

Afterword: High Success Approach

Emergency physicians care for a high volume of critically ill and injured patients, generally with no prior knowledge of patients' histories and, usually, with little or no warning of patients' arrival. Despite the careful, knowledgeable, compassionate practice of most emergency physicians, bad outcomes will occur. There is no way to completely avoid being named in a malpractice suit because a patient, patient's family, or patient's estate may sue despite the emergency physician's best efforts. However, there are some principles that may help minimize adverse outcomes and avoid litigation.

PRIORITIES

When evaluating a patient, the clinician should try to consider all threats to life, organ, and limb, and systematically rule them out. Many entities can be ruled out by history and physical; some will require ancillary testing or even admission. Mentally considering life, organ, and limb threats is probably the best way to avoid missing them.

High-risk Areas

Keeping in mind certain high-risk areas in the practice of emergency medicine can help the emergency physician avoid adverse outcomes that may lead to litigation.

Change of shift

One of these high-risk areas is change of shift, when a patient is already given a diagnosis and the patient is not re-evaluated by the new clinician. Sometimes the patient is discharged without a careful review of the chart or the labs and radiographs, so important findings may be missed.

Repeat visits

A patient who returns to the emergency department (ED) for re-evaluation within 72 hours of an ED evaluation represents a high-risk area. These patients are often written off as problem patients who did not follow instructions properly. Many of repeat patients need a re-evaluation because their discharge instructions were inadequate, their disease worsened, or the initial diagnosis was not correct. A repeat visit should be viewed by the clinician as an opportunity.

Private patients

Private patients fall into a high-risk area because sometimes the emergency physician does not realize that he is responsible for them. Under the Emergency Medical Treatment and Active Labor Act, a medical screening examination for medical emergency must be performed while waiting for the patient's private physician to arrive. The responsibility for the patient is shared between the emergency physician and private physician, and communication between the two may help avoid adverse

outcomes. Private physician's patients coming to the ED for a specific treatment must still be evaluated.

Admitted patients

Patients who are admitted to the hospital may have to wait in the ED for an inpatient bed for prolonged periods. The ED often does not have the physician and nursing resources to re-evaluate and care for admitted patients. The patients and families are often ignored, and if the patient's condition changes it may go undetected, leading to possible adverse outcomes and angry patients and families.

Against medical advice or refusal of care

It is important to ascertain and document that the patient understands his or her medical condition, the recommended treatment, the risks and benefits of the treatment, the risks of refusing treatment, and alternate treatment plans. It is the clinician's responsibility to determine that the patient has the capacity to refuse care or leave against medical advice.

Red Flags

It is important to recognize red flags when they appear.

Myocardial ischemia

In considering myocardial ischemia, recognize that classic symptoms, ischemic EKG changes, diaphoresis, history of coronary artery disease, and radiation of pain place patients at high risk.

Thoracic aortic dissection

When evaluating a chest pain patient, certain findings place patients at high risk for thoracic aortic dissection (TAD): pain of sudden onset at maximum severity, associated neurologic signs and symptoms, chest pain associated with syncope, presumed acute coronary syndrome not responding to treatment or with normal ECG and normal 6-hour troponin, family history of TAD, pregnancy, and new aortic insufficiency murmur.

Subarachnoid hemorrhage

In evaluating a patient with headache, recognize that sudden onset of a severe headache may represent a subarachnoid hemorrhage (SAH), and that family history of SAH dramatically increases the risk.

Abdominal aortic aneurysm

Recognize that abdominal pain, back pain, or flank pain with hypotension is a red flag for abdominal aortic aneurysm.

Pulmonary embolism

Remember to consider pulmonary embolism when there is unexplained tachycardia, tachypnea, hypoxemia, wheezing, or hypotension.

If the clinician is unable to exclude a life threatening diagnosis by history or physical, and there is still a doubt about whether it is safe to discharge the patient, it is safer to work up or admit the patient.

Communication

Communicating your thoughts with the patient, patient's family, and patient's primary care provider (PCP) is also a priority. Introducing yourself to the patient and family in a professional manner, and making it clear that you are the doctor taking care of the patient is helpful in establishing effective communication. Some patients may prefer to accept a small amount of risk rather than undergoing a test or an admission. It is

preferable to discuss openly your thought process with the patient and to involve the patient, family, and even the PCP in the decision. This open discussion may help prevent litigation in the event of an unexpected bad outcome.

Documentation

Careful documentation on the chart of your thought process, of why you do or do not think a patient has certain diagnoses, is also helpful from a medical legal point of view. It is also important to document your conversations regarding testing, therapy, and admission with the patient, the patient's family, and patient's PCP. This communication and documentation may help you demonstrate that there was no negligence in working up complaints that subsequently turned out to be more serious. A chart thoroughly demonstrating your reasoning is especially essential when potentially life-threatening chief complaints such as chest pain, shortness of breath, or headache are felt to be of benign causes.

It is helpful to address inconsistencies in the chart, rather than ignoring them. For example, when the triage note states one chief complaint and you work up a different chief complaint.

Documenting serial examinations in some detail is extremely helpful, and is far superior to simply checking a box that states "patient improved." It is also important to document the patient's condition on discharge from the ED, even for admitted patients.

Discharge Instructions

For patients being discharged, careful documentation of the treatment, including new prescriptions, reconciliation with existing medications, and the follow-up plan is essential. It is also essential that the patient and family understand the treatment (including medication reconciliation) and the follow-up plan, and are able to implement it. Document on the chart that the patient and family understand the treatment and follow-up plan and are comfortable with it. It should be stated and documented for all patients discharged from the ED that they should return to the ED immediately if they worsen.

SUMMARY

Unfortunately, bad outcomes will continue to occur in emergency medicine, despite the best efforts of the competent emergency physician. It is to be hoped that this issue provides some information that will help patients avoid bad outcomes and help emergency physicians avoid litigation.

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