LEGAL EAGLE EYE NEWSLETTER

April 2009 — *For the Nursing Profession* — Volume 17 Number 4

Pregnancy Discrimination: Light-Duty Policy Must Be Applied Uniformly, Pregnant Or Not.

A CNA who was working in a nursing home became pregnant.

About three months into her pregnancy she gave her supervisor a note from her physician stating, "My patient is pregnant and is required to be on light duty – sitting mostly – until the end of her pregnancy."

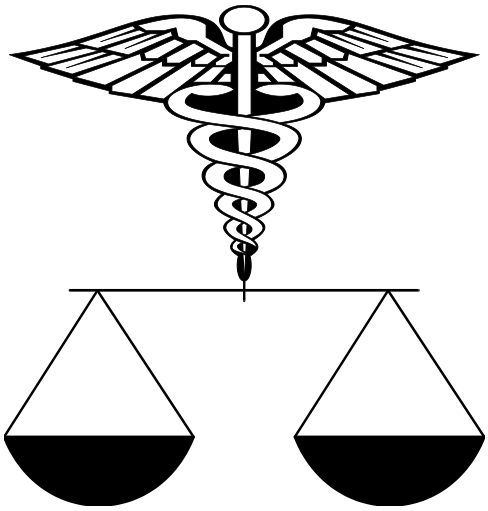
The facility declined to honor the physician's medical restrictions as written and did not follow up for clarification. The CNA was not scheduled for further work shifts.

Pregnancy Discrimination Lawsuit

The US District Court for the Northern District of Illinois upheld the CNA's right to sue for pregnancy discrimination.

The US Pregnancy Discrimination Act outlaws discrimination because of or on the basis of pregnancy, childbirth or related medical conditions.

The Act states expressly that women affected by pregnancy, childbirth or related medical conditions must be treated the same for all employment-related purposes, including receipt of benefits under fringe benefit programs, as other persons not so affected but similar in the ability or inability to work. The phrase "similar in the ability or inability to work" has been interpreted by the courts to refer only to factors other than pregnancy itself.



Another total-care caregiver was allowed to work on crutches and/or to use a wheelchair at work after she injured her knee off the job.

It is questionable at best how the facility can claim the right to deny light duty to a pregnant caregiver based on a policy that light duty is reserved only for caregivers who were injured on the job.

UNITED STATES DISTRICT COURT
ILLINOIS
March 16, 2009

Light Duty Policy Ostensibly Reserved for Injuries on the Job

The facility claimed it had a policy that light duty work assignments for total-care workers were available only to those who had been injured on the job.

The facility's policy is perfectly legal, at least as written. Pregnancy does not require reasonable accommodation, only equal treatment with others who are similar in all respects except for being pregnant.

Facility's Light Duty Policy Was Not Applied Uniformly

The CNA was able to point to at least two co-workers whose job descriptions, like hers, required physical ability to perform total patient care, who were allowed light duty for physicians' medical restrictions that did not stem from injuries they had sustained on the job.

According to the court, that gave the CNA a *prima facie* case of discrimination.

The court also mentioned that the facility's policy was never communicated to the CNA before she asked for light duty. That may be substandard human relations practice but it is not fatal to the defense of a discrimination claim, the court said.

The courts also do not delve into or judge the wisdom of employers' policies; the courts only care that policies are applied uniformly. **Woodard v. Rest Haven, 2009 WL 703270 (N.D. Ill., March 16, 2009).**

Inside this month's Issue ...
April 2009

New Subscriptions See Page 3

Protective Custody: Hospital Staff Did Not Violate Rights Of Intoxicated E.R. Patient.

The US District Court for the District of Connecticut dismissed the lawsuit filed by a disgruntled former emergency-room patient against the local police department, a police officer, an ambulance company, two EMT's, the local hospital, hospital security guards and the E.R. nurse.

The police were called by the bouncer closing up a local night spot who could not convince a drunken patron not to get into his car. The police found him passed out behind the wheel of his parked car. When they roused him he started crying uncontrollably. The police issued a citation, wrote up an emergency involuntary commitment form and called an ambulance.

The E.R. triage nurse at the hospital, with help from a security guard, got him into a hospital gown and took away his clothes, wallet, car keys, shoes and cell phone and locked those items up. About an hour later the man ran out of the hospital clad only in his hospital gown, was chased down by the security guards and was returned in handcuffs that were removed when he finally calmed down.

At about 5:30 a.m. he was finally given back his personal property and allowed to go home.

No Grounds for Patient's Lawsuit

The court ruled that the hospital personnel were taking appropriate measures to treat a patient who was incapacitated by alcohol intoxication and in need of restraint and supervision for his own safety.

Quoting an old case precedent the court said, "When a patient enters a hospital he is entitled to such reasonable attention as his safety may require; and if he is temporarily bereft of reason and is known by the hospital authorities to be in danger of self-destruction, the authorities are duty bound to use reasonable care to prevent such an act."

The patient's apparent medical needs not only permitted but obligated the hospital to detain him in a safe place as treatment for his condition. **Palmer v. Garuti, 2009 WL 413129 (D. Conn., February 17, 2009).**

A hospital and its staff cannot violate a patient's Constitutional rights unless hospital staff are acting at the behest and direction of law enforcement.

It was the police who responded to a disturbance at 2:00 a.m. outside a bar and it was the police who saw to it that the highly intoxicated and agitated individual was transported to the hospital in an ambulance.

However, once triage was begun by the E.R. nurse the hospital was treating an incapacitated patient who was in dire need of medical care and supervision.

The hospital was not acting as an arm of local law enforcement detaining, searching, examining or interrogating the individual as a criminal suspect.

Medical personnel are given a great deal of latitude in using urine and blood tests to identify and quantify the alcohol or other substances that are affecting an incapacitated individual and in making the decision to keep the person in protective custody until he or she is no longer incapacitated.

UNITED STATES DISTRICT COURT
CONNECTICUT
February 17, 2009

UTI: Negligent Care Implicated In Patient's Death From Sepsis.

The eighty year-old patient was accepted for a planned thirty-day stint of respite care in a long-term care facility.

He had had a prostatectomy and had a urostomy, making him particularly susceptible to urinary tract infections.

On admission his BUN and creatinine levels pointed to decreased renal function. His urine sample was described in his admission progress note as smelling strongly and containing a white sediment as well as white blood cells and bacteria.

The nurse practitioner ordered culture and sensitivity testing to determine a suitable antibiotic to address the infection.

Nothing further was done for eight days while the patient's status deteriorated. He became agitated and confused and complained of neck pain. A chest x-ray showed infiltrates in the lungs.

He went to acute care, then to a hospice and died before the month was out.

When the patient was accepted into long-term care he already had clear signs of a urinary tract infection.

UNITED STATES DISTRICT COURT
CALIFORNIA
September 12, 2008

The widow's lawsuit in the US District Court for the Northern District of California was settled before trial for $40,000.

The patient's estate's lawyers were prepared to present a case of failure to monitor and report the patient's health status, failure to recognize that the long-term care facility could not meet his needs and failure to comprehend that starting oral antibiotics after systemic sepsis had already set in was too little too late. **Immediato v. US, 2008 WL 5727440 (N.D. Cal., September 12, 2008).**

Psychiatric Commitment Denied: Disabled Resident Able To Sue For Malicious Prosecution.

A quadriplegic who has had bilateral leg amputations is a resident of the local county rehab facility. He has no use of his arms but can move his hands a little and can turn his head slightly from side to side.

Despite his physical limitations he is reportedly fully alert and his cognitive functioning is completely intact.

He has been able to communicate with staff, interact socially with other residents, participate in activities and actually ran for election and was elected president of the residents' council.

Flurry Complaints Leads to Psychiatric Commitment

After his election as patient representative the resident reportedly began a campaign of persistent complaints and reports about conditions at the facility such as alleged inadequate staffing.

After tolerating this behavior for several months the director of the facility reached the limit of his patience.

The director filed a petition with the local probate court to have the resident involuntarily committed to a psychiatric hospital, allegedly for drug and alcohol abuse, threats of self-harm and violent acting-out toward the caregiving staff in the facility.

Malicious prosecution can be the basis for a civil lawsuit asking for payment of damages.

Malicious prosecution occurs when a legal proceeding, civil or criminal, is lodged against another person without probable cause and with malicious intent and the proceeding ends in favor of the person against whom it was lodged.

Probable cause for filing a mental health petition against another person is not proven by the mere fact the police came and took the person into custody.

To sue for malicious prosecution it is generally required that the legal proceeding resulted in consequences above and beyond the annoyance and expense of successfully defending the legal proceeding itself.

CIRCUIT COURT, JEFFERSON COUNTY ALABAMA
July 7, 2008

One glaring legal deficiency in the whole process, right off the bat, was that the resident, his attorney and his guardian *ad litem* were never notified of the petition. The resident only found out about it when the police came to the facility and forcibly removed him to the local state hospital.

A court hearing was held at the state hospital about a week after the resident was placed there. The director of the resident's facility did not bother to appear.

The judge reached a decision solely on the basis of the resident's own lucid testimony at the hearing that there were no grounds for involuntary detention for further psychiatric evaluation or mental health treatment.

The resident was returned to the facility under the auspices of a protective order which now bars any changes in his placement without permission from the probate court.

Nevertheless, the resident has suffered a definite degree of isolation and ostracism from staff and other residents.

He also was not able to return to his private room which was given to someone else. Above and beyond the loss of personal privacy his sleep has been affected as he now has a roommate who must be tended to during the night by facility staff.

The jury in the Circuit Court, Jefferson County, Alabama awarded a verdict of $60,000 as compensatory damages and $20,000 more as punitive damages. **Evans v. Walker, 2008 WL 5685463 (Cir. Ct. Jefferson Co., Alabama, July 7, 2008).**

LEGAL EAGLE EYE NEWSLETTER
For the Nursing Profession
ISSN 1085-4924

Published monthly, twelve times per year.

Print edition mailed First Class Mail at Seattle, WA.

Electronic edition distributed by email file attachment to our subscribers.

E. Kenneth Snyder, BSN, JD
Editor/Publisher

PO Box 4592
Seattle, WA 98194–0592
(206) 718-0861

kensnyder@nursinglaw.com
www.nursinglaw.com

Emergency Room: Court Accepts Unusually Detailed Statement Of The Standard Of Care For Nursing Assessment Of Pediatric Patients.

The parents filed suit after their twenty-two month-old child died from dehydration twelve hours after discharge from the hospital's emergency room.

For the lawsuit the parents' attorneys filed detailed reports containing the expert opinions of a board-certified emergency physician and a certified family nurse practitioner with a faculty position at a major nursing school.

The attorneys representing the defendant emergency physician and emergency nurse practitioner challenged the parents' experts' qualifications as well as the substance of their expert opinions.

The trial judge overruled the challenge, upholding their qualifications and ruling that their opinions were right on the mark on the standards of care for physicians and nurses seeing pediatric patients in the emergency room. The Court of Appeals of Texas agreed that the parents' lawsuit can go forward.

Standard of Care

The standard of care for a Nurse Practitioner (NP) treating a nearly two year-old child in the emergency department with a history of vomiting and diarrhea requires that the NP understand that children with fluid and electrolyte disorders require meticulous diagnostic skills because serious illness may be overlooked with cursory examination or treatment.

The standard of care also requires that the NP obtain specific information from the parent or caregiver regarding the duration, severity and quantity of the vomiting and diarrhea and the order in which the symptoms developed.

Information regarding the presence or absence of fever and the consistency and content of stools should be obtained as well as the child's recent intake, appetite and ability to keep food and fluids down. The NP should also obtain information about whether other family members are ill, whether the child attends day care and whether the child has recently traveled.

The attorneys filed experts' reports setting out the legal standard of care with an unusual degree of detail.

COURT OF APPEALS OF TEXAS
February 19, 2009

The standard of care requires that the NP conduct a physical examination of the child that includes assessment of mental status (including signs of lethargy or anxiety), vital signs on admission and discharge (including temperature, heart rate, respiratory rate and blood pressure), assessment of skin turgor (including whether mucous membranes are moist or dry and whether the eyes are sunken) and a general assessment of the ears, throat, heart, lungs, abdomen and extremities.

The standard of care requires that a weight be obtained with a comparison of the child's usual weight (according to prior records or information from the parents). When there is a significant decrease in the child's weight (i.e. over 6%) and the child appears ill, the standard of care requires that a urine specific gravity and other serum studies (electrolytes, blood urea nitrogen and creatinine) be obtained to clarify the child's actual fluid and electrolyte status.

The standard of care requires that children with moderate dehydration (6% to 9%) be kept in the E.R. (or another supervised setting such as a physician's office or urgent care center) to be given a trial of oral replacement therapy. The dehydration is corrected by giving at least 60-120 ml/hour over several hours. Following this therapy, the child's hydration should be reassessed.

The child should not be discharged from the E.R. until the oral hydration therapy has been successfully given.

If the oral replacement therapy is not successful due to intolerance to oral intake or excessive continued losses, the child should be given IV fluids and evaluated for admission if necessary.

The standard of care requires that NP's be aware that the administration of Benadryl or other medications that cause drowsiness is not indicated for the treatment of vomiting and diarrhea due to acute gastroenteritis.

The NP should be aware that if a child is given Benadryl after discharge, the medication will likely make the child drowsy and the parents will not be able to assess whether the child's mental status and condition is deteriorating due to a fluid and electrolyte imbalance.

The standard of care requires that the NP provide both written and oral discharge instructions to the parent or caregiver.

For a child that has been evaluated for multiple episodes of vomiting and diarrhea that is being sent home, the discharge instructions must include specific information regarding the signs and symptoms of dehydration and the amount and types of fluid the child should be given at home.

The discharge instructions should indicate potential signs of worsening dehydration such as: dry lips and mouth, a dark color or a strong smell to the urine, not urinating very often or very much, little or no tears when crying, sunken eyes, not paying attention to toys or television, being difficult to wake up, vomiting up nearly everything he/she drinks or eats or feeling thirsty but drinking liquids makes the child vomit.

For a child with mild dehydration the discharge instructions should include information to give the child one or two teaspoons every 5 minutes (approximately 1-2 ounces per hour) of an oral rehydration solution; if the child does well, give bigger sips a little less often (every 5-10 minutes). Continue until the child is no longer thirsty, has adequate urinary output and is not showing any signs of dehydration.

(Continued on next page.)

Emergency Room: Pediatric Assessment, Care, Nausea, Vomiting, Dehydration (Continued).

(Continued from previous page.)

Deviations from Standard of Care
Pediatric Nurse Practitioner

The NP fell below the standard of care and was negligent by failing to recognize that the child was at least moderately dehydrated and required, at a minimum, oral replacement therapy to be given in the E.R.

The NP failed to obtain vital information from the mother including the duration, quantity and contents of the child's vomiting and the quantity, frequency and consistency of her stools over the past few days.

She also fell below the standard of care by failing to obtain and document information regarding the amount of the child's oral intake, appetite and urinary output over the past few days.

The NP fell below the standard of care by failing to obtain and document information regarding whether other family members were ill, whether the child attended day care and whether she had traveled recently.

The NP fell below the standard of care and was negligent by failing to obtain an adequate physical assessment of the child.

The NP did not adequately assess the child's mental status. She did not document the presence or absence of lethargy or anxiety. Documenting that a 21-month old is "alert and oriented" is not adequate.

The NP fell below the standard of care by failing to obtain the child's respiratory rate, blood pressure and oxygen saturation upon admission to the emergency room.

She also failed to meet the standard of care by allowing the child to be discharged without a second set of vital signs including temperature, heart rate, respiratory rate and blood pressure.

The NP was negligent by failing to assess and document the child's skin turgor including whether her eyes were sunken.

The NP deviated from the standard of care and was negligent when she failed to compare the child's usual weight with the weight obtained in the E.R. The mother informed the staff that the child's weight was down three pounds compared to the last weight done in her pediatrician's office. This weight reduction is consistent with severe dehydration because it indicates that the child had a nearly 11% weight reduction.

Since the child appeared ill and anxious and had a weight reduction consistent with severe dehydration, the NP was negligent when she failed to obtain lab studies (including urine specific gravity and if abnormal serum electrolytes, serum creatinine and serum BUN). If she had, the child's urine specific gravity and blood urea nitrogen more than likely would have been consistent with moderate to severe dehydration.

The NP was negligent when she discharged the child from the E.R. rather than initiating oral replacement therapy with oral rehydration solution (such as Pedialyte) over several hours.

The NP fell below the standard of care and was negligent when she instructed the mother to give the child Benadryl 6.25 mg every six to eight hours and when she failed to give specific written instructions about the signs and symptoms of worsening dehydration (as listed above) and to return to the E.R. if the child did not tolerate the oral replacement therapy at home (approximately one cup or more per hour until bedtime) or if she did not have an adequate urinary output (i.e. wet diapers).

Nurse Practitioner's Negligence
As Cause of Child's Death

The child had vomiting and diarrhea secondary to acute gastroenteritis and was moderately to severely dehydrated and needed treatment to replace her fluid deficit.

The autopsy findings constitute overwhelming evidence that the child's death was more than likely proximately caused by inadequately treated dehydration. The medical examiner found that the child appeared dehydrated with markedly sunken eyes, had dry appearing conjunctivae, had no urine in her bladder and had a postmortem BUN consistent with severe dehydration (57 mg/dL).

The comparison of the child's weight just prior to her death to her usual weight indicates that she was more than likely moderately to severely dehydrated while she was in the E.R.

The child also had fungal esophagitis, but this infection does not usually cause any significant problems and can easily be treated with an oral antifungal medication.

Fungal esophagitis did not cause the child's death although it may have caused her to experience pain upon swallowing.

The inadequate history and physical examination that was taken by the NP and the emergency room nurse caused the child's death.

If the NP, the physician or the emergency room nurse would have obtained an adequate history from the mother about the quantity and frequency of her vomiting and diarrhea, the NP, the physician or the emergency room nurse more than likely would have realized that the child was moderately to severely dehydrated and needed a trial of oral replacement therapy in the emergency room.

If the NP, the physician or the nurse had noted the child's respiratory rate and taken her blood pressure and conducted an adequate physical examination (including assessment of skin turgor) the NP, the physician or the nurse more than likely would have realized that she was moderately to severely dehydrated and needed the trial of oral replacement therapy in the emergency room, and if unsuccessful, intravenous fluids with possible admission to the hospital.

The Court went on to endorse the board certified emergency room physician's opinions as to the standard of care for an emergency physician supervising a nurse practitioner in the emergency room when caring for a dehydrated pediatric patient, finding that the physician's deviation from that standard of care also contributed to the unfortunate outcome. **Benish v. Grottie, __ S.W. 3d __, 2009 WL 417264 (Tex. App., February 19, 2009).**

Labor & Delivery: Lapse In Fetal Monitoring.

The patient was admitted for delivery of her third child. There were reportedly no special risk factors affecting this pregnancy.

A fetal heart monitor was attached in the labor and delivery unit. The fetal heart rate tracings were normal at the start.

The labor and delivery nurse assigned to the patient left the patient alone in her room at 3:30 p.m.

At 4:00 p.m. when the patient's nurse returned to the room she immediately recognized a slow fetal heart rate and called for an emergency cesarean.

The infant was delivered nine minutes later with poor Apgars and had to be taken to neonatal intensive care.

Now the child has serious developmental issues related to hypoxic brain injury at birth. An arbitrator awarded a cash payment of $3,594,656 for the child in addition to the defendant health maintenance organization's agreement to provide lifetime care which has a present estimated value of more than $26,000,000.

Lapse in Fetal Monitoring

There was a remote fetal monitor at the nurses station, but apparently no one was present at the nurses station between 3:30 and 4:00 p.m. to keep an eye on the monitor. The fetus's distress was not noted and acted upon until the nurse actually returned to the patient's room.

"Subsequent Remedial Measures"

The legal rules of evidence for civil cases expressly state that "subsequent remedial measures" are not to be taken as evidence of negligence.

Safety improvements after the fact do not necessarily prove negligence. The legal system does not want to penalize defendants in civil lawsuits who learn from their mistakes.

Nevertheless, it reportedly came out during the case that the hospital system changed its policies as a result of this incident and now requires the continuous presence of trained personnel at remote monitoring stations. **"S.A." v. Kaiser Foundation Hospitals, 2009 WL 692095 (Med. Mal. Arbitration, California, March 5, 2009).**

EMTALA: Nurses Did Not Violate The Law.

The US Emergency Medical Treatment and Active Labor Act (EMTALA) makes it unlawful for a hospital which has an emergency department to refuse to give an appropriate medical screening examination and necessary stabilizing treatment to any individual who comes to the emergency department seeking emergency care.

A motorcycle accident victim was brought to a hospital's E.R. with degloving injuries to a lower extremity. The hospital did not have a plastic surgeon on call and the only one who could be reached had had his hospital privileges revoked.

A family member of the victim, who was a nursing supervisor at another hospital, called a third hospital's E.R. The E.R. nurse on duty there called a plastic surgeon with privileges there, but he refused to treat the patient because the patient was already being treated.

Nurse Refused to Promise Admission
No EMTALA Violation

The E.R. nurse, after calling her unit director at home, refused to promise to admit the patient, having no authority to override a staff physician's decision.

The E.R. nurse reportedly did tell the family member that the patient would be handled the same as any other emergency case if she were brought to the hospital.

The Court of Appeals of Arkansas ruled that the hospital where the staff physician and E.R. nurses would not promise to admit the patient did not violate the US EMTALA.

No Specialized Capabilities
Hospital Has No Obligation
To Accept Transfer of Patient

The court noted in passing that a hospital with specialized medical capability pertinent to the particular patient's needs, e.g. a burn unit, shock unit or neonatal intensive care unit, does have an obligation under the EMTALA to accept and admit a patient transfer from the E.R. at a hospital that lacks such specialized capability, but that was not the situation here. **Thompson v. Sparks Regional Medical Center, __ S.W. 3d __, 2009 WL 700644 (Ark. App., March 18, 2009).**

Pathology: Nurse Faulted, Did Not Send Specimen To The Lab.

The patient went to her family physician's office to have a mole removed from her foot after the mole, several years old, began to grow and itch and turned red.

The physician told the patient he did not think the mole was cancerous, but he was going to send it to the pathology lab anyway.

Then the physician handed off the specimen to the office nurse.

The nurse apparently never prepared or sent the specimen to the lab.

The patient went to a different doctor to have her stitches removed. Then she transferred her primary care to still another medical group.

The lesion recurred. It was diagnosed as malignant melanoma and surgically removed a second time.

The first office nurse's error was discovered afterward when the medical charts from the different physicians' offices were sorted out.

The jury in the Circuit Court, Delaware County, Indiana awarded a verdict of $3,250,000.

Reportedly the patient recovered uneventfully from the surgery to excise the melanoma and has no residual disability. The jury believed, however, that she is at increased risk for recurrence of cancer.

The nurse was faulted by the expert witnesses at trial, first and foremost, for not sending the specimen to the lab.

The family practice physician, the experts said, erred by not having the patient come in to his office as routine practice to review the pathology results and make any necessary recommendations.

The physician or nurse should at least have logged the file for follow-up review. In this case that would have prompted them that the pathology specimen was not sent in, the experts said. **Mieth v. Yorktown Health & Diagnostic, 2008 WL 5666509 (Cir. Ct. Delaware Co., Indiana, June 25, 2008).**

Diabetic Patient Dead From Hypoglycemia: Jury Finds No Nursing Negligence.

The twenty-seven year-old patient was ten weeks pregnant when her ob/gyn admitted her to the hospital.

Her earlier pregnancies had not gone well. This time she was having a very difficult time with nausea and vomiting.

The patient's long-term health history was significant for a Type I diabetes. Once she was in the hospital her ob/gyn had an endocrinologist take over management of her diabetes. That entailed strictly controlling her nutritional intake, closely monitoring her blood-glucose levels and frequently adjusting her insulin dosages.

The documentation shows that the patient's nurses communicated frequently with the patient's physician and followed his instructions to the letter for the patient's blood-sugar testing and insulin dosages.

CIRCUIT COURT, CALHOUN COUNTY
ALABAMA
November 21, 2008

Her nurse found her unresponsive in bed at 6:40 a.m. on the day planned for discharge when the nurse came by for a scheduled blood-glucose test. She was pronounced ten minutes later. The post-mortem blood glucose was less than 20.

The jury in the Circuit Court, Calhoun County, Alabama was not swayed by speculation that the physician must have ordered too much or the nurse must have given too much insulin at midnight.

There was no evidence of negligence. **Lewis v. Zayed, 2008 WL 5691158 (Cir. Ct. Calhoun Co., Alabama, November 21, 2008).**

Premature Hospital Discharge: Nurse Faulted In Patient's Death.

The fifty-three year-old patient was admitted to the hospital for elective uvulopalatopharyngoplasty and a tonsillectomy to correct a longstanding problem with sleep apnea.

The surgery went well and her immediate post-operative recovery was unremarkable. She was discharged home the afternoon of the day of surgery.

The patient's discharge instructions after throat surgery were to return to the hospital if she experienced any bleeding from the mouth or had a temperature above 101°F.

UNITED STATES DISTRICT COURT
TEXAS
January 15, 2009

The next day the patient began spitting up blood and started running a slight fever. Her husband phoned the hotline number from the discharge paperwork.

The phone hotline nurse reportedly told the husband that the bleeding was no cause to worry and no medical follow-up was needed unless the patient's fever rose above 101°F.

The next morning the patient awoke with severe difficulty breathing, then collapsed and was taken to another hospital's E.R. in full cardiac arrest. She went into a coma and had four more arrests before she died four days later.

The judge in the US District Court for the Western District of Texas ruled the discharge itself was premature and that the post-discharge advice from the phone hotline nurse was below the standard of care. Damages of $313,390 were awarded to the husband. **Tello v. US, 2009 WL 531258 (W.D. Tex., January 15, 2009).**

Facts Concealed From Family: No Negligence, But Civil Fraud Lawsuit Can Go Forward.

The elderly stroke patient's internist ordered a nasogastric feeding tube.

The tube was confirmed ostensibly in the stomach by an x-ray, but an x-ray the next day showed it was in the lung, not the stomach. The tube was removed, re-inserted and again confirmed by x-ray in the stomach.

The patient died two days later. His post-mortem reportedly pointed to pneumonia aggravated by aspiration of nutrition into the lung.

The family's medical expert's opinion does not identify any error or omission by the physician or the hospital staff which fell below the standard of care. There is no proof of negligence.

However, the family still has grounds to sue if they can prove the physician or the hospital intentionally tried to conceal the facts.

COURT OF APPEALS OF GEORGIA
March 10, 2009

The Court of Appeals of Georgia ruled there was no evidence of negligence by the physician or the hospital staff.

Nevertheless, the family will be allowed their day in court to sue for fraud if they can prove that the internist or hospital staff intentionally tried to conceal the basic fact that aspiration of nutrition into the lung through the feeding tube was a factor in the patient's demise. **Roberts v. Nessim, __ S.E. 2d __, 2009 WL 597191 (Ga. App., March 10, 2009).**

LEGAL EAGLE EYE NEWSLETTER
For the Nursing Profession

Gunshot Wound: Jury Faults Care Given In E.R.

The male patient in his early twenties was brought in with a gunshot wound in his lower left leg. The bullet had fragmented after fracturing the tibia bone.

Surgery to repair the tibia led to compartment syndrome, further complications, additional surgeries and below-the-knee amputation.

The patient's lawyers sued the hospital and the orthopedist who took over his care shortly after he arrived in the E.R. but dismissed the hospital before the case went to trial.

During the first thirty-six hours before the first surgery the orthopedist and the nurses carrying out the orthopedist's orders only wiped the area of the wound with a sterile gauze pad soaked in Betadine but made no effort to irrigate or debride the wound. That was the lawyers' principal assignment of negligence at trial.

The jury in the District Court, Jefferson County, Texas awarded $1,535,000. **Sylvester v. Christus Health, 2009 WL 674320 (Dist. Ct. Jefferson Co., Texas, February 12, 2009).**

Weight Gain: Disabled Patient Obtains Settlement.

The thirty-six year-old patient is a highly dependent brain-injury victim who resides in a nursing facility.

Over time the resident was allowed to gain more than eighty pounds. It is not considered realistic that he will ever lose the weight.

Damages were claimed in his lawsuit against the facility filed in the Superior Court, King County, Washington, for the fact it is hard for him how even to get out of bed, causing isolation and humiliation.

The lawsuit alleged the weight gain resulted from negligence by facility staff not monitoring his caloric intake. Allegedly food was withheld as punishment at times while at other times he ate so much that he vomited on himself.

His lawsuit reportedly settled for $851,276 of which $465,000 went to the patient and $305,000 went to his attorneys as fees and $82,276 as litigation costs. **Sanderson v. Evergreen Rehab., 2008 WL 5644404 (Sup. Ct. King Co., Washington, October 13, 2008).**

False-Negative HIV Test: Patient Suicide Was Not Outside The Realm Of Possibility, Court Says.

As routine practice the reproductive clinic tested both husband and wife for HIV before attempting *in vitro* fertilization.

The clinic nurse told both spouses they were negative. The husband, in fact, had tested positive.

In vitro fertilization was attempted but failed.

A year later the husband tested HIV-positive during a routine insurance physical. He went to his own doctor for re-testing. He was told negative results come back right away but positive results take a while to become available.

His body was found at the bottom of a ravine, an apparent suicide, a few hours after he placed a call to his doctor's office and was told his results would not be available for another week or longer.

The clinic nurse told the husband, who actually was HIV positive, that he was negative. A year later he tested HIV-positive.

Having been faithful in his marriage, the only explanation he could see what that his wife had been unfaithful, had contracted the virus and had passed the virus to him.

His suicide can be linked to negligence in reporting a false-negative HIV result.

SUPREME COURT OF IDAHO
March 5, 2009

The Supreme Court of Idaho ruled that the reproductive clinic corporation, the physician and the office nurse could be held liable to the widow in a wrongful-death lawsuit.

The court ruled it was not outside the realm of possibility that the husband was driven to despair and then to suicide by the belief he must have contracted the virus from the only sexual contact he had had the previous year, his wife, who, in turn, must have contracted it from an outside party with whom she was having or had had an extramarital affair.

With correct information the patient could have received treatment and counseling for the medical and psychosocial issues brought up by his diagnosis. **Cramer v. Slater, __ P. 3d __, 2009 WL 540706 (Idaho, March 5, 2009).**