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ONLINE News

CITATIONS APPEAR 15 DAYS sooner on MEDLINE beginning in mid-April and one and a half months sooner than seen in print in *Index Medicus* it was announced by the National Library of Medicine. Formerly, MEDLINE and *Index Medicus* were updated monthly. Under the new semi-monthly update schedule, the first mid-month update will be in mid-April accelerating the loading of these citations by 15 days. These mid-April updates online (MEDLINE) will appear in print *(Index Medicus)* in the first half of June.

The updates now consist of 10,000-12,000 fully indexed citations. Both the records added at mid-month and those at the end will carry the same Entry Month (EM).

"Because the volume of literature is increasing steadily and because it is NLM's goal to make that literature available as quickly as possible, it was decided to update MEDLINE more frequently," a NLM spokesperson states.

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Online Literature Search Pivotal In Effective Cross-Examination During Malpractice Trial

by Jeffrey A. Haas, Esq., Attorney, San Francisco

All the elements of an old-style western melodrama — a Klondike saloon, misplaced medical records, changing testimony, and an Alaska earthquake during trial — were present in a malpractice case in Anchorage, Alaska. The case was: *Timothy Justice v. Alaska Hospital et al*, Alaska Superior Court, Third Judicial District, No. 3AN-86-00122. Attorney John Hansen of Anchorage and I represented the plaintiff.

What was not old-style was the important role played by a computer search of the medical literature used both by the defense and the plaintiff. Literature searches conducted before — and during — the trial became pivotal to effective cross-examination. The case demonstrates that today, it would be a foolish attorney, indeed, who would prepare his case in the malpractice medical arena without solid pretrial research which certainly includes the availability of online access of information from medical databases.

Before presenting a study of the case, let me interject this caveat: Though this article centers around the use of computer-accessed information to assist cross-examination, the issue was: What is the standard of care in emergency room treatment? An anatomy of what happened in this case and factors that led to the jury's verdict are of more than incidental interest to medical practitioners in today's litigious climate.

Under these circumstances, we attorneys as well as the physicians and institutions we defend or challenge can never lose sight of the ultimate objective: Provide quality patient care to make what is a fine healthcare delivery system even better. This will require the use of new tools and it should be accomplished without fear of unreasonable malpractice litigation. Using the computer to retrieve clinical information will help on both counts.

Case Study: The Plaintiff's Position

While out drinking and dancing in an Anchorage disco, the plaintiff suffered a grand mal seizure. Convulsing, he fell, causing a laceration over his left eye with brief loss of consciousness. Transported to the emergency room of the hospital in an ambulance by paramedics, he arrived in a postictal state and he was incoherent. In the emergency room, the gash was sutured. The patient was described as uncooperative and released into the night in the care of his employer who had been a medical corps-

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man during the Korean War.

During the course of the night and the following day the patient suffered head pain, was photophobic and spoke in incomplete sentences. The following evening, 25 hours after his initial visit, he visited the emergency room again. However, his medical record from the previous evening had been sent to a secretary for transcription and the paramedic run sheet, filled out by the team that transported him, had been sent to accounting for processing. Thus, the patient record was not viewed by the attending physician on the return visit. This physician's diagnosis was post-concussion syndrome with headache due in part to alcohol effect from the night before. Again the patient was discharged, this time by a physician who made no record of any history of seizure or loss of consciousness, presumably because he was not aware of these disorders.

Several days later, the plaintiff suffered a massive stroke from a congenital aneurysm and was rendered hemiplegic. The plaintiff claimed that, had appropriate care been provided, early-warning bleeding from the aneurysm, which caused the seizure and loss of consciousness, would have been discovered and the aneurysm clipped.

Position of the Defense

The defense took the position that the patient was drunk and was so treated. Further, it was claimed that the aneurysm had not bled prior to the plaintiff's visits.

Initially, the defense claimed that it was unable to locate the paramedic run report. Also, it was argued that since the plaintiff logged into the emergency room on the second night, he was presumed to have left against medical advice because there was no medical record of this visit.

This defense was changed when the note of the second visit and the paramedic run report surfaced. Thus, the case reverted to the original position: The plaintiff had a history of seizure, he lost consciousness and suffered head trauma. The issue was: What is the standard of care in an emergency room setting for these conditions?

Defense Witness Cites the Literature

During the trial, an expert witness for the defense, a board-certified emergency room physician from Seattle, testified that she had concluded that the treatment received was satisfactory and that the attending physicians had not fallen below the standard of care. During deposition, she suggested that a question that remained unanswered was: Would a CAT scan have detected a subarachnoid bleed? She extracted articles from the literature which, she said, led her to conclude that it would not have helped.

In pretrial preparation, I had requested two searches from a medical online search firm: One on subarachnoid hemorrhaging and the other on emergency care guidelines.

Important to the plaintiff's case was the defense witness' interpretation of some of the articles. To challenge this, we needed the full text. As the earth tremored in an unnerving Alaska earthquake, we called the search service in Los Altos, California, fearing that the call would not get through. It did; the service provided the full text of the document abstracted in the first search.

Having cited certain portions of these documents, the expert witness thus established that she deemed them to be reliable. Upon receipt of the full text, it was clear to me that a plain reading of the materials did not

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support her contention.

Strategy for the Plaintiff

In medical malpractice suits, abstracts or the full text of documents retrieved from a search of the literature cannot generally be admitted as evidence. Though the piece itself may not be admitted, it may be used, in some circumstances, during cross examination of an expert witness. This was the strategy we used. I read excerpts from the article and asked her to read particular passages as well. In this manner, the jury heard what was actually in the literature even though the article was not regarded as direct evidence.

As to the standard of care in an emergency room, the search retrieved core articles which were helpful in cross examination. From evidence presented, the initial diagnosis of the patient should have been a possible intra-cranial lesion. Then a differential diagnosis should have been completed to ascertain the true nature of his disorder and take appropriate action.

Essentially, the verdict of the jury hung on two points:

I. Where evidence indicates that the patient may be suffering from more than intoxication, there must be a period of observation and appropriate testing before being released. In this case, the paramedic report clearly indicated the presence of neurologic signs with grand mal seizure and a loss of consciousness, regained enroute to the hospital in the ambulance. This was ignored; perhaps because the patient's aggressive and obnoxious behavior after arrival was superficially attributed to intoxication alone. Thus, he was released without thorough examination.

2. In emergency room procedures, there must be scrupulous records management. In this case, the second doctor to see the plaintiff did not have the first doctor's report (it was dictated and sent out for transcription) nor the paramedics' report (it was sent to billing). Thus, in the event of a multiple visit, the second attending physician did not have the benefit of previous reviews.

The verdict: The jury ruled in favor of the plaintiff. It was unparalleled in the State of Alaska in a medical malpractice case and a degree of provincialism fell with it.

Prevalent but Inappropriate

It is becoming prevalent for all sides and special interests to exploit high monetary verdicts which, in my view, is inappropriate. The amount of the judgment is personal to the plaintiff; it need not be recounted here. It represents what my client lost. ❑