LEGAL EAGLE EYE NEWSLETTER

February 2024 *For the Nursing Profession* Volume 32 Number 2

Nurse As Patient Advocate: No Evidence That The Physician Was On The Wrong Path.

The legal case against the hospital focused on its nurses' actions after a patient experienced a stroke during a cardiac catheterization procedure.

As to the hospital, the patient's lawsuit alleged negligence in that the nurses failed to speak up or go up the hospital's chain of command to advocate with the cardiologist for a different medical course of action once it became known that the patient had suffered an acute stroke.

The cardiologist elected to administer medication to attempt to reverse the stroke and sent the patient to the hospital's ICU.

A CT was ordered in the ICU. That involved some delay for a radiology tech to return to the hospital after hours to perform the scan that was then promptly read remotely by a radiologist.

The cardiologist continued with anticoagulant medications in the ICU for another two hours, then ordered the patient transferred to another hospital, where another CT was done and then a craniotomy after which the patient was left with profound brain damage.

In the patient's lawsuit a completely different hypothetical course of action was spelled out for the cardiologist to have followed, and the nurses to have advocated for the patient.

That included immediate initiation of stroke protocols and immediate transfer to a higher-level care setting.

Liability for a nurse's failure to advocate with the physician on the patient's behalf presupposes that the physician was pursuing a course that constituted negligence, which could have been reversed by the nurse's advocacy.

If the physician's care was not negligent, a nurse cannot be blamed and held liable for failing to insist on a different course of action.

COURT OF APPEALS OF KANSAS
December 29, 2023

The Court of Appeals of Kansas rejected the faulty legal reasoning behind the family's legal arguments.

Nurses' liability exposure for failing to advocate with the physician for a different medical course of action presupposes that the course being pursued by the physician was itself negligent.

If the physician was not guilty of negligence under the circumstances, notwithstanding the light of 20/20 hindsight, there was no duty for the nurses to attempt to correct the physician through advocacy on the patient's behalf.

In this case the cardiologist settled with the patient prior to trial. Nevertheless the negligence of the cardiologist was still an issue for the jury. The jury still had to decide the legal case against the hospital for the nurses' alleged failure to advocate for the patient, and the hospital's exposure still could be mitigated by the cardiologist's own responsibility for the outcome.

The jury ruled the cardiologist's handling of the case after the occurrence of the stroke was not negligent.

With nothing to be found wrong with the physician's own handling of the case, legally there could be no negligence by the nurses for failing to advocate for a different course of action, regardless of how promising that might seem in the light of hindsight. **Nuesses v. Hospital, 2023 WL 9016152 (Kan. App., December 29, 2023).**

Inside this month's issue...

February 2024

New Subscriptions See Page 3

Nurse As Patient Advocate/Physician's Negligence/Liability
Spoliation Of The Evidence/Video Recording - Spoliation/Chart
Spoliation Of The Evidence/Anesthesia Monitor Strips Not Printed
Nursing Faculty/Publish Or Perish/Discrimination - Retaliation
Patient Abuse - Home Health/Reasonable Accommodation
Prison Nursing - Choking - Drainage Tube/Retained Inside Patient
Care Plan/Ordinary Negligence/Professional Negligence
EMTALA/Patient Removed - Sexual Assault Nurse Examiner

Resident Fall, Video Recorded Over, No Spoliation Of Evidence.

A wheelchair bound seventy nine year old resident was admitted to long term care with a primary diagnosis of dementia, after experiencing several falls at home.

She was assessed as a high fall risk on admission. The fall prevention interventions included in the care plan were not specified in the court record. The only reference made in the court record was that the defendant nursing facility had two expert witnesses who testified that the care plan itself was wholly adequate to meet the resident's needs.

Nevertheless, the resident fell numerous times in the facility. She went home a month after the last fall and died two months later from aspiration pneumonia.

The crux of the family's legal case against the facility was that the video surveillance system that had recorded several of the first falls automatically re-recorded over the memory of those incidents, rendering the video record lost forever.

The family urged the court to rule in their favor under the legal doctrine of spoliation of the evidence.

That doctrine empowers a court to punish a guilty party for destruction of critical evidence, all the way to the guilty party being held liable on what the lost evidence would be presumed to show.

No Spoliation of the Evidence

The New York Supreme Court, Appellate Division, refused to apply the doctrine of spoliation of the evidence.

If a lawsuit had been filed, or even a formal complaint or settlement demand been tendered, the nursing home would have been on notice of a duty to preserve any and all evidence potentially relevant to the case, especially evidence that would permit the opposition to make their case.

However, there was no suit pending and no claim or demand had been tendered at the time the video surveillance automatically reset itself and recorded over the record for the time frame in question.

There was no intentional or mistaken action that destroyed the evidence. It was lost in the ordinary course of business and was nobody's fault. **Van DeVeerdonk v. Nursing Center, __ N.Y.S. 3d __, 2024 WL 172939 (N.Y. App., January 17, 2024).**

A litigant should not be penalized for having discarded something in good faith pursuant to the litigant's normal business practices before litigation was pending or a specific legal claim was received.

An obligation for the party in control of the evidence to have preserved it at the moment in time when the evidence was destroyed must be proven by a litigant who seeks to hold their opponent guilty of spoliation of the evidence and eligible for a penalty from the court.

The party who destroyed the evidence may have done so intentionally or negligently, after being placed on notice of an obligation to preserve it.

Further, the court must be convinced that the evidence in question would have been supportive of the legal position of the opponent of the party who destroyed the evidence.

The penalty imposed on a party who has been adjudged responsible for spoliation of the evidence can include dismissal of certain aspects of their legal claim or defense.

The ultimate sanction is that the case can be decided in its entirety against the guilty party.

NEW YORK SUPREME COURT
APPELLATE DIVISION
January 17, 2024

Full Compliance With Disclosure Order: No Spoliation.

The trial judge decided to sanction a physician defendant in a patient's lawsuit, by instructing the jury that they could draw an adverse inference from the fact several items of evidence were not turned over to the patient's legal counsel.

There is no evidence the physician intentionally or even negligently failed to obey any order of the court to turn over patient records to the other side.

There was no basis to apply the legal rule of spoliation of the evidence.

NEW YORK SUPREME COURT
APPELLATE DIVISION
January 18, 2024

The New York Supreme Court, Appellate Division, overruled the trial judge's decision and exonerated the physician.

Point one was that most of the material that was sought by the patient's attorneys was in the patient's hospital chart. The physician did not have physical custody of the chart or any method of control over what the hospital did or did not do with the chart or personal responsibility for the hospital's action or inaction.

In fact the hospital turned over a certified copy of the hospital chart as the hospital was required under the discovery rules.

Missing from the chart were a typewritten rendition of a physician's handwritten chart entry that was in the chart, and an original bladder scan, for which a summary report from the chart was turned over.

Both of these issues the Court deemed inconsequential.

There was no proof the physician, after being put on notice that a claim was being made against him that would be followed with a civil lawsuit, made any effort to remove or destroy anything from the chart, evidence or not. **Richardson v. Physician, __ N.Y.S. 3d __, 2024 WL 187072 (N.Y. App., January 18, 2024).**

Monitor Memory Cleared Before Strips Printed: Court Declines To Find Spoliation Of Evidence.

The patient passed away ten days after an incident in the operating room during hip replacement surgery.

Problems began when the heart rate dropped dramatically, and CPR was not started immediately.

The drop in the heartrate would later be alleged to have been caused by incorrect, that is, excessive dosages of propofol and fentanyl administered by the nurse anesthetist.

Further negligence was alleged in the failure of the anesthesiologist to realize the drop in the heartrate had been medically induced by the operative narcotics, followed by failure to administer Narcan.

Instead, the anesthesiologist thought it was a pulmonary embolism and went ahead accordingly.

The pre-suit medical review panel cleared every member of the surgical team from fault, except the nurse anesthetist.

In an apparent attempt to bring the hospital, the surgeon and the anesthesiologist back into the case, the family's attorneys petitioned the court to apply the legal doctrine of spoliation of the evidence.

The focus of that tactical maneuver was the fact that no paper strips were printed from the anesthesia monitor and placed in the patient's chart, as was the hospital's usual and customary practice.

The hospital's protocol required the circulating nurse to ensure that all relevant documentation was included in the patient's chart.

The hospital made it incumbent on the surgical team to see that paper strips were printed from the anesthesia monitor and placed in the chart.

Printing the paper strips was to take place immediately, given that the monitor could only store electronic data from two cases, and would automatically delete all the data from the older of two stored cases when a new case was started.

The monitor here was apparently cleared manually rather than by default.

That being said, it is evident that the hospital was not put on notice of a potential legal claim until two weeks after the data was expunged from the monitor with no strip printed.

UNITED STATES DISTRICT COURT
LOUISIANA
January 17, 2024

No Spoliation of the Evidence

The US District Court for the Eastern District of Louisiana ruled expressly that the hospital did not follow its established protocol, which was to clear the monitor memory only after printing paper strips, and in doing so may have destroyed evidence useful to litigants suing the hospital.

However, the legal doctrine of spoliation of the evidence did not apply and did not afford the family a leg-up in the lawsuit, because the hospital technically was not on notice of a legal claim until days after the incident. The electronic memory of the anesthesia monitor apparently was expunged the same day as the procedure.

Hospital risk management received a letter from the patient's father requesting a copy of the patient's chart. Days later another letter was received, this time from a lawyer, requesting a copy of the chart.

Both letters were ignored. Neither was accompanied by an authorization for release of medical information signed by the patient while he was still alive, or by the personal representative of the estate. The patient's death occurred in between the sending of the two letters.

Nevertheless, if received before the electronic data was gone, either letter would have given the hospital the requisite legal notice to impose the duty to preserve anything a reasonable person would reckon to be potential legal evidence.

The Court did point out in passing that there were other ample sources of evidence for the family to bring a successful lawsuit. **Schafer v. Physician, 2024 WL 183587 (E.D. La., January 17, 2024).**

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

© 2024 Legal Eagle Eye Newsletter

Published monthly, twelve times per year.

Print edition mailed First Class Mail

Electronic edition distributed by email file attachment to our subscribers.

E. Kenneth Snyder, BSN, JD
Editor/Publisher

PO Box 1342
Sedona AZ 86339-1342
(206) 718-0861

kensnyder@nursinglaw.com
www.nursinglaw.com

Clip and mail this form. Or order online at www.nursinglaw.com/subscribe

Print $155/year ______ Electronic $120/year ______
Check enclosed _____ Bill me _____ Credit/Debit card ______
Visa/MC/AmEx/Disc No. ________________________________
Signature ________________________________
Expiration Date __________ CVV Code ______ Billing ZIP Code _______

Name ________________________________
Organization ________________________________
Address ________________________________
City/State/Zip ________________________________
Email for Electronic Edition* ________________________________

***Print subscribers are also entitled to Electronic Edition at no extra charge.**
Legal Eagle Eye PO Box 1342 Sedona AZ 86339-1342

Publish Or Perish: Nursing Faculty Member Denied Tenure, Discrimination Case Dismissed.

A university nursing faculty member who was born in China taught several years with the title assistant professor.

Finding her work satisfactory, the university renewed her employment with a two-year contract as an assistant professor in anticipation of a review at the end of her contract for permanent faculty tenure.

When the time came, she was not recommended for tenure and was informed her contract would not be renewed when it ran out several months later.

Right away she filed a charge of discrimination with the US Equal Employment Opportunity Commission, and when her contract ran out filed a lawsuit in US Federal Court.

The US Court of Appeals for the Sixth Circuit (Michigan) dismissed her case.

Her case was based on the plainly undeniable fact that six US born Caucasian colleagues in her tenure class achieved tenure, and she did not.

The Court, however, ruled it was necessary to examine the tenure decision process in detail to see if she and her so-called comparators were essentially similar in all respects except for non-minority status.

First of all, the Court believed that success, or lack of success, in contributing to peer-reviewed literature in the field is a legitimate basis for tenure, or denial of tenure, to a university faculty member.

It was undeniable that several of the comparators had each written or co-authored a handful of published articles, compared to her one such accomplishment.

Only one comparator was remotely similar, who co-authored one published study but had another that was accepted and was in the review and rewrite process.

No Retaliation

The alleged victim here could not claim her contract was not renewed in retaliation for her EEOC complaint.

True, her contract expired after she filed her complaint, but she had been notified before she filed her EEOC complaint that that would occur when the contract ran out, due to her inability to qualify for permanent tenure. **Lan Yao v. University, 2024 WL 209448 (6th Cir., January 19, 2024).**

A minority employee can show a prima facie case of discrimination based on differential treatment.

The employer can defeat the prima facie case by showing an ostensibly legitimate, non-discriminatory rationale for the differential treatment.

The employee then has the option to show the employer's given rationale is only a pretext for illegal discrimination.

The employee can prove pretext as the employer's motive by identifying one or more comparators.

A comparator is a non-minority employee similar to the minority alleged discrimination victim in all relevant respects except minority status, who was treated better or less harshly that the alleged victim.

The courts are very strict about the similarity that must be found between the alleged victim and the comparators, in all respects except minority status.

All of the non-minority comparators were faculty members who had published or co-authored more peer-reviewed material that the alleged victim and had made a larger contribution to knowledge in the field.

UNITED STATES COURT OF APPEALS
SIXTH CIRCUIT
January 19, 2024

Retaliation: Court Questions Taking Back Flexibility On Job Requirement.

A nurse was hired as a perioperative nurse educator for the hospital's surgery department.

One expectation at the time of her hiring was that she complete her perioperative nurse certification within ninety days.

She did not obtain the certification as planned within ninety days, but was assured several times that the deadline was flexible and would not affect her job.

That flexibility remained in effect until a complaint to the Joint Commission was traced to the nurse, having to do with orthopedic techs allegedly practicing beyond the scope of their competence.

The hospital successfully smoothed things over with the Joint Commission, then fired the nurse.

Adverse personnel action against an employee following closely in time after a complaint to an outside authority can be presumed to be motivated by an intent to retaliate.

CALIFORNIA COURT OF APPEAL
December 28, 2023

The California Court of Appeal ruled the nurse had grounds to sue for retaliation.

She was assured the requirement was flexible that she obtain a certification, then was abruptly fired for failing to meet the certification requirement on time.

Firing someone for not getting a needed certification might seem on its face to be legitimate. It might not be legitimate if it followed soon after a legally protected activity like making a complaint to an outside agency or authority as to a violation of patient health and safety standards.

The law varies from state to state on how long a presumption of retaliation persists between a protected activity by an employee and adverse personnel action. California is especially employee friendly on this issue. **Johnson v. Hospital, 2023 WL 8947093 (Cal. App., December 28, 2023).**

Abuse: Physical Or Psychological Injury Is Not A Requirement.

An aide was assigned to work with sixteen patients, including one who was seventy-one years old, nonverbal and suffered from a profound intellectual disability and other medical issues.

The aide wanted the resident to get out of bed so that the aide could remake the bed that the resident had soiled.

The resident did not respond, so the aide pulled him out of bed and down to the floor and then scooted him along by pushing him bodily with his foot.

The episode resulted in an administrative finding that the aide was not guilty of abuse, due to the fact the resident was not actually hurt.

In judging whether a caregiver's actions fit the legal definition of abuse, warranting being barred from future caregiving employment, it is not necessary to prove that the victim sustained any physical or mental injury.

Nor is it a defense that the victim was not physically wounded or made to suffer pain or mental distress.

The focus is solely on whether the caregiver willfully engaged in potentially injurious action.

COURT OF APPEALS OF
NORTH CAROLINA
January 2, 2024

The Court of Appeals of North Carolina ruled the finding of no abuse was legally erroneous, for focusing on the effect on the victim rather than the conduct of the alleged abuser.

Kicking or pushing a vulnerable person across the floor with one's foot is unacceptable behavior by a caregiver, regardless of the effect it has. **Department v. Aide, 2024 WL 16282 (N.C. App., January 2, 2024).**

Home Health: Employer Can Designate Direct Care As An Essential Job Function.

For an employee with a disability to qualify for protection under the anti-discrimination laws they must fit the definition of a qualified individual with a disability.

A qualified individual with a disability is one who can fulfill the essential functions of the position, with or without reasonable accommodation.

By definition, an accommodation sought by an employee that would dispense with the ability to perform an essential function of the job is not a reasonable accommodation and not something to which a disabled individual is entitled.

What the essential functions of a particular employee's position are is decided by the courts on a case by case basis.

It is a mixture of the employer's written job description and the actual practice in the employer's workplace as to what is customarily expected of employees who are not considered to have a disability.

The employer's job description is not the final word or the end or the analysis as to what is really essential in the specific employee's workplace.

UNITED STATES COURT OF APPEALS
FOURTH CIRCUIT
January 17, 2024

A nurse spent the last seventeen years of her forty year nursing career with the same home health agency.

After she had to have bilateral knee replacement surgery she gradually transitioned to a supervisory role that involved dropping in and checking on the direct-care nurses and possibly doing light tasks like drawing blood.

When the pandemic arrived, the agency was faced with increased patient demand and decreased ability to field direct care nurses. A directive went out that all nurses were absolutely required to be available for direct care, regardless of any accommodation to their role in the past.

A series of emails were exchanged with agency management, to the effect the nurse required a dispensation from direct care due to the residual problems with her knees, and management's adamant refusal to budge from the direct-care mandate.

The nurse was fired and sued for disability discrimination.

No Disability Discrimination

The US Court of Appeals for the Fourth Circuit (Virginia) ruled the nurse was not entitled to an accommodation in the form of a dispensation from direct patient care due to her disability.

Federal law lists the factors that determine whether a proposed accommodation is reasonable that dispenses with the employer's job description.

The first factor is the job description itself, that presumably was communicated to the employee when they applied or were interviewed. The employer's discretion is given great weight, but is not final.

Other factors that must be considered are how much time is spent on the job performing the essential function, and the experience of other employees with the allegedly essential function.

The classic example is a discriminatory requirement to be able to lift fifty pounds, which a disabled employee is unable to fulfill and is denied an accommodation, in a workplace where no one is ever actually required to lift fifty pounds. **Tartaro v. Home Health, __ F. 4th __, 2024 WL 174357 (4th Cir., January 17, 2024).**

Prison Nursing: Nurse Violated Inmate's Rights, Was Deliberately Indifferent.

A prison inmate complained to the prison nurse for almost three weeks that he was in serious pain from broken ribs, presumably inflicted upon him in a fight with another prisoner.

The nurse basically ignored him all that time before finally taking him seriously and referring him for medical care.

The Eighth Amendment to the US Constitution's Bill of Rights prohibits cruel and unusual punishment for criminal offenses.

One recognized form of cruel and unusual punishment is deliberate indifference to a prisoner's or pretrial detainee's serious medical needs by nursing or medical caregivers.

UNITED STATES DISTRICT COURT
TEXAS
January 18, 2024

The US District Court for the Southern District of Texas ruled the inmate had the right to sue the nurse for violation of his Constitutional right to be free from cruel and unusual punishment.

The Court pointed out there was no basis for the inmate to claim fault by the nurse or the prison management for the fact he sustained the rib injury that constituted a serious medical need.

How his serious medical need arose was irrelevant to his right that caregivers not be deliberately indifferent to that need.

Prisoners' suits against prison staff are referred under Federal law for review by a magistrate. That review is meant to throw out and does throw out the vast majority of such cases. Not this one, which the magistrate ruled had merit and should proceed. **Prisoner v. Nurse, 2024 WL 195963 (S.D. Tex., January 18, 2024).**

Drainage Tube: Nurse Practitioner Should Have Inspected.

Two days after a lumbar laminectomy a drainage tube was removed from the surgical site by a nurse practitioner.

Two months after discharge from the hospital the patient was still having back pain and went to see a different orthopedic surgeon than the one who did the surgery.

That physician obtained an MRI that showed buildup of fluid surrounding scar tissue that was impinging on the spine.

During a repeat surgery the second orthopedist found and removed a four-inch length of drainage tube that was presumably left over from the previous surgery, and not removed by the nurse practitioner.

The court accepts the opinion of the patient's expert witness, a nurse practitioner familiar with postoperative patient care.

The patient's expert testified that the piece of drainage tube taken out by the nurse practitioner in the hospital would have had an uneven distal end indicating it had been separated from a portion of drainage tube that was still inside the patient's body.

COURT OF APPEALS OF MICHIGAN
January 18, 2024

The Court of Appeals of Michigan accepted the evidence that the nurse practitioner who charted the discontinuance of the drainage tube must have been the one who performed the removal procedure, not an unnamed staff nurse the nurse practitioner speculated could have done it.

The Court further accepted that there was a direct link between the negligently removed drainage tube and the severe back pain the patient had to endure before going to another doctor for a second opinion. **Ahearn v. Health, 2024 WL 203796 (Mich. App., January 18, 2024).**

Choking Alleged: Court Sees Death From Natural Causes.

The elderly nursing home resident passed away shortly after finishing her lunch in the facility's dining room.

Her family followed up with a lawsuit claiming she died from asphyxia related to choking on her food.

The fact an outcome not desired occurs in a healthcare context, in and of itself, does not prove any departure by the patient's caregivers from the applicable standard of care.

NEW YORK SUPREME COURT
APPELLATE DIVISION
January 17, 2024

The New York Supreme Court, Appellate Division, agreed with the lower court's decision to throw out the family's case.

There was nothing in the record for the Court to consider that pointed to asphyxiation.

The death certificate identified cardiopulmonary arrest secondary to metastatic thyroid cancer.

It was a simple coincidence that the resident's time seemed to have come just as she was finishing her lunch.

That coincidence in no way proved that eating her lunch had anything to do with her death..

Nursing home staff, an RN and an LPN who were present testified she was making vocal, albeit unintelligible sounds at the moment of her passing.

The Court accepted that the ability to make sounds, not necessarily amounting to intelligent speech, is wholly inconsistent with choking.

The facility's legal defense was sufficient in that it relied on an affidavit from a nursing expert that no departure from the standard of care preceded or contributed to the resident's passing, nor could any action by facility staff have been causally related. **Weston v. Care Center, __ N.Y.S. 3d __, 2024 WL 172918 (N.Y. App., January 17, 2024).**

Care Plan Not Followed: Court Needs No Expert Opinion.

The resident fell in a long term care facility and sustained injuries.

In essence the legal case that followed boiled down to the fact her fifteen-minute checks and been upgraded the day before to constant one-on-one supervision.

It was clearly documented in her chart that the fall in question did occur, but was not witnessed. That made it fairly obvious that the constant monitoring that had been incorporated into the care plan was not being provided.

Ordinary Negligence vs Professional Negligence

The New York Supreme Court, Appellate Division, reviewed the expert opinions from the defense to the effect the fall risk assessment and care planning were wholly adequate for this patient's needs.

From a legal standpoint the family would need expert testimony from a qualified nursing expert to dispute the adequacy of the assessment and care planning.

The Court had no expert opinion to establish a deficiency in the assessment and care planning for this resident.

Since the family offered no such expert to contradict the nursing facility's experts, the nursing home argued for dismissal of the case.

However, the Court ruled that the family still had a basis to go forward with a case of ordinary negligence, which is conceptually very different from professional negligence.

Failure to follow the care plan, which the defendant facility insisted was wholly appropriate to meet the resident's needs, would be considered ordinary negligence.

In a nutshell, failing to provide the constant supervision mandated by the care plan was negligence.

The adequacy or appropriateness of that aspect of the care plan was not an issue, given that the facility itself had insisted it was appropriate and needed to be followed for the resident's health and safety.

The Court overturned the lower court's ruling that seemed to have lost sight of the difference between ordinary and professional negligence. **Currie v. Health, __ N.Y.S. 3d __, 2023 WL 8938888 (N.Y. App., December 28, 2023).**

It is an exercise of professional nursing or medical judgment to formulate a care plan specifying the fall prevention practices and protective equipment that are seen as necessary for the patient's health and safety.

To question that exercise of judgment in court after a potential liability incident requires an opinion from a qualified expert witness.

However, the simple act of failing to abide by the letter of the care plan can be faulted in court without the need for an expert opinion.

The Court can split the case into two aspects, one governed by the standard of proof for medical malpractice, and another that is governed by the less exacting rules that apply to cases of ordinary negligence.

In this case the fall risk assessment and care planning for that risk were wholly adequate. At least there has been no qualified expert testimony given to the court to demonstrate professional negligence.

However, the simple act of failing to follow the care plan is ordinary negligence.

An expert opinion is not necessary if the issue is not the adequacy of the care plan, but only whether it was followed.

NEW YORK SUPREME COURT
APPELLATE DIVISION
December 28, 2023

Emergency: Patient's Location Not Given To Paramedics.

An adult day care center participant appeared to be choking on her food during the lunch service.

Her distress was promptly noticed by a staff member who quickly made an announcement over the intercom that a nurse was needed in the cafeteria stat.

A nurse came to the individual's assistance, then a CNA. The CNA did the Heimlich maneuver successfully to remove the food choking her, but she was still unconscious and not breathing.

Two nurses did CPR until breathing was restored, then started O_2 and stayed with the participant on the floor.

The street address of the adult day care center has four separate entrances from the outside.

One entrance leads right into the cafeteria where the patient had been choking.

The paramedics could have quickly spirited her out of the building, into the ambulance and on to the hospital, if they had been told to go to that entrance.

Instead, eight minutes were wasted as the paramedics went around to each of the other entrances.

NEW YORK SUPREME COURT
KINGS COUNTY
December 28, 2023

The New York Supreme Court, Kings County, ruled the nurses' response and their care was completely proper.

However, the Court was persuaded to find negligence in that someone from the program location failed to tell the EMT dispatch exactly where the emergency was happening at the address for the center, which unduly delayed the response. **Roskin v. Care Center, 2023 WL 9059849 (N.Y. Super., December 28, 2023).**

Sexual Assault Nurse Examiner: Court Accepts Expert Testimony From Another Nurse, Based On Examiner's Report.

The defendant was charged and convicted of multiple offenses committed during the same incident. The charges included burglary, kidnapping and forcible rape. He was sentenced to spend basically the rest of his natural life incarcerated.

For reasons not specified in the court record, the Sexual Assault Nurse Examiner (SANE) who testified against him was a different certified SANE nurse from the same hospital than the one who did the victim's comprehensive sexual assault workup.

He appealed his convictions on the grounds that his Constitutional rights under the Confrontation Clause of the Sixth Amendment were violated.

A criminal defendant is entitled to be confronted by the witnesses against the defendant. That usually means the witness must physically come to court for face-to-face cross examination by the defendant or the defendant's legal counsel.

The rationale of the Confrontation Clause is to outlaw the medieval practice of convicting accused persons on the basis of uncorroborated hearsay.

The Court of Appeals of North Carolina found no impropriety or violation of rights.

The SANE nurse who testified had twenty five years personal experience conducting sexual assault exams. She also had extensive experience reviewing the work of other SANE nurses whom she supervised at the hospital.

The nurse who did the exam produced a comprehensive record which included photos of nearly every aspect of the victim's body.

The nurse who testified was able to form her own independent expert opinion from the well-documented findings of the other nurse who did the exam, that a sexual assault had indeed occurred.

An expert witness is permitted to arrive at an expert opinion admissible in court based on the expert's analysis of another competent expert's work.

The accused was in fact able to confront the witness against him in the person of the SANE nurse who actually testified.

It was not necessary for the prosecution to bring the examining nurse to court, given the thorough job she did examining the victim and documenting her findings. **State v. Defendant, __ S.E. 2d __, 2024 WL 157820 (N.C. App., January 16, 2024).**

E.R.: Patient Involved In Incident With Another Patient, Removed, Court Sees EMTALA Violation.

A patient came to the hospital emergency department, told the front desk he was not feeling well and asked to see a doctor.

While he was sitting in the waiting area another individual was being forcibly removed by hospital security.

The patient felt obligated to get involved and went over to try to "deescalate" the situation, as he would later describe his actions.

The security guards did not take his involvement well. They turned around and also escorted him out physically. Apparently they did not appreciate him recording the whole affair with his phone.

The patient went home. He still did not feel well, and called an ambulance to take him to a different hospital. There, according to the court record, abnormalities were found in his lab values.

The US Emergency Medical Treatment and Active Labor Act was enacted to require hospitals to offer medical screening examinations and necessary stabilizing treatment to all patients who present in the emergency department.

The EMTALA is particularly aimed at protecting persons in the emergency room whom the hospital does not want to treat for one reason or another.

UNITED STATES DISTRICT COURT
MISSOURI
January 17, 2024

The US District Court for the Eastern District of Missouri saw grounds for the patient to sue the first hospital for violation of his rights under the US Emergency Medical Treatment and Active Labor Act (EMTALA).

The Court looked only at the familiar language of the EMTALA. A patient who presents with symptoms and complaints of a serious medical condition is entitled to an appropriate medical screening examination and necessary stabilizing treatment.

The Court did not delve into the issue whether the hospital security officers had or did not have justification to remove him from the facility.

The Court did rule that the officers did not commit an assault in the course of removing him, but that did not justify a violation by the hospital of the patient's EMTALA rights. **Sproaps v. Hospital, 2024 WL 180860 (E.D. Mo., January 17, 2024).**