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Speice

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Assessment 20: Malpractice

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Source:

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**Assessment:**

Malpractice. It's quite possible it's the last words a doctor wants to hear in their entire career. Now all doctors make mistakes. But it is when a doctor makes a mistake so vital to the patient's health that it becomes life threatening, it is classified as malpractice. Not only is the patient in danger, but the ability for the doctors to practice, and the hospital's name. Majority

of the time it isn't intentional, but there is a huge deal of responsibility that when doctors do not take seriously provide disastrous results. As an incoming medical student, it is very important for me to understand the possibility and famous cases.

The first case is the Quaid's twins from "Dennis Quaid's Newborns Given Accidental Overdose." The twins has staph infections so the doctor attempted to give appropriate sized dose of Heparin, a blood thinning medication. Unfortunately, the wrong dosage was given to the Quaid infants — by 1000 times. The babies were left to vulnerable needing, at risk for death. Fortunately, after 11 days in intensive care the twins made a full recovery, and eventually the Quaid's settled the case with the hospital for $750,000, and the hospital was another $25,000 by the California Department of Public Health. This showed me that even in cases where the baby survives, their can still be a malpractice. I understand that if the same conditions had happened naturally, the doctor would not be at fault. But because it is drug administered, a doctor is at fault. This slightly scared me because I know that pediatrics will have the highest risk of malpractice because overdoes are so easy because of the small size This service as possible warning to myself to get a better at looking into measurements of smaller children. I knew this was a possibility before but seeing an actual case definitely increased the level of perception I have towards this topic.

The second article was the "Girl Has Second Transplant After Error." In 2003, Jesica Santillan came to the United States from Mexico to receive treatment for a severe heart condition.When doctors transplanted the organs, Jesica experienced severe brain damage, and her body was shutting down. At that point, medical staff realized that that the donor of the new organs did not have the same blood type as Jesica.While the physician attempted to rectify the

error by finding compatible organs, and performing a second surgery, the damage had been done. Jessica did not survive the operation. The doctor took responsibility for the error, and the hospital implemented a new system to double check transplants in order to prevent similar errors from occurring. This to me showed me that the head doctor is walas going to be responsible. This definitely surprised me because it  can be inferred that there were multiple people checking the blood types. Surgery, as I have learned takes a lot of planning a precision that is donte but just one person. But the doctor only took responsibility. This means that as the lead surgeon on a case, malpractices would fall under my responsibility more than anyone else. While I don't think this is completely fair, I don't understand as the person who reaps the most benefits and responsibility will also reap they save on the negative side. There has to be someone who will take the same in most cases. In other cases In Thing they perintes need someone to blame, enough there really isn't one because it is natural mispredicted results. This makes me take into account how much patients moutons may affect how I will be recipes so I need to be able to amenge a healthy and supportive relationship with all of my patients and their families.

The final article is “Family Sues after Man Gets Wide-Awake Surgery.” Sherman Sizemore underwent surgery in 2006. Two types of anesthesia were required for the operation, and while the first was administered correctly, but the second was not. Sixteen minutes into the surgery the medical team realized that he was still awake. Mr. Sizemore experienced nearly a half hour of surgery, complete with pain, while fully conscious. He was never told what happened. But although he was unable to point to a concrete memory of the incident,

something was clearly wrong. With no prior history of psychiatric or psychological conditions, Sizemore was suddenly panicked. He thought that people were trying to bury him alive, and suffered from insomnia and nightmares. He committed suicide just weeks after the surgery, but his family didn't fully make the connection between the surgery and his psychological struggles until a doctor mentioned the possibility while offering his condolences. This surprised me because the doctor actually fessed up, however he did it too late. Still an attempt to correct his wrongdoings definitely made me think that the had the patient's best interest in heart and he wasn't just doing it for the money. This made me realize how important it is to keep patients aware at all times, even at the risk of a malpractice. I always knew how much psychology and physical aspects go hand to hand, but to see the negative aspect and impacts are truly devastating. It sohwed the impact, similar to my original work, and surprised me that even wit at times when anesthesia is constantly evolving there still mistakes. It connected me back to one of the pediatric surgery invocation which was pediatric pain management and anesthesia. This made me realize how important that is as with ut proper anesthesia, the impacts on children could be even worse.

Overall, malpractice is something that can be easily avoided. It is risky and is caused by reckless behavior but not necessarily bad people. But once a malpractice result is given and and the impact is given, it will be very difficult for them to practice with the same respect and will likely had difficulty with returning to a report patient care system. I hope to never face a malpractice suit in my life but none the less I feel I have learned a lot about it and what can cause it. There are so many types of aways it could happen and the best plan of action is to

accept fault and apologize to those affected. That can save at least the respect people have for you as a person.

**Dennis Quaid's Newborns Given Accidental**

What should have been a blessed time for actor Dennis Quaid and his wife, Kimberly Buffington, turned into a time of anguish and anxiety, after their newborn twins nearly died from an accidental overdose of a blood-thinning drug.

Zoe Grace and Thomas Boone received a massive overdose of the blood-thinning drug Heparin — used to keep IV catheters from clotting — some time after their Nov. 12 birth at Cedars-Sinai Medical Center in Los Angeles. The incident was first reported by celebrity Web site TMZ.

TMZ reported Wednesday that while the babies are in stable condition, doctors are still concerned because they won't know for a week if the mistake will cause "long-term effects."

In a statement released to The Associated Press, Quaid's publicist, Cara Tripicchio, said, "Dennis and Kimberly appreciate everyone's thoughts and prayers and hope they can maintain their privacy during this difficult time."

While not mentioning the Quaids specifically by name, the hospital released a statement that confirmed that three of its patients had received 1,000 times the prescribed Heparin. Instead of 10 units per millimeter, the patients received 10,000 units.

According to TMZ, a pharmacy technician mistakenly stocked the 10 unit vials and 10,000 unit vials in the same drawer. Protocol at the hospital is to keep the different units separated.

"This was a preventable error, involving a failure to follow our standard policies and procedures," the hospital said. "Although it appears at this point that there was no harm to any patient, we take this situation very seriously."

But not every patient is lucky enough to survive such an overdose. Last year, a similar medical mistake killed three premature babies at Methodist Hospital in Indianapolis, including Dawn Jeffries and Demaya Nelson.

"You just don't make a mistake on nobody's kid. They're supposed to be professionals. That's not professional," said Maya's father, Dejuan Nelson, after the deaths.

In that case, the nurses grabbed vials of Heparin for adults instead of Hep-lock for children. The two medications are nearly identical and the pharmacy technician mistakenly stocked the cabinet with the wrong vials.

"Ultimately the blame for our errors falls upon the institution. This is a system failure," Methodist Hospital CEO Sam Odle said at the time.

Medical errors can be a weakness in any hospital. Each year 1.5-million patients suffer from mistakes with the medicine they're given, according to the Institute of Medicine.

"It's relatively easy to think that you're giving one when you're actually giving the other," said Dr. David Bates, professor of medicine at Harvard University Medical School.

Some hospitals are attempting to limit such mistakes and dangers. They have begun using bar code systems to match patients with the proper drugs and prevent incidents like the ones at Methodist Hospital and Cedars-Sinai.

Girl Has Second Transplant After Error

By Rob Stein
Washington Post Staff Writer
Friday, February 21, 2003; Page A01

A teenage girl who was near death after surgeons mistakenly implanted a heart and lungs with the wrong blood type into her chest underwent an emergency second transplant yesterday in a desperate attempt to save her life.

Jesica Santillan, 17, was in critical condition in the pediatric intensive care unit after her second four-hour heart-lung transplant at Duke University Hospital in Durham, N.C., where the original mix-up occurred.

The case again focused attention on the problem of mistakes in medicine. The National Academy of Sciences estimates they cause as many as 100,000 deaths a year in the United States.

"This particular incident is as horrendous an error as one can imagine," said Thomas Murray, president of the Hastings Center in Garrison, N.Y., a medical ethics think tank. "I was quite shocked to know that there were not multiple independent checks of things as critical as blood type before the organs were even accepted for transplant."

The second transplant operation began at about 6 a.m. yesterday after doctors located new organs that were the right blood type and size. To guard against another mistake, the hospital had three doctors check independently to confirm that the organs matched correctly this time, officials said.

The girl's new heart and lungs were working and she was taken off life-support, officials said. Doctors were optimistic about Santillan's prospects, but said it was too soon to know whether she would recover. About half of heart-lung transplant recipients survive five years, and Santillan may have suffered damage to other organs because of the botched transplant.

"She's as critical as a person can be, " said Duane Davis, a surgeon on the transplant team. "She has a number of hurdles to overcome."

Santillan's family was ecstatic that new organs were found so quickly. "Her parents feel some relief right now," said Renee McCormick, spokeswoman for a charity raising money for the teenager's care. "Everyone is incredibly hopeful and we're just so pleased, so thankful."

The United Network for Organ Sharing (UNOS) in Richmond, which coordinates organ distribution nationwide, is investigating the incident. Duke officials said the mistake occurred because doctors incorrectly assumed the blood type of the organ donor matched the recipient and failed to check for themselves. The hospital will now require additional compatibility checks in all transplants to make sure it does not happen again, officials said.

"This has been a difficult and heart-wrenching time for many people. At Duke, it has resulted in a tense reexamination of internal controls in transplantation," said William Fulkerson, the hospital's chief executive officer.

The hospital, UNOS and Carolina Donor Services, which obtained the organs, would not identify the new donor. The only details released were that the organs were not the result of a "directed donation," in which a donor's family specifies who will get the organs. But officials said Santillan received no preferential treatment.

Outside experts speculated that Santillan's rapidly deteriorating condition pushed her to the top of the waiting list to receive any suitable organs that became available.

Santillan was born in Guzman, Mexico, a small town near Guadalajara, with a deformed heart that caused a fatal condition known as restrictive cardiomyopathy. Three years ago, the teenager's parents paid a smuggler to spirit the family into the United States in hopes of getting her a transplant.

They settled in Louisburg, N.C., near Duke, but the girl's condition deteriorated and the family could not afford the $500,000 operation.

After hearing about her plight, a local building contractor, Mack Mahoney, established a foundation to raise the money for her transplant, which was performed Feb. 7.

The surgery went well, but doctors immediately realized their mistake when the teenager's body started rejecting the new organs. The organs were from a donor with type A blood; Santillan has type O blood.

The case illustrates that despite years of warnings, many hospitals have yet to add backup checks to life-and-death decisions, experts said.

"Carpenters have a rule: Measure twice, cut once. If it's good enough for carpenters it ought to be good enough for transplants," said Murray, the ethicist.

Kenneth McCurry, director of heart and lung transplantation at the University of Pittsburgh, said Santillan's prospects for survival were diminished somewhat since she had probably suffered damage to her kidney and liver from being kept on life-support machines after the first transplant.

Vital organs can be damaged while on life support because of a lack of adequate blood flow. She also faces a higher risk of infection from having undergone two operations.

"If these organs function well and she makes it through this period and the other organs recover, then she will have as good a chance of surviving as well as any other patient," McCurry said. "Only time will tell."

McCurry worried that the negative publicity from the case might discourage people from donating organs, exacerbating what is already a severe shortage. "There are literally thousands and thousands of transplants each year in the United States, and these things happen very infrequently," he said. "We need more organs, not fewer."

Santillan's second surgery was made possible when another donor was found at about 11:30 p.m. Wednesday. After the compatibility of the organs was confirmed, Santillan's family was notified early yesterday morning, and the second surgery was scheduled to be performed by James Jaggers, who did the first operation.

Santillan will be monitored "extremely carefully," said Davis, the surgeon. While "many body parts . . . aren't working as well as we'd like them to be working," there is "nothing that we know of that says any of the damage is irreversible," he said.

Since 1988, there have been nearly 800 heart-lung transplants in the United States. In 10 cases, the operation was performed twice on the same person, according to UNOS, but never before for this reason.

Santillan's benefactor, Mahoney, complained that Duke waited too long to admit its mistake. If Duke had taken action a few days earlier, Santillan would not have had to spend so much time on life support, he said.

"If you make a mistake, admit your mistake and take care of that child," Mahoney said.

Heather Adams, 12, a friend of Santillan's, made a brief, tearful appearance at the hospital's briefing on the teen's condition. "It was terrible when I found out, but now I just hope she makes it," she said. When a reporter asked Heather what she would ask others to do, she said: "Pray for her."

Special correspondent Bill Hatfield contributed to this report from Durham.

CHARLESTON, W.Va. — In the two weeks before he committed suicide, Sherman Sizemore thought people were trying to bury him alive.

Family members say the 73-year-old Baptist minister was driven to kill himself by the traumatic experience of being awake during surgery but unable to move or cry out in pain.

Sizemore's death has drawn attention to a little-discussed phenomenon called anesthesia awareness that some experts say may happen to 20,000 to 40,000 patients a year in this country. Typically they feel pain, pressure or other discomfort during surgery because they are not adequately anesthetized.

The causes can include doctor errors, faulty equipment or medical conditions so severe that the patient cannot be safely put under deep anesthesia.

"It's the first time I know of anyone succeeding in taking their own lives because of this, but suicidal thoughts are not all that uncommon" among such patients, said Carol Weihrer, president of the Virginia-based Anesthesia Awareness Campaign, which she founded after her own experience with anesthesia awareness.

**Patient given paralyzing drugs**

Sizemore, a clergyman and former coal miner from the town of Beckley, was admitted to Raleigh General Hospital on Jan. 19, 2006, for exploratory surgery to diagnose the cause of abdominal pain, according to a lawsuit filed March 13.

An anesthesiologist and nurse anesthetist who worked for Raleigh Anesthesia Associates gave Sizemore paralyzing drugs to prevent his muscles from jerking and twitching during the surgery, the complaint alleges. But it says they failed to give him general anesthesia to render him unconscious until 16 minutes after the first cut into his abdomen. The family says he suffered excruciating pain.

Moreover, the lawsuit says, Sizemore was never told that he hadn't been properly anesthetized, and was tormented by doubts about whether his memories were real.

The lawsuit, filed against Raleigh Anesthesia Associates by two of Sizemore's daughters, goes on to say that in the two weeks after his surgery, Sizemore couldn't sleep, refused to be left alone, suffered nightmares and complained people were trying to bury him alive.

On Feb. 2, 2006, Sizemore shot himself to death. His family says he had no history of psychological distress before his surgery. The abdominal pains were apparently related to gallbladder problems, according to the family.

"Being helpless and being in that situation can obviously be tough on people's psychological well-being," said Tony O'Dell, a lawyer for the family.

**Monitoring equipment reduces errors**

The Joint Commission on Accreditation of Healthcare Organizations, which accredits hospitals, says studies show that anesthesia awareness may happen in 0.1 percent to 0.2 percent of operations involving general anesthesia in this country.

Half of all such patients also report mental distress after the surgery, including post-traumatic stress disorder.

In 2005, the American Society of Anesthesiologists adopted guidelines calling for doctors to follow a checklist to make sure anesthesia is delivered properly. The ASA stopped short of endorsing brain-monitoring machines as standard equipment, saying doctors should decide on a case-by-case basis whether such devices are necessary.

"It could be that someday everybody who gets anesthesia will have a brain-wave monitor," said Dr. Robert Johnstone, a professor of anesthesiology at the West Virginia University School of Medicine.

Johnstone said such monitors are used at WVU, but in conjunction with other equipment anesthesiologists use to measure such things as blood pressure and body temperature. When such monitors and tests are used properly, he said, the chances of someone being awake are slim.

It was not clear whether Raleigh General uses such monitors. Calls to the hospital were not immediately returned.

Weihrer said that recognition of the experience and psychological counseling are often the only thing patients want.