Damned if you do, damned if you don't
by Greg Henry, MD

There is no winning in the medical-legal arena. The only way you win is not to play the game. Lawyers love the tPA in stroke issue for a variety of reasons. First of all there is no right answer. The science is not clear. Stroke is ubiquitous and as heart attacks go down, stroke keeps going up. There are also so many things that can go wrong in a coordinated stroke care system that a smart lawyer can almost always find something to bitch about.

The bottom line is that you can get sued for either giving or not giving the medication and it is worthwhile for physicians to understand what the tipping points are that push people in one direction or the other. Understand that the entire basis of tPA in stroke has gone way beyond the grounds of science. Huge egos are now involved. I often wonder how much of this science would get published if we did it anonymously with thethought of helping people instead of advancing our careers. Since that will not happen, just understand that big names and big egos will come together on opposite sides of this issue.

The concept of the standard of care never seems to be quite as unclear as in the stroke/tPA question. Everything from who is doing the reading of the CT scans to who is available in neurosurgical backup all come into play. What is often forgotten are the aims and desires of the patient. This really is a risk benefit analysis. Patients need to understand that this treatment is still in its infancy and in the best of all possible controlled series, one in every 19 patients who got the drug bled to death into their head.

There is no such thing as a totally safe procedure or medication. This is especially true with tPA, but to some extent the decision to accept the risk is that of the patient and their family and not the individual physician.

The principle risk to the emergency physician is when the documentation and the proof of what was done do not fully explain the involvement of family and the support services necessary to make this system function. Even the length of time from ordering a CT scan to when the CT scan reading is back represents a risk to the physician and hospital involved. Repeat examinations before and after CT scanning also presents a risk. When the family is willing to say in court and under oath that the patient was improved when they returned from the CT scan and the physician has nothing to defend the giving of the medication, there can be serious

trouble brewing. The contra indications to the giving of the medication are also important, but oft times overlooked. To some extent the package insert materials are behind the times.

The actual causes for lawsuits are multiple but defined. Emergency physicians are most commonly sued not when their hospital does not have a protocol and a system for giving the medication, but when decisions to medicate (its giving or not giving) are not clearly explained on the chart or to the patient. Failures to reexamine, system failures, and patients who fail to qualify because of time constraints, are all important. A growing area of suit is failure to arrange transport in a timely manner. If your hospital does not give the medication, do you have a relationship with a hospital which has such stroke services? And have you so informed the patient?

Another area is also the initial misdiagnosis of stroke. It is estimated that between 20 and 30 percent of what is initially thought to be stroke is a misdiagnosis and is a stroke mimic of some type. An inadequate or incomplete diagnosis is a poor defense when a potentially lethal drug has been given.

Also, expert testimony on both sides of this issue has become nothing less than bizarre. What is actually claimed to help or harm the patient has been exaggerated to the point of unbelievable and needs to be dealt with.

Lastly, the consent issue and the absolute candor in dealing with the family is still the key issue in preventing lawsuits. It is clear that a realistic appraisal and approach are needed if we are to stay out of the courtroom.

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