



## WHEN ONE OR THE OTHER MEANS BOTH

By Paul W. Chemnick, J.D.

Chemnick Moen Greenstreet recently settled a nursing negligence wrongful death case of a 73-year-old retired widower with two adult children for \$925,000.

His death was caused by sepsis (the spread of an infection) as a result of gauze being left in the deceased's open sternal wound, which had dehisced following coronary artery bypass surgery. Although it was apparent someone was negligent, their identity was unknown. But it was determined that they would have worked for one of two different hospitals, but not for both.

The deceased underwent emergency coronary artery bypass surgery on October 24, 2003. Unfortunately, he had a respiratory infection: methicillin-resistant *Staphylococcus aureus* or MRSA. He ultimately required a tracheostomy with ventilatory management in the ICU.

A CT scan was ordered to check for other possible causes of his persistent high fevers despite being on antibiotics. The scan revealed the presence of a substantial substernal hematoma, which was drained by a physician's assistant on November 7. As a result, the deceased was left with an open sternal wound about the size of a 50-cent piece near the distal end of his original incision. Although not noted in the record until almost two weeks later, the wound included a sinus track

or tunnel at least 3.5 cm long at the 12 o'clock position, running an inch or so under the skin.

The nurses at the first hospital were ordered to pack the open wound with wet-to-dry dressing to promote healing. A wetted 4 X 4-inch gauze would have been placed into the wound with dry gauze placed on top. This process not only absorbs seepage, but also provides a level of debridement because the gauze is replaced on a daily basis. While a 4 x 4 gauze would have fit in the open portion of the wound, it would not have fit into the track. The hospital's employees acknowledged that the standard of care would be to loosely pack the entire open space of the wound to promote healing from the inside out. This could have been accomplished by the use of gauze strips, commonly referred to with the brand name of NuGauze. However, there was no order to use NuGauze, it was not readily available on the floor, there was no notation that it was used, and the hospital did not bill for its use.

On the other hand, if one or more nurses at the first hospital happened to notice the existence of the track, obtained a gauze strip from elsewhere in the hospital and packed the wound with it, a different nurse changing the dressing the next day would not know to look for it. At least ten different nurses changed his dressing at the first hospital.

When the wound-care nurse at the first hospital documented the presence of the track on November 20, she ordered use of a wound vac instead of the wet-to-dry dressing. A wound vac involves the use of a black sponge cut to fit the shape of the wound, which in this case would include the area of the track. The sponge is then attached to a low pressure vacuum. It is designed to draw moisture from the wound, but is not strong enough to pull any retained gauze embedded in the track.

The deceased's condition gradually improved over the next 10 days so he was transferred to a less acute care hospital facility for continued ventilatory treatment of his respiratory infection and his open sternal wound. The wound by this time was down to 1.5 cm long, 1 cm wide, and 2.5 cm deep, with a 3.5 cm track or tunnel in the 12 o'clock position.

The second hospital treated the wound with a generic form of NuGauze, which comes in continuous strip out of a bottle. The nurses at the second hospital were all trained to pack the wound until it was loosely filled, leaving a couple of inches extending from the wound. They insisted they would never cut the strip before completing the packing, and that they would never use more than one piece of NuGauze in the same wound.

For the first couple of weeks at the second hospital, the deceased's condition continued to improve. His antibiotics were discontinued on the second day. His color was better, and the wound continued to heal normally. The track had closed over by the end of his first week. During the second week, he was weaned from the ventilator. He was tolerating his tube feedings well. He was able to transfer and sit in a wheelchair with moderate assistance, stand at the parallel bars, take steps in place, and engage in other therapeutic activity. His spirit had improved, and he was looking forward to eventually being discharged.

In the third week, however, things began to worsen. The wound dehisced to 2.5 cm x 1.7 cm x 3 cm. The deceased complained of abdominal pain, which continued despite medication. He slept poorly and became somewhat disoriented. He was then found to have a boggy, erythematous sternum, and his respiratory condition seriously deteriorated. On December 22, he was transferred back to the first hospital for surgical exploration after pus began to weep out from a place on the original incision a few inches above the open sternal wound.

When the entire incision was reopened, the surgeon found two, four-inch strips of what he referred to as NuGauze balled up an inch under the skin and an inch above the open sternal wound, along with copious amounts of creamy pus. Unfortunately, the strips were not sent to pathology, but were discarded immediately after surgery. This infection was also found to be MRSA. The deceased became septic, placed back on ventilatory support, and managed in intensive

care for 6-1/2 months before he finally succumbed. His condition fluctuated, but never returned to where he was when he initially was transferred to the second hospital.

Because the NuGauze was reportedly found near what would have been the apex of the track at the time he was transferred to the second hospital, and because that track had closed over by the end of his first week there, the strips were apparently either left in while the deceased was at the first hospital before initiation of the wound vac or sometime during his first few days at the second hospital. Also, the strips were likely left in on two separate occasions, apparently for the purpose of packing the track independently. The four-inch length would not be sufficient to pack the entire wound.

Of course, each hospital insisted their nurses could not have been to blame. Although we concluded it was more likely the gauze was left in at the second hospital, we wanted to keep both defendants in the case so they would end up pointing fingers at each other, and in order to avoid the empty chair. To avoid a motion to dismiss at the close of plaintiff's case, we concluded we would need to present conflicting evidence which, depending upon which version of the facts the jury believed, could implicate either of the two defendants. To do so, we planned to call the nurses who changed the deceased's dressings at both institutions. Since one or more of them must have left the gauze in the track, and since it would be a factual issue as to which nurse or nurses did so, we believed this would be an issue for the jury and therefore not a basis for dismissal.

Complicating this effort to keep both defendants in the case was the fact that all our expert witnesses testified in their depositions that it was unlikely the deceased would have continued to improve as he did if the gauze had been left in at the first hospital. Considering the deceased's overall weakened condition, the fact that he had an active MRSA respiratory infection, and the fact that the wound track was open until the end of the deceased's first week at the second hospital, it was highly likely that two pieces of balled up gauze strips in the open track would become colonized, and then infected within a week to ten days. In such case, the wound would not have continued to heal normally over the next three weeks, and it would not have taken a month before there were clear signs of infection.

Fortunately, our experts also testified it was still possible that the gauze was left in at the first hospital before using the wound vac since the patient was being treated with antibiotics and that with sterile technique, the colonization of the retained gauze might not have occurred until after the deceased was at the second hospital. However, to ensure our case would not be dismissed against the first hospital on this basis, we agreed to allow the second hospital's attorney to present their expert witnesses out of order, so that there would be expert witness testimony implicating the first hospital before we rested our case.

In addition to the issue as to which hospital was liable by way of respondeat superior, there were contested issues relating to causation and damages. By the time the deceased died on July 10, 2004, the sternal



wound had completely healed, and the local infection had cleared. The cause of death was listed as pulmonary failure due to severe organizing chronic pneumonia. Other significant conditions included severe coronary atherosclerosis. The deceased had MRSA pneumonia and coronary atherosclerosis before the incident with the retained gauze. Plaintiff's experts therefore had to project how these conditions would have likely improved "but for" the set-back from sepsis due to the infection from the retained gauze and to demonstrate the degree of organ damage, loss of nutritional reserve, deconditioning, and worsening of pneumonia accompanying the sepsis. Since the deceased lived for another 6-1/2 months in the ICU, our experts concluded that the septic episode likely tipped the balance, or as one put it, was "the straw that broke the camel's back."

Finally, there were issues concerning damages. The medical bills generated by the first hospital totaled \$1.4 million, although the amount paid by Medicare and the supplemental carrier were less than \$375,000. Since the balance of the medical bill was written off, and since we were suing the hospital providing those services, it was problematic to allege medical specials in excess of the amount paid, despite the language in the instruction allowing for the reasonable value of medical services. For purposes of mediation, we contended the reasonable value was neither the billed amount nor the amount accepted from Medicare and the supplemental carrier. We maintained that since hospitals are paid by individuals with and without insurance at different rates, and from

entitlement programs such as Medicare and Medicaid at different rates as well, the reasonable value of such services should be the melded rate representing what hospitals reasonably must receive for the goods and services provided to remain viable and competitive. The hospital could not remain so if it only received payments based on the schedule approved by Medicare.

The reasonable value of all these medical services, however, was only the starting point for determining special damages in this case. All experts agreed that the deceased would have remained at the second hospital for a period of time even without the retained gauze. The estimates ranged from a few months to six months, with various estimates of continuing lesser levels of care. The issues were therefore: (1) how much more care was likely required as a result of the retained gauze, and (2) what was the reasonable value of that additional care. We are now in the unenviable position of trying to negotiate with Medicare on this issue. We have had similar cases with Medicare, settled over a year ago, where again the issue was whether their claim of lien should be reduced to reflect the level of care that would otherwise have been provided.

The other difficult issue relating to damages is the fact that the personal representative of the estate brought the action on behalf of the statutory beneficiaries. The deceased was close to his daughter, who was appointed personal representative of the estate, but his son had been estranged for many years. Often, beneficiaries have similar losses of relationship and are able to agree to the division among themselves. In this case, the two

children were estranged from each other. Fortunately, the brother obtained personal counsel, with whom we managed to negotiate a percentage division of all general damages between the two adult children. We felt this was important in order to avoid a conflict in presenting the children's claim of loss of relationship. Because the jury could allocate a sizable portion of the general damages to pre-death pain and suffering, this would be an asset of the estate and therefore divided equally between the two children since there was no will.

Although the case did not settle at mediation, we continued to negotiate both directly and through the mediator, the Hon. Terrence Carroll, and ultimately reached a settlement with contributions from both hospitals based upon their risk at trial.

*Paul Chemnick, J.D., is a partner in the Seattle law firm Chemnick Moen Greenstreet, where his practice is limited to medical negligence claims.*