

TRIAL

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Medical negligence
Healing the hurt

Revised discovery rules



Negligence in the emergency room

Presenting clear medical evidence will enable jurors to determine what went wrong—and who is responsible.

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Emergency room (ER) negligence cases are both urgent and terrifying

to helpless clients harmed by inadequate care in the ER. They knew they were in trouble, and they did the best they could to save themselves, but in the end they had no control.

The craft of advocating emergency medicine cases involves recognizing what went wrong, showing the jury the reasonable conduct that could have prevented the injury, and persuading jurors with strong evidence that allows them to analyze the case and empathize with the client. The urgency of emergency medicine itself makes the evidence even more powerful.

Successfully litigating these cases requires an understanding of the medicine underlying the injury and its possible prevention. If there is some reasonable conduct that could have prevented the injury, then that is the standard of care likely to have been violated.

Doctors and nurses must consider a list of differential diagnoses by looking at possible causes of a condition based on the patient's age, the mechanism of injury (how the patient was injured), and the

patient's signs (objective evidence perceived by the examining physician) and symptoms (subjective sensations perceived by the patient). They must then rule out the different potential diagnoses—beginning with the most life-threatening—and give immediate treatment to avoid the patient's death or disability. Minutes count in the treatment of most conditions.

Many medical negligence cases that arise out of the emergency room involve failure to diagnose. Other areas of potential negligence include

- the hospital's failure to have and properly maintain adequate radiography equipment;
- the ambulance personnel's failure to transport the patient to a facility qualified or equipped to handle trauma;
- the ER physician's failure to call for an immediate radiology consultation or other appropriate consultations; and
- the radiologist's failure to require good-quality X-rays of the patient.

HMOs and other insurance companies are also liability targets because they restrict access to care and limit testing. Most managed care cases are medical negligence cases brought against a managed care organization under the theory of respondeat superior or bad faith. In the ER

setting, the HMO puts nonphysician personnel on the front line of patient triage and care, often through a required telephone advice line.

ER patients see many professionals who are potential defendants. The obvious parties are the hospital, radiologist, and ER doctor. Consultants such as general surgeons, trauma surgeons, neurosurgeons, orthopedic surgeons, and obstetrician/gynecologists (OB/GYNs), as well as nurses, emergency medical technicians, and other clinical care providers are potentially responsible parties as well. Standards of care vary, but all health care professionals—both pre- and in-hospital—must use the knowledge and skill that a reasonable clinician would use under similar circumstances.

For doctors and other health care providers, most medical negligence losses come from failing to diagnose a particular condition. Examples include the failure to diagnose nervous system diseases, such as meningitis; cardiovascular diseases, such as acute myocardial infarction; pulmonary diseases, such as pulmonary embolus; urogenital diseases, such as ectopic pregnancy; and traumatic injuries, such as fractures and head injuries.

The failure to order a radiologic consultation can result in liability, as can the failure to interpret X-rays correctly. Responsibility for interpreting films and other diagnostic studies lies with the radiologist, the attending physician, and any specialist consulted. The standard of care for ER physicians and radiologists dictates that they review the film. If a specialist is consulted, he or she should also review the film. For instance, most neurosurgeons believe they are more skilled at detecting potential spinal fractures on X-ray, magnetic resonance imaging (MRI), and computerized tomography (CT) scans than a general radiologist or neuroradiologist, because the spine is the focus of their specialty.

Clinical evaluation

The physician or other professional must make a clinical evaluation as quickly as possible. The diagnosis should be based on a complete history, a thorough physical examination, and all appropriate laboratory and radiographic tests. The ER physician

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may not be able to arrive at a specific diagnosis but is expected to rule out potentially life-threatening and other serious conditions that demand early treatment, consultation, and referral to an appropriate specialist.

The medical history should include the mechanism of injury—if it is traumatic in nature—when the pain started, its location, and its character. The physical exam should include noting the general appearance of the patient and his or her vital signs.

Classic signs and symptoms of the condition should be considered within any differential diagnoses. Often, ignoring obvious signs and symptoms or failing to order lab or radiographic tests will form the basis of a medical negligence case.

Some of the life-threatening conditions seen in the ER most often include abdominal, chest, or shoulder pain; infections and fevers; orthopedic injuries; obstetric and gynecologic emergencies; and headaches. For each of these conditions, there are standard injuries or diseases the doctor should consider or rule out.¹

Abdominal pain. When evaluating abdominal pain, the physician should rule out appendicitis, volvulus (twisted intestine), intussusception (an unfolding of one segment of an intestine within another) and abdominal aortic aneurysm.² With these conditions, time is of the essence, as shock and death can occur rapidly. A delay in operating also forms the basis of many claims.

Chest pain. When evaluating chest pain, the physician should rule out myocardial

infarction, pulmonary embolism, cardiac tamponade (fluid accumulation in the layer between the double membrane that protects the heart, which interferes with blood pumping), and pneumonia.

Shoulder pain. For this common ER complaint, there is a long and diverse list of possible causes, including trauma or disease in the shoulder joint. Myocardial infarction, pulmonary embolism, pneumonia, ectopic pregnancy, and cervical fractures have all been known to appear only as shoulder pain.

Infections and fever. Life-threatening infections and fevers of unknown origin are frequent emergency medicine problems that may result in the rapid death of a patient who is not diagnosed and treated early on. Several tests are available in the emergency room to diagnose and guide treatment of conditions triggered by infection, such as meningitis, epiglottitis, toxic shock syndrome, pneumonia, and bacteremia (bacteria that can reproduce in the bloodstream).

The cause of fever is usually not life-threatening, but the correct approach to a patient with an unexplained abnormal temperature is to rule out urinary tract infections, which can progress to serious kidney infection, and bacteremia, which can progress to potentially fatal sepsis. A white blood cell count or urinalysis should be obtained, and broad spectrum intramuscular antibiotics should be given to prevent sepsis.

Orthopedic injury. Many ER visits involve trauma to the extremities, compartment syndromes (in which a nerve, blood vessel, or tendon is constricted due to swelling within a closed anatomic space), open fractures, extensor tendon injuries, rib fractures, and skull fractures. These patients may also have more life-threatening connective tissue injuries, and shock from blood loss due to a closed fracture is another serious problem. Emergency room physicians should presume a spinal injury in any patient who has sustained injury or trauma to the neck, head, or back until proven otherwise. The doctor should immobilize the patient and periodically check neurological signs, have X-rays taken and reviewed, and refer the patient

to appropriate neurosurgical care.

Obstetric and gynecological emergencies. These cases require immediate OB/GYN consultation. A pregnant woman who is bleeding requires the placement of a fetal monitor to determine whether the baby is in danger of oxygen deprivation. If so, a cesarean section to prevent the baby's death or brain damage should be performed immediately for a viable fetus of at least 25 weeks. The failure to recognize and hospitalize a patient who is suffering from preeclampsia (characterized by hypertension, protein in the urine, and swelling in the extremities) can result in complications, including death of both fetus and mother.

Ruptured ectopic pregnancies are also life-threatening and must be ruled out in any woman of childbearing age who comes in with an irregular menstrual pattern that began recently, lower abdominal or pelvic pain, evidence of a pelvic mass, or any signs of recent blood loss. These patients must be prepared for surgery immediately.

Headaches. ER doctors commonly confront patients with severe headaches. They must rule out causes ranging from simple tension to infections resulting in meningitis to intracranial hemorrhage. A timely CT scan can provide an immediate diagnosis for appropriate treatment.

Diagnosis

An accurate diagnosis of any fracture, and most diseases, has clinical and radiographic components. The attorney must understand the steps to diagnosis so he or she can educate jurors about how the experts formed their opinions and what diagnosis should have been made.

A clinical diagnosis involves making a differential diagnoses list of potential injuries or diseases that need to be ruled out by radiological or laboratory tests. Many emergency room physicians use an algorithm (a step-by-step method of solving a problem) as a checklist for obvious differential diagnoses, which also provides a treatment protocol.

The clinical diagnosis of a traumatic injury, for example, is based on three factors: the mechanism of injury, findings

from the physical examination, and the patient's age.

For example, knowing that a patient with severe back pain and obvious multiple bodily trauma was ejected from a car in a crash should alert the ER physician and the radiologist to the potential for spinal fractures. Based on this information, the doctor should order full lateral and front-to-back X-rays and/or a CT scan. He or she should also arrange appropriate consultation with a neurosurgeon or orthopedic surgeon.

Films are unnecessary only when an injury or disease can be confidently excluded. Clinical examination will determine which films are needed. Radiographic diagnosis confirms the clinical diagnosis and provides anatomical detail about the injury or disease.

All traumatic events should trigger fracture analysis, and skeletal films are among the most common X-rays ordered in the emergency room. The emergency clinician should ensure that the radiologist knows how the patient was injured so he or she can properly evaluate the films for the clinician.

Many negligence cases involve missed fractures. To interpret radiological films properly, the doctor and radiologist should look for potential fractures. Then they must read the films systematically. While there is some disagreement about the specific system to be used, all involve looking within the entire film (at the "four corners of the film"). There are three radiographic signs that indicate a fracture: identification of a fracture line, changes in the surrounding tissue, and alterations in the skeletal contour or alignment.

The systematic approach for the diagnosis of a fracture is taught in medical school and described in the highly regarded text *Emergency Radiology*.³ It takes into account the intricate defining characteristics of each type of fracture. Radiological film in at least two perpendicular planes, usually frontal and lateral views, are necessary to visualize a fracture adequately.

Chest films are frequently ordered radiographic studies in the emergency department. They can help diagnose pulmonary

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disorders, including pneumonia and collapsed lung, and thoracic trauma. For patients who are experiencing chest pain and having difficulty breathing, chest films show a high incidence of abnormalities. The preferred radiographic studies of the chest are the back-to-front and lateral views.

Although skeletal X-rays can rule out most fractures, a negative abdominal radiograph does not exclude serious causes of abdominal pain. Plain radiography should be used only in abdominal cases with suspected perforation and obstruction. In other cases, CT and ultrasound scans are more accurate. Ultrasound should be used when the emergency room physician suspects appendicitis, abdominal aortic aneurysm, or ectopic pregnancy or other gynecological disorders.

Developing the case

The successful outcome of the ER negligence case, like any case, depends on careful case selection, aggressive discovery, and detailed preparation. After interviewing the ER patient or family member, the attorney should get the medical records and films from the hospitals and health care providers involved in the patient's care as soon as possible.

Cases arising from a traumatic event nearly always follow the same path through the emergency room. During case screening and preparation, the plaintiff attorney should consult general medical experts, who can evaluate where the responsibility for the patient's care lay and make a judgment about basic causation with reference to supporting medical literature.

To understand the liability in the case, an attorney will often need to consult both an ER physician and a radiologist. After these experts review the case, additional specialists—such as an orthopedic surgeon, OB/GYN, or a pulmonary patholo-

gist—may be needed.

For example, a neurosurgeon is a crucial expert in a multiple trauma case involving the head or spine to determine the applicable standard of care and causation. Hiring an upper-level resident in the pertinent specialty from a local teaching hospital may be an effective way to learn the medicine.

Working with the experts, the plaintiff attorney must determine how best to present the case to the jury. A leading defense attorney once said, "The plaintiff always has the advantage because he or she gets to decide what the case is about." The plaintiff goes first in voir dire, opening statement, and closing argument; calls the first witness; and chooses the issues on which to focus the jury.

Consider this example. In an ER case involving a pregnant woman, an emergency physician, and an obstetrician, the plaintiff attorney would define the issues as follows:

The first issue in this case, ladies and gentlemen, is whether this fetus was in distress from a lack of oxygen. The second issue is whether the baby should have been rescued by an emergency cesarean section, which the defendant failed to perform. And the third issue is whether the failure to diagnose and treat this lack of oxygen caused the brain damage.

The defense lawyer would attempt to steer focus away from the care—or the lack of care—involved by defining the legal issues this way:

Ladies and gentlemen, the first issue in this case is whether the labor and delivery were or were not managed by caring, qualified, compassionate professionals. We say they were. The second issue is whether this labor and delivery went as well as they could have, given the circumstances. We say they did. The third issue is whether this child's brain disorder occurred during the prenatal period—months before this labor and delivery ever took place—and we say that it did.

Rather than chasing the defendant's issues, the plaintiff, with the tremendous advantage of going first, can disprove or rebut them indirectly while keeping the jury's focus on the plaintiff's issues at every stage of the trial. What the jury really wants to know is what happened to the plaintiff and how the injury could have been prevented. With a good understanding of the medicine and proper framing of the issues, the plaintiff attorney can shift the burden of proof by showing that the outcome could have been prevented with reasonable conduct.

Building a theme can also help the plaintiff's case. The theme provides a moral underpinning for the story, as well as the unifying image or concept each juror uses to understand it.⁴ Focusing the theme more on the health care providers' tasks and responsibilities than on the results of medical negligence increases the plaintiff's chance of winning.

Effective themes for ER medical negligence cases might include "heed the warnings," if the patient's symptoms were disregarded; "first, do no harm"; "priorities," if the issue is profits versus care; or "many warnings, long ignored," if the medical professionals should have caught the problem before it was too late. When HMOs are also involved, "health against wealth" and "profit versus patient" are effective themes to explain the takeover of health care in the United States by profit-driven business interests.

Subthemes can also be developed for parts of the case. For example, in the damages presentation, a subtheme like "not what she has, but what she lost" is universally effective. It creates empathy by focusing on the patient's lost enjoyment of life or the meaning behind losing a mother, father, son, or daughter rather than focusing jurors on the current condition of the client. Sympathy lasts minutes, but empa-

thy for the intangible losses of dreams and familial relationships makes a more lasting impression on the jury.

Expert witnesses

At trial, the plaintiff will need an array of expert witnesses. Depending on the facts of the case, the liability expert may be an ER physician, a radiologist or neuroradiologist, a trauma surgeon, a maternal/fetal-medicine specialist, a nurse specialist, or an infectious-disease specialist. The subsequent treating physician is often the plaintiff's best expert witness, especially if the doctor has since moved from the jurisdiction and is no longer concerned with the censure of his or her peers in the community.

ER physician experts base their opinions about liability on the Advanced Trauma Life Support standards, guidelines, and testing published by the American College of Surgeons,⁵ as well as other literature and board-certification standards.⁶

Jurors are expected to understand both the functioning of the human body and the medical procedures involved in the case. The plaintiff's experts should cover anatomy, physiology, and pathophysiology (the physiology of disordered function); the procedures the defendant used; why the procedures were incorrect or misapplied; and, if possible, why the diagnosis was missed. Having the plaintiff's experts teach the medicine to the jury makes them the jury's experts. Jurors learn from these teachers something new and challenging. The expert develops a rapport with the jurors, who then feel an affinity for the expert.

The jury must learn in a few days what the attorney had months to absorb. It is important that the experts keep the science simple. Once jurors understand the medicine, they can more clearly evaluate the medical decisions involving diagnoses and treatment and reject expert opinions that contradict their newfound knowledge. The jury becomes empowered to sort out the conflicting testimony.

To streamline the science, the attorney should bring all original medical records and films to court and have a condensed time line for the experts to reference. A series of medical illustrations can show the anatomy and illustrate what happened.

Certain types of evidence are particularly powerful in ER medical negligence cases involving failure to diagnose. Any films and studies from the time of the overlooked injury or disease are direct demonstrative evidence. PowerPoint or similar presentation software can be used to project the film on to a large screen for jurors to view easily.

Medical-record documents should be enlarged and graphically enhanced to highlight important features. Just drawing a circle in an empty space on a chart where information is missing can be as compelling as pointing out what is there. The attorney should also use summary boards listing short testimonial quotes of the defendant's admissions on important points and any other evidence for which a longer-lasting impression is needed to supplement the temporary view on a screen.

Countering common defenses

The defendant ER physician will argue that he or she is not involved in reading films and relies on the radiologist to do so. To counter this argument, the plaintiff's expert should cite literature, such as *Emergency Radiology* and the simple algorithm outlined, to explain the ease with which a systematic approach reveals the abnormalities present on the films.⁷ The plaintiff attorney also should show that the diagnosis of injuries combines clinical and radiological diagnoses. The ER physician is clearly responsible for the clinical aspect, since many radiologists do not even see the patient. All other consultants, including the radiologist, are also responsible for reviewing the films.

The defendant radiologist will argue that he or she had no duty to know how the patient was injured and that the findings were subtle and appreciable only in hindsight. The plaintiff's radiology experts should state that clinical knowledge of the mechanism of injury is required and that a systematic approach to reviewing films, with a heightened suspicion of the injury or disease that was missed, should have been followed.

Defendants inevitably ask their experts to look at the case films blindly, without giving them any information about the plaintiff's injury or disease. This is a setup

for defense testimony that no reasonable physician could have seen the "subtle" findings or abnormalities on the films because the defendant's experts did not see them until they were told what the problem was.

This strategy can be countered by giving the plaintiff expert only the facts he or she would have as a physician interpreting films. The hindsight defense will seem implausible if the plaintiff's expert read the films, diagnosed the condition without knowing the final outcome, and found the abnormality to be "obvious."

When the plaintiff's expert is asked on cross-examination, "Isn't this a matter of judgment?" the answer is "No." Even if the defendant was in the ER and saw what was happening, liability is not just a matter of the defendant's judgment versus the judgment of the plaintiff's expert. The case is being tried because the defendant's judgment was terrible and violated the standard of care. No reasonable clinician exercises his or her judgment under these circumstances in that way.

In the end, ER medical negligence cases come down to one thing: trust. The patient is forced to trust everyone—the doctors, the nurses, the technicians, and the hospital. That trust has been betrayed. The plaintiff lawyer redresses that betrayal by providing clear, well-presented medical evidence, gaining the jurors' trust and enabling them to return a just verdict. □

Notes

1. See generally STANLEY E. PREISER ET AL., *PREPARING AND WINNING MEDICAL NEGLIGENCE CASES* (1989).

2. For descriptions of these and other conditions, visit *MEDLINEplus*, a service of the National Library of Medicine, at <http://nlm.nih.gov/medlineplus/dictionaries.html>.

3. DAVID T. SCHWARTZ & EARL J. REIS-DORFF, *EMERGENCY RADIOLOGY* (2000).

4. See generally PAUL M. LISNEK & ERIC G. OLIVER, *THE COMPLETE LITIGATOR: REALITY, PERCEPTION, AND PERSUASION IN AND OUT OF COURT* (1994).

5. See the American College of Surgeons Web site at www.facs.org.

6. See the American Board of Emergency Medicine (www.abem.org), as well as various specialty boards recognized by the American Medical Association (www.ama-assn.org) and the American Board of Medical Specialists (www.abms.org), which provide certification.

7. SCHWARTZ & REIS-DORFF, *supra* note 3.