FAILURE TO DIAGNOSE: ANEURYSM
EMERGENCY MEDICINE CLOSED CLAIM STUDY

By Michele Luckie, Risk Management Representative

The following closed claim study is based on an actual malpractice claim from TMLT. This case illustrates how action or inaction on the part of physicians led to allegations of professional liability, and how risk management techniques may have either prevented the outcome or increased the physician’s defensibility. The ultimate goal in presenting this case is to help physicians practice safe medicine. An attempt has been made to make the material less easy to identify. If you recognize your own case, please be assured it is presented solely to emphasize the issues of the case.

Presentation

A 46-year-old man complaining of right flank pain was taken by EMS to the emergency department for treatment. The pain had begun sometime prior to admission, and extended from his right post rib area down to his right buttck. There was no prior history of this pain, but he had been under treatment for hypertension. His urine had been dark for several days.

Physician action

The emergency medicine physician evaluated him in the ED. The physical exam revealed him to be in intense pain. His vital signs were essentially normal, but his abdomen was found to be soft and nontender. Laboratory tests indicated blood chemistries to be normal and urinalysis to be positive for hematuria.

The patient was given medication for pain several times. The ED physician listed in his differential diagnosis the possibility of kidney stones, pancreatitis, urinary tract infection and dissecting aneurysm. The patient had an IVP without evidence of contrast in the right renal collecting system or ureter. A CT scan of the abdomen and pelvis was performed without contrast. The right kidney showed decreased enhancement when compared to the left kidney. There was no evidence of stones, but that could be explained by some distal ureteral obstruction. Other etiologies suggested were renal arterial embolus versus renal vein thrombosis. The radiologist’s suggestion was that a renal ultrasound should be performed to evaluate the renal vasculature if a follow-up KUB failed to demonstrate a distal ureteral obstruction.

The patient was observed and appeared to be pain free. The emergency physician consulted with a urologist who suggested no further studies. The patient was released with a final diagnosis of right renal colic and was to follow up with the urologist in four days.

The patient appeared in the emergency department of another hospital less than 24 hours later. He was complaining of continued back pain with numbness and coolness in the right leg. He was evaluated and found to have evidence of severe pain, acute onset renal failure, dehydration, some gastrointestinal bleeding and vascular insufficiency of the right lower extremity. The patient was stabilized, and after being seen in consultation was transferred to the ICU of the hospital.

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Multiple studies and surgeries were performed during the patient’s two-and-a-half-month hospitalization. He initially had an MRI of the chest and abdomen, a CT of the chest, transesophageal echocardiogram and aortogram. He was taken to surgery and had a repair of a dissecting aortic aneurysm. This involved the descending aorta from the chest to the bifurcation, with involvement of the celiac artery, right renal artery, superior mesenteric artery and right iliac artery. The patient had a very stormy postoperative course. He had a second surgery that included a colectomy and ileostomy. He subsequently developed gangrene and had amputation of the second through the fifth fingers of the right hand and all toes. He developed progressive renal failure, had a permacath implanted, and began receiving dialysis three times weekly. He had extreme weakness in the lower extremities, and was undergoing physical therapy to improve this problem. At the time of discharge, the patient was still on tube feedings, but his ability to handle oral feeding was improving. The patient also had an ileostomy and was on dialysis. He was scheduled for rehabilitation and ileostomy care. The patient underwent dialysis for a few months and subsequently recovered his kidney function.

Allegations

Plaintiffs alleged that the emergency physician failed to investigate, properly diagnose, and treat a vascular source of the patient’s clinical signs, symptoms and complaints, and misdiagnosed renal colic. They also alleged that he failed to obtain appropriate consultations with specialists in a timely manner. They state that he failed to respond to the patient’s symptoms and radiologic information and make recommendations at a time when a dissecting aneurysm reasonably could have been detected and properly treated. They further alleged that the physician should have admitted the patient for observation, diagnostic evaluation and treatment.

The hospital was also sued. The plaintiffs alleged that the nurses failed to adequately assess the patient’s pain and pain history and failed to properly communicate the initial nursing assessment and evidence of the patient’s complaints of chest pain and presenting medical history to the emergency physician.

Legal implications

The biggest hurdle in the defense of this physician was that he put dissecting aneurysm in his differential diagnosis then did not pursue diagnostic studies to rule it out. While he ordered a CT of the abdomen and pelvis, it was done without contrast. He did note in the chart that this did not show an aneurysm. However, to rule out dissection a CT with no contrast would have to be performed. Secondly, the radiologist recommended further tests, that had they been performed, would have ruled out renal problems and shifted him back to suspected dissection. And, third, there is the nurse’s note that the patient vomited just prior to discharge and no documentation that the defendant altered the plan for discharge.

Plaintiffs alleged that because of the delay, the dissection became larger. This created insufficient blood flow causing problems with the bowel. The patient subsequently suffered gangrene in the extremities resulting in amputation of toes and fingers. He had a stormy and long hospital course with subsequent rehabilitation.

Both emergency medicine consultants who reviewed this case were critical of the fact that the correct diagnosis was considered, but appropriate testing was not done to verify the dissecting aneurysm. The consultation obtained from a dissection expert made it possible to defend this case more on causation than on liability. He testified that the loss of the digits on the hands and feet were the result of an adverse reaction to heparin. This testimony helped lessen the damages and get the case resolved for a more reasonable amount.

Disposition

It was projected that a jury verdict in this case could possibly exceed policy limits. After several weeks of mediation and negotiation, the case was settled on behalf of the emergency physician for an amount in the low six figures. The hospital settled for the same amount with negligence shared equally by both parties.

Risk management considerations

The recognized benchmark in the medical-legal community is called the standard of care. The legal definition of this term is “that degree of care and skill which is ordinarily employed by the profession generally, under similar conditions and in like circumstances.” When the standard of care is being questioned, obviously the actual care rendered will be meticulously reviewed. A detailed diagnosis and a disposition consistent with the diagnosis are very important. The diagnosis and the disposition must be medically in keeping with the charted history, physical examination, and interval progress notes of all the individuals who entered this information on the chart. If any conflict exists in the chart regarding potentially serious outcomes, the chart may be used against those who generated it. Charting a differential diagnosis implies that the listed diagnoses will be systematically ruled out by comparing clinical findings.
Combating physician stress and burnout

By Barbara Rose, Senior Risk Management Representative

Physician, heal thyself!

“Self-love my liege is not so vile a sin/As self-neglecting.”
(King Henry V, Act 2, scene 4)

Shakespeare wrote with acumen in relation to life and its realities. Self-neglect may have been as prevalent in the 1500s as it is in 2004. In today’s stress-filled world, with no exception or reprieve for physicians, these lines serve as a reminder that one who neglects his own health may be perceived as careless in regard to the health of his patients. Self-care is unlikely to be a part of the physicians’ training and no doubt ranks low on a list of priorities. Many physicians do not have a personal physician for their own care. From this fact, it is a short leap to the premise that a stressed out physician may make more medical errors and have more malpractice lawsuits.

Health is much more than the absence of disease. We all experience stress in our lives. How we deal with it depends on many factors — age, maturity, work, relationships, and approach to life — to name a few. One study with 130 physician responders revealed data indicating the use of “approach-to-life wellness-promotion practices is associated with increased psychological well-being among physicians.”

From analysis of this survey, five wellness-promotion elements evolved and included relationships, self-care, work, spirituality, and approaches to life. Among the respondents who reported use of any of the elements, there was a trend toward increased psychological well-being. When use of the five categories was compared, the approach-to-life practice was linked to significantly higher levels of psychological well-being.

Identifying burnout

What are the characteristics of burnout? There are many including fatigue, inability to concentrate, anxiety, irritability, insomnia, depression and, at times, increased use of alcohol or drugs. The most distinct characteristic of burnout is likely to be a loss of interest in one’s work and/or personal life. Some studies suggest that burned out physicians have more trouble relating to patients, and the quality of care they provide may suffer. Physicians need to achieve balance in their lives. Medicine is their profession but one’s personal and community life must not be neglected.

According to stress management experts, the risks of today’s physicians experiencing burnout are greater than ever as they deal with lower reimbursement, managed care issues, patients with unrealistic expectations, and rising medical liability insurance costs. Past generations of physicians were taught to keep going when things got tough. That continues to be the ethos for some physicians.

Burnout does not have to result in a career-ending event. Having recognized burnout and the need for help, options are available for physicians. The Texas Medical Association Committee on Physician Health and Rehabilitation is dedicated to the promotion of physician health and well-being. For more information access the TMA web site at www.texmed.org.

Assess the balance in your life — all aspects — emotional, social, intellectual, spiritual, occupational, financial and physical. Achieving balance provides resilience and the energy to “deal with stress, avoid burnout, and extract the greatest meaning and joy from everything life has to offer.” The warning signs of stress and burnout include:

- Emotional and physical exhaustion;
- Physical symptoms such as headaches, chest pains, depression, sleepiness, digestive problems;
- Anger, anxious or irritable behavior toward others; outbursts of temper;
- Inability to take on additional tasks;
- Feelings of helplessness and loss of control;
- Persistent thoughts of quitting work;
- Sarcasm, negativism and cynicism in one’s surroundings;
- Feeling guilty when at rest or play; and
- Placing blame on others.

How to beat burnout

- Identify stressors and focus on what you can control. Learn to cope with things you cannot control.
- Slow down and leave your work at the office.
- Make time for yourself and your family.
- Prioritize what is important and urgent.
- Vary your workload and know your limits.
- Exercise, eat right and get enough sleep.
- Connect with those around you.
- Find ways to have fun each day.

Physicians who have “hit the wall” after ignoring stress and have progressed to burnout, have coped in a variety of ways. These include leaving medicine abruptly, early retirement, a career change within medicine if options are available, time-off with and without family to reflect and recover. This writer met a cardiologist several years ago who was at the pinnacle of his career in medicine. He was retiring in a few months and had enrolled in a cooking school in Europe.

In lieu of a choice without money worries, the burned out physician who wants and needs to continue his/her career will recognize that support and options for recovery are available. Whether a retreat, a physician support group, a trip never taken, or a sabbatical to reconnoiter and recover, the method will vary among physicians. Find a solution uniquely meaningful and take action.

To quote Steven Miles, MD, “There is a presumption that, unless you are invincible, you are a less-than-optimal physician, which is simply not true.” Men and women with the same human weaknesses present in all of us apply to medical schools. As medical students, residents, fellows and practicing physicians, our humanness with all its

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incumbent foibles remains. The difference in response to stress and avoidance or burnout is influenced by all facets of life. Recognizing stress and burnout, reflecting, reevaluating goals and values, taking action to intervene, and finding a balance is the key. We all have choices and one should include acknowledging our needs. Maintain flexibility in life. Physician, do no harm and heal thyself!

References

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Physicians who wish to complete the online application must have an email address and will have up to 30 days to complete the application. Applicants also have the option to print out a copy of the application before sending it to TMLT. Visit www.tmlt.org to learn more.