HEALTH LAW

What You Don't Know

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In the late 1970s I read a book by Samuel Shem called *The House of God*. The book is about an intern in a New York hospital during his first year of residency. His senior resident, "The Fat Man," coins a number of laws about surviving residency. One of them—"If you don't take a temperature you can't find a fever"—can be extrapolated to all sorts of questions, tests, and exams. People who know me will say that I don't ask a ton of questions when my gut tells me that I probably don't want to know the answer.

Reference this exchange:
23-year-old female patient: I think I have an STD in my throat.
Me: Why do you think that?
Patient: My throat hurts.
Me: I understand that but why do you think it is an STD?
Patient: I got drunk at a party and fell asleep with my mouth open.
Me: Wow, what kind of party was it?
Patient: An all-girl party.

Really? Did I need to know that? I would have actually been better not knowing it because of course the second those words came out of her mouth my mind went to the physical contortions necessary for her to come to that conclusion—yuck. What kind of friends does this poor girl have—desperate, depraved gymnasts?

That aside, there are some things we as providers need to know or figure out in the moment. Over the years, I have compiled a list of things we need to know, say, chart or do in real time (and a few we don't).

1. Although very rare, you have seen this admonition previously: "Drug seekers with recurrent back pain" are a set up to miss a spinal epidural abscess. Danger Will Robinson!!! Fewer than 10% of patients with epidural abscess present with the triad of back pain, fever and focal neurological deficits.
2. Do not discuss potential or filed medical malpractice claims outside a protected peer-review environment with anyone other than your attorney or your spouse. You will be asked during your deposition who you spoke with about the case.
3. Failure to inform a patient about an abnormal test is a red-flag issue. If the patient ultimately is diagnosed with the condition you neglected to mention you will have some things to defend. Example: A patient presents for an upper respiratory infection. You do a chest x-ray that does not show an infiltrate but does show a small nodular-looking density that you believe is a nipple shadow. The film is dutifully sent for an over-read. The radiologist report comes back with; "suspicious nodule on the right side which appears to be in the middle lobe. Also noted is pleural thickening. Suggest follow-up chest radiograph in 3 months or CT scan to further evaluate lesion." If you do not inform the patient and the patient is diagnosed with lung cancer 2 years later you will be considered negligent.
4. I have been involved in two cases where a provider "lost" an important but damning sheet of the medical record (which others already had) or materially altered the chart to his/her own benefit. Besides losing the malpractice claim (once discovered, this behavior is not defensible) the provider had to defend his license in front of the state medical board. Do not ever alter or remove part of the medical record. If you make changes, date, time and initial the entry.
5. I know we all occasionally believe that we work in a "low-risk environment" but let me remind you; we don't. Ur-

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gent care is a very high-risk environment. Even higher than the emergency department. It is high risk because everyone, including the patients, thinks it is low risk and we can all be lured into a false sense of complacency. Remember: Worst first!

6. If a patient or the parent of a patient is intoxicated you should do everything in your power not to let the individual get behind the wheel. Note, you cannot physically restrain anyone but you should call the police.
7. If the radiologist states that the films are inadequate, you need to repeat them.
8. If you are going to discharge a patient who has a complaint/issue/diagnosis (headache, chest pain, shortness of breath, transient altered mental status, syncope, visual changes) that could come back to haunt you both, document the pertinent negatives and your thought process.
9. If you order a test, be prepared to address and deal with the result. Sending a patient home with a positive d-dimer or significantly decreased absolute neutrophil count that is not addressed in the medical record is a set up for a medical misadventure.
10. If you spoke with a consultant about a particular patient, write the date, time, name of the consultant and what he/she said in the chart. A consultant's memories can become very sketchy after a suit is filed.
11. Low-risk radiographs (that is, normal chest x-rays) and low-risk chest pains account for a very substantial percentage of malpractice cases in urgent care medicine. It is rarely the obvious issue/complaint that becomes problematic. Example: "I have an acute onset of crushing midsternal chest pain associated with shortness of breath and sweating and, oh by the way, my father and mother both died of heart attacks at the exact age I am now." I think we would all be on top of this one.
12. Minor head injuries in patients on Coumadin are by definition not minor. Every patient on a blood thinner (there are a lot of new ones) requires a CT scan as well as a follow-up scan to ensure that there is no delayed bleeding.
13. Patients with testicular pain need an ultrasound to evaluate for torsion. Relying on your physical exam to differentiate torsion from epididymitis will not protect the patient or you.
14. Providers have a duty to warn known or unknown but predictable third parties[i] (that is, partners of patients should be treated for STDs) Note: I am sure I don't want the names of the girls at the party.
15. Providers have a duty to warn patients about possible side effects, drug-drug, drug-food, drug-herbal interactions, fall risks, etc. while taking a medication. If the medication you are prescribing requires your DEA, you have a duty to warn the patient not to drive, operate machinery, etc. because (see end note) you have a duty to warn unknown but predictable third parties.
16. Radiological images should be over-read. Ensure your facility has a mechanism in place to identify and then follow up on x-ray discrepancies that necessitate a change in management or follow up.
17. Read the notes of others before discharging a patient. I have been involved in numerous cases where the nurse or tech notes shoot the provider in the foot. If you document, "The patient presents with a slight headache" but the triage nurse documents, "The patient presents with the worst headache of his life" and the patient ultimately goes on to have a subarachnoid hemorrhage after you discharge him, you will have some explaining to do.
18. The same patient presenting more than twice with the same complaint needs to be figured out / admitted on the third visit.
19. What do you do when your patient lacks capacity to consent to or refuse care? Document very well why, in your estimation, the patient lacks capacity and have another competent adult opine on the record. If your judgment is reasonable, done in good faith, supported by the facts, well documented in the chart and other witnesses, you should be fine. There is a seminal case from the early 20th century called Schloendorff v Society of New York Hospitals that addresses this very question. In the case, Justice Cardozo wrote, "Every human being of adult years and sound mind has a right to determine what shall be done to his own body."
20. You should instruct a patient to return to your center or the emergency department immediately if his symptoms worsen or don't improve or if new symptoms develop.

As medical providers, we live and die by what we (and others) chart, what we do and the lengths we go to help our patients. You have come a long way for the opportunity to care for others. Don't let a lapse in judgment or documentation send you back.

Epilogue: My young lady with the sore throat simply had a positive strep screen and was treated with penicillin. Her discharge instructions read as follows: Fill your prescription and take all your medications as prescribed. Do not stop them once you start feeling better but continue until you take all the medications as prescribed. Use Tylenol for pain or fever and return immediately if worse or no better or if you cannot keep your medications down or develop new symptoms. Get a new set of friends. If the first thing that goes through your mind after waking up at a party is "which one of you ....." you are hanging out with the wrong group. ■

[i] Tarasoff v. Regents of University of California. Case involves a psychiatric patient who had rape and murder fantasies about a young coed. The treating psychologist did not warn Ms. Tarasoff or inform the police and the psychiatric patient killed Ms. Tarasoff.