THE FLORIDA SENATE

SPECIAL MASTER ON CLAIM BILLS

Location
408 The Capitol

Mailing Address
404 South Monroe Street
Tallahassee, Florida 32399-1100
(850) 487-5237

November 17, 1999

SPECIAL MASTER'S FINAL REPORT	DATE	COMM	ACTION
The Honorable Toni Jennings	11/19/99	SM	Favorable
President, The Florida Senate	12/08/99	HC	Favorable
Suite 409, The Capitol	02/10/00	FR	Fav/1 amend
Tallahassee, Florida 32399-1100			

Re: SB 20 - Senator Howard Forman
Relief of Virgilio Chavez and Anagely Chavez, a minor

THIS $600,000 CLAIM IS BASED ON A CONSENT FINAL JUDGMENT, SUPPORTED BY A SETTLEMENT AGREEMENT IN WHICH THE NORTH BROWARD HOSPITAL DISTRICT HAS AGREED TO COMPENSATE THE CLAIMANTS FOR INJURIES AND DAMAGES SUSTAINED FROM THE DEATH OF CRUZ CHAVEZ, WHO WAS WIFE TO VIRGILIO CHAVEZ AND MOTHER TO ANAGELY CHAVEZ, IN AN INCIDENT OF HOSPITAL MALPRACTICE.

FINDINGS OF FACT:

Cruz Chavez who was 9 months pregnant was taken by her husband, Virgilio Chavez, to Broward General Medical Center on the evening of October 4, 1996, to check on her pregnancy and to confirm the date of delivery of her unborn child because she was 2 days past her due date. At 6:40 p.m., the hospital staff in the labor triage area of the hospital's labor and delivery department evaluated Cruz Chavez and started an intravenous administration of fluids at 6:40 p.m., to hydrate Mrs. Chavez.

Around 8:11 p.m., Virgilio Chavez notified hospital staff that his wife, Cruz Chavez, was experiencing a seizure. Dr. Michael L. Lewis, who was present at the time, described the seizure activity as a grand mal seizure. Although Dr. Winston O. Bliss was on call when Cruz

Chavez was originally presented to the hospital, Dr. Lewis was the attending physician. Both physicians provided obstetrical and gynecological care at the hospital as employees of Sunlife OB/GYN Services of Broward County, Inc. Sunlife is an entity that contracted with the North Broward Hospital District to provide obstetrical and gynecological care to indigent patients at Broward General Medical Center.

An anesthesia team that was present in the triage area evaluating another patient assisted Dr. Lewis in response to Mrs. Chavez's seizures by establishing an airway, starting oxygen, and administering 10 milligrams of Valium®. Dr. Lewis ordered the administration of magnesium sulfate to treat the seizures. The order required the intravenous administration of a loading dose of 4 grams of magnesium sulfate to be mixed in a 100cc bag of five percent dextrose in water. Under the order, the loading dose was to be administered at a flow rate of 200cc per hour.

At a rate of 200cc per hour, the administration of the loading dose should have taken approximately 30 minutes. The medical records for Mrs. Chavez indicate that the loading dose was started at 8:30 p.m., and completed by 8:37 p.m., with 100cc being absorbed. Broward Memorial Hospital maintained a policy and procedure for pre-eclamptic/eclamptic patients requiring magnesium sulfate. When not otherwise contravened by a physician's order, the policy required nursing staff to infuse a loading dose of magnesium sulfate over 15-20 minutes via an infusion pump.

Dr. Lewis's order to treat Mrs. Chavez's seizures also required a maintenance dose of 20 grams of magnesium sulfate mixed with 1000cc of five percent dextrose in ringers lactate to be intravenously administered at a rate of 100cc per hour. Based on the intravenous therapy infusion record, nursing staff initiated the infusion of the maintenance dose at 8:38 p.m., and discontinued it at 8:40 p.m., with nothing absorbed.

The claimants presented deposition testimony that is consistent with the intravenous infusion therapy record.

A nurse testified that after receiving the order from Dr. Lewis, she retrieved four vials of magnesium sulfate from the PYXIS medication dispensing machine and charged the vials to patient "A." The pharmacy records show that four vials of magnesium sulfate were withdrawn from the PYXIS dispensing machine at 8:19 p.m.

Conflicting testimony was provided regarding what strength and unit size of magnesium sulfate was available on October 4, 1996, from the PYXIS dispensing machine. The nurse testified that she remembers that two different strengths of magnesium sulfate were stocked in the PYXIS machine. The Regional Manager of Pharmacy Services at Broward General Medical Center who reviewed the PYXIS logs from October 4, 1996, testified that the only strength of magnesium sulfate stocked at that time was magnesium sulfate(50 percent - 20 milliliters).

The nurse testified that she mixed what she believed to be the loading dose by withdrawing approximately 8cc from one vial. The nurse handed the loading dose in an intravenous solution to another nurse who then hung and administered the solution to Mrs. Chavez. The nurse who prepared the loading dose of magnesium sulfate, testified that she placed the remaining three vials in the area near the patient in order to be utilized for the preparation of the maintenance dose. The nurse who mixed the loading dose went back to the PYXIS machine, credited patient "A" and charged Mrs. Chavez for the four vials.

The nurse who prepared the loading dose did not advise any of the other nursing staff that she had withdrawn a sufficient amount of magnesium sulfate to be used for both loading and maintenance doses ordered by Dr. Lewis. At 8:26 p.m., another nurse withdrew two additional vials of magnesium sulfate charged to Mrs. Chavez, and that nurse provided deposition testimony that she prepared the maintenance dose ordered by Dr. Lewis. There is no evidence of what ultimately happened to the three additional vials which were left by the nurse who prepared the loading dose. Around 8:15 p.m., Mrs.

Chavez was admitted to labor and delivery but was not physically transferred to a room until 8:35 p.m.

At around 8:37 p.m., Mrs. Chavez had a cardiopulmonary arrest and resuscitation efforts commenced. At 8:41 p.m., a "code blue" was called. Mrs. Chavez was intubated and ventilated by the anesthesia team and one amp of calcium chloride was given followed by one amp of epinephrine. The code team arrived and the patient was given resuscitation. After the cardiopulmonary arrest, an ultrasound was performed and revealed no fetal cardiac motion. The claimants provided deposition testimony by Dr. Lewis that the fetus died in-utero sometime around the time of Cruz Chavez's cardiopulmonary arrest on October 4, 1996. The attending physician testified that an emergency caesarean section was not performed to extract the fetus because it would warrant undo risk on the mother and further destabilize her already weakened condition. Mrs. Chavez was transferred to the intensive care unit and lab results from blood taken during her cardiopulmonary arrest revealed that Chavez had a magnesium level of 13.2 milligrams per deciliter.

The parties have stipulated that it is unrefuted that the magnesium level of 13.2 milligrams per deciliter resulted from either an excessive amount of magnesium sulfate being administered by the hospital staff, or an amount of magnesium sulfate being administered too quickly into Mrs. Chavez's blood stream, or a combination of both. Neither the hospital policy for the administration of magnesium sulfate nor the guidelines for use of the PYXIS dispensing system used on October 4, 1996, required the pharmacy or nursing staff to make independent calculations and verifications of a physician's order for magnesium sulfate and the medication actually dispensed.

On October 4, 1996, Mrs. Chavez suffered severe brain damage and was placed on a ventilator and remained in an unresponsive comatose state until her death. During the next 10 days, the medical staff monitored the deterioration of Mrs. Chavez's neurologic examination and electroencephalogram. Dr. Lewis and Dr. James

Cimera, the neurologist, jointly advised the family that based on their evaluation and diagnosis that Cruz Chavez was brain-dead. After consultation with the family, life support was removed. Dr. Julio Coello pronounced Cruz Chavez dead on October 14, 1996, at 6:30 p.m., An autopsy was requested by her family and later performed by the Broward County Medical Examiner's Office.

Prior to her admission to Broward General Medical Center on October 4, 1996, Cruz Chavez received prenatal care at the Sunshine Health Center, Inc., in Pompano Beach and was considered healthy and in good shape physically. On May 26, 1993, Cruz Chavez gave birth to her first child, Anagely, at Broward General Medical Center. Cruz Chavez had no complications during the pregnancy, labor and delivery of Anagely. Three days after Anagely's delivery, Cruz Chavez had headaches with dizziness and seizures and was hospitalized at Broward General Medical Center. The exact cause of the seizures was undetermined. At the time of discharge, on June 5, 1993, Cruz Chavez was asymptomatic, and was placed on Dilantin® (phenytoin sodium) and Coumadin® (sodium warfarin) for several months to control the seizure activity. After being taken off these medications Mrs. Cruz did not suffer from any further seizure activity until the incident on October 4, 1996.

The survivors of Cruz Chavez include Virgilio Chavez, her widower, age 30, who is employed as a roofer with County Line Constructors in Ft. Lauderdale, Florida and Anagely Chavez, her daughter, age 6.

EXPERT TESTIMONY: Claimants presented the deposition testimony of Eroston A. Price, Associate Medical Examiner, Broward County Medical Examiner's Office, the pathologist who performed the autopsy of Cruz Chavez. Dr. Price testified that there is not any evidence that Chavez received or ingested, any medications or toxins, prior to her admission to Broward General Medical Center which would account for an increased magnesium level of 13.2 milligrams per deciliter. Dr. Price testified that a normal range of magnesium of 1.7 to 2.2 milligram per deciliter in the

blood would be considered a therapeutic level of magnesium in the body. Dr. Price testified that symptoms of magnesium toxicity appear at blood levels of 3.5 to 5 milligrams per deciliter. Dr. Price testified that within a reasonable degree of medical probability, in her opinion, the cause of death of Cruz Chavez was hypoxic encephalopathy (brain damage) secondary to magnesium sulfate toxicity.

Both Dr. Price and the attending physician, Dr. Lewis, testified that the unborn fetus was a normal healthy fetus and that the delivery of a normal viable fetus would have been anticipated if Mrs. Chavez had not had the cardiopulmonary arrest. Drs. Price and Lewis both testified that based on their medical opinion, the fetus died at around the time of Mrs. Chavez's cardiopulmonary arrest. If Mrs. Chavez's seizure activity had been appropriately treated with the magnesium sulfate both physicians testified that she would have survived the seizures and had a normal delivery of the unborn fetus.

CONCLUSIONS OF LAW: In 1996, the Broward General Medical Center was licensed and operated by the Respondent, North Broward Hospital District. The District contracted with Sunlife OB/GYN Services of Broward County, Inc., to provide obstetrical and gynecological services to indigent patients at Broward General Medical Center. North Broward Hospital District is liable for the negligent acts of its employees and agents. The claimants have established to my satisfaction, by a preponderance of the evidence, that the hospital staff owed Cruz Chavez a duty of care, that their applicable duty to Cruz Chavez was breached by the hospital' s medical and nursing staff, and that claimant's damages were a proximate and foreseeable result of that breach.

As in many cases of this nature, the various named defendants shared the responsibility for the result, and although reasonable people may disagree with the allocation of the responsibility among the defendants, I find that the sum to be paid by the North Broward

Hospital District is supported by the evidence against it, in light of all the circumstances.

THE SETTLEMENT: Suit was filed for wrongful death and for negligent stillbirth in the Circuit Court of Broward County against North Broward Hospital District d/b/a Broward General Medical Center, Sunlife OB/GYN Services of Broward County, Inc., Sunshine Health Center, Inc., an entity that provided Cruz Chavez's prenatal care and two individual physicians.

The Circuit Court in Broward County granted the motion for final summary judgment dismissing the claims against Drs. Lewis and Bliss, and Sunlife OB/GYN Services of Broward County, Inc., and entered a final judgment on April 13, 1999. The Circuit Court in Broward County granted the motion for final summary judgment dismissing the claims against Sunshine Health Center, Inc., and subsequently entered a final judgment on April 19, 1999. The Florida Supreme Court recognized a parent's cause of action for infliction of emotional distress as a result of a stillbirth. However, the court reiterated the well established principle that there is no wrongful death cause of action for the death of a stillborn fetus. *Tanner v. Hartog*, 696 So.2d 705 (Fla. 1997). The claimants then proceeded with the claims against North Broward Medical Center.

Prior to trial, the claimants and North Broward Hospital District entered into a settlement for the total sum of $800,000 with $400,000, for the claimant, Virgilio Chavez and $400,000, for the claimant, Anagely Chavez, a minor. The Circuit Court in Broward County entered a final judgment on July 20, 1999. The North Broward Hospital District has already paid $200,000. Payment of the $600,000 balance is contingent on the passage into law of this claim bill to be paid in the amount of $300,000 to Virgilio Chavez and $300,000 to Anagely, partly in the form of an annuity.

RESPONDENT'S POSITION: The District did not admit liability. As part of the settlement, the District has agreed to support the passage of Senate Bill 20 (2000) in the current amount of $600,000 out of existing funds allocated for such

purposes. The payment of the settlement will not involve any likelihood of a tax increase in the North Broward Hospital Taxing District.

GUARDIANSHIP ACCOUNT: To protect the funds paid or to be paid by the Respondent and to ensure their proper expenditure, Virgilio Chavez, the natural father of Anagely Chavez, has been appointed the guardian of a trust account with Sun Trust Bank for the benefit of Anagely. The Circuit Court in Broward County has retained jurisdiction over expenditures from the account and has entered an order that no withdrawals may be made without a court order.

ATTORNEYS FEES: The attorney for the claimants have provided the Senate with an affidavit to the effect that the fees will be limited to 25 percent of all gross amounts paid or to be paid by the North Broward Hospital District, either before or after the claim bill is enacted into law.

RECOMMENDATIONS: Accordingly, I recommend SB 20 (2000) be reported FAVORABLY.

The Fiscal Resource Committee adopted the following amendment to Senate Bill 20:

Clarified that the $300,000 payment to Anagely Chavez, a minor, is to be paid to the "guardianship account" of Anagely Chavez.

Respectfully submitted,

Barry J. Munroe
Senate Special Master

cc: Senator Howard Forman
Faye Blanton, Secretary of the Senate
Jo Ann Levin, House Special Master