

Medical Negligence in the Emergency Department

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- ◆ Risk in the ED
- ◆ Common clinical patterns of EM negligence cases seen in Courts
- ◆ What to seek beginning each case beyond case notes



- ◆ 1.4 million patients per yr in Ireland
- ◆ Human & environmental factors:
- ◆ High ratio of junior to senior staff
- ◆ Supervision limited
- ◆ High turnover- 3-6 month duration
- ◆ **Anything & Everything**
- ◆ Reliance on Locums



Errors

- ◆ Predictable
- ◆ Preventable
- ◆ Enabled by dysfunctional work environment



Mitigate against that risk

- ◆ Teaching & induction courses
- ◆ Guidelines
- ◆ Human factors training
- ◆ Senior review on patients going home eg board rounds
- ◆ IT system with checks
- ◆ GP and patient follow-up advice

Risk reduction & clinical governance

- ◆ Review x-rays
- ◆ Note review
- ◆ M&M meetings
- ◆ Risk register



Postgraduate education

- ◆ Human Factors Training
- ◆ Simulation training
- ◆ Communication
- ◆ Teamwork within hierarchy
- ◆ Admission of error and open disclosure





Staffing

- ◆ Over reliance on locums
- ◆ From agency- no interview or screening
- ◆ Consultant not on MC Specialist Register
- ◆ Dr Hadiza Bawa Garba case



*Common clinical negligence
claims in Emergency
Medicine*

- ◆ Undifferentiated
- ◆ Where outcome can range from mild to catastrophic...”grey area” cases



Common clinical negligence claims

- ◆ Chest pain
- ◆ Headache
- ◆ Missed “minor” injuries

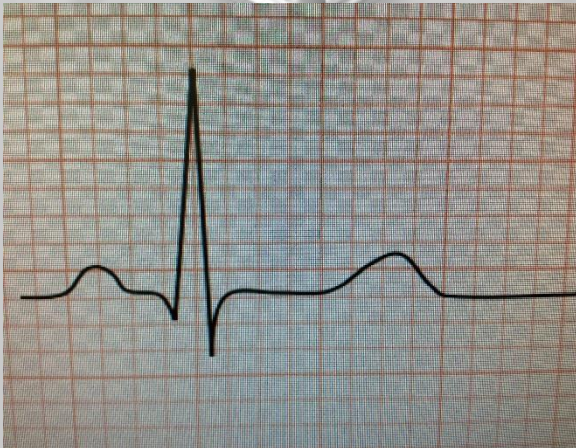
Chest pain

- ◆ Very common presentation
- ◆ 65yr man gardening after his lunch with flu like symptoms
- ◆ Muscular injury
- ◆ Indigestion
- ◆ Chest infection
- ◆ Shingles
- ◆ “Heart attack” myocardial infarction
- ◆ Aortic dissection

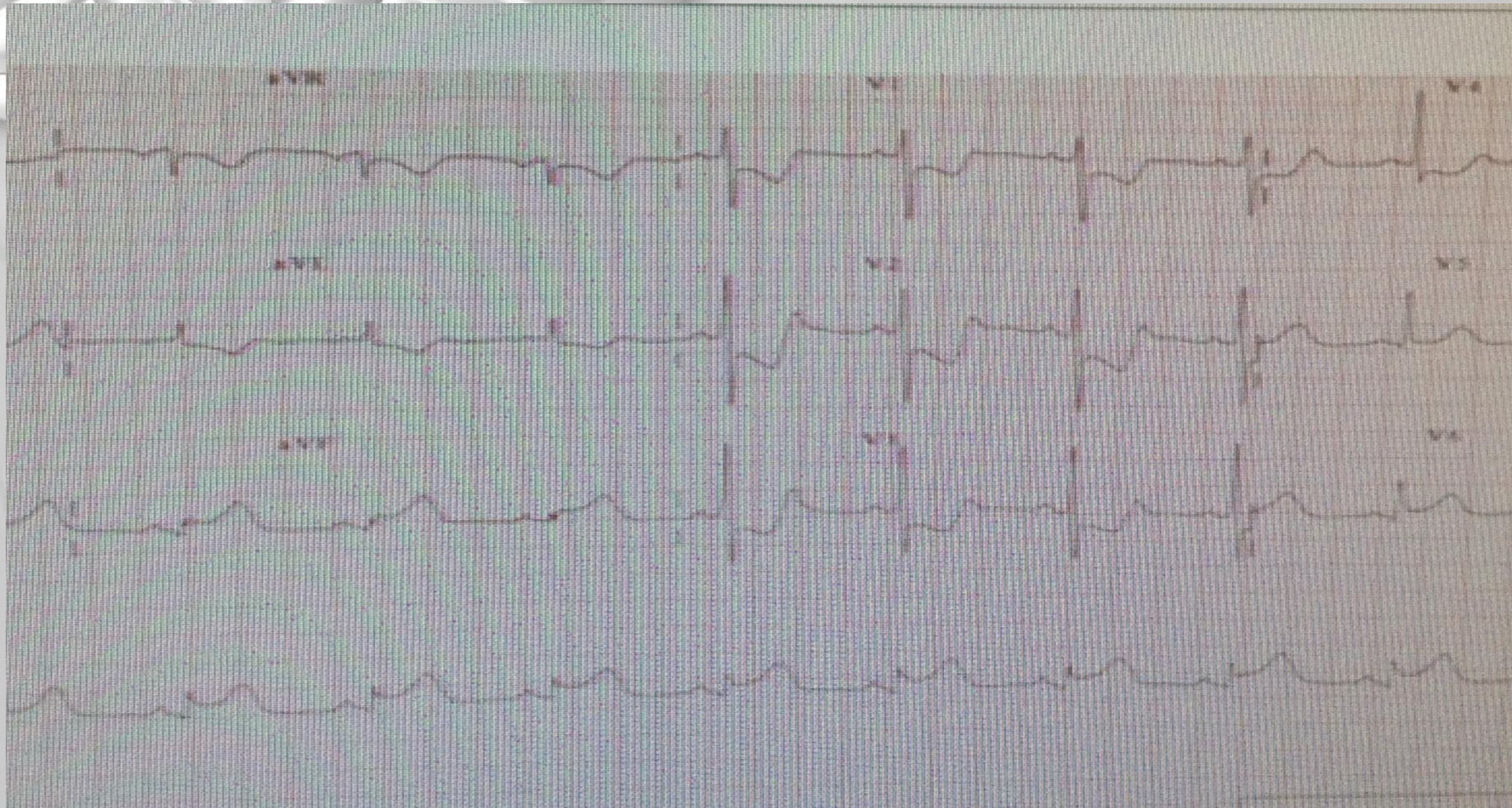


Risk stratify

- ◆ Previously 72 hours observation
- ◆ Risk scoring systems
- ◆ Pathways incl triple assessment of :
 - ◆ ECG
 - ◆ Cardiac enzyme blood tests
 - ◆ History & risk-profile still the most important



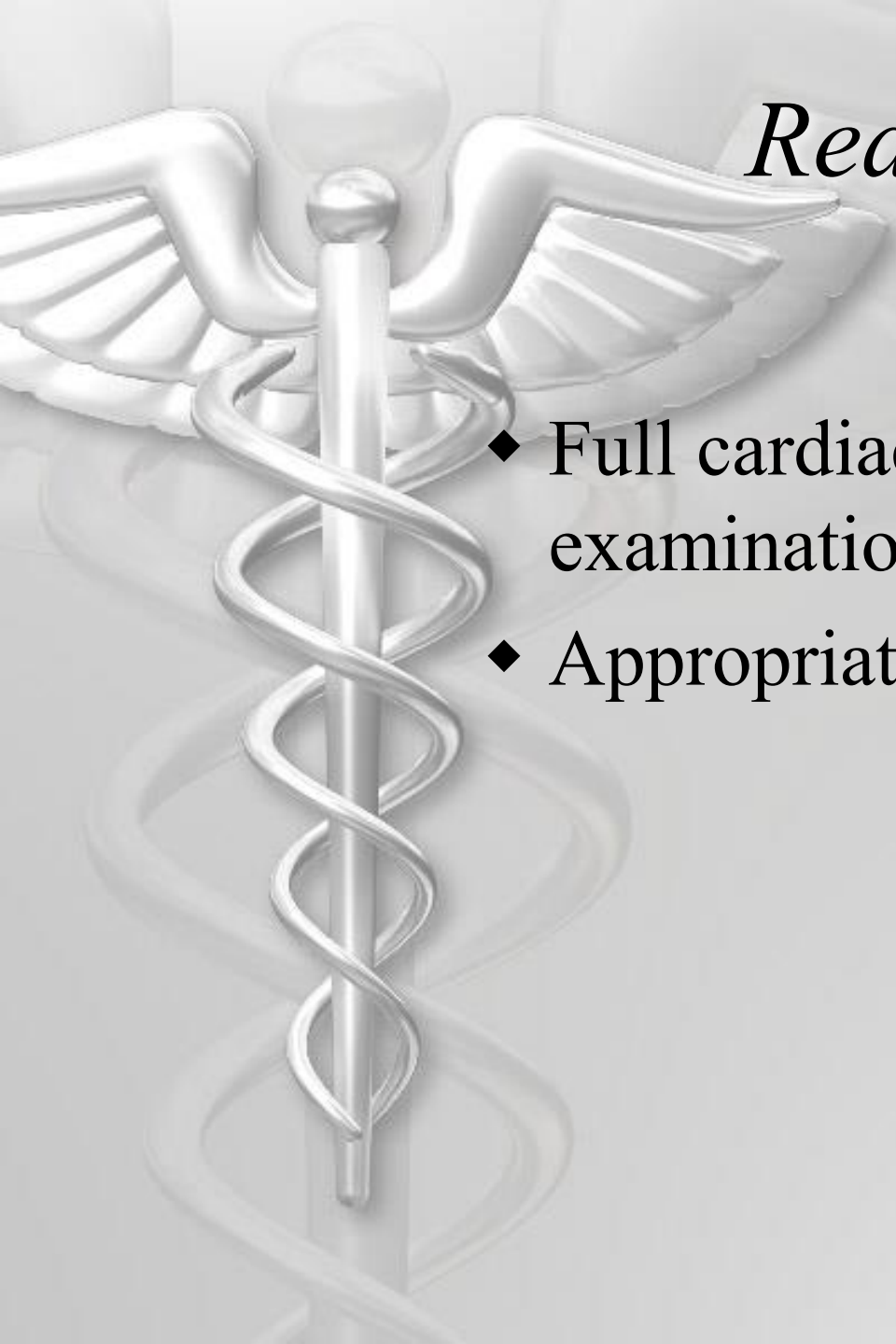
ECG





Reasonable standard

- ◆ History eliciting nature of pain
- ◆ Associated symptoms
- ◆ Risks- smoking
- ◆ Family history
- ◆ High cholesterol
- ◆ High blood pressure
- ◆ Cocaine use



*Reasonable standard
expected*

- ◆ Full cardiac and respiratory examination
- ◆ Appropriate investigations



Room for Error

- ◆ **History** -Failure to give adequate weight to risks
- ◆ Too much weight to early results that are normal.
- ◆ Investigations- Misinterpretation of ECG
- ◆ Timing of blood tests
- ◆ Failure to arrange follow up or give advice to return
- ◆ Catastrophic consequence, death and heart failure



*26 year old female with
chest pain*

- ◆ Muscular
- ◆ Chostochondritis
- ◆ Pulmonary Embolus
- ◆ Chest infection
- ◆ Cardiac cause e.g. myocarditis



Reasonable care expected- full History

- ◆ Family history
- ◆ Clotting disorders
- ◆ Full obstetric history incl miscarriages
- ◆ Drugs incl. OCP
- ◆ Smoking
- ◆ Travel
- ◆ Recent surgery
- ◆ DVT



Specific features of pain

- ◆ Pleuritic pain
- ◆ Shortness of breath (dyspnoea)
- ◆ Coughing blood (haemoptosis)
- ◆ Palpatations

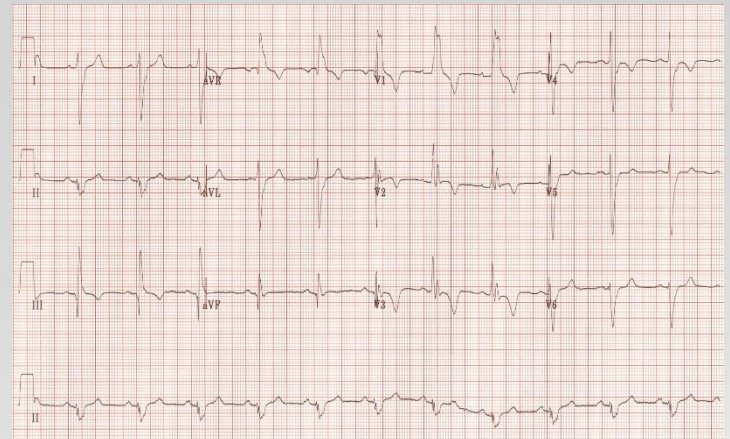


Full examination

- ◆ Include calves
- ◆ Full respiratory exam
- ◆ Risk stratify
- ◆ Wells Criteria

Appropriate investigations

- ◆ D-Dimers
- ◆ CXR
- ◆ ECG- specific changes
- ◆ CT Pulmonary Angiogram





Room for error

- ◆ Failure to explore risks in History
- ◆ Too much weight to investigations
- ◆ Failure to treat before results final



*56 year old man with chest
pain*

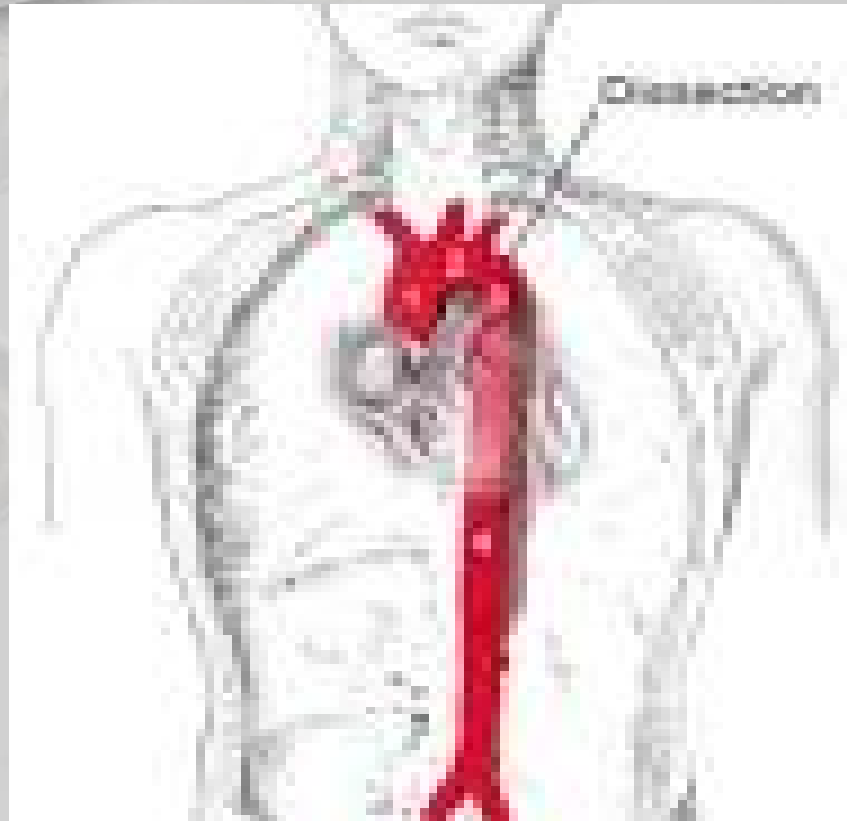
- ◆ Tearing pain
- ◆ “Out through my back”
- ◆ High blood pressure



Differential

- ◆ Indigestion
- ◆ Pancreatitis
- ◆ Acute coronary syndrome
- ◆ Gallstones
- ◆ Aortic Dissection

Aortic Dissection





Risks

- ◆ High blood pressure
- ◆ Smoker
- ◆ Family History
- ◆ Connective tissue disorders
e.g. Marfans
- ◆ Trauma
- ◆ Anticoagulants



Reasonable care expected

- ◆ Full History
- ◆ Full exam incl. blood pressure both arms
- ◆ Echo
- ◆ CXR- widened mediastinum
- ◆ CT Angiogram Thorax



Aortic dissection





Management

- ◆ Depending on grade
- ◆ Surgical
- ◆ Manage blood pressure
- ◆ Avoid anticoagulants



Room for error

- ◆ Atypical presentation
- ◆ Failure to think of it
- ◆ Failure for timely access to CT



*Myocardial Infarction,
Pulmonary Embolus,
Aortic Dissection*

- ◆ Catastrophic consequence & death if not treated in time
- ◆ Seek notes
- ◆ Seek grade of doctor
- ◆ Seek guidelines
- ◆ Seek discharge policy incl follow up
- ◆ Seek teaching record
- ◆ Seek timeline of investigations & treatment

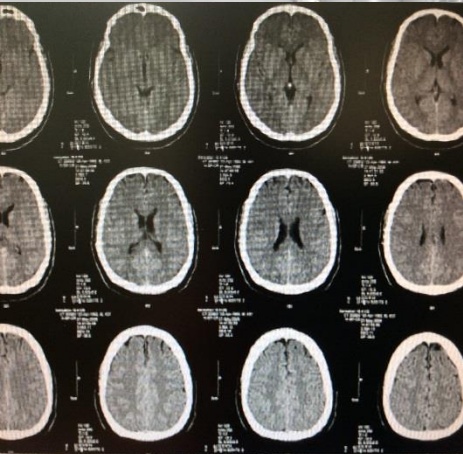
Headache

- ◆ 42 yr old woman headache and nausea
- ◆ Mild benign headache
- ◆ Meningitis
- ◆ Hemorrhage
- ◆ Stroke
- ◆ Carbon monoxide poisoning
- ◆ Tumour



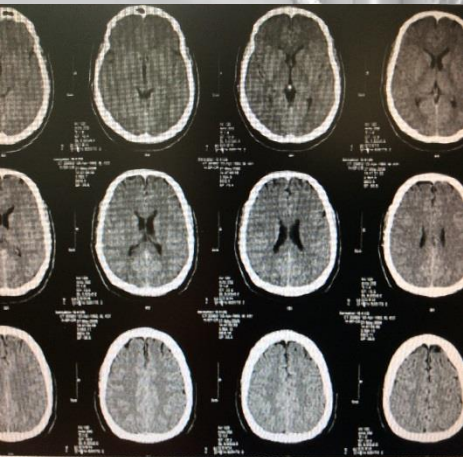
Headaches

- ◆ Very common, high volume
- ◆ Risk of CT v balance
- ◆ **History ...red flags**
- ◆ Full exam
- ◆ Guidelines
- ◆ Senior doctor requesting a CT
- ◆ Period of observation
- ◆ Follow up



Error occurs...

- ◆ Failure to recognize “red flag” symptoms
- ◆ Failure to take proper history and heed concerns of relatives
- ◆ Failure to give follow up
- ◆ Failure to follow guidelines
- ◆ Expand discovery search





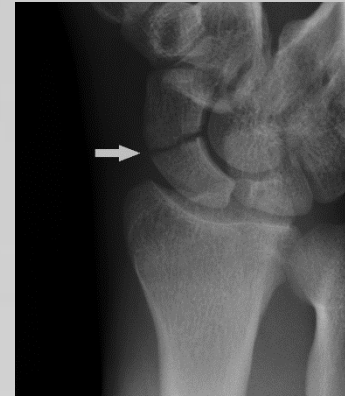
Missed "minor injuries"

- ◆ Again high volume
- ◆ Distracting injury
- ◆ Not apparent initially but severe consequences if missed
- ◆ Hands and feet
- ◆ Sports & various professions
- ◆ Hand dominance

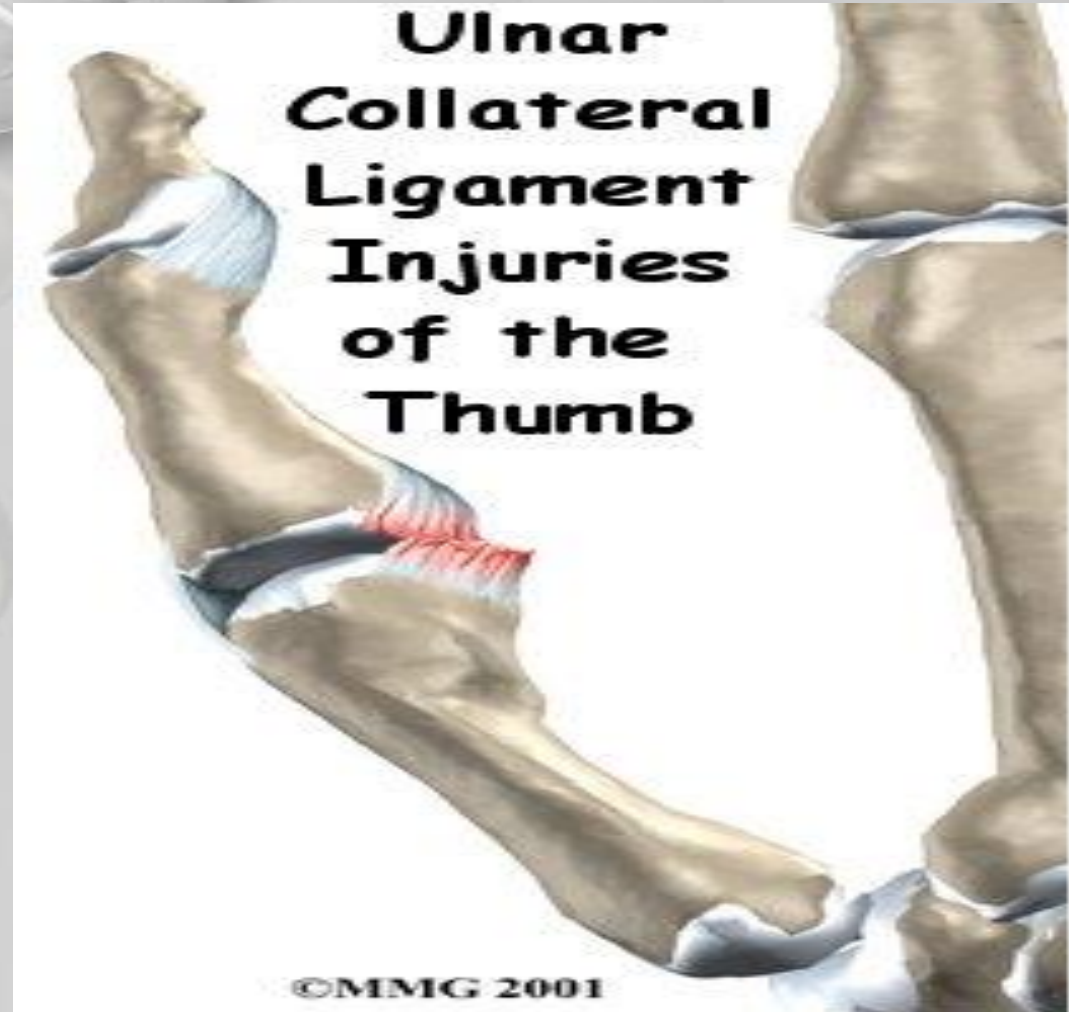
Scaphoid injuries

FOOSH

- ◆ X-ray of limited use
- ◆ Poor blood supply
- ◆ Splint if suspicious
- ◆ Review in 10 days +/- MRI scan
- ◆ Often missed in major trauma or wrist X-ray normal
- ◆ Seek guidelines & teaching



Skier's- thumb





“soft tissue” injury

- ◆ Quads rupture
- ◆ ACL tear
- ◆ Achilles rupture
- ◆ Talofibular ligament inversion injury
- ◆ Normal X-ray
- ◆ MRI excellent
- ◆ Follow-up review

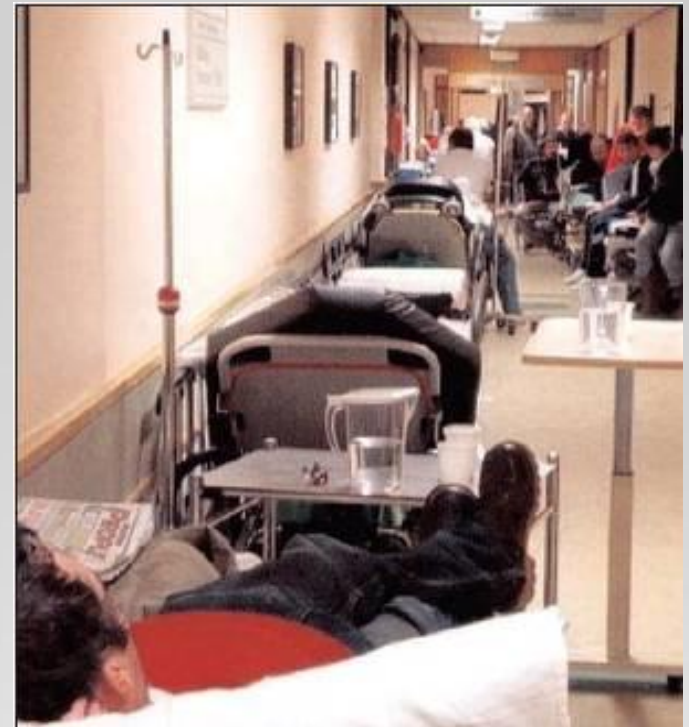


*Greatest risks to patient
safety in Irish EDs*

- ◆ Overcrowding
- ◆ Recruitment crisis

Overcrowding

- ◆ Resigned acceptance & tolerance



Wealth of scientific international evidence



- ◆ Australia, North America, Canada, Ireland
- ◆ Research proves overcrowding leads to fatal errors
- ◆ IAEM estimate 350 patients per year **die** as a direct result of overcrowding



Why so dangerous?

- ◆ No monitoring
- ◆ Drug errors...wrong investigations
- ◆ Infection control



No safe examinations

No confidential history

Entry block



Overcrowding

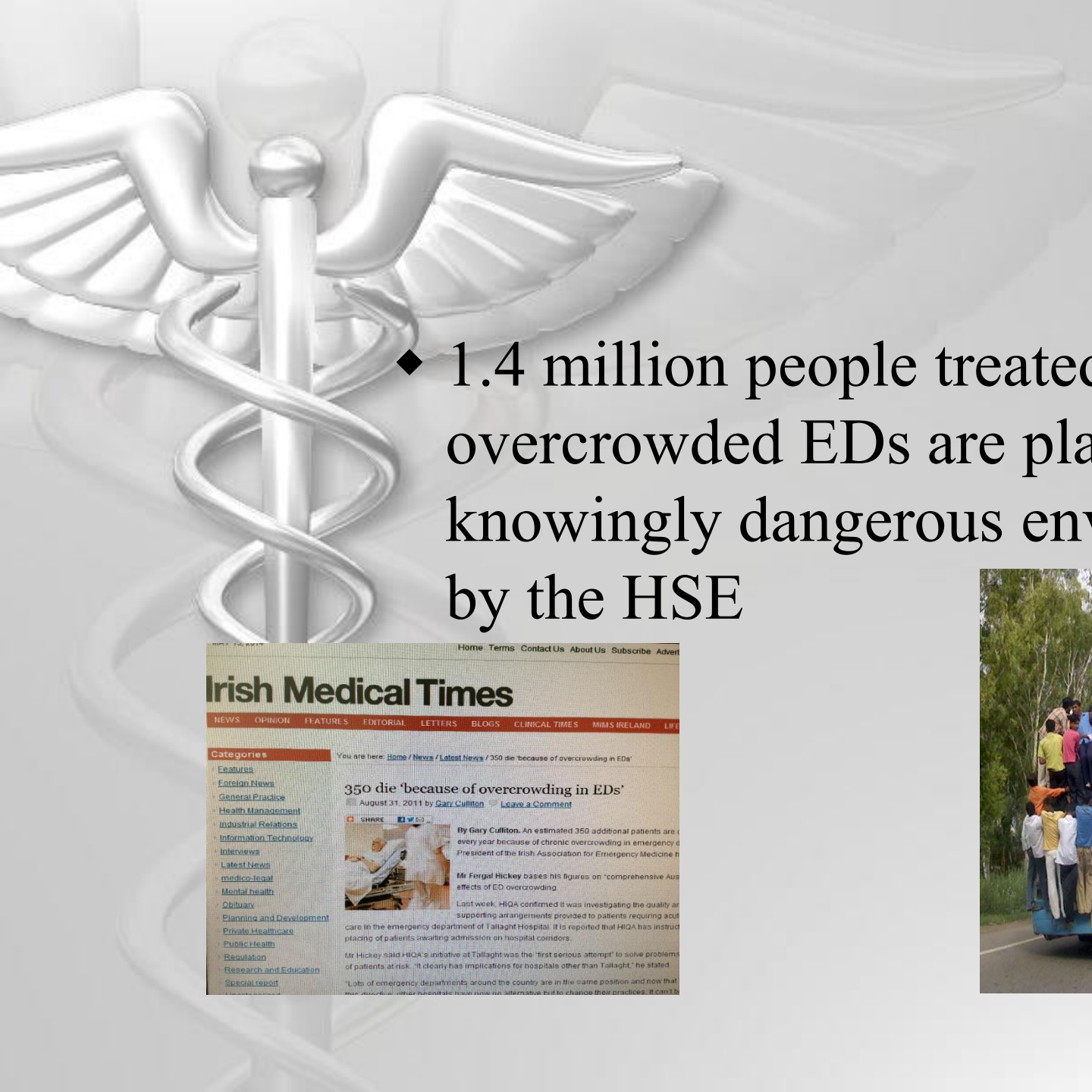


Report of the investigation into the quality, safety and governance of the care provided by the Adelaide and Meath Hospital, Dublin incorporating the National Children's Hospital (AMNCH) for patients who require acute admission

8 May 2012

Safer Better Care

- ◆ HIQA report in 2012
- ◆ 76 recommendations
- ◆ Advised HSE overcrowding is dangerous and unsafe & should cease
- ◆ Unlike the Courts, HIQA have no powers of sanction against Hospital

- 
- ◆ 1.4 million people treated in overcrowded EDs are placed in a knowingly dangerous environment by the HSE



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350 die 'because of overcrowding in EDs'

August 31, 2011 by [Gary Culliton](#) [Leave a Comment](#)

By Gary Culliton. An estimated 350 additional patients are every year because of chronic overcrowding in emergency d President of the Irish Association for Emergency Medicine h

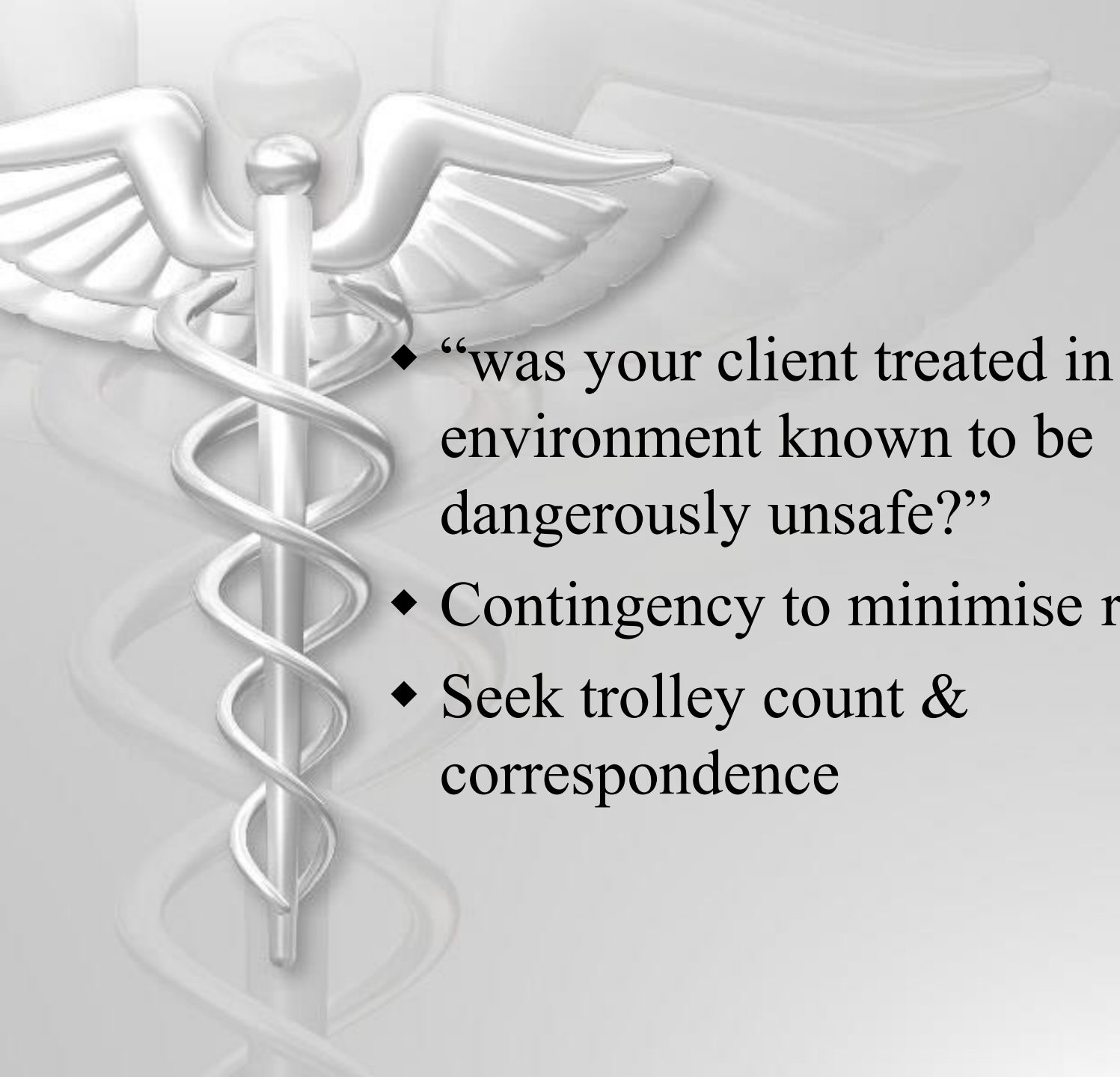
Mr Fergal Hickey bases his figures on "comprehensive Aus effects of ED overcrowding.

Last week, HICA confirmed it was investigating the quality ar supporting arrangements provided to patients requiring acut care in the emergency department of Tallaght Hospital. It is reported that HICA has instruct placing of patients awaiting admission on hospital corridors.

Mr Hickey said HICA's initiative at Tallaght was the "first serious attempt" to solve problems of patients at risk. "It clearly has implications for hospitals other than Tallaght," he stated.

Lots of emergency departments around the country are in the same position and now that the medical profession have time on their side to change their practices, it can't b





- ◆ “was your client treated in an environment known to be dangerously unsafe?”
- ◆ Contingency to minimise risk?
- ◆ Seek trolley count & correspondence

Reasonable standards

- ◆ Bolam test
- ◆ Dunne v NMH
- ◆ Reasonable doctor....Should the Courts ask what is a reasonable Hospital?
- ◆ Corporate governance failures lead to clinical governance failures causing poor clinical outcome
- ◆ Powers of sanction



What are you doing holding that patient's chart?!

One of these patients on a trolley might see it!



DATA PROTECTION OFFICER VISITS...



EM clinical negligence claim

- ◆ Are Guidelines evidence based?
- ◆ Clinical care pathways
- ◆ Organisational hazards & risks identified & monitored
- ◆ Overcrowding: Patient knowingly placed in dangerous environment
- ◆ Seek discovery of correspondence between clinicians and hospital regarding risks, staffing, overcrowding

Thank you



