LEGAL EAGLE EYE NEWSLETTER

December 2003 — *For the Nursing Profession* — Volume 11 Number 12

Digoxin Overdose: $1.5 Million Punitive Damages.

The fifty-eight year-old patient went to the hospital's intensive care unit following cardiac bypass surgery.

On his second post-op day he began to have cardiac arrhythmia. The graduate nurse caring for him asked her supervising nurse what to do and was told to phone the cardiologist.

The cardiologist ordered .25 mg of digoxin. The graduate nurse said the cardiologist ordered 1.25 mg, so the supervising nurse phoned for 1.25 mg of digoxin from the pharmacy.

However, believing the patient was rapidly getting worse, the supervising nurse told the graduate nurse not to wait for the medication from the pharmacy but instead to get the digoxin to fill the order from the stocks kept in the ICU and give it right away.

The graduate nurse, acting alone without supervision, obtained three .5 mg vials from the ICU stocks and pushed two and one-half of them into the patient's IV line, that is, 1.25 mg.

Shortly thereafter the hospital pharmacist phoned the supervising nurse to question the amount of the digoxin order she had phoned in. Only then did she realize she had allowed the graduate nurse to push five times the amount that was actually ordered.

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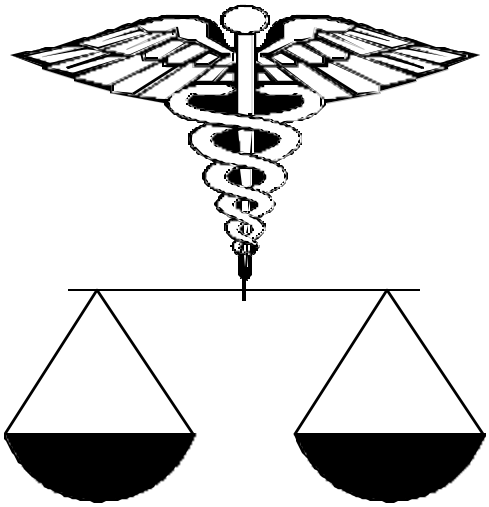

The graduate nurse did not know better than to give five times what was ordered.

The supervising nurse did not question the medication order the graduate nurse said the physician gave her.

The charge nurse did not clarify the supervising nurse's responsibility to watch the graduate nurse carefully and check her medications.

SUPREME COURT OF ALABAMA
October 31, 2003

Pressure Sore Was Avoidable: Civil Monetary Penalty Upheld.

Federal regulations for long-term care facilities require a facility to ensure that a resident who enters the facility without a pressure sore does not develop a pressure sore unless the resident's clinical condition was such that a pressure sore was unavoidable.

A resident who has or who develops a pressure sore must receive necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.

The Court of Appeals of Ohio pointed out in a recent decision that a state survey team only has to establish that a resident developed a pressure sore some time after admission.

Then the legal burden of proof is upon the nursing facility to prove the quality of the resident's care was so good that the pressure sore was unavoidable. If the facility cannot prove the care was good enough, the pressure sore is considered avoidable and a civil monetary penalty can be imposed.

The Court of Appeals reviewed the nursing care plan itself and how it was and was not carried out and found the facility's quality of care substandard.

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Elopement From Nursing Home: Court Sets Limits On Nursing Home's Liability.

A developmentally disabled adult resident eloped from a nursing home and died from injuries, heat exhaustion and exposure. His mother sued the nursing home for damages. The lawsuit alleged negligence as well as abuse and neglect, the latter allegations bringing the lawsuit within the ambit of the state's Nursing Home Residents' Bill of Rights.

Nursing Home Not Automatically Liable For Elopement

At this stage in the litigation there has been no determination whether the nursing home was guilty of civil negligence or any violation of the deceased's rights. The Court of Appeal of Louisiana has only defined the rules of engagement for how the lawsuit must be characterized.

Professional Skill and Judgment

Nursing homes, the court pointed out, are faced with conflicting legal duties in the area of resident elopement.

Nursing homes are required to maintain the least restrictive environment possible, a policy which minimizes the appropriateness of physical and chemical restraints. At the same time they must protect residents from the consequences of the residents' cognitive and behavioral impairments, the very reasons some residents go to nursing homes.

According to the court, when a nursing home is sued for resident elopement, the nursing home has the right to defend as if being sued for medical malpractice.

The state's procedural formalities for medical malpractice apply. Those formalities, like prompt filing of expert witness reports and medical review panels, are designed to weed out non-meritorious cases as early as possible.

There must be expert medical testimony as to the standard of care and violation of the standard of care. A jury should not be allowed to speculate on the issue of negligence without guidance from expert testimony. **McKnight v. D & W Health Services, Inc., __ So. 2d __, 2003 WL 22518215 (La. App., November 7, 2003).**

Federal regulations, the state's nursing home residents' bill of rights and other state regulations promote the policy of residents being able to live in the least restrictive environment possible.

There is a strong policy of freedom from physical and chemical restraints and freedom to exercise the right of self-determination.

Nursing homes at the same time have the responsibility to supervise and protect residents from the potential consequences of their own cognitive and volitional impairments.

The conflicting legal duties imposed upon nursing homes require them to maintain a delicate balance between patients' freedom from restraint and the need for protective restraint of impaired patients.

The exercise of these competing duties is subject to professional standards of skill and care.

When a resident elopes the question of whether there was negligence is the same as in medical malpractice cases.

COURT OF APPEAL OF LOUISIANA
November 7, 2003

Freedom Of Speech: Federal Court Throws Out Nurses' Suit, Sees No Issues Of Public Concern.

Nurses' right to free speech becomes an issue when nurses speak out on issues of public concern. Nurses cannot face adverse consequences from a public-agency employer for exercising their Constitutional rights.

The Constitutional right of Freedom of Speech can be an issue for nurses working in a public hospital, employees of a governmental agency.

Freedom of Speech, as a Constitutional right, only applies to speaking out on matters of public concern.

Private grievances over transfers, seniority rights, scheduling, attendance, work rules, etc., are not matters of public concern.

The First Amendment does not apply.

UNITED STATES DISTRICT COURT ILLINOIS
October 29, 2003

However, the US District Court for the Northern District of Illinois did not see any public policy issues in the case to elevate it out of the realm of an ordinary labor/management dispute.

The nurses at a state developmental center had no valid claim that their employer violated their Constitutional rights. **Berry v. Illinois Dept. of Human Services, 2003 WL 22462547 (N.D. Ill., October 29, 2003).**

Healthcare Negligence Investigations: Court Sets The Rules For Contact With Plaintiffs' Lawyers.

In a lawsuit alleging wrongful death of a nursing home patient due to nursing negligence, that is, a morphine overdose, the nursing home's parent corporation sought a court order to prevent the lawyers for the family of the deceased from contacting former employees who had worked at the nursing home, as potential witnesses in the case.

The Supreme Judicial Court of Massachusetts went to great lengths to explain the lawyers' ethical rules that apply in these situations.

Current *versus* Former Employees

Current employees of a healthcare employer are strictly off limits to private contacts by plaintiffs' lawyers. Current refers to the moment in time when contact is to occur with the lawyer. Employees of a corporation, management or rank-and-file, are considered to have legal representation by the corporation's legal counsel in all matters where the corporation is a defendant or potential defendant.

It is strictly unethical for a lawyer to contact a person privately who is represented by legal counsel without going through the legal counsel for permission or without serving a subpoena to require testimony.

Former employees of a healthcare facility are permitted but are not required to speak with plaintiffs' lawyers about a negligence claim, whether it is still under investigation or suit has actually been filed.

Such persons are often a valuable source of information and actual testimony that can aid a victim of malpractice in carrying the day.

A lawyer is ethically bound to identify himself or herself, state that he or she is a lawyer, identify whom he or she represents and what the case involves, ascertain that the potential witness is not and does not want to be represented by a lawyer of the witness's own choosing and must ask permission to speak with the potential witness.

When not under subpoena to testify, a witness has the option to refuse to talk.

SUPREME JUDICIAL COURT
OF MASSACHUSETTS
October 29, 2003

Former employees are allowed to speak with lawyers whose clients have claims against the former employer. That is, a nurse who worked at the nursing home when the incident occurred, who no longer works at the nursing home or for the corporate parent at the time the lawyer makes contact, can but does not have to speak with the patient's lawyers.

Subpoena

When served with a subpoena to testify in a pre-trial deposition or in court, a witness must appear as ordered and must testify, unless a court order is entered beforehand dissolving the subpoena.

Technical issues about the validity of a subpoena and the required manner of service vary from locality to locality and must be left to knowledgeable legal counsel. There is no right simply to ignore a subpoena because it is believed the subpoena is invalid or was not properly delivered or because the witness does not believe he or she has to testify or should have to testify or does not want to testify.

Medical Confidentiality Rules Apply To Caregivers

The lawyer must be able to show that he or she has permission from the patient or the patient's guardian or probate administrator to discuss confidential matters about the patient's healthcare.

A caregiver cannot violate the caregiver's own obligation to preserve other patients' medical confidentiality even when everything is kosher with respect to the client whom the lawyer represents. **Clark v. Beverly Health and Rehabilitation Services, Inc., 440 Mass. 270, 797 N.E. 2d 905, 2003 WL 22434624 (Mass., October 29, 2003).**

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Digoxin Overdose: Large Jury Verdict For Nursing Negligence (Continued).

(Continued from page 1)

The next night the patient began to experience complications from digoxin toxicity. He was given Digibind, the digoxin-specific antidote, but nevertheless went into cardiac arrest. He was revived but suffered hypoxic damage to multiple organ systems. He had a portion of his intestines removed and his right leg amputated. He is now unable to ambulate, has a colostomy and has residual brain damage.

Nurses' Errors Went Beyond Negligence

The Supreme Court of Alabama found the nurses' actions went beyond negligence. The nurses acted callously and wantonly, the legal threshold which must be crossed before punitive damages are considered appropriate.

However, the jury's award of $2.5 million in punitive damages was excessive in the court's opinion. The verdict was scaled down to $1.5 million.

Nurses / Supervision Faulted

The court faulted the graduate nurse for not knowing or ascertaining the maximum dosage of a dangerous drug she was giving and for misinterpreting the physician's order.

The court also more broadly faulted the facility's system for assigning patients and tasking and supervising nurses.

Nursing Negligence

The Graduate Nurse

Every nurse has a fundamental responsibility to know the correct usual dosage, the maximum safe dosage and the potential side effects of every medication the nurse will administer.

In this case the graduate nurse testified she knew that digoxin could, among other things, completely stop a patient's heart and that it was important to administer it in the correct dosage.

That being said, however, the graduate nurse also testified she had never given digoxin and made no effort to look it up in a reference book or to obtain supervision from a more experienced nurse before giving it.

Although assigned to care for various patients in the ICU, she was not a licensed nurse. She was a recent nursing-school graduate who had taken but had not yet received the results from her nursing board examination.

She had never administered digoxin to a patient before she administered it to this patient erroneously.

Normally her nursing mentor made the phone calls to the physicians. She believed the nursing staff was trying to help her get experience in speaking with the doctors when she made the call in which she was given the digoxin order.

She did not repeat the order back to the physician or attempt to confirm that he had ordered 1.25 mg of digoxin IV.

The supervising nurse herself had been licensed only seven months. She had her own patients and understood from the charge nurse she was only required to be available if the graduate nurse had questions and was not responsible for directly overseeing what the graduate nurse was doing.

SUPREME COURT OF ALABAMA
October 31, 2003

The graduate nurse also stated she was still finding it difficult to consult with physicians, to report changes in her patients' medical conditions and to take orders from physicians over the phone. She did not make the effort to repeat orders back to the physician to make sure she had the orders absolutely correct, and the court roundly faulted her for not making that her routine practice.

Going hand-in-hand with that, the nurse did not know enough about what she was doing to speak up about the order she believed she had heard for five times the usual and two and one-half times the maximum safe dosage.

Pre-Packaged Dosages

Furthermore, according to the court, medications given in hospital settings are often pre-packaged in single-use containers with the usual dosage or no more than the maximum dosage that can be given safely at any one time.

A nurse is expected to wonder why it would take three containers of a pre-packaged IV medication to fulfill a physician's order. In this circumstance, according to the court, a nurse is expected to consider whether the order was misinterpreted, mistakenly transcribed or just plain wrong, and take appropriate action before endangering the patient.

Negligent Nursing Supervision

The court did not question the wisdom, *per se,* of assigning a graduate nurse to a patient in the ICU.

However, the court believed the charge nurse was at fault to some degree. The graduate nurse had taken her board exam but had not yet received the results. The nurse assigned to supervise her had passed her board exam and been licensed only seven months earlier.

The charge nurse did not explicitly explain to the newly-licensed nurse she was expected to supervise the graduate nurse closely, not simply make herself available in the event the graduate decided to ask questions.

(Continued on next page)

Digoxin Overdose: Jury Verdict For Nursing Negligence (Continued).

(Continued from previous page)

The supervising nurse had never worked with the graduate nurse and was unaware of her lack of experience.

The charge nurse should have more carefully delineated the supervising nurse's responsibilities for overseeing the graduate nurse.

According to the court, a charge nurse not only evaluates and tasks nurses appropriately in caring for patients but also evaluates and tasks more experienced nurses in overseeing less experienced nurses in how they care for their patients.

Supervising Nurse Faulted For Medication Error

The court believed the supervising nurse herself should have questioned the 1.25 mg order. She should not have told an inexperienced nurse to fill an order from floor stocks and go into the patient's room alone to give it, as it was a potentially dangerous drug to be given IV.

The court said the supervising nurse should have been in the room with the graduate nurse when she was giving an IV med she had never given before. The court did acknowledge there was some confusion which could be attributed to the charge nurse rather than the supervising nurse over the extent of the supervising nurse's actual responsibilities.

However, as far as the patient's lawsuit was concerned it made little practical difference which nurse was at fault and to what degree they were at fault, or to what degree any of the nurses could be excused from blame for inadequate supervision by their superiors or by faulty institutional policies, as their employer the hospital itself was the defendant. **Mobile Infirmary Medical Center v. Hodgen, __ So. 2d __, 2003 WL 22463340 (Ala., October 31, 2003).**

End-Stage Alzheimer's: No Negligence In Patient's Death From Pneumonia.

The physician had spoken with the daughter and had been told of the family's wishes for conservative terminal care.

The family had wanted a DNR order in her chart and confirmed it with the nurses three days before she died.

To the physician that meant the patient would be given comfort care and the disease would be allowed to progress in its natural course.

The nursing staff monitored and attempted to treat her rapid weight loss, swallowing problems, pressure sores and general decline.

The nursing staff detected signs of pneumonia and immediately faxed a report to the physician. The patient died about ninety minutes later.

The medical examiner testified she was well nourished. Her pressure sores, very common in bedridden Alzheimer's patients, were being treated and were not infected.

Pneumonia is a common cause of death in Alzheimer's patients and is often not responsive to antibiotics.

COURT OF APPEALS OF TEXAS
October 30, 2003

The Court of Appeals of Texas rejected allegations of nursing and medical negligence leading to the death in a nursing home of a seventy-five year-old end-stage Alzheimer's patient

Pneumonia

The medical expert retained by the family's attorneys agreed with the patient's treating physician that pneumonia is a very common immediate cause of death in Alzheimer's patients. Such patients have problems with aspiration and in the end stages lose the ability to cough.

Pneumonia can strike and take the patient very quickly, even with the best of care. Antibiotics are often not effective to treat pneumonia in Alzheimer's patients, the medical experts all agreed.

Leaving aside the issue of the DNR order, the court could find no negligence in pneumonia striking and taking this patient apparently in less than two hours.

Feeding Tube

The court did not fault the physician or the nursing home's nursing staff because no attempt was made to use a nasogastric or a gastrostomal feeding tube with this patient.

First, the physician and nurses had the understanding the family did not want such measures taken, which would have involved invasive interventions which would not have improved the quality of her life in its terminal stages.

Secondly, there is danger of complications actually making things worse. There is always a risk of infection. Alzheimer's patients are prone to aspiration of stomach contents and have a strong propensity to pull out their feeding tubes.

Pressure Sores

There were pressure sores, but the medical examiner believed they had been treated competently by the nursing staff and were unavoidable in light of the patient being bedridden and, although adequately nourished, in a state of general decline. **Krawl v. Murray, 2003 WL 22453828 (Tex. App., October 30, 2003).**

Neuro Procedure, Post-Op Fall: Multiple Instances Of Nursing Negligence.

After a shunting procedure to drain fluid from her brain the elderly patient was admitted to a medical surgical unit. While a patient there she was found on the floor of her room with a broken hip and a broken arm. Apparently she got up and tried to walk and fell. She needed surgery for the broken hip and had to go to a nursing home rather than going home with her family.

After she died her family filed suit and obtained a verdict of $181,612.51 against the hospital, which the Court of Appeals of Michigan affirmed in a recent unpublished opinion. The case raised multiple instances of nursing negligence by the hospital's staff nurses.

Nursing Student Not To Work Independently

A nursing student was given independent responsibility for the patient's care, contrary to the hospital's standard practices. According to the court, nursing students are to work under close direct supervision from a licensed registered nurse. It is a breach of the legal standard of care for a nursing student to have independent unsupervised responsibility for a patient.

Patient Not Restrained

The court pointed to the patient's chart records before the surgery showing that she had been in a Posey vest before the surgery to keep her from trying to arise from bed on her own.

The court questioned why the nursing staff did not use the Posey after her surgery, when her cognitive status presumably would be worse than before surgery.

The lack of restraints after surgery led the court to question whether the patient was ever actually assessed by the nursing staff. Her neuro status was to be assessed every two hours. Patient safety should always be an ongoing nursing issue whether or not repeat assessments have been ordered. **Humpert v. Bay Medical Center, 2003 WL 22442923 (Mich. App., October 28, 2003).**

The family members testified the deceased had suffered from sundowner's syndrome, meaning the patient would become confused and disoriented to her surroundings at the end of the day.

The neurosurgeon was also concerned about the potential for patient confusion as a complication of the neuro shunting procedure just performed.

The nursing staff must perform an assessment of the patient's need for various safety precautions. In this case a nursing neuro assessment was to occur q 2 hours.

The neurosurgeon ordered restraints at the discretion of the nursing staff, but the patient was not restrained.

A bed sensor alarm was ordered to detect when the patient left the bed but there was no record and apparently no one turned it on.

The patient should have been placed in a room near the nurses' station for close observation, but instead was placed in a room down the hall.

COURT OF APPEALS OF MICHIGAN
UNPUBLISHED OPINION
October 28, 2003

Faulty Infection Control: Court Sees Immediate Jeopardy.

The US Circuit Court of Appeals for the Fourth Circuit recently upheld the decision of US Department of Health and Human Services officials to terminate Medicare and Medicaid funding and to impose a $10,000 per day civil monetary penalty for twenty-three days, based on a state survey of a long-term care facility in South Carolina.

The court did not go into the specifics except to say that a long-term care facility must make an effort to identify the nature and cause of a resident's infection and must keep track of the cause, status, severity and treatments of other residents who develop the same infection, according to Federal regulations governing quality of care in long-term care facilities.

A state of immediate jeopardy is the legal terminology for the most serious deficiency inspectors can find, justifying a $10,000 per day penalty. **Sea Island Comprehensive Healthcare Corp. v. US Dept. of Health & Human Services, 2003 WL 22451772 (4th Cir., October 29, 2003).**

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Pressure Sores Were Avoidable: Civil Monetary Penalty Upheld (Continued).

(Continued from page 1)

Pressure Sores Developed While A Resident In The Facility

During a routine state survey inspection of the long-term care facility a particular resident's chart was reviewed.

The seventy-six year-old resident's chart revealed he had been ill and bedridden for a substantial period of time approximately four and one-half months prior to the survey.

During that time he developed a pressure sore on his right ankle. A week later he was assessed as high risk for development of additional pressure sores. Nevertheless about one month after the first pressure sore was noticed another pressure sore appeared, this time on his left hip.

A nursing progress note indicated two days after the first pressure sore was noticed that it was healing. A week later it was not healing, that is, no improvement was being seen. And that was followed by a progress note two weeks later that an area on the hip was persistently reddened.

Only after the second pressure sore showed up was there a notation of a physician's order for an egg crate mattress and nursing progress notes to the effect that an egg crate mattress was being used.

Care Planning Substandard

The general care plan in effect for the resident required the nurses to monitor his skin integrity, monitor his nutritional status and see that he was turned frequently during intervals he was bedridden.

The survey team could find no flow charting or nursing progress notes indicating that the general care plan was being followed.

No Acute / Episodic Care Plan Second Pressure Sore Was Avoidable

In addition, the survey team concluded, and the Court of Appeals agreed, that when a bedridden resident develops a pressure sore it is imperative that the nurses develop and implement an acute or episodic care plan to promote healing of the pressure sore and, more importantly, to prevent additional pressure sores.

The issue is whether the second pressure sore was avoidable.

The resident developed a pressure sore on September 6. On September 14 the resident was assessed at high risk for development of additional pressure sores. On October 7 there was another pressure sore.

To prove a care deficiency existed the survey team only has to show a resident developed a pressure sore after admission to the long-term nursing facility. That is a prima facie case.

The facility has to prove the pressure sore was clinically unavoidable, that is, the facility furnished all the care necessary and the pressure sore developed anyway.

The facility has to be able to prove an appropriate care plan was adopted and followed, through contemporaneous documentation.

Problematic behavior by the resident that hindered implementation of the care plan also must be documented as it occurs.

The legal rule is, if it was not documented it did not happen, and that goes against the facility's legal burden of proof.

COURT OF APPEALS OF OHIO
October 28, 2003

Once the resident is found to have developed a pressure sore, the survey team concluded the facility's acute or episodic care plan should include:

1. Close observation of the resident's skin;
2. Change of wet or soiled linens;
3. Use of an egg crate or air mattress to relieve pressure;
4. Turning every two hours;
5. Range of motion exercises; and
6. Proper nutrition and hydration.

Further, it was absolutely essential that the care plan be carried out and that progress notes be entered showing how the care plan is being carried out, evaluated and modified as necessary to meet the patient's acute needs.

Civil Monetary Penalty

The survey team calculated that the facility was not in compliance with Federal regulations dealing with skin integrity and prevention of pressure sores from the day the ankle lesion was noted not to be healing until it appeared from the chart that appropriate medical and nursing interventions were underway following discovery of the second lesion on the hip, that is, $350 per day for twenty-eight days, totaling $9,800. The local county court reduced the penalty to $8,050, but the Court of Appeals overruled the local court and reinstated the $9,800 figure that was imposed by the state survey team.

Nursing Documentation Inadequate

The Court of Appeals pointed to the testimony of the facility's own director of nursing for a general statement of the legal standard for nursing documentation.

Anything and everything that nurses observe or do for a resident must be documented, including difficulties rendering care or outright refusal of care. If the resident takes the linens off the bed three times a day and the nurse replaces them three times a day it must be documented.

Anything not documented simply did not happen. **Pineview Manor, Inc. v. Dept. of Health, 2003 Ohio 5762, 2003 WL 22434603 (Ohio App., October 28, 2003).**

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For the Nursing Profession

Home Health: Nurse Trips, Falls On Client's Wheelchair Ramp.

A home health hospice nurse filed a lawsuit against her clients after she tripped and fell from the wheelchair ramp in front of their home. After she had entered the home was going back to her car for supplies when she fell.

The nurse fractured her right leg in the fall and had to have two surgeries.

The lawsuit focused on the lack of handrails on the wheelchair ramp. The nurse testified she did not know what caused her to fall.

The Court of Appeals of Ohio acknowledged a home health nurse would have the right to sue a client under these circumstances, if the nurse could prove the client was negligent and that the client's negligence caused her injuries.

The jury ruled the clients were negligent for having no handrails but the nurse did not convince the jury that was the reason why she fell. **Lyon v. Stacho, 2003 Ohio 5823, 2003 WL 22456997 (Ohio App., October 30, 2003).**

Hypertonic Saline Solution: Nursing Negligence In Wrongful Death.

The patient's father filed suit against the hospital, a hospital staff nurse and two private-duty nurses who were responsible for his thirty-three year-old daughter receiving a fatal 3% IV saline solution instead of a .3% solution.

The details given by the New York Supreme Court, Appellate Division, were sketchy. However, it appeared the staff nurse gave the hypertonic solution to one private-duty nurse who hung it and then was relieved by the second private-duty nurse who let it finish infusing.

The father settled with the hospital for an unspecific sum, but the court has ruled the father can continue his suit against the nurses, as can the hospital continue its suit for indemnification from the nurses for the settlement paid to the family. **Siegel v. Long Island Jewish Medical Center, __ N.Y.S.2d __, 2003 N.Y. Slip Op. 17790, 2003 WL 22439814 (N.Y. App., October 27, 2003).**

Patient Confidentiality: Nurse Fired For Giving Records To Attorney For Understaffing Lawsuit.

Because a nurse had been complaining about staffing issues at the hospital some of the unit nurse managers did not want her on their units and she was put in the float pool.

A lawsuit was filed against the hospital alleging negligence due to understaffing. The nurse in question was not a part of the underlying incident. However, it became known to the plaintiff's lawyers that she was complaining about understaffing issues.

She agreed to supply the lawyers with material she copied from other patients' charts to support the lawyers' allegations of an understaffing problem at the hospital. The lawyers put the material into the court record without cutting out the actual patients' names.

The nurse was fired.

There is no evidence the nurse was fired for any reason other than giving patients' confidential medical documents to the attorney who was suing the hospital for alleged understaffing.

The whistleblower law protects employees for reporting violations of the letter of the law to proper authorities, not for publicizing what the employee believes are substandard practices.

SUPREME COURT OF KANSAS
October 31, 2003

The Supreme Court of Kansas ruled there were grounds to fire her for violation of the state Nurse Practice Act which requires nurses to maintain patients' medical confidentiality.

The state whistleblower law did not help the nurse. The law only applies to violations of the law reported to proper legal authorities. It does not protect an employee with a generalized subjective belief that the employer's policies and practices are substandard while no specific statute or regulation is being violated by the employer.

The nurse could not prove her employer was motivated to retaliate against her for her general complaints about understaffing issues, the court ruled. **Goodman v. Wesley Medical Center, __ P. 3d __, 2003 WL 22475604 (Kan., October 31, 2003).**