Not the Standard of Care: ED Case Studies in Medical Malpractice

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Disclosures

I have no personal or financial interests to declare.

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Outline

1. Pre-test questions
2. FOUR ‘real life’ case examples
3. Methods for malpractice prevention
4. Post-test questions

Disclaimers

Not intended as legal advice.

The cases are real.

We can learn from other’s mistakes.

Pre-test Question #1

All of the following are methods to reduce your risk of being sued for medical malpractice except…

A. sitting down at the bedside
B. being friendly & courteous with patients
C. avoiding unpleasant physical exam techniques/procedures
D. minimizing distractions in the workplace
E. avoiding tunnel vision from triage

Pre-test Question #2

Which if the following is NOT one of the top three reasons for an ED ‘bounce back’ (a patient return within 72-hours)?

A. bleeding problem
B. abdominal problem
C. mental health problem
D. urological problem

Pre-test Question #3

What is it called when a clinician fails to consider alternative diagnoses once they form an initial impression, even though data (including laboratory results) might contradict the initial impression?

A. recency bias
B. anchoring bias
C. affect heuristic bias
D. outcome bias

Outline

1. 38 year old male with knee injury
2. 35 year old male with low back pain
3. 42 year old female with left arm numbness and left sided neck pain
4. 41 year old female with dyspnea on exertion

Outline

1. 38 year old male with knee injury
2.
3.
4.

Case #1

February 23

- 38-year old male
- Chief complaint on triage face sheet:
  - Knee pain and knee swelling

Case #1

Vital signs:

- None documented by the provider

Vital signs in nursing note:

- Temp: 97.3
- Pulse: 109
- Respirations: 18
- Blood pressure: 130/65
- SpO2: 97% RA

Case #1

Diagnoses: knee sprain

Discharge instructions:

1. Crutch walking instructions
2. Knee immobilizer instructions
3. Follow up with orthopedics within 1-week
4. Return precautions
5. Medications:
    - hydrocodone/APAP (Lortab) 5/325mg, PRN pain, #20
    - ibuprofen (Motrin) 800 mg, TID, #30

Case #1

February 23 (same day, 6-hours after discharge)

- Patient brought in by rescue squad
- EMTs found him sitting on couch c/o severe pain to left knee/calf/foot
- Area visibly swollen
- Pain 8/10 at rest, 10/10 with movement
- Patient had removed immobilizer because of tingling in his foot
- EMTs splinted him and transported him to the ED

Case #1

In the ED:

- X-rays of left knee show tibial plateau fracture
- CT scan of the left knee more specifically revealed comminuted, bicondylar tibial plateau fracture

Case #1

Stryker compartment pressure measurements:

- Normal: <8 mmHg
- Critical value (must fasciotomy): 20-30

Our patient:

- Lateral compartment: 18
- Anterior compartment: 52
- Superficial posterior compartment: 16
- Deep posterior compartment : 44

Case #1

- Evidence of compartment syndrome in the left lower extremity
- Required emergent decompression fascia anatomy of ***all four*** lower leg compartments
- Patient then transferred to trauma hospital for subsequent treatment of the fracture

Case #1

The patient subsequently sued the original ED provider and the hospital

What went wrong?

Case #1

History

- Patient presents w/ knee pain & knee swelling w/ onset just prior to arrival
- Non-contact, twisting injury of left knee while playing football w/ friends
- Planted foot, twisted knee, felt a pop
- Denies traumatic blow. No prior knee injuries
- Denies numbness/tingling in the extremity

- Exacerbating factors:
  - movement of the knee, weight-bearing, and walking
- Alleviating factors:
  - none

Case #1

Physical Exam

- Normal strength
- No tenderness
- No deformity
- Left knee with swelling, effusion
- ROM is restricted by pain
- Pain with anterior drawer test. No laxity within joint
- Mild tenderness with posterior drawer
- No tenderness or laxity with varus or valgus stress

Case #1

Lab/imaging: None

Case #1

Comforting Features

- Denied traumatic blow: a non-contact, twisting injury is less likely to cause fracture (but is certainly possible)
- No signs of neurovascular compromise at initial visit

Case #1

Disconcerting Features

- Provider did not document any vital signs, was only in the nursing notes
  - Tachycardia (109), indicating pain?

- Physical exam does not make sense:
  - Has effusion & ↓ROM, but normal strength?
  - No tenderness?
  - Does not appear to use special tests correctly. Misuses “tenderness”

- Rapid onset of effusion, think → hemarthrosis

Case #1

Disconcerting Features (continued)

- Inability to bear weight, move the knee

- No alleviating factors

- D/C instructions did not include RICE (ACE wrap)
- Crutches provided, but no instructions on weight-bearing status

Case #1

Other notes

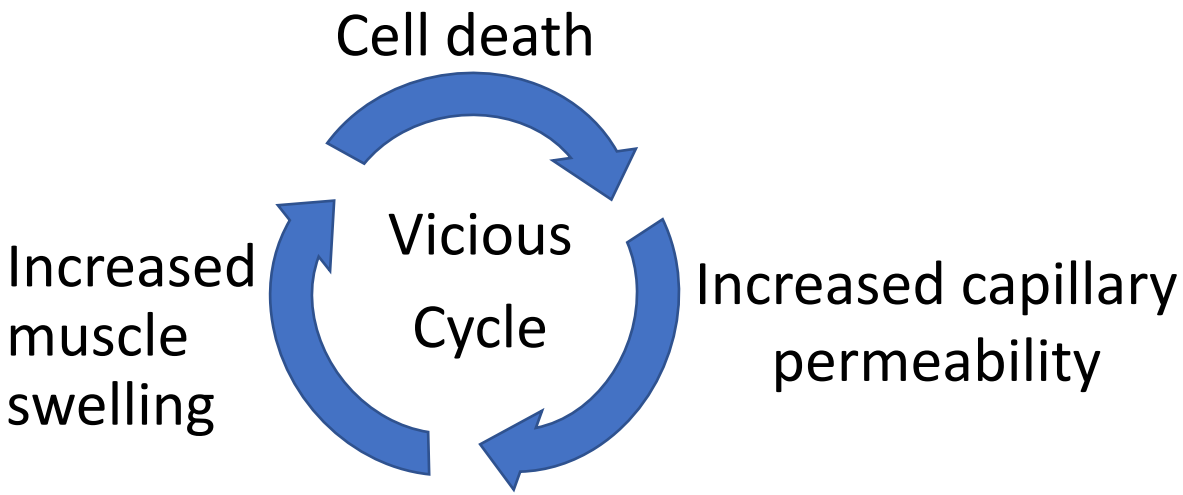
- Effusion alone should have prompted x-ray…
- …even more so with how quick it came on, likely a hemarthrosis

Case #1

Compartment Syndrome

- Increased hydrostatic pressure in closed osteo-fascial space resulting in ***decreased perfusion*** of muscle & nerves within compartment

- Raised pressure within closed space with potential to cause ***irreversible damage*** to the contents of the closed space



Case #1

Compartment Syndrome

- Muscle Ischemia
  - <4 hours: reversible damage
  - 4-8 hours: variable
  - 8+ hours: irreversible changes

- Nerve Ischemia
  - <1 hour: normal conduction
  - 1-4 hours: neuropraxic damage (reversible)
  - 8+ hours: axonotmesis (irreversible change)

- Myoglobinuria after 4 hours -> renal failure

Case #1

Compartment Syndrome

- Internal Causes:
  - hemorrhage
  - fractures (tibia, forearm, femur)
  - swelling secondary to blunt trauma (crush injury)
  - drug/EtOH overdose
  - arterial injury

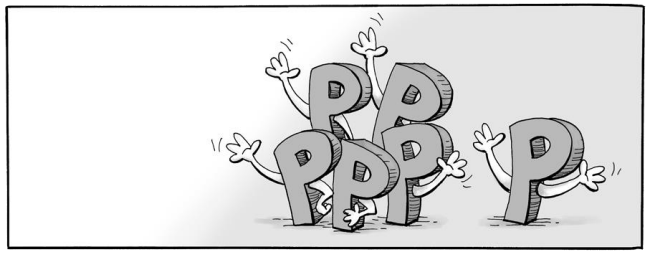
- External Causes
  - tight casts
  - tight dressings

Case #1

Compartment Syndrome

- Difficult diagnosis – must have ***high index of suspicion***

- Classic signs of “the 5 P’s”
  - pain, pallor, paralysis, pulselessness, & paresthesias



- Problem: many are signs of ESTABLISHED compartment syndrome where ischemic injury already taken place!

Case #1

Compartment Syndrome

- Most important symptom of impending compartment syndrome is ***pain disproportionate to the injury***

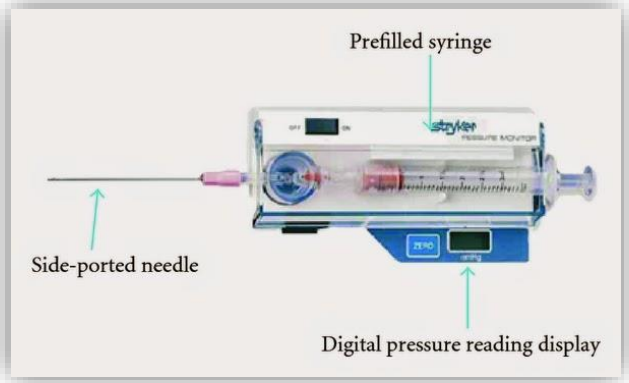
- Pain
  - passive muscle stretching
  - out of proportion
  - progressive
  - not relieved by immobilization or elevation
  - patient will not initiate motion on own

Case #1

Compartment Syndrome

- Physical exam
  - tense, shiny skin
  - tense, tight compartment on palpation

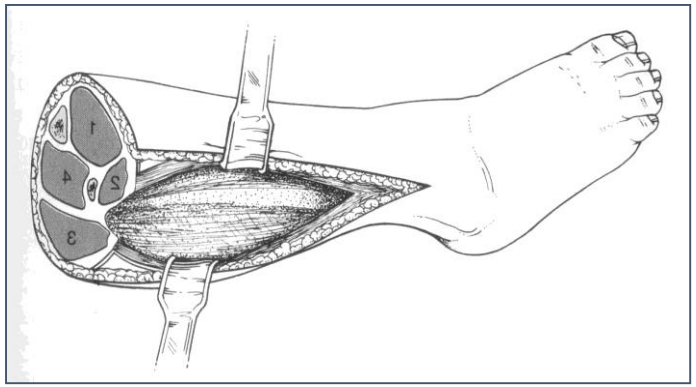
- Testing
  - measure intra-compartmental pressure: “Stryker”



Case #1

Compartment Syndrome

- Once diagnosis made: immediate surgical ***fasciotomy***



Outline

1

2 35 year old male with low back pain

3

4

Case #2

August 28

- 35-year old male
- Seen in ED for chief complaint of low back pain
- Don't know a lot about this visit
- Patient was discharged with Vicodin and Robaxin

Case #2

August 30 (two days later, different ED)

- Chief complaint on triage face sheet:
  - Back pain, numbness in legs

Case #2

Vital signs:
Temp: 98.0, oral
Pulse: 89
Respirations: 16
Blood pressure: 178/108
SpO2: not obtained

Case #2

Diagnosis: acute on chronic lumbar back pain

Discharge instructions:

1. Follow-up with PCP within 1-2 days
2. Follow-up with spine specialist as discussed
3. Return precautions
4. Follow up with PCP regarding elevated blood pressure
5. Medications:
    - methylprednisolone (Medrol dosepak) 4 mg tablets
    - oxycodone/APAP (Percocet) 5/325mg, PRN pain
    - diapzepam (Valium) 2 mg

Case #2

September 1 (2 days later)

- Return to ED via rescue squad with ↑back pain & Ⓑ radicular leg pain
- Worsening symptoms including numbness “from the waist down” x2 days, and inability to urinate
- Lumbar spine MRI: cauda equina syndrome (CES)
- Transferred for surgical decompression of disc herniation at L4 – L5, but developed foot drop on the right side and continued incontinence

Case #2

Now on disability and suffered "damage to his marital relationship”

- Sued provider & hospital for $75,000

What went wrong?

Case #2

History (August 30 visit)

- ED with worsening symptoms over past week
  - 10/10 throbbing pain
  - Numbness and tingling “from the waist down”
  - Trouble urinating

Case #2

Provider note specifically said:

- History of herniated disc and chronic back pain, sees neurologist
- Worsening over past week
- Numbness from the waist down, with saddle paresthesia
- Patient with numbness in legs before, but this is worse
- Some difficulty urinating, but is able to urinate

Case #2

Review of Symptoms:

- Genitourinary:
  - (+) Mild urinary retention

- Neurologic:
  - (+) Numbness to bilateral lower extremity
  - (+) Saddle paresthesia

Case #2

Physical Exam

- Neurologic:
  - AAOx3
  - No focal neuro-deficits
  - Cranial nerves II-XII intact
  - Normal sensory. Normal motor
  - Normal speech. Normal coordination

Case #2

ED course

- hydromorphone (Dilaudid) 1mg, IV x1
- diazepam (Valium) 5mg, IV x1
- ondansetron (Zofran) 4mg, IV x1

- Pain decreased to 5/10

Case #2

Labs/Imaging

- Lumbar spine CT:
  - Moderate-to-high grade disc herniation at L4 – L5 causing high-grade stenosis of the central canal with possibility of 2nd disc herniation

Case #2

Comforting Features

- CT scan impression did not specifically state “cauda equina syndrome”
- CT scan impression *suggested elective* MRI for further assessment

Case #2

Disconcerting Features

- Lumbar spine MRI should have been the ***first study*** done
- It should have been a ***stat*** study
- If CT lumbar spine, at least do with contrast (CT myelogram)
- Red flags:
  - worsening pain
  - urinary retention
  - saddle anesthesia
  - bilateral lower extremity symptoms
- All was listed multiple times on HPI, ROS, PE, and nursing notes

Case #2

Provider Deposition

- Claimed that patient refused to see neurosurgeon, but nothing in the chart about this
- No AMA form
- Furthermore, why would the provider consult neurosurgery unless something acutely wrong?

Case #2

Other Notes

- Lumbar spine MRI one of the only reasons for acute MRI in ED
- No rectal exam?
- No bladder scan?
- CES is ***true surgical emergency***

Case #2

Other Notes

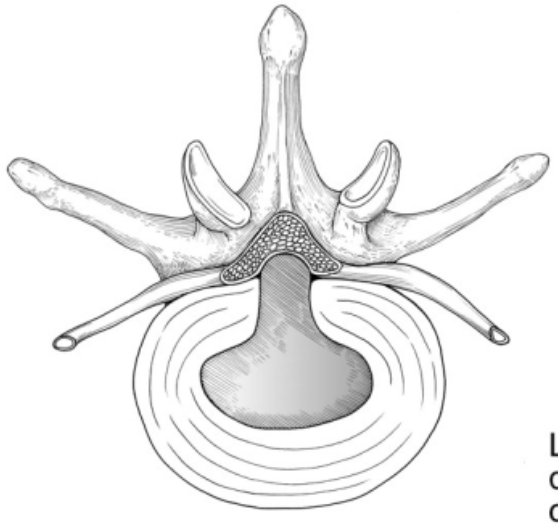
- Radiologist report is poor (report said “chronic”, “elective MRI”)
  - may have led provider down wrong path…but shouldn't have
  - …is still not an excuse…it said central canal!

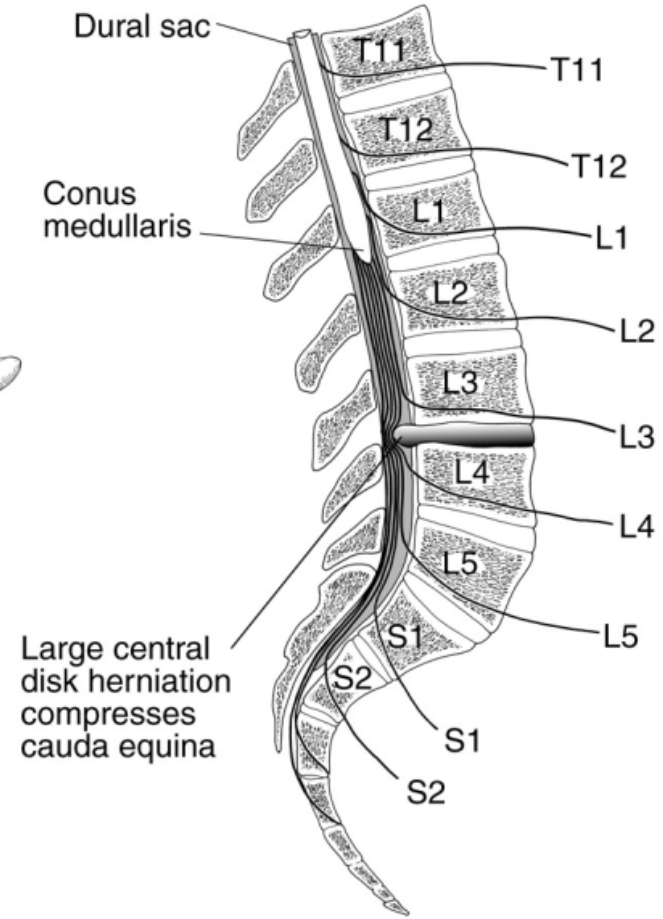
- Plaintiff claimed the patient should have “seen a physician”, and the lack of doing so broke the standard of care
  - not true, not required by state law

Case #2

Cauda Equina Syndrome (CES)

- ***central*** disc protrusion
  - Typically occurs at L4-L5 or L5-S1

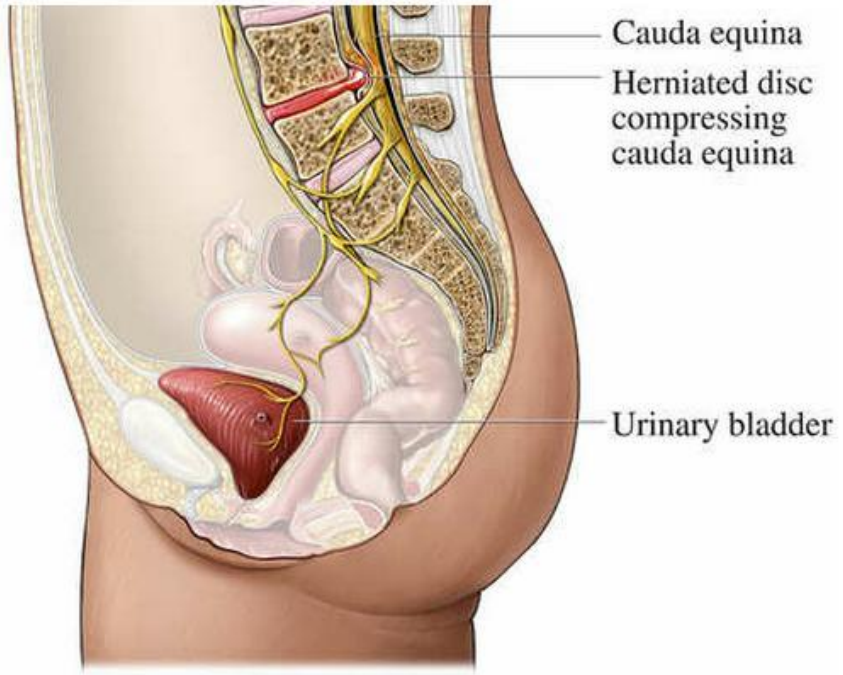




Case #2

Cauda Equina Syndrome (CES)

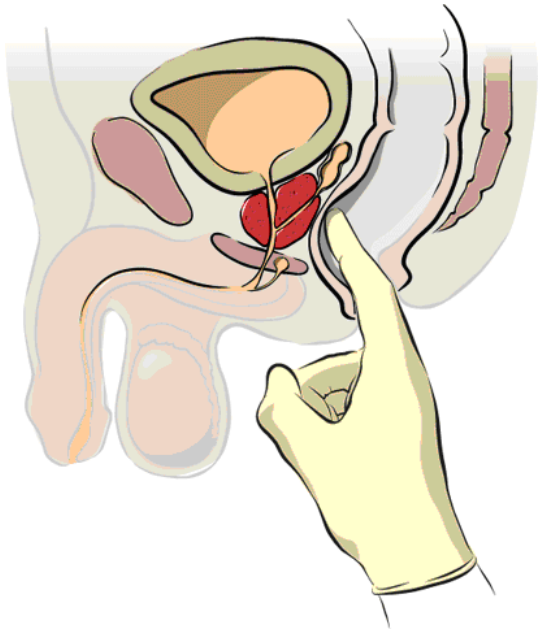
- History
  - urinary retention or incontinence
  - decreased rectal tone
  - ***bilateral*** radicular symptoms (leg pain/weakness)
  - perineal sensory deficits (***"saddle anesthesia"***)



Case #2

Cauda Equina Syndrome (CES)

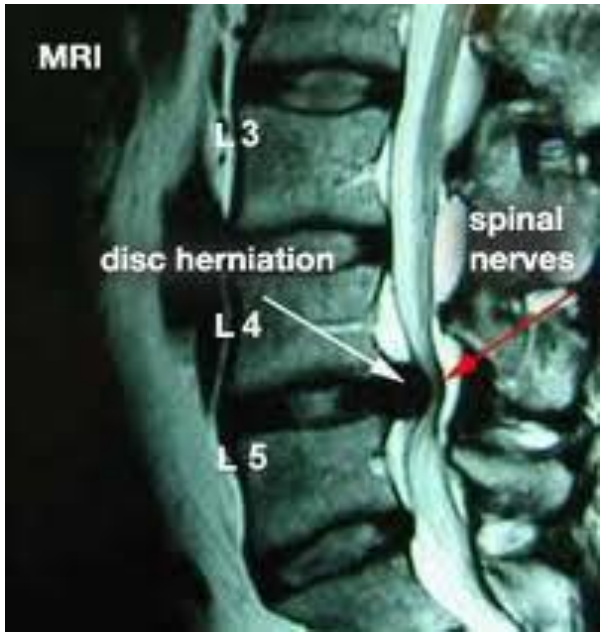
- Physical Exam
  - Full back exam (ROM, strength, straight leg raise test, etc.)
  - Neurologic exam
  - Digital rectal exam
    - sphincter tone (S2-4)



Case #2

Cauda Equina Syndrome (CES)

- Imaging: ***emergent*** lumbar spine MRI



Case #2

Cauda Equina Syndrome (CES)

- Important topic because…
  - 85% of people will experience LBP at some point in their life
  - Top Primary Care complaints:
    1. hypertension
    2. dyslipidemia
    3. diabetes
    4. ***low back pain***

Outline

1

2

3 42 year old female with left arm numbness and left sided neck pain

4

Case #3

June 13

- 42-year old female
- Chief complaint on triage face sheet:
  - “Past 2-3 days w/ left side neck pain that radiates up into left side of head. Also left arm and leg numbness/tingling. Denies slurred speech or blurred vision”

Case #3

Vital signs:

- Temp: 97.7, oral
- Pulse: 77
- Respirations: 16
- Blood pressure: 146/94
- SpO2: 98% RA

Case #3

Diagnoses:

1. Cervical paraspinal muscle strain
2. Cervical radiculopathy

Discharge instructions:

1. Rest & relax the muscles using comfortable pillows
2. Heat, massage, or cold packs several times per day
3. Acetaminophen or ibuprofen PRN
4. Follow-up with Ortho spine specialists
5. Return precautions
6. Medications:
    - cyclobenzaprine (Flexeril)
    - hydrocodone/APAP (Lortab) 5/325mg, #20

Case #3

June 14, 0130 (really, later the night of the initial visit)

- Patient's husband discovered her incontinent, unresponsive, and with leg convulsions
- Patient returned to ED via rescue squad
  - Had altered mental status
  - Combative & posturing - first decerebrate, then decorticate
  - BP: 242/147, Pulse: 102
  - Intubated. Stat head CT: diffuse subarachnoid hemorrhage
  - Transferred

Case #3

Patient suffered "permanent and profound brain damage”

- Sued provider & hospital for $10 million
- “Should have had a head CT the first time”

What went wrong?

Case #3

History (original ED visit):

- Patient reported suffering from neck pain for prior 2-3 days, after a visit to trampoline park
- Also numbness in left arm & leg. Denied blurred vision, speech problems
- Lightheaded with nausea, but no vomiting
- Patient was “using iPad while in the room”
- Denied LOC, back pain, fever, CP, SOB, & weakness
- Admitted history of HTN but not on meds for it. No PCP
- Reported "injury" at trampoline park. Using BC powder without relief

Case #3

Nursing notes:

- Patient “speaking in full and logical sentences”
- Patient with “steady gait”
- BP elevated but “remainder of vital signs are within normal limits”
- GCS 15

Case #3

Physical Exam

- Full ROM of the neck with no signs of trauma
- No swelling, contusions, abrasions, or tenderness to palpation
- Normal neurologic exam, "without any motor or sensory deficits".

Case #3

Labs/imaging

- Cervical spine X-rays: ***possible, bilateral*** C4 foraminal narrowing

Case #3

Comforting Features

- No acute onset, no "thunderclap" - it was present x2-3 days
- Related to an injury
- No vomiting
- No change in mental status
- C-spine X-rays show possible stenosis (something to "hang your hat on”?)
- No focal weakness, a relatively normal physical exam
- No acute distress, using iPad

Case #3

Disconcerting Features

- Numbness/tingling were in both the upper ***and*** lower extremities

- BC powder = aspirin (anti-platelet)

- C-spine X-rays
  - Show *bilateral* stenosis (not just left-sided)
  - Do not account for the leg numbness/tingling

Case #3

- Headaches
  - Did provider ask patient about history of headaches?
  - Did patient have history of ***migraine*** headaches? Was she previously worked-up for migraines?

- Trampoline park
  - Was her head/neck simply ***sore from jumping*** on trampolines?
  - Or did she actually ***fall; have trauma*** to her head/neck?

- Why cervical radiculopathy diagnosis?
  - Pain radiated ***up*** to head/neck, ***not down*** to shoulder/arm

Case #3

Provider deposition

- Admitted not knowing true history of trampoline park, did not know if trauma occurred or not

- Said that she performed CN assessment, later admitted not testing visual acuity or visual fields (CN II, III, IV, & VI)

Case #3

Provider deposition

- Admitted not doing cerebellar testing (did not actually see patient walk)
- Admitted subarachnoid hemorrhage was not on her differential diagnosis
- Stated that patient had lack of slurred speech, nuchal rigidity, and altered mental status…however all of these are very ***late*** findings

Case #3

Other notes

- Description of the neurologic exam is very weak

- Collaborating MD saw the patient after the APP, just prior to discharge
  - BP was slightly higher than at triage
  - MD documented that patient was dizzy, but no change in the plan

Case #3

Other notes

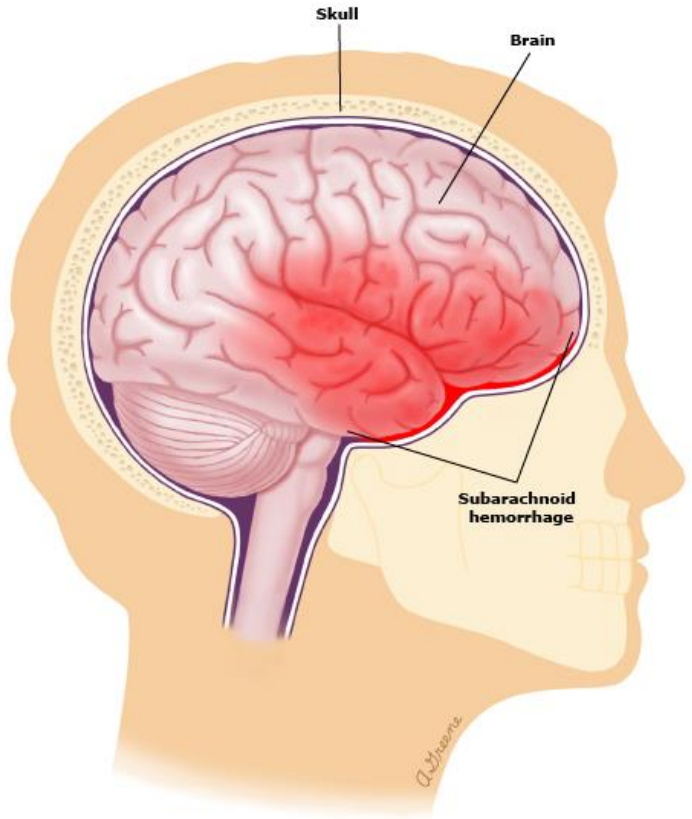
- Canadian head CT rules & New Orleans head CT rules ***do not apply*** because this was not a trauma

- Even if head CT had been done at original visit, it may have missed subarachnoid hemorrhage
  - lumbar puncture is also needed
  - would have only been done if SAH suspected

Case #3

Subarachnoid Hemorrhage

- Characteristics
  - often ***spontaneous***, without trauma
  - with or without exertion
  - may present as sudden death
    - 10-15% patients die before reaching hospital



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Case #3

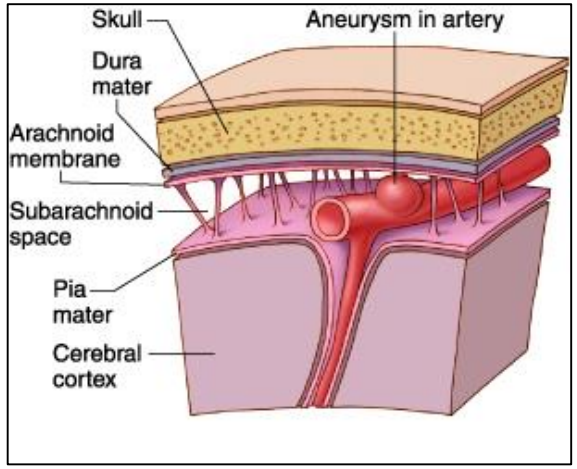
Subarachnoid Hemorrhage

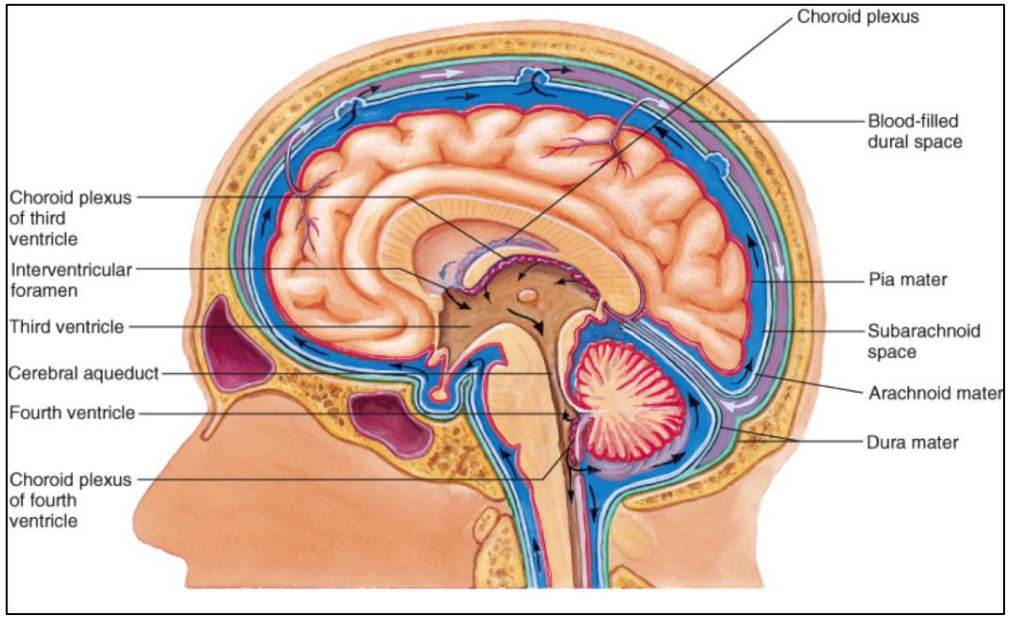
- History
  - ***confusion/altered mental status***
  - ***headache – rapid “thunderclap” onset, “worst of life”***
  - nausea/vomiting
  - photophobia
  - drowsiness
  - dizziness
  - seizures
  - altered speech

Case #3

Subarachnoid Hemorrhage

- Physical Exam
  - nausea and vomiting
  - seizure (typically a late finding)
  - altered mental status
  - ***meningismus***

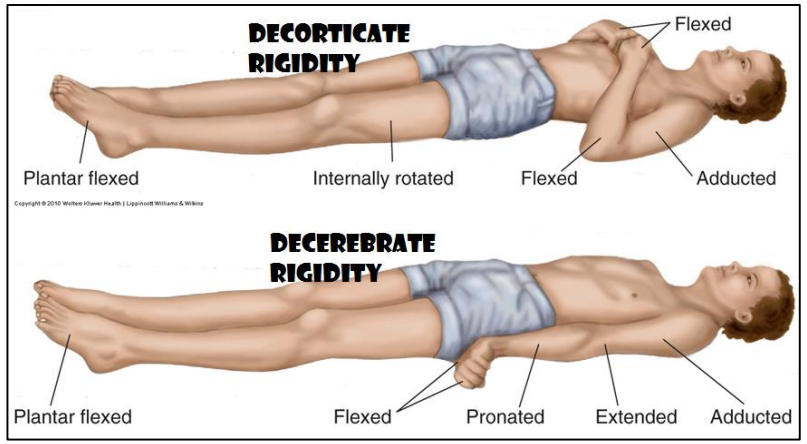




Case #3

Subarachnoid Hemorrhage

- Physical Exam – later stages…
  - contralateral hemiparesis
  - ipsilateral pupillary dilation
  - posturing is BAD prognostic sign
  - GCS?

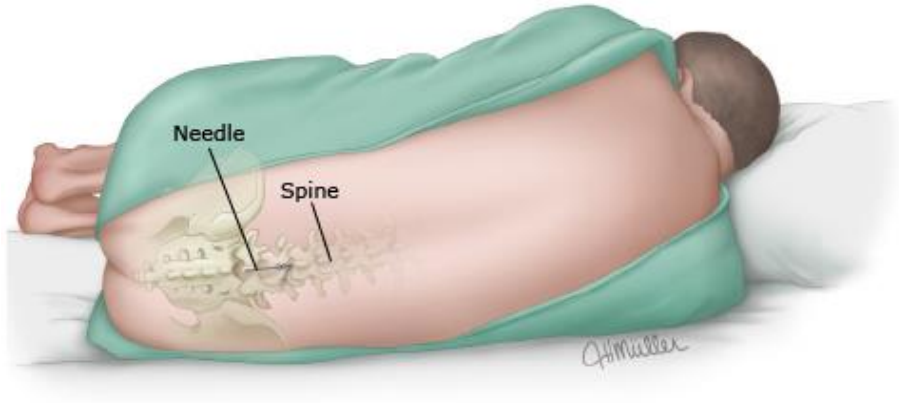


Case #3

Subarachnoid Hemorrhage

- Imaging: ***non-contrast brain CT*** (“gold standard”)
  - but only 98% sensitive for SAH

- Negative brain CT with clinical concern for SAH requires further investigation with ***lumbar puncture***



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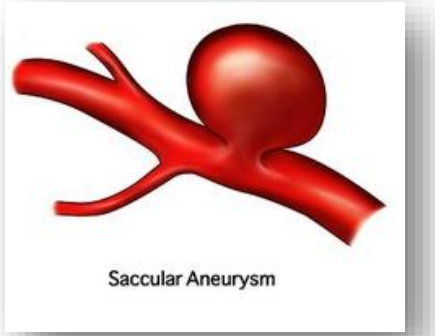
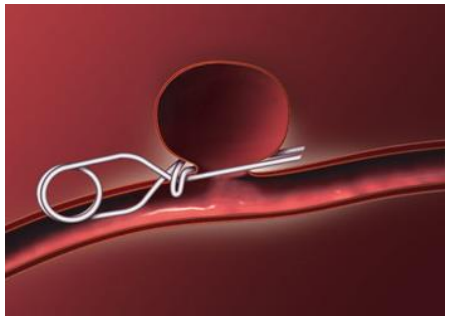
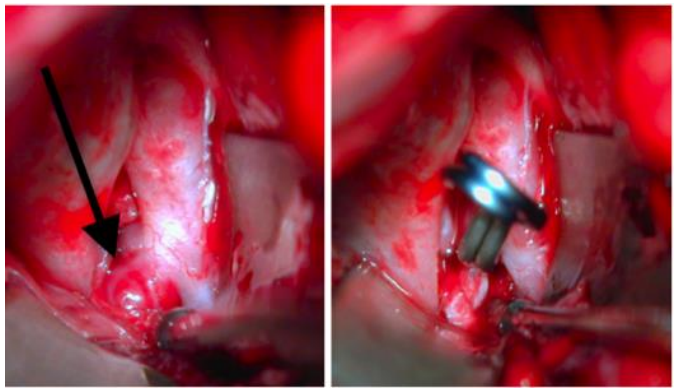
Case #3

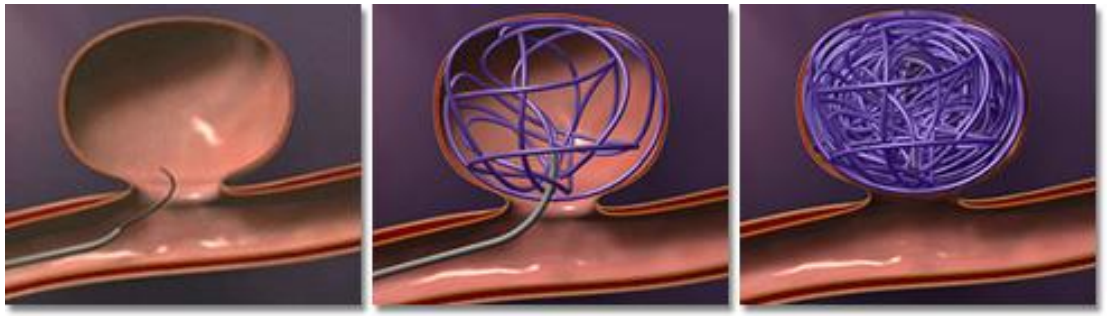
Subarachnoid Hemorrhage

- Most often caused by ruptured ***saccular*** aneurysm
- Treatment:
  1. clipping (open procedure)
  2. coiling (endovascular procedure)









Case #3

Subarachnoid Hemorrhage

- Mortality rate: 51%
  - 10-15% die before reaching the hospital
  - 25% die within 24 hours of onset
  - 45% die within 30 days

Outline

1

2

3

4 41 year old female with dyspnea on exertion

Case #4

April 17 – Urgent Care

- 41-year old female
- Chief complaint:
  - Dyspnea on exertion

Case #4

Vital signs:

- Temp: 98.4
- Pulse: 112
- Respirations: 18
- Blood pressure: 110/75
- SpO2: 97% RA

Case #4

Diagnosis: Unspecified asthma, uncomplicated

Discharge instructions:

1. Follow-up with PCP within 10 days
2. Medications:
    - albuterol inhaler, 2 inhalations q4-6 hours, PRN breathing
    - fluticasone (Flonase) nasal spray, 2 sprays each nostril, once/day
    - montelukast (Singulair), one PO daily

Case #4

April 18 (the next day)

- Brought to ED by friend
- While in ED, patient went into respiratory arrest and died
- On autopsy found to have multiple bilateral pulmonary emboli

Case #4

Patient's family sued:

- Urgent care
- Provider
- Collaborating physician
- Emergency department

What went wrong?

Unfortunately, a lot went wrong!

Case #4

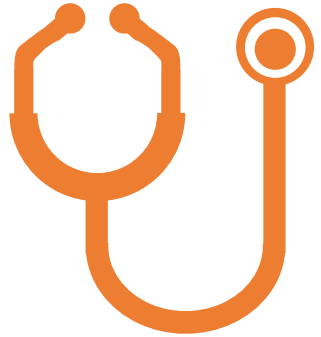
History (urgent care – original visit)

- Chief complaint: Dyspnea on exertion
- After one flight of stairs, patient had to “stop & catch her breath”
- After walking dog for one block, felt SOB, had near syncope
- Returned home to rest
- Then mid-sternal chest tightness & difficulty taking deep breaths
- Denied cough, fever/chills
- Remote Hx of exercise-induced asthma, not requiring meds in some time
- Former smoker (unsure how recent)

Case #4

Vital signs:
- Temp: 98.4
- Pulse: 112
- Respirations: 18
- Blood pressure: 110/75
- SpO2: 97% RA

Physical Exam
- "vitals noted, appears well”
- Able to speak in full, clear sentences. Talking with clear phonation
- Eyes clear
- Nasal turbinates with mild swelling, no drainage
- Pharynx is not enlarged
- TMs without erythema
- Neck supple
- Lungs with no wheezing or rhonchi. No increased work of breathing
- No cyanosis or clubbing



Case #4

Labs/imaging

- None

Notes: “peak flow reviewed and appears well performed”

Case #4

Further History

- Patient came back to UC the next morning
- Provider noted that patient appeared "anxious" and had “increased work of breathing”
- Pulse = 110. Respirations = 20
- Lung exam: no wheezing

- albuterol/ipratroprium (DuoNeb) provided
- Patient discharged

Case #4

Further History, continued…

- Later that afternoon, patient had syncopal episode while walking dog
- Bystander called 911, patient called her PCP
- Patient spoke with PCP over the phone, was convinced to go to a hospital that was further away than where rescue squad would have taken her
- Also convinced her to let friend drive her there
- On route, patient had episode of "blankly staring x20 seconds”
- Friend pulled over and patient vomited

Case #4

Further History, continued…

- In emergency department:
  - Pulse: 107
  - Respirations: 24
  - SpO2: 94%
- ED physician noted that patient's mother had history of DVT
- Lungs were clear with no wheezing

Case #4

ED workup:

- EKG: sinus tachycardia

- CBC with diff: WNL
- CMP: WNL
- Troponin: 0.055 (elevated, normal is <0.040)
- β natriuretic peptide: 2040 (elevated, normal is <125)
- D-dimer: 10,462 (elevated, normal is <500)

- Chest CTA: bilateral pulmonary emboli with left basilar atelectasis

Case #4

While in ED:

- Respirations remained at 24, but SpO2 ↓ to 89%
- Hospital admission was in process

- Patient got up to go to bathroom
- While in bathroom she had a generalized tonic-clonic seizure
- Was given Ativan 1mg, IV

- In postictal state had apneic breathing & bradycardia
- Tried intubation, but difficulty
- Tried video-assisted intubation, but when into respiratory arrest
- Coded on/off x120 minutes but was ultimately declared deceased

Case #4

Comforting Features: none

Case #4

Disconcerting Features

Urgent Care - **First visit**

- Simply did not have PE on differential
- Risk factors:
  - BMI of 33.2 (obesity)
  - Former smoker (unsure of how recent)
  - Resting tachycardia (112)
  - Mid-sternal chest tightness
  - Family history (mother DVT)
- If diagnosis is asthma, why did patient have ***no cough*** and ***no wheezing?***

Case #4

Disconcerting Features, continued

Urgent Care - **Second visit**

- Still with resting tachycardia (110)
- Borderline tachypnea (20)
- Still no cough and no wheezing
- “Increased work of breathing"
- Appeared "anxious"

Case #4

Disconcerting Features, continued

Primary Care Physician

- Giving advice over the phone? (cannot do a physical exam)
- Recommending a hospital that is further away?
- Recommending friend's car instead of the ambulance?

Case #4

Disconcerting Features, continued

Emergency Department

- CT scan findings communicated to ED physician at 8:30 PM
  - Heparin not ***ordered*** until 8:58 PM

- Patient found on bathroom floor at 10:20 PM
  - Pronounced dead at 12:44 AM
  - She was never given heparin while in the ED

Case #4

Pulmonary embolus

- clinical presentation is ***highly variable*** - must have high index of suspicion
  - absence of known risk factors ***does not rule out VTE***

- poor correlation between PE size & symptom severity
  - i.e, large PEs can be asymptomatic

- Approximately 300,000 ***fatal PE's*** occur per year (Murin 2002)
  - in 25% of cases, sudden death is the first/only symptom
  - Close to 60% of patients die after undetected PE (Heit 2002)

Case #4

Pulmonary embolus

- Risk factors

INHERITED	ACQUIRED
factor V Leiden	recent “major” surgery
prothrombin gene mutation	trauma
protein S deficiency	presence of central venous catheter
protein C deficiency	malignancy
anti-thrombin deficiency	pregnancy
dysfibrinogenemia	limb immobilization
	estrogen supplement
	smoking
	obesity
	prolonged sitting
	other**

**testosterone, tamoxifen, IV drug use, nephrotic syndrome, chronic liver dz, PCOS, chronic renal dz, renal transplant, RA, heart failure, post-MI, air pollution, IBD, asthma, post-stroke

Case #4

Pulmonary embolus

- ***Historical Factors*** — The Evidence
  - new/sudden onset dyspnea → 73% of PE patients
  - pleuritic chest pain → 44%
  - orthopnea → 38%
  - non-productive cough → 34%
  - hemoptysis → rare

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Case #4

Pulmonary embolus

- ***Physical Exam Factors*** — The Evidence
  - tachypnea → 57% of PE patients
  - tachycardia → 26%
  - crackles/rales → 18%
  - decreased breath sounds → 17%
  - jugular venous distention → 14%

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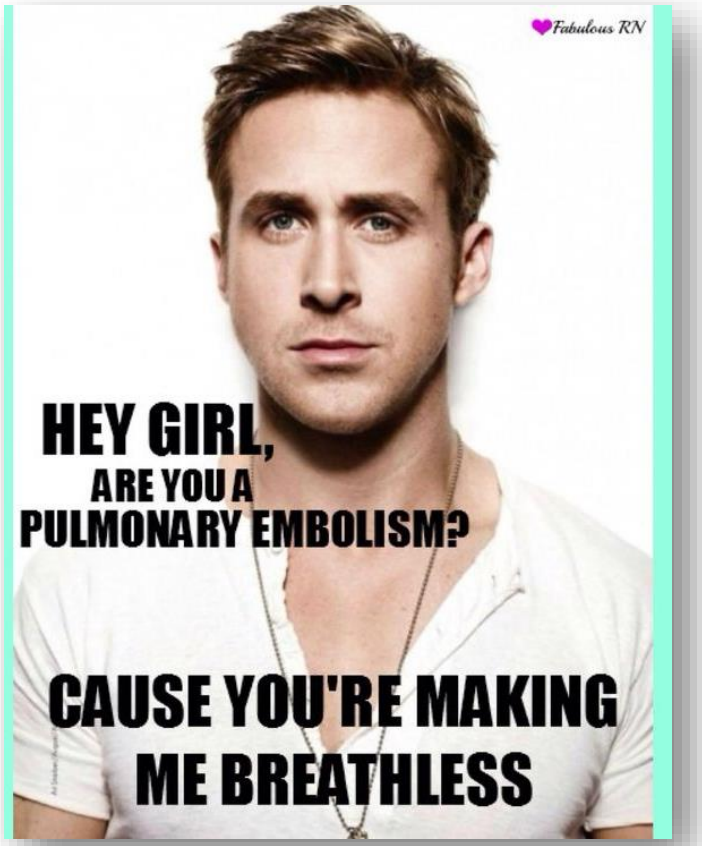

Fabulous RN
HEY GIRL,
ARE YOU A
PULMONARY EMBOLISM?
CAUSE YOU'RE MAKING
ME BREATHLESS

Risk Management

- FACT: patients are much more likely to pursue litigation if they were unhappy, frustrated, or did not like the staff, ***regardless of the actual outcome***

- Therefore, do not be an incompetent provider AND a jerk…
  …if you're potentially incompetent clinically, at least be nice!

Risk Management

The Philosophy of “YES”

- CC: possible ankle sprain
  - Pt: “can I have something stronger for pain?”

- CC: fall, hit shoulder
  - Pt: “can I get an MRI of my shoulder?”

Risk Management

Return Visits (“bounce backs”):

- start all over again!

Research study: 75% of return ED visits were…

1. wrong diagnosis
2. change/progression in disease
3. poorly understood discharge instructions

Risk Management

- Don’t forget the basics: ***look at*** and ***interpret*** all vital signs
- Exposure: get patients ***undressed!*** Take diapers off
- If the facts/tests don’t fit what you’re seeing in the patient – stop & rethink things

Risk Management

- Don’t be afraid of the “do over”
  - If an unpleasant encounter with a patient: start over!

- **Never let a resting tachycardia walk out the door**

Risk Management

Cognitive Biases

- **Anchoring bias**: selectively focus on info that supports initial impression
- **Confirmation bias**: once you form an opinion, you have a tendency to only notice the evidence that supports it, and you ignore contrary evidence
- **Availability/Recency bias**: judge the likelihood of a disease because of recent experience – diagnose based on the relevant examples that come to mind

Risk Management

Where do we make errors?

1. Educational deficiencies

2. Tired/sleep deprived

3. Distraction with unnecessary tasks
   - interruptions from MAs, nurses, techs, etc.

Risk Management

Where do we make errors?

4. Avoidance of unpleasant situations
   - rectal exam, pelvic exam, etc.

5. Cueing/Tunneling
   - from triage level
   - from pre-made documentation sheet

Risk Management

Name things for what they are!

- Temp: 97.7, oral
- Pulse: 102
- Respirations: 22
- Blood pressure: 100/62
- SpO2: 92% RA

"HR is up a little bit, respirations are OK, BP is good, and Sats are OK"

vs.

"Tachycardic. Tachypneic. Hypotensive. Borderline hypoxic"

Risk Management

How do patients judge the ***quality*** of healthcare?

- Clean
- Friendly
- Courteous
- Fast

How do patients judge the ***clinical competence*** of providers?

- Dress and appearance
- Listening skills
- Empathy and caring

Risk Management

First Impression

The Greeting

- ***ED wait time*** is the most frequent complaint among patients in post care surveys

- Examples:
  - “Hi, I’m Nicole, one of the PAs. I’m sorry about your wait. We are really busy tonight”.
  - “Hi, I’m Dave, one of the PAs. I see you arrived around an hour ago, thank you so much for waiting for us today. Now I am going to give you my full attention so we can get you feeling better”.

Risk Management

First Impression

- Managing Time Expectations - COMMUNICATE:

Labs	60 minutes
Ultrasound	60 minutes
X-rays	45 minutes
CT	60-90 minutes

Risk Management

Perception

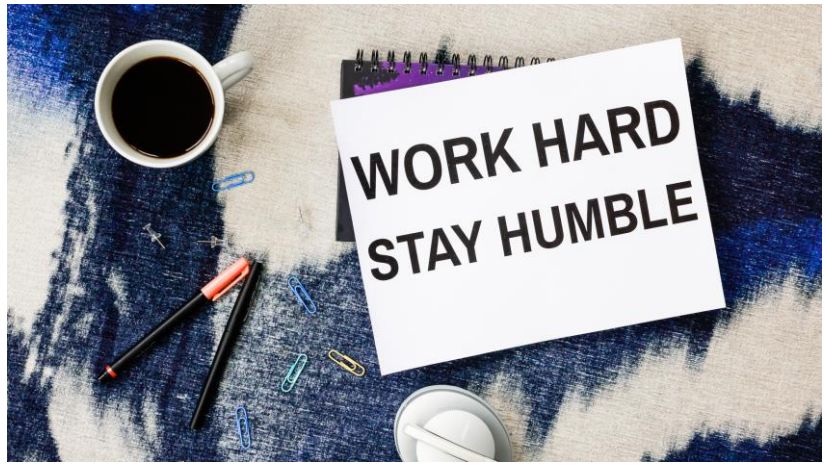
- Take a seat! ***Sit down*** at the patient's bedside
  - eliminates you towering over a patient
  - demonstrates that you ***plan to be present*** and listen

- Evidence that ***patients perceive the provider spent more time*** with them if the provider had sat down

Risk Management

We can learn very much from other people's mistakes…

- but remember, "hindsight is 20/20"
- remain humble!



Post-test Question #1

All of the following are methods to reduce your risk of being sued for medical malpractice except…

A. sitting down at the bedside
B. being friendly & courteous with patients
C. avoiding unpleasant physical exam techniques/procedures
D. minimizing distractions in the workplace
E. avoiding tunnel vision from triage

Post-test Question #1

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C. avoiding unpleasant physical exam techniques/procedures
D. minimizing distractions in the workplace
E. avoiding tunnel vision from triage

Post-test Question #2

Which if the following is NOT one of the top three reasons for an ED ‘bounce back’ (a patient return within 72-hours)?

A. bleeding problem
B. abdominal problem
C. mental health problem
D. urological problem

Post-test Question #2

Which if the following is NOT one of the top three reasons for an ED ‘bounce back’ (a patient return within 72-hours)?

A. bleeding problem

B. abdominal problem

C. mental health problem

D. urological problem

Post-test Question #3

What is it called when a clinician fails to consider alternative diagnoses once they form an initial impression, even though data (including laboratory results) might contradict the initial impression?

A. recency bias
B. anchoring bias
C. affect heuristic bias
D. outcome bias

Post-test Question #3

What is it called when a clinician fails to consider alternative diagnoses once they form an initial impression, even though data (including laboratory results) might contradict the initial impression?

A. recency bias
B. anchoring bias
C. affect heuristic bias
D. outcome bias

Thank you!

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