LEGAL EAGLE EYE NEWSLETTER

August 2004 *For the Nursing Profession* Volume 12 Number 8

Understaffing: Court Blames DON For Death, Aide Did Not Have Time To Read Care Plan.

The resident's care plan called for two people to work with her any time she was transferred from her wheelchair to her bed.

She was considered a dependent transfer. Any time a dependent transfer was carried out the facility's rules called for a transfer belt to be used.

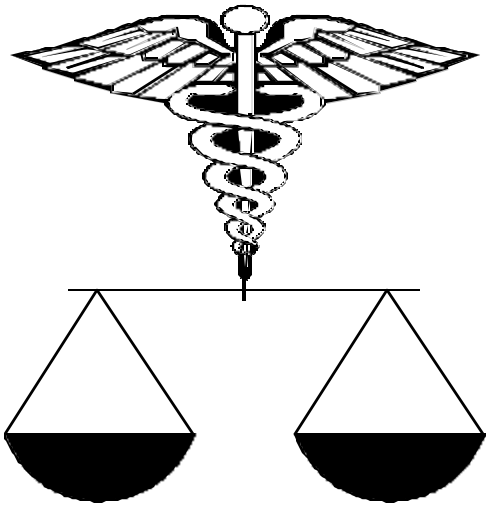
One certified nurses aide tried to transfer the resident from her wheelchair to her bed. She fell to the floor. She died the next day. The medical examiner ruled trauma from the fall was the cause of death. The family sued the nursing facility, the administrator and the director of nursing.

The jury awarded $856,000 to the family, finding the administrator and the director of nursing negligent.

The Court of Appeals of Texas, in a memorandum opinion, agreed with the jury that the administrator and director of nursing were negligent, but overturned the jury's verdict on evidentiary grounds and ordered a new trial.

Understaffing
Aide Did Not Have Time
To Read The Care Plan

The aide testified she did not read the care plan because she did not have time. Had she read the care plan she would have known this resident was a two-person transfer.



The aide did not read the care plan that called for a two-person transfer.

The jury was entitled to conclude the aide did not read the care plan because the aide did not have time because the facility was understaffed.

The administrator and the DON deliberately allowed the facility to go understaffed.

COURT OF APPEALS OF TEXAS
MEMORANDUM OPINION
June 23, 2004

Had she read the care plan, this tragic incident would not have occurred, according to the court.

Medicare guidelines required the facility to provide sufficient staffing so that 191 minutes of certified aide time would go to this resident in any 24 hour period. However, general staffing levels at the facility would allow only 105 minutes for this resident, in clear violation of Medicare standards.

On the day in question the situation was worse because two aides called in sick. The administrator and director of nursing knew the facility was critically understaffed but did not call in off-duty personnel, did not phone the facility's four sister facilities in the area to locate available staff or go to a nursing agency to get help, the court said.

The court laid the blame squarely on the administrator and director of nursing for the resident's death.

Evidence of Other Falls

The judge allowed the family's lawyers to present evidence there were more than 800 other falls at the facility. Without proof they all happened under similar circumstances the judge was in error to allow that evidence in the case, and a new trial was ordered. **Penalver v. Living Centers of Texas, Inc., 2004 WL 1392268 (Tex. App., June 23, 2004).**

Inside this month's issue ...

August 2004

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Nurse As Aides' Supervisor: Court Upholds Nursing Board's Disciplinary Action.

The Supreme Court of Appeals of West Virginia has upheld a one-year license suspension imposed upon a registered nurse by the state nursing board.

The basis for the suspension was the grossly unprofessional manner in which the nurse carried out her job responsibilities to supervise non-licensed homemaker personnel working in Medicaid clients' homes.

An inspector from the state department of health and human services selected at random five of the nurse's agency's clients' cases to review.

The inspector found numerous violations. Several of the homemakers did not have the required in-service training hours. In-home client files were absent or had not been reviewed monthly by the supervising nurse.

Homemakers were absent when they should have been present. The supervising nurse documented a client visit in which she found the homemaker absent, but an audit of the personnel records indicated the homemaker actually was there. That led to the conclusion the supervising nurse did not actually make the visit.

Unprofessional Conduct
Supervision of Non-Licensed Personnel

The court noted that the state's nurse practice act defines unprofessional conduct for a nurse to include falsification of documentation regarding the delivery of nursing care, whether or not the nurse is the one actually performing the care.

Supervision of other personnel necessarily involves true and correct documentation of how such personnel have or have not performed their patient-care duties.

It is unprofessional conduct warranting severe disciplinary action for a nurse to document falsely that the nurse or another person in the nurse's charge has performed services that have not been rendered, the court ruled. **Williams v. West Virginia Board of Examiners, __ S.E. 2d __, 2004 WL 1432298 (W. Va., June 24, 2004).**

The nurse was employed by an agency that had a state Medicaid contract to provide in-home homemaker services.

The nurse did not provide direct patient care herself.

The nurse's responsibility was to oversee and to document homemaker services provided to clients by the agency's homemaker personnel.

The Board of Nursing has the authority and the responsibility to regulate conduct by a nurse which is derogatory to the morals or standing of the nursing profession.

Such conduct can include falsifying patient records or intentionally charting incorrectly, or improperly, incompletely or illegibly documenting the delivery of nursing care.

The nurse apparently documented a supervisory visit to a homemaker client she never actually made.

The nurse also failed to ascertain that home-care files were present in each client's home and documented that she reviewed such files that did not exist.

SUPREME COURT OF APPEALS
OF WEST VIRGINIA
June 24, 2004

No Designated Driver: Case Should Have Been Cancelled.

The patient was to have a colonoscopy at an outpatient medical center. The procedure was to be performed with the patient under heavy sedation.

When the patient arrived for the procedure the nurse asked him how he would be getting home afterward. He gave the name of a friend, but the friend did not show up.

The patient signed a form post-procedure acknowledging that he was leaving the center against medical advice.

He tried to drive himself home alone, had a one-car accident and died from his injuries. His widow sued the outpatient center for negligence.

The outpatient center's own policies and procedures said that a procedure should be cancelled and rescheduled if there is no one accompanying the patient to drive him home afterward.

COURT OF APPEALS OF ARKANSAS
June 23, 2004

The Court of Appeals of Arkansas overruled a lower court judge's ruling that the outpatient center owed no legal duty to the patient in this situation.

The Court of Appeals agreed with the lower court judge that the center's nurses gave the patient all the proper warnings before and after the procedure. The Court agreed there was nothing legally the center could have done to stop him from leaving.

The Court of Appeals believed the best course of action would be not to start a procedure in the first place with a patient who has driven in unless a suitable designated driver is standing by. **Young v. Gastro-Intestinal Center, Inc., __ S.W. 3d __, 2004 WL 1398610 (Ark. App., June 23, 2004).**

Health Plans: US Supreme Court Bars Suits For Damages Over Patient-Care Decisions.

In the past few years health insurance plans and health maintenance organizations have been sued successfully in state courts for professional malpractice over patient-care decisions made by their nurses, doctors and other healthcare professionals.

Although the US Employee Retirement Income Security Act of 1974 (ERISA) has been on the books for some time, patients' lawyers have convinced a lot of judges that benefit-allocation decisions and patient-care decisions are separate issues.

While suits to recover the value of health benefits or services wrongfully denied are strictly regulated by ERISA, judges have ruled that suits which can be characterized as suits over patient-care decisions are eligible for all of the economic and non-economic damages customarily awarded by juries in medical malpractice lawsuits.

Landmark Case
Involves Nurse's Discharge Decision

Many of the cases in this area of the law, including the US Supreme Court's recent landmark ruling, have involved patient-care decisions by health-plan nurses employed to review patients' cases.

In the recent landmark case, one of the patients who sued was discharged from the hospital against her treating physician's recommendation because of a health plan's case-review nurse's decision the patient's clinical situation did not meet the plan's criteria to continue as an inpatient in the hospital.

This is a fairly common scenario in these cases as they have been coming out of the state courts. We have been reporting them from time to time in this newsletter when they involve nurses' potential liability for their errors and omissions.

Health insurance plans and health maintenance organizations are governed by the US Employee Retirement Income Security Act of 1974 (ERISA).

Health insurance plans and health maintenance organizations can be sued in the Federal courts to obtain benefits wrongfully denied to a beneficiary.

Health insurance plans and health maintenance organizations cannot be sued in Federal or state court for professional negligence in making patient-treatment decisions that adversely affect patients' health or well-being.

Such suits would bring into play all of the economic and non-economic damages customarily awarded by juries in medical malpractice lawsuits, which was not the intent of Congress.

SUPREME COURT
OF THE UNITED STATES
June 21, 2004

Benefit Allocation
Medical Costs = Damages

Viewed as a benefit-allocation case, the patient would be able to sue at most for the cost of a certain number of additional hospital days times the daily rate.

Patient Care / Malpractice
Damages = Medical Costs,
Pain and Suffering,
Loss of Earnings, Future Disability, etc.

Viewed as a patient-care decision, to treat someone outpatient as opposed to inpatient, the damages alleged for post-surgery complications once the patient finally did get back into the hospital, allegedly caused by being sent home early, could be very substantial.

The Supreme Court's ruling will free some nursing and other healthcare professionals from liability considerations. However, this is a hot political topic. There could be Congressional action to overturn or modify the Court's ruling. **Aetna Health Inc. v. Davila, __ U.S. __, 124 S. Ct. 2488, 72 USLW 4516 (U.S., June 21, 2004).**

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Deep Vein Thrombosis: Court Stresses Importance Of Post-Op Ambulation By Nurses.

The patient underwent a three-hour open abdominal surgery. Due to her weight and age, she was considered at-risk for deep vein thrombosis (DVT), but no anti-clotting device or medication was used during the surgery.

The surgeon wrote orders for post-surgical ambulation by the nursing staff, specifically to reduce the risk of a DVT.

A nurse unsuccessfully attempted to walk the patient approximately three hours after the surgery. No attempt was made to ambulate her at any time the next day.

First Ambulation
46 Hours After Surgery

Forty-six hours after her surgery the patient was walked from her bed to the chair in her hospital room. Three hours later she was walked with a walker for a distance that was not specifically noted in her chart. Four hours later she was walked no more than ten feet as she could not tolerate the pain.

Twenty-one hours later she was walked about ten feet. Four hours later, as she was being ambulated, she collapsed and died. A pathologist ruled she died from a pulmonary embolism.

Court Criticizes Nurses' Failure To Ambulate

The Appellate Court of Illinois was very critical of the nurses for failing to appreciate the importance of post-operative ambulation of patients for whom the physician has ordered ambulation as a precaution against DVT.

However, the court felt obliged to throw out the jury's verdict against the hospital and the physicians responsible for the patient's post-surgical care. All of the expert witnesses on both sides of the case were physicians; none of them were licensed as nurses. In Illinois only a professional licensed in the same profession can testify as an expert on the professional standard of care. The court ordered a new trial. **Garley v. Columbia Lagrange Memorial Hosp., __ N.E. 2d __, 2004 WL 1469414 (Ill. App., June 30, 2004).**

As a general rule a physician is not considered competent as an expert witness on the legal standard of care for nurses.

Physicians often have no first-hand knowledge of nursing practice except for observations made in patient-care settings.

A physician rarely, if ever, teaches in a nursing program nor is a physician responsible for content in nursing texts.

In many situations a physician would not be familiar with the standard of care or with nursing policies and procedures which govern the standard of care.

Therefore, a physician's opinions would not be admissible in evidence in jurisdictions which hold the expert must be familiar with the standard of care in order to testify as an expert.

Some states allow a physician to testify if there is a foundation for the physician's knowledge of nursing practices. In Illinois, however, there is a strict rule that to testify about nursing standards the expert witness must be licensed as a nurse.

APPELLATE COURT OF ILLINOIS
June 30, 2004

Catheterization: Nurses Ruled Not Responsible For Permanent Urinary Retention.

The patient had gallbladder surgery. Although the surgeon did not order it, the post-op nurses catheterized him in-and-out three times in 24 hours and got 1,600, 1,100 and 1,700 cc's of urine.

Later he developed permanent urinary retention due to an over-distended bladder and is unable to void. He sued the hospital. The jury sided with the hospital.

The Court of Appeals of Kentucky pointed to expert medical testimony that permanent retention is caused by chronic rather than acute episodic over-distention of the bladder. The nurses had no reason to anticipate his permanent condition would result from their care. **Ellis v. Caritas Health Services, Inc., __ S.W. 3d __, 2004 WL 1532435 (Ky. App., July 9, 2004).**

Newsletter Online.

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Employment References: Court Refuses To Hold Prior Employer Responsible For Sexual Assault Committed At Nursing Home.

The family of a now-deceased nursing home resident believed she was sexually assaulted by an employee of the nursing home.

Family Sued Previous Employer Over Employment Recommendation

The probate administrator of the deceased resident's estate filed a lawsuit on behalf of the family against the nursing home where the employee had previously worked. The lawsuit alleged the previous nursing facility negligently supplied a favorable employment reference to his next employer which led to his being hired and placed him in a position to assault the resident in question.

The Supreme Court of Indiana ruled there were no legal grounds for the family's lawsuit. In its opinion the court carefully reviewed the delicate situation in which employers can find themselves.

Reports, Rumors Were Investigated, Not Proven At First Facility

The facility where the man had worked before, which supplied the recommendation upon which he was hired at the facility where he allegedly committed the assault upon the resident, had heard reports and rumors of sexual misconduct involving elderly psychiatric and Alzheimer's patients.

According to the court, the reports were looked into but it could not be substantiated that any misconduct had occurred. No formal investigation was conducted. No written report was prepared or placed in the facility's or the man's personnel file.

Employer's Liability To Employees False Statements In Personnel Files, Employment References

The court pointed out that employers face legal liability to their employees and former employees for false statements in personnel files and employment references. The law gives employers a qualified legal privilege against lawsuits by their employees for information contained in personnel files and job references, but only to the extent that there is reasonable grounds to believe it is true.

Nursing home management owes a duty to the residents of other nursing facilities not to make intentional misrepresentations in employment references.

That is, if a resident of another facility is harmed by an employee hired at the other facility on the basis of false information deliberately supplied in an employment reference, the resident has the right to sue the employee's former employer who supplied the false information to the latter employer.

On the other hand, an employer has no duty, and in fairness to the employee cannot repeat rumors and innuendo regarding an employee.

Employers face legal liability to their current and former employees for statements in employment references which cannot be substantiated and which damage the current or former employee's employment prospects.

In this case there was no proof of any conscious, deliberate misrepresentation by the former employer.

SUPREME COURT OF INDIANA
June 29, 2004

Job references cannot be based upon rumors and innuendo which have not been substantiated as factual, the court pointed out.

The former supervisor, whose facility was now a defendant in this lawsuit, had checked off on a pre-printed reference form that the man fulfilled his job responsibilities adequately and would be eligible for rehire.

Given that the rumors and innuendo of sexual misconduct were not and could not be substantiated, the court ruled the first facility fulfilled all its legal obligations to its former employee as well as the residents of nursing facilities where he would later work. Those residents had no right to sue.

Deliberate Misrepresentation In Job Reference Could Be Grounds For Legal Liability

If the family could prove the first facility made a conscious, deliberate misrepresentation of proven facts, there would be grounds for legal liability.

If someone makes a false statement knowing it is false and that another person will rely upon the statement in taking action, the person making the false statement is legally liable to those harmed by the action taken in reliance upon the truth of the statement.

Applying the general common-law principles to this situation, the court ruled there would be legal liability if a current or former employer were deliberately to cover up proven facts which would be significant to a later employer in making a hiring decision, the person is hired and an innocent person is harmed as a result of the facts having been covered up. **Passmore v. Multi-Management Services, Inc., 810 N.E. 2d 1002, (Ind., June 29, 2004).**

Skin Care: Court Says CMS Must Consider Skilled Facility's Explanations For Non-Compliance With Federal Regulations.

A skilled nursing facility was cited by state department of health inspectors for deficiencies in violation of Medicare and Medicaid regulations. The US Centers for Medicare and Medicaid (CMS) services imposed a civil monetary penalty on the facility to enforce compliance.

The facility requested a hearing before an administrative law judge to contest the citations and the civil monetary penalty. The administrative law judge ruled in favor of CMS and upheld the citations and the penalty. The facility filed an appeal with the US Circuit Court of Appeals for the Sixth Circuit.

The Sixth Circuit Court upheld some of the citations. The Court also ruled in favor of the facility that the facility should have been allowed to present its explanations which the administrative law judge should have considered before ruling.

Aide In-Service Training

Federal regulations (42 CFR 483.75(e)(8)(i) require at least twelve hours of annual in-service training for nurses aides. Failure to supply and document such training for all aides every year is a violation of CMS regulations.

Housekeeping / Facilities

The inspectors took issue with the cleanliness of the facility and with sanitary conditions in the kitchen.

The inspectors also found that the facility staff on duty were unable to start the facility's emergency electric power generator. It was no defense to a violation that required annual inspection records were available for the generator.

Patient Care

Skin Protection Not Being Used

The inspectors found that two specific residents were without their elbow and heel protectors at multiple times during the days of inspection, even though the residents' physicians had ordered the protectors to be worn at all times because of the high danger of pressure-sore development.

The Federal regulation (42 CFR 483.25(h)) dealing with pressure-sore care in nursing homes is not a strict-liability law. The legal standard is reasonableness, not absolute strict liability.

That is, a nursing home is allowed to offer reasons for ostensible failures to adhere to a resident's comprehensive plan of care.

Federal regulations for quality of care in nursing homes are meant to promote the highest practicable physical, mental and psychosocial well-being.

The nursing home is not necessarily guilty of a violation just because certain residents were observed without their skin protectors that had been ordered by their physicians.

Some justifications are acceptable; others are not.

If a nursing home is cited for ostensibly violating a resident's comprehensive plan of care, and wants to claim justification based upon practicability, the nursing home has to have the nursing and/or medical documentation to back it up.

UNITED STATES COURT OF APPEALS
SIXTH CIRCUIT
June 28, 2004

Physician's Orders Disregarded

Violations Upheld

The Court soundly rejected the facility's argument that these two residents did not need their skin protectors because the protectors would not prevent the development of unavoidable pressure sores and because other treatments such as the use of pressure-relief mattresses were being used to prevent development of pressure sores.

The Court ruled that a skilled nursing facility cannot defend against charges it failed to adhere to a physician's orders by arguing that the orders are incorrect or misguided.

If the staff of a facility believes that a resident does not need elbow or heel protectors or some other treatment ordered by a physician, the proper course of action is to rework the patient's comprehensive plan of care though the channels outlined in the Federal regulations.

Patient Interference With Care

Facility's Arguments

Should Have Been Considered

The facility wanted to argue before the administrative law judge that the patients themselves interfered with the implementation of their physicians' orders.

The facility offered an affidavit from the facility's administrator that some residents moved or shifted their skin protectors or were uncooperative with care or the staff had to remove the protectors to provide necessary treatment and personal care.

The Court validated the legal principle that the Federal regulations for nursing facilities are not strict-liability laws. That is, the focus is on the highest *practicable* level of well-being for residents. CMS is not supposed to impose a violation and/or a civil monetary penalty without hearing the facility's arguments as to the practicability of carrying out the care plan with the regulations' overall goals in mind.

(Continued on next page.)

Skin Care: Court Says CMS Must Consider Skilled Facility's Explanations For Non-Compliance With Federal Regulations (Cont.)

(Continued from previous page.)

Treatment Records Lacking

That being said, however, although the facility should have been allowed to present its evidence on the issue of practicability of care, that evidence was not strong in this case.

The facility did not point to any patient-care records or written statements from treatment staff to back up the administrator's affidavit that patients were interfering with their own care. The administrative law judge would have to look carefully at the evidence when the case came back before her.

Focus on Avoidable Pressure Sores

With respect to other residents who did suffer from pressure sores the Court felt that the pressure sores were unavoidable, that is, that all appropriate treatment measures were taken with respect to avoidable pressure sores.

The Court ruled the administrative law judge would have to focus on the overall quality of care given the residents, rather than making a knee-jerk judgment that the facility was in violation just because certain aspects of the care plans were not being followed.

The facility would be able to point out that one or more pressure sores did improve or fully resolve for a resident who nevertheless had other sores which appeared and/or progressed other places on his body, evidence that he was receiving the best care practicable under the circumstances.

Prior Owner's Problems Irrelevant

In general, a nursing facility's past history of non-compliance can be a factor in computing how large a civil monetary penalty to impose for a particular violation. The Court ruled, however, that if the facility could show it "cleaned house" when new management took over, it would get a fresh start in this regard. **Crestview Parke Care Center v. Thompson, __ F. 3d __, 2004 WL 1432719 (6th Cir., June 28, 2004).**

Code of Federal Regulations 42 CFR Part 483 – Requirements for States and Long Term Care Facilities.

Sec. 483.20 Resident assessment.

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(k) Comprehensive care plans.

(1) The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the following--

(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under Sec. 483.25; and

(ii) Any services that would otherwise be required under Sec. 483.25 but are not provided due to the resident's exercise of rights under Sec. 483.10, including the right to refuse treatment under Sec. 483.10(b)(4).

(2) A comprehensive care plan must be-

(i) Developed within 7 days after completion of the comprehensive assessment;

(ii) Prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and

(iii) Periodically reviewed and revised by a team of qualified persons after each assessment.

Sec. 483.25 Quality of care.

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Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being in accordance with the comprehensive assessment and plan of care.

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(c) Pressure sores. Based on the comprehensive assessment of a resident, the facility must ensure that--

(1) A resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and

(2) A resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.

Sec. 483.75 Administration.

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(e) Required training of nursing aides.

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(8) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. The in-service training must--

(i) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year.

LEGAL EAGLE EYE NEWSLETTER
For the Nursing Profession

Labor And Delivery: Nurses Did Not Report Decelerations To Ob/Gyn, Court Finds Nursing Negligence.

The jury awarded more than $12,000,000 to the mother who suffered pelvic damage during delivery and to the infant who was born with severe cerebral palsy.

The Supreme Court of Colorado upheld Colorado's cap on malpractice damages, but ruled the lower court erred in computing just how it was to be applied to reduce the verdict.

Nurses Failed To Notify Doctor Of Abnormal Fetal Monitor Tracings

The typical scenario in labor and delivery cases involving nursing negligence is that the nurses fail to notify the physician of monitor tracings that indicate the fetus is experiencing fetal distress from lack of oxygen.

In this case the nurses phoned the physician, who was nearby in the physician's lounge, and told her there were "mild to moderate variable decelerations" at 11:15 p.m.

At 11:24 p.m. there was a sharp decline in the fetus's condition, according to the court, based on the decelerations appearing from the monitor. The nurses repositioned the mother and gave her oxygen but did not phone the physician again for more than an hour.

At 12:45 a.m. the nurses did call the physician. She came in and immediately attempted a very difficult expedited vaginal delivery which severely injured the mother and did not promptly relieve the fetus's distress.

The court believed the nurses should have reported the decelerations seen shortly after 11:15 p.m. as evidence of fetal acidosis mandating a prompt cesarean section. They should have insisted the physician come to the delivery room to look at the monitor strips herself.

The physician testified she would have promptly ordered a cesarean at 11:24 p.m. if the nurses had informed her of the true seriousness of the situation. **Garhart v. Columbia/Healthone, L.L.C., __ P. 3d __, 2004 WL 1433331 (Colo., June 28, 2004).**

Nurse's Duty To Advocate For Patient: Court Puts Roadblock In The Way Of Patient's Right To Sue.

Nurses have a legal responsibility to advocate for their patients. That is, when a nurse believes a physician is ignoring the correct treatment measures or is pursuing inappropriate measures, the nurse must take action.

Nurses are required to access the nursing chain of command, as the courts phrase it.

A staff nurse must go to the charge nurse. The charge nurse, if there is reason, must go to the unit manager, house nursing supervisor or director of nursing. Depending on the level of time urgency, the highest-level nursing officer available must approach the physician, if it appears necessary, then go over the physician's head within the medical chain of command until a suitable resolution is achieved.

A nurse has the responsibility to access the nursing chain of command when the nurse has reason to question a physician's treatment decision.

However, for a patient to sue, the patient must have solid evidence that if the nurse had accessed the chain of command it would actually have affected the physician's treatment decisions for the better.

DISTRICT COURT OF APPEAL
OF FLORIDA

The courts are imposing liability on nurses for failing to advocate in this manner for their patients. The courts also expect healthcare institutions to have policies so that any nurse at any level in the hierarchy has his or her duties and authority clearly spelled out.

The District Court of Appeal of Florida, however, has severely limited a patient's right to sue.

The court affirmed a lower court judge's decision to direct the jury to return a verdict in favor of a hospital. The judge's rationale was that the patient's attorneys failed to prove that the nurses accessing the nursing chain of command would have affected the physician's treatment decisions. **McKeithan v. HCA Health Services of Florida, Inc., __ So. 2d __, 2004 WL 1462100 (Fla. App., June 30, 2004).**