

SAMPLE CASE

MEDICAL MALPRACTICE POST-OPERATIVE ASPIRATION INSURANCE DEFENSE

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THE LEGAL NURSE CONSULTATION WAS ASKED BY THE DEFENSE COUNSEL TO PREPARE A SUMMARY, CHRONOLOGY AND DISCUSSION IN REGARDS TO THE ALLEGATIONS OF THIS MEDICAL MALPRACTICE CLAIM.

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C—C Medical Record Review

Summary

Mr. C was a 45 year old male, employed by J. J. Inc as a general contractor and resided at 123 Time Line, USA. On 2/8/01 several weeks following a work injury which resulted in an open comminuted right ankle fracture, Mr. C was taken to the operating room at General Hospital, Time Line USA for a 3rd surgical procedure to apply an external fixator device to the fracture. Mr. C suffered complications during the surgery which was later determined as aspiration of food material and resulted in subsequent death.

Past Medical History

- Comminuted Right Ankle Fracture (work accident) with compromised right leg blood supply 1/19/01
- Esophageal Dysfunction / Spasm Cardio-esophageal Junction confirmed by EGD and X-ray – 1984; treatment continued 6/91 and 3/92;
- Diffuse Esophageal Dilation confirmed by X-ray of the esophagus - Upper GI w/ Barium contrast – normal 8/8/94
- Hiatal Hernia 11/15/99; incidental finding chest x-ray 1/19/01
- Suggestive Achalasia 1/19/01
- Mediastinal Widening due to esophagus dilation confirmed by chest x-ray 2/1/01

Past Surgical History:

- Right ankle pinning with vascular bypass graft 1/19/01
- Fasciotomy closure 1/29/01

Social History: married, 2 children, non-smoker, occasional / social alcohol intake

Allergies: No known drug allergies

Summary: Course of Events

On 1/19/01 Mr. C sustained an open comminuted fracture of the right ankle as a result of a work accident. The fracture was severe enough that it was felt to have compromised blood supply to the leg. Mr. C was immediately transported to the emergency room at General Hospital, Time Line, USA for treatment. He was assessed and evaluated by S—S--, MD Orthopedic Surgeon on call at the time. Consultation was requested in regard to the vascular compromise and provided by M—T--, MD Cardiovascular / Thoracic Surgery. Dr. S felt the situation was critical and would require surgical repair. Pre-operative Chest X-ray was obtained which revealed a dilated esophagus **which was felt to suggest Achalasia** with a persisting Hiatal Hernia. This same day, Mr. C was taken to emergency surgery and underwent debridement of the wound and pinning of the fracture as well as a vascular bypass graft placement to restore blood flow to the leg. Spinal anesthesia was administered and Mr. C recovered from the surgery without adverse event.

Over the next 10 days Dr. S and Dr. T continued to monitor Mr. C's ankle fracture and leg wounds. Infectious Disease Consultation was requested and Mr. C was assessed and evaluated by B—Bb, MD Infectious Disease Specialist. Antibiotics were prescribed and Dr. B continued to follow. Mr. C was managed primarily on bed-rest, allowing occasional ambulation within the room and bathroom for brief interval. He ate regular meals without complaints and was able to consume the majority of the meal. He had one episode of nausea and emesis, early in the morning 1/20/01 and felt to be related to prior day's surgery. Compazine was prescribed by Dr. S and relief was verbalized by Mr. C. Later in the day on 1/20/01 and again on 1/21/01 Mr. C verbalized complaints of nausea without emesis described as "coming and going". No intervention was required and by the evening of 1/21/01 Mr. C verbalized relief of nauseous symptoms. Dr. S and Dr. T both felt this was related to the prior surgery. References or considerations in regard to the Pre-operative chest x-ray findings are not documented.

On 1/29/01 Mr. C underwent a second surgery to close the Fasciotomy wound of the right ankle. Again, spinal anesthesia was provided and again no complications were noted. He had been NPO after midnight the night prior. Once through the recovery period, Mr. C was given a regular diet and he continued on a regular diet with complaints. On one occasion McDonald's was brought in by the family. The diet points illustrate that he was asymptomatic in regards to any esophageal dysfunction.

On 2/1/01, a PICC line was installed for antibiotic therapy. A chest x-ray was performed to confirm placement. Results were compared to the prior chest x-ray dated 1/19/01. Finding on 2/1/01 revealed a mediastinal widening which was felt to be due to esophageal dilation (p. 464). Plans were in place for a third orthopedic surgery to place an external fixator. On 2/7/01 the nurses' notes revealed that Mr. C was instructed in regards to NPO status, he verbalized a understanding. Instruction and Consent forms were signed by Mr. C and witnessed by the nursing staff. It was also documented that NPO instruction was reinforced multiple times during evening hours.

On 2/8/01 Mr. C was taken to the operating room for the planned 3rd surgery. Dr. S performed a Right Ankle External Fixator device placement. Once more, Spinal anesthesia with sedation was provided. The Surgical Pre-Operative Check List and the Anesthesia Evaluation Form again revealed that Mr. C reported he had been NPO prior the procedure. Anesthesia induction occurred at 1335. Mr. C's vital signs and oxygenation were within normal ranges and he remained stable for the first 35 minutes of the procedure. Apparently between 1410 and 1415 Mr. C had an episode of vomiting. His blood pressure dropped to 80/40, hear rate slowed to 50. The ABC's of resuscitation were initiated and a Code Blue was called as a precautionary major. Immediately upon witnessing this episode A. -K, MD Anesthesiologist suctioned Mr. C and intubated and Dr. S was notified. Page 79 the O.R. Nursing Notes described the emesis as fresh food and the contents of the stomach were sent to pathology. Dr. S arrived at approximately 1415 at that point it was noted that Mr. C was breathing spontaneously and pulse was low but steady and strong. T—N--, MD Anesthesiologist arrived at 1427. Protocol for Advanced Cardiac Life Support was initiated it appears that Dr. T—N--, became the director of the code. The code continued until 1455 at which time the team had successfully stabilized Mr. C and he was transferred to the recovery room and subsequently to the ICU. Approximately 1505 the pathology results in regard to the contents of Mr. C's stomach returned. The report revealed digested "food stuff".

Following the course of events in the O.R. Dr. S had a conversation with Mr. C's wife. The content of the conversation was not documented however immediately following that conversation Dr. S spoke with the charge nurse of the surgical floor. Dr. S. documented that the charge nurse had assured him the Pre-Operative NPO protocol had been followed prior to surgery and that Mr. C. verbalized an understanding of the recommendation. Dr. S. instructed the charge nurse to inventory the food items in Mr. C's room and an extensive list was prepared and noted (page 1336).

4. Mr. C exhibited no symptoms of GI distress or dysfunction prior the surgery. As diagnostic investigation is usually prompted by subjective complaints or objective findings why would these providers further investigate for GI complications?
5. The description and character of the emesis obtained intra-operatively suggest "fresh food". As the nursing staff well documents instruction and compliance with NPO status it will be important to discuss with the staff the manner in which NPO was monitored, further confirm Mr. C's verbalization of understanding and compliance in regard to NPO status as well as discuss with family members their observations and understanding of NPO status.
6. An extensive inventory list describing empty candy wrappers, potato chip wrappers present in Mr. C's room was provided by the nursing staff which strongly suggests the intake of food items prior the surgery. It will be important to discuss with the nursing staff the manner in which they monitored Mr. C's intake. It may also be important to further investigate the manner in which these types of food were provided to Mr. C. and perhaps the time-period in which they were provided. Had these items been given to him a couple days prior the surgery or the evening before surgery? Did family bring them in or perhaps another visitor?

Weaknesses:

1. Past tests and GI work-up were done at G-Hospital and should have been on Mr. C's chart. It is usual and customary for the attending physician to request all old records to the floor for review and inclusion of any pertinent data in the current record. Considering some the records may have been too old for retrieval; the Chest X-ray 11/15/99 and esophagus x-ray 8/8/94 should have been readily available. NOTE: Anesthesia and the Surgeon are primarily responsible to obtain old records however the plaintiff may maintain the nursing staff is also responsible for being aware for past diagnostic findings; if that point is made the plaintiff may argue that the nurses failed to notify the physician of abnormal diagnostic results.
2. There was no chest x-ray performed in preparation of the surgery. However a chest x-ray was obtained 1 week prior (before 2nd surgery) which showed no cardiac abnormalities and most likely was considered complete; cardiopulmonary anomalies are the primary purpose of chest x-ray versus the incidental GI findings that might be viewed. It will be important to discuss with the treating providers as well as the medical expert Radiologist and perhaps Anesthesia the significance of no chest x-ray in regard to Mr. C's outcome. As the plaintiff may maintain further work up was warranted, it will be important to further discuss with the treating providers the assessment findings that assured them no further action was necessary (i.e. no subjective patient complaints, not currently on treatment).
3. The signature on the Anesthesia Evaluation is illegible and remains unclear as to who performed the evaluation. Clearly Dr. A provided the anesthesia. As this may allow a window of opportunity for the plaintiff to maintain a lack of continuity in care it will be important to determine the author of the anesthesia evaluation and in what manner the information was communicated to Dr. A. (*Usually these forms accompany the patient, into the O.R. suite as well as a verbal report*).
4. There are some inconsistencies in the nursing and medical documentation in regards to the patient's past medical history with reference to GI Status. It will be important to discuss with the nursing staff and treating providers the manner in which they gained their information regard Mr. C's past medical history (i.e. from Mr. C, his wife, previous documented history, other family members). Where they aware of his GI history?
 - ER nursing assessment; no pre-existing conditions

- Dr. S initial H&P does not address past history in any fashion. (This may be due to emergent status on admission).
 - Dr. M Vascular surgeon initial consultation note does not address past medical history
 - Med/Surg Nursing Admission Assessment noted: "Acid Reflux under past medical history; nausea / hypoactive bowel sounds under GI Assessment; patient complain of history acid reflux occasionally takes mag/alum products.
 - Dr. B, Infectious Disease Consultation documents; "past medical history – "unremarkable".
 - Dr. D. Pulmonary Consultation documents; "no obvious medical problems"
 - Dr BG Neurology Consultation documents; "past medical history – none".
 - Dr. H Gastroenterology documented: "past history of reflux and Hiatal hernia". As he is the GI specialists he would be the one to most likely "pick up" on this diagnosis however he did not note Achalasia as a pre-existing diagnosis.
5. The providers that do note GI symptoms, document in a manner suggestive of "generic or insignificant" complaints further supported by the fact that Mr. C failed to report any prescription drugs or therapy or offer any information in regards to prior work-up for GI complaints, which would indicate minimal problems therefore it will also be important to further discuss with the Medical Experts as well as the treating providers the frequency and/or typical overall population use of over the counter anti-acids for minor digestive problems particularly among people in this age group; in order to establish a relatively benign/shallow complaint offered by Mr. C at the time of these interviews.

Suggestions for Expert Testimony

1. Orthopedic Surgeon
2. Gastroenterologist
3. Anesthesiologist
4. Medical / Surgical Nurse

Suggestion for Additional Discovery

1. Past Medical History, Gastroenterology and/or Family Medicine Clinic to further investigate the extent of Mr. C's. Reflux Disease (GERD).

Sample Work Product: Post-Operative Aspiration

Response to Allegations

Response to Allegations

Full Name	Description
<p>1 Failed to inform the patient of risk and complications of spinal anesthetic.</p>	<p>Duty falls to the surgeon and Anesthesiologist. A signed consent form is present in the record page 1436. S--S--, M.D. also documents the gravity of the patient's condition and serious nature of the surgery to be performed.</p>
<p>2 Failed to take precautions in administering anesthesia</p>	<p>Again, this duty falls to the responsibility of the Anesthesiologist and is dependent on his knowledge and skill. If the hospital is not exonerated from this allegation and it is required we are able to do further research into applicable standards.</p>
<p>3 Failed to recognize symptoms of deteriorating condition intraoperatively</p>	<p>This duty would fall to all present in the OR. Perioperative records and code record indicate the health care responded in a timely and appropriate manner to the emesis and ensuing hypotensive, bradycardic episode.</p> <ul style="list-style-type: none"> • Airway was established by intubation • He was noted to have spontaneous respirations and pulse.
<p>4 Failed to properly resuscitate the patient</p>	<p>Code Team is responsible for this duty. As previously stated there are some discrepancies and/or inconsistencies in the documentation of events.</p> <ul style="list-style-type: none"> • these should be clarified to confirm compliance • we should request to obtain for medical review the code strips <p>Based on the medical records provided</p> <ul style="list-style-type: none"> • Drug were administer appropriately • Defibrillation was administered in an appropriate and timely manner in response to the ventricular fibrillation noted. <p>Note: If the rhythm strips confirm these details, a chart that parallels the medication and defibrillation of the actual code in correlation with the ACLS protocol may be a useful exhibit tool to illustrate the successful efforts of the staff to resuscitate Mr. Ca--.</p>
<p>5 Failed to meet the standard of care when providing surgical and anesthetic care.</p>	<p>Duties fall to the responsibility of the surgeon and anesthesia providers. It will be important to identify the group employing the anesthesia providers. Again, if needed we can research the appropriate anesthesia medication and precautions in presence of the diagnosis of GERD, Achalasia and/or gastrointestinal anomalies. It may be significant to research these details prior retaining the anesthesia medical expert.</p>

Discussion of Diagnosis / Review of Literature**Anesthesia preparation:**

NPO status simply means "nothing by mouth" that includes fluids, foods and many times even oral medications. Prior to induction of anesthesia it is very important the patient stomach is empty therefore most often the patient is put on an NPO status for 6-12 hours before the procedure. In some cases clear liquids are allowed up to 2 hours prior the procedure. Clear liquids include any drink you can see through such as water, black coffee, fruit juices without pulp (apple), some carbonated beverages (soda pop).

Food and Fluids are restricted to reduce the risk of aspiration by reducing the stomach contents at the time of the procedure. Aspiration occurs when an object or liquid is inhaled into the respiratory tract following a regurgitation of stomach content into the throat. Aspiration during anesthesia is uncommon but if it does occur it can cause severe complications,

The three main phases of anesthesia are 1) induction which involves intravenous anesthetics, often along with inhaled anesthetics. As these drug enter directly into the blood stream unconsciousness usually takes place in less than a minute. 2) Maintenance and monitoring, the anesthesiologist carefully monitors breathing heart rate, and blood pressure along with other vital function. Anesthesia is adjusted based on the patients responses during the procedure and 3) Emergence is the final phase when the procedure is completed, anesthetic is discontinued. The body clears the anesthesia and the effects begin to wear off. How quickly this happens depends on the drugs used.

General anesthesia affects the whole body. Most side effects are minor and can be easily managed. However, general anesthesia also suppresses the normal throat and gag reflexes which naturally prevent anesthesia therefore an endotracheal tube is inserted to help prevent aspiration.

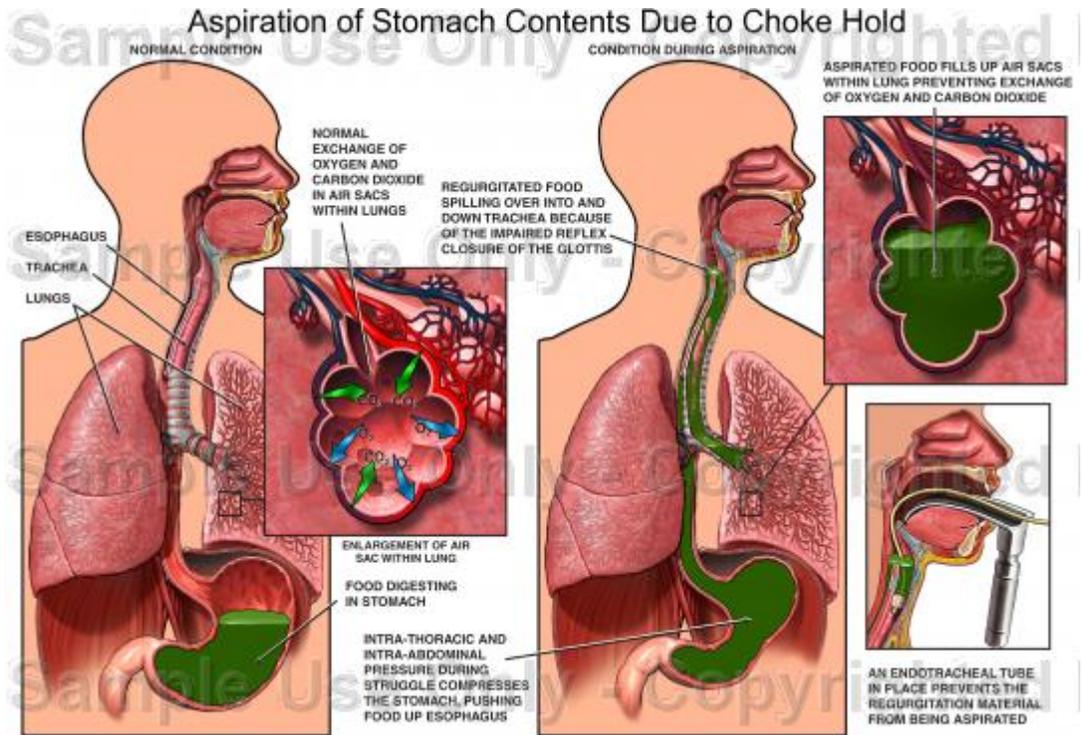
Endotracheal intubation is the insertion of a soft rubber or plastic tube into the "windpipe" through the nose or mouth. As well as minimizing aspiration the intubation is also done to deliver oxygen or inhaled anesthetic directly into the lungs and is quite commonly used with general anesthesia to help control breathing during the surgery. Serious complication are rare, however quite often the patient will experience a sore throat or even hoarseness from the tube.

Aspiration can occur silently without the anesthesiologist knowledge. The most common signs and symptoms include; **tachypnea** (*increased heart rate*), **rales**, **cough**, **cyanosis**, **wheezing and fever**. This can occur during the procedure or in the first few, (commonly 1-2) hours after.

Aspiration can produce pulmonary embarrassment by severe mechanisms, but the classic "Mendelson Syndrome" (sequence of events following the aspiration of gastric contents) is caused by chemical injury due to acid material. Critical values for gastric pH and volume, , are considered to be pH < 2.5 and volume >0.4 ml/Kg.

Simply, aspiration occurs when some kind of material enters the pharynx from the trachea and can occur during the course of general anesthesia when the patient airway reflexes are depressed.

The diagram shows the relationship of the stomach, esophagus and lungs as well as the endotracheal tube insertion. When food items enter the respiratory anatomy it can fill and block the air sacs inhibiting the air exchange. As the endotracheal tube enters the airway via the "throat" it can simulate choking thus initiate the gag reflex causing peristalsis or motion reflexes into the stomach resulting in vomiting the contents. The patient is on his back inhibiting the contents to expel therefore allows the opportunity to enter the open airway.



Several risk factors can be related to aspiration. Usually these risks are related to the patient's predisposing factors such as: delayed

gastric emptying or regurgitation of stomach contents. Sometimes the patient has a difficult airway to manage or if the patient is extremely obese.

The consequences of pulmonary aspiration depend on the type of material aspirated, its volume and its pH. Even a small amount of acidic material can cause a severe pneumonitis. When an acidic fluid is aspirated it can immediately cause alveolar-capillary breakdown, resulting in interstitial edema (swelling), intra-alveolar hemorrhage, atelectasis increasing airway resistance and commonly hypoxia. These changes usually start immediately or within minutes and often worsen within a period of hours or may result in immediate respiratory failure.

Respiratory Acidosis occurs when the lungs cannot remove all the carbon dioxide, the normal metabolic by-product produced by the body. Because of this disturbance of acid-base balance, body fluids become excessively acidic. In severe cases, the carbon dioxide builds up very quickly, leading to severe disturbances in the acid-base of the blood.

Respiratory acidosis can be a sign of respiratory failure, with dangerously low blood oxygen levels. Excessive respiratory acidosis may lead to confusion, lethargy and poor organ function, low blood pressure and shock.

Respiratory Arrest is a prolonged apnea which means the absence of spontaneous breathing. This is life threatening and require immediate attention. In the case of aspiration this is very similar to drowning, which is suffocation from fluid or water. As the heart and the lungs are each dependent on the other, these ventilation abnormalities create circulatory shock leading to a cardiac dysfunction and eventually cardiac arrest.

Sample Work Product: Post-Operative Aspiration

Case Research: Literature

Preoperative Evaluation

Case Research: Preoperative Evaluation

Authority Name	Extract Text
Berry and Kohn's Operating Room Technique, 8th ed., Atkinson and Fortunato, Mosby 1996	<p>Preoperative Teaching should take place in three levels</p> <ol style="list-style-type: none"> 1. Information - explanation of procedure, patient care activities and physical feelings that the patient may encounter during the perioperative experience. 2. Psychosocial support - interactions enhance coping mechanisms to deal with anxiety and fears, and provide emotional comfort. 3. Skill training - guided practice of specific tasks to be performed by the patient in the postoperative period can decrease anxiety, hasten recovery and help to prevent complications.
Berry and Kohn's Operating Room Technique, 8th ed., Atkinson and Fortunato, Mosby 1996	<p>Admission to Holding Area</p> <p>The nurse greets the patient by name and introduces herself. Duties to complete at this point include:</p> <ol style="list-style-type: none"> 1. Verify identification 2. Verified surgical procedure, site surgeon 3. Review chart for completeness <ul style="list-style-type: none"> • Medical history and physical examination • Laboratory reports • Consent forms 4. Takes vital signs 5. Verifies allergies and medication history 6. Checks skin tone and integrity 7. Verified physical limitations 8. Notes mental state. 9. Covers patient hair with cap 10. Put clean gown and warm blanket on patient <p>The holding area nurse records pertinent findings on the perioperative nursing record. If a perioperative nursing assessment has not been done, the hold area nurse must asses the patient's needs, formulate the nursing diagnoses and expected outcomes and prepare the individualized plan of care. If the patient has been sedated this can be difficult.</p>
Berry and Kohn's Operating Room Technique, 8th ed., Atkinson and Fortunato, Mosby 1996	<p>Since the 1920's nursing leaders advocate the importance of both psychological and physycological preparation for surgical patients. For all patients preoperative physical preparation is designed to help the patient overcome the stresses of anesthesia, pain, fluid and blood loss, immobilization and tissue trauma.</p> <p>Preoperative patient interviews should be performed by perioperative nurses who are experienced and possess complete knowledge of surgical procedure.</p> <p>Steps to Successful Preoperative Visits.</p> <ol style="list-style-type: none"> 1. Review the patient's chart and records. Focus on medical and nursing diagnosis and surgical procedure to be performed. The following data should be assessed and evaluated by both medical and nursing staff. <ul style="list-style-type: none"> • Biographic information including; name, age, sex, family status ethnic background education, patterns of living, previous hospitalization and surgical procedures, religion. • Physical Findings to include; vital signs, height, weight, skin integrity, allergies, presence of pain, drainage, bleeding, state of

Case Research: Preoperative Evaluation

Authority Name	Extract Text
**	<p>consciousness and orientation, sensory or physical deficits.</p> <ul style="list-style-type: none"> • Special therapy such as; tracheostomy, inhalation therapy, hyperalimentation • Emotional status; understanding, expectations, specific problems concerning comfort, language barriers <p>Baseline parameters are essential for accurate intraoperative and postoperative assessments.</p>
<p>Lippincott Manual of Nursing Practice., 6th ed., Nettina (editor) Lippincott-Raven 1996</p>	<p>Preoperative Care / Patient Education</p> <p>Patient education is a vital component of the surgical experience. Preoperative patient education can be offered through conversation, discussion, audiovisual.</p> <p>Teaching strategies include;</p> <ol style="list-style-type: none"> 1. Obtain a data base - determine what the patient already knows. 2. Ascertain patient psychosocial adjust to impending surgery 3. Determine cultural or religious beliefs <p>Plan and implement teaching program</p> <ol style="list-style-type: none"> 1. at patients level of understanding 2. plan presentation 3. include family 4. encourage participation 5. provide time and encourage questions. 6. demonstrate essential techniques, provide opportunity for practice <p>Provide general information to include</p> <ul style="list-style-type: none"> • details of preoperative preparation • offer general information on surgical procedure • tell when surgery is scheduled • let patient family know they will be kept informed • describe post anesthesia care unit • stress importance of active participation post operative recovery.
<p>Miller: Anesthesia, 5th ed., Copyright © 2000 Churchill Livingstone, Inc</p>	<p>Anesthesia Medical Consultation (Page 876)</p> <p>An anesthesia medical consultation increases the awareness of surgeons and patients regarding the expertise of the anesthesiologist on perioperative medicine. For one thing, this type of consultation may initiate diagnostic and/or therapeutic actions for a specific medical problem. For example, instead of providing a general "clearance" for anesthesia and surgery, the APEC anesthesiologist may recommend referral of the patient to a specialist such as a cardiologist, for evaluation of a specific intraoperative concern.</p> <p>The job of the anesthesiologist is not simply to put the patient to sleep and to wake him or her when surgery is over, but to maintain homeostasis during the assault of surgery and to provide pain relief to blunt the effects after the assault. To do this, the anesthesiologist must interfere with the stress response induced by pain, anticipate periods when the stress response will not be present, plan for the rare situations in which the patient's medical problems may occur acutely, and, at the same time, manage the</p>

Case Research: Preoperative Evaluation

Authority Name	Extract Text
**	<p>patient's chronic medical conditions.</p> <p>Gastrointestinal diseases may increase the potential for aspiration of gastric contents. For example, the gastroparesis of ulcer disease is often accompanied by solid food in the stomach, and inflammatory bowel disease may be accompanied by arthritis of the neck. Gastrointestinal disease also increases the potential for dehydration, electrolyte disturbances, and anemia. The presence of gastrointestinal or hepatic disease can give clues about possible endocrine, pulmonary, or cardiac disease (e.g., gastritis in the alcoholic patient could indicate the need to search for alcoholic cardiomyopathy).</p>

Sample Work Product: Post-Operative Aspiration

Fact Chronology 6/7/84 - 1/29/01

Authored by:

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A Legal Resource Service**

Fact Chronology 6/7/94 - 1/29/01

Date & Time	Source(s)	Fact Text	Description
Thu 06/07/1984	<p>General Hospital</p> <p>G.H. Physician Progress Notes W--H-- W--, M.D. Page GH 01</p>	<p>Esophogram Findings reveal: Prominent dilation of the entire thoracic esophagus consistent with Cardiospasm or perhaps a stricture at the Cardio-esophageal junction. Evidence of gastritis and diffuse peptic disease is seen affecting the entire duodenum.</p>	
Tue 08/07/1984	<p>General Hospital</p> <p>G.H. Physician Progress Notes W--H-- W--, M.D. Page GH 03</p>	<p>Inpatient Admission: History and Physical findings reveal a Chief Complaint of:</p> <ul style="list-style-type: none"> • Difficulty Swallowing <p>Impression:</p> <ul style="list-style-type: none"> • Possible stricture of the esophagus • Possible spasm of the esophagus. 	
Thu 08/09/1984	<p>General Hospital</p> <p>G.H. Endoscopy Report B--B--, M.D. GH 06</p> <p>G.H. Cytopathology Report P--P--, M.D. GH 09</p>	<p>EsophagoGastroDuodenoscopy: a/k/a EGD</p> <p>Endoscopic Examination:</p> <ul style="list-style-type: none"> • Minimal, if any, duodenitis otherwise normal • No evidence of ulceration, old or new • Body of stomach was normal • On withdrawal it was seen that the esophagus appeared slightly dilated but not greatly so, and there was peristaltic and tertiary contraction both coming and going./ • No inflammation of the esophagus <p>Dilators used:</p> <ul style="list-style-type: none"> • 44 French - no problem • 66 French - no problem <p>*There was slight hesitation at the cardia, but no appreciable resistance.</p> <p>Post Operative Diagnosis</p> <p>* Overall picture here is esophageal motility disorder with weak peristalsis in the esophagus and failure at time of the sphincter to relax.</p> <p>* No true cardiospasm is present at this time</p>	
Fri 08/10/1984	<p>General Hospital</p> <p>General Hospital, Discharge Summary Page GH 04</p> <p>General Hospital, Nursing</p>	<p>Discharge Summary reveals: Discharge Diagnosis:</p> <ul style="list-style-type: none"> • Spasm of the Cardio-esophageal junction <p>Discharge Instructions at this time include:</p> <ul style="list-style-type: none"> • Tagemet 300 mg at bedtime 	<p>These discharge medications are used to decrease the acidity of the stomach and improve the motility.</p>

Fact Chronology 6/7/94 - 1/29/01

Date & Time	Source(s)	Fact Text	Description
**	Discharge Instructions L-- S--, R.N.	<ul style="list-style-type: none"> • Maalox 1 ounce 4 time daily • Librax one pill before meals • Reglan 10 mg 4 time daily 	**
Sun 06/09/1991	General Hospital General Hospital, Emergency Room Note L--L--, M.D. S--S--, M.D. (Orthopedist)	Emergency Room Note reveals a Chief Complaint of: <ul style="list-style-type: none"> • Dislocated Right Shoulder after MVA (*Note: ER assessment sheet reveals taking "no medications")	
Wed 03/25/1992	General Hospital General Hospital, Emergency Room Note R--R--, M.D.	Emergency Room note reveals a Chief Complaint of: <ul style="list-style-type: none"> • Laceration Left Hand (*Note: Again nursing assessment reveals not currently taking routine medications)	
Mon 08/08/1994	General Hospital General Hospital Radiology Reports K--M--, M.D.	Esophagus Xray reveals: Findings: <ul style="list-style-type: none"> • Diffuse esophageal dilatation down to the esophago-gastric junction where there is a narrowing present. Upper GI with Barium: Findings: <ul style="list-style-type: none"> • Normal 	
Sat 12/05/1998	General Hospital General Hospital Radiology Reports M--M--, M.D.	Chest Xray: Reason for exam: <ul style="list-style-type: none"> • Left Lower Lobe Pneumonia Impression: <ol style="list-style-type: none"> 1. No acute abnormality identified 2. Specifically, no sign of pneumonia on the left side 	
Mon 11/15/1999	General Hospital General Hospital Radiology Reports Page 56 M--M--, M.D.	Chest Xray: Reason for exam: <ul style="list-style-type: none"> • Complaints of chest pain after lifting injury ten days ago. Findings reveal: <ul style="list-style-type: none"> • Comparison is made to a study of 12/5/98. An air fluid level is present within the middle mediastinum. This appears to lie within a dilated esophagus. While no definite air fluid level is noted on the prior view, some dilatation of the esophagus was probably present in 	

Fact Chronology 6/7/94 - 1/29/01

Date & Time	Source(s)	Fact Text	Description
**	**	retrospect. • Hiatal Hernia is also evident • No infiltrates or effusions • Cardiovascular structures are unremarkable for age. • Markedly dilated esophagus with associated air fluid level is frequently seen with Achalasia. Esophageal strictures may produce a similar finding. Impression: 1) Markedly dilated esophagus suggestive of Achalasia 2) Hiatal Hernia	**
Fri 01/19/2001 12:10 p.m. CT	General Hospital General Hospital, Emergency Dept., Nursing Assessment S--Er--, R.N. Page 1311	Emergency Department Nursing Assessment reveals: Allergies/Reactions - None Past hospitalizations/surgeries: • Back Surgery 30 years ago Pre-existing conditions: • Reported as none Medications: • Reported as No Current Medications.	
Fri 01/19/2001 12:15 p.m. CT	General Hospital General Hospital, Emergency Room Record Page 62-64 N--N--, M.D. S--S--, M.D.	Emergency Department Physician Records reveals: Chief Complaints: • Open Fracture of the right tibia (*Note: Medications listed as "None") N--N--, M.D is listed as attending however does not appear to have seen the patient at this time. S--S--, M.D. is noted as examining patient.	
Fri 01/19/2001 12:15 p.m. CT	General Hospital General Hospital, Radiology Report, Chest Xray H--M--, M.D. Page 462	Chest Xray: Chief Complaint: Trauma, Pain Pre-op * Compared with prior study of 11/15/99, current examination reveals: • dilated esophagus - suggesting Achalasia • persisting Hiatal Hernia • Cardiopulmonary anatomy is unchanged without acute Cardiopulmonary Disease Impression: Stable esophageal distention suggesting Achalasia with Hiatal Hernia * No Acute Disease.	

Fact Chronology 6/7/94 - 1/29/01

Date & Time	Source(s)	Fact Text	Description
<p>Fri 01/19/2001 12:28 p.m. CT</p>	<p>General Hospital General Hospital, Electrocardiogram Page 504 machine generated no provider listed</p>	<p>EKG report reveal: Normal Sinus rhythm with occasional premature ventricular contraction</p> <p>* Otherwise Normal EKG</p>	<p>Premature Ventricular Contraction a/k/a PVC</p> <p>The contraction of the cardiac ventricle prior to the normal time, caused by an electrical impulse to the ventricle arising from a site other than the sinoatrial node.</p> <p>The PVC may be a single event or occur several times in a minute or in pairs or strings. Three or more PVCs in a row constitute ventricular tachycardia.</p>
<p>Fri 01/19/2001 12:45 p.m. CT</p>	<p>General Hospital General Hospital, Admission History and Physical S--S--, M.D. Page 69</p>	<p>Admission H & P reveals: Reports to the Emergency with extreme pain and was unable to provide a very accurate past medical history other than; Chief Complaint: Injury to leg from accident with mechanical equipment.</p> <p>Physical Examination: do not address GI specifically, but notes: * Abdomen Unremarkable.</p> <p>Diagnosis: 1) Open comminuted displaced intra-articular fracture of the distal right tibia and fibula. 2) Loss of circulation of the right foot.</p>	
<p>Fri 01/19/2001 1:00 p.m. CT</p>	<p>General Hospital G.H. Physician Progress Notes page 201-202 S--S--, M.D.</p>	<p>Physician Progress Note reveals; Patient and his mother were explained x-rays and severe nature of injury and that patient may lose his leg. Extensive surgery is necessary on the fractured bones and damaged blood vessels and there were many risks with the surgery and his leg would never be normal.</p>	
<p>Fri 01/19/2001 1:15 p.m. CT</p>	<p>General Hospital General Hospital, Anesthesia Evaluation Page 96 R--R--, M.D.</p>	<p>Pre/post Anesthesia Evaluation reveals;</p> <ul style="list-style-type: none"> • Central nervous system, cardiovascular, respiratory, endocrine, kidney and liver are all noted as negative • No family history of anesthesia problems • Patient had back surgery with general anesthesia, with no problems • Recent drug therapy and/or current medications states as "none" 	

Fact Chronology 6/7/94 - 1/29/01

Date & Time	Source(s)	Fact Text	Description
**	**	<ul style="list-style-type: none"> • Patient reports NPO (nothing by mouth) since 10:30 a.m. 	**
Fri 01/19/2001 1:56 p.m. CT	General Hospital General Hospital, Anesthesia Record Page 97-99 R--R--, M.D.	<p>Anesthesia Record Reveals; Anesthesia Begins now</p> <ul style="list-style-type: none"> • Does not appear to be airway in place • Oxygen delivered at 4L/Nasal Cannula • SaO2 92-99% • Epidural Catheter inserted for purpose of post operative pain 	<ol style="list-style-type: none"> 1. Oxygen saturation is an indicator of the percentage of hemoglobin saturated with oxygen. Normal oxygen saturation levels are 97% to 99 %. 2. Epidural catheter is a very fine plastic catheter that is place through the skin into the epidural space in the spine. This catheter is left in place for a period of time allowing access to the epidural space to inject medication, such as local anesthetics and/or narcotic for pain relief.
Fri 01/19/2001 2:00 p.m. CT	General Hospital General Hospital, Operative Report S--S--, M.D. M--M--, M.D.	<p>Operative Report Reveals; Preoperative Procedure: Irrigation and debridement of open wound of right lower leg with decompression of compartments and stabilization of the fracture by insertion of a Steinmann pin through the plantar aspect of the foot across the subtalar joint and ankle joint into the tibia. Performed under spinal anesthesia.</p> <p>Intraoperative Vascular Consultation: { Occurred intraoperatively during initial emergency surgery to stabilize fracture. Does not address past history }</p> <p>Impression: Open cominuted right tibial/fibular fracture, just above ankle Plan: Intraoperative arteriography, vascular reconstruction if necessary.</p>	
Fri 01/19/2001 8:00 p.m. CT	General Hospital General Hospital, Operative Report S--S--, M.D.	<p>Operative Report reveals; Surgery ended at this time Post operative Procedure:</p> <ol style="list-style-type: none"> 1. Intraoperative right femoral arteriography 2. Explorations of right posterior tibial and peroneal vessels 3. Explorations of right anterior tibial vessels 	

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**	**	4. Ligation of right peroneal and posterior tibial arteries 5. Right popliteal to posterior tibial bypass using reverse saphenous vein for compartment fasciotomy.	**
Fri 01/19/2001 8:01 p.m. CT	General Hospital General Hospital, Physician Orders S--S--, M.D.	Physician Orders reveal 1. Pepcid 20 mg IV every 12 hours	
Fri 01/19/2001 10:00 p.m. CT	General Hospital General Hospital, Nurses Notes Page 1318 C--C--, R.N.	Narrative Nursing Notes reveal; Received from post anesthesia care unit at this time Alert and oriented, able to move all extremities	
Sat 01/20/2001 12:20 a.m. CT	General Hospital General Hospital, Floor Nursing Assessment P--D--, R.N. Page 1313	Medical / Surgical Nursing Assessment reveals; Height 6'1" Weight 209# Allergies - none Hospitalization and Surgeries: 1. Back Surgery 30 years ago 2. History of "acid reflux" Medications: None Review of Systems 1. Neurological - normal 2. EENT (eyes, ears, nose, throat) assessment - normal 3. Skin - normal 4. Respiratory - normal 5. Circulatory - normal 6. Gastrointestinal - normal • Nausea and hypoactive bowel sounds are checked • Diet noted as regular (before surgery/admission) • Patient complains of a history of "acid reflux occasionally take Mag/Alum products 7. Genitourinary - normal 8. Musculoskeletal - normal except for current surgery 9 Psychosocial - normal	Note: appear this was the time the notes were enter into the computer. The initial nursing assessment should be completed up arrival/admission to the floor. It will be important to define with C--C--, R.N. and P--D--, R.N. the rational for this time frame. The plaintiff may maintain this time lapse as pertinent to the patient outcome. Ideally, nurses would document at the exact time of the action, however realistically this is not always possible. In turn it is not uncommon for computer entries to be completed by the end of the shift. Standard for normal commonly consists of Tolerate diet, no heartburn, nausea and vomiting. abdomen soft non tender, bowel sound present, regular bowel movements continent.

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Date & Time	Source(s)	Fact Text	Description
Sat 01/20/2001 7:15 a.m. CT	General Hospital General Hospital, Nurses Notes M--R--, R.N. Page 1318	Narrative Nursing Notes reveal; Patient complains of nausea, previously had emesis per night nure Compazine given per prn orders	Emesis note however nurses note fail to document and assess time, amount and characteristic of emesis.
Sun 01/21/2001	General Hospital General Hospital, Physician Orders S--S--, M.D. Page 208	Prochlorperazine (Compazine) 10 mg IM PRN (as needed) for nausea.	
Tue 01/23/2001 9:00 a.m. CT	General Hospital G.H. Physician Progress Notes S--S--, M.D. Page 215	Physician Progress notes reveal; Patient denies pain. Does have mild numbness in both legs CE (epidural catheter) removed intact, no apparent anesthesia complications.	
Wed 01/24/2001 4:59 a.m. CT	General Hospital General Hospital, Nurses Notes S--Ss, R.N. Page 1323	Patient has snacks in room	
Sat 01/27/2001	General Hospital General Hospital, Consultation Notes B--Bb-, M.D. Page 76-77	Infectious Disease Consultation requested by S--S--, M.D., reveals: Initial Consultation for evaluation of a fever, suspected infection of leg wounds. Past medical history is noted as Essentially unremarkable.	
Sun 01/28/2001 3:00 p.m. CT	General Hospital General Hospital, Physician Orders R--R--, M.D. Page 227	Physician Orders (Anesthesia) reveal: 1. NPO after midnight for solids 2. Clear liquids until 0800 and then NPO 3. Offer clear liquids at 0730 4. Pepcid 20 mg po now with sip of water 5. Reglan 20 mg po now with sip of water 6. Valium 5 mg po now with sip of water 7. May continue Oxycodone with sip of water	Pepcid is routine given pre-operatively to decrease acidity of the stomach. Reglan is routinely given pre-operatively to decrease nausea secondary to anesthesia and narcotics. Oxycodone is used for pain. This may present with a decrease of gastric motility, this can present in

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	**	**	**	the smooth muscle of the stomach as well as the duodenum, which delays the digestion of food in the small intestine. A Medical Expert review will be needed to determine this finding as pertinent to the outcome of Mr. Ca--..
	Mon 01/29/2001	General Hospital General Hospital, Pre-surgical Check List No Signature Page 108	Pre-surgical Check List reveals: Patient NPO after midnight Pepcid and Reglan given as preoperative medications.	
	Mon 01/29/2001	General Hospital General Hospital, Pre/Post Anesthesia Evaluation R--R--, M.D. Page 113	Pre/Post Anesthesia Evaluation: Relevant History reveals; • Central Nervous System, Cardiovascular, endocrine, Kidney and Liver are Negative • Respiratory System - Hx of GERD GERD is also noted in Recommendations Box NPO status box - Left Blank.	R--R--, M.D.'s preoperative evaluation fails to provide evidence of assessment and evaluation of previously noted history of GERD. In turn this entry does not document an assessment and evaluation of this patient's NPO status. It will be important to review and confirm these findings with the Medical Expert Anesthesiologist.

Sample Work Product: Post-Operative Aspiration

Glossary of Terms

Glossary of Terms

Full Name	Description
Achalasia	<p>Failure to relax; said of muscles, such as sphincters, the normal function of which is a persistent contraction with periods of relaxation.</p> <p>Achalasia of the cardia Failure of the cardiac sphincter to relax, restricting the passage of food to the stomach.</p> <p>In advanced cases, dysphagia is marked and dilation of the esophagus may occur. SYN: cardiospasm.</p>
Arterial Blood Gases	<p>Literally, any of the gases present in blood; operationally and clinically, they include the determination of levels of pH, oxygen (O₂), and carbon dioxide (CO₂) in the blood.</p> <p>ABGs are important in the diagnosis and treatment of disturbances of acid-base balance, pulmonary disease, electrolyte balance, and oxygen delivery. Values of the gases themselves are usually expressed as the partial pressure of carbon dioxide or oxygen, although derived values are reported in other units. Several other blood chemistry values are important in managing acid-base disturbances, including the levels of the bicarbonate ion, HCO₃, blood pH, sodium, potassium, and chloride</p>
Arteriogram	<p>A radiograph of an artery after injection of a radiopaque contrast medium, usually directly into the artery or near its origin. A catheter is usually inserted into a peripheral vessel and guided to the affected area by use of the Seldinger technique. The recording can be either serial film or digital imaging.</p>
GERD	<p>GERD gastroesophageal reflux disease.</p> <p>Management</p> <p>The primary goal of therapy in these patients is symptom relief. Diagnostic evaluation can, however, be useful in selected GERD patients to confirm the diagnosis, direct therapy, or identify complications. Regardless of whether diagnostic tests are used, the therapy of GERD need not necessarily progress in a stepwise fashion, beginning with the most conservative treatments. In some patients, such as those with severe or atypical symptoms, intensive medical therapy is appropriate as the initial treatment plan and may in fact help establish the diagnosis of GERD.</p> <p>Diagnostic Evaluation</p> <p>The history is usually sufficient to confirm the diagnosis of GERD and to warrant appropriate treatment. However, GERD patients can also have atypical symptoms, leaving one to rely on diagnostic studies to confirm that abnormal acid reflux is occurring and potentially responsible for the syndrome in question.</p> <ul style="list-style-type: none"> • Endoscopy should be used as the first diagnostic test of suspected GERD because it provides a means for both detecting and managing complications of GERD as well as excluding other diseases. • Ambulatory 24-hour pH monitoring is the most widely used test to establish the presence of excessive gastroesophageal reflux and to correlate symptoms temporally with reflux. • An alternative management strategy for a patient with suspected GERD is an empirical trial of potent antisecretory therapy. Several investigators have demonstrated that 1- to 2-week therapeutic trials with proton pump inhibitors identify most individuals likely to respond to prolonged therapy, including a substantial fraction of individuals judged not to have reflux on the basis of ambulatory pH monitoring studies.

Glossary of Terms

Full Name	Description
**	<p>In summary, GERD patients are usually well managed by using a careful medical history and empirical trials of antireflux therapy. Patients with long-standing symptoms or warning signs may benefit from endoscopic evaluation. Ambulatory pH monitoring is unnecessary in most patients but can be of value for patients refractory to antireflux therapy or for documentation of abnormal acid reflux in an individual who is being evaluated for antireflux therapy</p>
Hiatal Hernia	<p>The protrusion of the stomach upward into the chest through the esophageal hiatus of the diaphragm. The abdomen and chest are separated by a sheetlike muscle called the diaphragm. The esophagus goes through an opening (the hiatus) in the diaphragm to connect to the stomach. The upper stomach bulges through this opening to create a hiatal hernia. There are 3 types of hiatal hernia: sliding, paraesophageal, and mixed.</p> <ul style="list-style-type: none"> • Sliding hiatal hernia - In a sliding hiatal hernia, part of the stomach moves through the diaphragm so that it is positioned outside of the abdomen and in the chest. The lower esophageal sphincter (LES) often moves up above its normal location in the opening of the diaphragm. Most people with a sliding hiatal hernia have no symptoms, and it is often diagnosed when a person is being evaluated for other health concerns. However, if the LES moves above the diaphragm, it may not close well and stomach acid and juices may back into the esophagus (acid reflux). • Paraesophageal hernia - In a paraesophageal hernia, the stomach bulges up through the opening in the diaphragm (hiatus) alongside the esophagus (upside-down stomach). The LES remains in its normal location inside the opening of the diaphragm. This type of hernia most commonly occurs when there is a large opening in the diaphragm next to the esophagus. The stomach and, rarely, other abdominal organs (such as the intestine, spleen, and colon) may also bulge into the chest in a paraesophageal hernia. • Mixed hernia - In a mixed hiatal hernia, the LES is above the diaphragm as in a sliding hiatal hernia, and the stomach is alongside the esophagus as in a paraesophageal hiatal hernia. Paraesophageal and mixed hiatal hernias often have no symptoms or minimal symptoms. Symptoms may include vague, nonspecific abdominal complaints such as feeling full after a meal and indigestion. If not treated, the hernia can grow. This can result in twisting (volvulus) of the stomach (possibly leading to gangrene), which requires emergency surgical treatment. Because of the risk involved in emergency treatment, it generally is recommended that all people with these types of hernias undergo surgery regardless of the symptoms. <p>It remains unclear from the provided medical records, as to what type of hernia was previously diagnosed for J--Ca-- . It will be important in this case to request and obtain all films, office visits and diagnostic studies to discover the type of hernia J--Ca-- had. This area should also be reviewed by a strong GI medical expert to determine the significance of this finding as pertinent to the events in the OR.</p>

Sample Work Product: Post-Operative Aspiration

Medication Profile

Medication Profile

Full Name	Description
Compazine	<p>DRUG CLASS: Antiemetics/antivertigo; Antipsychotics; Phenothiazines</p> <p>Indications: Anxiety disorder, generalized; Nausea; Schizophrenia; Vomiting</p>
Crystalloid solutions	<p>Crystalloids are fluids that contain water and electrolytes. They are grouped as balanced, hypertonic, and hypotonic salt solutions. Crystalloid solutions are used to both provide maintenance water and electrolytes and expand intravascular fluid. The replacement requirement is 3- or 4-fold the volume of blood lost because administered crystalloid is distributed in a ratio 1:4 like extracellular fluid, which is composed of about 3 L intravascularly (plasma) and about 12 L extravascularly (i.e., about 20% should remain in the intravascular space).</p>
Lasix	<p>DRUG CLASS: Diuretics, loop</p> <p>Indications: Edema; Edema, pulmonary; Hypertension, essential</p>
Librax	<p>DRUG CLASS: Anticholinergics; Benzodiazepines; Gastrointestinals</p> <p>Indications: Enterocolitis, acute, adjunct; Irritable bowel syndrome; Ulcer, peptic, adjunct</p>
Maalox	<p>Antacid - over the counter</p>
Oxycodone	<p>DRUG CLASS: Analgesics, narcotic</p> <p>Indications: Pain, moderate to moderately severe Gastrointestinal Tract and Other Smooth Muscle</p> <p>Oxycodone causes a reduction in motility associated with an increase in smooth muscle tone in the antrum of the stomach and duodenum. Digestion of food in the small intestine is delayed and propulsive contractions are decreased. Propulsive peristaltic waves in the colon are decreased, while tone may be increased to the point of spasm resulting in constipation. Other opioid-induced effects may include a reduction in gastric, biliary and pancreatic secretions, spasm of sphincter of Oddi, and transient elevations in serum amylase.</p>
Pepcid	<p>DRUG CLASS: Antihistamines, H2; Gastrointestinals</p> <p>Indications: Adenoma, secretory; Gastroesophageal Reflux Disease; Ulcer, duodenal; Ulcer, gastric; Zollinger-Ellison syndrome; Esophagitis, erosive a/k/a Famotidine</p> <p>Famotidine is a competitive inhibitor of histamine H2-receptors. The primary clinically important pharmacologic activity of famotidine is inhibition of gastric secretion. Both the acid concentration and volume of gastric secretion are suppressed by famotidine, while changes in pepsin secretion are proportional to volume output.</p>

Medication Profile

Full Name	Description
Reglan	<p>DRUG CLASS: Antiemetics/antivertigo; Gastrointestinals; Stimulants, gastrointestinal</p> <p>Indications: Intubation, intestinal; Gastroparesis, diabetic; Nausea, postoperative; Nausea, secondary to cancer chemotherapy; Gastroesophageal Reflux Disease; Vomiting, postoperative; Vomiting, secondary to cancer chemotherapy</p>
Tagemet	<p>DRUG CLASS: Antihistamines, H2; Gastrointestinals</p> <p>Indications: Acid/peptic disorder; Adenoma, secretory; Hypersecretory conditions, gastrointestinal; Mastocytosis, systemic; Gastroesophageal Reflux Disease; Ulcer, duodenal; Ulcer, gastric; Zollinger-Ellison syndrome</p>

Sample Work Product: Post-Operative Aspiration

Health Care Providers

Health Care Providers

Full Name	Title	Works For
S--Ss, R.N.	Registered Nurse	General Hospital, Surgical Floor
J--B--, R.N.	Registered Nurse	General Hospital / Code Team
B--B--, M.D.	Gastroenterologist	Gastroenterology Associates
P--D--, R.N.	Registered Nurse	General Hospital, Surgical Floor
R--R--, M.D.	Anesthesiologist	General Hospital, Anesthesia Department.
R--LP, R.N.	Registered Nurse	General Hospital, Surgical Floor
M--R--, R.N.	Registered Nurse	General Hospital, Surgical Floor
L-- S--, R.N.	Registered Nurse	General Hospital, 3rd Floor
W--H-- W--, M.D.	Internal Medicine Specialist, Primary Care	Internal Medicine Associates
H--M--, M.D.	Radiologist	Radiology Associates P.C., General Hospital medical staff.
A--K--, CRNA	Certified Registered Nurse Anesthetist	General Hospital, Anesthesia Department
B--Mc--, R.N.	Registered Nurse	General Hospital, Code Team
C--C--, R.N.	Registered Nurse	General Hospital, Surgical Floor
D--H--, R.N.	Registered Nurse	General Hospital, PACU (recovery room)
S-- B--, R.N.	Registered Nurse	General Hospital, PACU (recovery room)
T-- A--, R.N.	Registered Nurse	General Hospital, Surgical Floor
K--C--, R.N.	Registered Nurse	General Hospital / Code Team
C--B--, M.D.	Neurologist	Neurology Associates, P.C.
M--M--, M.D.	Vascular Surgeon	Cardiovascular and Thoracic Surgeon, P.C.
S--Er--, R.N.	Registered Nurse	General Hospital, Emergency Department.
S. Ba--, R.N.	Registered Nurse / Code team recorder	General Hospital / Code Team
B--Bb-, M.D.	Infectious Disease Specialist	Internal Medicine Associates
M--L--, R.N.	Registered Nurse	General Hospital, Surgical Floor

Health Care Providers

Full Name	Title	Works For
S--S--, M.D.	Orthopedist	Orthopedic Associates
N--N--, M.D.	Family Practice Physician	Family Practice Associates, P.C.
K--M--, R.N.	Registered Nurse	General Hospital, Intraoperative personal
P--P--, M.D.	Pathologist	General Hospital, Laboratory
J--J--, R.N.	Registered Nurse	General Hospital, House Supervisor
T--N--, M.D.	Cardiologist	Cardiology Associates P.C.
J--N--, M.D.	Cardiologist	Cardiology Associates P.C.
R--R--, M.D.	Emergency Room Physician	General Hospital, Emergency Department
M--Y--, R.N.	Registered Nurse / Circulator	General Hospital, Intraoperative Personal
J-- Sm--, R.N.	Registered Nurse	General Hospital Emergency Dept
D--S--, M.D.	Anesthesiologist	Anesthesia Associates, P.C.
J--Ca--	Patient	
S--M--, R.N.	Registered Nurse / Scrub Nurse	General Hospital, Intraoperative Personal
S--B--, R.N.	Registered Nurse / Circulator	General Hospital, Intraoperative Personal
M--M--, M.D.	Radiologist	Radiology Associates P.C.
G--M--, R.N.	Registered Nurse / Charge Nurse	General Hospital, Surgical Floor
L--L--, M.D.	Emergency Room Physician	General Hospital, Emergency Department
R--C--, RNFA	Registered Nurse, First Assistant	General Hospital, Intraoperative Personal
K--M--, M.D.	Radiologist	Radiology Associates P.C.

Sample Work Product: Post-Operative Aspiration

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