food and fluids **well**

FTD Appendicitis - Recommendations

*Document continuing **or** worsening pain and:
- -Observe
- -Consult
- -Admit

FTD Appendicitis - Recommendations

Discharge:
- **"Abdominal** Pain - Cause **unknown"**
- **Mandatory** follow-up at 8-24 **hours** to PMD or ED

FTD Appendicitis - Recommendations

- **Telephone** follow-up by charge nurse or EP
- **Return** if condition worsens

Failure to Diagnose Myocardial Infarction

Chest Pain: Missed AMZ

- **At 12,500-50,000** missed **AMIs/yr (incidence** of suits unknown) case rate **of $150-300** K, *emergency* physician exposure is staggering **(>2** billion)

Chest Pain: Litigation Overview

*Misinterpretation of the ECG.

-Missed obvious changes of AMI

-Not recognizing serial changes

-Failure to order old EKG for comparison

-Failure to recognize the importance of the non-specific EKG change.

Chest Pain: Litigation Overview

- Failure to take and record a careful history.
- Failure to recognize the "unusual" presentation.
- Misinterpretation of bedside maneuvers, especially the GI cocktail.

Chest Pain: Litigation Overview

- Failure to recognize the importance of a history of CAD.
- Ruling out AMI with a normal EKG.

Case Review - Case # 1

- 66-year-old with substernal chest and left arm pain.
- No new EKG changes.
- P.E. was unremarkable.
- Discharged.
- The patient died within 10 hours.

- The defendant emergency physicians argued:
  - -that the chest pains bad subsided in the ED, and
  - -the left arm pain had been ongoing for 2 days.
- Therefore, it was musculoskeletal pain.

Case Review - Case # 2

- A 38 y.o. male with a history of CAD experienced substernal chest pain and epigastric burning.

*The pain radiated into his arm.

- The EKG was normal.

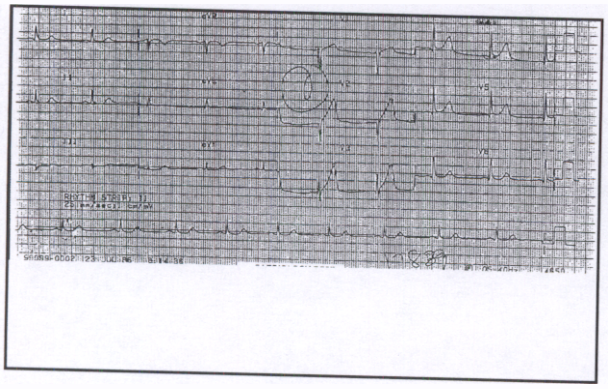
*The EP diagnosed reflux esophsgitis.

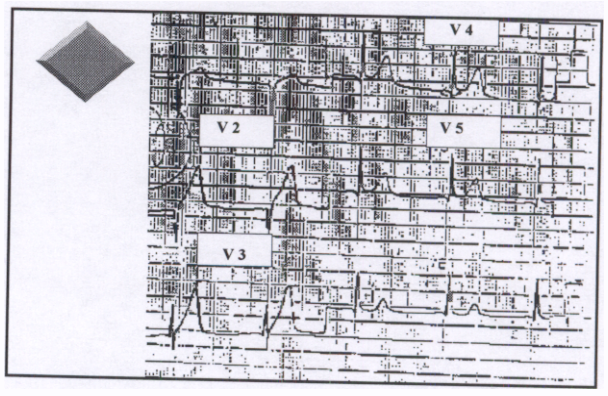
- He died that night from AMI.

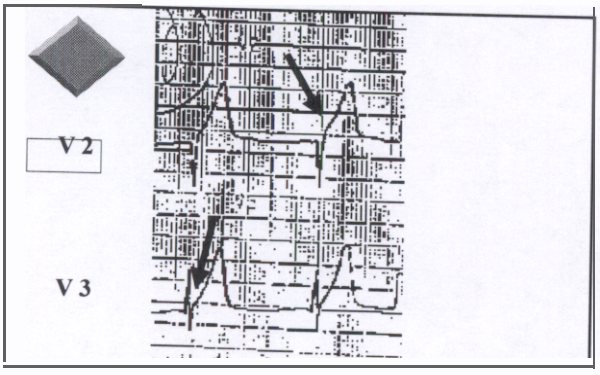
Case Review - Case # 3

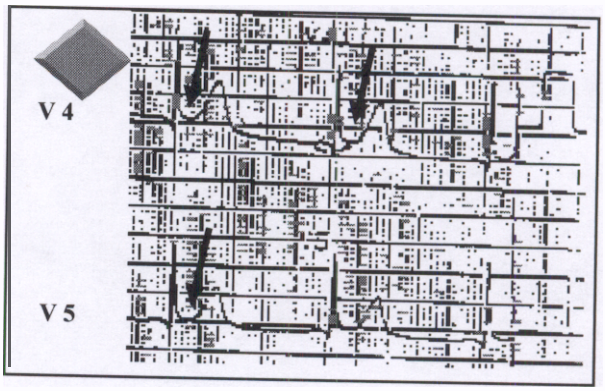
- The patient was a 58-year-old male who complained to the triage nurse of intermittent pain in the left shoulder for months, worse for 2 days.
- The emergency physician noted "patient in no distress."
- The P.E. was unremarkable.

- The pain was relieved post Demerol plus Vistaril.
- The physician read the EKG as no acute changes.
- Review EKG





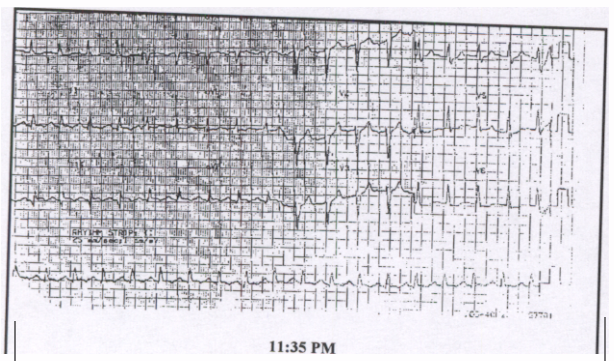




Case Review - Case # 4

- A 45-year-old male who awoke from sleep with left anterior chest and jaw pain.
- The pain responded to 2 sublingual NTG.
- The pain lasted < 5 min. There was no shortness of breath or diaphoresis.

- The patient had a history of pacemaker insertion secondary to CAD and had a CABG 10 years prior.
- The physician ordered two sequential EKGs which showed signilicnnt changes and progression of ischemia.
- Review the EKGs.



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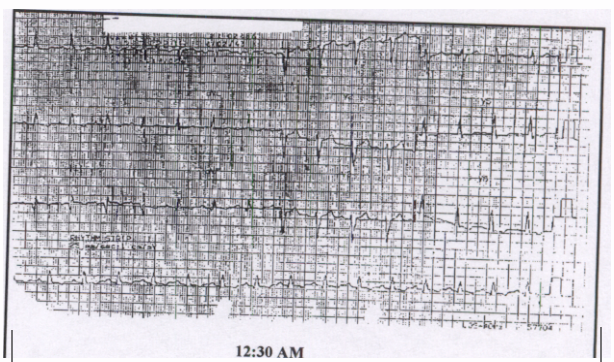

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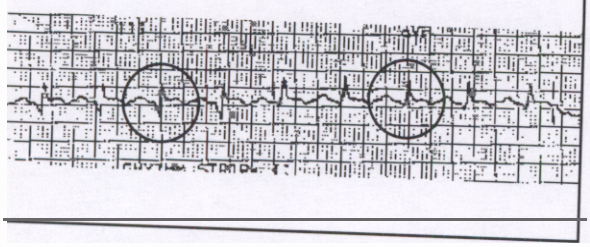
Lead AVF



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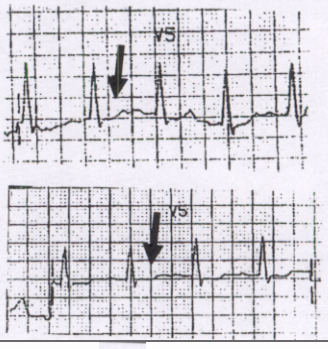
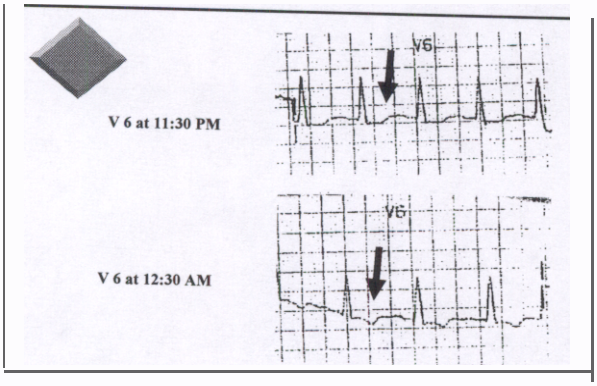
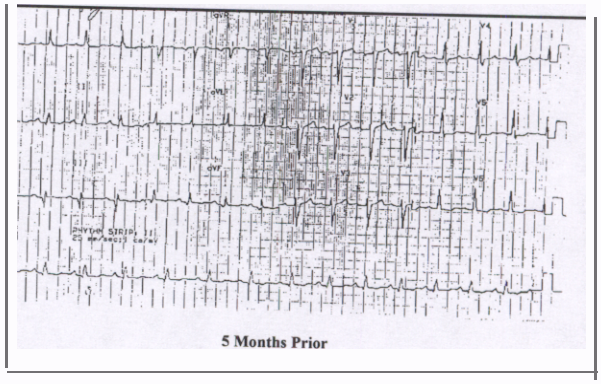
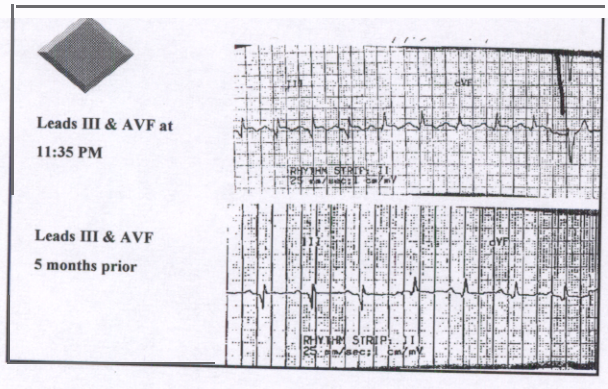


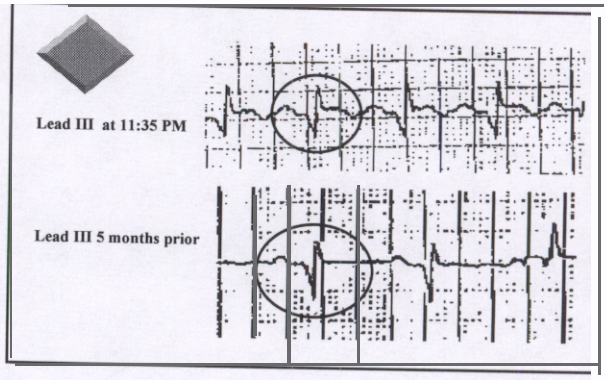


- **The** patient was discharged witb a diagnosis of **"acute** chest **pain** resolved, ? **angina** snack."
- **The** patient died of acute MI 12 **hours** post-discharge.

- The physician never asked for an old EKG which was available in medical records.
- **Review** the old EKG.



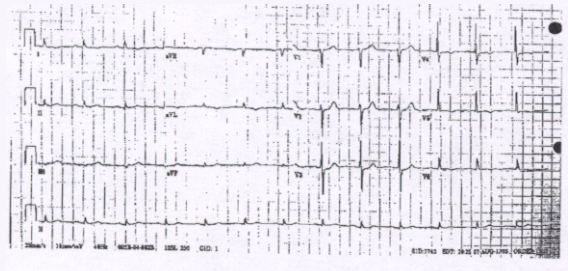




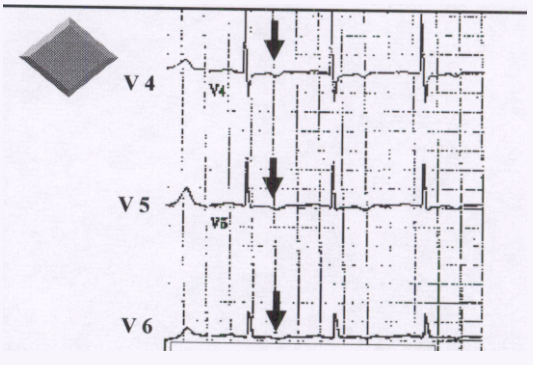
Case # 5 - No Acute Changes

- 72 y.o. male presented to the emergency department with a burning epigastric pain for 4 days.
- Nursing note states the patient had mid chest pain, unable to sleep lying down, and sweating.
- He had a lot of gas.
- He had a history of diabetes and HTN

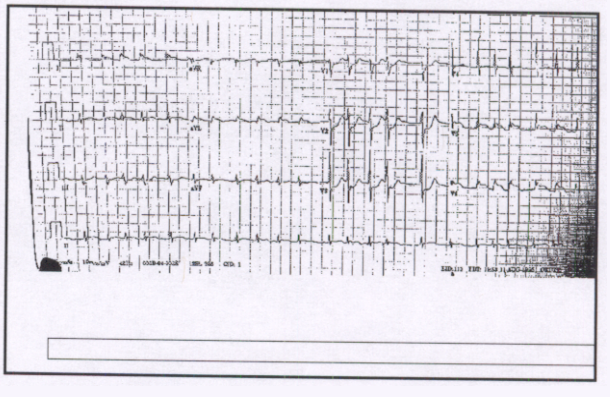
- The private physician had sent the patient in to get checked out in case it was a heart attack.
- The emergency physician noted "there has been no chest pain."
- The emergency physician read the EKG as "NSR, no changes."
- Review the EKG.

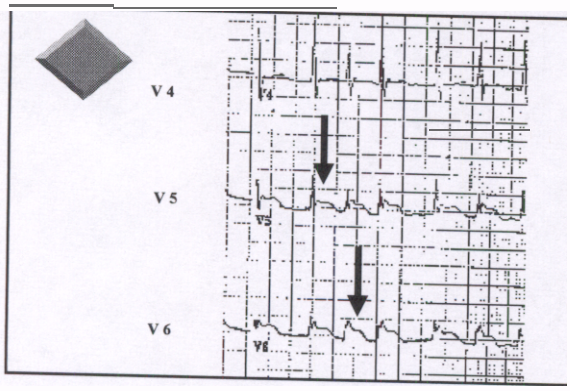


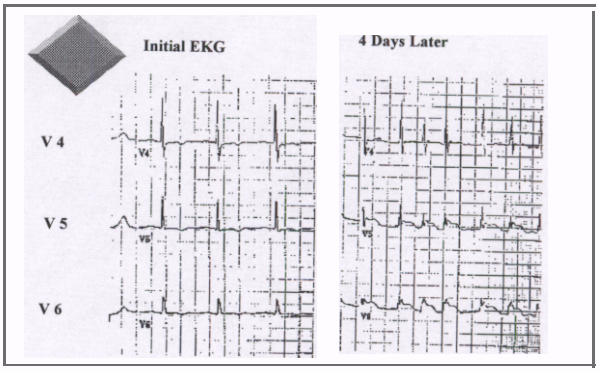
Non-specific EKG changes - Suggest lateral wall ischemia



- One of the nursing notes during the ED visit stated that the patient gets nauseated and sweaty when the pain is bad.
- The EP diagnosed a GI problem and discharged him with esopbagitis.
- The patient returned 4 days later with an *cute lateral wall infarct.







Managing the Risk of AMI

*Prevent the "true misses."

- **Don't** be misled by bedside maneuvers.
- Recognize that the "normal" EKG **may** be **c/w AMI.**
- A "non-specific" is **a** positive finding with C.P.

Managing the Risk of AMI

- **Low** threshold for consultation
- Know the "unusual" presentations (i.e. variant **angina)**
- **Institute a** missed **AMI case** and EKG review
- **Don't** rely on EKG computer interpretation

*Rule Out Programs

Thrombolysis

Thrombolytic Therapy - Litigation Overview

*Standard of care - **Reperfusion** therapy

*Failure to administer

- **– FTD AMI**
- -Fail to recognize other indications (e.g. new **BBB)**

Thrombolytic Therapy - Litigation Overview

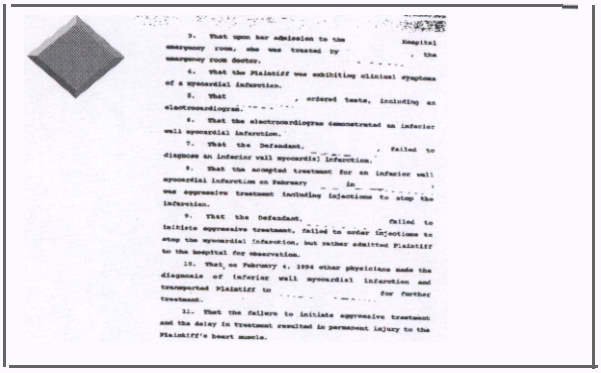
- **Delayed** administration
  - -Admission without administration
  - -Reliance **upon a** cardiologist or PMD
- **Improper** administration (e.g. contraindication)

Thrombolysis Case Review: A Case of Bad Lawyering

- **A** 54 **y.o.** male presented to **an** emergency department with chest pain.
- **He** ultimately had an acute MI.
- **There were no** changes on the initial EKG diagnostic of acute MI.

*The plaintiff brought his **case** on one issue only:

"The EKG was diagnostic of inferior wall acute MI, and the emergency physician failed to administer **a lytic** agent."



3. That upon her admission to the Hospital emergency room, she was treated by , the emergency room doctor.

4. That the Plaintiff was exhibiting clinical symptoms of a myocardial infarction.

5. That , ordered tests, including an electrocardiogram.

6. That the electrocardiogram demonstrated an inferior wall myocardial infarction.

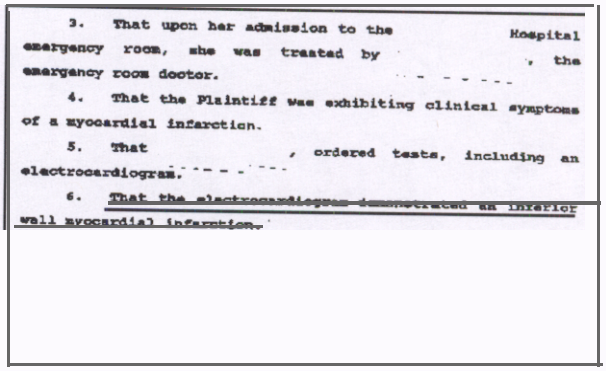
7. That the Defendant, , failed to diagnose an inferior wall myocardial infarction.

8. That the accepted treatment for an inferior wall myocardial infarction on February in , was aggressive treatment including injections to stop the infarction.

9. That the Defendant, failed to initiate aggressive treatment, failed to order injections to stop the myocardial infarction, but rather admitted Plaintiff to the hospital for observation.

10. That on February 4, 1994 other physicians made the diagnosis of inferior wall myocardial infarction and transported Plaintiff to for further treatment.

11. That the failure to initiate aggressive treatment and the delay in treatment resulted in permanent injury to the Plaintiff's heart muscle.



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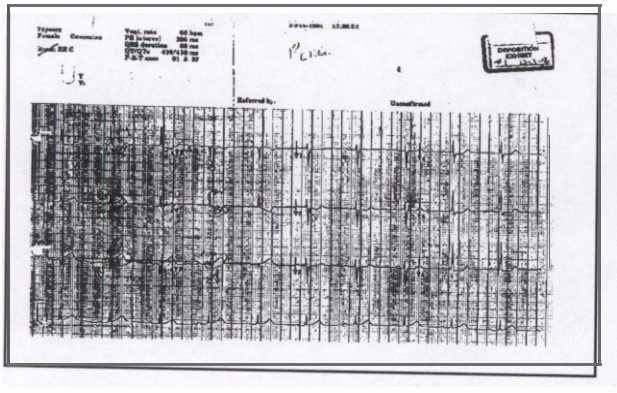
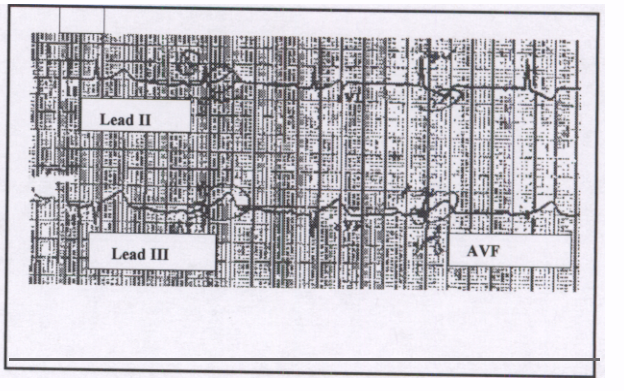
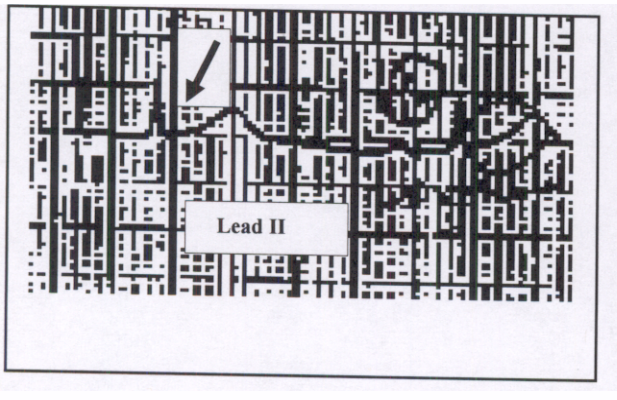
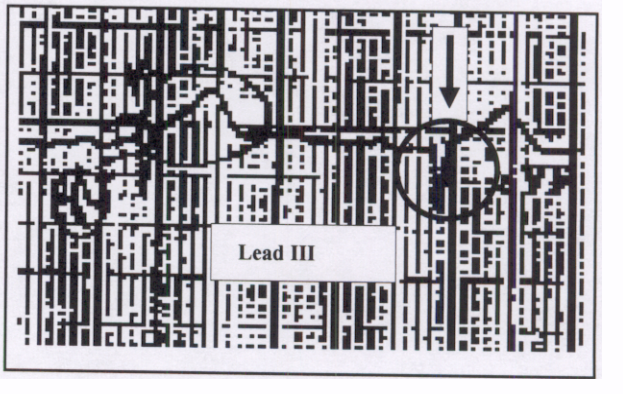
The Case Turns on the EKG

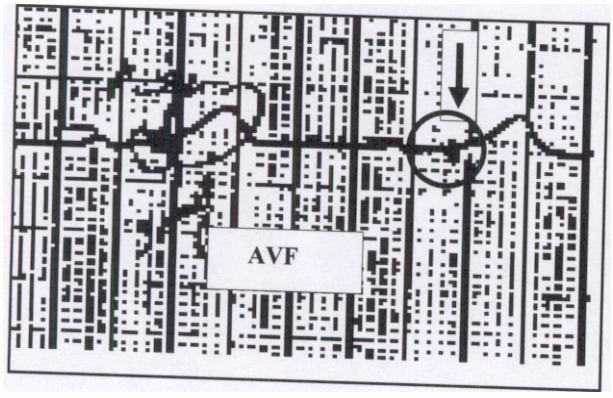
- Review the EKG and look for signs of inferior wall MI.
- Does this EKG demonstrate the ST segment criteria for acute MI?











- The lawyer tried to convince the jury that there was diagnostic ST segment elevation in the inferior leads.
- The defense emergency medicine expert got into the jury box with a ruler and the EKG and demonstrated to every juror that the EKG did not meet criteria for lytic administration.

- Defense verdict - The jury *was* out for 12 minutes.

The jury relied on the standard of care.

- The literature is clear that patient's who do not have the requisite ST segment elevation do not benefit from lytic administration.

Communication & Professionalism

Communication & Professionalism

- What prompts patients to sue doctors?
- A review of 3787 pages of litigation transcript

- Arch Int Med (1994) 154(12)

Communication & Professionalism

- Devaluing the patient and/or family views
- *Delivering information poorly
- Failing to understand the patient and/or family perspective
- Devaluing the patient and/or family views.

Communication & Professionalism

- The literature consistently shows that the quality of the patient-physician relationships has an impact on the frequency of malpractice litigation.
- Silence may be golden, but it causes malpractice suits.

Problem Areas

- *Patient anger
- Perceived incompetent care - "The physician never examined me."
- *Unrealistic expectations
- 3 Fellow health care providers comments

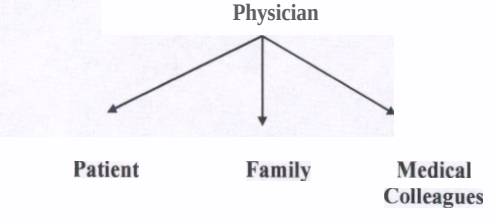
Communication & Professionalism

Recommendations:

- Make eye contact
- Touch the patient in greeting
- Sit down; it changes the patient's perception.
- Let the patient help in decision-making.
- Telephone follow-up
- Close the door (if there is one)

Key to Risk Redaction

Effective Communication



Discharge & Disposition

Discharge and Disposition

- A key moment in the patient-physician relationship
- Many lawsuits hinge on what happens in these few moments
- Correctly done, shifts some responsibility to the patient

Discharge and Disposition

- Close follow-up is your hedge in high-risk cases
- Think logically through each discharge decision
- Phone follow-up is a blessing

The Patient - Physician Relationship & Duty to Third Parties

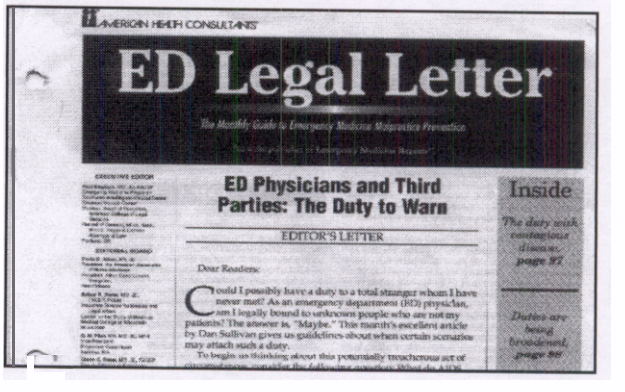
Does the EP have a legal relationship with:

*The patient in the ICU whose x-my she just checked for NG tube placement?

- The child in the waiting room with a temp. of 103 F?

Does the EP have a legal relationship with:

- The patient sent in by the PMD for direct admission, perched in your ED?
- A 2 y.o. child en route to your hospital with shortness of breath?
- When does the relationship end?


AMERICAN HEALTH CONSULTANTS

ED Legal Letter

The Monthly Guide to Emergency Medicine Malpractice Prevention

ED Physicians and Third Parties: The Duty to Warn

EDITOR'S LETTER

Dear Readers:

Could I possibly have a duty to a total stranger whom I have never met? As an emergency department (ED) physician, am I legally bound to unknown people who are not my patients? The answer is, "Maybe." This month's excellent article by Dan Sullivan gives us guidelines about when certain scenarios may attach such a duty.

To begin us thinking about this potentially treacherous set of

Inside

The duty with contagious diseases, page 97

Duties are being broadened, page 80

Duty to Third Parties

- **At common** law, no duty to protect one **person** from another.

*Courts are increasingly recognizing the physician's duty to third parties.

- **Classic** case: Tansoffv. Regents of the University of California.

Duty to Third Parties

- **General** Premise: You **are** required to use reasonable care to protect your patient, and you may be required to prevent reasonably foreseeable injuries to third parties.

Duty to Third Parties

Does the EP and ED staff have **a** duty to keep third parties safe from harm?

+A patient you sent home with **an** eye patch gets in **a** ear accident. You did **warn** about driving. The driver of the other car sues you for negligent discharge.

Duty to Third Parties

Does the EP and ED staff **have a** duty to keep third parties safe from harm?

- **A 25-year-old** homicidal patient absconds because you did not restrain him.
- He kills **a** patient on the sidewalk outside the ED. Are you liable?

In-House Emergencies

- **Recognize** as **a** high risk venture.
- **Good** Samaritan coverage may apply.
- **EPs** will want to be sure that their malpractice insurance policy specifically **covers** in-house.

*In-house **can** only be covered **when** it is reasonable to leave the ED.

Pediatric Meningitis

Missed Meningitis - Common Fact Patterns

- **Febrile - Illness: Non-CNS focus of infection.**
- **Febrile Illness: Apparent CNS FOCUS.**
- **Neonatal meningitis**
- **Hyperpyrexia**

Missed Meningitis - Common Fact Patterns

- **The Febrile Seizure**
- ***Delay in Antibiotics**
- **Other non-CNS pediatric conditions.**

Risk Management Recommendations

Take the Team Approach

- ***Get the emergency department organized in the approach to the febrile child.**
- **Train nursing and triage personnel to recognize and expedite the care of sick children.**
- **Re-check febrile children in the waiting room on a regular basis.**

Take the Team Approach

- **Try and get the medical staff involved.**
- **Schedule next day office visits if possible, or a return to the ED.**
- **Get the staff involved in telephone re-cheeks.**
- **Keep a log or permanent record of staff and patient call-backs.**

Communication Skills

- Fine tune your communication skills.
- Make a connection with the family.
- Make eye contact, sit down, and listen carefully.
- Take enough time with the family to piece together the subtle clinical clues.

Communication Skills

- Communicate your professionalism via a tbomugh physical examination.
- When you leave the examination mom, let there he no mistake, that child was thoroughly examined.

Quality Improvement

- Educate the entire department or office staff regarding the expectations.
- Perform a regular review of the medical records of children with fever.
  - -Vital signs and repeat temps
  - -Neck exam, Kernig and Brudzinski
  - -Wellness evaluation or observation score
  - -Discharge instructions, mandatory re-check

The Febrile Child Summit

- Schedule a febrile child "summit" between the emergency physicians and pediatricians:
  - –Create a channel for communication.
  - -Decide on the age cutoff for full septic work-ups in neonates.

- -Create a follow-up program fur febrile children.
- -Decide on the approach to the febrile seizure.

Red Flags

- Recognize the red flags in the management of the febrile child:
  - -Complaints of lethargy or irritability
  - -Breathing abnormality or significant diet change
  - -Temperature over 106

Be Aggressive

- Set a low threshold for when you decide that meningitis is in the differential diagnosis.
- Once you have made that decision, the clock is ticking.
- The diagnostic evaluation and initiation of antibiotics should occur at the earliest possible time.
- Communicate this urgency on the record.

Follow Your Rules

- After you have made decisions on best practice, stick with them.
  - -Septic work-up in neonates
  - -Febrile seizures
  - -Discharge
  - -Telephone follow-up

Create A Record

- You can't know which febrile child will go on to develop a serious bacterial infection.
- You can't know which child with other non-specific complaints will develop a serious illness.
- Take the same risk managed approach in every case.

Refusal of Care

Refusal of Care

- LWOT
  - -Left the waiting room; no authorization from the MCO
  - -Left the waiting room; did nut want to wait

LWOT - No authorization from MCO

- MCO denial does not change the duty under EMTALA.
- Document tbe offer of a screening exam and treatment.
- Make sure the document becomes part of the permanent medical record.

Refusal of Care

Parent refuses care for a minor:

- If non-emergency courts support parents decision
- If emergency, courts mandate treatment. Therefore, treat, and consider taking temporary protective custody.

Refusal of Care

Parent refuses care for a minor:

- Courts assert the states interest in protecting the child.

*Parents may not make martyrs out of their children.

Religious Beliefs

Jehovah's Witness

- Transfusion will lead to loss of eternal life.
- NO whole blood, packed cells, white cells or plasma.

Religious Beliefs

Jehovah's Witness

- No autotransfusion of pre-deposited blood.
- Many permit the use of albumin, immunoglobulins, hemophiliac factor, hetastarch, dialysis and heart lung equipment.

Refusal of Care

Based on Religious Belief:

*Patient competent - Respect his/her wishes

- Patient not competent:
  - -Patient's wishes clear: withhold tx.
  - -Patient's wishes not clear: treat
- Don't go it alone

Subarachnoid Hemorrhage

Litigation Overview

Recognizing Critical Historical Factors

- The physicians failure to recognize the clinical significance of certain historical factors.
- In many of these cases, the diagnosis should have been suspected.
- Consider the following malpractice cases. In each case, the physician did not consider SAH or initiate a diagnostic work-up.

- A 34 y.o. male was taken by ambulance to the hospital for complaints of a "sudden onset of a severe headache."
- A 29 y.o. female presented with a headache that "started abruptly and was quite severe."

- A 36 y.o. female with a "sudden onset of a headache while watching TV last night."
- Each of these patients was discharged nod returned later with an SAH. In each case, the physician was sued for the failure to diagnose.

Risk Analysis

- In these cases, the physician failed to perform a careful risk analysis.

*Sometimes an obvious clue is missed because there is no risk history.

CT-LP

- The failure to perform a lumbar puncture after a negative CT scan when the physician has a high clinical suspicion of SAH.

The Non-Specific or Transient Neurologic Change

- These cases involve the physician's failure to recognize non-specific or transient ❑ eurologic changes.

Triage Pain Shots

*The emergency physician fails to perform a complete examination or does no exam because the private physician or neurologist has called in an order to for a pain shot

- The patient is treated discharged.

The Sentinel Bleed

- The patient has had a small sentinel leak from the aneurysm, or possibly a small bleed into the wall of the aneurysm resulting in a headache of mild to moderate severity, or perhaps some subtle neurologic changes such as dizziness, photophobia, etc.

The Legal Fiction

- These are malpractice cases focused on an ED or clinic visit where the patient had a headache but the SAH was not present or was sub-clinical.
- However, because of the temporal relationship of the visit to the ultimate bleed and poor documentation, the clinician is named in the suit,

- With good documentation of a complete exam this case results in a defense verdict.
- It is surprising how often the neurologic exam is missing from these records.

Risk Management Recommendations

Suspect SAH in Patients With:

*Acute onset of headache

- Nausea or vomiting
- Neck pain
- Seizure

*Altered mental status or other neurologic signs

History is Critical

- The standard of care mandates a complete neurologic history and physical in headache patients.
- Prior to discharge, the pbysicinn should he able to document that:
  - -this is riot the worst headache ever, and if relevant,
  - -the pain not different form other headaches.

Focused Physical Examination

- Vital signs
- Fuuduscopic exam
- Neck exam
- Neurologic exam

  mental status, cranial nerves, motor & sensory, Babinski, cerebellar signs, gait

CT - LP

*When the diagnosis is entertained, unenhanced computed tomography of the brain should be performed emergently.

- If CT is negative, lumbar puncture is always indicated when the suspicion of SAH is high.

Threshold Statements: The Call to Action

- Certain phrases result in an aggressive SAH work up, such as:
  - -"the worst headache of my life"
  - -"sudden onset of severe pain"
  - –"have never had a headache like this"

Exam, Observe, Re-Exam

- A period of observation and a re-examination represent good patient care, and are very protective in the event of subsequent litigation.

*Add a telephone follow-up and you can provide a very convincing case to the jury.

Headache Monitors

- Rate of onset of the headache
- Severity
- Use of CT and LP
- Documentation of the neuro exam
- Patient's condition after observation and before discharge
- Telephone follow-up

Telephone Advice

Telephone Advice

- **ACEP:** Against any substantial diagnosis or treatment recommendation by telephone.
  - -Patients recently discharged may call for additional explanation (meds, instructions, etc.)
  - – First aid and access to care
  - -Advice by qualified professionals
  - -Quality assurance

Telephone Advice

- Literature: Most telephone advice is wrong.
- Advice may create a patient- physician relationship
- Any delay in treatment may result in litigation

Telephone Advice

- Booming market in telephone advice
- Strongly recommend use of policies, protocol, and system for documentation

Wound Care

Wounds

Why are there so many wound-related lawsuits?

- Frequent ED complaint
- Inadequate history and exam
- Complications nut discovered if not suspected
- Failure to obtain x-ray

Wounds

Why are there so many wound related lawsuits? (cont.)

- Mistaken reliance on "normal" tendon function
- Inadequate wound care
- Reluctance to use a consultant
- Inadequate discharge instructions

Wound Care: Recommendations

- Careful history

*Assume complications until proven otherwise.

- Complete exam for foreign body, tendon and joint injury.

Wounds

- Consider a F.B. during each exam
- Ortho consult in high pressure or knuckle injuries

Wounds

- X-ray for lacerations with metal or glass.

3 Protocol for ED wound care

*High index of suspicion for retained F.B.

Wounds

- Careful discharge planning:
  - -possible missed F.B.,
  - -wound checks,
  - -preprinted wound care instructions