THE SULLIVAN GROUP

TSG NEWSLETTER

SAVING LIVES - REDUCING RISK

From The Editor

Now that I have recovered from taking (and passing!) my third emergency medicine board examination, it is time to get back to the newsletter.

I recently had the pleasure of attending the Cayman Captive Conference and prepared a short summary of emergency medicine malpractice trends for my Risk Retention Group's board meeting. As one of my partners is fond of saying, you need to skate to where the puck is going to be. This certainly holds true in risk and safety in emergency medicine. Based on the literature and practice trends, what are the new risks, what are the patient safety issues, and where is our potential liability? What can we do to keep patients safe and minimize exposure to litigation?

In preparing this newsletter, I have relied to some extent on a 20 year review (through 2006) of emergency medicine malpractice published by the Physician Insurance Association of America (PIAA), to a great extent on the experience of TSG clients, the experience of my medical group's Risk Retention Group, and our ongoing review of recent adverse events, incidents, and new claims ■

Wishing you and your families a safe, peaceful, and joyous holiday season

From
The TSG Family

In This Issue...

Don't Forget The Basics

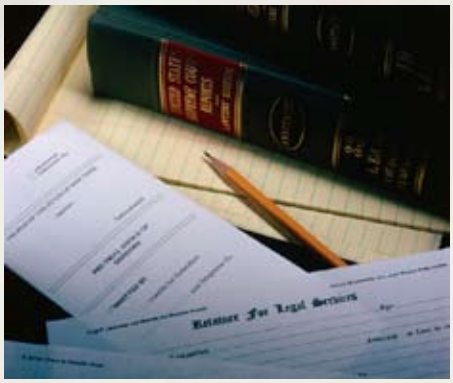
All resources point in the same direction. Abdominal pain and chest pain related claims are frequent and costly and must remain a high priority for all emergency practitioners.

According to PIAA, between 1985 and 2006, the most common patient conditions for which claims were filed against emergency physicians were acute myocardial infarction (AMI) and symptoms involving the abdomen and pelvis. For claims closed in 2006 alone, the most prevalent patient condition was also AMI, and 4 of 10 claims resulted in an indemnity payment. The next most prevalent condition was symptoms involving chest pain.

In the 20-year cumulative data, claims involving errors in diagnosis cited appendicitis as the most prevalent condition that was incorrectly diagnosed by emergency practitioners. This condition was followed by acute myocardial infarction, symptoms involving the abdomen or pelvis, chest pain, and meningitis. Of these, errors in diagnosing AMI resulted in the highest percentage of paid claims (60.4%) and errors in diagnosing meningitis resulted in the highest average payment ($437,670).

Things have changed dramatically with regard to the incidence and failure to diagnose meningitis in the last 20 years. With the H. Flu vaccine, meningitis should begin to fall off the radar screen for frequency, but certainly not for severity (dollar amount) of claims. However, AMI, other chest pain related pathology, and abdominal related claims remain frequent and costly events from all data resources TSG utilized in putting together this report. Keep your risk and safety efforts pointed in this direction ■

Stroke



If you have not seen stroke related litigation yet, you will soon. Stroke related lawsuits are hitting the radar screen. There are a couple common fact patterns.

The first is the failure to administer tPA. There is now enough literature to establish this treatment option at least as a best practice, if not an evidence-based practice. Hospitals need to be ready, willing, and able to administer tPA to the appropriate patient population. If you and the hospital are not prepared, you are at significant risk. These claims result in huge dollar amount settlements and judgments.

Although there has been controversy over the administration of tPA for stroke, much of that has been resolved. At each meeting of the American College of Emergency Physician's (ACEP) Medical Directors Academy, I ask 100 Medical Directors if they and their hospitals are administering tPA for stroke and also how many believe that this is appropriate manage-

ment. Three years ago about 25% of the audience raised their hands, indicating that they had a stroke program and believed in the management. Last month (Nov. 2008) I asked again, and it appeared that every hand in the room went up. This pendulum has swung.

There remain physicians who don't want to administer the drug and don't believe that there is enough medical evidence behind the management strategy. This is dangerous territory. If you don't believe in administering the drug, don't work in a hospital with a stroke program.

Many national organizations, including the American Heart Association and the American Stroke Association (ASA), believe that this is acceptable and appropriate treatment. The ASA and the Joint Commission have teamed up to create a primary stroke center certification. If you are still fighting this fight, from a risk perspective you have already lost.

The second common scenario is tPA administration that is not consistent with established protocol. In reviewing the claims, patients typically develop an intracranial bleed and decompensate or die. The allegation is improper administration of the drug based on time frame, blood pressure elevation, or one of the other contraindications. Stay strictly within the parameters of the protocol.

Also, get Neurology involved if you have any neurologists left at your hospital who are willing to participate in a stroke program. It is very useful, but certainly not mandatory, to have a consultant's opinion in this high risk area.

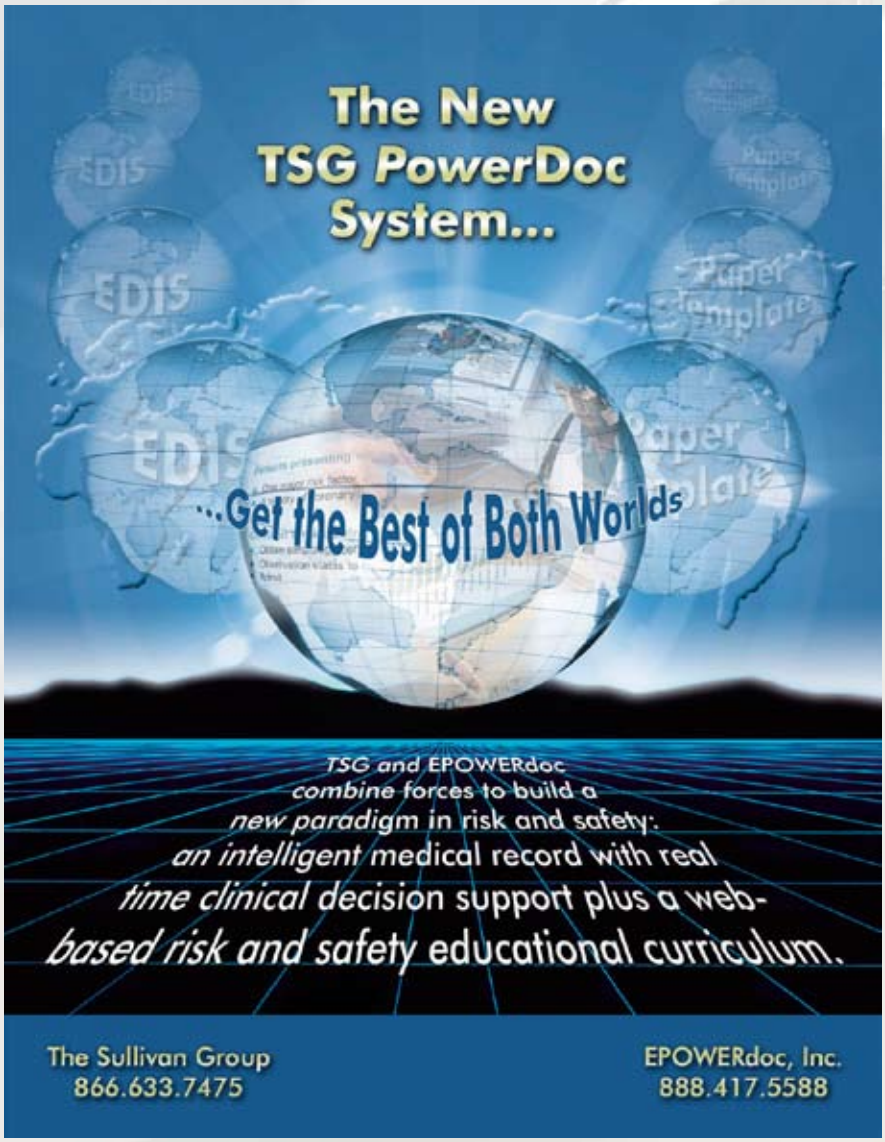
This is a key area for a risk and safety initiative. Organize the hospital system behind the program, involve the entire medical staff, coordinate the ED physicians and nurses as a team, and carefully monitor stroke program related activities ■

Sepsis

If the recent sepsis literature is accurate, we have been significantly under treating sepsis patients. The current medical literature suggests a number of opportunities to improve sepsis patient outcomes. TSG's experience with hospitals that have initiated sepsis programs strongly suggests that appropriate re-hydration, measurement of serum lactate, and other measures have had a dramatic impact on morbidity and mortality.

It is important for emergency and other practitioners as well as hospitals to stay current with the state of the literature related to sepsis. It is too early to declare with certain-

Introducing A New & Safe Way To Practice



ty that the failure to begin these therapies represents substandard care. However, when therapy can change the outcome to the extent suggested by the recent literature, it may become necessary to evaluate your current approach and make some adjustments. You don't want to be one of the early plaintiff attorney's test cases for the failure to utilize appropriate management strategies in the treatment of sepsis patients.

There is additional information on sepsis and sepsis bundles at a web site called Surviving Sepsis Campaign http://ssc.sccm.org ■

Acute Coronary Syndrome (ACS) Litigation

We mentioned chest pain and the failure to diagnose MI above. This section is focused on time frames in ACS management. There is a growing recognition regarding the urgency of getting appropriate patients to coronary artery intervention at the earliest possible

time. As a result, time frames have become a hot topic: door-to-ECG, door-to-doctor, door-to-cath lab, and door-to-balloon.

TSG believes that this will become a new focus in ACS litigation. The overall incidence in failure to diagnose MI appears to be declining according to several large national emergency medicine organizations. That is great news. Practitioners have recognized that reduced chest pain with the administration of an antacid does not rule out ACS, and the failure to stop chest pain with the administration of nitrates does not rule out ACS. ECG interpretation has become more sophisticated. As a result, we have made some headway in "failure to diagnose MI."

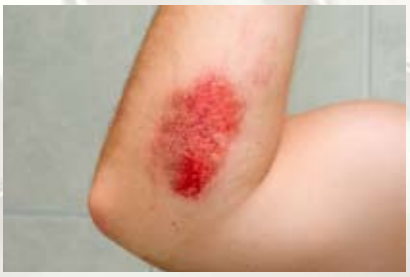
The future will bring allegations related to delays in management. If your average time from door-to-ECG is 30 minutes, it is unlikely that the average time to cath lab will be 90 minutes. The ED is the key to initiating and expediting the evaluation and management of ACS patients.

EDs with rapid door-to-ECG times typically have a "first touch" policy. That is, the first person to make contact with the chest pain patient is responsible for obtaining the ECG or making sure someone else does. It is particularly helpful to have an ECG machine and recliner or stretcher in triage for those times when there is no stretcher space available. Any system that relies on pagers and busy technicians is destined to fail.

Although the 10-minute door-to-ECG is just a guideline promulgated by the American Heart Association and the American College of Cardiology, it is a laudable goal, and rapid ECG acquisition is required to get patients to the cath lab in a timely fashion.

This is a high profile process that is widely publicized. Plaintiffs' attorneys will utilize these "guidelines" in their allegations of malpractice ■

Community MRSA



These cases have definitely hit the liability radar screen. TSG is seeing two types of cases. The first is the practitioner's failure to treat a local skin infection that is at risk for MRSA with appropriate antibiotics. The practitioner treats with the tried and true Keflex or Augmentin, but the infection does not respond. The patient may return as the infection worsens and is ultimately admitted with sepsis. The failure to recognize MRSA and treat it with appropriate antibiotics results in patient morbidity and mortality.

Practitioners should be aware of the "look" of the MRSA skin infection and the fact patterns that increase the risk of MRSA, and they should prescribe the appropriate antibiotics. With the increasing incidence of MRSA infections, practitioners should provide early follow up for re-evaluation. When patients return with skin infections that are not responding to antibiotic therapy, practitioners should consider MRSA, obtain cultures, and change to Bactrim or other antibiotics that treat this infection.

The second type of case is the perispinal abscess. This is absolutely anecdotal, but should be of interest. These patients present with severe neck or back pain, often at several levels, with no apparent mechanism of injury. The patients may or may not exhibit neurologic symptoms. The claims fact pattern is often a discharge with a diagnosis of "musculoskeletal pain." The discharge diagnosis is often not consistent with presentation. If there is no mechanism of injury, consider a perispinal process.

It appeared to TSG that there was an increasing number of perispinal abscess cases about 4 years ago. Since then, I have asked the Medical Directors at the ACEP Medical Directors Academy if they are seeing this disease entity. Specifically, I ask how many have seen a perispinal abscess in the last two years. Four years ago there weren't many hands up, but still a surprising number of practitioners had made this diagnosis. Last month (Nov. 2008) when I asked, well over half of the Medical Directors raised their hands. This is anecdotal but striking, and clearly a matter of concern. Upon further inquiry, many of these cases were Community MRSA without a high

REMINDER . . .

TSG offers a Failure To Diagnose Perispinal Abscess course. Below are some comments from physicians who recently completed the course.

"Cases were particularly helpful. I have completely re-thought my approach to this, as I was overly depending on LOCALIZED symptoms and fever to consider this diagnosis."

"This diagnosis is supposed to be rare. However, I have seen several cases recently, and am shocked how common it can be."

If you're interested in this course, ask your Facility Administrator to add it to your curriculum or go directly to our web site www.thesullivangroup.com and view it independently.

risk mechanism such as IV drug abuse.

A delay in diagnosis of a perispinal space occupying process is obviously a dangerous scenario. Following discharge there may be a dramatic worsening of the patient's condition sometimes with irreversible neurologic deficits.

Practitioners should consider this possibility in back or neck pain patients that

present without an obvious mechanism of injury, especially if accompanied by any neurologic symptoms, and those who are febrile or have a course consistent with a febrile illness.

If you have any interesting cases of perispinal abscess, we would very much appreciate a call to discuss the specifics including the presentation and etiology of the infection ■

Spontaneous Onset Of Bleeding

This seems like an overly broad subject area. TSG has seen an increasing incidence of spontaneous onset of bleeding in various parts of the body including perispinal, intracranial, gastrointestinal, urologic, and others. There have been enough related claims that we recently published a course on the subject.

Although once again anecdotal, TSG has not seen these types of claims in the past. The spontaneous bleeds into the perispinal space are very similar to the perispinal abscess in that patients present with an acute onset of back pain with no apparent mechanism of injury. Practitioners don't usually consider a spontaneous perispinal bleed in the differential diagnosis. Delay in diagnosis can be catastrophic.

Assuming that, in time, it will be clear that this is not anecdotal, but rather a real increase in morbidity and mortality related to spontaneous onset of bleeding, we question the cause. Our educated guess is that there are a lot of patients on various types of blood thinners and antiplatelet agents. The number of patients on Coumadin, Plavix, aspirin and other related medications has increased dramatically. The TSG medical staff has considered this topic at length and has not come up with any other plausible explanations for this apparent increase in claims related to spontaneous bleeds.

Once again, if any readers have experience with the perispinal bleed or have thoughts on this subject, please feel free to contact us ■

The Failure To Diagnose Fractures

This is not a look into the crystal ball but rather a straightforward observation that "failure to diagnose

fracture" claims do not appear to have decreased over the last several years. Most TSG clients' failure to diagnose fracture rates have remained steady. As a result, TSG is currently creating a failure to diagnose fracture library in order to attack this ongoing issue ■

Waiting Room Risk

Patient volumes are steadily increasing and inpatient beds are more difficult to find. The result is increased throughput times and more patients with significant problems sitting in the waiting room. The claims clearly demonstrate risk moving from the ED into the waiting room. It is difficult to fix throughput since it is largely a hospital, not an ED, problem. Getting everyone on board to create a workable system solution has proven elusive.

Maybe your ED has figured this out, and it is not an issue. If you have not solved this problem, there are more and sicker patients in your waiting rooms. As a result, there is increased risk in your waiting rooms. The claims related to that risk have hit the radar screen.

EDs need to implement a system solution to waiting room risk. The following are steps you may take:

1. Make sure your entire triage staff is aware of the "seconds to minutes emergencies." All patients in certain categories should come into the ED immediately whether there is a stretcher space or not. Examples include the neonate with a fever, chest pain patients over a certain age, the acute scrotum, the TIA/stroke patient, etc.

2. Re-evaluate patients in the waiting room. This may require more staff, but another FTE is probably less expensive than malpractice litigation and associated EMTALA allegations for the failure to screen and stabilize. More importantly, patient safety is the highest priority ■

If you have a significant throughput problem, consider risk and safety in your waiting room.

Holds, Holds, Holds

There are a lot of patients holding in ED hallways. Unfortunately this includes ICU holds, and sometimes regular admits are in the hallway for days. After two or three ED shifts go by, the next ED practitioner may have no clue of the complexities of patient care required for the hallway patient. Although TSG has not seen claims directly on point, this must increase ED risk.

Ultimately these patients get assigned to an admitting physician. Does this transfer the risk away from the ED

physicians and nurses? It should. However, the ED staff will certainly be named in the lawsuit, and a jury will decide their fate. This is an untenable situation and hospitals must take an organized approach to fix this problem.

Often the hospital administration will turn to the ED staff to solve the hold problem. This is not an ED problem. It is a hospital problem and it can often be solved by a hospital team approach and a systems solution. Discharge admitted patients earlier in the day, implement a bed-ahead program, open an admit holding unit, and consider other creative solutions. Get this risk out of the emergency department ■

That concludes TSG's look to the future of emergency medicine risk, safety, and exposure to malpractice litigation. We make every effort to stay a step ahead and provide risk and safety recommendations to avoid medical errors.

Please let us know your thoughts. Are you seeing any alarming trends? Do you have an interesting case in the areas described above? We would love to have you share that experience. Was this overview helpful? We would love to hear from you.

Thanks ■

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