Scenario 1

A 62-year old anesthesiologist, Dr. Joe Smith, is preparing an anesthetized patient in the operating room for placement of an internal jugular central venous catheter. The patient is to undergo a laparoscopic colectomy. The charge nurse, John Jones, notices that Dr. Smith has opened the CVP kit and placed it on the patient's chest but has not washed his hands and has not used the gown that his staff have available for him. He is pulling on a pair of sterile gloves after wiping a chlorhexidine prep swap over the patient's right neck. Dr. Sheila Marconi, the surgeon, is scrubbing at the sink outside the room.

Nurse Jones: Dr. Smith, are you planning on washing your hands and using a gown for this procedure?

Dr. Smith: No, this is a simple procedure. I've done thousands of them and have never had an infection.

Nurse Jones: Our hospital has a policy for washing hands and using sterile gowns when placing a central line.

Dr. Smith: Well, Dr. Marconi is already washing her hands and will be in here in just a few minutes. I want to get this line placed quickly so we don't have any delays. We've got a long day ahead of us.

Nurse Jones: I understand but we're working really hard here at this hospital to avoid central line infections. You really need to follow our policy.

Dr. Smith: I understand but let's just not worry about it for this first case. It will only take me a minute.

Dr. Smith proceeds to place his needle and, while threading the guide wire, the end of it appears to brush against Dr. Smith's scrub suit top and arm.

Nurse Jones: Dr. Smith, you've got a contaminated wire. I was afraid something like this would happen. Let me get you another kit.

Dr. Smith: No, it never touched anything. We're just fine.

Nurse Jones: No way! I saw it touch your arm. Pull it out. If you'd had followed our policy and put on a gown, this would never have happened.

Dr. Smith: I'm telling you it never touched me. And we're giving antibiotics, anyhow.

Dr. Smith proceeds to thread the catheter over the wire. Nurse Jones runs to the door and calls to Dr. Marconi.

Nurse Jones: Dr. Marconi, Dr. Smith has contaminated his central line. You've got to get in here.

Dr. Smith: Are you nuts? You're way out of line. I'm the doctor here and that line is perfect.

Nurse Smith: You're being obstinate and dangerous.

Dr. Marconi, entering the room: Joe, what's going on? John tells me that you contaminated the catheter. Is that true?

Dr. Smith: No way! He's crazy. That line is perfect.

Dr. Marconi: John, I'm not sure what to say. I've worked with Joe for years and he's never had a problem.

Nurse Jones: Well, I can only tell you what I saw. First, Dr. Smith refused to follow our policy, washing his hands or gowning up. Then he proceeded to contaminate the guide wire and placed the catheter even though I told him the wire was contaminated. He's jeopardized our patient.

Dr. Smith: You're full of BS. You've had it out for me ever since I was a little late last week. Sheila, John's crazy and I'm ready to go. Let's get started.

Dr. Marconi: OK, that's good enough for me. John, please get me my gown and let's move on.

Nurse Jones: No way, Dr. Marconi. I'm calling Lisa Hernandez, my nurse manager. We'll let her decide this. And Dr. Smith is a liar. He's done this before. He's always refusing to follow our policies. He shouldn't be allowed to work here. I sure wouldn't want him taking care of me.

Outcome: The case proceeded and the central catheter was not changed. On her fourth postoperative day, the patient developed a blood stream infection. The catheter was removed. She recovered from the infection over a 15-day period. Three months after hospital discharge, she developed a right knee prosthesis infection. On postoperative month 8, she was readmitted, had her was prosthesis removed, and was started on long-term antibiotics.

Was her postoperative blood stream infection related to the placement of the apparently contaminated central catheter? A jury believed it was. The patient was awarded $1.2 M, with $500,000 of that total given for punitive damages. The anesthesiologist lost his privileges to work at the hospital, was given a conditional medical license for two years, and had to complete two medical board-required courses related to infection control. His malpractice carrier did not pay the punitive damages -- the anesthesiologist ultimately paid $400,000 personally, with the patient's approval to forego the final $100,000 payment.