

IN RE ARBITRATION OF

**IN THE CIRCUIT COURT OF JEFFERSON COUNTY, ALABAMA
BIRMINGHAM DIVISION**

IN RE ARBITRATION OF

**ROSALYN GARDINER AS THE
PERSONAL REPRESENTATIVE OF
THE ESTATE OF LILLIE BELL HOPSON**

PLAINTIFF

vs.

**SSC BIRMINGHAM OPERATING
COMPANY, LLC d/b/a FAIRVIEW
HEALTH & REHABILITATION
CENTER, INC. *et al.***

DEFENDANTS

CIVIL ACTION NO: CV-2008-901737.00

ARBITRATORS' AWARD

The arbitrators appointed to hear and decide this matter, to-wit: Phillip E. Adams, Jr.; Bernard Harwood; and Rodney A. Max (hereafter collectively the "Panel") having completed on December 8th the arbitration hearing, and having thereafter met and conferred at length to reach their collective findings and fact, determinations of applicable law and dispositive conclusions, do hereby unanimously find, hold and determine as follows:

As a threshold matter, the Panel expresses its appreciation for the thorough preparedness, expertise and conscientiousness with which counsel for each side ably advocated on behalf of their respective clients, yet doing so at all times with professionalism and civility. As a further threshold matter, the Panel acknowledges its appreciation for the dedicated, loving care Mrs. Rosalyn Gardiner provided to her mother, Lillie Bell Hopson, over the course of the years

following the onset of Ms. Hopson's Alzheimer's disease and varied health problems. The Panel notes that other family members also rendered loving service in that regard, but the unfailing dedication of Ms. Gardiner was particularly impressive to the Panel.

The parties and the Panel are constrained and controlled in this proceeding by the provisions of (1) the "Alabama Medical Liability Act," codified as Section 6-5-480 et seq. of the Code of Alabama of 1975, and (2) the "Medical Liability Act of 1987," codified as Section 6-5-540 et seq., and which supplements the earlier act.

Section 6-5-542(2) declares that:

"The standard of care is that level of such reasonable care, skill, and diligence as other similarly situated health care providers in the same general line of practice, ordinarily have and exercise in like cases. A breach of the standard of care is the failure by a health care provider to comply with the standard of care, which failure proximately causes personal injury or wrongful death. This definition applies to all actions for injuries or damages or wrongful death whether in contract or tort and whether based on intentional or unintentional conduct."

Section 6-5-548(a) mandates that in a medical liability case, "the plaintiff shall have the burden of proving by substantial evidence that the health care provider failed to exercise such reasonable care, skill, and diligence as other similarly situated health care providers in the same general line of practice ordinarily have and exercise in a like case." The introductory paragraph to Section 6-5-549 states, "In any action for injury or damages or wrongful death, whether in contract or in tort, against a health care provider based on a breach of the standard of care, the minimum standard of proof required to test the sufficiency of the evidence to support any issue of fact shall be proof by substantial evidence." That same code section declares that "the standard of proof required shall be proof by substantial evidence," and that the fact finder must "be reasonably satisfied by substantial evidence that the health care provider failed to comply with the standard of care and that such failure probably caused the injury or death in question." (emphasis supplied)

Finally, Section 6-5-551 states that “[a]ny party shall be prohibited . . . from introducing at trial evidence of any other act or omission,” other than that included in the complaint as “a detailed specification and factual description of each act and omission alleged by plaintiff to render the health care provider liable to plaintiff [including] when feasible and ascertainable the date, time, and place of the act or acts.”

In Husby v. South Alabama Nursing Home, Inc., 712 So.2d 750, 753 (Ala. 1998), the Alabama Supreme Court explained,

“[W]e note that, for purposes of the Alabama Medical Liability Act, a nursing home is considered a hospital and, therefore, that [the nursing home in question] is covered by the provisions of that Act. *Ex parte Northport Health Service, Inc.*, 682 So.2d 52, 55 (Ala.1996). The defendants cite *Barton v. American Red Cross*, 829 F.Supp. 1290 (M.D.Ala.1993), *aff'd*, 43 F.3d 678 (11th Cir.1994), for the proposition that the focus should be on the individual practitioner whose specific action is alleged to have fallen below the standard of care. We accept that proposition, and we conclude that the focus in this case should be on the standard of care owed by the nurses who rendered direct care to Husby. Also, when a defendant is not an individual, it is logical to limit the admissible expert testimony to that coming from witnesses who are, as to the specific individual whose actions formed the basis for the litigation, similarly situated. Thus, we will apply the same standard of care, that governing a nurse administering direct care, to all three defendants.

Albeit a federal district court case, The Estate of Thomas Gene Bradley v. Mariner Health, Inc., et al., 315 F.Supp.2d 1190 (D.C.S.D. Ala. 2004) contains a valid and succinct summary of the principles that guide and control the Panel’s decision-making in this case:

“The determinative issue regarding Defendants’ liability is whether they exercised such reasonable care, skill and diligence as other nursing homes would ordinarily exercise under similar circumstances and, if not, whether the alleged breach proximately caused the harm and death at issue. *Keebler v. Winfield Carraway Hospital*, 531 So.2d 841 (Ala.1988). If Defendants provided reasonable care, they have fulfilled any duty owed to Plaintiff, notwithstanding an unfortunate outcome. *McMickens v. Callahan*, 533 So.2d 579 (Ala.1988). Under the [Alabama Medical Liability Act], for Plaintiff to prevail in an action against a nursing home, Plaintiff must establish by substantial evidence: (1) the appropriate standard of care; (2) a deviation therefrom by Defendants’ nursing personnel; and (3) proximate cause between the act or omission constituting the breach and the subsequent death. *Peden v. Ashmore*, 554 So.2d 1010 (Ala.1989).”

The certified "Certificate of Death" introduced as a hearing exhibit states that the "final disease or condition resulting in death" was hyperglycemic coma; "due to (or as a consequence of) pneumonia;" "due to (or as a consequence of) renal failure;" "due to (or as a consequence of) dementia." Under Alabama case law, this Certificate of Death constitutes prima facie evidence that the death was caused as stated in it, but the party opposing that conclusion may refute the prima facie case by offering contrary evidence. McCoy v. McCoy, 549 So.2d 53 (Ala. 1989) Plaintiff's causation expert, Dr. Gerald Gowitt, expressed the opinion that the hyperglycemic coma should more properly have been designated a complication of Ms. Hopson's hyperglycemia which, in turn, was attributable to the fact that she was an undiagnosed diabetic whose diabetes was untreated, causing her to develop hyperglycemia. It was further his opinion that the April 18, 2008 lab report of a blood sugar level of 250 was essentially diagnostic for the presence of diabetes, such that the responsible health care provider should have instituted care. He also was of the opinion that if appropriate care had been instituted, the hyperglycemic state would not have occurred. In essence, Dr. Gowitt opined that Ms. Hopson did not die of her chronic condition of dementia, but rather from the metabolic disruptions produced by the hyperglycemic coma.

Plaintiff's standard of care/breach of the standard of care expert witness, Ellen L. Lewis, was of the opinion that a person having a random blood sugar of 200 or above should be considered a diabetic, and would need diabetic treatment. It was Ms. Lewis' opinion that it was then the responsibility of the nursing home to bring the 250 blood sugar value to the attention of either the nurse practitioner following her under the auspices of the attending physician, or the attending physician himself. It is undisputed that the attending physician was Dr. Dick Owens, and that his nurse practitioner was Vickie Griffith. The April 29, 2008 lab report containing the 250 "glucose" level was issued at 4:00 pm and Ms. Griffith "signed off" on the same the

following morning. Ms. Griffith had the authority under Alabama Nurse Practitioner licensing law to make diagnoses, order laboratory tests and x-ray tests, and order treatments. Ms. Lewis acknowledged during the hearing that nurse practitioners make medical judgments. Conversely, she, as well as every other witness who testified, were clear to the fact that neither registered nurses, nor licensed practical nurses, nor nurses' aides can perform any of those functions. Ms. Lewis was of the opinion that if Ms. Griffith signed that lab report yet took no further action, despite having information about Ms. Gardiner's earlier concern about a change in her mother's condition, Ms. Griffith breached the standard of care. The Panel finds, however, that Ms. Griffith and Dr. Owens were independent contractors for whose breaches of the standard of care the defendants would have no legal liability. That is not to say that the Panel concludes that Ms. Griffith in fact breached the standard of care, because Dr. Owens vouched for Ms. Griffith's professional competency and expertise and was of the opinion that, given all of the circumstances of Ms. Hopson's medical conditions and medical treatments as of the 250 glucose level of 250 on April 29th, it was entirely appropriate that Ms. Griffith elect to "let things settle down" with respect to all of Ms. Hopson's ongoing medical conditions, and defer ordering any follow up blood glucose levels for several weeks. Moreover, Dr. Owens testified that if someone at the nursing home had elected to go over nurse practitioner Griffith's head to contact him directly about the 250 glucose level, he wouldn't have taken any action different than what nurse Griffin did. He said he knew of no policy that required a doctor to be contacted for a one-time blood glucose reading of 250. The Panel notes that nurse practitioner Griffith had been seeing Ms. Hopson since June of 2006, and was well-familiar with her medical picture as of the time she reviewed the May 29th lab report.

With respect to the particularized claim that nurse Diana Miller fell below the standard of care in not independently taking note of the 250 blood glucose level lab report, the Panel notes

that it was ultimately established by the testimony and documentary record that when the lab report was faxed to the facility on the afternoon of April 29, 2008, at 3:25 pm, Ms. Miller had already completed her 7:00 am to 3:00 pm shift and left for the day. She was thereafter on vacation until she returned to work on May 8th. Accordingly, she, individually, would not have had occasion to note the lab value and there is no showing that it was a breach of the standard of care that she was not acquainted with the same when she returned to work, although, as she testified, she “probably” should have been made aware of the results even on a delayed basis. Nonetheless, there was no testimony that any failure by the other staff affirmatively to bring to her attention a nine-day-old 250 glucose level, was a breach of the standard of care.

It was the opinion of defense experts Dr. Richard Rosenthal and Dr. Albert Edwin Hines, III, that Ms. Hopson’s terminal condition of hyperglycemic coma (alternatively referred to by the acronym “HHS” and “HONK”) were caused by pneumonia, the presence of which in Ms. Hopson was documented by the medical records associated with her May 19, 2008 admission to UAB Highlands Hospital. Likewise, they were of the opinion that the April 28, 2008 glucose level of 250 was not diagnostic of diabetes, but rather would suggest only that the patient might need to be retested in several weeks. They both expressed the opinion that the most common cause of HHS is infection, and that the most common precipitating infection is pneumonia. Dr. Rosenthal testified that HHS can “flare” within 12 or 24 hours.

Follow up testing for the blood sugar level was planned for May 18th, and the testimony of Dr. Rosenthal and Dr. Hines would support a finding that such a delayed interval was appropriate under the standard of care. Although there was not a doctor’s order recorded for that follow up testing, the directive for it was entered in the chart and Dr. Hines opined that the most reasonable explanation was to assume that the entering nurse forgot to write down an order she received from Dr. Owens, as opposed to exceeding her authority and unilaterally

ordering such a lab test. Moreover, Dr. Owens testified that some of his physician's notes were missing from Ms. Hopson's record on account of the fact that there had been some errant email referrals of such notes by him to various nursing homes and that lightning had struck his medical transcriptionist's home at one point and wiped out a lot of his physician's notes before they could be forwarded. At any rate, Ms. Hopson left the nursing home on May 19th, dispatched to UAB Highlands Hospital, before the planned lab tests could be performed.

Quite a bit of testimony was received concerning "gaps" in the nurses' notes, attributed by defense witnesses to the practice of "charting by exception." The Panel simply notes that there was ample testimony, and record documentation, that multiple staff members were physically present in the room with Ms. Hopson on the days in question, attending to her by way of "flushing" her peg tube six times a day and administering "crushed" medicines through her feeding tube three times a day, such that nine times a day a nurse was going in to see her, with the opportunity for observation and assessment. Regardless of whether gaps in the nurses' notes might be due some criticism, Dr. Gowitt, as the plaintiff's sole "causation" expert, did not undertake to attribute any causal connection between such omissions and Ms. Hopson's ultimate deterioration and demise.

Dr. Gowitt did not attempt to link Ms. Gardiner's expression of concern to nurse Diana Miller on Friday, April 18, 2008, that Ms. Gardiner thought her mother might have had a stroke, to Ms. Hopson's death. Nurse Miller testified that she responded to that information from Ms. Gardiner by assessing Ms. Hopson and did not personally perceive any signs or symptoms of a stroke. Nonetheless, she wrote on a lab report for that date which was then placed in the "lab book" for nurse practitioner Griffith or Dr. Owens to review, the fact that Ms. Gardiner was concerned that her mother maybe had had a stroke. Nurse practitioner Griffith signed off on that lab report, with nurse Miller's notations thereon, and the Panel finds that nurse Miller thereby

discharged her duty to communicate that information. Moreover, nurse Miller's nursing notes reflect that on the following Monday, April 21st, she called Dr. Owens, and thereafter noted his new orders. Nurse Miller testified that she told Dr. Owens during that conversation that Ms. Gardiner had a concern that her mother may have had a stroke. For his part, Dr. Owens testified that he was sure Ms. Miller had called him about the situation, because "she's a very compulsive sort of individual," with respect to her professional duties. Obviously, nurse practitioner Griffith was aware of Ms. Gardiner's concern that her mother may have had a stroke, and the Panel cannot indulge in speculation that when Ms. Miller called Dr. Owens at the commencement of her next shift, on Monday, April 21, 2008, she did not include within her discussions that fact.

The Panel heard testimony concerning the fact that the medication Seroquel was not appropriately charted in the record, but, again, Dr. Gowitt did not undertake to link any such charting errors to Ms. Hopson's final deterioration and ultimate demise.

The Panel has carefully reviewed the provisions variously referenced by the parties from the prototype "Resident Admission and Financial Agreement" and the "Medical Services Agreement" relating to the duties of a medical director, and cannot conclude therefrom that Dr. Owens, in his capacity as medical director, had a duty to diagnose and treat patients. Rather, paragraph 3.3 of the Medical Services Agreement stipulates that any services he was to provide in that regard were to be in his independent role as an attending physician.

As noted previously, to the extent that either Dr. Owens, as attending physician, or nurse practitioner Griffith, acted in any manner which fell below the applicable standard of care (which the Panel is not called upon to determine, and, therefore, expressly does not determine), their acts or omissions in that regard could not be attributable to the defendants. In particular, Ms. Lewis did not undertake in her testimony to fault Dr. Owens in any respect (nor could she, not being a "similarly situated health care provider"), although she did ascribe a breach of the standard of

care to nurse practitioner Griffith; and Dr. Gowitt did not undertake to attribute to any breach of the standard of care by Dr. Owens or nurse practitioner Griffith any involvement in his scenario of the links in the cause of death. Consequently, even if the Panel were to fully accept the opinions of Dr. Gowitt and plaintiff's "rebuttal" expert Dr. Reginald M. Smith that a blood glucose level of 250 would be sufficient in and of itself to make a diagnosis of diabetes, the Panel finds that the standard of care of the nurses at Fairview Health and Rehabilitation Center was satisfied when that lab report information was communicated to nurse practitioner Griffith. Even Ms. Lewis acknowledged that the duty of the nurses would be to communicate that information to either the physician or the nurse practitioner.

CONCLUSION

The Panel, while certainly impressed with the loving dedication of Ms. Gardiner to the care and well being of her mother, Ms. Hopson, nonetheless must adhere to the strictures of the legal principles controlling medical liability actions set forth in the statutes and case law previously cited. Applying the same, to the best of their ability, the Panel members find that there has been no showing that any acts or omissions by the nurses (or even the medical director) at Fairview Health and Rehabilitation Center constituted a breach of the applicable standard of care and probably caused the final cascade of medical problems culminated in Ms. Hopson's death. Accordingly, the Panel orders, adjudges and decrees that the issues are determined in favor of the defendants and enters an award in their favor.

DETERMINED AND ORDERED this the 16th day of December, 2011.

Bernard Harwood

Bernard Harwood, Chairman

Phillip E. Adams, Jr.

Phillip E. Adams, Jr.

Rodney A. Max

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