*chapter two*

# Communications and Information Management

My words fly up, my thoughts remain below:
Words without thoughts never to heaven go.

*William Shakespeare,* English Dramatist & Poet (*1564–1616*), Hamlet, *Act 3 Scene 3*

*Communication* is the exchange of thoughts, messages, or information as by speech, signals, writing, or behavior. It is the art and technique of using words effectively to impart information or ideas.[1] The process of communication includes both verbal and nonverbal messages. Communication requires a sender, a message, and an intended recipient, the receiver.

Communications can be transmitted verbally through words, which are the tools of thought. The more words you thoroughly understand, the more effectively you can articulate your thoughts and ideas to other people. The sender of information can also transmit a message through body language, posture, gestures, facial expressions, and eye contact. Clothing styles, hairstyles, and tone of voice are forms of nonverbal communication. Nonverbal communication has been called the *silent language* and plays a key role in day-to-day life from, for example, employment relationships to romantic gestures. During face-to-face communication, body language and the tone of one's voice play a significant role, and they may have greater impact on the listener than the intended content of spoken words.

The problems of effective communication have existed since the creation of the first man and woman. Just as Eve trusted her first impression regarding the serpent's temptation that eating the fruit of a certain tree would make her and Adam "as gods, knowing good and evil" (Genesis 3:1–24), each person often accepts first impressions as reality. It takes time for individuals to understand one another, and it seems that few are willing to make that commitment.

Both managers and employees tend to perceive each new experience as reinforcing preconceived notions and biases and, at the same time, screening out those things that do not strengthen their ideas or individual conceptions of the real world. There is a tendency to make value judgments from one's own perspective and to evaluate all new knowledge according to its positive or negative impact on preconceived beliefs.

Barriers to successful communication include *message overload*, which can occur when a person receives too many messages at the same time. Employees, for example, may spill out to a manager those things that have been bothering them for weeks or even years during a conversation. It is important the manager focus on one issue at a time and keep the conversation on track. Employees often need reassurance that the manager understands the employees have other concerns that will be heard—not forgotten or ignored—and worked out. Managers who develop a trust relationship with their employees will be more able to keep conversations in focus. Effective communication requires that one take the time to clearly communicate his or her thoughts in order to save time later having to clear up misunderstandings.

The process of communication is more difficult in multilingual and multicultural environments. A simple whistle may be a gesture of approval in one culture, whereas it may be a sign of disapproval in another. The various dialects and semantic differences within a given language further complicate the process of meaningful communication.

The sender's personal filters and the receiver's personal filters may vary based on different religious beliefs, regional traditions, cultures, gender, race, and more, which may alter the intended meaning of the message. Barriers to effective communication include the *noise interferences* (1) environmental (e.g., disruption of communication by a barking dog); (2) physiological-impairment (e.g., deafness, blindness, pain); (3) semantic (e.g., "coke" could refer to coal, cocaine, or a certain cola); (4) syntactical (e.g., mistakes in grammar); (5) organizational (e.g., corporate policies on

grievance procedures that differ with the employee handbooks); (6) cultural (e.g., stereotyping the followers of a particular religion because of extremists); and (7) psychological (e.g., stress, fear, anger, or sadness that may cause someone to lose focus in the moment and thus distort effective communications).

The American Academy on Communications in Healthcare provides programs for helping caregivers improve communications among one another and among themselves, patients, and family.

**It's all about communication. And relationships.**

Whether you are an RN or the CEO of a health system, a practicing physician or a first-year doctoring course teacher, a researcher or a student, a patient or a caregiver, you know that communication is the key to exceptional patient care.

For more than 30 years, the American Academy on Communication in Healthcare (AACH) has been in the forefront of research, teaching relationship-centered healthcare communication.

If you are looking for ways to improve patient safety, interdisciplinary teamwork, patient satisfaction scores, or just want to work on individual communication skills, AACH can help.

AACH improves health care through education, research, and practice that focuses on communication and relationships with patients, families, and healthcare teams.

For more research information into improving communications in health care refer to the AACH website http://www.aachonline.org/.

Words convey our thoughts to others. Our ears hear varying sounds and our brains translate them into meanings or thoughts. The written word is only a symbol to the eye of the spoken word heard by the ear. The spoken word dies as soon as it is spoken; but the written word remains for others to see and interpret. Many words suggest more than they literally mean. Think of the associations called up in one's mind by the word "home." It can remind us of both happy and sad moments.

It is through words that we communicate our thoughts and stir our emotions. Consider the following quote when thinking of the power of words, while each person looks inwardly into himself or herself:

I am Me. In all the world, there is no one else exactly like me. Everything that comes out of me is authentically mine, because I alone chose it—I own everything about me: my body, my feelings, my mouth, my voice, all my actions, whether they be to others or myself. I own my fantasies, my dreams, my hopes, my fears. I own my triumphs and successes, all my failures and mistakes. Because I own all of me, I can become intimately acquainted with me. By so doing, I can love me and be friendly with all my parts. I know there are aspects about myself that puzzle me, and other aspects that I do not know—but as long as I am friendly and loving to myself, I can courageously and hopefully look for solutions to the puzzles and ways to find out more about me. However I look and sound, whatever I say and do, and whatever I think and feel at a given moment in time is authentically me. If later some parts of how I looked, sounded, thought, and felt turned out to be unfitting, I can discard that which is unfitting, keep the rest, and invent something new for that which I discarded. I can see, hear, feel, think, say, and do. I have the tools to survive, to be close to others, to be productive, and to make sense and order out of the world of people and things outside of me. I own me, and therefore, I can engineer me. I am me and I am Okay.

*Virginia Satir,* American Psychologist and Educator *(1916–1988)*

E-mails have become a major means of communication, but they often seem "flat" without tone-of-voice and timing cues and do not adequately transfer the intent of the communication. Telephone conference calls are also at a disadvantage (unless those calls include video linkup), because important body language cues are missing between/among the parties on the line. Direct verbal communications are the most effective way to communicate with others.

For good or ill, your conversation is your advertisement. Every time you open your mouth, you let men look into your mind. Do they see it well- clothed, neat, businesslike?

*Bruce Barton,* American Author and Politician *(1886–1967)*

The following *closet drama* should help the reader better understand communications and the real world of working relationships. It is anticipated that legal and ethical issues will be applied here. Many professionals, regardless of their field of training, will undoubtedly face similar issues during their career. This drama ends with a variety of thought-provoking questions.

### Leadership Fails the Communications Test

Organizational leadership must develop a strategy for effectively communicating with managers and employees on a continuing basis. Communication is an ongoing process and not a one-time campaign.

*Gp*

Jack, a nurse at Community Hospital, had exercised his right to appeal a decision of his manager and the human resources department. Level III of the appeal process allowed for a meeting with the hospital's Vice President of Operations, and it did so at a hospital that touted the importance of communications between employees and management. Although Jack had reached the third level of his appeal, the human resources director stated that the VP would not be available to meet directly with the nurse but would be available to conduct a conference call with him on the phone, to which Jack reluctantly agreed (not that he had much of a choice).

Body language, tone of voice, background noise that included other unknown listeners, and the drawn out appeal process served only to frustrate Jack. *The appeal process and the hospital's management team appeared to be window dressing to Jack*.

The final step in the process allowed for Jack to take his appeal to the CEO of the hospital. The CEO was as untimely in responding to the appeal as other managers involved in the appeal process had been. Ultimately, the CEO refused to meet with Jack, even though the two men had previously met on a more personal basis in Los Angeles.

The remaining events of Jack's grievance are presented next in conversational form.

**Shirley:** Jack, you said that you never received a copy of the Grievance Policy. In one of our conversations, I indicated that you could find the policy on our dedicated website. For your convenience, I have printed a copy for you.

**Jack:** I was referred to the online employee handbook for information regarding the grievance procedure. The online copy of the handbook is dated January 2011. During our conference call you stated that you believed it to be out of date. You now provide me with a copy of "Grievance Process" that was effective November 2005. Which of the two documents is in effect?

**Shirley:** Jack, official policy always takes precedence over the handbook. We have had some technical issues with the handbook in that when we update one section, other sections revert back to older editions. I am not sure if this is human error or technology.

**Jack:** Computers don't edit handbooks. My email from my manager referred me to the "Employee Handbook," which was signed with a letter by the CEO to employees. It did not mention anything about a policy. Actually, you remain out of compliance even with the policy. The grievance policy to which you are referring provides "Informal Process" steps, which you failed to follow.

**Shirley:** What are you talking about?

**Jack:** The policy states in Step I of the grievance process that the manager is to meet with the employee within 5 working days following receipt of notification of a grievance. It also provides that the employee making the grievance has a right to appear before a committee of his or her peers to explain his or her grievance and obtain a recommendation from the committee as to any right or wrong committed by the hospital. That never happened! So you were out of compliance with your own policy.

**Shirley:** Well, it is your responsibility to follow hospital policy.

**Jack:** This should not be an adversarial process. As HR director, one would expect that you would have helped guide me, the employee, and kept the appeal process on course. Explaining to me 5 months into the grievance that I was not in compliance with policy was not a good-faith gesture. Your failure has served only to cause a rift between senior management and myself. No one seems to want to come forward and accept responsibility for not leading. We call it leadership. Leaders lead, they do not sit back and watch an employee follow a wrong path for 5 months.

**Shirley:** Well it is up to you to follow the policy.

**Jack:** Then if I was following the wrong policy, why did you allow me to proceed under the wrong grievance policy?

**Shirley:** Well, ugh.

**Jack:** That policy also provides that immediately after the discussion with the manager, the employee is then provided with a written response. As you know I have been requesting the written response, as was promised months ago. Further, the written information outlined as a requirement in your policy is required to be provided.

**Shirley:** Well, we never had a grievance like this before.

**Jack:** Wow, I wonder why? By the way, don't you think employees should receive clarification when discrepancies exist between hospital policy and what appears in the employee handbook? Employees should understand that you intend policy to take precedence over the handbook. I would suggest that you pull the handbook off line until such time as you can match it up with policy.

**Shirley:** Well, I will be sure this is addressed.

**Jack:** This grievance could have been handled with transparency and fairness from the beginning. I still remain hopeful that, going forward, apologies will be forthcoming from the managers and that this grievance will be handled in accordance with the

purpose of the policy which states, "To provide employees with a formal process for the fair review and equitable resolution of employment concerns."

**Shirley:** Earlier this week, I received your request to forward your grievance information to the CEO. I will give him a package on Monday and will ask him, at that time, approximately when his review will be completed. Meanwhile, I will place you on an unpaid leave of absence until this issue is resolved.

**Jack:** I would assume that you would not threaten me with a retaliatory action by placing me at this time on an unpaid leave of absence. It sounds as though you are being presumptuous in knowing the CEO's response. You have given yourselves months to conduct a mysterious investigation, and now, you cannot wait for the CEO's decision regarding my grievance and want to place me on an unpaid leave of absence.

**Shirley:** Well, you should have followed the grievance policy procedure.

**Jack:** I think we are traveling in circles at this point. So you take no responsibility for failing to assure that the grievance process was on track?

**Shirley:** I think that I already answered that question.

**Jack:** As you know, this is the second time that HR, managers, in-house counsel, the compliance officer, and outside counsel have wrongfully advised the CEO. As you recall, after your incorrect advice to the CEO, it took the Department of Labor to correct your wrong when you financially penalized me for taking Family Medical Leave. I await the CEO's response to my grievance.

[In the meantime, Jack speaks with Frank, a CEO from another hospital, in New York City.]

**Frank:** Hey Jack, how is it going?

**Jack:** I am fine.

**Frank:** I can't stop thinking about the shabby treatment you have been getting from the hospital. I sure hope that something good will come of all this. They certainly do know how to fabricate a storyline. Sounds like a trumped-up nonissue that became an issue, and as the snowball ran down hill, they had to cover-up their mistakes to protect their jobs. Unfortunately, you became the victim. I think they became obsessed with defending their actions.

[Four weeks later, Jack receives a follow-up communication from Shirley.]

**Shirley:** The CEO has requested that I communicate his decision regarding your grievance, as he decided it is not necessary to speak with you. He confers with the Vice President's decision. As you know, they are both new to the hospital and, therefore, had to rely on our decisions.*

**The playwright who wrote this closet drama remains anonymous and retains the rights of ownership of the information contained herein.*

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### Discussion

1. Based on the facts presented, describe how you would have handled Jack's grievance.
2. Was the grievance process an illusion? Did leadership merely go through the motions of a grievance? Was it somewhat like advertising a position when you already know whom you are going to pick? Is this an example of *don't confuse me with the facts—I've already had others make up my mind*? Discuss your answer.
3. Discuss the communication issues in this case.

The key to success in management is the ability to understand, and to respond appropriately to, communications. The communication of thoughts and ideas are made possible by a common language. Although the spoken word is not the only method of conveying a thought or idea, it is the most useful, sophisticated method. Human beings are the only mammals that have developed the ability to communicate by spoken language. Can you imagine how difficult it would be if a manager and employee had to act out a message, as do certain species of bees, by means of a complex dance to describe the location of nearby nectar?

The damage that can result from unskilled communications is incalculable, and *the supervisor may find that the poor communication experience with one employee is compounded by its effect on other employees.* As noted by Patrick Delany, "Think all you speak, but speak not all you think. Thoughts are your own; your words are so no more."[2]

Figure 2-1 is a model of the *process of communication* by way of formation, transmission, and translation between two persons. The addition of multiple personalities in group conversations can give rise to an exponential growth in the distortion factor. The reader should review the model carefully to obtain a general understanding of the complex nature of the communication process.

The development of one's character depends on many lifetime influences (e.g., language, education, religion, past and present experiences, culture, environment, work, and physical traits) as presented in Figure 2-1.

There are 16 selected, individual, personality and ability traits listed in the figure, which describes certain characteristics of a communicator and a receiver at stated times in their lives. The figure illustrates how each individual has developed each particular trait; for example, the communicator is an introvert and the receiver is an extrovert. The percentiles at the top of the columns indicate the degree to which each person in the communication process has developed a specific trait.

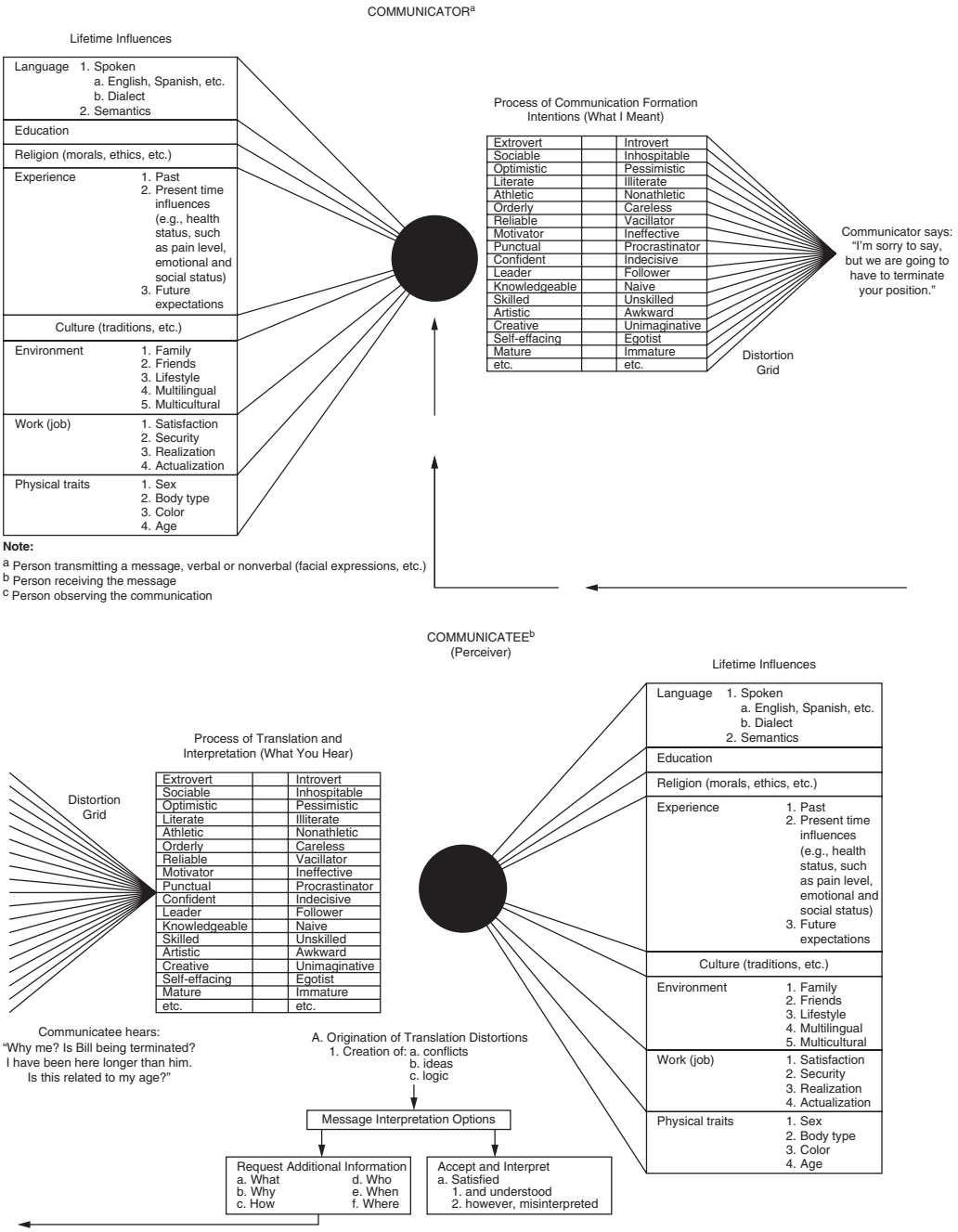


**Figure 2–1** The Process of Communication

It should be noted that ability and personality traits are not independent of one another, illustrated by the distortion grid in Figure 2-1. The distortion grid represents a melting pot for an individual's wants, needs, and expectations. The interaction of the various traits within each individual that processes and acts on a given message at a given time can give rise to conflict, ideas, logic, and so forth. It is extremely important each party to a conversation realizes that one's response or reactions will be significantly influenced by both lifetime influences and recent life experiences.

A message conceived of, and conveyed by, the communicator can be somewhat different from what is heard and understood by the receiver and/or a third-party observer, although an individual observing a two-way conversation generally recognizes more readily what message each party to the conversation is attempting to convey. That varying interpretations can be made of a transmitted message illustrates the need for feedback, which in turn can be useful in developing a framework for understanding the message. Without such a framework, problem solving becomes more difficult due to intentional or unintentional distortions that can occur during the communication process.

Managers who do not provide a setting for feedback are providing, instead, an environment for unmotivated and disgruntled staff. As one studies the communication model, it quickly becomes evident that there are thousands of factors affecting each individual's behavior and communication.

Each party in a conversation should request clarification when he or she is not sure of the true intent of the message conveyed. Failure to request clarification can lead to misunderstandings and inappropriate actions.

Managers should provide a setting for both informal and formal communications, and each party in a conversation should be put at ease. The manager should remember that the stress factor present in a given conversation causes a proportionate rise in the distortion factor. If a message is emotional, the manager should take time to clear the air. One's ability to communicate with the manager is certainly much easier in a sympathetic setting than in an antagonistic setting.

If a message is not clear to the manager, he or she should request that the message be rephrased. The rephrased message may provide clarity and perhaps even convey a completely different meaning than what the unclear original message seemed to imply. The manager, to reassure the employee that the message is clearly understood, should repeat back to the employee the question raised or comment made.


### Don't Let Hospitals Make You Sick

The problem is not that we have an epidemic of negligent doctors. Rather, it's that the healthcare system has grown so complicated that there is a greater chance than ever of things falling through the cracks.

Another problem is that hospitals produce massive amounts of data including lab and X-ray reports, medication lists, doctors' orders, and dietary restrictions. It is easier than ever for critical communications to get lost, and hospitals often don't have thorough backup systems.

*Dr. Ranit Mishori,* The Washington Post, [Parade Magazine], *February 8, 2009*

### Communications: Documentation Sparse and Contradictory

**Citation:** *Feeney v. New England Med. Ctr. Inc.*, 615 N.E.2d 585 (Mass. App. Ct. 1993)

#### *Facts*

The plaintiff, an administrator, alleging that the death of his son was caused by medical malpractice, commenced this action against the emergency department physician, the nurse on duty, and the hospital.

On December 1, 1987, at 10:16 p.m., an ambulance team of the Boston Department of Health and Hospitals found 26-year-old Mr. Feeney intoxicated, sitting on a street corner in South Boston. Mr. Feeney admitted to alcohol abuse but denied that he used drugs. He was physically and verbally combative and had trouble walking and speaking intelligibly. His condition interfered with the team's conducting an examination of him, so his vital signs were not taken.

At 10:45 p.m. Mr. Feeney was picked up by the ambulance and arrived at the hospital. No observer could doubt that the patient was highly intoxicated with alcohol. The autopsy report in fact revealed an ethyl alcohol blood level of 0.39%, a very dangerous condition. A physician or nurse could readily recognize a grave risk to the patient through depression of the respiratory system: "in the short run, the systemic effects [of the ingestion of ethanol] with the potential for the greatest negative outcome involves depression of the respiratory system." Id. at 586–587.

The documentation for the period between 10:45 p.m. and 11:30 p.m. was *"sparse and contradictory,"* as stated by Dr. McGoey, one of the experts. Id. at 587. The next entry on the emergency department record after 10:45 p.m.

is at 11:30 p.m., made when the patient was brought to the examining room. He was then without respiration and was cyanotic with his pupils fixed and dilated. On the physician documentation record, in which the emergency department physician wrote out the course of the case to the end, he reported (secondhand) that a nurse returned 20 minutes after 10:45 p.m. and found the patient unresponsive and without respiration.

The record goes on to report that the patient was pronounced dead after about 30 minutes of "code." If (referring to the emergency department record) the nurse returned to the patient at 11:30 p.m., then, inferentially, the patient had not been monitored for 45 minutes. On the other hand, if (referring to the physician documentation record) the patient was seen at 11:05 p.m., there was room for the inference that a lapse of 25 minutes intervened between that visit and the commencement of "code." An expert suggested that the former was the "more probable scenario." On either basis, a gap appears, needing explanation. Id. at 587.

A Suffolk County medical tribunal found the administrator's offer of proof insufficient and entered judgment against the physician, dismissing his complaint. The administrator appealed.

### *Issue*

Was the offer of proof made by the administrator sufficient to support a medical malpractice action against the hospital and the emergency department physician and nurse?

### *Holding*

The Appeals Court of Massachusetts held that the administrator's offer of proof was sufficient to sustain his cause of action.

### *Reason*

The minimum standard of care for nursing required monitoring the respiratory rate of the patient every 15 minutes; this "would more likely have permitted the nursing staff to observe changes in the patient's breathing patterns and/or the onset of respiratory arrest." As for the emergency department physician, he failed to evaluate the patient and to initiate care within the first few minutes of Mr. Feeney's entry into the emergency facility. The emergency physician had an obligation to determine who was waiting for physician care and how critical was the need for that care. Had the standards been maintained, respiratory arrest might have been averted.

According to the autopsy report, respiratory arrest was the sole cause of death.

The failure to provide adequate care could be rationally attributed to the staff nurse assigned to the area in which the patient lay, as well as to the physicians in charge. The hospital was implicated on the basis of the acts or omission of its staff.

### Discussion

1. Do you agree with the court's finding?
2. What effect, if any, might cases of this sort have on the care being rendered in emergency departments?

### Communications: Failure to Communicate with the Patient

**Citation:** *Follett v. Davis*, 636 N.E.2d 1282 (Ind. Ct. App. 1994)

In 1987, the plaintiff, Ms. Follett, had her first office visit with Dr. Davis. In the spring of 1988, Ms. Follett discovered a lump in her right breast and made an appointment to see Dr. Davis. The clinic had no record of her appointment. The clinic's employees directed her to radiology for a mammogram. Neither Dr. Davis, nor any other physician at the clinic, offered Ms. Follett an examination. In addition, she was not scheduled for a physician's examination as a follow-up to the mammogram. A technician examined Ms. Follett's breast and confirmed the presence of a lump in her right breast. After the mammogram, clinic employees told her that she would hear from Dr. Davis if there were any problem with her mammogram.

The radiologist explained in his deposition that the mammogram was not normal. Dr. Davis received and reviewed the mammogram report and considered it to be negative for malignancy. He did not know of the new breast lump because none of the clinic employees had informed him about it. The clinic, including Dr. Davis, never contacted Ms. Follett about her lump or the mammogram. On April 6, 1990, Ms. Follett called the clinic and was told that there was nothing to worry about unless she heard from Dr. Davis. On September 24, 1990, Ms. Follett returned to the clinic after she had developed pain associated with that same lump. A mammogram performed on that day gave results consistent with cancer. Three days later, Dr. Davis made an appointment for Ms. Follett with a clinic surgeon for a biopsy and treatment. She kept her appointment with the surgeon. Nevertheless, this was her last visit with the clinic, as she subsequently transferred her care to other physicians.

In October 1990, the biopsy confirmed the diagnosis of cancer. Ms. Follett filed a lawsuit, and the superior court, in a medical malpractice action, entered summary judgment for the physician and clinic on the grounds that the statute of limitations had tolled, and the patient appealed.

### *Issue*

Was the doctrine of continuing wrong applicable so that the period of limitations did not begin to run until the patient's last visit to the clinic?

### *Holding*

The Court of Appeals of Indiana held that the doctrine of continuing wrong was applicable so that the period of limitations did not begin to run until the patient's last visit to the clinic.

### *Reason*

Ms. Follett claimed the wrong she suffered was a continuing wrong. The doctrine of continuing wrong is simply a legal concept used to define when an act, omission, or neglect took place. The statutory period of limitations begins to run at the end of the continuing wrongful act. The evidence shows that, after she had found a lump in her breast, she went to Dr. Davis, her regular obstetrician/gynecologist, and the clinic for aid. Dr. Davis and the clinic, through the clinic's employees and agents, undertook to treat her ailment. That undertaking ended only when the clinic's surgeon performed the biopsy and therefore was continuous in nature. When the sole claim of medical malpractice is a failure to diagnose, the omission cannot as a matter of law extend beyond the time the physician rendered a diagnosis. When Ms. Follett last visited Dr. Davis on September 24, 1990, and last visited the clinic on September 27, 1990, the evidence most favorable to her demonstrated that, had clinic procedures been followed, Dr. Davis or another doctor at the clinic would have had occasion to diagnose her problem before either of those dates. On August 20, 1992, Ms. Follett timely filed her proposed complaint within 2 years of the last visits to Dr. Davis and the clinic.

### Discussion

1. What are the pros and cons as to when the statute of limitations should reasonably begin to run?

2. Do you think all of the 50 states should agree as to when the statute of limitations should begin to toll?
3. What are the communications issues involved in this case?

### Communications: Failure to Report Patient's Deteriorating Condition

**Citation:** *Flores v. Cyborski*, 629 N.E.2d 74 (Ill. App. Ct. 1993)

The patient was admitted to the hospital after having complained of abdominal and lower back pain. She was given tests, after which she was diagnosed as having kidney infection and possible pneumonia. A physician was called in to see the patient. Diagnostic tests were ordered, including blood, sputum, and urine cultures. The physician visited the patient soon after the phone call. The patient complained that she was experiencing chest pain and had a congestive cough. Her white blood count was elevated, which indicated the patient had a possible infection. After studying the results of the patient's tests and chest X-rays, the physician concluded that the patient had lower-lobe pneumonia. He prescribed the broad-spectrum antibiotic Keflin. The next day, the patient said she was feeling better, her lungs sounded better, and her elevated temperature had decreased. Two days later, she told the nurses she was experiencing shooting pains and shortness of breath. She also had a pulse rate of 180, but the nurses did not notify the physician until the patient was in cardiac arrest. She died later that day.

The patient's estate sued the physician for negligence in treating the patient. Dr. Sharp, who was the brother of an associate at the plaintiff's law firm, testified that the defendant had deviated from the standard of care. He stated that the defendant failed to obtain blood gas tests, prescribe an appropriate antibiotic, and prescribe that the antibiotic be administered intravenously. He further testified that the lowering of the patient's temperature was due to the administration of Tylenol, not to an improvement in the patient's condition. The defendant's experts stated that the physician had complied with the applicable standard of care and that the death was unexpected and sudden. Her decreased white blood cell count and the data that had been collected from all who had examined her indicated that she was getting better. The jury returned a verdict for the defendant, and the plaintiff appealed.

#### *Issue*

For impeachment purposes, did the court have a right to allow into evidence the testimony regarding the sibling relationship between the plaintiff's expert and attorney during cross-examination?

### *Holding*

The Appellate Court of Illinois affirmed the verdict for the defendant. The court, for impeachment purposes, had a right to allow into evidence the testimony regarding the sibling relationship between the plaintiff's expert and attorney during cross-examination.

### *Reason*

The physician's testimony may have been colored by his relationship with his brother. The jury was correctly permitted to consider that possibility in order to judge the credibility of the physician as a witness.

The issue of whether the nurses' failure to respond to the change in the patient's condition constituted the proximate cause of the patient's death was for the jury to decide. Moreover, there was no evidence that the physician caused the patient's suffering and death.

### Discussion

1. Take the position of the defense attorney and explain, giving specific reasons, why the physicians did not breach the applicable standard of care.
2. Discuss what additional evidence would have been helpful to the plaintiff's case.
3. What action should the nurses have taken upon discovering a significant change in the patient's condition?
4. Describe those changes in a patient's condition that would trigger a need to notify a patient's attending physician.
5. What educational processes should an organization have in place to prevent similar incidents from reoccurring?

## Communications: Progress Notes and Office Records

**Citation:** *Dardeau v. Ardoin*, 703 So.2d 695, 97-144 (La. App. 1997)

The plaintiff, Ms. Dardeau, alleges that when she was 28 years old, she came under the care of Dr. Ardoin for routine examinations. She contends that after her first visit with Dr. Ardoin, he recommended and performed radical surgery consisting of a bladder suspension, cystocele repair, rectocele repair, complete hysterectomy, and removal of her ovaries. According to the plaintiff, Dr. Ardoin injured her obturator nerve during the cystocele surgery, and that as a result, she has sustained permanent paralysis in her right leg.

The Louisiana Medical Mutual Insurance Company (LAMMICO) contends that when Ms. Dardeau was first seen by Dr. Ardoin, she complained that coughing, sneezing, jumping, or running caused a loss of urine, and she related a history of a tubal ligation after the birth of her second child. Dr. Ardoin noted a cystocele (or herniation of the bladder), a rectocele (or herniation of the rectum through the vagina), and some uterine descensus (or falling of the uterus). He recommended conservative treatment and advised Ms. Dardeau to return in one month.

According to the defendant, the plaintiff's complaints persisted and Dr. Ardoin recommended diagnostic studies. After review of the diagnostic studies, he suggested surgery to correct the urinary incontinence and to repair the cystocele and rectocele. Dr. Ardoin also recommended a hysterectomy due to the uterine descensus and complaints of dyspareunia (or pain with intercourse) and dysmenorrhea (or painful menstruation). After a discussion of the procedures, the plaintiff executed three consent forms, which were introduced into the record. A second opinion was obtained from Dr. Cantu who agreed with Dr. Ardoin's findings and recommendation for surgery.

After surgery, the plaintiff complained of leg pain. It was determined by the defendant that she suffered from a rare, but known, complication of injury to the obturator nerve. The record reflects that a medical review panel rendered a unanimous opinion that Dr. Ardoin did not breach the standard of care in his treatment of Ms. Dardeau, and that Dr. Ardoin had adequately informed her that serious complications could occur in connection with the surgical procedures. Furthermore, the panel found that Dr. Ardoin recognized the complication early and addressed it appropriately.

The jury concluded that Dr. Ardoin obtained Ms. Dardeau's informed consent prior to surgery; that a reasonable person would have accepted the risk of nerve injury based upon the medical condition of the plaintiff at the time of the surgery; that Dr. Ardoin was not guilty of substandard conduct constituting malpractice; and that the plaintiff's injury was not caused by any substandard conduct on the part of Dr. Ardoin.

Dr. Ardoin passed away prior to trial. The plaintiff complained in brief that the introduction of progress notes or office chart by Dr. Ardoin constituted hearsay evidence. She argued that LAMMICO defended this case on unauthenticated progress notes that claimed to be made by Dr. Ardoin.

### *Issue*

Was there error on the part of the trial court as to the admissibility of the physician's progress notes or office chart?

### *Holding*

The appeals court found no error on the part of the trial court as to the admissibility of the physician's progress notes or office chart and affirmed the jury verdict and the judgment of the trial court.

### *Reason*

The plaintiff's own expert testified that he relied upon Dr. Ardoin's office chart to render his opinion in the case. Ms. Dardeau argues that LAMMICO attempted to introduce Dr. Ardoin's office chart through Ms. Fontenot, Dr. Ardoin's receptionist, who could not provide any of the qualifying circumstances set forth in La. Code Evid. arts. 803 and 804 that could ensure the trustworthiness of these records. More specifically, plaintiff argued that Ms. Fontenot did not have personal knowledge of the information contained in the progress notes and had no recollection of anything in the office chart.

A significant portion of Dr. Ardoin's chart was included in the records of Humana Hospital of Ville Platte, which were introduced at trial without objection. Dr. Ardoin's office chart was admissible because it was created during the course of his treatment of the plaintiff and constituted a record maintained in the course of a regularly conducted business activity [La. Code Evid. art. 803(6)]. Dr. Ardoin's receptionist, Ms. Fontenot, testified at trial that the office chart was created in connection with Dr. Ardoin's business, that the entries in the chart were made at the time of treatment, and that the entries were made by Dr. Ardoin who had personal knowledge of the information in the chart. Ms. Fontenot testified that she never saw any chart being altered or falsified by Dr. Ardoin, nor did Dr. Ardoin request that she alter any office chart. There was no evidence presented by the plaintiff that would indicate that Dr. Ardoin's records were untrustworthy.

### Discussion

1. What was the appeals court's reasoning for allowing the physician's progress notes and office records to be admissible as evidence?
2. What is the danger of allowing written records admitted into evidence when the author of such records is not available for cross-examination?
3. What is the danger of not allowing written records to be admitted into evidence when the author of such records is not available for cross-examination?

**Communications: Inadequate Record Keeping**

**Citation:** *United States v. Veal*, 23 F.3d 985 (6th Cir. 1994)

### *Facts*

In October 1990, United States Drug Enforcement Administration (DEA) investigators received reports from drug wholesalers that the defendant, Mr. Veal, was making inordinately large purchases of Doriden and Tylenol 4. Doriden, a sleeping medication, and Tylenol 4, a pain medication containing codeine, are Schedule III controlled substances. These drugs have a heroin-like effect when ingested in combination. The combination is commonly referred to in the illegal drug market as "fours and doors." Although a registered pharmacist pays anywhere from four to seven cents a pill of either variety, a single dose of the "fours and doors" combination costs about $20 on the street.

On October 5, 1990, DEA investigators went to the defendant's pharmacy to serve him with a notice of intent to inspect his records, prescriptions, and inventory. The defendant agreed that the agents could perform the inspection 4 days later, at which time he said he would turn over his records. When the agents returned on October 9, 1990, the defendant asked them whether they would be removing the records. The officers answered that the records would be seized only if they were found to contain incriminating evidence. The defendant responded, "So you'll take my records." The officers reiterated that they would only take the records if they were incriminating; the defendant then withdrew his consent to the search, and the officers left the premises. The officers subsequently obtained a search warrant pursuant to which they went through the defendant's pharmacy records. They discovered significant discrepancies between his controlled substance purchases and quantities accounted for. The records also revealed that the defendant had filled numerous phony prescriptions for Doriden and Tylenol 4. Some of the prescriptions bore the name of a fictitious physician, and others bore the names of actual physicians who testified at trial that they had not written the prescriptions.

The defendant was tried on a 13-count indictment. The jury returned a verdict of guilty on six counts and not guilty on the remaining counts. A motion for acquittal or a new trial was denied, and the defendant appealed.

### *Issue*

(1) Did the evidence support a conviction for the possession and illegal distribution of controlled substances? (2) Did the evidence support a conviction

on record-keeping charges? (3) Was there ample evidence to support a finding that the fraudulent character of the prescriptions should have been obvious to the defendant?

### *Holding*

The Court of Appeals for the Sixth Circuit held that (1) the evidence supported a conviction for the possession and illegal distribution of controlled substances, (2) the evidence supported conviction on record-keeping charges, and (3) there was ample evidence to support a finding that the fraudulent character of the prescriptions should have been obvious to the defendant.

### *Reason*

The government established that a fictitious physician issued some prescriptions and that other prescriptions were facially invalid. Several experts testified about the well-known combination of "fours and doors" and stated that any reasonable pharmacist should have been suspicious of prescriptions calling for that combination. A pharmacist acting in good faith would have called to verify the prescriptions, according to the government's evidence, and the defendant did not do so.

The evidence against the defendant was also sufficient to support the finding of guilt on the charges of inadequate record keeping. In order to convict Mr. Veal on these charges, the government was required to show only that the defendant under:

21 U.S.C. §§ 827(a)(3) and 843(a)(4)(A) had not kept a complete and accurate record of each [controlled] substance manufactured, received, sold, delivered, or otherwise disposed of by him….

The evidence introduced at trial included the results of an extensive audit that tended to show that the defendant had failed to account for significant quantities of the controlled substances he handled. The audit assumed the validity of all of the distributions documented by the defendant, and it demonstrated that the defendant had failed to account for 951 Doriden tablets (9% of his total purchases of Doriden during the audit period), nearly 1,600 Tylenol 4 tablets (19% of his total purchases of Tylenol 4 during the audit period), and 3,227 Tylenol 3 tablets (21% of his total Tylenol 3 purchases). The government was not required to prove that the missing tablets were dispensed illegally; what actually happened to those substances had no bearing on the record-keeping charges.

### Discussion

1. When a pharmacist is charged with filling invalid prescriptions, what must be proven to sustain a conviction?
2. What are the causes of the wide variety of billing scams committed across the nation?
3. Do you think that the use of generic medications increases or decreases the likelihood of such scams? Explain.

### Communications: Alteration of Records

**Citation:** *Dimora v. Cleveland Clinic Found.*, 683 N.E.2d 1175 (Ohio App. 8 Dist. 1996)

#### *Facts*

Ms. Dimora, a 79-year-old woman, was admitted on October 18, 1993, as a patient at the Cleveland Clinic. She had difficulty in ambulating and transferring, requiring an attendant while using a walker. Her condition was noted numerous times on her chart. She was evaluated as high risk for falls.

On November 5, 1993, Ms. Dimora was preparing to be discharged from the clinic. After using the toilet with the assistance of a student nurse, she lost her balance and fell backward. The fall caused a severe bruising to her thorax and resulted in the breaking of five or six ribs. Mrs. Dimora's fall was noted in the nursing notes, and in the discharge summary by the attending physician, who examined her subsequent to the fall. Upon examination, Ms. Dimora was "found to have good strength in all four extremities," was "without pain of movement," and had a "small 5 × 8 cm area" on the right posterior thorax "slightly scraped." The area was noted to be "non-tender with deep palpitation and there was no evidence of crepitus." Ice and lotion were applied to the abraded area. No X-rays were taken at the clinic after the fall, and no further treatment was administered by the clinic. Ms. Dimora's broken ribs were not diagnosed until the following day, when X-rays were taken at Marymount Hospital.

Ms. Dimora's daughter, granddaughter, and caregiver testified that when they arrived at the hospital to pick up Ms. Dimora, she was crying and complaining of pain, and her side was all red. Ms. Dimora's daughter testified that one of the nurses said Ms. Dimora had fallen when she was left alone in the bathroom. The three women each testified that they had difficulty getting Ms. Dimora in and out of the car because she was in so much pain. Both movement and breathing caused Ms. Dimora pain for a few weeks.

Subsequent to this fall, Ms. Dimora required much more care, and she was unable to enjoy many of her former activities.

The plaintiff–appellee Ms. Dimora filed a complaint against defendant–appellant Cleveland Clinic Foundation (the Clinic) alleging that the Clinic negligently provided medical care and treatment for her during her confinement there. Ms. Dimora further claimed punitive damages, alleging that the Clinic and/or its agents and/or employees intentionally falsified her medical records or inaccurately reported her condition to avoid liability for their negligence.

The defendant moved for a directed verdict, claiming that the plaintiff had failed to demonstrate alteration of the record and malice on the part of the Clinic, asserting, therefore, that the claim for punitive damages must fail. The trial court denied this motion. The jury awarded a verdict in favor of Ms. Dimora in the amount of $25,000 for compensatory damages and $25,000 in punitive damages.

### *Issue*

(1) Did the trial court properly determine that reasonable minds could differ on the issue of whether the progress notes and the discharge notes were falsified or inaccurately reported to avoid liability for the medical malpractice or negligence of hospital personnel? (2) Did the trial court err when it denied the appellant's motions for directed verdicts on the appellee's claims for negligence and for punitive damages?

### *Holding*

The trial court properly determined that reasonable minds could differ on the issue of whether the progress notes and the discharge notes were falsified or inaccurately reported to avoid liability for the medical malpractice or negligence of hospital personnel. Therefore, the trial court did not err when it denied the appellant's motions for directed verdicts on the appellee's claims for negligence and for punitive damages.

### *Reason*

The claim of the appellee for punitive damages alleges that the clinic, through its agents and/or employees, intentionally falsified her medical records or inaccurately and improperly reported the fall incident to avoid liability for its medical malpractice or negligence.

In a case involving medical malpractice where liability is determined and compensatory damages are awarded, punitive damages pled in connection with the claim for malpractice may be awarded upon a showing of actual malice, defined as: the intentional alteration, falsification, or destruction of medical records by a physician to avoid liability for his or her medical negligence.

At trial, the testimony presented by witnesses for the appellee indicated that the right side of Ms. Dimora's body was red, bruised, and painful after the fall. Three witnesses testified that Ms. Dimora was crying and in pain approximately 45 minutes after the incident, while she was still in the hospital.

Testimony was offered that broken ribs would be painful upon deep palpation. Pictures were offered into evidence indicating large areas of bruising on Ms. Dimora's body on the day after the event.

Appellant contends that this record accurately reflects the incident. However, the testimony presented by the appellee is in apparent conflict with the description of the incident, the injury, and Ms. Dimora's demeanor. The evidence showed that Ms. Dimora had fallen and broken five or six ribs; yet, upon examination, the physician noted that she was smiling and laughing pleasantly with no pain upon deep palpation of the area. Other testimony indicated that she was in pain and crying. The discrepancy between the written progress notes and the testimony of the witnesses who observed Ms. Dimora was sufficient to raise a question of fact as to the possible falsification of documents by the physician to minimize the nature of the incident and the injury of the patient due to the possible negligence of hospital personnel. The testimony of the witnesses, if believed, would be sufficient to show that the physician falsified the record or intentionally reported the incident inaccurately to avoid liability for the negligent care. Such conduct is the type of intentional and deceptive behavior more indicative of actual malice. If such evidence is believed, the jury could award punitive damages. With the proper caution exercised in instructing the jury as to when punitive damages are proper, the issue of punitive damages should have been submitted to the jury.

The trial court properly determined that reasonable minds could differ on the issue of whether the progress notes and the discharge notes were falsified or inaccurately reported to avoid liability for the medical malpractice or negligence of hospital personnel. Therefore, the trial court did not err when it denied the appellant's motions for directed verdicts on the appellee's claims for negligence and for punitive damages.

### Discussion

1. Do you agree with the court's finding? Why?
2. What would you have done differently if you were the hospital? Nurse? Physician?

### Communications: Falsification of Records

**Citation:** *Moskovitz v. Mount Sinai Med. Ctr.*, 635 N.E.2d 331 (Ohio 1994)

#### *Facts*

The facts giving rise to this appeal involved the conduct of Dr. Figgie, who failed to timely diagnose and treat a malignant tumor on Mrs. Moskovitz's left leg and altered certain records to conceal the fact that malpractice had occurred.

In 1978, Mrs. Moskovitz was treated by Dr. Gabelman for a tumor on her left leg. The tumor was removed and found to be benign. In 1984, Dr. Gabelman completely and successfully removed a second mass. In 1985, Mrs. Moskovitz was referred to Dr. Figgie, an orthopaedic surgeon, for treatment of a degenerative arthritic condition in her knees. In October 1985, Dr. Figgie performed surgery on Mrs. Moskovitz. Mrs. Moskovitz underwent additional knee surgery performed by Dr. Figgie in May 1986.

On October 2, 1986, Mrs. Moskovitz visited Dr. Figgie's office, complaining of a lump on her leg. Dr. Figgie did not recommend a biopsy of the lesion.

On November 3, Mrs. Moskovitz was admitted to University Hospitals for a right knee revision. Prior to surgery, Mr. Magas, a registered nurse, examined Mrs. Moskovitz. Mr. Magas's written report of the examination, signed by Dr. Figgie, noted the existence of a firm nodule measuring 1 cm × 1 cm on Mrs. Moskovitz's left Achilles tendon. Dr. Figgie performed the right knee revision on November 5. Following surgery, Dr. Balourdas, a resident physician at University Hospitals, examined Mrs. Moskovitz on Dr. Figgie's behalf. A discharge summary prepared by Dr. Balourdas (and signed by Dr. Figgie) noted the existence of a "left Achilles tendon mass, [1] × 1 cm. nodule." The report indicated that the mass had been present for some time.

On November 10, 1987, Dr. Figgie removed the mass. On November 13, the tumor was found to be an epithelioid sarcoma, a rare form of malignant soft-tissue cancer. A bone scan revealed that the cancer had metastasized to Mrs. Moskovitz's shoulder and right femur.

Following the diagnosis of cancer, Mrs. Moskovitz's care was transferred to Dr. Figgie's partner at University Orthopaedic, Dr. Makley, an orthopaedic surgeon specializing in oncology. Dr. Makley received Dr. Figgie's

original office chart, which contained seven pages of notes documenting Mrs. Moskovitz's course of treatment from 1985 through November 1987. Dr. Makley thereafter referred Mrs. Moskovitz to radiation therapy at University Hospitals. Apparently, in November 1987, without Dr. Figgie's knowledge, Dr. Makley sent a copy of page 7 of Dr. Figgie's office notes to the radiation department at University Hospitals.

In December 1987, Dr. Figgie, or someone on his behalf, requested that Dr. Makley return Dr. Figgie's office chart pertaining to the care of Mrs. Moskovitz. In December 1987, Dr. Makley was Mrs. Moskovitz's primary treating physician, and Dr. Figgie was no longer directly involved in Mrs. Moskovitz's care and treatment.

Dr. Makley's secretary forwarded the chart to Dr. Figgie's office. Dr. Figgie's secretary then sent a copy of the chart to Dr. Ashenberg, Mrs. Moskovitz's psychologist. Dr. Ashenberg received the copy sometime between December 14 and 18, 1987.

In January 1988, Dr. Makley's secretary requested that Dr. Figgie's office return the chart to Dr. Makley. At this time, it was discovered that the original chart had mysteriously vanished. On October 21, 1988, Mrs. Moskovitz filed a complaint for discovery in the Court of Common Pleas seeking to ascertain information relative to a potential claim for medical malpractice. Mrs. Moskovitz died on December 5, 1988, as a result of the cancer. Prior to her death, her testimony was preserved by way of videotaped deposition.

Dr. Makley, in his January 30, 1989, deposition, produced a copy of page 7 of Dr. Figgie's office chart. That copy was identical to the copy ultimately recovered by the plaintiff's counsel from the radiation department records at University Hospitals. The copy produced by Dr. Makley contained a typewritten entry dated September 21, 1987, which states: "Mrs. Moskovitz comes in today for her evaluation on the radiographs reviewed with Dr. York. He was not impressed that this [the mass on Moskovitz's left leg] was anything other than a benign problem, perhaps a fibroma. We [Figgie and York] will therefore elect to continue to observe." However, the photostatic copy revealed that a line had been drawn through the sentence "We will therefore elect to continue to observe." The copy further revealed that beneath the entry Dr. Figgie had interlineated a handwritten notation: "As she does not want excisional Bx [biopsy] we will observe." The September 21, 1987, entry was followed by a typewritten entry dated September 24, 1987, which states: "I [Figgie] reviewed the X-rays with Dr. York. I discussed the clinical findings with him. We [Figgie and York] felt this to be benign, most likely a fibroma. He [York] said that we could observe and I concur." At some point, Figgie

had also added to the September 24, 1987, entry a handwritten notation, "see above," referring to the September 21, 1987, handwritten notation that Mrs. Moskovitz did not want an excisional biopsy. Id. at 336.

Dr. Figgie, at his deposition on March 2, 1989, produced records, including a copy of page 7 of his office chart. As his original chart had been lost in December 1987 or January 1988, Dr. Figgie had this copy made from the copy of the chart that had been sent to Dr. Ashenberg in December 1987. The September 21, 1987, entry in the records produced by Dr. Figgie did not contain the statement "We will therefore elect to continue to observe." Apparently, that sentence had been deleted (whited out) on the original office chart from which Dr. Ashenberg's copy (and, in turn, Dr. Figgie's copy) had been made, in a way that left no indication on the copy that the sentence had been removed from the original records. Id. at 336.

During his deposition, Dr. Figgie maintained that he did not discover the mass on the left Achilles tendon until February 23, 1987, and that Mrs. Moskovitz had continually refused a workup or biopsy.

During discovery, another copy of page 7 of Dr. Figgie's office chart, identical to the copy produced by Dr. Makley during his deposition, was recovered from the radiation department records at University Hospitals, this copy of the record had been received by the radiation department in November 1987, when Dr. Makley referred Mrs. Moskovitz to radiation therapy. It became apparent that the final sentence in the September 21, 1987, entry had been deleted from Dr. Figgie's original office chart sometime between November 1987, when the radiation department obtained a copy of the record, and mid-December 1987, when Dr. Ashenberg received a copy of the record from Dr. Figgie's office. Presumably, that alteration occurred in December 1987 while the original chart was in the possession of Dr. Figgie.

Eventually, Dr. Figgie's entire office chart was reconstructed from copies obtained through discovery. The reconstructed chart contains no indication that a workup or biopsy was recommended by Dr. Figgie and refused by Mrs. Moskovitz at any time prior to August 10, 1987.

In her videotaped deposition, Mrs. Moskovitz claimed that she never refused to have the tumor biopsied. The panel found in favor of all defendants participating in that proceeding with the exception of Dr. Figgie. The panel made the following findings regarding Dr. Figgie:

The jury believed the decedent would have had a very good chance of long-term survival had the tumor been found to be malignant before it exceeded one centimeter in size. The trial court entered judgment in accordance with the jury's verdict.

The court of appeals upheld the finding of liability against Dr. Figgie on the wrongful death and survival claims. The court of appeals found that the appellant was not entitled to punitive damages as a matter of law.

### *Issue*

(1) Is an intentional alteration or destruction of medical records to avoid liability sufficient to show actual malice? (2) Can punitive damages be awarded whether or not the act of altering or destroying records directly causes compensable harm?

### *Holding*

The Supreme Court of Ohio held that the evidence regarding the physician's alteration of the patient's records supported an award of punitive damages, regardless of whether the alteration caused actual harm.

### *Reason*

The jury's award of punitive damages was based on Dr. Figgie's alteration or destruction of medical records. Dr. Figgie's alteration of records was inextricably intertwined with the claims advanced by the appellant for medical malpractice, and the award of compensatory damages on the survival claim formed the necessary predicate for the award of punitive damages based on the alteration of medical records.

The purpose of punitive damages is not to compensate a plaintiff but to punish and deter certain conduct. If the act of altering and destroying records to avoid liability is to be tolerated in our society, the court could think of no better way to encourage it than to hold that punitive damages were not available in this case. Dr. Figgie's conduct of altering records should not go unpunished. The court warned others to refrain from similar conduct through an award of punitive damages.

Dr. Figgie's alteration of records exhibited a total disregard for the law and the rights of Mrs. Moskovitz and her family. Had the copy of page 7 of Dr. Figgie's office chart not been recovered from the radiation department records at University Hospitals, the appellant would have been substantially less likely to succeed in this case. The copy of the chart and other records produced by Dr. Figgie would have tended to exculpate Dr. Figgie for his medical negligence while placing the blame for his failures on Mrs. Moskovitz.

A unanimous panel of arbitrators determined that records were altered with bad motive and that Dr. Figgie was the responsible party. The Supreme

Court believed that the appellate court simply substituted its judgment for that of the jury and, thereby, invaded the province of the finder of fact.

### Discussion

1. Do you consider the evidence sufficiently adequate to establish that the surgeon intentionally altered, falsified, or destroyed the patient's medical records to avoid liability for medical negligence? Explain.
2. If you found it necessary to clarify an entry that you made in a patient's medical record, what procedure would you follow?
3. Is the use of correction fluid the preferred way to clarify your entries?

### Communications: Charting by Exception Risky Business

**Citation:** *Lama v. Borras*, 16 F.3d 473 (lst Cir. 1994)

#### *Facts*

In 1985, the patient, Mr. Lama, was suffering from back pain. Dr. Alfonso, the patient's family physician, provided some treatment but then referred him to Dr. Borras, a neurosurgeon. Dr. Borras concluded that the patient had a herniated disc and scheduled surgery. Prior to surgery Dr. Borras neither prescribed nor enforced a regimen of absolute bed rest, nor did he offer other key components of conservative treatment.

On April 9, 1986, while operating on the patient, Dr. Borras discovered that the patient had an extruded disc and attempted to remove the extruded material. Either because Dr. Borras failed to remove the offending material or because he operated at the wrong level, the patient's original symptoms returned in full force several days after the operation. Dr. Borras concluded that a second operation was necessary to remedy the recurrence.

On May 15, Dr. Borras operated again on the patient. Dr. Borras did not order pre- or postoperative antibiotics. It is unclear whether the second operation was successful in curing the herniated disc. On May 17, a nurse's note indicated that the bandage covering the patient's surgical wound was "very bloody," a symptom which, according to expert testimony, indicates the possibility of infection. On May 18, the patient was experiencing local pain at the site of the incision, another symptom consistent with an infection. On May 19, the bandage was soiled again. A more complete account of the patient's evolving condition was not available, because the hospital instructed nurses to engage in charting by exception, a system whereby nurses did not record qualitative observations for each of a day's three shifts

but, instead, made such notes only when necessary to chronicle important changes in a patient's condition.

On May 21, Dr. Piazza, an attending physician, diagnosed the patient's problem as discitis—an infection of the space between discs—and responded by initiating antibiotic treatment. Mr. Lama was hospitalized for several additional months while undergoing treatment for the infection.

After moving from Puerto Rico to Florida, Mr. Lama filed a tort action in United States District Court for the District of Puerto Rico. While the plaintiff did not claim that the hospital was vicariously liable for any negligence on the part of Dr. Borras, he alleged that the hospital was itself negligent in two respects: (1) failure to prepare, use, and monitor proper medical records; and (2) failure to provide proper hygiene at the hospital premises.

At the close of the plaintiff's case and at the close of all the evidence, the defendants moved for judgment as a matter of law. After the jury returned a verdict awarding plaintiff $600,000 in compensatory damages, the defendants again sought judgment as a matter of law. The district court ruled that the evidence was legally sufficient to support the jury's findings, and an appeal was taken.

### *Issue*

Did the evidence support a jury conclusion that the hospital had been negligent in pursuing a charting by exception policy in the postoperative monitoring of the patient, whereby records were entered in the patient's chart only when necessary to chronicle important changes in the patient's condition?

### *Holding*

The United States Court of Appeals for the First Circuit held that the evidence supported a jury conclusion that the hospital had been negligent by maintaining a charting by exception method of recording notes in the patient's record, which involved charting only important changes in the patient's condition.

### *Reason*

The defendants argued that the plaintiff failed to prove a general medical standard governing the need for conservative treatment. The court disagreed. The plaintiff's chief expert witness, Dr. Udvarhelyi, testified that, absent an indication of neurological impairment, the standard practice is for a neurosurgeon to postpone lumbar disc surgery while the patient undergoes

conservative treatment, with a period of absolute bed rest as the prime ingredient.

The hospital could not seriously dispute that the plaintiff introduced sufficient evidence on the elements of duty and breach. The hospital did not contest the plaintiff's allegation that a regulation of the Puerto Rico Department of Health, in force in 1986, requires qualitative nurses' notes for each nursing shift. Nor did the hospital dispute the charge that, during the patient's hospital stay, the nurses attending to him did not supply the required notes for every shift but, instead, followed the hospital's official policy of charting by exception. The sole question, then, was whether there was sufficient evidence for the jury to find that the violation of the regulation was a proximate cause of harm to Mr. Lama.

The hospital questioned the plaintiff's proof of causation in two respects. First, the hospital claimed that the plaintiff did not prove that the charting by exception policy was a proximate cause of the delayed detection of the patient's infection. Second, the hospital argued that there was no causal relationship between the belated diagnosis of the infection and any unnecessary harm suffered.

There was evidence from which the jury could have inferred that, as part of the practice of charting by exception, the nurses did not regularly record certain information important to the diagnosis of an infection, such as the changing characteristics of the surgical wound and the patient's complaints of postoperative pain. Indeed, one former nurse at the hospital who attended to the patient in 1986 testified that, under the charting by exception policy, she would not report a patient's pain if she either did not administer any medicine or simply gave the patient an aspirin-type medication (as opposed to a narcotic). Further, since there was evidence that the patient's hospital records contained some scattered possible signs of infection that, according to Dr. Udvarhelyi, deserved further investigation (e.g., an excessively bloody bandage and local pain at the site of the wound), the jury could have reasonably inferred that the intermittent charting failed to provide the sort of continuous danger signals that would be the most likely to spur early intervention by the physician.

The hospital claimed that even if faulty record keeping was a cause of the delayed diagnosis, the plaintiff failed to demonstrate a link between the timing of the diagnosis and the harm the patient eventually suffered. Drawing all inferences in favor of the plaintiff, it appeared that he acquired a wound infection as early as May 17 (when a nurse noted a "very bloody" bandage) or May 19 (when Mr. Lama complained of pain at the site of the wound).

The wound infection then developed into discitis on or about May 20 (when Mr. Lama began experiencing excruciating back pain). While there may have been no way to prevent the initial wound infection, the key question then becomes whether early detection and treatment of the wound infection could have prevented the infection from reaching the disc interspace in the critical period prior to May 20. Dr. Udvarhelyi testified that "time is an extremely important factor" in handling an infection. A 24-hour delay in treatment can make a difference, and a delay of several days "carries a high-risk . . . that the infection will [not be] properly controlled." Id. at 481.

The jury could have reasonably inferred that the diagnosis and treatment were delayed at least 24 hours (May 19 to 20), and perhaps 72 hours (May 17 to 20). As a result, the jury could have reasonably concluded that the delayed timing of the diagnosis and treatment of the wound infection was a proximate cause of the patient's discitis.

### Discussion

1. What is charting by exception?
2. What are the pros and cons of charting by exception?

### Communications: Failure on Multiple Levels

**Citation:** *Martin v. Ricotta*, NY Slip Op 32976(U) (N.Y. Sup. Ct., 12/15/2009)

#### *Facts*

The decedent infant was admitted to Stony Brook University Hospital, PICU, to the service of the attending PICU specialist, Dr. Fenton, to determine why the infant developed respiratory dysfunction. During that admission, the infant underwent a tracheostomy based on the need for chronic ventilation. She also had placement of a gastrostomy tube for nutritional support for failure to thrive. Dr. Fenton performed a right femoral central line placement but inadvertently cannulated the artery and immediately removed the line. Thereafter, the infant's right leg was allegedly pale but had a positive femoral pulse; however, decreased and inadequate perfusion of blood through the arterial system of the leg was noted. Ultimately, the infant was seen by Dr. Ricotta, who performed an emergent thrombectomy on the infant's right lower extremity but found no clot. Dr. Jacob was the anesthesiologist who administered anesthesia to the infant plaintiff.

It is claimed that Dr. Ricotta administered 162 mg Papaverine, intraoperatively, which dosage was 27 times the recommended dose. It is further claimed that in addition to the alleged incorrect dose of Papaverine being administered, the Papaverine was contraindicated as the infant was receiving beta-blockers. Shortly after the administration of the Papaverine, the infant went into cardiac arrest. Attempts at resuscitation were unsuccessful, and the infant was pronounced dead in the operating room. It is claimed that these aforementioned alleged departures proximately caused the death of the infant. The plaintiffs subsequently commenced an action against Dr. Fenton, Dr. Jacob, and Dr. Ricotta.

Dr. Fenton and Dr. Jacob claim that it was later learned that the surgical technician employed by Stony Brook University Hospital, Jack Levine, ORT, had "improperly" accepted a vial containing Papaverine, requested by Dr. Ricotta, and that although Levine was not authorized to accept or prepare medications, he failed to advise Dr. Jacob, the anesthesiologist, of that fact. Drs. Fenton and Jacob claim that Levine drew the contents of the vial into a syringe and placed it at the end of the operating table, allegedly without diluting it, and the patient received a lethal dose when the medication was administered by Dr. Ricotta.. Dr. Jacob had advised Dr. Ricotta of the proper dosage of the Papaverine for the infant when asked by Dr. Ricotta. Drs. Fenton and Jacob argue that it was the duty of the circulating nurse, Mr. Cruz, to dilute the medication, and Cruz did not do so that day. Therefore, Drs. Fenton and Jacob argue that they bear no liability in this action.

As per the summary judgment request by defendents Drs. Fenton and Jacob, an order granting summary judgment dismissing plaintiffs' complaint was granted, and the complaint was dismissed with prejudice as asserted against them. The summary judgment request by the defendant Dr. Ricotta to dismiss the plaintiffs' complaint was denied.

### *Issue*

(1) Did the plaintiffs raise factual issues with regard to Dr. Ricotta's use and administration of the Papaverine precluding summary judgment? (2) Did the plaintiffs' expert raise a factual issue with regard to the defendants Dr. Fenton or Dr. Jacob to preclude summary judgment being granted to them?

### *Holding*

It was determined that the plaintiffs have raised factual issues with regard to Dr. Ricotta's use and administration of the Papaverine to preclude summary

judgment in this action. It was also determined that the plaintiffs' expert does not raise a factual issue with regard to the defendants Dr. Fenton or Dr. Jacob to preclude summary judgment being granted to them.

### *Reason*

It is claimed by Dr. Ricotta that he determined in the operating room there was no specific blood clot causing the lack of perfusion and ordered Papaverine to dilate the blood vessel and increase the blood flow. He therefore requested that anesthesia determine the correct dosage of the Papaverine for the infant, and Dr. Jacob, the anesthesiologist, determined a dosage of upwards of 9 mg but eventually agreed on 7 mg. Dr. Ricotta claims it was the responsibility of the operating room staff, specifically the circulating nurse, to procure the medication and to ensure the appropriate dosage was aspirated into the syringe for administration. Dr. Ricotta also claims that the person who scrubbed in, and was later determined to be a surgical technician, prepared the syringe in violation of hospital policy. Dr. Ricotta claims he administered the Papaverine provided in the syringe intravenously over a 5- to 10-minute period, not knowing of the incorrect dosage. When he thereafter left the operating room to speak with the infant's mother, the infant experienced cardiac arrest. Therefore, Dr. Ricotta argues he bears no liability in this action.

Dr. Ricotta did not know who was discharged with the responsibility of drawing up the 7 mg of Papaverine, and stated that normally the nurse draws up the medication. He subsequently learned that Mr. Levine the scrub technician drew up the Papaverine. He believed that Mr. Levine stepped out of protocol by drawing up the medication. Dr. Ricotta testified that the operating room nurse was not in the operating room at the time and he trusted that the syringe he had received was of the correct dosage. He stated that usually the Papaverine is diluted to 1 mg per cc, so when he saw the 7cc syringe and knew they were going to give 7 mg of Papaverine, he made an assumption that it was 7 mg of Papaverine. He infused the drug slowly over 8 to 10 minutes. He and Dr. Jacobs were watching the infant's blood pressure and there were no changes in her vital signs. He let Dr. Rubin, the resident, close the wound and had left to speak to Mrs. Martin but was called back in when the infant went into cardiac arrest. Dr. Fenton was also called in. Resuscitation was not successful. He, Dr. Fenton, and Dr. Jacob thereafter spoke to Mrs. Martin. Dr. Ricotta learned later that the Papaverine had not been diluted, and after that, he was instructed by the hospital not to have further contact regarding the situation. Hospital representatives took over management of the situation; spoke to the infant's pediatrician (Dr. Martinez), jointly

came to the conclusion that there had been a medication error, and through Dr. Biancaniello, strongly encouraged staff not to speak further with the family.

The plaintiffs' expert opined within a reasonable degree of medical certainty that Dr. Ricotta departed from accepted standards in his care and treatment of the decedent infant on May 12 and 13, 2006, firstly, when he ordered and administered Papaverine for the infant, and secondly, when he failed to confirm the dose of Papaverine prior to administering the drug, resulting in the administration of 162 mg, or 27 times the recommended dose. It is the expert's further opinion that the failure of Dr. Ricotta to ascertain the correct dose of the Papaverine, and his administration of the incorrect dose of Papaverine (which could have been avoided), were substantial factors in the cause of the infant's death.

### Discussion

1. Do you agree with the court's decision?
2. Should the staff have been encouraged not to speak to the family? Discuss your answer.
3. Should the hospital bear any fault?
4. From an ethical point of view, what trust issues do you see at play in this case?

### Communications: X-Ray Findings

**Citation:** *Bouley v. Reisman*, 645 N.E.2d 708 (1995)

#### *Facts*

On February 16, 1986, Ms. Bouley was involved in an automobile accident. That afternoon she went to the emergency department at the Malden Hospital because she had been experiencing pain in the area of her left ribs, which were injured in the accident. Ms. Bouley was seen by the defendant, Dr. Reisman, a specialist in emergency medicine and an employee of Emergency Care, Inc. (ECI).

After Dr. Reisman conducted a physical examination of Ms. Bouley, he ordered X-rays taken of Ms. Bouley's left ribs. She went to the X-ray department where four X-rays were taken: three showing the left ribs at different angles, and one a posterior, anterior chest X-ray. She then returned with her X-rays to the emergency department. Because it was after 5 p.m. on Sunday, there was no radiologist on duty when the X-rays were taken.

Dr. Reisman read and interpreted the X-rays, including the chest X-ray. He wrote "OK" on the reading form and discharged Ms. Bouley. He made a discharge diagnosis of "contusion left ribs" and wrote that her condition upon discharge was "good." He then referred her X-rays to the radiology department for review by a radiologist the following day.

The defendant, Dr. Sitzman, a radiologist, was on duty the next day. He read all of Ms. Bouley's X-rays that morning. When he read Ms. Bouley's chest X-ray, he saw an indeterminate density in the right upper lobe of her lung. It was Dr. Sitzman's opinion that the density represented a "significant positive finding" that required further investigation. However, no physician at the Malden Hospital, including Drs. Reisman and Sitzman, informed Ms. Bouley of the presence of the density. Ten months later at the Lahey Clinic, the density seen by Dr. Sitzman was diagnosed as a malignant lung cancer. Ms. Bouley died from lung cancer on February 19, 1987.

### *Issue*

Did the judge have discretion to give detailed instructions to the jury about its role in determining the credibility of witnesses and the inferences it might draw from the direct and circumstantial evidence presented at the trial?

### *Holding*

The judge had discretion to decide whether or not to include the instruction. The appeals court found no abuse of that discretion; the judge gave detailed instructions to the jury about their role in determining the credibility of witnesses and the inferences that they might draw from the direct and circumstantial evidence presented at the trial.

### *Reason*

Dr. Sitzman testified that when the emergency department refers a patient to him, it is his personal practice to report significant positive findings (such as that he saw in Ms. Bouley's chest X-ray) both through a written report and through a telephone report to the emergency department. It was his practice not to ask for anyone in particular when he called but, rather, to give the information to whoever answered the telephone. It was Dr. Sitzman's impression that his oral report of a significant positive finding would always be written down by the person receiving the telephone call in the emergency department. Dr. Sitzman had no actual memory of making a telephone call concerning the Bouley matter but testified that he consistently telephoned

in such situations and must have done so then. The physician who had been on duty in the emergency department the day that Dr. Sitzman read Ms. Bouley's X-rays could not remember any such telephone call. If Dr. Reisman had received a telephone call from Dr. Sitzman, there should have been some notation made in Ms. Bouley's medical record about the contents of the telephone message. No such notation appeared in Ms. Bouley's record.

The plaintiff submitted the following request for an instruction by the judge to the jury:

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If you find that it was required of all personnel in the emergency department at the Malden Hospital on February 16, 1986 to make a written record of any telephone calls made by a radiologist reporting abnormal X-rays and that this written record would be made in the emergency department record of the patient or in an addendum to the patient's emergency department record, you may find from the lack or absence of a written record of such a telephone call in the Lillian Bouley's emergency department records or in the addendum to it, that no such telephone call was ever made by the radiologist in this case.

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The judge did not include the instruction in his charge to the jury. The plaintiff renewed her request. The evidence, however, that there was no notation in Ms. Bouley's record of Dr. Sitzman's telephone call would not necessarily warrant the jury's drawing the inference that Dr. Sitzman did not make the call. The lack of a notation in Ms. Bouley's record could have meant that (1) Dr. Sitzman did not call; (2) Dr. Sitzman did call, but the message he left was not passed on to the emergency department physician; or (3) Dr. Sitzman did call, the message was passed on to a physician, but no notation was made on the record. Therefore, several inferences were possible from the lack of a notation, not just the one that was the subject of the requested instruction.

Further, there was conflicting evidence concerning whether the standard of care expected of a qualified radiologist required a telephone call to the emergency department about the significant positive finding in Ms. Bouley's X-ray. While plaintiff's expert and Dr. Sitzman himself testified that the standard of care required a telephone call, there was evidence from Dr. Sitzman's expert and from Dr. Sitzman (he contradicted his earlier testimony) that the standard of care required only a written report, not an oral report. Consequently, a finding that no phone call was made was not decisive on the issue of Dr. Sitzman's negligence because the jury would still have had to determine whether the standard of care required that he make such a call.

### Discussion

1. Do you consider this case a people problem or a systems failure? Why?
2. What safeguards might the hospital and physicians implement to prevent similar occurrences in the future?

### Communications: Retention of X-Ray Records

**Citation:** *Rodgers v. St. Mary's Hosp. of Decatur*, 597 N.E.2d 616 (Ill. 1992)

#### *Facts*

Mr. Rodgers filed a medical malpractice action in the circuit court of Macon County on May 27, 1986, alleging the wrongful death of his wife, who died at the hospital 2 days after giving birth to their son. Named as defendants in the medical malpractice action were Mrs. Rodgers's obstetricians, her radiologists, and the hospital.

Mr. Rodgers filed a complaint for damages against the hospital alleging that the hospital breached its statutory duty to preserve for 5 years all of the X-rays taken of Mrs. Rodgers (see Ill. Rev. Stat. 1987, ch. 111 1/2, ¶ 157-11 [X-Ray Retention Act]). He claimed that the X-rays were crucial to proving his case against the obstetricians and radiologists.

On April 12, 1988, on motion of the hospital, the circuit court dismissed that complaint without prejudice. Mr. Rodgers amended his complaint and brought a medical malpractice action against the hospital on May 25, 1989, the day after he reached an $800,000 settlement with the obstetricians. In his complaint, Mr. Rodgers alleged that his wife's death was caused by a sigmoid colonic volvulus, and that the condition appeared on an X-ray that the hospital had a duty to preserve. He alleged that the hospital's failure to preserve the X-ray was a breach of its duty arising from the X-Ray Retention Act and from the hospital's internal regulations. Mr. Rodgers asserted that because the hospital failed to preserve the X-ray, he was unable to prove his case against the radiologists. The circuit court entered judgment in favor of the hospital, and Mr. Rodgers appealed.

#### *Issue*

Was there a private cause of action that existed under the X-Ray Retention Act, and did Mr. Rodgers state a claim under the Act?

#### *Holding*

The Supreme Court of Illinois held that a private cause of action existed under the X-Ray Retention Act, and Mr. Rodgers stated a claim under the Act.

### *Reason*

The X-Ray Retention Act provides that "Hospitals which produce photographs of the human anatomy by the X-ray or roentgen process on the request of licensed physicians for use by them in the diagnosis or treatment of a patient's illness or condition shall retain such photographs or films as part of their regularly maintained records for a period of 5 years. . . ." (Ill. Rev. Stat. 1987, ch. 111 1/2, ¶ 157-11).

The hospital argued that the statute is merely an administrative regulation to be enforced exclusively by the Public Health Department. The court disagreed. Nothing in the statute suggests that the legislature intended to limit the available remedies to administrative ones. "The threat of liability is a much more efficient method of enforcing the regulation than requiring the Public Health Department to hire inspectors to monitor the compliance of hospitals with the provisions of the Act." Id. at 619.

The hospital also argued that its loss of one X-ray out of a series of six should be considered de minimus and not a violation of the statute. The court disagreed, finding that the statute requires that all X-rays be preserved, not just some of them. The court concluded that Mr. Rodgers had stated a cause of action against the hospital for failure to preserve the X-ray for use in litigation. Whether the missing X-ray proximately caused Mr. Rodgers to lose his case against the radiologists and to settle for less than the full amount of the judgment is a question for the trier of fact.

### Discussion

1. What records should a hospital maintain?
2. How long should patient records of X-rays, electrocardiograms (ECGs), etc., be maintained?

### Failure to Record Treatment: Below Standard of Care

**Citation:** *Pellerin v. Humedicenters Inc.*, 696 So.2d 590, 96-1996 (La. App. 1997)

### *Facts*

The plaintiff had gone to the emergency department at Lakeland Medical Center complaining of chest pain on February 22, 1988. An emergency department physician, Dr. Gruner, examined her and ordered a nurse, Ms. Tangney, to give her an injection consisting of 50 mg of Demerol and

25 mg of Vistaril. Although Ms. Tangney testified she did not recall giving the injection, she did not deny giving it, and her initials are present in the emergency department record. Ms. Tangney further testified to what she routinely does when administering injections such as the one plaintiff received. Ms. Tangney admitted she failed to record the site and mode of injection in the emergency department records. She said she may have written this information in the nurse's notes, but no such notes were admitted into evidence.

A medical review panel rendered an opinion in favor of Dr. Gruner, Ms. Tangney, and the hospital, finding no breach of the standard of care. However, at trial in 1996, the jury returned a verdict in favor of plaintiff and against Ms. Tangney and awarded $90,304.68 in damages.

### *Issue*

Did the evidence show that the plaintiff's injury was caused by Ms. Tangney's breaching the standard of care required of nurses?

### *Holding*

The appeals court found that there was sufficient evidence to support a jury finding that Ms. Tangney had breached the applicable standard of care in administering an injection of Vistaril into Ms. Pellerin's hip.

### *Reason*

"To prove medical malpractice, the plaintiff must establish by a preponderance of the evidence: the standard of care, a breach of that standard, causation, and damages." A determination of whether a hospital has breached the duty of care owed to a particular patient depends on the facts and circumstances of the case, and in finding or refusing to find a breach of duty, the fact finder has great discretion.

The plaintiff's expert in pharmacology, Dr. Krefft, testified that Vistaril could cause tissue damage if it is not injected into the muscle. Dr. Krefft testified that the plaintiff had nerve damage, that damage to the nerve is consistent with damage to subcutaneous tissue, and that such damage can occur from injection of Vistaril. Dr. Krefft qualified this, however, by stating an injection of anything could cause nerve damage, because the needle itself could be responsible. Both Dr. Krefft and Dr. Chugden (a member of the medical review panel and defense expert in emergency department medicine) testified that cutaneous neuropathy is more likely to be caused by the mechanics of injecting a needle than by the drug being injected.

The verdict of the jury is very much supported by the record. Ms. Tangney admitted that she failed to record the site and mode of injection in the emergency department records. According to the testimony of two experts in nursing practice, failing to record this information is below the standard of care for nursing. While these omissions could not have affected the administration of the injection, they tend to indicate that in this instance Ms. Tangney did not follow accepted procedure while performing her job. The nurses' testimony alone would not necessarily be enough to support the jury's decision, but when it is added to the other evidence presented, the jury's verdict cannot be said to be erroneous.

### Discussion

1. Discuss the theory upon which the hospital is liable.
2. If the nurse had maintained more accurate records, would she have been excused from liability? Discuss your answer.

## NOTES

1. *The American Heritage Dictionary of the English Language,* 4th ed. (New York: Houghton Mifflin Company, 2000), 373.
2. Edwards, T. et al., *The New Dictionary of Thoughts* (Cincinnati, Ohio: Standard, 1977), 636.