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Engaging ER Physicians and Hospitalists as Allies in Patient Safety

The Mutual Presents at the CSHRM Annual Conference 2015

Big Picture Stats

- 91% of the lawsuits that go to trial are won by the defendant
  - All specialties (source PIAA data 2009-2013, Exhibit 4.2, Closed Claim Comparative 2014 Edition)
- Less than .01% of patient visits culminate in a lawsuit against an emergency medicine specialist.
- Too early to know with hospitalists.

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Big Picture Stats (PIAA Data Sharing Project)

Medical Misadventure	CWI % Emergency	Ave. Ind.	CWI % Hospitalist	Ave. Ind.
Errors in diagnosis	31.77	$237,134	21.3	$234,038
No medical misadventure	9.30	$270,038	14.3	$345,721
Failure to supervise or monitor case	n/a	n/a	18.2	$237,500
Failure to recognize a complication of treatment	n/a	n/a	9.1	$605,250
Medication errors	18.56	$36,664	21.9	$299,826
Improper performance	23.01	$147,001	10.3	$253,333
Failure/delay in referral or consultation	n/a	n/a	40.0	$241,563
Failure to instruct or communicate with patient	n/a	n/a	25.0	$143,750
Not performed	30.12	$131,239	66.7	$314,167
Failure to properly respond	n/a	n/a	50.0	$136,667

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Engaging Physicians

- Case based
- Peer-to-peer
- Physician vetted
- Collaborative program development
- Focused on controllable and relevant

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Building Effective Alliances

- Real Cases
- Real Issues
- Real Barriers
- Real Solutions

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"Neck: normal inspection. Neck supple."

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Case 1: Provider-to-Provider Hand-off

- Presentation: A 59 y/o male BIBA, after syncope, fell down flight of stairs, ALOC. Fall not relayed to ED doc by medics.
- Cervical spine precautions taken including neg X-ray and collar in place. However note in EMR states "neck supple"
- Pt. has unexplained hypotension, poor respiratory effort and requires intubation in ED.
- Pt. admitted to ICU. Treated by 2 Hospitalists, 2 Intensivists, Neurologist, and 4 Radiologists.

Case 1: Provider-to-Provider Hand-off

- Outcome: 19 hours later Hospitalist-2 orders the cervical collar removed, Quadriplegia due to cervical fracture.

- Plaintiff seeks $28 million. Hospital, Intensivist 1 (came to ED), Intensivist 2, Hospitalist 1 (admitted), Hospitalist 2 (removed collar), Hospitalist Group, Neurologist, Critical Care, EP, ED Group, 4 Radiologists. Confidential Settlement.

- Contributing Cause: Intensivist-1 asked EP to consider a trauma surgeon consult and get a cervical spine MRI and claims that 60-90 minutes later he said the same thing to Hospitalist-1. Neither Hospitalist-1 nor EP recall him saying this.

- *Deposition Testimony* Neck normal inspection – neck supple – Hospitalist 2 believed this to mean that Dr. EP had already examined the neck.

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Case 1: Patient Safety Issues

Patient/Family

- Failure to get an accurate history caused diagnostic path toward medicine instead of trauma.

Physician

- Medic did not communicate that the patient had fallen down stairs.
- "neck supple" was clicked in error – others rely on the chart.
- Hospitalist did not do a neuro exam before clearing c-spine collar.

Hospital

- Unable to hold a unified defense among codefendants.

"A consultation was done with the neurosurgeon, at the ED, and the impression was this is not an emergency and an MRI can wait until tomorrow"

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Case 2: Diagnostic Momentum

- Presentation: A 49 year old male presented with complaints of lower back pain x 1 week and feeling of tingling/numbness in both legs that morning.
- Seen earlier in other ED, now more pain/numbness. Decreased sensation R>L. Some urinary retention.
- CT Lumbar—disc bulges. MRI recommended. Discussed with Neurosurgeon who felt MRI could wait until morning. Admitted to hospitalist.
- Hospitalist notes further decrease strength. 11p: nurse notes paralysis, did not call hospitalist.
- MRI done about 14 hours later.

Case 2: Diagnostic Momentum

- Outcome: Delayed diagnosis. T10-T11 cord compression.
- Paraplegic. Est. medicals $7.0-10.0 million. EP1, EP2, Neurologist, Hospitalist, Hospital and Nurse Registry. Confidential Settlements
- Contributing Cause:– When the Hospitalist conducted an examination at 22:00, the patient had 1-2/5 motor weakness. The Hospitalist should have intervened immediately requesting an MRI STAT, plus contacted the neurosurgeon. That was not done. – *Defense Neurosurgeon Expert*
- She received written orders containing various instructions for signs/ changes requiring notification to the on-call physician. None of these concerns changed in the patient's neurological status. – *Codefendant Night shift Nurse*

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Case 2: Patient Safety Issues

Physician

- CT scan limited to lumbar region. PA noted unilateral hyper-reflexia .
- Supervising ED physician evaluation not charted.
- Neither EP or Neurosurgeon documented telephone consult.
- Anchoring on the clinical plan.

Hospital

- Hospitalist and Nurse failed to act upon patient's worsening condition.

"Too big to fit into MRI scanner here, therefore admit for management with transfer to open MRI tomorrow."

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Case 3: Patient Advocacy

- Presentation: First visit, a 26 year old morbidly obese male presented with complaint of back pain similar to previous episodes. Exam unremarkable. DX: Sciatica

- Second visit (next day): BIBA with increased pain and inability to walk. MRI ordered but pt. too large to fit into scanner. Plan for open MRI next day. Herniated disk, possible cord compression. Hospitalist accepts.

- Pt. condition deteriorates that night with urinary retention. MRI not ordered STAT and done late next day. Results called back to ED, delay getting to hospitalist.

Case 3: Patient Advocacy

- Outcome: Failure to diagnose Cauda Equina Syndrome and timely order MRI. Partial paralysis-mobility deficits.

- Global Demand $5.8 million. EP-1, EP-2, Hospital, Hospitalist-1, Hospitalist-2, Neurosurgeon-1 & Radiology Group. Confidential Settlement.

- Contributing Cause: The study result would be sent to the floor if the imagining center was aware the patient was admitted. – *Radiologist*
- He did not recall receiving a telephone call from anyone regarding an MRI on the patient. – *Emergency Physician2*
- A neurosurgeon would never have admitted the patient without an MRI. – *Defense Emergency Medicine Expert*

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Case 3: Patient Safety

Patient/Family

- The neurosurgeon was attempting to cover for himself…he continued. to go over the timelines of when the MRIs were obtained.

Physician

- Early call to Neurosurgeon not done.
- CT myelogram not considered or MRI (why wait?)
- Time sensitive Dx "possible cord compression"/ MRI order not "stat".

Hospital

- Reliable system of communicating clinical information.

Think Systems

- Avoidable
  - Communications
  - Coordination
  - Cognitive Error
  - Documentation
  - Interaction with consultants and RNs
  - Systems Failures
- Unavoidable
  - Judgment Calls
  - Good medicine, bad outcome

Patient Safety Barriers

- Lack of formal ingrained process for provider-to-provider hand-offs
- Limited availability of consultants
- Lack of resources, e.g. access to MRI, RN staffing
- Practicing to the metrics
- Unreliable systems of communicating clinical information

Patient Safety Solutions

- 'Working diagnosis" and Cognitive Pause
- Admission criteria and dispute resolution pathway
- Promote provider-to-provider hand-offs from the top
- Patient advocacy above all else
- Joint departmental meetings and social activities

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