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Post-Surgical Care: Jury Faults Nurses For Patient's Death After Coronary Bypass.

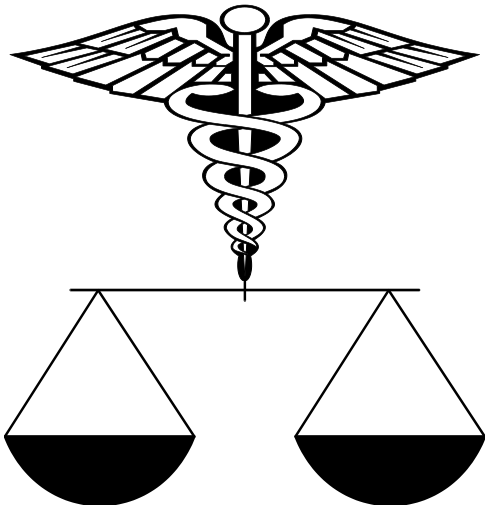
After a stress test and an abnormal echocardiogram the patient's angiogram revealed 95% blockage in the left main coronary artery and 100% blockage of the mid-portion of the right coronary artery. The patient's cardiologist referred him to a cardiothoracic surgeon for evaluation.

The surgeon performed coronary artery bypass surgery the next day without complications. The patient was stable and able to talk shortly after he got to the hospital's intensive care unit.

At 5:00 p.m. in the ICU the next day after surgery the BP dropped to 81/53. The nurses reportedly decided to wait for another reading outside the parameters specified in the surgeon's post-operative orders before calling him. At 6:00 p.m. the BP was 79/45. The nurses called and got an order for albumin which seemed to correct the problem for the time being.

Patient's Vitals Outside Parameters ICU Nurses Did Not Call Physician

At 10:00 p.m. the systolic fell to 89. At 12:00 a.m. the BP was 80/56, pulse 90+ and the lungs were clear. At 2:00 a.m. the BP was 81/55, at 5:00 a.m. 89/68. Still no call was placed to the surgeon even though the patient was less responsive and was falling asleep, complaining of chest tightness and not putting out hardly any urine.



After coronary artery bypass surgery the cardiothoracic surgeon left orders for the nurses in the intensive care unit to call him if the patient's heart rate fell below 60 or rose above 120, if the systolic pressure fell below 90 or rose above 150, if the respirations rose above 28 or if the urine output fell below 30cc per hour.

COURT OF APPEALS OF INDIANA
April 4, 2011

The surgeon's PA came in to see the patient at 7:00 a.m. on routine rounds. The surgeon came in at 9:30 a.m. and ordered blood tests and an echocardiogram. Then he had the patient sent to the cardiac catheterization lab where the patient soon expired from what was described in the court record as an anoxic cerebral event.

The Court of Appeals of Indiana endorsed the jury's verdict against the hospital for the ICU nurses' negligence which, in the opinion of a cardiothoracic surgeon called to testify as an expert witness on the family's behalf, caused the patient's death.

The patient would still be alive if the nurses had phoned the patient's cardiac surgeon right away when the vital signs fell outside the parameters the surgeon specified when the patient went to the ICU, the expert testified.

An experienced cardiothoracic surgeon could have intervened and saved the patient's life if promptly notified by the patient's nurses of the true status of the patient's post-operative progress.

A medical review panel had also concluded before the lawsuit was filed that the hospital, not the treating physicians, was responsible for the patient's death. **Elkhart General Hosp. v. Williams, 2011 WL 1233648 (Ind. App., April 4, 2011).**

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