Medical Malpractice cases

- **8 February 2011**
- A six year old boy is admitted to the Children's Assessment Unit (CAU) at Leicester Royal Infirmary following a referral from his GP. Jack Adcock, who had Down's Syndrome and a known heart condition, had been suffering from diarrhea, vomiting and had difficulty breathing.

- Jack was receiving supplementary oxygen and Dr Bawa-Garba prescribed a fluid bolus and arranged for blood tests and a chest x-ray. At 10.44am the first blood gas test was available and showed a worryingly high lactate reading. The x-ray became available from around 12.30pm and showed evidence of a chest infection.

- Dr Bawa-Garba was heavily involved in treating other children between 12-3pm, including a baby that needed a lumbar puncture. At 3pm Dr Bawa-Garba reviewed Jack's X-ray (she was not informed before then that it was available) and prescribed a dose of antibiotics immediately, which Jack received an hour later from the nurses.

- A failure in the hospital's electronic computer system that day meant that although she had ordered blood tests at about 10.45am, Dr Bawa-Garba did not receive them until about 4.15pm. It also meant her senior house office was unavailable.
- During a handover meeting with a consultant which took place about 4.30pm, Dr Bawa-Garba raised the high level of CRP in Jack's blood test results and a diagnosis of pneumonia, but she did not ask the consultant to review the patient. She said Jack had been much improved and was bouncing about. At 6.30 pm, she spoke to the consultant a second time, but again did not raise any concerns.

- When she wrote up the initial notes, she did not specify that Jack's enalapril (for his heart condition) should be discontinued. Jack was subsequently given his evening dose of enalapril by his mother after he was transferred to the ward around 7pm.

- At 8pm a ‘crash call’ went out and Dr Bawa-Garba was one of the doctors who responded to it. On entering the room she mistakenly confused Jack with another patient and called off the resuscitation. Her mistake was identified within 30 seconds to two minutes and resuscitation continued.
- This hiatus did not contribute to Jack’s death, as his condition was already too far advanced. At 9.20pm, Jack died.

Dr. Hadiza Bawa-Garba

- Not in the US, still illustrative of issue
- Timeline:
- **2011:** 6-year-old Jack Adcock died at Leicester Royal Infirmary.
- **2011-2015:** Dr. Bawa-Garba treated Jack Adcock and was later convicted of gross negligence manslaughter.
- **2017:** suspended her from the medical register.
- **2018:** ruled she should be erased from the register, but she successfully appealed this decision.
- **2018-2019:** Following the appeal, the cleared her to return to work.

- Was this negligence? Thoughts?
- Consider: Why does this case get criminal charges but not the heparin mix up for Dennis Quads twins?

Potential Answer?

- One was UK and one was USA?
- Poss, but let's look at a USA case.....

Julie Thao

- https://www.healthcareinnocenceproject.org/case-study-julie-thao/

- **The fatal error:** On July 5, 2006, at St. Mary's Hospital in Madison, Wisconsin, a labor and delivery nurse named Julie Thao mistakenly infused an epidural pain medication (bupivacaine with fentanyl) intravenously into Jasmine Gant. Gant was meant to receive an IV antibiotic (penicillin) for a strep infection.
- **The patient:** Jasmine Gant was 16 years old and in labor. She suffered a seizure and died shortly after receiving the incorrect medication.
- **The outcome for the infant:** Gant's baby boy was delivered via emergency Caesarean section and survived.

- **Contributing factors:** An investigation into the error revealed numerous system failures and human factors, including:
  - The nurse was reportedly in the middle of a 20-hour shift and was fatigued.
  - The epidural medication and IV penicillin were stored similarly, and the epidural bag was not properly secured.
  - Standard safety protocols were ignored, including failing to scan the bar code on the medication bag and the patient's wristband, which would have detected the mix-up.
  - The nurse did not read the medication bag's large pink warning label, which stated "FOR EPIDURAL ADMINISTRATION ONLY".

- **Aftermath and consequences:**
  - Nurse Julie Thao was initially charged with felony criminal negligence. The charges were later reduced, and she pleaded no contest to two misdemeanors.
  - She received a license suspension and served probation.
  - The case led to increased scrutiny of hospital safety protocols, particularly regarding medication administration and bar-code scanning technology.

- Was that fair?
- Again, what about cases like the Dennis Quad twin case?

- In November 2007, actor Dennis Quaid's newborn twins, Thomas Boone and Zoe Grace were hospitalized at Cedars-Sinai for staph infections. They required intravenous (IV) treatment, and a standard low-concentration dose of heparin (10 units/ml) was ordered to flush their IV lines.
- Through a series of failures, the twins and one other patient were administered high-concentration heparin (10,000 units/ml), a dosage meant for adults.
- Hospital investigations later revealed multiple lapses in procedure, including pharmacy technicians failing to verify the drug concentration and nurses not checking the vials before administering the drug. The error occurred twice, over an eight-hour period.

- **Hospital response:** Later that night, a nurse noticed one of the twins bleeding but did not inform the parents of the medication error when they called. Hospital staff attempted to reverse the effects of the overdose. The Quaids were only notified of the crisis the next morning when they arrived at the hospital.

- **Medical outcome:** The overdose thinned the twins' blood to a dangerous degree, putting them at high risk for internal bleeding. Hospital staff administered protamine sulfate to counteract the heparin's effects. The twins survived after 11 days in the intensive care unit and appeared to have made a full recovery, although the long-term effects were unknown at the time.

Aftermath

- **Lawsuit against Baxter Healthcare:** The Quaids filed a lawsuit against Baxter Healthcare Corp., the drug's manufacturer. They argued that the company was negligent because the low-concentration and high-concentration vials of heparin had very similar packaging and labeling, which contributed to the error.

- **Settlement with hospital:** In a separate legal action, the family settled with Cedars-Sinai Medical Center for $750,000. Cedars-Sinai acknowledged its multiple system failures.
- **Patient safety advocacy:** The incident turned Quaid into a patient safety advocate. He and his wife founded the Quaid Foundation to raise awareness about preventable medical errors. He testified before Congress, arguing that pharmaceutical companies should be held accountable for drug-related injuries.
- **Industry changes:** In the wake of the Quaids' case and other similar incidents, Baxter changed the labeling and packaging for its heparin products

This one is interesting.....

- Let's look at the actual court filing on the appellate level.
- https://scholar.google.com/scholar_case?case=3099638014509743103&q=Colorado+vs.+Dr.+Geoffrey+Kim&hl=en&as_sdt=6,33&as_ylo=2021