Healthcare Law Case Studies

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NUR 648 Healthcare Law and Policy

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June 21, 2020

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Tort Case Study:

Ms. Gadner was driving her car on the highway when another car driven by Mr. Sneed passed her, sideswiped her, ran her off the road, and drove off. She caught up with Mr. Sneed and forced him to stop. She got out of the car and started to walk to his car when he drove away. When she was walking back to her car, Mr. Otis struck her with his vehicle. Gadner was transported to Bay Hospital, a small rural hospital, where Dr. Dick, a second-year pediatric resident, was the attending emergency room physician.

Upon arriving at Bay, Gadner's skin was cool and clammy and her blood pressure was 95/55, indicative of shock. Gadner received 200 cc's per hour of fluid and was x-rayed. She actively requested a transfer because of vaginal bleeding. Nurse Gilbert voiced her own concerns about the need for a transfer to the other nurses in the emergency room, but not to Dr. Dick.
Dr. Dick did not order a transfer.

Bay is a rural hospital and is not equipped to handle trauma patients with multiple injuries like Gadner. Bay had no protocol or procedure for making transfers to larger hospitals. Bay breached its own credentialing procedures in hiring a physician who lacked the necessary training, expertise, or demonstrated competence to work the emergency room. Dr. Moon, the hospital's chief of staff had screened Dr. Dick, but a proper evaluation was not performed before he was hired. A second-year pediatric resident is not normally assigned to an emergency room setting because they lack enough experience to handle true emergency cases.

The nurses failed to notice that Gadner was in shock and this failure was substandard. After they initially noted that she arrived with cool and clammy skin and blood pressure of 95/55, they did not advise Dr. Dick that the patient was likely in shock; they failed to place her on IV fluids, elevate her feet above her head and give oxygen as needed. Dr. Dick ordered the administration of 500 cc's of fluid per hour, but Gadner received only about 200 cc's per hour because the IV infiltrated, delivering the fluid to the surrounding tissue instead of the vein. The nursing staff normally would discover infiltration and correct it. Scanty nurse's notes reveal that vital signs were not taken regularly, depriving Dr. Dick of critical and ongoing information about Gadner's condition.

Nurse Gilbert administered Valium and morphine to Gadner, following Dr. Dick's orders, a mixture of drugs counter-indicated for a patient with symptoms of shock. Nurse Gilbert did not notice or protest.

Three hours after arriving at Bay, Gadner "coded" and Dr. Dick tried unsuccessfully to revive her. After she "coded," Dr. Dick attempted to use the laryngoscope, following standard practice, but the one provided was broken. He then ordered epinephrine, but there was none available in the emergency room. A coroner performed an autopsy and it was determined that Gadner died of treatable shock.

Questions:

1. Excluding Mr. Sneed and Mr. Otis, list the potential defendants involved in the case.

2. Specify which of the potential defendants have a possible legal liability to Ms. Gadner's estate by stating the legal theories of liability (ex: corporate negligence). Describe the person/entity's actions from the facts which create that liability under the legal theory you have identified (ex: breach of credentialing procedures in hiring).

3. Based on the legal theories and the facts you have identified, develop a VERY SPECIFIC list of short term (next 1 - 2 months) corrective actions the hospital must take immediately to remedy the problems. Be sure to have a short term corrective action for EACH of the legal issues you identified.

4. Then, develop a second VERY SPECIFIC list of long term (6 – 12 months) corrective actions the hospital must take to ensure this situation does not happen again. Be sure to have a long term corrective action for EACH of the legal issues you identified. (This list should NOT be same as the short term actions, but should instead build upon EACH of them.)

Answer table:

Defendants	Legal liability	Actions from the facts	Short-term corrective actions (next 1-2 months)	Long-term corrective actions (next 6-12 months)
Bay Hospital	***A. Corporate negligence doctrine***			
	1. Has the duty to select and retain only competent physicians to make sure patients are appropriately taken cared (Furrow et al., 2015).	1. Breached its own credentialing procedures in hiring a physician who lacked the necessary training, expertise, or demonstrated competence to work in the emergency room.	1. Ensure proper evaluation is done before hiring a new emergency department physician. 2. Review the credentialing procedures with Dr. Moon about hiring, evaluation, and the duty to properly select employees. 3. Conduct internal investigation on Dr. Moon according to hospital bylaws and implement proper disciplinary actions.	1. Ensure that the hospital bylaws are reflective of the actual credentialing procedures as well as the quality control committee meets regularly to discuss any new hires. 2. "Hospitals must query the Data Bank at least every two years for each member of their medical staff"" (Furrow et al., 2015, p. 10)." 3. If Dr. Moon was found accountable for not performing his duties well and replacement of his position will be decided, ensure that the new employee is performing the hiring processes and evaluation correctly.
	2. Has the duty to use reasonable care in the maintenance of safe and adequate facilities and equipment (Furrow et al., 2015).	2. Dr. Dick attempted to use the laryngoscope, but the	1. Replace the laryngoscope in the emergency room and ensure that all equipments and supplies are in proper working condition.	1. Ensure that there is an effective system of regularly checking the condition and replacement of all supplies and

		one provided was broken.	2. Re-educate staff to promptly report broken supplies or equipments for immediate replacement.	equipments to provide quality care and services.
	3. Has the duty to properly supervise medical staff and other providers (Furrow et al., 2015).	3. The hospitals is negligent of its supervion of Dr. Dick, a pediatric resident, who had been placed on emergency duty by the hospital.	1. Place Dr. Dick on temporary leave while investigation is ongoing. 2. Replace Dr. Dick with a physician appropriate to handle real emergency cases. 3. Ensure that residents are under the supervision of attending physicians and are performing their duties limited to their scope of practice.	1. Quality control and management to perform regular checks of residents performance and if proper supervision was given by the attending physicians. 2. Re-educate and retrain residents and attending physicians about their scope of practice expected of their specific roles, as a resident and as a direct supervisor, respectively.
	4. Has the duty to formulate, adopt and enforce adequate rules and policies to ensure quality care for patients (Furrow et al., 2015).	4. Bay hospital has no protocol or procedure for making transfers to larger hospitals.	1. Create protocols and procedures for transferring patients to larger hospitals and make sure they are reflective of the EMTALA. 2. Review leadership's knowledge about EMTALA.	1. To retrain employees under EMTALA and to ensure that the hospital has the correct policies and procedures. 2. Quality control team and management to check the effectiveness of the new policy and procedures.
	B. Vicarious liability 1. It is type of "secondary liability in	1. Considering Dr. Dick is probably a contractor of the hospital. He was	1. Investigate Nurse Gilbert and Dr. Dick liabilities per hospital bylaws and implement	1. Ensure that Quality Control/Improvement meets regularly to check nursing notes,

	which a person or entity is held legally responsible for the actions or omissions of another person with whom they have a particular legal relationship" (A.S.T.H.O., n.d. p.1).	negligent but also showed malpractice. Please refer to Dr. Dick's negligent anc malpractice acts as a defendant. 2. Considering Nurse Gilbert is a direct employee of the hospital. She was negligent under an act of malpractice. Please refer to Nurse Gilbert's liable acts as a defendant. 3. Considering Dr. Moon is a direct employee of the hospital. He was negligent in that he failed to perform the appropriate hiring process of the physician.	disciplinary actions accordingly. Place them on temporary leave to avoid another possible damage to patients while investigation is ongoing. 2. Investigate Dr. Moon per hospital bylaws on hiring processes and implement disciplinary actions accordingly. Temporarily suspend hiring power and responsibility until re-education and retraining about proper credentialing and hiring is done. 3. Re-educate and re-train nurses and doctors in the emergency room on standards of practice and legal liabilities as well as EMTALA. 4. Ensure that nurses are appropriately documenting patient care and vital signs in accordance with hospital policy and retrain them as appropriate.	as well as care provided by physicians. Also, ensure that Peer Review is utilized appropriately to make sure care provided at the emergency room is of utmost quality. 2. Ensure that Quality Control/Improvement meets regularly to assess the hiring process and appropriateness of new hires. 3. Ensure that employees are updated with their skills to perform competence based on the standards of practice and the standards of the Joint Commission.
	C. Emergency Medical Treatment and Active Labor Act (EMTALA)	1. The hospital is not equipped to handle trauma patients with	1. Create protocols and procedures for transferring patients to larger hospitals and	1. To retrain employees under EMTALA and to ensure that the hospital has the correct policies

	An emergency medical condition is defined as "a condition manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in placing the individual's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of bodily organs" (A.C. E.P., n.d., p. 1). Under the provisions of EMTALA, hospitals have these obligations (A.C. E.P., n.d., p. 1). 1. "Any individual who comes and requests must receive a medical screening examination to determine whether an emergency medical condition exists." 2. “If an emergency medical condition exists, treatment must be provided until the emergency medical condition is resolved or stabilized. If the hospital does not have the capability to treat the emergency medical condition, an "appropriate" transfer of the patient to another hospital must be done in accordance with the EMTALA provisions.	multiple injuries like Ms. Gadner. Dr. Dick was negligent on the medical screening examination to determine that emergency condition exists, which is shock. Therefore, transfer orders was not given. Although treatment was provided, negligent actions of both Nurse Gilbert and Dr. Dick did not resolve or stabilize the emergency medical condition, which lead to the patient's death. The autopsy report showed that the patient died of treatable shock.	make sure they are reflective of the EMTALA. 2. Review leadership's knowledge about EMTALA.	and procedures. 2. Quality control team and management to check the effectiveness of the new policy and procedures.

Dr. Dick	***A. Negligence (Duty, Breach, Cause, Harm)*** The specific elements of a negligence claim are: "(1) the defendant owes the plaintiff a duty of care (including a duty of ordinary care); (2) the defendant breached that duty by failing to meet the applicable standard of care; (3) the defendant's actions resulted in harm to the plaintiff; and (4) the defendant's breach of duty was the cause of the plaintiff's injury" (A.S.T.H.O., n.d. p.1). ***B. Medical Malpractice*** It "occurs when a hospital, doctor or other health care professional, through a negligent act or omission, causes an injury to a patient". The must have (1) a violation of the standard of care; (2) an injury was caused by the negligence; and (3) the injury resulted in significant damages (A.B.P.L.A., n.d., p. 1).	1. Dr. Dick's duty was to examine the patient as well as stabilize and treat within the extent of his and the facilities capabilities as well as his treatment and expertise. He failed to examine the patient appropriately, as well as treat the patient appropriately, and failed to foresee that his capabilities were not sufficient and initiate a transfer under EMTALA. He, thus, caused the death of the patient and the consequences of his actions/inactions would have been foreseeable by any competent person with his credentials. 2. Ordering of valium and morphine that is both contraindicated for	1. Put Dr. Dick on temporary leave as the board of medical practice investigates and to prevent more harm to patients.	1. Ensure that he does not try and practice outside his expertise and scope of practice. 2. Ensure that he is in compliance with disciplinary actions. 3. Ensure that his evaluations for his residency program are valid. 4. Ensure that the standards of care of employees meets the expectation of The Joint Commission. 5. Before allowing to resume his role, ensure that his skills and competencies were of the highest standard through retraining.

		patients undergoing shock.		
Nurse Gilbert	A. ***Medical Malpractice*** The Joint Commission defines malpractice as "improper or unethical conduct or unreasonable lack of skill by a holder of a professional or official position" (James, 2007). Hypotethically if this incident happened in North Dakota, according to the Standards of Practice for Registered Nurses, one of the standards related to registered nurse (RN) professional accountability is that the RN shall "base nursing decisions on nursing knowledge and skills, the needs of clients, and registered nursing standards" (N.D.A.C., Section 54-05-02-04, p. 2). Among the standards related to RN scope of practice is to (N.D.A.C., Section 54-05-02-05, p. 2): 1. "Conduct a comprehensive nursing assessment determined by the knowledge, skills, and abilities of the registered nurse and by the client's immediate condition or needs."	1. Failed to perfom the standards of practice (per the state board of nursing). 2. With the immediate condition of the patient from a trauma, the nurse failed to perform comprehensive assessment that would have allowed her to identify the signs and symptoms of shock and apply nursing-driven interventions necessary for it. She failed to closely monitor and reassess the outcome of IV fluid administration, which would have lead her to find out the infiltrated IV. She failed to closely monitor the vital signs and document them carefully that is expected for an	1. Place Nurse Gilbert on temporary leave as the board of nursing investigates and to prevent more harm to patients. 2. To ensure she is acting within the scope of her competencies, to ensure that she is appropriately trained, to ensure that nurses within the facility are following appropriate policies and procedures.	1. Ensure that the nurse is compliant with the appropriate disciplinary actions imposed by the board of nursing. 2. Ensure that the standards of care of nurses meets the expectation of the Joint Commission. 3. Retrain nurses on the standards of practice. 4. Before allowing to resume her role, ensure that her skills and competencies were of the highest standard through retraining.

	2. "Develop a plan of care based on nursing assessment and diagnoses that prescribe interventions to attain expected outcomes." 3. "Utilize decisionmaking, critical thinking, and clinical judgment to make independent nursing decisions and nursing diagnoses." 4. "Evaluate and document the client's response to nursing care and other therapy." 5. "Identify changes in client's health status and comprehend clinical implications of client's signs and symptoms as part of expected. unexpected, and emergent client situations." 6. "Communicate, collaborate, and consult with other health team members."	emergency condition as well as an evaluation of IV fluids treatment. In terms of critical thinking and decision making that is expected for an emergency nurse on traumatic cases, she fell short in communicating and consulting with the doctor the need for the patient to be transferred to a larger hospital based on her assessments. Overall, she failed to perform the professional skill that is expected of an RN, especially in the emergency department. 3. The actions mentioned can also be compared against the organization's policy in treating emergency situations, such as shock.		

References

A.B.P.L.A. (n.d.). *What is medical malpractice?* Retrieved from https://www.abpla.org/what-is-malpractice

A.C.E.P. (n.d.). *EMTALA fact sheet*. Retrieved from https://www.acep.org/life-as-a-physician/ethics--legal/emtala/emtala-fact-sheet/#:~:text=The%20Emergency%20Medical%20Treatment%20and,has%20remained%20an%20unfunded%20mandate.

A.S.T.H.O. (n.d.). *Liability issues in emergencies*. Retrieved from https://www.astho.org/Programs/Preparedness/Public-Health-Emergency-Law/Emergency-Authority-and-Immunity-Toolkit/Liability-Issues-in-Emergencies-Fact-Sheet/

Furrow, B. R., Greaney, T. L., Johnson, S. H., Jost, T. S., & Schwartz, R. L. (2015). *Health law: Hornbook series* (3rd ed.). West Academic.

James, M. S. (2007). *Malpractice vs. negligence*. Retrieved from https://www.nursingcenter.com/journalarticle?Article_ID=727909&Journal_ID=54030&Issue_ID=727854#P12

Standards of Practice for Registered Nurses. N. D.A.C., Section 54-05-02-04. Retrieved from https://www.legis.nd.gov/information/acdata/pdf/54-05-02.pdf

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