

Organ Transplant: Patients Diagnosed With Hepatitis C.

The kidney transplant recipient and the donor both sued the hospital after each was diagnosed with Hepatitis C following the transplant.

The recipient sued for being infected with Hepatitis C from the donor.

The donor sued over a blood sample not drawn for medical diagnosis as she was told but drawn for forensic purposes after the recipient's infection was discovered, and over losing a kidney she should not have been allowed to donate.

The donor is the recipient's significant other and the mother of his child.

Institutional Failure to Communicate

The hospital's selection criteria required donors to be screened to rule out Hepatitis C along with a host of other factors being taken into consideration.

Three physicians independently reviewed the donor's chart and concluded she was suitable. However, the chart contained no documentation that donor Hepatitis C screening had been done.

Two months later, just before the actual transplant procedure, a sample of the donor's blood was sent to the lab for Hepatitis C screening specifically ordered by the transplant surgeon himself.

A report came back from the lab that the sample contained an insufficient quantity of blood for the Hepatitis C test.

The lab report was faxed to the nurse who served as transplantation coordinator. She simply entered it in the donor's chart and made a note that another sample had to be obtained and sent to the lab for Hepatitis C screening. That was never done. A week later the transplant went ahead.

Court Ruled On Discovery Issues

There has yet been no court ruling whether the hospital is or is not liable.

The Superior Court of Pennsylvania ruled the state Department of Health is not a professional health care provider and thus the particulars of its investigation do not fall within the peer review privilege and are available to the patients' attorneys.

The Court ruled the details of the hospital board's meeting to discuss the matter fall under the peer review and attorney-client privileges and will not be disclosed. **Yocabet v. UPMC**, ___ A. 3d ___, 2015 WL 3533851 (Pa. App., June 5, 2015).

The hospital was cited by state Department of Health inspectors for violation of Federal Medicare conditions of participation found at 42 CFR §482.90.

A transplant center must actually use its written patient selection criteria in determining a patient's suitability for placement on the waiting list or for transplantation.

If a transplant center performs living donor transplants, the center must also use its written donor selection criteria in determining the suitability of candidates for donation.

The transplant center must document in the living donor's medical records the living donor's suitability for donation.

Federal regulations do not specify the actual criteria to be used for donor selection.

This facility was given an extensive plan of correction which assigned responsibilities for different aspects to different staff members at the transplant hospital.

Nevertheless, the Department of Health is not a professional health care provider as defined in the state's peer-review privilege statute. The Department's investigation and conclusions are not privileged.

SUPERIOR COURT OF PENNSYLVANIA
June 5, 2015

Wrongful Birth: Communication Breakdown Leads To Large Verdict.

After abnormalities found in a routinely scheduled prenatal ultrasound at eighteen weeks were reported to the physician the physician told staff members to arrange a follow-up appointment.

Miscommunication resulted in failure to schedule the appointment. Having been told nothing to the contrary, the mother believed her pregnancy was proceeding normally.

Another ultrasound three months later showed clear signs of hydrocephaly in the fetus which by then was almost at term, which a nurse reported to the mother.

Further testing confirmed that the child if born alive would have profound deficits from a malformed head and brain.

Nevertheless, rather than undergo late-term termination of her pregnancy the mother elected to deliver her baby.

The breach of the standard of care by the patient's caregivers did not cause the fetus's condition.

Rather, the patient was deprived of the opportunity to make a meaningful choice whether to continue or terminate her pregnancy.

UNITED STATES DISTRICT COURT
WEST VIRGINIA
May 29, 2015

The US District Court for the Southern District of West Virginia did not entertain any serious argument the mother and child were not entitled to sue for wrongful birth.

The only meaningful question was how much to award as damages.

Nurses played significant roles in that aspect of the case. They testified as expert witnesses as to the special care this child would need at various stages in his life. Even though his troubled life would likely be cut short of normal life expectancy the Court awarded \$12,116,165.00. **Simms v. US**, ___ F. Supp. 3d ___, 2015 WL 3457519 (D. W.Va., May 29, 2015).