LEGAL EAGLE EYE NEWSLETTER

December 2008 *For the Nursing Profession* Volume 16 Number 12

Post-Surgical Nursing Care: Court Reinstates Jury Verdict For The Deceased's Family.

After cervical fusion surgery the surgeon checked on the patient in post anesthesia recovery and determined he was ready for transfer to an acute care med/surg hospital unit.

Ten minutes after the patient arrived on the med/surg unit the patient's wife called the patient's nurse to the room and reported her husband was anxious, was having trouble breathing and did not feel right. The nurse changed the dressing on the surgical site and left the room.

Over the next hour and fifteen minutes the wife repeatedly tried to tell the staff nurses that the patient was having trouble breathing.

Eventually the staff nurse and the charge nurse went to the room and found the patient gasping for air and losing consciousness.

The nurses called a code. An anesthesiologist and the E.R. physician tried unsuccessfully for twenty minutes to intubate the patient.

The surgeon finally came in to the hospital from his home and performed an emergency tracheostomy, but by that time the patient was essentially brain dead.

Life support was discontinued after eleven days and the patient passed away. The widow sued the hospital.

When anxiousness and breathing trouble were first brought to the nurse's attention she should have started an oxygen mask and called the surgeon.

Someone could have taken the initiative to get the patient transported back to post-anesthesia recovery where the right personnel and equipment were already standing by.

COURT OF APPEALS OF TEXAS
November 20, 2008

Jury Finds Nursing Negligence

The jury awarded the widow $2,200,000 from the hospital as damages for the negligence of the patient's nurse in failing to appreciate the patient's condition and failing to summon medical help promptly.

Notwithstanding the jury's verdict the judge entered a defense judgment for the hospital, but the Court of Appeals of Texas reversed the judge's decision and reinstated the jury's verdict.

The Court of Appeals ruled there was ample evidence presented at trial to educate the jury as to the standard of care for what the staff nurse should have done and for the jury to conclude that if the nurse had not failed to initiate appropriate medical interventions the patient would have survived, more likely than not.

With a patient recovering from neck surgery no unnecessary delay is acceptable in responding to respiratory distress. As the minutes tick away it becomes less likely that intubation will be possible.

In reckoning the time line it must be recognized that if intubation cannot be accomplished, the patient has to be taken to the O.R. and personnel and supplies assembled for a tracheostomy, all the while with the clock ticking on a life-threatening emergency. **Guerra v. Corpus Christi Med. Ctr., __ S.W. 3d __, 2008 WL 4938231 (Tex. App., November 20, 2008).**

Inside this month's issue ...

December 2008

New Subscriptions
See Page 3

Lyme Disease: Jury Finds Clinic Nurse Practitioner Did Not Depart From Standard Of Care.

The Court of Appeal of California reviewed the evidence in meticulous detail and approved a jury's verdict of no negligence in a patient's lawsuit over Lyme disease allegedly contracted from a tick bite for which she was treated at a state university student health center where the treating nurse practitioner was on duty.

Second Opinion Was Advised

The nurse practitioner advised the patient to seek a second opinion when she adamantly objected to his decision not to start prophylactic antibiotics.

The court accepted his explanation that he told her to get a second opinion because of her anxiety, not because he believed he himself was not competent to handle the situation or had any doubt about his diagnosis and prognosis.

The nurse practitioner did not give antibiotics, a decision based on the CDC's published recommendations, because of the possibility of an allergic reaction and because antibiotics can give a patient a false sense of security and the patient need not watch for signs and symptoms and return to the clinic if necessary.

Blood tests were not ordered, again because it would be contrary to the CDC's recommendations. According to the experts, antibodies which would indicate a positive test result do not appear for four to six weeks and testing would have been inconclusive at the time of treatment.

No Follow Up Appointment
No Negligence

If the nurse practitioner had been the one to inform the patient about the possibility of Lyme disease, the experts said, he should have scheduled a follow up appointment thirty to forty-five days down the line.

However, the patient in this case was the one insisting she had been exposed to Lyme disease and thus she was fully aware of the signs and symptoms and the need for medical attention if they showed up.

Conser v. California State Univ., 2008 WL 4950975 (Cal. App., November 20, 2008).

The patient showed no signs or symptoms of Lyme disease, although that is far from definitive in a patient who reports a tick bite only seven hours earlier.

The nurse practitioner did not prescribe prophylactic antibiotics, based on CDC guidelines against doing so for Lyme disease. The CDC's overall rationale is to clamp down on overuse of antibiotics that might lead to community resistance.

The nurse practitioner knew there is a low incidence of Lyme disease in the locale where the patient was bitten, based on prior conversations with physicians, medical literature he had read and seminar presentations he had attended.

The nurse practitioner had also read literature that Lyme disease transmission requires the tick to attach for twenty-four to seventy-two hours and is usually accompanied by the head of the tick remaining within the wound. The patient reported she brushed the tick away just as she was bitten and the nurse practitioner carefully examined the wound and found nothing within.

COURT OF APPEAL OF CALIFORNIA
November 20, 2008

Family Member Panics: License Suspended, Nurse Refused To Contact The Doctor.

The sixteen-month-old child was in the hospital for surgeries to correct ongoing problems related to prematurity.

Concerned because her baby was grunting and flailing her arms the mother insisted that the nurse call the physician.

The nurse checked the infant and reassured the mother. Hours later the nurse called in the nurse practitioner and the nurse practitioner phoned the physician.

The nurse was reported to the state board of nursing and her license was suspended for three months.

The Court of Appeal of Louisiana ruled that "urgency and panic in the mother related to the status of her child" was sufficient reason to compel the nurse to contact the physician as the mother requested, notwithstanding hospital policy that an LPN usually reported to the nurse practitioner who, in turn, made decisions whether or not to contact the physician. **Lawhead v. Louisiana State Board, __ So. 2d __, 2008 WL 4766830 (La. App., October 28, 2008).**

Defibrillator: Code Team Nurse Fired.

The New York Supreme Court, Appellate Division, ruled that a registered nurse on the hospital's code team could be terminated for misconduct for failing to put the defibrillator on the proper setting, causing defibrillator treatment to be delayed unnecessarily during a code, and for failing to report her own error.

The patient could not be revived and died. **Thomas v. County of Rockland, 865 N.Y.S.2d 661 (N.Y. App., October 14, 2008).**

Psych Nursing: Crisis-Line Nurse Ruled Not Liable In Patient's Wrongful-Detention Lawsuit.

Based on statements made over the phone to the crisis-line nurse at the state hospital, police officers went to the caller's home and transported her against her will to the state hospital.

The caller was promptly released from short-term detention after a thorough psychiatric evaluation indicated no basis existed to apply for a court order allowing the facility to hold her as a patient.

The patient turned around and sued the nurse, the hospital, the police officers and the city for violation of her civil rights.

The US Circuit Court of Appeals for the Ninth Circuit ruled that grounds were lacking for her to have sued any of the defendants named in the case.

It was certainly true in hindsight that there was no basis in fact for the nurse to have notified the police, for the police to have taken her from her home to the hospital for an evaluation or for the hospital to have held her even temporarily before she was released.

However, according to the court, when a former patient sues alleging a civil-rights violation, the sole question is the state of mind of the persons who participated in the patient's involuntary detention.

The state of mind of the persons who participated in the patient's involuntary detention is the sole question in an involuntary psychiatric patient's civil rights lawsuit alleging wrongful detention.

That is fundamentally a different question than the underlying issue whether grounds did or did not exist for involuntary detention and treatment.

The law provides legal immunity from a patient's lawsuit to a healthcare professional who can show that facts existed pointing to a reasonable belief that the person was gravely disabled or an immediate threat of harm to self or others.

Good faith confers legal immunity whether or not the person was gravely disabled or a threat to self or others.

UNITED STATES COURT OF APPEALS
NINTH CIRCUIT
November 6, 2008

Good Faith Entitled Nurse To Legal Immunity

The nurse's successful defense to the lawsuit was her explanation of how she admittedly misinterpreted the caller's statements over the phone as a verbalization of a present intention to harm herself.

According to the court, the nurse reasonably believed her conduct was lawful in relaying what she believed the patient had told her to the police and prompting the police to go to her home, pick her up and take her to the hospital.

She was entitled to qualified immunity because, on the basis of what she understood the circumstances to be, she reasonably believed she was acting in accordance with the state statute allowing involuntary psychiatric detention in what she had reason to believe was an emergency situation.

The police, in turn, had probable cause to pick up and transport the patient based on what the crisis-line nurse told their dispatcher even though they themselves conducted no independent testing of their detainee's mental status.

Personnel at the hospital had probable cause to hold the patient and to conduct a psychiatric evaluation based on what the police told them they had been told by the nurse, the court ruled. They complied fully with the law by promptly releasing her after finding there was no basis to keep her. **Duarte v. Begrin, 2008 WL 4831482 (9th Cir., November 6, 2008).**

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

Indexed in
Cumulative Index to Nursing & Allied Health Literature™

Published monthly, twelve times per year.
Mailed First Class Mail at Seattle, WA.

E. Kenneth Snyder, BSN, RN, JD
Editor/Publisher
PO Box 4592
Seattle, WA 98194–0592
Phone (206) 440-5860
Fax (206) 440-5862
kensnyder@nursinglaw.com
www.nursinglaw.com

Nurse As Patient's Advocate: RN's License Suspended For Incompetence, Gross Negligence.

The patient died in the ICU one hour after a confrontation occurred on a hospital med/surg unit between a senior resident physician and the med/surg unit RN charge nurse.

The charge nurse's conduct did not cause or contribute to the patient's death, according to all of the post-mortem medical evidence.

The charge nurse nevertheless had to answer for her conduct before the State Board of Nursing to charges of incompetence and gross negligence. The Board suspended her license for three years. The California Court of Appeal upheld the Board's decision.

Nurse Physically Countermanded Physician's/Treatment Team's Plan of Care for Respiratory Distress

The upshot was the charge nurse unplugged the bed from the wall, disconnected the patient's cardiac monitor and O_2 and physically pushed the bed out of his room, off the unit, down the hall, into and out of an elevator and into the ICU on a different floor, just as the senior resident, a junior resident, two respiratory therapists and a staff nurse were about to intubate him.

The charge nurse testified after the fact it was her understanding of hospital policy that a patient could not be intubated on a med/surg unit and absolutely had to be transferred to the ICU before intubation could occur, regardless of the fact everyone else concerned with his care believed that immediate intubation was necessary.

The senior resident had the necessary training and experience to perform the intubation with the assistance of those standing by and all the necessary supplies were at hand, having just been assembled from the med/surg unit's crash cart.

With hindsight, the court confirmed the medical experts' assessment that the senior and junior residents were correct in their judgment that the patient required immediate intubation and that the nurse was incorrect to believe that intubation could wait until he got to the ICU.

There is no question a nurse has the duty to act as the patient's advocate by initiating action to change decisions which are against the interests of the patient.

There are even some circumstances which justify a nurse's refusal to follow a physician's order.

It is permissible for a registered nurse directly to disobey a physician's order that is inaccurate or unsafe.

When a nurse directly disobeys a physician's order there is always the possibility that the evidence after the fact will support the physician's rather than the nurse's assessment of the clinical issues and the physician's professional judgment about what to do.

It is always the best course for the nurse to communicate the nurse's concerns to the physicians and the rest of the treatment team.

It is not a reasonable course of action, as a general rule, for a nurse preemptively to substitute his or her own judgment without communicating with other team members and without communicating with other nurses, nursing supervisors and/or other physicians.

CALIFORNIA COURT OF APPEAL
November 13, 2008

In the ICU his respiratory distress was resolved and his vital signs returned to normal 25 minutes before he finally went into cardiac arrest, coded and died.

His cause of death was officially linked to multiple medical problems which included renal failure but did not include respiratory distress.

Violations of Nursing Standards
Failure to Communicate Her Concerns

The board of nursing was highly critical of the charge nurse's failure to communicate her concerns to the rest of the treatment team. A nurse's legal duty to advocate for the patient is, first and foremost, a duty to communicate, in most cases with the physician or physicians, before the nurse takes decisive pre-emptive action.

The charge nurse testified she fully understood that the patient's low O_2 saturation and stat lab values did point to significant respiratory acidosis and that intubation was necessary. She further testified that intubation was the first step in setting up the patient on a respirator and that respirators and care for respirator patients were only available in the ICU.

However, not having spoken with the physicians before she physically took control of the patient she failed to realize the physicians intended to intubate and bag the patient immediately and to continue to bag him on the way to the ICU, which all the medical experts agreed after the fact was the correct course of action.

ABC's of Patient Assessment

All physicians and nurses have been trained that the most important patient-assessment data point is an adequate airway. An airway cannot wait while the pro's and con's are debated, unlike many other hypothetical clinical scenarios where there is time for that.

In this particular case the physicians wanted to insure an adequate airway right away on the spot but the nurse wanted to wait a few minutes later while the patient was undoubtedly in immediate jeopardy. **Finnerty v. Board of Registered Nursing, __ Cal. Rptr. 3d __, 2008 WL 4881531 (Cal. App., November 13, 2008).**

Compartment Syndrome: Nurses Reported The Signs But Did Not Advocate For The Patient.

During the patient's total right knee replacement surgery the orthopedist reportedly noticed the popliteal vein had been damaged and called in a vascular surgeon to repair it.

The next day it was decided the patient would be ready to be transferred from the hospital to a rehab facility in two days time.

The patient later testified that starting right after her surgery her right foot was pale, her lower leg was pale and she had difficulty moving her right ankle and the toes on her right foot.

On admission to the rehab facility three days after surgery the nursing staff picked up right away on signs of compromised circulation in the foot, including edema in the foot and ankle.

The nursing staff reported the problem to the vascular surgeon and to the physical medicine/rehabilitation specialist who was managing her care in the rehab facility.

Two days after admission the vascular surgeon came in to see the patient and decided a fasciotomy had to be done as compartment syndrome had set in. The fasciotomy was done the next day. The procedure was not successful to stave off ischemia and several days later he patient had to have the leg amputated below the knee.

The patient's lawsuit in the Circuit Court, Cook County, Illinois resulted in a $3,150,000 settlement from the physicians and the rehab facility.

The rehab facility was faulted because the nurses merely reported the signs and symptoms but did not actually advocate for timely medical intervention by the treating vascular surgeon or by another physician. **Toomire v. Cacioppo, 2008 WL 4923819 (Cir. Ct. Cook Co., Illinois, April 4, 2008).**

Labor & Delivery: Staff Nurse Did Advocate For The Patient.

When a nurse has reason to believe the patient's welfare is being jeopardized by the physician's action or inaction, the nurse has a legal obligation to advocate for the patient.

Hospital policy established a chain of command to be observed in situations compelling nursing advocacy.

The staff nurse was first to go to the charge nurse.

The charge nurse, if unable to resolve the situation with the physician, was to go to the nursing supervisor.

If the nursing supervisor could not resolve the situation satisfactorily with the treating or attending physicians, the nursing supervisor had to go to the medical director of the facility.

The courts, state and Federal regulators and accrediting organizations recognize two separate and independent legal obligations for nursing advocacy.

Facilities have the obligation to establish a chain of command for nursing advocacy and train their nurses about it in-service.

Nurses have the obligation to activate the chain of command when activation proves necessary.

SUPERIOR COURT, MONMOUTH COUNTY
NEW JERSEY
March 19, 2008

The infant was delivered by cesarean section with profound neurological deficits which, based on acidotic blood gases obtained at the time of birth, were blamed on oxygen deprivation during labor.

The medical issues became very complicated when the mother's ob/gyn and a consulting surgeon related her complaints of abdominal pain during labor to acute appendicitis which they deduced required an emergency appendectomy. The appendectomy went ahead as an open procedure starting with a McBurney incision. When the mother lost over 3,500 cc of blood the physicians decided to change course and do a cesarean. Then they discovered intraoperatively that the appendix was fine and there had been no need to remove it.

Nursing Advocacy

As the physicians were preparing to go ahead with the surgery a perioperative nurse repeatedly warned the physicians that the monitor tracings pointed to fetal distress. They did nothing so the nurse went to the charge nurse.

The charge nurse also did nothing so the staff nurse went over the charge nurse's head to the house supervisor. The supervisor also did nothing to alter the course of events.

Nurses, Hospital Dismissed From Case

The judge in the Superior Court, Monmouth County, New Jersey dismissed the staff nurse, charge nurse and the hospital from the case before the jury returned a verdict of $18,842,278 against the two physicians.

The staff nurse fulfilled her legal obligations. The charge nurse and the nursing supervisor, however, did not, notwithstanding clear directives established by the hospital outlining what they were expected to do in this situation.

The judge's reasoning was that no proof was presented that the medical director of the facility, if informed by the house nursing supervisor what was going on, in fact would have stepped in and corrected the situation. **Kowalski v. Palav, 2008 WL 4925670 (Sup. Ct. Monmouth Co., New Jersey, March 19, 2008).**

Informed Consent: Perioperative Nursing Notes Compel Dismissal Of Medical-Battery Lawsuit.

The patient was diagnosed with metastatic squamous cell carcinoma, which explained the neck mass and persistent sore throat that brought him to his physician's attention.

Three weeks after making the diagnosis the physician wrote a detailed note about the office visit in which he explained his plan for a comprehensive neck dissection at the site of the mass, including the goals, rationale, risks and treatment recommendations associated with the procedure. The note ended with the statement that, "We will arrange a date for him."

No Consent Form Was Signed

The patient never signed a surgical consent form at the doctor's office or at the hospital. Some time after the procedure the patient sued the physicians claiming that the absence of his signature anywhere on the dotted line made it an open and shut case of medical battery.

The US District Court for the District of Minnesota ruled that not signing did not necessarily prove he did not consent. As the court read the perioperative nursing records, the patient did, in fact, understand what was to happen and did consent.

Perioperative Nursing Record

A pre-op nursing record dated the day of the surgery included a box checked next to the statement, "Patient verbalizes understanding of perioperative instructions." The same record had a nurse's initials next to the statement, "Planned procedure and physician confirmed with patient."

The circulating nurse in the operating room also wrote a note on the Interoperative Nursing Record stating, "patient could state surg procedure to neck & purpose."

The bottom line, the court ruled, was that the patient was informed and did consent to the operation in the physician's office, whether or not his physician had him sign a consent form as his physician should have. The nursing documentation was ample corroboration for that fact. **Studnicka v. Pinheiro, 2008 WL 4717471 (D. Minn., October 24, 2008).**

Battery is an archaic term left over from the old English common law that refers to touching another person without permission. It usually refers to use of force as in an assault and battery. Battery is grounds for a civil lawsuit for damages.

Medical battery is the term used when a physician or other caregiver goes ahead with a medical procedure upon the body of a patient without the patient's consent. Medical battery is likewise grounds for a civil lawsuit for damages.

Informed consent laws spell out the steps physicians and others can take to keep themselves off the hook for medical battery.

The informed consent laws prescribe explicitly the basic language expected to be found in a medical consent document.

More importantly, the informed consent laws go on to state that the patient's signature on a properly drafted informed consent document is prima facie evidence the patient did consent to the procedure and, therefore, prima facie evidence there was no medical battery.

UNITED STATES DISTRICT COURT
MINNESOTA
October 24, 2008

Deep Vein Thrombosis: Elderly Patient Died Following Lasik Eye Surgery.

A long-term care facility in Will County, Illinois recently paid an out-of-court settlement of $250,000 to settle a wrongful death claim on behalf of the estate of a resident who died from a deep vein thrombosis following Lasik eye surgery.

The eye surgery center was not alleged to be at fault and was not brought into the case.

Settlement negotiations with the long-term care facility centered on allegations that the facility did not do enough to push fluids and failed to react to lab values pointing to dehydration which increased the possibility of DVT's.

Further, the facility reportedly did not provide compression stockings and did not push for mobility following the procedure. **Marosi v. Butterfield Healthcare, 2008 WL 4900847 (Will Co., Illinois, August 1, 2008).**

Fall: Nursing Home Did Not Secure Bed From Rolling.

A long-term care facility in Allegheny County, Pennsylvania recently paid an out-of-court settlement of $450,000 for a patient who fell and broke her hip.

The patient died of unrelated causes and the settlement was actually paid to her family via her probate estate.

The patient reportedly landed on the floor after her bed slipped out from under as she tried to sit on it.

The wheels apparently were not locked. Better yet, it was alleged, the bed should have been situated against the opposite wall so it would have nowhere to go. **Derobio v. Manorcare, 2008 WL 4900966 (Allegheny Co., Pennsylvania, July 1, 2008).**

Race Discrimination: Court Awards Damages To Caucasian Nurse Who Was Harassed On The Job By African-American Co-Workers.

The US District Court for the District of Delaware awarded damages in excess of $220,000 to a Caucasian LPN, finding that she was subjected to on-the-job harassment by African-American co-workers and managers based on her race, to the point she was forced to resign and find other employment.

In making its ruling the court reviewed many of the general principles that apply across the board in employment race discrimination cases.

Racial Harassment

The court found evidence of a racially hostile work environment. The LPN was routinely referred to by co-workers as a "white girl" and comments were made in stage whispers behind her back that all whites "smell like colostomy bags." Reportedly the LPN's co-workers started an office pool as to the date she would resign as a result of discriminatory treatment.

Differential Discipline

The court noted, without elaborating on the details, that the LPN in question received verbal reprimands and had formal written warnings placed in her personnel file for conduct for which African-American nurses were not disciplined.

Other Caucasians Were Harassed

Racial harassment was directed at other Caucasian employees before the LPN was hired and during her employment, a fact accepted by the court as evidence that a racially hostile work environment existed at the facility and was tolerated by facility management.

LPN Complained Before Resigning

Co-worker harassment, as a general rule, to serve as grounds for a discrimination lawsuit, must be reported to facility management. After the harassment is reported management must be given reasonable time to investigate and rectify the situation and must fail to do so if the victim is to have grounds to sue.

The court ruled the LPN did all she could by way of complaints before the actually resigned.

Damages in the form of back pay are available to a victim of on-the-job race discrimination who has been constructively discharged, that is, forced to abandon his or her employment.

Back pay is calculated as the difference between the actual income the individual has earned up to the court date subtracted from the amount the individual would have earned but for the employer's discriminatory conduct.

Damages for emotional distress require evidence of actual injury. Sleeplessness, headaches, humiliation and embarrassment, although intangible, are considered actual injuries.

Punitive damages can be awarded to a victim of discrimination if the employer engaged in discriminatory practices with actual malice or with reckless indifference to the victim's rights as protected by Federal law.

Here the defendant employer ignored the victim's complaints and had been aware of similar complaints from other Caucasian employees.

UNITED STATES DISTRICT COURT
DELAWARE
October 27, 2008

Constructive Discharge

Constructive discharge is the legal term for an employee being forced to resign as a result of on-the-job victimization by the wrongful conduct of a manager, supervisor or co-workers.

Constructive discharge is the opposite of voluntary resignation. As a general rule employees who resign voluntarily and then take less desirable or lower paying employment cannot claim their losses are the former employer's liability.

In this case the LPN was off work altogether for several months, then took a job paying $3.75 per hour less than what she was earning. The accumulation of damages for the pay differential ceased, the court ruled, when the defendant facility closed, that is, when the nurse would have been laid off in any event.

Mental Anguish, Emotional Distress

Professional treatment for emotional problems or for mental health issues is not a legal prerequisite to a discrimination victim being entitled to compensation for mental anguish and emotional distress.

In this case the LPN did seek medical attention for stomach problems and was prescribed medication for a sleep disorder, and her physicians could relate these issues to embarrassment, anxiety and depression from her job situation. The court awarded $100,000 out of the total judgment for this component of the case alone, along with $736.00 for medical bills.

Attorney Fees

The US Civil Rights Act and many state anti-discrimination laws allow the court to award damages to the victim for attorney fees. This is meant to permit access to justice for those who cannot afford an attorney and to prevent diminution of the recovery for a contingency fee.

In this case the facility defaulted and there was no trial. The attorneys nevertheless did have to submit uncontested proof of the claim and were given $12,000+. **Reczek v. JHA Wilmington, 2008 WL 4723021 (D. Del., October 27, 2008).**

LEGAL EAGLE EYE NEWSLETTER
For the Nursing Profession

Nurse As Patient, Malpractice Plaintiff: Jury Imposes A Higher Standard For Contributory Negligence.

A registered nurse died from metastatic breast cancer at age thirty-four.

She was survived by her husband and three young children. Her husband, as administrator of her probate estate, sued the physician specialist in breast surgery to whom his late wife first reported the lump in her right breast. He also sued the ob/gyn who was following her pregnancy. His late wife was pregnant with their third child at the time the breast lump issue first came up.

The ob/gyn's insurance settled for an undisclosed sum right before the case went to trial. In the trial, however, the jury declined to impose liability upon the breast surgeon.

Nurse/Patient Neglected To Follow Up
Jury Finds Contributory Negligence

Individuals who served on the jury in the Superior Court, Richmond County, Georgia reportedly disclosed afterward they thought the deceased's own neglect in failing to follow up with diagnostic and treatment recommendations was as much the cause of the unfortunate outcome as any malpractice by her physicians.

When she first reported the lump the physician sent her for an ultrasound. A board certified radiologist read it and recommended a biopsy. The breast surgeon did a repeat ultrasound five days later at the clinic visit at the same time he passed on the recommendation for a biopsy and told the patient to return in thirty days.

Her ob/gyn reportedly diagnosed clogged milk ducts, the nurse never revealing to her ob/gyn that the other physicians wanted a biopsy, obviously to rule out cancer.

Nothing else happened for approximately ten months until the patient returned to the breast surgeon with swelling which initially diagnosed as mastitis. During a procedure to relieve the swelling the pathologist confirmed it was breast cancer. **Gough v. Tucker, 2008 WL 2404428 (Sup. Ct. Richmond Co., Georgia, March 26, 2008).**

Arbitration: Patient Was Incompetent, Wife Held Power Of Attorney, Case Ordered Into Arbitration.

The deceased's patient's wife sued the nursing home alleging negligence in his care.

The Court of Appeal of Tennessee ruled in favor of the nursing home that the issues will be decided in arbitration, not before a jury in civil court. That is, the arbitration agreement was valid.

The wife signed the agreement as the person named in the durable power of attorney for healthcare decisions the patient signed before he succumbed to Alzheimer's. The power of attorney became active when the patient became incompetent to make his own decisions.

The arbitration agreement was presented to the wife as optional. It was explained to her before she signed. The arbitration agreement was a separate document from the admissions contract.

The durable power of attorney gave the patient's wife the authority to make decisions for him in the event he became incapacitated.

There is no question the patient was not competent to make his own decisions, being afflicted with Alzheimer's and having had a stroke.

The patient's incompetence triggered his wife's authority to act on his behalf.

COURT OF APPEALS OF TENNESSEE
November 19, 2008

The wife herself had her own issues at the time she signed, that is, she was in chemo for cancer. However, the court said, her medical issues did not prevent her from understanding what she was doing. She had no solid medical evidence that she herself was legally incompetent at the time she signed.

The arbitration agreement, as drafted by the lawyers, did not attempt to alleviate the nursing home from its basic duty to provide safe and effective care or attempt to limit the legal consequences in the event the nursing home breached its duties to the patient. The agreement merely shifted the forum for disputes from jury trial in civil court to so-called alternative dispute resolution. **Mitchell v. Kindred Healthcare, 2008 WL 4936505 (Tenn. App., November 19, 2008).**