

**CASE SELECTION: EVALUATING THE RECORDS TO DETERMINE
WHICH CASES TO REJECT OR TAKE**

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CASE SELECTION: EVALUATING THE RECORDS TO DETERMINE WHICH CASES TO REJECT OR TAKE

The key to success is early identification and treatment of stroke patients before neurologic deficits become irreversible.¹

STROKE- THE BIG PICTURE

As with any case, an attorney's decision to accept or reject a stroke case must necessarily depend upon the specifics of the particular case under consideration. However, in considering a specific case, it is important to think about the big picture within which that one case will be viewed. The big picture for stroke is not a pretty one. It is universally recognized that stroke is a major public health problem. Here are some pertinent statistics that paint the big picture of this serious condition:

- Stroke is the third leading cause of death, behind heart disease and cancer
- There are approximately 700,000 new strokes in the United States every year
- Every 45 seconds someone in the United States suffers a stroke
- On average, every three minutes someone dies of a stroke
- Stroke is a leading cause of serious, long term disability in the United States
- Over 80% of strokes are ischemic strokes²

What these statistics tell you is that millions of Americans are significantly impacted by this medical condition. The defense will use these statistics to send a message to the jury. That message is simple and compelling: the plaintiff's condition is the direct result of a major public health problem, not medical negligence by the physician or hospital. Therefore, when reviewing

¹ Marx, Rosen's Emergency Medicine: Concepts and Clinical Practice, 5th ed (2002)

² Due to the prevalence of strokes of ischemic origin, my discussion is limited to ischemic strokes. Even with this limitation, this paper can only scratch the surface of this evolving and volatile topic.

a potential stroke case, it must be reviewed in the context of the big picture and you must answer the question of whether the records clearly support an assertion that the patient's poor outcome was due to medical neglect rather than the natural course of the disease.

TYPICAL CLAIMS IN A STROKE MEDICAL MALPRACTICE CASE

Most stroke malpractice actions will fall into one of three categories, either (1) failure to diagnose (2) failure to treat in a timely manner, or (3) improper treatment. Among medical professionals, there is a medical mantra of "time is brain" and "every minute counts." These recognized principles emphasize the importance of a proper and timely diagnosis of stroke and the institution of proper and timely treatment for stroke. They should be used as the building blocks of any stroke malpractice action.

FAILURE TO DIAGNOSE

According to the National Stroke Association, the five most common stroke symptoms include:

1. Sudden numbness or weakness of face, arm or leg, especially on one side of the body;
2. Sudden confusion, trouble speaking or understanding;
3. Sudden trouble seeing in one or both eyes;
4. Sudden trouble walking, dizziness, loss of balance or coordination;
5. Sudden severe headache with no known cause.

Note that the word "sudden" precedes the description of each of the five most common stroke symptoms. When reviewing the records, pay close attention to how the onset of symptoms is described, that is, whether the symptoms are described as chronic complaints or

acute complaints, whether their onset was sudden or gradual. It is incumbent upon the healthcare provider to ask appropriate questions to elicit details regarding the onset of the symptoms as far as whether they were sudden or gradual.

As with most medical conditions, a laundry list of medical conditions other than stroke may appropriately be in a differential diagnosis with these symptoms. The presence of one or more of these common stroke symptoms does not necessarily establish a diagnosis of stroke, rather, the presence of these symptoms requires the practitioner to include stroke in the differential diagnosis. Given the serious consequences that frequently result from stroke, once included in the differential diagnosis, proper steps must be taken in a timely manner to confirm whether the patient is suffering from stroke. The significant harm caused by stroke is one way you can use the dire statistics of stroke to support your claim that the diagnosis of stroke must be aggressively pursued in the presence of symptoms that could be caused by a stroke even though they may also be consistent with many other diagnoses.

I recently heard it said by a stroke expert that the diagnosis of stroke is 90% clinically based. Therefore, it is imperative that the practitioner obtain an accurate history and perform a complete neurological physical examination. The failure to obtain a complete history or obtaining an inaccurate history may lead to a failure to diagnose stroke. An appropriate history should identify risk factors for stroke which would include high blood pressure, heart disease, diabetes, smoking, carotid artery disease, prior history of stroke, high cholesterol and transient ischemic attacks (TIA), among others. Similarly, an incomplete physical examination may obscure the cause of the patient's presenting signs and symptoms. Inspect the records to make sure the patient had an evaluation of motor function, sensation, gait, speech, vision, and orientation. Given the importance of clinical factors in diagnosing stroke, careful attention

should be paid to the history and physical examination when reviewing the medical record in a stroke case.

Another area to consider in a failure to diagnose stroke case is the interpretation of imaging studies. Stroke can be confirmed on imaging studies based on the identification of the lack of flow or slow flow through an artery. If radiological studies were ordered as part of the patient's work-up, those studies should be obtained and reviewed. I have handled at least one case where the radiologist interpreted an MRA as normal when in fact there was an absence of flow demonstrated in the basilar artery. That misinterpretation of the film altered the treatment decisions by the attending physician. The patient's condition progressed over the course of the next few days. It was the plaintiff's contention that the plaintiff's condition would not have worsened if the treatment that would have been provided with a correct interpretation of the films had been pursued.

A case may also be based upon the failure to obtain appropriate imaging studies. For example, if stroke is suspected, there may be a need to obtain imaging studies to demonstrate the location of an occlusion in the artery. The site of the occlusion may affect treatment decisions such as whether to use Heparin, intra-arterial tPA or whether to transfer.

TIMELINESS OF TREATMENT

Remember that an acute ischemic stroke is caused by impaired flow of blood to the brain. Therefore, the treatment of acute ischemic stroke is all about restoring adequate blood flow to the brain in a timely manner. The goals of timely treatment are to reverse the signs and symptoms of stroke that have already occurred or to at least prevent the signs and symptoms from progressing.

Allegations based on untimely treatment of stroke typically fall into one or more of the following categories:

1. Complete failure to provide any treatment of stroke;
2. Delayed treatment of stroke;
3. Failure to transfer.

Failure to treat

For many years stroke was viewed by the healthcare profession as unpreventable and untreatable. Some healthcare practitioners have been reluctant to abandon that firmly entrenched fatalistic attitude about stroke. As a result, some healthcare providers approach stroke patients with “watchful waiting” rather than by providing prompt treatment. Those interested in changing the attitudes about the importance of treating stroke as an emergency use an analogy to heart attack treatment and emphasize a stroke is a “brain attack” and “time lost is brain lost.” Despite these educational efforts, it is entirely possible to review records and see that stroke was correctly diagnosed but no treatment for stroke was provided. Even with a total lack of treatment for a diagnosed stroke, there will still be highly qualified stroke experts who will say the lack of any treatment is acceptable because there is no scientific proof that treatment would have changed the outcome.

Delayed treatment

Delays in treatment can and do occur at any point in the chain of care after the patient enters the healthcare delivery system. Because stroke is an acute event, many patients initially seek care for their symptoms from hospital emergency departments. An uninformed triage nurse may code the patient as non-urgent and leave him sitting for an extended period of time in a waiting room; an emergency room physician may not institute therapy himself or may delay in

calling a neurologist while “waiting and watching” the stroke patient; or, the neurologist when called may not come to see the patient, may not order therapy or may not act quickly in obtaining definitive imaging studies to define the source of the patient’s symptoms. It is not unusual to see delays at more than one of these points in the delivery of care and treatment for a stroke victim.

One context in which time is recognized as being of particular significance is with patients who are candidates for thrombolytic therapy. There are well defined criteria for the use of tPA. It is generally accepted that intravenous tPA must be administered to an appropriate candidate within three hours of the onset of stroke symptoms. Onset of symptoms is generally defined as the last time the person was known to be asymptomatic. Therefore, if a person wakes up with symptoms of stroke, the three hour clock starts to run not from the time they woke up, but from the time they went to sleep without symptoms. For intra-arterial tPA, the time for use is somewhat less strict with accepted times varying between six to twelve hours of the onset of symptoms.

In evaluating a potential stroke case, one should determine whether the hospital has developed or adopted criteria for the use of tPA. It is important to evaluate whether nursing personnel have been properly trained and are aware the hospital has criteria for the use of tPA; do they know what the criteria are; are they aware of the time sensitive nature of the use of tPA; have they moved the patient through the process in a timely manner so as not to lose the opportunity to treat with thrombolytics.

Failure to transfer

Another important aspect of stroke care is recognition by healthcare providers and facilities of their own limitations in the diagnosis and treatment of stroke. If a patient presents to a rural hospital with signs and symptoms of a stroke which that facility is incapable of treating,

there must be a prompt transfer of the patient to a facility capable of handling the patient. Keeping a patient at a hospital that is incapable of handling a patient's stroke progression can support a claim of negligence.

IMPROPER TREATMENT

There are several recognized therapies for acute ischemic stroke. These include the use of antithrombotic therapy, including antiplatelets (aspirin), and anticoagulants (Heparin), and thrombolytic therapy, including intravenous tPA, intra arterial tPA, or other endovascular techniques, or a combination of these therapies. There will be circumstances where an antiplatelet is given and Heparin should be added based upon a change in the patient's signs or symptoms or based upon more precise imaging studies. There may be a case based upon the failure to administer tPA when it should have been given or based upon the administration of tPA when its use was contraindicated. If a patient is a candidate for thrombolytic treatment, Heparin should not be given. Thus, the giving of Heparin can result in a patient being denied thrombolytic therapy that could reverse the patient's condition.

HOSPITAL LIABILITY

An area of potential liability of the hospital is a failure to enact a program for stroke care. It has been well established in the medical literature that stroke centers improve the outcome of patients with acute ischemic stroke.³ A hospital that holds itself out as having expertise in the diagnosis and treatment of stroke has an obligation to act reasonably in establishing a program to provide proper and timely diagnosis and treatment to those patients.

THE CAUSATION BUGABOO

³ Recommendations for the Establishment of Primary Stroke Centers, JAMA, Vol. 283, No. 23 (2000)

In most stroke cases, a major issue will be causation. There is a lot of controversy in the medical literature and among neurologists as to the efficacy of different available treatment regimens. Thus, you may well have a case of screaming negligence based on a failure to diagnose or to timely treat a stroke, but a significant question will be presented as to “so what.” For example, most neurologists will tell you that for certain specific stroke subtypes, Heparin is effective in preventing stroke progression. However, the defense will argue there is no randomized controlled clinical study that establishes the efficacy of Heparin in halting stroke progression. There is ample literature embracing the use and effectiveness of Heparin in certain subtypes of stroke. Conversely, there is ample literature asserting the absence of a randomized controlled clinical study establishing that Heparin is an effective therapy militates against its use.

Intravenous tPA was approved by the FDA for treatment of acute ischemic stroke in 1996. There are strict criteria establishing when it can be used and there are many contraindications to its use. Despite the acceptance of intravenous tPA by the neurological community, there are emergency medicine opinions that tPA is not standard of care for emergency physicians.⁴

Intra-arterial tPA for the treatment of acute ischemic stroke has not been approved by the FDA. Its use for this purpose is an off label use. However, intra arterial tPA under certain circumstances has been found to be extremely beneficial and effective. Not all hospitals will have intra arterial tPA, however, those that do are obligated to offer it to patients when appropriate and are obligated to know when it is indicated and when it is contraindicated.

Thrombolytic agents have the potential of reversing a patient’s neurologic impairments before they become irreversible. Thus, there may be a patient who presents with significant

⁴ Solomon, R.C., TPA for Acute Ischemic Stroke: The Standard of Care?, American College of Emergency Physicians (2004)

neurologic impairments, even quadriplegia, whose condition can be reversed and the patient be left with no neurologic deficits. On the other hand, antiplatelets and anticoagulants will usually not reverse a patient's neurologic impairments but will only prevent further progression. Of course preventing progression can be of great importance. It can mean the difference in a patient who progresses to a "locked-in" state due to lack of timely or appropriate treatment and a patient who would have had only minimal neurologic impairment with proper and timely treatment. It can mean the difference in a patient who is totally disabled versus someone who is capable of returning to work with limited incapacity.

Lee v. Satilla Health Services, Inc., 220 Ga. App. 885 (1996) is recommended reading for anyone handling a stroke case. In Lee, it was alleged there was a failure to diagnose and treat a patient for stroke. The plaintiff contended her discharge from the emergency department "prevented the administration of therapies that could have prevented the progression of the stroke." The hospital moved for summary judgment on four different grounds, one of which was proximate cause, and the motion was granted. The hospital contended there was no proof to a reasonable degree of medical certainty that the patient's outcome would have been different if she had been diagnosed correctly in the emergency department. The opinion cites extensively to the testimony of the plaintiff's expert in support of its reversal of the summary judgment. Importantly, the appellate court noted that the lack of "scientific data" to prove early diagnosis and treatment would have changed the outcome was not determinative on the issue of causation. The court looked approvingly upon the expert testimony by the witness that "[t]here is evidence that we actually can make a difference" and held that the absence of scientific data to support that position was why it was just an opinion and could not be stated to a medical certainty.

The Lee decision was commented upon in Sanders v. Cowart, 231 Ga. App. 303(1998). In Sanders, the court affirmed the trial court's exclusion of evidence the plaintiff's "small strokes" were caused by the trauma of having a physician's examining lamp dropped on her head. The court found the evidence did not establish a probability that the trauma caused the "small strokes." The court noted that in Lee there was adequate evidence of proximate cause because the expert testified there was a probability the defendant's negligence **exacerbated** the plaintiff's injuries.

CONCLUSION

Malpractice actions based on failure to diagnose and treat stroke are complicated, time consuming and expensive. The controversy in the medical profession as expressed in their literature guarantees that your assertions at trial will be countered by strong evidence. Make sure the medical records provide clear evidence of negligence, that your client has a significant, permanent disability and that your case presents a good argument on causation supportable by recognized stroke experts before you advise a client to pursue an action of this nature.