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Mold lawsuit highlights serious risk to patients, liability

Families claim mold from construction killed pediatric cancer patients

The deaths of three young cancer patients within a month of each other at St. Joseph's Hospital in Tampa, FL, were caused by toxic mold released during a hospital construction project, according to a lawsuit brought by the parents. Their claims against the hospital could result in a significant payout, and the case is getting the attention of health care risk managers across the country, who are suddenly wondering if they are doing enough to prevent and control the risks from toxic mold in their facilities.

The hospital is facing a daunting adversary in this case. The families are represented by Tampa attorney **Steve Yerrid**, JD, well known in the legal field as one of the lawyers who took on the tobacco industry and won big. That case ended in a settlement in 1997 that awarded the state of Florida $13 billion and Yerrid more than $200 million in fees. Yerrid says he took this case because of what he describes as egregious negligence by the hospital.

Yerrid says the three young patients were exposed to toxic mold by a hospital construction project that was ongoing during their admission. With

EXECUTIVE SUMMARY

A Florida hospital is facing allegations that toxic mold from a construction project caused the deaths of three young cancer patients within a month. The case is bringing more attention to a patient safety risk that experts say must be addressed with stringent policies and procedures for any construction or event involving water damage.

- The Florida case is being brought by a well-known plaintiff's attorney with a track record for winning big verdicts.
- The hospital faces a potentially huge payout.
- Most toxic mold risks can be avoided with preventive steps before and during construction or water damage.

weakened immune systems, they were killed by the fungus in the air, he says. **(See p. 40 for more details on the three deaths.)**

The lawsuit claims that the hospital did not adequately protect the children from the contaminated dust and airborne particles created by demolition and the removal of plaster walls and ceiling tiles. St. Joseph's released a statement saying the hospital does use barriers to keep airborne contaminants out of patient areas during construction projects, and filters also are used. The construction was part of a $1 million renovation to the children's oncology center, which tripled the size of the outpatient area where pediatric cancer patients receive chemotherapy.

Yerrid points out that, unlike many malpractice cases, this case does not allege any negligence or wrongdoing by the clinical staff. Rather, the lawsuit claims that the fault all lies with the hospital itself, which it claims, undermined the good work of the clinicians by not controlling the mold.

"As a matter of course, cancer patients frequently get infections. But when construction occurs, there must be an awareness that the likelihood of fungi being introduced to these poor patients is certainly and significantly increased," he says. "It is well established that this is a risk. It is required that there be protocols in place and that they be rigorously followed."

The case probably will involve debate over how well the protocols were followed, Yerrid says. He says he will make the argument that the protocols for controlling construction dust are not especially complex or difficult to carry out, yet the hospital failed to do so. **(See p. 40 for more on how to prevent mold toxicity.)**

"The message for risk managers ought to be that the simple things that you can do to lessen the risk and the liability exposure should be done without fail," he says. "We worry and fret over the huge things — the complicated delivery of a baby, the transplant procedure, the chronically ill patient — and those things receive great attention. But sometimes the simple things can cause tremendous problems."

Keith Brown, JD, a senior attorney with the New York City Law Department, says the risk from mold lawsuits is "enormous" for hospitals. Mold lawsuits are part of the "toxic tort" area of law, he explains, which began with asbestos litigation.

"Hospitals clearly have an obligation to prevent this kind of exposure, and the trend is for the personal injury bar to pursue this vigorously," Brown explains. "My experience has been that risk managers are much more concerned with medical malpractice, and toxic tort seems to go by the wayside. You hear a lot about medical malpractice and insurance, but you hardly hear any talk or resources going to the environmental concerns like mold exposure."

To address the concerns, Brown says risk managers should be in close contact with the maintenance department and require regular inspections of the ventilation system and the infrastructure, with reports on file to prove that you were doing inspections and making a good-faith effort to deter and detect mold exposures.

"When you can prove that you did the

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inspections and nothing turned up, you're OK," he says. "It's when you didn't even bother to check, or you found something and didn't act on it, that liability is imposed by the law."

Tara Fappiano, JD, a partner with Havkins Rosenfeld in White Plains, NY, with a specialty in mold litigation, and fellow partner **Gail Ritzert**, JD, in Mineola, NY, say risk managers must be aware of all guidelines pertaining to mold abatement and control. Examples include the federal Environmental Protection Administration (EPA) guidelines, the City of New York's Guidelines on Assessment and Remediation of Fungi in Indoor Environmental Environments, and the Centers for Disease Control and Prevention's revised 2001 guidelines, which include planning preventive measures for infection control before hospital construction projects begin.

By familiarizing themselves with the applicable guidelines, Ritzert says, risk managers put themselves in a position to take the steps necessary to prevent or minimize the exposure. They also are in a position to incorporate specific insurance recommendations in vendor and subcontract agreements. For building owners, leases must be changed to reflect need for coverage. Risk managers also should familiarize themselves with the condition under which mold grows and how it spreads to have an idea on what risks lurk behind the walls and ceilings, she adds.

Notify insurer immediately

Fappiano says the first and most natural response when one is faced with the presence of mold is to try to rid the property of the condition immediately. While that is the right idea, she says risk managers should realize there are other important steps that need immediate attention.

"Notice should be given to an insurance carrier as quickly as possible to avoid any argument of late notice. The carrier should also be given the opportunity to inspect and test the condition before any remediation is done. From a health perspective, and because often times mold conditions have not reached a toxic level, this will ensure that appropriate actions are taken to address the problem," she says. "If the carrier disclaims coverage or opts not to test, such testing should still be done. Then, if necessary, it is important to enlist the services of a qualified abatement contractor to remediate the condition."

Post-remediation testing, including surface and air sampling, also is essential to ensure that any potential health hazards have been eliminated, Fappiano says. While the connection between the presence of mold and resulting injuries has been difficult to prove, such testing arguably provides objective evidence that the hazard no longer exists, if there was a hazard in the first place.

On the coverage end, it is essential that the risk manager review the insurance policy very carefully. After a spate of mold claims and litigation, many insurers implemented a mold exclusion to most general liability policies. Even many environmental insurance policies — ordinarily specifically drafted to cover pollution exposures — inserted mold and fungi exclusions to their definition of pollution conditions. **(See p. 42 for more on insurance coverage for mold.)**

If a facility wants to purchase mold coverage, they often must affirmatively provide a copy of their mold management plan to the underwriters. If mold is a concern or consideration, the risk manager must ascertain how each exclusion may apply and take the necessary steps to secure environmental coverage. Additionally, if subcontractors are hired to perform work in an area where mold may be an issue, the risk manager must review the subcontractor's entire insurance policy to ascertain the coverage and exclusions included therein.

The Tampa lawsuit comes as no surprise to the industry experts and those individuals involved in compliance, says **Marlene Linders**, president and CEO of Philders Group International, a consulting company in Heathrow, FL, that addresses mold toxicity. Linders says the emergence of both air- and waterborne pathogens, chemical exposure, and infectious diseases are on the rise. The importance of employee, occupant, and patient safety — and exposure to those biologicals and chemicals —

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has become a major concern, especially during health care construction, she points out.

The need for training and certification involved in the construction process (contractors, builders, developers, architects, engineers, subcontractors, suppliers, and attorneys) is essential, Linders says.

"Contractors are slack on meeting compliance, as well as adherence to requirements. There are no applicable construction standards or protocols for project safety. There are also no specific training and certifications offered unless hospitals engage contractors in their own training program," she explains. "This is neither feasible nor cost-effective for them, so for too many hospitals, the entire process is without any type of checks and balance during the construction activities." ■

Children died from infections related to mold

High-powered Tampa, FL, attorney **Steve Yerrid**, JD, says the three children at the center of the lawsuit against St. Joseph's Hospital did not have to die from toxic mold. If only the hospital had taken the right steps to control the risks associated with a construction project, the children might have survived, he says.

All of the children's infections were traced to aspergillus, a common mold found in soil, air, and construction dust. Most people are not affected by it, but it can be deadly to those with weakened immune systems. Yerrid provides this description of the children's experiences:

• Mathew Gliddon, 5 years old, had been fighting acute lymphoblastic leukemia for three years. During one hospital stay in March 2008, his parents, Mathew and Karen Gliddon, complained to infection control nurses about odors and fumes seeping into the patient's room from smokers and vehicles outside the hospital. They also expressed concern about construction workers mingling with the children as they were transported to the main hospital for treatment. When Mathew died on April 16, 2008, an autopsy showed the cause of death as chemotherapy and a fungi infection.

• Sierra Kesler, 9 years old, was born with Down syndrome and also had acute lymphoblastic leukemia. With her cancer in relapse, Sierra returned to the hospital in April 2008 for treatment and began experiencing significant respiratory distress. She died May 2008, and the autopsy listed the cause of death as fungal pneumonia with underlying leukemia.

• Kaylie Gunn-Rimes, 2 years old, suffered from the same disease, acute lymphoblastic leukemia. In January 2008, she spent three weeks at St. Joseph's for an allergic drug reaction, but tests showed no signs of cancer at the time. By February, she had developed a lung infection and died in May 2008 of respiratory failure. ■

Mold management plan a must for hospitals

Any facility subject to water intrusions from flooding, faulty HVAC systems, or any source of water into the building envelope should have a written mold management plan, says **Suzanne M. Avena**, JD, an attorney with Garfunkel Wild in Great Neck, NY, specializing in environmental law.

Regular facility inspections for mold and moisture should be conducted and protocols put in place on how to address obvious mold within 48 hours, she says. Phone numbers of consultants to call and a designation of internal supervisors assigned to address the issue should be clear. Immediate and effective communications by hospital administration with affected patients and personnel is key.

"I have counseled hospital clients which have discovered mold conditions too late, wherein the employees had already called OSHA and there was a lot of misinformation being disseminated by disparate hospital parties as to the extent of the problem," Avena recalls. "As soon as we took control of the problem, a proactive, corrective plan was in place, and regular communication was conducted with OSHA and hospital personnel to ensure that the health of the occupants was being addressed. Copies of the mold abatement report, including air sampling clearance results, were made available upon request, and medical monitoring was conducted of those occupants who felt they may have been unduly exposed to the mold."

SOURCE

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Other liability that mold presents is during the sale or leasing of facilities. Avena says she has represented facilities in New York City that are over 100 years old, wherein certain portions of the building — although vacated — were in decrepit condition and had to either be remediated or demolished because of mold and other environmental issues before transfer of ownership interest could take place. There are requirements under financial disclosure laws, such as Financial Interpretation Number (FIN 47), whereby the hospital can be exposed to liability if it fails to disclose a cost associated with the restoration and eventual retirement of certain assets such as buildings and equipment.

In addition to lawsuits from both patients and employees, there is potential liability from regulatory agencies, which can initiate enforcement actions against the hospital, Avena says. Such actions may include financial fines and penalties, in addition to required corrective actions. Even though there are no federal laws or regulations pertaining to mold, some states and municipalities have laws and/or guidelines for institutional settings such as schools and hospitals.

"If violations are particularly egregious, the hospital can even be considered criminally liable. If there is substantial physical exposure to occupants, patients can initiate common-law tort actions against the hospital," Avena says. "However, it is not easy to prove causation of injuries as resulting from mold exposure. So many other causes can result in the respiratory and cognitive deficiencies that are symptomatic of toxins from mold. However, just the specter of litigation is a blemish to the public image of health care facilities. Furthermore, the legal and frictional costs of litigation — in terms of taking time away from regular business to respond to law suits — are very expensive and worrisome to administration." ■

SOURCES

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Building materials, cleanup key to mold

Most health care providers are more at risk for mold toxicity than the Florida hospital now facing lawsuits related to pediatric deaths, says one mold suppression expert.

Charles Perry, a principal of Environmental Assurance Group, an insurance carrier in West Hartford, CT, says from what he knows of the Florida case, the hospital was more aware and taking more steps to prevent toxic mold than the average hospital in the country.

"I don't think most hospitals are really aware of this risk at all," he says.

Avoiding mold toxicity and the related liabilities often must start in the earliest stages of planning for a construction project at the hospital, Perry says. Many choices made up front, particularly the type of materials used by the contractors, can determine your risk for mold toxicity not only during the construction, but also for many years down the road.

The materials that will lower the risk of mold formation will cost more than using the cheapest, standard-grade drywall and other supplies, Perry says, but the expense can be worthwhile.

"The lowest bid sometimes doesn't turn out to be the most cost-effective if you have to spend money later on ripping out walls, replacing the material, cleaning up a mold situation, and drawing on your insurance," he says. "It's pennies and nickels in cost differential, but it's a matter of changing habits. You've got to be foolish not to be using the best materials and best building practices."

About 90% of all mold-related insurance claims involve drywall, Perry says. Mold is a living organism that requires moisture, and its favorite food is cellulose, such as the paper on the outside of drywall. That means typical drywall is an ideal environment for formation of mold. Building products that have a nonpaper exterior can go a long way to preventing mold formation, Perry says.

The benefit is so dramatic that insurers are beginning to push for the use of those products, often called "paperless drywall," Perry says.

"Insurers are finding that there is a 50% or greater differential in the exposure for mold liability and they are beginning to reflect that in the cost of the insurance," he says. "You will pay less if you

use these materials that lower the chance of having a toxic mold problem."

Perry also cautions that making the right choices in the planning stages for a project is not enough. You must follow through and constantly monitor to ensure that the right steps are being taken to avoid mold toxicity, that the promises made by your contractors are actually being fulfilled.

Vigilance is important, Perry says, because you cannot trust contractors to know how to prevent and suppress mold. An independent inspector can be useful during the construction process and also as part of your response to any water intrusion that can lead to mold.

Testing for mold is vital for hospitals, says **Robert Weitz**, chief operating officer of RTK Environmental Group, an environmental consulting group in Stamford, CT. Not only does routine testing alert you to a potential problem at the earliest stage, but it also proves your due diligence in protecting your patients.

"The hospital in Tampa may have had a testing program, and this just slipped through for some reason, but what we typically see is that these mold problems become serious when there is no testing program," he says. "It is tempting when money is so tight to cut something like pre-emptive testing and think you can get by without it, but that's when we find problems like this."

Weitz recalls working with one hospital that had a water leak in a patient care area, an incident that often leads to mold formation because the drywall gets wet. The hospital was told to open the walls and expose the drywall so it could dry thoroughly, but administrators balked at the cost of carrying out that advice, about $75,000 in addition to the other cleanup and repair costs.

Because they hesitated and tried to go cheap, the mold continued to spread and, in the end, the hospital ended up with repair bills that were three times what they would have paid if they had done it right the first time, he recalls.

"The thinking today is that you have to treat mold like a fire. You have to address it very aggressively and very quickly. If you're hesitant to spend that extra money to do it right and to do it right now, look at your potential liability," Weitz says. "The first patient you send into that area when you know you haven't done your best to prevent mold exposure, that person is potentially a lawsuit that will cost you far more then in the long run. You could pay millions because you wanted to save $30,000." ■

Insurance recovery may be hard for mold damage

Don't assume that your insurer will cover mold-related liability, cautions **David Dekker**, JD, an attorney specializing in construction for Howrey LLP in Washington, DC.

Insurers began including mold exclusion clauses in general liability and property policies in the late 1990s, as a response to a spike in mold claims and case law determining that the standard pollution clauses did not cover mold claims, he says. To make sure you have coverage for mold claims, Dekker says you can negotiate with the insurer to remove the mold exclusion clauses — not very likely unless you have significant bargaining power — or you can buy a pollution policy or environmental insurance to specifically cover such a claim.

"However, you must be careful when buying one of these pollution policies off the shelf. In my experience they usually are not very clear about whether they cover mold or not, and you don't want to just assume they do," he says. "In most cases, if you push the carrier, they will add an endorsement clarifying that it covers mold, but you can't just buy a pollution policy and think you've covered yourself for mold. It all depends on how they define a pollution event."

Dekker also cautions risk managers to check the credentials of mold consultants carefully to ensure that they are qualified to provide advice on such an important issue. At the same time, however, he says risk managers must be wary of consultants who overstate the risk.

"Some consultants tend to spread a mold hysteria, overreacting when a little bit of mold is found," he says. "Make sure you have people who know what they are doing, but don't get crazy about it. If it rains overnight and there's a little bit of mold forming, you've got to deal with it. But you don't need three guys in space suits showing up at your construction project." ■

SOURCE

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Ruling may up risk for 'apparent authority'

Risk managers take some solace in knowing that not every allegation of malpractice will fall on the hospital, that sometimes the individual physician or physician group will be responsible for defending the claim. But there is cause for concern with a recent court ruling that could increase the chance of the hospital being held responsible under the "apparent authority" concept.

Also known as "ostensible authority," "apparent authority" is the idea that the patient sometimes can reasonably assume the doctor was performing as a hospital employee even if that is not actually the case. The theory was confirmed recently by a New Jersey state appellate court, which held that a hospital may be vicariously liable for a staff doctor whom a patient reasonably believes is providing treatment on behalf of the hospital. In *Estate of Cordero v. Christ Hospital,* the plaintiffs asked the Superior Court of New Jersey to reconsider the trial court's dismissal of vicarious liability claims against the hospital. *(Editor's note: The appellate ruling can be found on the web site: www.sitemason.com/files/hR0RBm/njmalpracticedecision.pdf.)*

The case involved Ramona Cordero, an insulin-dependent diabetic, who was treated by a member of an anesthesiologist group that contracted with the hospital. Before the day of the surgery, Cordero had never met the anesthesiologist, who wore no identification showing his affiliation with the anesthesiology group. He also did not advise Cordero that the hospital assumed no responsibility for the anesthesiologist. Cordero suffered brain damage from the procedure. She remained in a vegetative state until her death 3½ years later.

At trial, the court dismissed the claim for vicarious liability, saying the plaintiffs failed to present evidence either that the hospital "actively held out" the doctor as its agent or that it misled the patient into believing that he was its agent.

The appellate court, however, concluded that affirmative action is not necessary to mislead the patient. In its ruling, the court explained that while a hospital is generally immune from liability for the negligence of independent contractors, such as doctors, there is an exception when the hospital's actions or omissions suggest that the doctors act on its behalf. The court cited a number of factors that can determine whether the doctor has been "clothed with the trappings" of apparent authority:

- whether the hospital provided the physician;
- the nature of the medical care and whether it is typically an integral part of treatment received at a hospital (e.g., anesthesiology, radiology, emergency care, etc.);
- notices of the relationship or disclaimers of responsibility;
- the patient's opportunity to reject care or select a different physician;
- the patient's prior contacts with the doctor;
- special knowledge about the doctor-hospital relationship.

The hospital's contract with the anesthesia group established a system under which the arrival of a specialist with no prior contact with the patient, and who did not explain his relationship with the hospital, could lead a reasonable person to assume that the doctor was an agent of the hospital, the court concluded. Most importantly for risk managers to note, the court pointed out that the hospital failed to take any action to deter this reasonable inference. Considering the circumstances, the appellate concluded that the plaintiffs could pursue their vicarious liability claim against the hospital, and also that the plaintiffs were entitled to a rebuttable presumption that Cordero believed the doctor to be the hospital's agent.

Cases alleging apparent authority are becoming more common, says **Claire Miley**, JD**,** a health care attorney at Bass Berry in Nashville, TN.

"We are seeing a growing number of these cases, especially with respect to hospital-based specialists, such as anesthesiologists, radiologists, and emergency medicine doctors. Courts are making it harder for hospitals to disavow liability for

EXECUTIVE SUMMARY

A recent appeals court ruling in New Jersey could put hospitals at higher risk for "apparent authority" liability in which a jury can hold the hospital responsible for the actions of a nonemployee physician. The case should prompt risk managers to review and improve methods for clearly distinguishing nonemployees.

- Signage and waivers may reduce the risk.
- Apparent authority is not a new threat, but the ruling may solidify its legitimacy in other courts.
- Pay attention to details when describing physician and hospital relationships.

SOURCES

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the actions of these types of doctors, and patients are increasingly successful in asserting that they reasonably believe that these types of doctors 'work for' the hospital," she says. "Thus, with respect to these specialties, hospitals may have to increase their efforts to dispel any impression that the doctor is acting on behalf of the hospital."

Steven R. Antico, JD, an attorney with Garfunkel Wild in Hackensack, NJ, says the New Jersey ruling could have influence across the rest of the country. Some jurisdictions already have dealt with the question of apparent authority and issued similar rulings; but in those jurisdictions without settled case law, plaintiffs may point to the New Jersey ruling as support for their arguments.

"This New Jersey case spoke quite succinctly and clearly, saying a hospital could have additional exposure if it does not take addition steps to eliminate or substantially mitigate that exposure," he says. "The apparent authority doctrine is one that risk managers must seriously consider and ask themselves if they are adequately conveying to patients that a doctor may be providing service in the hospital but is in fact independent of the hospital."

Miley and Antico say hospital risk managers need to put patients on notice that independent staff doctors are not employees of the hospital and do not act on the hospital's behalf. Inserting a disclaimer into the patient's consent to treatment form may help to accomplish this purpose but may not be enough to avoid liability. **(See article, right, for more advice on how to avoid apparent authority.)**

Risk managers should consider having hospital staff specifically call attention to the disclaimer when interacting with the patient. Giving the patient an opportunity to find another physician if the patient does not want to receive treatment from the on-call anesthesiologist, radiologist, or other doctor may further protect the hospital, Miley says.

"Additionally, hospitals may consider removing any hospital insignia from the lab coats and scrubs worn by independent staff doctors and may instead require these doctors to wear identification showing that they are nonemployees," Miley says. "And when hospitals post listings of their independent staff physicians on their web sites, the hospitals may want to make clear that they do not employ these doctors."

None of those steps guarantee that a court won't find apparent authority, but Antico says the efforts establish a record of good faith and intent.

"You can point to all the efforts you made to inform the patient, to make the doctor's status clear and distinct from the hospital," he says. "It still might not be enough for the court, but you'll be in a better position than some hospitals that have to try to argue that the patient should have just known about the intricacies of hospital staffing and physician contracts." ■

Details matter with 'apparent authority'

David V. Kramer, JD, an attorney with DBL Law in Crestview Hills, KY, points out that a disclaimer on the consent form must be worded carefully to ward off claims of "apparent authority."

"The language should be framed in such a way that the hospital doesn't seem to be undermining patients' confidence in the quality of the care provided by doctors or its medical staff," he says. "Also, since many hospitals do employ some hospital-based physicians, this language should be carefully crafted to avoid misleading patients into thinking that no doctors whatsoever work for the hospital, when in fact, some do."

Small details can make a difference in these cases, says **Robert M. Wolin**, JD, an attorney with the law firm of Baker Hostetler in Houston. He recalls an Idaho case in which the court focused on the fact that the physician's scrub shirt had the hospital's name on it. The patient reasonably assumed that the doctor worked for the hospital, the court determined.

"We recommend that you do not allow that kind of misunderstanding by letting contract physicians wear hospital scrubs or other garments that include the hospital's logo. They should wear clothing that clearly displays their own name along with the physician group they belong to," he says. "This can seem like such a

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small thing, even petty, but the courts clearly are saying it matters."

Signage indicating that some or all physicians are independent contractors should be placed prominently, Wolin says, and to the extent possible, patients should be offered the chance to select their own physicians. This would specifically counter one issue cited by the courts.

"That becomes a problem when you have exclusive contracts with anesthesiology or surgery groups," Wolin says. "To the extent that there is an exclusive agreement, it is very likely — barring some very good notification to the patient — that a court would hold the doctor is an agent of the hospital under apparent authority."

Advertising can be a problem when it comes to discouraging apparent authority, Kramer says. Hospitals must be cognizant of the fact that advertising can negate attempts to give patients notice that they don't employ doctors in certain specialties. Wolin agrees, saying there can be a never-ending fight between marketing and risk management on this issue.

"Marketing wants to portray all the doctors and everyone at the hospital as one big happy family. It looks really good in the commercials," he says. "But risk management wants to say, no, they don't belong to us. You have to strike a balance, but you have to know you're taking a risk when you put that kind of image out in the community." ■

How to win that 'unwinnable' case

Every risk manager eventually faces that malpractice lawsuit that seems too big, too tragic, too difficult to fight. When the circumstances are terrible and you can't imagine trying to explain your actions to a lay jury, the temptation can be strong to just settle it and make it go away — even if that means paying a large sum beyond your insurance limits.

No one wants to reach that point, but sometimes it seems the case is just unwinnable. A recent case in Florida, however, serves as a reminder that you shouldn't be too hasty in reaching that conclusion.

In that case, a Fort Lauderdale, FL, jury found an emergency department physician, the nurses, an internist, and a surgeon not responsible for a quadruple amputation on a patient suffering from a kidney stone. The plaintiffs alleged that the amputation was the result of an ED physician's failure to diagnose and failure to properly treat once complications arose. The mother of two, now a quadruple amputee, appeared before the jury and evoked great sympathy, yet the jurors found in favor of the defendants.

So how did the hospital and the other defendants manage a win? **James J. Nosich**, JD, the defense attorney with the firm of McGrane Nosich in Coral Gables, FL, says the defendants knew that they were not responsible for the tragic outcome and insisted on proving that to the jury.

Nosich defended the ED physician along with attorney **Marc P. Ganz**, JD, also of McGrane Nosich. The verdict came on Jan. 12, 2009, when a jury found no liability against the ED physician, the ED nurses, an internist, and a surgeon. Ganz and Nosich say they realized from the outset that sympathy for the patient would present an obstacle to obtaining a fair and impartial jury. However, through extensive jury selection, they were able to convince the jury to set aside the natural sympathy for Lisa Strong, 40-year-old mother of two, and focus on the facts of the case.

The trial took about 10 weeks and consisted of rigorous cross-examination and a battle of the medical experts. The plaintiffs alleged that the

EXECUTIVE SUMMARY

A hospital's experience with a recent malpractice lawsuit shows that even the most challenging cases can be won with good strategy and perseverance. The lawsuit followed an unanticipated quadruple amputation that was sure to evoke sympathy from a jury.
- Careful jury selection was key to the verdict.
- The defendants explained the difficulties facing emergency physicians.
- Many hospitals would have settled for a large sum instead of continuing to fight.

ED physician failed to diagnosis a "classic" presentation of a kidney stone that led to septic shock while the patient was still in the ED. The plaintiffs further alleged that the ED physician failed to properly treat the shock and then provided improper information to the internist over the telephone, causing him not to come into the hospital on a timely basis.

The plaintiffs went on to say all negligence by the subsequent treating physicians was causally connected to the ED physician, since they relied on the alleged medical mismanagement and wrong diagnosis by the ED physician.

"Obviously, this case involved catastrophic damages," Ganz says. "The plaintiff and her family were brought into the courtroom to testify, while experts on her behalf testified as to the significant economic damages associated with quadruple amputations."

The ED was defended on the medicine and the simple fact that although the plaintiff suffered from significant damages, her life was saved by the ED physician, Ganz says. Significant time was spent in trial by the attorneys for the ED physician discussing the disadvantages that plague any ED physician when faced with an unusual presentation of an underlying serious medical condition, he says.

Nosich says the case clearly was a challenge from the outset. The physicians, insurers, and the other parties on the defense side struggled with how to respond, because the plaintiff was asking for far more money than contractual limits of their malpractice coverage. The plaintiffs might have been willing to settle for the insurance limits, Nosich says, but the plaintiff was demanding much more out of pocket.

The defendants couldn't afford to meet those terms, yet they also didn't want to take the case to trial. No one liked the idea of a quadruple amputee mother appearing before a jury.

"You always have to worry, even if you believe the medicine is on your side and you have a good doctor, whether you can overcome the amount of sympathy that comes with that type of case," Nosich says. "I thought that everyone would be held liable because of the sympathy, so I wanted to be one of the defendants who might be held the least culpable percentage-wise. We were prepared mentally to take a hit."

Nosich tried to focus the jury on the medicine, explaining that the patient came to the ED with a kidney stone blocking the ureter, which produced symptoms consistent with a number of conditions, including kidney infection and gallstones. During the work-up for those diagnoses, the patient crashed from severe sepsis. Ischemia of the limbs set in quickly, and it may have been encouraged by the medications that kept the patient's heart beating. The woman survived the incident but the ischemia led to a quadruple amputation.

The malpractice allegation was that the ED physician failed to recognize the obstructed kidney stone quickly enough and get an expedited computed tomography (CT) scan. Everyone in the case acknowledged that a CT scan would have shown the kidney stone, Nosich says, and that would have prompted intervention by a urologist.

"They tried to say it was simple, that if you just removed the kidney stone, everything would have been fine," Nosich says. "I showed the jury that the diagnostic process was much more difficult than that."

Nosich employed several teaching aids for the jury, including moving time lines and PowerPoint presentations. He focused on helping the jurors understand what was reasonable under the circumstances, rather than what would have been ideal in retrospect. **(See story, below, for more details on the defense strategy.)**

Nosich also kept coming back to what he considered the theme of his entire defense, a message that was brutally to the point.

"I told them that she might have lost her arms and legs, but my physician saved her life," he says. "In closing arguments, I told them that every year on her birthday, her kids can bring her flowers and a cake instead of taking flowers to her grave. That's a hard thing to say, but that's really what it came down to." ■

Good witness prep can improve odds

When defense attorney **James J. Nosich**, JD, of McGrane Nosich in Coral Gables, FL, was faced with a seemingly unwinnable case of a quadruple amputee alleging failure to diagnose, he didn't hold out much hope of his client being found not liable. But he vowed to fight, and the defense strategy began with the jury selection, trying to select jurors who could put sympathy aside and concentrate on the facts of the case.

"That effort to redirect them from sympathy to the medicine was started in jury selection and

SOURCES

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continued all the way through the trial and to closing arguments," Nosich says. "At the end, they had to face the plaintiff, who was crying and who obviously needed money. But in the end, they gave her zero dollars, which must have been tough for them."

The plaintiff had asked for $75 million in the closing argument. Nosich says he and his colleague were able to show the jury that emergency department (ED) patients often have underlying medical conditions that complicate their care that cannot be instantly detected or cured by even the best physicians. Nosich spent time explaining the realities of the typical ED, contrasting it with the idealized expectations set forth by the plaintiff's attorney.

"I call that one 'the hospital located in Lawyerland,'" he says. "Plaintiffs' attorneys always think that everything can happen in seconds or minutes and that decisions are always 100% right. But we presented a case that showed you can't demand that the defendants perform as if they were in a hospital in Lawyerland."

Defendant made a good impression

Nosich and Ganz also benefitted from having a physician defendant who made a good impression on the jury.

"I have a philosophy that, even if the physician is wrong, if I can show that she is compassionate, and caring, and smart, and the jury would like to have her as the physician for their own family members. I can win the case every time," he says.

Nosich also attributes part of the win to the physician being thoroughly prepared for deposition and trial testimony. He says he and his team spent nearly 100 hours preparing the physician by going over the facts of the case, presenting sample questions, and coaching her on how to respond to aggressive manipulation by the plaintiff's attorney.

"It's not to fool the jury but to make her aware of the kind of trick questions that she would likely hear, the ways they would try to trip her up, and the kind of mocking that is intended to get under her skin and make her say something she shouldn't," Nosich says. "We used some extraordinary preparation to make sure she could remain composed and show her true self in court, which is the calm, compassionate, caring person that she is at work in the ED." ■

CE objectives

After reading this issue of *Healthcare Risk Management*, the CE participant should be able to:
- **Describe** legal, clinical, financial, and managerial issues pertinent to risk management in health care.
- **Explain** how these issues affect nurses, doctors, legal counsel, management, and patients.
- **Identify** solutions, including programs used by government agencies and hospitals, for hospital personnel to use in overcoming risk management challenges they encounter in daily practice. ■

COMING IN FUTURE MONTHS

■ Safe Surgery Saves Lives program

■ Risks of hiring surgeon temps

■ Hotline alerts managers to problems

■ Continuing education: What you need

CNE Questions

Nurses participate in this continuing education program by reading the issue, using the provided references for further research, and studying the questions at the end of the issue. Participants should select what they believe to be the correct answers, then refer to the list of correct answers to test their knowledge. To clarify confusion surrounding any questions answered incorrectly, please consult the source material. After completing this semester's activity with the **June** issue, you must complete the evaluation form provided and return it in the reply envelope provided in that issue in order to receive a certificate of completion. When your evaluation is received, a certificate will be mailed to you.

13. What does Keith Brown, JD, say about mold toxicity and hospitals?
A. Hospitals have no obligation to prevent mold exposure.
B. Hospitals clearly have an obligation to prevent this kind of exposure and the trend is for the personal injury bar to pursue this vigorously.
C. Hospitals have an obligation to prevent mold exposure only with new construction.
D. Hospitals have an obligation to prevent mold exposure only on pediatric units.

14. According to Charles Perry, what is one way to reduce the risk of toxic mold exposure?
A. Use alternative building materials such as paperless drywall.
B. Use only nonorganic building materials.
C. Avoid masonry whenever possible.
D. Use only "green" building techniques.

15. In *Estate of Cordero v. Christ Hospital,* what did the Superior Court of New Jersey cite as one factor in determining whether a patient could reasonably assume a physician was an agent of the hospital?
A. The patient's state of consciousness and ability to communicate.
B. The patient's opportunity to reject care or select a different physician.
C. Whether the patient expressed any interest in knowing the physician's relationship to the hospital.
D. Whether the hospital billed the patient on the physician's behalf.

16. According to James J. Nosich, JD, what was one key to winning his recent quadruple amputation case?
A. An unlikable, unsympathetic plaintiff.
B. Court rulings that excluded damaging evidence.
C. Malpractice allegations that were clearly frivolous.
D. A defendant physician who was thoroughly prepared for deposition and trial testimony.

Answers: 13. B; 14. A; 15. B; 16. D.

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Failure to diagnose child's bacterial infection leads to amputation: $3 million settlement

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News: A child presents at a hospital emergency department (ED) complaining of a fever and rash. A physician's assistant employed by the hospital examined the child and described the rash in the child's chart. The child was discharged with instruction to see a pediatrician but with no guidance as to how to manage the fever. The child's symptoms became worse, and the child was eventually diagnosed with staph sepsis. The child required amputation of portions of both hands and both feet. A $3 million settlement was reached during mediation.

Background: The plaintiff, a 4-year-old girl, was seen in a hospital ED due to a developing fever and rash with pustules in her mouth. The ED nurse first documented "petical rash" in the plaintiff's chart, later replacing it "pustule rash." As opposed to petechial rashes, which cause red/purple spots that do not blanch on pressure, pustule rashes cause raised bumps on the skin filled with pus. Once triage was completed, the plaintiff was seen by a certified physician's assistant ("PA"). The plaintiff's temperature was taken, and it was discovered that she was suffering from a 103°F fever. The PA documented a "macular/papular rash" in the plaintiff's chart and did not further document the rash in the girl's mouth. In general, rashes may be described as macular (showing flat, red spots), papular (showing small, raised, solid bumps), or macular and papular (a combination of macules and papules). The parents provided further information to the PA by indicating that the plaintiff had brick-red skin and that they were able to write their names into her back by placing pressure on it with their fingers.

The plaintiff was eventually discharged with limited instructions from the PA to visit a pediatrician. The instructions carried with it no referrals of pediatricians in the area, time frames, or treatment suggestions for her ongoing fever. There also is no evidence that the plaintiff was seen by a physician while in the ED. The next day, the plaintiff's condition worsened, and the plaintiff's parents took her to another hospital ED. The subsequent hospital's ED transferred the patient to a third hospital, where she was diagnosed with staph sepsis. Sepsis is a bacterial blood infection that causes high fever, rapid heartbeat and breathing, weakness, dizziness and affected consciousness, and often arises from skin vascular catheters, infected intestine in extremely ill patients or those receiving long-term antibiotic treatment. Sepsis is

often hard to diagnose and treat and may be life-threatening. Common symptoms of staph sepsis include: pain or swelling around a cut, or an area of skin that has been scraped; boils or other skin abscesses; blistering, peeling, or scaling of the skin (most common in infants and young children); and enlarged lymph nodes in the neck, armpits, or groin. Ultimately, the infection became worse and the plaintiff required amputation of portions of both feet and both hands. She was later fitted with prosthetics that gave her the ability to run and walk.

The plaintiff argued that the defendants, through its employed nurse and PA, had been negligent in failing to diagnose the bacterial infection during her first visit to the ED. She further accused that the PA had performed a deficient examination that failed to address the need for additional testing. The plaintiff believed that she should have been seen by a physician at some point during her visit and not solely by a PA.

The defendant contested plaintiff's allegation stating that the PA's examination and diagnosis of the plaintiff was proper based on the type of rash observed and the fact that it was consistent with a viral infection. The defendant further argued that the bacterial infection that later arose in the plaintiff is extremely rare and that the plaintiff's parents should have returned the girl to the defendant's ED for proper treatment.

The parties reach a settlement during mediation in the amount of $3 million.

What this case means to you: This child presented with what appears to be a classic case of a well-known childhood malady, scarlet fever. Given her symptoms, any health care practitioner familiar with the treatment of children should have been suspicious that this child had some form of bacterial infection. The fact that the ED staff at the first hospital missed this altogether speaks to the need to have triage professionals who have pediatric experience available to assess and treat children in hospital EDs. The ED staff providing emergency services to the community at large should, at the very least, be trained in one of the most common of childhood illnesses, streptococcal infection.

The rash is the most striking sign of scarlet fever. It usually begins appearing like a severe sunburn with tiny bumps that may cause itch. Areas of rash usually turn white when pressure is applied to them. The rash will usually appear initially on the neck and face and later spreads to the trunk, and then to the rest of the body. In body creases, especially around the underarms and elbows, the rash forms classic red streaks. The palms of the hands or soles of the feet are not affected and are pale in contrast to the "scarlet hue" of the outer skin surfaces.

Aside from the rash, there are usually other symptoms that help to confirm a diagnosis, including a reddened sore throat, and a fever above 101° F (38.3°C). The tonsils and back of the throat may be covered with a whitish coating, or appear red, swollen, and dotted with whitish or yellowish specks of pus. Early in the infection, the tongue may have a whitish or yellowish coating. A child with scarlet fever also may have chills, body aches, nausea, vomiting, and loss of appetite. Headache also is a frequent complaint. It is common for the child to first complain about a very sore throat that appears red to the eye, and the tongue often has a coated appearance. The child will have difficulty swallowing, as the lymph nodes of the neck are frequently swollen and tender to touch.

Group A beta-hemolytic *Streptococcus,* or *Streptococcus pyogenes*, causes scarlet fever. This is the same bacterial infection that causes strep throat, but the strain of bacteria causing scarlet fever releases toxins that produce the rash. Strep can spread from one person to another by fluids from the mouth and nose. In rare cases, scarlet fever may develop from a streptococcal skin infection such as impetigo. In those cases, the child may not experience a sore throat or related symptoms.

If a person infected with this bacterial infections coughs or sneezes, the bacteria can become airborne. Alternatively, the bacteria may be present on things the person touches, such as toys or other objects in a day care setting. If the child had been around other infected individuals, she may have inhaled the bacteria or may have touched something that was contaminated and then touched her own nose or mouth, thereby transmitting the bacteria. The incubation period of the bacteria usually is two to four days.

If scarlet fever is not treated, a person may be contagious for a few weeks even after the illness itself has passed. In rare cases, someone may carry scarlet fever strep bacteria without being sick. Therefore, it is difficult to know if you have been exposed. Strep bacteria also can contaminate food, especially milk, but this mode of transmission is not as common.

For those reasons, strep throat is the scourge of institutional settings where children congregate. Children 5 to 15 years of age are more likely than

other people to get scarlet fever. The bacteria make a toxin that can cause the scarlet-colored rash, but not all streptococci bacteria make this toxin and not all kids are sensitive to it. Two kids in the same family may both have strep infections, but one child (who is sensitive to the toxin) may develop the rash of scarlet fever while the other may not.

More common complications that may result from untreated scarlet fever include bacterial infection of the blood or sepsis, otitis media, meningitis, endocarditis, pneumonia, pus-filled abscess in the throat, sinusitis, and skin infections, all of which are common in children and extremely contagious.

Scarlet fever rarely results in serious complications, but without proper treatment conditions such as rheumatic fever, an inflammatory disease that can affect the heart, joints, skin, and nervous system may occur. Long-term effects may include damage to heart valves and other heart disorders that were common before the advent of antibiotics. Appropriate treatment of strep bacteria infection greatly reduces the risk of rheumatic fever. Complications also can cause kidney damage, and some researchers believe strep bacteria infections are associated with an autoimmune disorder that significantly exacerbates psychiatric symptoms in children who have neuropsychiatric disorders.

Acute *Streptococcus pyogenes* infections also may present as a form of cellulitis, which is an infection of the deep layers of the skin. Invasive, toxigenic infections can result in necrotizing fasciitis, myositis, and streptococcal toxic shock syndrome. This is an extreme and rare presentation, but left untreated, *Streptococcus pyogenes* can be deadly.

Diagnosis is relatively straightforward, as this is a common illness among school-aged children. An exam to determine the condition of the child's throat, tonsils, and tongue is conducted. The neck is examined to determine if lymph nodes are enlarged. The appearance and texture of the skin rash is assessed. If your doctor suspects strep as the cause of the child's illness, he or she also will swab the back the throat to collect material that may harbor strep bacteria. Tests for the strep bacterium are important because a number of conditions can cause the signs and symptoms of scarlet fever, and those illnesses may require different treatments. If there are no strep bacteria, then some other factor is causing the illness.

A physician may order one or more laboratory tests such as a throat culture, which is reliable but can take up to two days to make a strep diagnosis. Another common test is the rapid antigen test, which can be completed during a physician visit and is used to detect antigens associated with strep bacteria infection but is less reliable than a throat culture.

The physician also may be able to order a relatively new rapid test that uses DNA technology to detect strep bacteria from a throat swab in a day or less. These tests are at least as accurate as throat cultures, and the results are available sooner. This would be the test of choice in an ED situation where the technology would be more readily available and quicker, more accurate results are preferred.

The fact that the ED staff at the first hospital missed this all together speaks to the need to have triage professionals who have pediatric experience available to assess and treat children in hospital EDs.

If the child has scarlet fever, the physician will likely prescribe a broad-spectrum antibiotic medication. If the child does not improve within 24 to 48 hours after starting the medication, the physician should be notified as the antibiotic may not be sensitive to the bacterial strain. Penicillin was the gold standard for many years, but with the emergence of resistant organisms, a culture and sensitivity is conducted on the throat scab, and other new-generation antibiotics may be necessary.

The child must complete the full course of prescribed antibiotics as directed by the physician, even when the child begins to feel better. Failure to follow the treatment guidelines may not completely eradicate the infection and will increase the child's risk of developing post-strep disorders. The child will no longer be contagious after 24 hours on antibiotics and can return to school when he or she is feeling better and no longer has a fever.

While scarlet fever seems to apply to this case given the narrative, an alternate possibility is staphylococcal scalded skin syndrome (SSSS), which presents as an acute exfoliation of the skin following an erythematous cellulitis. It is caused by an exotoxin from a staphylococcal infection.

Similar to the toxins produced by *Streptococcus pyogenes*, this toxin is produced by *Staphylococcus aureus*, a prodromal localized *S. aureus* infection of the skin, oral or nasal cavities, throat, or GI tract. Such an infection often is not apparent before the SSSS rash appears. Staphylococcal scalded skin syndrome presents as a red rash followed by diffuse

epidermal exfoliation. There are similar symptoms common to both *Streptococcus* and *Staphylococcus* such as fever (although some patients may be afebrile), irritability, general malaise, tenderness to palpation, diffuse erythematous rash with a sandpaper-like appearance that is accentuated in flexor creases.

A difference in the presentation between the two organisms is the appearance of the skin. In a staphylococcal infection, the rash looks blistered with ill-defined blebs below the epidermis. Nikolsky's sign may be present where gentle stroking of the skin causes separation at the epidermis. Exfoliation of skin may be patchy or sheet-like in nature. Involvement may occasionally be localized or patchy rather than diffuse. Facial edema may be present, and dehydration may be significant. Most children do not appear severely ill.

SSSS primarily is a disease of children. Most children (62%) are younger than 2 years, and almost all (98%) are younger than 6 years. Reports are increasingly implicating community-acquired methicillin-resistant *Staphylococcus aureus* (MRSA) as a cause of SSSS. The narrative refers to staph sepsis, but this child's presentation was more in keeping with *Streptococcus,* particularly the necrotizing fasciitis that was the likely cause for her amputations. Definitive diagnosis for either is made virtually in the same manner through an accurate oral history from the parent, visual assessment, and laboratory testing. Antibiotics sensitive to the particular organism are ordered.

With all of this said, it is evident that the ED nurse and the PA at the first hospital encounter seriously missed the signs and symptoms of common strep or staph infection. The narrative does not indicate if an oral history was obtained from the parents of the child. Questions that should have been asked and documented include: The duration of the fever? When the rash initially started and how did it appear? How extensive was the rash? Did it look flat and angry or was it lumpy and bumpy? Was the child nauseated? How did she act before she became obviously ill? Did she complain of a headache or a sore throat? Does she have a stiff neck or swollen glands? Did she have a recent traumatic skin laceration or abrasion?

A social history also is helpful in diagnosing childhood illnesses, as children frequently spread the same illness among themselves. Does the child attend school or day care? Are any other children in the class sick? Are skin rashes going around? Is MRSA an issue at the center? Do any other family members have a cold or sore throat? Was she listless, sleepy, or lethargic? Was she irritable and cranky?

The answers to those questions are the key to substantiating the suspicion of scarlet fever or staph infection. The next step would include some form of laboratory testing to affirm the diagnosis and isolate the proper organism. The narrative does not indicate that either occurred in this scenario. The parents and child apparently left the ED without medication, which was, most likely, the root cause of the serious progression of her condition.

An accurate assessment of her mouth and throat, together with palpation of the neck, also would be telling. Given this presentation, a board-spectrum antibiotic would have most likely been effective in preventing or at least containing the ensuing sepsis until a full culture with sensitivity panel could be returned and reviewed.

This child's untreated infection led to the necrotizing fasciitis that eventually claimed her hands and feet. Had she been correctly diagnosed when her parents had first sought help, she would have been well and healthy within a week to 10 days. There was no evidence of any discharge planning in this case, which is a mandatory obligation on the part of both the attending medical staff and the hospital providing the services.

The child was referred to a pediatrician, but without the due haste that this situation demanded. The PA obviously had limited knowledge of pediatric conditions and should have consulted a physician before dismissing the child and her parents from the ED. They were not provided instructions on how to manage her care at home, what to be on the lookout for in terms of possible complications, how to safeguard the spread of the disease to other members of the household, and when the child may return to school/day care. They were given no follow-up appointments, as this type of infection should be recultured to assure that the antibiotic was effective. This child had a high fever that is more common in a bacterial infection than with a viral infection, but the PA seemed to have fixated on a viral diagnosis.

Given the long-term, life-altering impairments affecting a 4-year-old child that were obviously the result of a serious misdiagnosis, the hospital was wise to settle this case. Juries are particularly sensitive to cases involving children and the extreme suffering those children endure as a result of often careless mistakes.

(Editor's note: This case involved anonymous parties in Orange County, CA.) ■