Life Support: Court Discusses Hospital's Legal Responsibility.

If there is an actual dispute or even a question about the validity of a document which appears to permit the hospital to withhold life support, or appears to authorize a specific person to give the hospital permission to do so, the hospital must provide life support until the matter is resolved appropriately.

In this case that meant intubating the patient and ventilating her. The patient should have been intubated whether or not the son specifically requested that she be intubated.

A formal meeting should have been called to involve the adult children, the person the patient had years earlier named in her medical power of attorney, the attending physician, representatives from the hospital's administration, nursing services and ethics committee and a patient advocate.

If that meeting did not result in an acceptable resolution, papers would have to be filed in the local court for a judicial decision.

However correct in defining the standard of care, the family's expert was too vague how the hospital's breach of that standard affected the ultimate outcome for this patient.

COURT OF APPEALS OF TEXAS
April 30, 2015

After the sixty-seven year-old patient passed away her adult children sued.

They claimed the hospital ignored its legal duty to investigate the validity of the documents the patient signed several years earlier which appeared to authorize medical providers to withhold life support.

One son had raised concerns with the patient's caregivers about his mother's capacity to sign those documents due to her history of mental illness. He requested an investigation of the circumstances of the signing of those documents before the hospital went ahead.

Standard of Care
Hospital's Duty to Investigate

The Court of Appeals of Texas accepted an opinion as to the legal standard of care for the hospital from the family's expert, a board certified internist with extensive experience in geriatric medicine.

The physician stated that a hospital is required to ascertain the validity of a document signed by the patient which ostensibly authorizes withholding of life-saving treatment. If there is a dispute or even a question about its validity, a DNR order cannot be placed in the medical chart or life support withheld until the dispute or question is appropriately resolved.

There should have been a formal meeting to bring together the family, the surrogate decision-maker named in the power of attorney, the attending physician, representatives of the hospital's administration and nursing services, a patient advocate and a representative of the hospital's ethics committee.

If that meeting did not result in a resolution, papers should have been filed for the matter to be taken up in court.

While all of the above was pending the hospital should have provided life support. In in this case that meant intubation and mechanical ventilation of the patient.

No Proof of Causation

However, in the final analysis the Court was compelled to dismiss the family's lawsuit. There was no convincing proof that the hospital's going ahead without an investigation and stopping life support affected the patient's ultimate outcome. **Texas Health v. Frausto, 2015 WL 1941515 (Tex. App., April 30, 2015).**

Patient Suicide: Nurses Not Held Responsible.

Police officers arrested an individual on charges of domestic violence and endangerment of a child after he assaulted his estranged girlfriend in a public parking lot.

The girlfriend reportedly told the arresting officers that he was suicidal and needed to be watched carefully.

At the jail, however, the prisoner received a standard booking and was turned over to the jail nursing staff for a routine intake health assessment.

The arresting officers never relayed any information to the nurses about their prisoner being suicidal.

The nurses found the prisoner calm and coherent. He candidly reported past mental health treatment for depression and a suicide attempt via a medication overdose four years earlier. He denied any current suicidal impulses.

No suicide precautions were implemented. He hanged himself in his cell.

A jail nurse testified that if she had been informed the prisoner intended to hurt himself he would have been put in a stripped cell and a fifteen-minute behavior watch would have been started immediately. He would have been seen by a psychiatrist within at least twenty-four hours.

UNITED STATES COURT OF APPEALS
SIXTH CIRCUIT
May 12, 2015

The US Court of Appeals for the Sixth Circuit (Ohio) ruled the police officers may have been negligent for failing to relay to the nurses the fact that they had been told the prisoner was suicidal.

The lawsuit originally named the jail nurses and their employer, but they were voluntarily dismissed by the prisoner's estate's lawyers because no legal case could be made out against them. **Mantell v. Health Professionals, __ Fed. Appx. __, 2015 WL 2191559 (6th Cir., May 12, 2015).**