When the Hand that Heals, Kills, What is the Remedy?

Or

How to deal with Medical Errors

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Objectives

• Medical Ethics: Definitions
• Medical Errors: Definitions
• Initiatives to detect and address medical errors:
  – Worldwide
  – Lebanon
  – AUBMC
• Cases
• Discussion
Values in Medical Ethics

- **Autonomy:** Choice to accept or refuse treatment made by patient
- **Beneficence:** Care provided should be for the best benefit of the patient
- **Non-Maleficence:** Care should not be harmful (primum non nocere)
- **Justice:** Care should be distributed fairly and equally
- **Dignity:** For both caregiver and patient
- **Truthfulness and Honesty:** Informed consent
“Primum, non nocere”
First, do no harm

• Non-maleficence
The doctrine of “Double Effect”

- Aquinas: Homicidal self defense
- Similar acts, can be morally different
- Intentional versus non-intentional
- Ex: vaccines, abortion, craniotomy
- Four Conditions before an act is morally acceptable:
  - The *nature-of-the-act condition*. The action must be either morally good or indifferent.
  - The *means-end condition*. The bad effect must not be the means by which one achieves the good effect.
  - The *right-intention condition*. The intention must be the achieving of only the good effect, with the bad effect being only an unintended side effect.
  - The *proportionality condition*. The good effect must be at least equivalent in importance to the bad effect
Medical Error

• a preventable adverse effect of care whether or not it is evident or harmful to the patient

• This might include:
  – an inaccurate or incomplete
    • Diagnosis
    or
    • Treatment
    of an ailment

• As a general acceptance, a medical error occurs:
  – when a health-care provider chose an inappropriate method of care
    or
  – the health provider chose the right solution of care but executed it incorrectly.

Medical errors are often described as human errors in healthcare
Top 10 causes of death in the USA

• Heart disease: 631,636
• Cancer: 559,888
• Stroke (cerebrovascular diseases): 137,119
• Chronic lower respiratory diseases: 124,583
• Accidents (unintentional injuries): 121,599
• Diabetes: 72,449
• Alzheimer's disease: 72,432
• Influenza and Pneumonia: 56,326
• Nephritis, nephrotic syndrome, and nephrosis: 45,344
• Septicemia: 34,234
Medical errors

Causes

- 400,000-1.2 million error-induced deaths during 1996–2006 in the United States. These casualties have been, in part, attributed to:
  - Human Factors
    - Variations in healthcare provider training & experience, fatigue, depression and burnout.
  - Diverse patients, unfamiliar settings, time pressures.
  - Failure to acknowledge the prevalence and seriousness of medical errors
  - Medical complexity
  - Complicated technologies, powerful drugs.
  - Intensive care, prolonged hospital stay.
  - System failures
  - Poor communication, unclear lines of authority of physicians, nurses, and other care providers.
  - Complications increase as patient to nurse staffing ratio increases.
Medical errors

Causes ct’d

- Disconnected reporting systems within a hospital: fragmented systems in which numerous hand-offs of patients results in lack of coordination and errors.
- Drug names that look alike or sound alike.
- The impression that action is being taken by other groups within the institution.
- Reliance on automated systems to prevent error
- Inadequate systems to share information about errors hamper analysis of contributory causes and improvement strategies.
- Cost-cutting measures by hospitals in response to reimbursement cutbacks
- Environment and design factors. In emergencies, patient care may be rendered in areas poorly suited for safe monitoring. The American Institute of Architects has identified concerns for the safe design and construction of health care facilities.
- Infrastructure failure. According to the WHO 50% of medical equipment in developing countries is only partly usable due to lack of skilled operators or parts. As a result, diagnostic procedures or treatments cannot be performed, leading to substandard treatment.
Impact

• Recently, the U.S. Office of the Inspector General released a report estimating that medical complications contribute to 180,000 patient deaths per year, and that overall, these complications cost Medicare up to $4.4 billion annually.
To Err is Human
Building a Safer Health System

• An IOM report issued from 1999
• The report was based upon analysis of multiple studies by a variety of organizations and concluded that between 44,000 to 98,000 people die each year as a result of preventable medical error
• it set a minimum goal of 50 percent reduction in errors over the next five years
“Crossing the Quality Chasm”

• **Crossing the Quality Chasm: A New Health System for the 21st Century**
  – The committee on the Quality of Health Care in America released this report on March 1, 2001.

• This report urgently calls for change to the health care system processes to improve the level of quality. It analyzes this dilemma, and explores potential ways in which change could be implemented in the health care system.
IHI and its partners in this Campaign encourage hospitals and other health care providers to take the following steps to reduce harm and deaths:

• **Deploy Rapid Response Teams** ...at the first sign of patient decline
• **Deliver Reliable, Evidence-Based Care for Acute MI** ...to prevent deaths from heart attack
• **Prevent Adverse Drug Events** ...by implementing medication reconciliation
• **Prevent Central Line Infections** ...by implementing a series of interdependent, scientifically grounded steps called the "Central Line Bundle"
• **Prevent Surgical Site Infections** ...by reliably delivering the correct perioperative antibiotics at the proper time
• **Prevent Ventilator-Associated Pneumonia** ...by implementing a series of interdependent, scientifically grounded steps including the "Ventilator Bundle"
Swiss Cheese Model

Organizational models of accidents

• Cumulative act effects
• Medical errors can be the result of "system flaws, not character flaws"
• Inspired from the Aviation industry
Swiss Cheese Model
Organizational models of accidents

Some holes due to active failures

Other holes due to latent conditions (resident “pathogens”)

Successive layers of defences, barriers and safeguards

Losses

Hazards
Patient Safety

• **Patient safety** is a new healthcare discipline that emphasizes the reporting, analysis, and prevention of medical errors that often lead to adverse events.

• The frequency and magnitude of avoidable adverse patient events was not well known until the 1990s, when multiple countries reported staggering numbers of patients harmed and killed by medical errors.

• Recognizing that healthcare errors impact 1 in every 10 patients around the world, the WHO calls patient safety an endemic concern.
The goal was to develop standards for patient safety and assist UN member states to improve the safety of health care.

- facilitates the development of patient safety policy and practice in all WHO Member States.
- At the Fifty-Ninth World Health Assembly in May 2006. Since 2004, significant progress was achieved in six areas:
  - The First Global Patient Safety Challenge, which for 2005-2006 (addressing health care-associated infection) developed the *WHO Guidelines on Hand Hygiene in Health Care*.
  - A patient involvement group, Patients for Patient Safety, built networks of patients’ organizations from around the world, through regional workshops.
  - A patient safety taxonomy was developed to classify data on patient safety problems.
  - Prevalence studies conducted on patient harm in ten developing countries.
  - A WHO Collaborating Centre was established to develop and disseminate safety solutions.
The Patient Safety and Quality Improvement Act of 2005 (PSQIA)

• It passed in the Senate July 21, 2005 by unanimous consent, and passed the House of Representatives on July 27, 2005
By 2006, the National Guideline Clearinghouse (NGC) contained more than 1,700 disease-specific diagnosis, management and treatment recommendations, developed from current medical literature.

The goal of the NGC is to provide health professionals and institutions, health plans and health care purchasers an accessible mechanism for obtaining objective clinical practice guidelines.

Adoption of guidelines has been slowed by physician and hospital concern that practice guidelines threaten physician autonomy and authority, fuel malpractice liability, and allow managed care insurers to curtail patient care expenditures.
Joint Commission on Accreditation of Healthcare Organizations

- Founded in 1951 JCAHO is an independent, not-for-profit organization that evaluates and accredits nearly 15,000 health care organizations and programs in the US.
- On-site survey by a Joint Commission survey team at least every three years.
- Accreditation by JCAHO is required for participation in Medicare.
- Since the accreditation rate is over 90%, there have been questions raised regarding the effectiveness of these surveys.
- In 1997, JCAHO began including outcomes and other performance data for problem areas in health care and.
  - prevention of falls
  - patient identification
  - reducing hospital infections and pressure ulcers
  - improving hospital staff communication.
  - "do not use" list of abbreviations
Sentinel events

AND

Root cause analysis

To

- make improvements to the underlying processes, and monitor the effectiveness of the changes.

- Although the cause of most sentinel events is human error, changes in organizational systems will reduce the likelihood of human error
  - protect patient from human factor

- Specific causes of sentinel events and the solutions that hospitals then used successfully to reduce risks are publicized by JCAHO annually. Alerts have included issues as varied as:
  - wrong site surgery
  - restraint deaths
  - transfusion and medication errors
  - patient abductions.
Medical Malpractice
Elements of the case
Professional negligence (Tort)

1. Plaintiff
2. **Legal duty** (duty of care)
3. **Breach of duty**
   - Proximate cause
4. **Damages**
Editor's choice

Facing up to medical error

...The American report succeeded in getting the attention of most of the media and of the president, and we must be optimistic that the United States is embarked on a comprehensive response to the problem. Meanwhile, the British media have been concentrating on the tragic case of a man who died after having the wrong kidney removed. The easy, understandable, and completely wrong answer to such an incident is to blame those who made the mistake. In fact—as several articles in this issue make clear—the correct response is to redesign systems so that errors are acknowledged, detected, intercepted, and mitigated. Leaders must recognize the problem, and we hope (perhaps vainly) that this BMJ may start the debate in Britain and other countries that is already happening in the United States. This issue is a first for the BMJ in that none of the authors of the editorials are British (in fact they are all American) and three of the four major papers are from the United States. This happy state of affairs arises because the Americans lead the world...
Effect of Reducing Interns’ Work Hours on Serious Medical Errors in Intensive Care Units

Christopher P. Landrigan, M.D., M.P.H., Jeffrey M. Rothschild, M.D., M.P.H., John W. Cronin, M.D., Rainu Kaushal, M.D., M.P.H., Elisabeth Burdick, M.S., Joel T. Katz, M.D., Craig M. Lilly, M.D., Peter H. Stone, M.D., Steven W. Lockley, Ph.D., David W. Bates, M.D., and Charles A. Czeisler, Ph.D., M.D., for the Harvard Work Hours, Health and Safety Group
A  Traditional Schedule

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Clock Time

B  Intervention Schedule

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<td>Intern 4</td>
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Clock Time
Effect of Reducing Interns’ Work Hours on Serious Medical Errors in Intensive Care Units

• Interns made 36 percent more serious medical errors during a traditional work schedule than during an intervention schedule that eliminated extended work shifts. These included significantly more serious medication errors and 5.6 times as many serious diagnostic errors. As a consequence, the overall rates of serious medical errors were significantly higher during the traditional schedule than during the intervention schedule.
In the article

• Prior interventions that have proved successful in reducing serious medical errors in ICU settings have included:
  – the use of computerized provider order entry
  – on-site monitoring of orders by clinical pharmacists.
ADVERSE EVENTS IN HOSPITALS: NATIONAL INCIDENCE AMONG MEDICARE BENEFICIARIES
FINDINGS

• An estimated 13.5 percent of hospitalized Medicare beneficiaries experienced adverse events during their hospital stays.

• Of the nearly 1 million Medicare beneficiaries discharged from hospitals in October 2008, about 1 in 7 experienced an adverse event that met at least 1 of our criteria (13.5 percent).

• This rate projects to an estimated 134,000 Medicare beneficiaries experiencing at least 1 adverse event in hospitals during the 1-month study period.

• We calculated incidence rates for adverse events that met our three criteria: 0.6 percent of beneficiaries had an NQF Serious Reportable Event, 1.0 percent had a Medicare HAC event, and 13.1 percent experienced an adverse event resulting in the four most serious categories of patient harm.

• An estimated 1.5 percent of Medicare beneficiaries experienced an event that contributed to their deaths, which projects to 15,000 patients in a single month.
Temporal Trends in Rates of Patient Harm Resulting from Medical Care

Christopher P. Landrigan, M.D., M.P.H., Gareth J. Parry, Ph.D.,
Catherine B. Bones, M.S.W., Andrew D. Hackbarth, M.Phil.,
Donald A. Goldman, M.D., and Paul J. Sharek, M.D., M.P.H.
Summary

- Between 2002 and 2007, the number of patients experiencing infections acquired in the hospital, medication errors, complications from diagnostic techniques or treatments, and other such "harms" did not change.
- Researchers looked at 2,300 patient admission records from 10 randomly selected hospitals in North Carolina.
- They found 588 incidents (25.1 harms per 100 admissions) of patient harm resulting from medical procedures, medications, or other causes. Two-thirds of these complications were considered preventable by reviewers at the hospitals themselves.
Conclusions

• In a study of 10 North Carolina hospitals, we found that harms remain common, with little evidence of widespread improvement. Further efforts are needed to translate effective safety interventions into routine practice and to monitor health care safety over time.
Limitations:

– Started after effect of initiative
– Funded by the “Rx Foundation”?

Also in the article:

Our findings validate concern raised by patient-safety experts in the United States and Europe that harm resulting from medical care remains very common. Though disappointing, the absence of apparent improvement is not entirely surprising. Despite substantial resource allocation and efforts to draw attention to the patient-safety epidemic on the part of government agencies, health care regulators, and private organizations, the penetration of evidence-based safety practices has been quite modest.

- Only 1.5% of hospitals in the United States have implemented a comprehensive system of electronic medical records
- Only 9.1% have even basic electronic record keeping
- Only 17% have computerized provider order entry
- Physicians-in-training and nurses alike routinely work hours in excess of those proven to be safe.
- Compliance with even simple interventions such as hand washing is poor
Do you admit errors?

• Do you tell the institution?
• Do you tell the patient

• VitalSmarts and the AACN found that 84 percent of healthcare professionals observe colleagues take dangerous shortcuts when working with patients and yet less than 10 percent speak up about their concerns.
• Since that time, the healthcare community has turned to safety tools and checklists to reduce unintentional slips and errors.
• *The Silent Treatment* (2011) has found that the effectiveness of safety tools is undercut by undiscussables. Every day, healthcare professionals are making calculated decisions to not speak up—even when safety tools alert them to potential harm.
• *The Silent Treatment* reveals that despite the safety interventions taken in the last decade, *silence still kills*. Safety
In Lebanon

- **LOP**: responsible for “deontologie medicale”: medical ethics, code of conduct abiding by its members.
- LOP can exert disciplinary measures/sanctions
- Law 313/2001: any interested person can complain to the LOP concerning any physician that he/she accuses of error or professional negligence, even unethical treatment
- Commissions are formed and the medical file is thoroughly reviewed.
- If possibly guilty: to the Disciplinary Council
In Lebanon

- **Disciplinary Council**: will interrogate (with lawyers) the 2 parties
- Can ask for a medical commission (experts and specialists) to review the case.
- If found guilty: sanctions (4 types)
  - Warning
  - Blame
  - Temporary Suspension
  - Permanent Suspension
At AUBMC

• **Risk Management:** In addition to tackling complaints and lawsuits

• Chief of staff office monitors several factors, and if standard of care not met, investigation is started, these include:
  
  – **Infection control:**
    
    • CL Infections
    • Urinary catheters
    • Hand Hygiene
    • Nosocomial Infections
At AUBMC

– Consent for: Procedures and Anesthesia
– Record confidentiality: Audit V.I.P. records
– Record dictation within 24 hours (OR)
– Radiology T.A.T.
– Wrong Lab tests
– Transfusion mistakes
– Risk Management: Patient falls
– Readmissions-Reoperations within 30 days
– Medication error:
  • Wrong medication
  • Wrong dose
At AUBMC

• In addition, departments have internal monitors for deviation of standards of care and errors:
  – Dept of Emergency Medicine:
    • 72 hour returns
    • M & M
    • Pathways
• Dept of Surgery:
  – Tissue Committee
  – M & M
    • At the division Level
    • At the Department level
• Dept of Internal Medicine:
  – When deviation of standard of care detected
THE LEBANESE PHYSICIAN: A PUBLIC’S VIEWPOINT

THALIA ARAWI
Abstract

...The physician traits most desired by the public were found to be:

✓ moral traits (41%)
✓ interpersonal traits (36%)
✓ scientific traits (19%)

... The most unwanted traits/behaviours were:

✓ a lack of interpersonal traits (57%),
✓ a lack of moral traits (40%)
✓ a lack of scientific skills (3%).

• The physician-patient relationship was perceived, in general, as being a flawed one.
<table>
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<tr>
<th>Traits/behaviours</th>
<th>Definition</th>
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<tr>
<td>Humane:</td>
<td>The physician is caring and deals with the patient as a human being not as a thing or an object.</td>
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<td>Honest:</td>
<td>The physician is truthful about the diagnosis and does not hide information from the patient.</td>
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<td>Ethical:</td>
<td>The physician is respectful of time and moral laws, and does not view medicine as if it were a business or a trade.</td>
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<td>Not materialistic:</td>
<td>The physician does not treat the patient simply as a commodity that will bring her money. Rather, as a patient who suffers from an illness and has to be cured. Money comes in the second place for her.</td>
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<tr>
<td>Compassionate:</td>
<td>The physician feels with her patient.</td>
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<td>Humble:</td>
<td>The physician does not act as if she were a demigod and has a respectful attitude towards all patients regardless of their socio-economic background. She is modest and does not treat her patients as if they were inferior to her.</td>
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<td>God fearing:</td>
<td>The physician does not act as if she were all powerful and does not forget that she is ultimately accountable for the consequences of her actions or omissions.</td>
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<td>Good listener:</td>
<td>The physician is ready to give enough time to her patient and is attentive. She does not read the newspaper or the internet while she is interviewing him, nor ask a question without listening to the answer.</td>
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<tr>
<td>Respects patients:</td>
<td>The physician respects her patients and does not treat them as if they were objects. They are persons with rights and dignity and a physician should keep this in mind during her encounter with them.</td>
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<td>Has good interpersonal skills:</td>
<td>The physician is someone with whom the patient can feel that he can actually open up. She should be welcoming and comfortable to talk to.</td>
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<td>Gives time to patients:</td>
<td>The physician is ready to give each patient the amount of time necessary to understand his case, to answer his questions, to offer explanations and treatment.</td>
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<td>Caring:</td>
<td>The physician makes her patient feel that she is caring and not simply a scientist or a surgeon waiting to operate on him.</td>
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<td>Patient:</td>
<td>The physician is ready to answer all questions even if they seem dull to her and is willing to provide explanations as often as is necessary.</td>
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<tr>
<td>Smiles:</td>
<td>The physician has a friendly appearance. The facial expressions are part of the healing process. Being greeted by frowning faces does not help the patient. It creates hurdles in the healing process. Patients worry about calling such doctors when something is wrong.</td>
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<tr>
<td>Is not haughty:</td>
<td>The physician has a humble attitude that will allow a comfortable exchange of opinions and ideas with patients.</td>
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<tr>
<td>Explains thoroughly:</td>
<td>The physician is ready to give each patient the amount of time necessary to understand his case; to answer his questions; explain the situation to him and to offer him treatment.</td>
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<td>Traits/behaviours</td>
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<tr>
<td>Materialistic:</td>
<td>The physician is basically concerned about making money not about curing her patients.</td>
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<td>Inhumane:</td>
<td>The physician does not feel with her patient’s pain and suffering and treats them as a disease.</td>
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<td>Not caring:</td>
<td>The physician treats the patient as if he were a case and not as a human being. There is no personal touch or interest in the physician-patient encounter.</td>
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<td>Negligent:</td>
<td>The physician sometimes gives prescriptions that the patient is allergic to, forgets to request necessary test or to follow up on important issues.</td>
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<td>Does not admit mistakes:</td>
<td>The physician does not admit that she made an error either in treatment or in judgment.</td>
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<td>Dishonest:</td>
<td>The physician often does not tell the patient what is really wrong with him, and does not admit it when she is faced with something beyond her capacities.</td>
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<td>Hurried:</td>
<td>The physician makes the patient feel that she is busy and needs to see the next patient.</td>
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<td>Does not discuss with patients:</td>
<td>The physician does not discuss with the patient his situation, rather, simply requests tests or offers treatment.</td>
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<td>Unfriendly:</td>
<td>The physician is not welcoming and does not make the patient feel comfortable in her presence.</td>
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<td>Treats patients as a number or case:</td>
<td>The physician does not deal with the patient as a person. In the presence of the physician, the patient feels as if he were reduced to an organ or an illness.</td>
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<td>Disrespectful:</td>
<td>The physician does not respect the patient. She does not greet him properly when he enters and sometimes ridicules him.</td>
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<td>Arrogant:</td>
<td>The physician treats the patient as if he were an inferior being and assumes a superior attitude because she is a doctor.</td>
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<td>Does not respect appointments:</td>
<td>The physician keeps the patient waiting for a very long time.</td>
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<td>High-handed:</td>
<td>The physician holds a standoffish attitude vis-à-vis the patient which often causes a barrier in communication.</td>
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<td>Treat patients as inferior:</td>
<td>The physician acts as if the patient is a person with lesser intelligence, less deserving than she is, and communicates with him condescendingly.</td>
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<td>Pretentious:</td>
<td>The physician pretends she knows the solution to all problems and can treat the disease even if she ought to refer the patient to someone else.</td>
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<td>Annoyed with questions:</td>
<td>The physician makes the patient feel that he has asked too many questions.</td>
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<td>Does not listen to patients:</td>
<td>The physician is not attentive to what the patient has to say. She does not concentrate on complaints nor on answers to questions which she raises mechanically.</td>
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<td>Does not give patients enough time:</td>
<td>The physician sees the patient for a short time and acts as if he is not her priority. She is too busy for him.</td>
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At AUBMC

• Soon: Patient Safety Organization
Credentialing agencies
“Label of quality”

Independent reviewers:

- JCI
- NSQIP
- MAGNET
- L.O.P.
AUBMC and Lawsuits

- More frequent (At any time ~ 20 ongoing)
- Case reviewed, if hospital finds own fault, attempt to settle
- If not -> court
- All AUBMC attendings have malpractice insurance
Case 1

- 82 y.o. female with CHF, HTN, ESRD, and A.fib on AC is brought to ICU at 4pm from dialysis because of hypotension. Workup reveals coagulopathy (INR>6) and sepsis for which treatment is initiated. Patient develops large right thigh hematoma secondary to femoral blood draw done by resident. Specific type and cross-matched blood not available, hematoma is observed and hemoglobin is 9 in am of next day (ini:13).

- No blood is ever given. She arrests at 1pm.
Case 2

• A Emergency physician decides to biopsy by fine needle aspiration a patient, who is a physician himself. The procedure’s potential complication – retroperitoneal bleeding - is much higher than the open approach that the physician does not know how to perform if needed. Both surgeon and patient know this fact. The patient is not willing to undergo the open approach because of time constraints. The patient willingly signs his consent.

• The needle biopsy becomes complicated by bleeding and the patient dies.
Case 3

- An intern brings blood to be given to patient X. The nurse and himself (both exhausted and overworked) verify the paperwork and transfuse patient Y.
- The patient has no side effects whatsoever.
Case 4

- A 56 yo is brought to the ED because of an altered mental status and high grade fever. Patient’s private physician informs the ED physician about his medical history which includes poly-substance abuse, psychiatric conditions, in addition to COPD on steroids and HTN. Patient is found to have renal failure and is admitted to a regular floor where his fever remains elevated. His condition deteriorates, gets intubated and moved to the ICU where he is found to have rhabdomyolysis, and gets dialyzed.
- He arrests the next day. Fever never went down.
- At home at his bedside, brother later found 2 boxes of tramadol. Patient was also on high dose SSRI and antipsychotics.
Case 5

• An Emergency Physician refuses to stop lecturing despite the audience asking for grace
Questions?
Thank you!

Special Thanks to:
Dr Thalia Arawi
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