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MEDICAL LIABILITY ALERT®
A monthly nationwide review of medical liability for
PHYSICIANS ■ HOSPITALS ■ HEALTH CARE ADMINISTRATORS
with medical liability analysis and risk management advisory
by Ira J. Zarin, Esq.

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Medical Practice Liability

Business Practices/Unfair Competition . . 3
Informed Consent 6
Peer Review 7
Defensive Actions/Countermeasures to Malpractice Suits 8
New/Expanded Liability 11
Insurance 13
See full Table of Contents on Page 2

Malpractice Review with Analysis

$2,900,000 RECOVERY - Emergency department negligence - Failure to diagnose and treat spinal injury 1

$2,978,000 VERDICT - Radiology - Hospital negligence - Failure to timely interpret small bowel study - Bowel leak following surgery 16

$2,500,000 VERDICT - Wrongful death and survival action - Failure to detect bowel laceration during incisional hernia repair surgery 17

$1,750,000 VERDICT - Ob/Gyn - Negligent use of fundal pressure during shoulder dystocia - Brachial plexus injury - Erb's palsy 19

$1,000,000 GROSS VERDICT - Primary care - Neurology - Failure to diagnose stroke 21
See full Table of Contents on Page 2

Malpractice Verdicts by Specialty

Dental 23
Hospital Neglience 24
Ob/Gyn 25
Orthopedics 27
Orthopedic Surgery 28
Pathology 29
Plastic Surgery 30
Rehabilitation Center Negligence 31
Surgery 31

See full Table of Contents on Page 3

Malpractice Review

Malpractice Verdict Review with Analysis

$2,900,000 RECOVERY - EMERGENCY DEPARTMENT NEGLIGENCE - FAILURE TO DIAGNOSE AND TREAT SPINAL INJURY - TETRAPLEGIA.

CASE SUMMARY

In this medical malpractice action, the plaintiff, age 62, was admitted to the defendant emergency department after she was involved in a motor vehicle accident wherein her vehicle was struck in the rear. Upon admission to the emergency department, the plaintiff was complaining of neck and bilateral shoulder pain. The defendant emergency room physician ordered X-rays of the plaintiff's cervical spine, amongst other studies, and reviewed the plain film studies himself, which he called normal except for "degenerative joint disease." As a result, the plaintiff's cervical spine was "cleared" by the defendant, and the plaintiff was discharged with a diagnosis of acute cervical muscle strain. The plaintiff contended that the defendant violated the standard of care when he failed to diagnose the plaintiff's spinal injury.

CASE DETAILS

Six days later, the plaintiff was brought back by ambulance to the same emergency department, on a backboard and with a cervical collar in place. The emergency department triage records noted the motor vehicle accident of six days before, the plaintiff's continued complaints of head and neck pain, and the fact that the plaintiff could not feel her arms, was suffering visual and auditory hallucinations, and had spasms in her arms, legs, and body. The triage nurse also documented limited handgrip bilaterally and the plaintiff's inability to lift her arms. The emergency room doctor noted that a radiologist had never read the cervical spine films performed six days earlier, and as a result, a radiologist reviewed them for the first time that day, also calling them essentially normal.

The emergency room doctor ordered a CT-scan of the plaintiff's neck, but then canceled it and performed no imaging whatsoever of the plaintiff's cervical spine that day and admitted the plaintiff to the hospital as an in-patient with a single diagnosis of altered mental status secondary to a medication she was taking. Two days later, the plaintiff was noted to have no use of her arms and legs and was mediflighted to a Boston hospital. Despite treatment to stabilize her spine and surgery, the plaintiff remains tetraplegic to this day.

Had the matter gone to trial, the plaintiff was prepared to call experts in emergency medicine, radiology and neurosurgery to testify that the defendant emergency room physician and the defendant radiologist who reviewed the plaintiff's cervical spine plain films failed to recognize abnormalities at C5-6 suggestive of ligamentous injury, which required further imaging studies. If such tests had been ordered, it would have resulted in the timely diagnosis and treatment of the plaintiff's cervical spine injury. Additionally, the plaintiff's experts were prepared to testify that the second defendant emergency room physician

Continued on page 15

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Table of Contents

Medical Practice Liability

BUSINESS PRACTICES/UNFAIR COMPETITION

- Upon the closure of a hospital, other area hospitals could not take on the closed facility's residents with reimbursement from medicare 3
- A nurse at a hospice who was terminated after she reported alleged inappropriate activity to a supervisor may have been entitled to whistleblower protection 4
- A male attendant in a psychiatric hospital could not prove sexual discrimination based on being called to more emergencies requiring patients be subdued than were female attendants . . . 5

INFORMED CONSENT

- In the absence of a consent form for the performance of a vaginal hysterectomy, a patient who suffered nerve injury after the surgery was entitled to $500,000 in damages 6

PEER REVIEW

- An osteopath had his license sanctioned including a $20,000 administrative fine for treating multiple patients for pain with excessive opioids 7

DEFENSIVE ACTIONS/COUNTERMEASURES TO MALPRACTICE SUITS

- Experts who testified as to the national standard of care for an 86-year-old patient who underwent hip replacement surgery did not show familiarity with the local standard of care 8
- A hospital patient whose foot was injured while being transported by an attendant for an x-ray had to comply with the medical malpractice statute of limitations 9
- A driver who negligently caused injuries to a woman in an accident could not obtain indemnity from the hospital where she later died after settling with the decedent's estate 10

NEW/EXPANDED LIABILITY

- A patient proved that it was more likely than not that she would have been cured of her rectal cancer before it metastasized if sent for chemotherapy and radiation earlier 11
- Hospital nurses did not timely detect tachysystole, timely contact the attending doctor or timely administer terbutaline to an infant eventually diagnosed with Hypoxic Ischemic Encephalopathy (HIE) 12
- A psychologist treating two minor children may have had a duty to warn authorities of suspected child abuse by a parent 12

INSURANCE

- Three dentists could not proceed with a class action suit against several dental insurers based on RICO since they did not allege specific acts of misrepresentation in their complaint 13

Medical Malpractice Review with Analysis

- **$2,900,000 RECOVERY -** Emergency department negligence - Failure to diagnose and treat spinal injury 1
  Tetraplegia. *(Failure to diagnose ongoing spinal injury and instead arriving at a diagnosis of altered mental status secondary to the medication she was taking brings finding of deviation and large settlement)*

- **$2,978,000 VERDICT** - Radiology - Hospital negligence - Failure to timely interpret small bowel study - Bowel leak following surgery . 16
  Chemical and bacterial peritonitis - Abdominal hernia - Disfiguring scarring. *(Radiology group found solely responsible for failure to timely diagnose and treat bowel leak when the surgeons who caused the leak were exonerated because it was a known occurrence that happened in the absence of deviation)*

- **$2,500,000 VERDICT** - Wrongful death and survival action - Failure to detect bowel laceration during incisional hernia repair surgery . 17
  Negligent post-operative care - Peritonitis - Sepsis. *(Failing to re-examine a patient's bowel at the end of surgery to repair an incisional hernia to ensure that there were no lacerations or leaks was ruled a deviation from the acceptable standard of care)*

- **$1,750,000 VERDICT** - Ob/Gyn - Negligent use of fundal pressure during shoulder dystocia - Brachial plexus injury - Erb's palsy. 19
  Verdict rendered for maximum amount under state malpractice cap. *(Defendant's denial that the use of fundal pressure after encountering shoulder dystocia was a deviation was not sustained where the proofs and opinions clearly indicated that to do so was a deviation from acceptable standards of practice)*

- **$1,000,000 GROSS VERDICT** - Primary care - Neurology - Failure to diagnose stroke 21
  Jury finds contributory negligence by plaintiff for pre-treatment smoking habit.*(Atypically, the jury finds liability against a primary care physician and a referred-to neurologist for misdiagnosing a pending stroke as a migraine headache, but then reduces the award finding the patient's smoking habit constituted contributory negligence)*

Medical Malpractice Verdicts by Specialty

Dental

$275,000 VERDICT - Negligent administration of anesthetic during endoscopic procedure - Paresthesia 23

DEFENDANT'S VERDICT - Alleged trigeminal neuralgia as result of teeth extraction - Pharmacological treatments, injection of alcohol into nerve and injections of anesthetics and glycerol - Neurectomy and Gamma Knife surgery.....23

Hospital Negligence

$410,000 RECOVERY - Negligent appendectomy - Failure to timely diagnose post-operative bleeding - Sepsis - Death.....24

DEFENDANT'S VERDICT - 58-year -old ICU patient suffers decubitus ulcers requiring surgery.....24

Ob/Gyn

$89,033 VERDICT - Failure to remove mesh following surgical procedure - Infection - Failure to timely diagnose cause of infection - Abscess necessitating additional surgery - Lost earnings 25

DEFENDANT'S VERDICT - Plaintiff contends that defendant surgeon negligently nicked bowel during tubal ligation surgery - Permanent scarring and flatulence ...25

DEFENDANT'S VERDICT - Alleged failure to diagnose ovarian mass - Surgical removal of ovary and appendix - Supposed reduction in fertility 26

Orthopedics

$230,000 CONFIDENTIAL RECOVERY - Incorrect procedure performed - Persistent pain at site of incision - Continued pain from DeQuervain's tendonitis.....27

Orthopedic Surgery

DEFENDANT'S VERDICT - Alleged negligent performance of open reduction/internal fixation following wrist fracture - Tendon rupture.....28

DEFENDANT'S VERDICT- Orthopedic surgery - Alleged sciatic nerve damage during total hip replacement surgery - Permanent foot drop allegedly leads to fall three years later.....28

Pathology

DEFENDANT'S VERDICT - Surgical sponge left inside decedent after laparoscopic hysterectomy contributes to her death - Pathologist performing autopsy allegedly conceals true cause of death by removing or chopping up internal organs.....29

Plastic Surgery

DEFENDANT'S VERDICT - Capsular contracture requiring multiple revision surgeries following breast augmentation surgery.....30

Rehabilitation Center Negligence

$300,000 VERDICT - Substance abuse center negligence - Failure to properly monitor, treat alcohol withdrawal - Failure to follow-up on abnormalities identified on EKG and lab results - Cardiac arrhythmia and death.....31

Surgery

$7,000,000 VERDICT - Alleged hip replacement surgery mistake results in one leg longer than the other - Retrial on damages only.....31

DEFENDANT'S VERDICT - Bowel perforation during laparoscopic hernia repair surgery - Failure to detect perforation prior to completion of surgery - Additional surgery required - Emotional distress alleged 32

$1,300,000 VERDICT - Alleged surgical error in repair of superior labral anterior-posterior tear - Subsequent failure to diagnose.....32

Medical Practice Liability

Business Practices/Unfair Competition

UPON THE CLOSURE OF A HOSPITAL, OTHER AREA HOSPITALS COULD NOT TAKE ON THE CLOSED FACILITY'S RESIDENTS WITH REIMBURSEMENT FROM MEDICARE.

After the closure of a hospital, other hospitals in the are were not able to assume responsibility for resident doctors from the closed facility with reimbursement from Medicare, the U.S. Third Circuit Court of Appeals has held.

Hackensack University Medical Center trained residents at its facility as part of the resident training program for the University of Medicine and Dentistry of New Jersey (UMDNJ). Pursuant to the Medicare Act, Hackensack received Medicare payments under the Prospective Payment System to reimburse it for certain costs associated with its medical education program. These payments were based on the number of full-time equivalent residents (FTEs) trained at the hospital.

In February 1997, another hospital that trained residents from UMDNJ, United Hospital, declared bankruptcy and closed permanently. United had 49 FTE residents. Besides Hackensack and United, three other hospitals trained UMDNJ residents in 1996. Following United's closure, the other hospitals began negotiating the placement of the displaced residents. The four hospitals subsequently reached an agreement according to which United's FTEs were reallocated among them, with 12 allocated to Hackensack. The agreement was entered into long after United had shut down. United was, therefore, not a signatory.

In 1997, Congress enacted the Balanced Budget Act capping the number of residents for whom Medicare provided reimbursement to the levels that existed in 1996. However, in cases where hospitals shared residents, the Act allowed adjustments to the number of FTEs at each hospital as long as the aggregate number in the affiliated group remained capped. Based on the agreement, Hackensack asked the Medicare Intermediary, Blue Cross and Blue Shield of New Jersey, to permanently raise its resident cap by 12 FTEs. The Intermediary denied this request (although it did allow a temporary adjustment).

On appeal, the Provider Reimbursement Review Board (PRRB) agreed with the Intermediary that the agreement was not an "affiliation agreement" with respect to United under regulations which allowed members of an affiliated group to reallocate their aggregate FTEs because United was not a signatory to the agreement and did not exist at the time it was entered into. Thus, United's FTEs could not be reallocated to the other hospitals. The PRRB, therefore concluded that the Intermediary correctly denied Hackensack's request for a permanent increase to its resident cap.

Hackensack filed a complaint in a federal court seeking additional Medicare payments that had been denied by the Intermediary. Both parties sought summary judgment. The trial judge ruled against Hackensack and this ruling was affirmed on appeal. The appellate court decided that the 1997 Act did not permit the reallocation of residents formerly working at United, at least in part, to Hackensack.

COMMENTARY

The Balanced Budget Act of 1997 "capped" the number of FTEs that a hospital could claim for Medicare Direct Graduate Medical Education costs and Indirect Medical Education costs. The Act states that: "the total number of full-time equivalent residents . . . may not exceed the number of such full-time equivalent residents for the hospital's most recent cost reporting period ending on or before December 31, 1996." Congress did, however, allow for a permanent exception to the cap by permitting rules that allowed member institutions of an affiliated group to elect to apply the FTE cap on an aggregate basis. Regulations defined an "affiliated group" as follows: "Two or more hospitals located in the same urban or rural area . . . or in contiguous areas if individual residents work at each of the hospitals during the course of the program . . . ."

According to the appellate court, under this definition, the group of hospitals that entered into the agreement after the United shutdown was not an affiliated group that included United. The individual residents no longer worked at United and United was not a signatory to the agreement to redistribute its FTEs. Therefore, the hospitals were no longer affiliated with United. The court found that it would violate the statute to allow Hackensack to unilaterally increase the number of its residents solely because one of the hospitals in the region had gone out of business.

Congress may choose to limit its budget exposure for the cost of residents. It may do so by limiting the number of residents for which it will reimburse a hospital or a group of hospitals. A hospital that assumes responsibility for residents from a facility that has closed without advice of counsel as to whether they will be reimbursed by Medicare for the costs of these residents, runs the risk of not being reimbursed.

REFERENCE

Hackensack Univ. Med. Ctr. V. Sebelius, 2010 WL 1936264 (3rd Cir. 2010).

A NURSE AT A HOSPICE WHO WAS TERMINATED AFTER SHE REPORTED ALLEGED INAPPROPRIATE ACTIVITY TO A SUPERVISOR MAY HAVE BEEN ENTITLED TO WHISTLEBLOWER PROTECTION.

A nurse at a hospice who reported allegedly improper narcotic distribution and other alleged improper activity to a supervisor may have been wrongfully terminated in violation of Maryland's Health Care Worker Whistleblower Protection Act, the state's Court of Appeals has ruled.

The plaintiff, a nurse employed by Montgomery Hospice, Inc., claimed she was wrongfully discharged in violation of Maryland's Health Care Worker Whistleblower Protection Act. Among other things, she alleged that she attempted to bring to her supervisor's attention charting that was not consistent with the health and safety of clients. For example, she noted that an admission by one of Montgomery's RNs was not properly documented. She complained to the Director of Admissions who defended the alleged failure and took no action. On another occasion, the plaintiff found that "starter packs" of medications, including narcotics, were being sent and entered into every patient's chart. She subsequently learned that the "starter pack" orders, which contained adult narcotic doses, were sent to pediatric patients.

The Director, when confronted by the plaintiff, claimed that these "starter packs" did not actually go out. However, a mother of a patient told the plaintiff that she had received one. The plaintiff learned that

UMDNJ University of Medicine & Dentistry of New Jersey

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Although this publication serves to alert Health Care Professionals to litigation affecting their practice, because of variations in fact patterns and local jurisdictions, specific legal consultation should be obtained before acting on any information contained herein.

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with medical liability analysis and risk management advisory
by Ira J. Zarin, Esq.

Founder
Ira J. Zarin, Esq.

Editor in Chief
Jed M. Zarin

Business Development
Gary Zarin
garyz@jvra.com

Production Assistant
Christianne M. Cain

Assisted Search
Tim Mathieson

Court Data Coordinator
Jeffrey S. Zarin

Customer Services
Meredith Whelan
meredithw@jvra.com

Circulation Manager
Ellen Loren

Web Development & Technology
Juris Design
www.jurisdesign.com

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such "starter packs" had been delivered to all pediatric patients, including ones where the family situation was unstable with many children present and little close supervision in the house. In addition, the plaintiff complained about narcotics being sent out to individuals who were not hospice patients, improper documentation of narcotic drugs, and treatment with narcotics provided to patients without a physician's order.

The plaintiff ultimately sent e-mails to management regarding her observations. Soon thereafter, she was terminated. The plaintiff filed an action against Montgomery alleging wrongful termination in violation of the state's Whistleblower Act. Montgomery moved for summary judgment which was granted. However, this ruling was reversed on appeal. The appellate court concluded that the report of unlawful acts to an external board was not a condition precedent to a civil action under the Act.

COMMENTARY

Many jurisdictions have enacted whistleblower statutes to protect health care employees from negative employment consequences after reporting actions by a health care facility that violated laws or endanger patients. Maryland's statute states: "that an employer may not take personnel action as reprisal against an employee who disclosed or threatened to disclose to a supervisor or board an activity, policy, or practice of the employer that was in violation of a law, rule, or regulation . . . provided information to or testified before any public body conducting an investigation, hearing, or inquiry into any violation of a law, rule, or regulation by the employer; or objected to or refused to participate in any activity, policy or practice in violation of a law rule, or regulation." However, such protection applied only if the employee had a reasonable, good faith belief that the employer had, or still was, engaged in such activity; the activity posed "a substantial and specific danger to the public health or safety;" and, before reporting to the board, the employee reported the activity to a supervisor or administrator of the employer in writing and afforded the employer a reasonable opportunity to correct the activity.

The question in this case was whether the plaintiff was entitled to assert a wrongful discharge action under the Act even though she never reported the defendant's alleged improper activity to an external board. The appellate court answered "No," explaining, for example that where an employer corrected the activity that created a substantial danger and terminated the employment of the "meddlesome" employee who reported the problem that had been corrected, an external report requirement did not exist.

The purpose of a whistleblower statute is to encourage employees to come forward and report violations without fear of losing their job. Such a statute may also be designed to ensure that as many alleged violations as possible are resolved informally within the workplace. Accordingly, an employee who invokes a whistleblower statute may be protected even where the violation is cured after notification to the employer.

REFERENCE

Lark v. Montgomery Hospital Inc., 994 A.2d 968 (Md. 2010).

A MALE ATTENDANT IN A PSYCHIATRIC HOSPITAL COULD NOT PROVE SEXUAL DISCRIMINATION BASED ON BEING CALLED TO MORE EMERGENCIES REQUIRING PATIENTS BE SUBDUED THAN WERE FEMALE ATTENDANTS.

A male attendant in a psychiatric hospital could not establish that he was discriminated against on the basis of gender because he was called to respond to more emergencies requiring a patient be subdued than were his female counterparts, in part because he did not show any adverse employment action, a federal court in Indiana has decided.

The plaintiff worked the night shift at Madison State Hospital as a PA 4, responsible for making sure patients were safe, dressed, fed and cared for. Code Green was the term used at Madison to describe situations where staff members were summoned to a particular

unit to subdue or restrain a patient when the need arose. The duty to respond to a Code Green alert was rotated among all staff members.

According to the Code Green Response Logs, during an 18 month time period, there were 57 Code Green alerts on the night shift. Of those 57 incidents, the plaintiff had responded to 11 and participated in six. There had also been one incident where a female nurse called and specifically asked to have a man sent to her unit. In that incident, the plaintiff helped to calm the patient down so that a physical restraint was unnecessary.

According to the plaintiff, employees should be required to respond to Code Green alerts regardless of whether they had the physical strength to restrain a patient, because "they're trained just like we are." He acknowledged that restraining patients was physically demanding and dangerous work. The plaintiff was 5 feet 10 inches tall and weighed 245 pounds.

Since obtaining his position at Madison, the plaintiff applied to transfer to other units on six occasions. He also applied for transfer to the day shift on his unit one time. These requests were denied by the Director of Nursing Services and the positions were filled by other female employees whom the plaintiff believed had less work experience than he did.

For a period of time, the plaintiff believed that there was not enough staff assigned to his unit and during this period, he was called upon to subdue an angry patient who bit him. He filed a grievance unsuccessfully. After the plaintiff filed a second grievance, the Director issued a letter of reprimand for "taking down" a patient. The plaintiff filed a grievance over the letter of reprimand, and it was taken out of his file.

The plaintiff eventually filed an action in a federal court against Madison alleging gender discrimination. Madison moved for summary judgment which was granted. The court explained that the plaintiff did not demonstrate any adverse employment action on which his claim could be based.

COMMENTARY

Generally, a plaintiff can show that he was a victim of unlawful discrimination either by providing direct evidence or by proceeding under the indirect, burden-shifting method. That approach requires a plaintiff to first establish a prima facie case of discrimination by showing that he was a member of a protected class; that he was meeting his employer's legitimate expectations; that his employer took an adverse employment action against him; and that he was treated less favorably than at least one similarly-situated female colleague.

The plaintiff alleged that his having to shoulder almost all of the burden of actually physically dealing with violent patients constituted an adverse employment action. Adverse employment actions in the context of a disparate treatment case usually have to affect the terms and conditions of one's employment, typically resulting in economic injury or tangible job consequence. The mere fact that an employee had a heavier workload than coworkers might not amount to an adverse employment action. There were 57 Code Green alerts on the night shift. Of those, the plaintiff responded to 11 and participated in 6. Moreover, he could recall only one incident in which a female nurse called and specifically asked for a man to be sent to her unit.

The court concluded that this evidence did not show that the plaintiff's job responsibilities were materially affected as a result of these events. Moreover, there was no evidence that the requests for his help were motivated by a prohibited animus. Instead, it appeared that they were due to necessity and that someone of his stature (5 feet 10 inches and 245 pounds) would be called upon to help.

In addition, the plaintiff failed to identify even one female PA 4 who was subject to the same supervisor and the same standards, but was treated more favorably than him (i.e., was not required to respond to a Code Green alert when it was her turn on rotation). Nor did he identify who received the transfers about which he complained of other than to say that they were given to female employees who, in his opinion, had less work experience.

To sustain a discrimination claim based on gender, a medical employee has to meet several legal criteria. Establishing that he suffered an adverse employment action is one of these requirements. To meet the standard for this required element, the plaintiff usually has to also show actions that have had a demonstrable affect on his employment status or conditions including specific economic harm.

REFERENCE

Wilkerson v. Indiana Family Social Services Administration, 2010 WL 2091895 (S.D. Ind. 2010).

Informed Consent

IN THE ABSENCE OF A CONSENT FORM FOR THE PERFORMANCE OF A VAGINAL HYSTERECTOMY, A PATIENT WHO SUFFERED NERVE INJURY AFTER THE SURGERY WAS ENTITLED TO $500,000 IN DAMAGES.

A patient who suffered nerve injury following a vaginal hysterectomy was entitled to $500,000 in damages from a hospital that could not produce a form in which the patient consented to the procedure, an appellate court in Louisiana has decided.

The plaintiff went to the Medical Center of Louisiana (MCLNO) seeking treatment for pelvic pain. Subsequently, she underwent a vaginal hysterectomy. During recovery, she experienced weakness and

pain, impaired movement, and disability in her right leg. Even though she underwent physical therapy, her condition failed to improve. Testimony indicated that she had suffered nerve injury during the procedure.

The plaintiff filed a complaint with the Medial Review Panel including a claim for lack of informed consent against MCLNO. The Panel found that there was material issue of fact concerning the plaintiff's consent that should be resolved by the court and litigation followed. MCLNO had already provided the plaintiff with a full certified copy of her medical record, which did not contain a signed consent form.

After filing the complaint, the plaintiff requested the production of any and all written consents signed by her. Approximately five months later, MCLNO responded stating that the requested documents could not be produced "due to flood damage caused by Hurricane Katrina." The plaintiff moved for summary judgment on the ground that MCLNO failed to present evidence that a genuine issue of material fact existed as to whether she had consented to the surgery. In support of the motion, she provided an affidavit attesting that no written or verbal consent was given from her to perform the vaginal hysterectomy.

The trial judge granted the plaintiff's motion, awarding her $500,000 in damages, and this ruling was then affirmed on appeal. The appellate court concluded that the plaintiff established all the elements of her lack of informed consent claim and that MCLNO failed to present an unresolved material issue of fact as to whether her consent was given in light of its inability to produce a signed consent form.

COMMENTARY

In some jurisdictions, including Louisiana, an informed consent claim is treated as a malpractice action requiring the plaintiff to establish the standard of care, breach of that standard, and the causal connection between the health care provider's alleged negligence and the plaintiff's claimed injuries. The test for determining causation was whether a reasonable person in the patient's position would have consented to the procedure if fully informed of the risks and complications.

In this case, the court found that the breach of that standard of care was found to have been established through the plaintiff's affidavit stating that she was not informed as to the risks associated with the vaginal hysterectomy and that she never signed a consent form for the procedure. Additionally, the certified copy of her medical record lacked any indication that written or verbal consent was obtained.

As for causation, the trier of fact was charged with determining whether a reasonable person in the patient's position would have consented to the procedure had full disclosure been made. Although the plaintiff's medical record provided the trial court with information regarding her condition at the time of the operation and the necessity of the procedure, the appellate court found that it could not second-guess the trial judge's finding of causation.

Finally, the plaintiff was able to establish her injuries through the affidavit of a board certified orthopedic surgeon who discussed damage to nerves after the vaginal hysterectomy; a vocational and rehabilitation counselor who performed a vocational assessment based on the plaintiff's physical limitations due to the injuries caused by the vaginal hysterectomy, which indicated a complete loss of her annual earning capacity; and an economist who calculated lost past and future wages.

When an informed consent claim is treated as a malpractice claim, all the required elements of such an action have to be established by the plaintiff. The absence of a signed consent form may have assisted the plaintiff in proving her claim. Together with the patient's testimony that she was not informed of the risks of the procedure and that she would have not undergone the surgery if so informed, the lack of a signed informed consent form may indicate a breach of the standard of care and that the breach caused the plaintiff's injuries.

REFERENCE

Jordan v. State Bd. of Adm. Of La State Univ. . . ., 2010 WL 2105883 (La. App. 2010).

Peer Review

AN OSTEOPATH HAD HIS LICENSE SANCTIONED INCLUDING A $20,000 ADMINISTRATIVE FINE FOR TREATING MULTIPLE PATIENTS FOR PAIN WITH EXCESSIVE OPIOIDS.

The treatment by an osteopath of several patients complaining of pain, one of whom died, with excessive opioids was found to constitute unprofessional conduct justifying sanctioning his license including the imposition of a $20,000 administrative fine, the Court of Appeals of Washington has held.

The defendant osteopath had treated a patient for lower back pain and numbness in his left knee by prescribing Duragesic and Percocet (opioids) for pain, without conducting a physical examination. Over the next several days, he increased the dosage for Duragesic and Percocet and prescribed clonazepam. The patient returned several years later, after which the defendant diagnosed colitis and prescribed oxycodone and Xanax. The patient again visited the defendant after a car accident and he prescribed pain medications including a fentanyl patch. The next morning, the patient died. The Medical Examiner concluded that the patient died from acute intoxication due to fentanyl, diazepam, oxycodone and carbamazepine.

The defendant treated another patient for back pain and prescribed various opioids and benzodiazepines. The defendant treated a third patient for shoulder pain prescribing Soma and benzodiazepines. Even though the defendant later learned that the police had arrested this patient for prescription drug forgery, he continued to provide him with pain medication. With respect to another patient he treated for chronic pain, despite evidence that this patient was not taking pain medication as prescribed, he relied on the patient's own diagnosis of rheumatoid arthritis to serve as the basis for continued pain treatment.

The New York Board of Osteopathic Medicine and Surgery issued a Statement of Charges against the defendant alleging unprofessional conduct for providing treatment to these patients, and others that fell below the standard of care. The Board found the defendant committed unprofessional conduct and imposed sanctions including prohibiting him from prescribing Schedule II and Schedule III controlled substances until he completed a Board approved training course or residency regarding pain management; requiring that any and all diagnostic MRI, CT, or Dexa scans taken be reviewed by a qualified radiologist; an d(3) ordering him to pay a $20,000 administrative fine. Two courts affirmed this ruling. The appellate court decided that the evidence of the defendant's treatment of various patients for pain using opioids supported the sanctions imposed.

COMMENTARY

Generally, a professional board has the authority to adopt standards of professional conduct or practice. Washington's Board of Osteopathic Medicine and Surgery adopted the standard set forth in a statute which provides that: "[i]ncompetence, negligence, or malpractice which results in injury to a patient or which creates an unreasonable risk that a patient may be harmed" constitutes unprofessional conduct.

After hearing from expert witnesses, the appellate court found that the Board's decision based on the defendant's behavior with respect to multiple patients in treating their pain with various opioid drugs was properly supported. The court also found the sanctions appropriate. The Board's requirement that all diagnostic scanning be reviewed by a qualified radiologist and that he schedule an office inspection to confirm appropriate shielding for his scanning equipment were based on allegations that the defendant improperly diagnosed and treated rheumatoid arthritis, for which he used the scanning equipment. As to the $20,000 penalty, a statute authorized the Board to impose a "fine for each violation . . . not to exceed five thousand dollars per violation." The defendant was found to have violated the statutory standard on more than four occasions.

Incompetence or negligence by a physician may constitute unprofessional behavior. Thus, in addition to malpractice damages, a physician may have his license sanctioned for such conduct. The likelihood that a professional board will investigate and charge a physician with unprofessional conduct increases where there are multiple charges of incompetence or negligence or where his treatment has resulted in the death of a patient.

REFERENCE

Plaintiff: Washington State Bd. Of Osteopathic Medicine and Surgery, 2010 WL 1223128 (Wash. App. 2010).

Defensive Actions/Countermeasures to Malpractice Suits

EXPERTS WHO TESTIFIED AS TO THE NATIONAL STANDARD OF CARE FOR AN 86-YEAR-OLD PATIENT WHO UNDERWENT HIP REPLACEMENT SURGERY DID NOT SHOW FAMILIARITY WITH THE LOCAL STANDARD OF CARE.

Experts who testified as to the national standard of caring for an 86 year old patient who eventually underwent hip replacement surgery, and suffered from other ailments, did not demonstrate familiarity with the local standard of care, the Court of Appeals of North Carolina has held.

The patient was admitted to The Brian Center Health and Rehabilitation-Hendersonville. He was 86 years old and suffered from dementia, peripheral vascular disease, hypothyroidism, high blood pressure and chronic obstructive pulmonary disease. He had previously experienced several bouts of pneumonia. He was at high risk for falling and was believed to have fallen several times at home. A comprehensive care plan provided nine measures to mitigate his risk of falling. However, when the patient experienced a fall, his care plan was not revised.

Brian Center staff reported a general, noticeable deterioration in the patient's condition on two later occasions and he was again diagnosed with pneumonia. The next month, he fell three times, but the staff concluded that he sustained no injuries. The patient was transferred to Pardee Hospital where another x-ray revealed a fractured left hip. He underwent hip replacement surgery, then was admitted to Pardee Care Nursing Home. He was readmitted to Pardee Hospital a month after with a methicillin-resistant staphylococcus infection. He suffered from pneumonia secondary to that infection, and was admitted to hospice care where he died. The death certificate listed pneumonia as the primary cause of death.

The plaintiff filed an action against Brian Center and others. Three expert witnesses testified on behalf of the plaintiff. The jury returned a verdict finding that Brian Center caused the decedent's injury, but not his death, and awarded his estate $200,000. The jury also held Brian Center liable for punitive damages in the amount of $600,000. However, the judgment was reversed on appeal. The appellate court explained that the plaintiff's expert

witnesses testified based on a national standard of care, but did not indicate they were familiar with the local standard of care that applied to this case, which the plaintiff was required to provide, entitling the defendants to a directed verdict.

COMMENTARY

Ordinarily, a plaintiff has to establish the standard of care through expert testimony. North Carolina has a statute that provides that in medical malpractice cases, the plaintiff has to prove that the provider did not act in accordance with "the standards of practice among members of the same health care profession with similar training and experience situated in the same or similar communities" at the time of the alleged malpractice.

Earlier cases in North Carolina had interpreted this statute to require more than establishing a national standard of care. Instead, a court was obliged to consider whether an expert was familiar with a community that was similar to the defendant's community in regard to physician skill and training, facilities, equipment, funding, as well as the physical and financial environment of the local medical community.

The plaintiff presented three witnesses, admitted as experts in their respective fields, who testified to the standard of care applicable to The Brian Center. Their testimony indicated that the witnesses were of the opinion that a national standard of care applied. However, they did not testify to any familiarity with The Brian Center or the community in which it was located or whether its standards of practice were, in fact, the same or different from the national standard.

For many medical situations, a national standard of care has been developed. However, even where such a standard exists, parties to a malpractice suit may point to deviations from the national standard due to local conditions. Where local differences affect the standard of care, experts familiar with a national standard may have to account for these local differences or risk being disqualified as standard of care witnesses.

REFERENCE

Hawkins v. SSC Hendersonville Operating Company, 690 S.E.2d 35 (N.C. App. 2010).

A HOSPITAL PATIENT WHOSE FOOT WAS INJURED WHILE BEING TRANSPORTED BY AN ATTENDANT FOR AN X-RAY HAD TO COMPLY WITH THE MEDICAL MALPRACTICE STATUTE OF LIMITATIONS.

A hospital patient whose foot was injured while being transported in a wheelchair by an attendant for an x-ray was required to comply with the statute of limitations governing actions for "professional negligence," rather than ordinary negligence, a California appellate court has held.

The plaintiff had injured his head in an accident and was taken to the UCLA Medical Center. While at UCLA, he was seated in a wheelchair and was being taken from a CT procedure to have an x-ray taken. While in the process of being transported, the plaintiff's right foot was rammed into a wall by the attendant pushing the wheelchair.

The plaintiff filed an action against UCLA alleging that the attendant pushing the chair engaged in ordinary negligence by striking the wall with the wheelchair and as a result, causing injuries to his right foot. He also claimed that this injury caused cellulitis. The plaintiff testified that immediately after his foot was rammed into the wall, he told the attendant that he thought his foot was broken and that he was in "a lot of pain." The day after the incident, the plaintiff was examined by a physician who told him that there was a possible fracture and an infection. His leg looked red, bruised and was very painful. Upon discharge, the plaintiff was put on antibiotics for cellulitis.

UCLA sought dismissal of the action on the grounds that the medical malpractice statute of limitations had expired by the time the plaintiff filed suit. The plaintiff responded that the person pushing the wheelchair was not a "health care provider" and was not rendering health care services as these phrases were defined in the state's medical malpractice statute and that the shorter malpractice statute of limitations did not apply.

The trial court agreed with UCLA. Its dismissal of the action was then affirmed on appeal. The appellate court explained that the attendant pushing the plaintiff's wheelchair was involved in the rendering of professional services at UCLA that fell within the ambit of the state's medical malpractice statute so that the timeliness of the plaintiff's suit had to be judged against its limitations period.

COMMENTARY

A statute of limitations defines the time frame a plaintiff has to file an action. Medical malpractice statutes of limitations can be shorter than the limitations period governing ordinary negligence actions and the question in this case was which statute of limitations applied. The answer to this question turned on whether the accident that caused the plaintiff's injuries should be characterized as "professional negligence" or "ordinary negligence."

As in other jurisdictions, California had a statute that defined "professional negligence." It stated that "professional negligence" was a "negligent act or omission to act by a health care provider in the rendering of professional services, which act or omission is the proximate cause of a personal injury or wrongful death." The appellate court explained that for an act to be professional negligence, it did not have to be performed by a physician. For example, previous California cases had held that the negligent operation of an ambulance (running into a curb) by a licensed emergency medical technician constituted professional negligence, as was the failure to secure a rolling x-ray table and

leaving a patient unattended and unrestrained on a hospital gurney. In addition, the handling of a wheelchair was not all that was involved. The plaintiff was undergoing medical tests at the defendant medical center. Part of the process of administering multiple tests was moving a patient from one test site to another. A hospital had a duty to use reasonable care and diligence in safeguarding a patient committed to its charge. Moving the patient safely from test site to test site was found to be a part of the professional services rendered by the defendant.

A state's malpractice statute of limitations usually does not apply only to alleged acts of negligence by a physician. In a hospital setting, for instance, many other employees perform professional services to which a malpractice limitations period may apply in a suit claiming negligence by such employees. Since the malpractice statute of limitations may be shorter than the one governing ordinary negligence, which statute applies could be critical in determining whether an action is timely or not.

REFERENCE

Torihara v. Regents of the Univ. of Cal., 2010 WL 1972262 (Cal. App. 2010).

A DRIVER WHO NEGLIGENTLY CAUSED INJURIES TO A WOMAN IN AN ACCIDENT COULD NOT OBTAIN INDEMNITY FROM THE HOSPITAL WHERE SHE LATER DIED AFTER SETTLING WITH THE DECEDENT'S ESTATE.

A driver who was at fault in causing serious injuries to a woman in an accident could not obtain indemnity from the hospital to which she was taken and where she later died, after settling with the decedent's estate, according to a recent Supreme Court of Mississippi decision.

A woman was seriously injured in a motor vehicle accident with a tractor trailer. She was transported by ambulance to the emergency room at Forrest General Hospital (FGT) where she was diagnosed with a closed head injury and admitted to the intensive care unit. Three days later, doctors attempted unsuccessfully to wean her from a ventilator. The next day, a spontaneous breathing trial proved unsuccessful, and the woman remained dependent on sedation and a ventilator. She then underwent a tracheostomy to provide long-term access for the breathing tube utilized by the ventilator.

However, no order was given that the tracheostomy tube be suctioned periodically. Over the next twelve hours, the tube was suctioned only twice, despite several notations that the patient had developed a severe, productive cough after insertion of the tube. Seven and one-half hours after the tube was last suctioned, the patient began coughing while being bathed by a nurse, dislodging the tube. Attempts to suction and reinsert the tube were unsuccessful. She went into cardiopulmonary arrest and died.

After entering into a settlement with the decedent's estate, the company that owned the tractor trailer filed an action seeking indemnity from FGT alleging that the wrongful death of the decedent arose as a result of its conduct. FGT moved to dismiss the complaint. This motion was granted and this ruling was affirmed on appeal. The appellate court agreed with the trial judge that, under Mississippi law, since the driver was negligent he could not obtain indemnity from FGT.

COMMENTARY

The question presented by this appeal was whether a negligent party in a motor vehicle accident which resulted in serious injuries to the other driver could seek indemnity from a health care provider whose subsequent treatment allegedly was negligent and caused the death of the other driver. Mississippi courts have held that an obligation to indemnify may arise from a contractual relation, from an implied contractual relation or out of liability imposed by law. When one person is required to pay money which another person in all fairness should pay, then the former may recover indemnity from the latter in the amount which he paid, provided the person making the payment has not conducted himself in a wrongful manner so as to bar his recovery. They have elaborated that two critical prerequisites were generally necessary for the invocation of noncontractual implied indemnity. The damages which the claimant sought were to shift were imposed as a result of some legal obligation to the injure person; and the claimant did not actively or affirmatively participate in the wrong.

The defendant hospital argued that the trucking company was a joint tortfeasor, and as such was not entitled to indemnity as there was no right of indemnity between joint tortfeasors. The company responded that its own negligence was far removed in time from the decedent's death since she had continually improved medically, was making a recovery and would have survived with only mild to moderate disability, but for the separate negligent acts of the hospital. Nevertheless, the appellate court decided that Mississippi law simply did not allow indemnity by a party that was actively negligent.

Where a person sues two parties for negligence that caused injuries or death, a court may permit an allocation of fault and responsibility for damages. However, this may not be so in all jurisdictions where the injured party sues or settles with one negligent party who then seeks indemnity from another purported negligent party. Under these circumstances, some jurisdictions may deny indemnity on the ground that a negligent party may not obtain indemnity from another party who may have also been responsible for damages to the injured party.

REFERENCE

J.B. Hunt Transportation v. Forrest Gen. Hosp., 34 So.3d 1171 (Miss. 2010).

New/Expanded Liability

A PATIENT PROVED THAT IT WAS MORE LIKELY THAN NOT THAT SHE WOULD HAVE BEEN CURED OF HER RECTAL CANCER BEFORE IT METASTASIZED IF SENT FOR CHEMOTHERAPY AND RADIATION EARLIER.

A patient proved that it was more likely than not that she would have been cured of her rectal cancer before it metastasized to her pelvis if she had been sent earlier by her general surgeon for chemotherapy and radiation as suggested by her CEA levels, the Court of Appeals of Kentucky has held.

The plaintiff saw the defendant, a general surgeon, with complaints of severe rectal pain and some bleeding. He visualized an anal fissure and prescribed medication. Over the following two months, the plaintiff continued to see the defendant for this problem. During this time, the defendant noticed that the fissure's appearance had changed and obtained a biopsy which revealed a cancerous lesion.

Three months after the initial visit, the defendant performed surgery to remove the lesion. Prior to surgery, he ordered a CEA (carcinoembryonic antigen) test to monitor the growth of the cancer. At trial, the plaintiff's experts stated that a normal CEA level for a nonsmoker, such as the plaintiff, was 2.5, and 5.0 for a smoker. For a year and a half following surgery, the defendant monitored the levels of CEA in the plaintiff's body. The first CEA test six months after surgery was 1.7. Four months later, it was 5.2. The next CEA test ten months later was 68.3. The defendant informed the plaintiff that this CEA result "looks quite good," and that he did "not see anything to suggest malignancy."

He later admitted that he missed the results of last test and conceded that, had he seen this result, he would have suspected a recurrence. Six months after, the plaintiff returned to see the defendant with complaints of perineum pain. He ordered a CEA test that results in a level of 112.2. A biopsy revealed a recurrence of the cancer in the plaintiff's pelvis. The defendant referred her to an oncologist for chemotherapy and radiation. After completing the course, the plaintiff's CEA level dropped to 26.5 However, because the cancer had recurred in a different location (i.e., in the sacrum, rather than the rectum), doctors defined it as a metastasis. Following additional surgery, the plaintiff's CEA levels returned to normal. However, a year later, her CEA levels began to rise again, this time to 6.9. Because this indicated a second recurrence, doctors informed the plaintiff that curative treatment was no longer an option, that her cancer was terminal and they transitioned her to palliative treatment. She had a second local recurrence of cancer approximately five years after for which she underwent surgery.

The plaintiff filed a malpractice action against the defendant, and others. A jury entered a verdict for the plaintiff and the resulting judgment was affirmed on appeal. The appellate court decided that the plaintiff established that the defendant's negligence caused her injury by showing through expert testimony that she was more likely than not to have had her cancer cured if she received chemotherapy and radiation earlier.

COMMENTARY

A key issue on which the appellate court focused was the causation element of the plaintiff's claim. In Kentucky, a plaintiff had to prove within reasonable medical probability that she would have recovered absent the doctor's negligent conduct. Stated differently, a plaintiff had to prove, by a probability greater than or equal to 51 percent, that she would have recovered absent the alleged malpractice.

The defendant argued that the plaintiff failed to adduce evidence sufficient to prove, with reasonable medical probability, that the defendant's failure to refer her for additional radiation and chemotherapy after the initial surgery caused her cancer to recur and, therefore, that he was entitled to a directed verdict. One of the plaintiff's experts, a medical oncologist, testified that out of 100 people with cancer identical to the plaintiff's between 70 to 80 would have no recurrence of cancer solely as a result of surgery. Of the remaining 20 to 30 people, five to 10 would have no recurrence as a result of radiation and chemotherapy treatments in addition to surgery. But, 10 to 25 people would have a recurrence of cancer regardless of any combination of surgery, chemotherapy, and radiation. He also testified the plaintiff needed to receive chemotherapy and radiation soon after the initial surgery to obtain any benefits from these treatments, not 16 months later as had occurred. Two expert witnesses testified the defendant should have detected an anomaly in the patient's CEA test 18 months before he sent her to an oncologist, when the level was 5.2. According to the appellate court, the plaintiff would have been 60 percent likely to achieve a cure had she received therapy earlier. As such, she met the 51 percent threshold necessary to overcome a directed verdict based upon causation.

When a malpractice defendant seeks a directed verdict or a judgment notwithstanding the verdict, the plaintiff is usually entitled to every favorable inference from the evidence. Thus, expert testimony that could be interpreted to indicate that the plaintiff has established all the required elements of her case may suffice to defeat the defendant's motion. Even where there is conflicting expert testimony, once the plaintiff has raised questions of fact and obtained a favorable verdict, the defendant may experience difficulty in having an appellate court set it aside.

REFERENCE

Walton v. Johnson, 2010 WL 1253185 (Ky. App. 2010).

HOSPITAL NURSES DID NOT TIMELY DETECT TACHYSYSTOLE, TIMELY CONTACT THE ATTENDING DOCTOR OR TIMELY ADMINISTER TERBUTALINE TO AN INFANT EVENTUALLY DIAGNOSED WITH HYPOXIC ISCHEMIC ENCEPHALOPATHY (HIE).

Hospital nurses did not timely detect tachysystole, timely contact the attending physician or timely administer Terbutaline to an infant eventually diagnosed with hypoxic ischemic encephalopathy (HIE), according to a recent decision by the Court of Appeals of Minnesota.

Immediately after his birth at Ortonville Area Health Services (OAHS), the plaintiff required bag and mask ventilation for one and one-half minutes and he was blue for 45 minutes. He was also flaccid for at least 30 minutes (i.e., he had no muscle tone and was limp). His respirations were slow and irregular for 13 minutes, and he had "a grunting and substernal retraction respiratory pattern" for at least 30 minutes. He breathed very rapidly for at least two hours and had an abnormal response to stimuli for at least 30 minutes.

The day after his birth, the defendant doctor arranged for the plaintiff to be flown to another hospital where he stayed for 12 days. While there, he experienced seizures and periods when he stopped breathing. When he was over three months old, doctors learned that the plaintiff had severe brain damage, and he was diagnosed with cerebral palsy. A pediatric neurologist was of the opinion that at his birth, the plaintiff suffered from hypoxic ischemic encephalopathy (HIE).

The plaintiff filed a malpractice action against OAHS and his initial attending physician. According to one of the plaintiff's expert witnesses, his condition at birth was "due to the hyperstimulation probably tachysystole that was not recognized." This expert elaborated that had Terbutaline been given to the child, the results would have been different. Another expert offered by the plaintiff testified that his condition at birth was due to "hours of gradually or reduced oxygen" that resulted from "too many contractions," and that tachysystole had not been properly identified and treated.

A jury returned a verdict for the plaintiff finding the physician 70 percent liable and OAHS 30 percent liable, awarding more than $9.5 million in damages. The defendants both sought a judgment notwithstanding the verdict which was denied. This ruling was then affirmed on appeal. As to OAHS, the appellate court concluded that there was sufficient expert testimony to support a finding that its nurses failed to detect the plaintiff's tachysystole, administer Terbutaline or contact the defendant physician when they should have.

COMMENTARY

The hospital contended on appeal that it was entitled to a judgment because the evidence was insufficient to prove that the nurses, on whose actions its liability was based, were negligent in failing to properly observe the plaintiff's condition, administer appropriate treatment and contact the defendant physician earlier.

Two of the plaintiff's expert witnesses addressed the standard of care applicable to the nurses. One stated that a nurse should, when watching and attending to a labor patient, know about hyperstimulation and tachysystole, and that nurses were expected to be able to determine duration, frequency, and strength (or quality) of contractions accurately; and were required to identify and treat tachysystole rather than wait and see if problems develop with the baby and then treat the problems.

The other expert testified that accepted standards of practice required nurses to be able to recognize hyperstimulation or tachysystole and that the presence of tachysystole for more than "just a brief period of time" should automatically set up an alert that something was wrong. He concluded that the nurses should have recognized this was occurring, told the physician about it, and between the two of them come up with treatment, namely, Terbutaline. The nurses admitted that they neither gave Terbutaline nor contacted the defendant physician to explain why they did not want to administer Terbutaline despite the presence of tachysystole or hyperstimulation.

Timely detection of a disease or condition may be an essential prerequisite to effective treatment. Nurses are usually on the front line and may be held accountable for observing the signs and symptoms of certain diseases or conditions, administer treatment quickly and/or notify the attending physician. The failure by nurses to comply with what is required of them by the applicable standard of care can result in liability to the hospital or medical clinic that employs them.

REFERENCE

Perseke v. Ross, 2010 WL 1286843 (Minn. App. 2010).

A PSYCHOLOGIST TREATING TWO MINOR CHILDREN MAY HAVE HAD A DUTY TO WARN AUTHORITIES OF SUSPECTED CHILD ABUSE BY A PARENT.

A psychologist treating two minor children may have had a duty to warn authorities or the noncustodial father of suspected child abuse by the custodial mother, a Florida appellate court has ruled.

The divorced mother of two children had filed an emergency motion in a family court for the appointment of a therapist, alleging that her and her estranged husband could not agree on a therapist to treat their minor children and that an emergency situation existed as one of the children had threatened to kill himself and had a plan for how he was going to do so. She requested the court appoint the defendant, a psychologist, as the treating therapist which

the court did. The court directed that both parents be kept advised of appointment dates, progress, diagnosis and treatment.

The mother had also accused the father of sexually abusing the children and a court later denied him access to the children pending investigation by the Florida Department of Children and Family Services. The Department ultimately determined the allegations of sexual abuse to be unfounded. However, the father was never reunited with the children, and a year later, the mother gave morphine tablets to the two children and placed them in a van parked inside a garage with the engine running. One of the children managed to escape and survive, but the other was unable to escape and died.

The father filed a wrongful death action against the psychologist alleging that while the mother had exclusive custody of the children, the psychologist received reports from other counselors and experts indicating that the mother had previously abused the children and posed a substantial risk to them. The complaint alleged that as part of the duties owed the children while providing them therapy and treatment, the psychologist was required to exercise reasonable care in reviewing all materials in the children's case histories provided by other counselors and experts, identifying any signs and symptoms indicating the children were being abused by the mother, and also notifying the father and other proper authorities of reasonably suspected abuse.

The psychologist moved for summary judgment which was granted. However, this ruling was reversed on appeal. The appellate court reasoned that the plaintiff's expert raised an issue of fact with respect to whether the psychologist knew or should have known that the children were subjected to ongoing abuse by their mother such that the psychologist was required to warn appropriate authorities of any suspected abuse.

COMMENTARY

The key issue on appeal in this case was whether the defendant owed a duty of care to the plaintiff. The defendant argued there was no duty that required a psychologist to protect a client (the children) from the actions of a third party (the mother) after having discovered the potential danger the third party posed. In short, the defendant asserted she did not have a duty to identify third parties and warn the court or other authorities of potential harm to the children.

The plaintiff submitted the affidavit of a board certified psychiatrist who addressed the standard of care owed by a psychologist treating abused children. In his opinion, the defendant should have recognized that the children's symptoms were most likely the result of ongoing emotional, physical and/or sexual abuse at the hands of their mother, that the children's symptoms could not be effectively treated so long as they remained in the sole unsupervised custody of their mother without access to their father, and that the children were in continuing danger of abuse and physical harm while in the custody of their mother. He concluded that the defendant was required to notify appropriate authorities of the suspicion that the children were suffering abuse.

Contrary to the contention of the defendant, according to the appellate court, the complaint did not assert a duty on the part of the defendant to predict, control, or prevent the actions of her patients' mother. Instead, it alleged that the defendant owed a duty to treat the children that, given the facts in this case, included the duty to warn about reasonably suspected, ongoing abuse.

A therapist owes a duty to patients she is treating, including minors. The scope of that duty and exactly what action it might require would be determined by the specific circumstances. Further, in determining whether the duty to provide reasonable care gives rise to a duty to warn third parties such as authorities of potential abuse of a child, a court might be expected to focus on whether this risk of harm was foreseeable.

REFERENCE

Estate of Rotell v. Kuchnle, 2010 WL 2178581 (Fla. App. 2010).

Insurance

THREE DENTISTS COULD NOT PROCEED WITH A CLASS ACTION SUIT AGAINST SEVERAL DENTAL INSURERS BASED ON RICO SINCE THEY DID NOT ALLEGE SPECIFIC ACTS OF MISREPRESENTATION IN THEIR COMPLAINT.

A group of dentists could not proceed with a class action suit against several dental insurers based on the mail or wire fraud provisions of the Racketeer Influenced and Corrupt Organizations Act (RICO) because they did not set forth in their complaint detailed allegations of specific misrepresentations by the insurers, the U.S. Eleventh Circuit Court of Appeals has held.

The plaintiffs were three dentists practicing in Illinois, Nebraska, and Maryland. The defendants were dental insurance companies Cigna Corporation, Connecticut General Life Insurance Company, Cigna Dental Health, Inc., MetLife Inc., and Metropolitan Life Insurance Company. The plaintiffs contracted with the defendants to provide dental services to the defendants' members through dental service managed care plans. The complaint included a claim for violation of RICO. More specifically, the complainit alleged that the defendants "engaged in a systematic, fraudulent scheme to diminish payments [to the plaintiffs and the class] through automatic downcoding, Current Dental Terminology ('CDT') code manipulation and improper bundling." The defendants moved to dismiss the RICO claims.

The trial judge granted the motion and this ruling was then affirmed on appeal. The appellate court concluded that the complaint failed to allege a pattern of racketeering activity predicated on a scheme to commit acts of mail and wire fraud, as alleged. It reasoned that the complaint failed to set forth any specific misrepresentations in the communications the plaintiffs referenced, any connection between the alleged misrepresentations and any particular acts of downcoding or bundling, or any allegations as to how the defendants agreed to engage in an illegal scheme to defraud dental providers.

COMMENTARY

RICO requires that a plaintiff prove that a defendant participated in an illegal enterprise "through a pattern of racketeering activity." "Racketeering activity" is defined to include such acts as mail and wire fraud. Mail or wire fraud occurs when a person intentionally participates in a scheme to defraud another of money or property and uses the mail or wires in furtherance of that scheme. To prove a pattern of racketeering in a RICO case, a plaintiff has to show at least two racketeering predicates that were related, and that they amounted to or posed a threat of continued criminal activity. The plaintiffs' allegations also had to comply with a standard requiring that in alleging fraud or mistake, a party state "with particularity" the circumstances constituting fraud or mistake. In this context, courts have held that a plaintiff had to allege the precise statements, documents, or misrepresentations made; the time, place, and person responsible for the statement; the content and manner in which these statements misled the plaintiffs and what the defendants gained by the alleged fraud.

The plaintiffs in this case alleged that the defendants represented in their on-line advertising, in their provider agreements, and in their fee schedules, that their in-network providers would be compensated for covered procedures based on commonly accepted dental practice, standard coding practice and the defendants' fee schedules. They argued that these advertisements, agreements, and fee schedules were fraudulent because they indicated benefit payments lower than what the plaintiffs believed were due to them under their fee-for-service agreements with the defendants, which promised payments "in accordance with standard dental coding procedures." The plaintiffs contended that they performed procedures worthy of larger benefits payments, but that the defendants bundled and downcoded them.

Additionally, the plaintiffs alleged that the only way the alleged scheme of downcoding and bundling could work was if the defendants "agree[d]" to employ the "same" devices and tactics. Thus, the plaintiffs did not allege parallel schemes among competing dental insurers, but a single scheme consisting of identical conduct in which all the defendants agreed to participate. The complaint set out at least six examples of e-mail and letter communications between the defendants and the plaintiffs. However, they did not point to a single specific misrepresentation by the defendants regarding how the plaintiffs would be compensated in any of these communications, nor did they allege the manner in which they were misled by any documents.

In a RICO action, a plaintiff usually has to allege specific conduct that violates the statute. Medical or dental plaintiffs and the insurers they work with may have a difference of opinion regarding the coding that was and should be used in processing claims. However, that in itself may not create a basis for inferring that a scheme-driven deception occurred where the complaint provides no details of fraud or conspiracy by each of the defendants (i.e., specific acts of deception and misrepresentation).

REFERENCE

American Dental Assoc. v. Cigna Corp., 605 F.3d 1283 (11th Cir. 2010).

...departed from applicable standards of care by failing to have performed any diagnostic imaging studies of the plaintiff's cervical spine when the plaintiff returned with new and lingering symptoms suggestive of a neurological injury.

The case settled four weeks prior to the scheduled trial date in the amount of $2.9 million.

RISK MANAGEMENT ADVISORY

In this case, the plaintiff's experts in emergency medicine, radiology and neurology all indicated that the defendants emergency medicine physician and radiologist, who reviewed the plaintiff's cervical spine films, negligently failed to recognize abnormalities at C5,C6 suggestive of serious ligamentous injury which in itself required further imaging studies that were not performed. These experts opined that if such testing had been performed, it would have resulted in a timely diagnosis and treatment of the plaintiff's cervical spine injury. As a result, the plaintiff's cervical spine was cleared by this defendant emergency room physician and the patient was discharged with a diagnosis of acute cervical muscle strain.

These conclusions were reached without the benefit of a radiologist reviewing the films, which had been the intent apparently, but which was not carried out until the patient returned some six days later with a serious exacerbation of the previous symptomatology. The evidence indicated that the defendant emergency medicine physician who first examined the patient at the hospital had, in fact, ordered x-rays of the plaintiff's cervical spine, among other studies, and had reviewed the plain film studies himself, which he stated were normal except for degenerative joint disease.

When the patient returned six days later, she was brought back by ambulance to the emergency department on a backboard with a cervical collar in place. At that time, the emergency department image records noted the motor vehicle accident of six days earlier with the plaintiff having now complained of serious head and neck pain and the fact that the plaintiff could not feel her arms, and was in addition suffering visual and auditory hallucinations with spasms in her arms, legs and body. The triage nurse also documented limited hand grip bilaterally and the plaintiff's inability to lift her arms. Despite all of these findings noted in the record, the emergency medicine physician simply ordered a CT scan of the plaintiff's neck, but later canceled it and performed no image testing whatsoever of the patient's cervical spine that day. Despite all of these particular ominous findings at the time of the second admission, the record indicates that the patient was simply admitted to the hospital as an in-patient with a single diagnosis of altered mental status secondary to the medication she was taking.

Practitioners are indeed reminded by the circumstances of this case that what might not have been a deviation six days earlier for a failure to rule out the more serious of the potential threatening diagnoses which was ultimately later arrived at, became a deviation when the patient returned with increased symptomatology and the defendant nonetheless failed to rule out the more serious of the potentially threatening diagnoses of cervical spine injury. Furthermore, the fact that the defendant decided upon the far less serious condition of altered mental status secondary to medication being taken was found by the jury to be a serious deviation from acceptable standards of practice.

Practitioners are also reminded that although they are not necessarily charged with the responsibility of arriving at a correct diagnosis in every case, particularly when that diagnosis initially had far less symptomatology than that which has developed at a later time, they will not be excused for a failure to rule out the more serious of the potential threatening diagnoses at a later time when the condition persists or gets worse with increased and more serious symptomatology. In this regard, practitioners should remember that the fact that the more serious of the potential threatening diagnoses can be far less expected than the more common and less threatening diagnosis arrived at, they cannot expect to avoid liability for a failure to rule out the more serious of the potential threatening diagnoses because it is far less common and expected. This is particularly so where the patient suffers injury by the failure to timely arrive at the appropriate diagnosis to the peril of the patient.

In these situations, it is the seriousness of the potential threatening diagnoses that may be involved in a particular case that requires the ruling out of the most consequential diagnoses, even where such a diagnosis is far less expected and far less frequent than the more frequent diagnosis erroneously arrived at in any particular case.

REFERENCE

Middlesex County, MA. Plaintiff Patient vs. Defendant Emergency Department. Reference information withheld in accordance with settlement agreement. Attorney for plaintiff: Robert A. Shuman of Robert A. Shuman & Associates, P.C. in Sharon, MA.

$2,978,000 VERDICT - RADIOLOGY - HOSPITAL NEGLIGENCE - FAILURE TO TIMELY INTERPRET SMALL BOWEL STUDY - BOWEL LEAK FOLLOWING SURGERY - CHEMICAL AND BACTERIAL PERITONITIS - ABDOMINAL HERNIA - DISFIGURING SCARRING.

CASE SUMMARY

The female plaintiff, a 65-year-old woman, underwent surgery to remove an ovarian cyst in January 2000. During the surgery, the plaintiff suffered a bowel leak. There was a ten day delay in diagnosing the bowel leak despite repeated diagnostic imaging studies that that were taken at the defendant hospital and interpreted by its radiologists. The evidence demonstrated that one radiologist failed to timely interpret a small bowl study which resulted in a two day delay in taking the plaintiff back to surgery in order to repair the leak. In the interim, the plaintiff was required to ingest barium for the small bowel X-rays. The bowel was leaking into her abdomen, causing her to suffer chemical peritonitis along with the underlying bacterial peritonitis. The plaintiff had to undergo several surgeries to repair the injuries and two skin graft procedures. She was left with a very large abdominal hernia and permanent disfiguring scarring as a result of the incident.

CASE DETAILS

The plaintiff brought suit against the defendant hospital and radiologists, alleging negligence in failing to timely diagnose and treat the bowel leak. The defendants denied the allegations of negligence and disputed liability.

After a seven day trial, the jury deliberated for five hours and returned its unanimous decision in favor of the plaintiff and against the defendant. The jury awarded the plaintiff the sum of $2,978,000, consisting of $1,250,000 for past non-economic damages, $1,500,000 for future non-economic damages and $228,000 for medical expenses.

RISK MANAGEMENT ADVISORY

In this case, the plaintiff's entire cause of action was against the defendant radiology group for their alleged negligence in failing to timely diagnose and treat the bowel leak. It is interesting to note that there was no liability assessed by the judge and jury against the surgeons for their participation in this whole event, particularly the surgical intervention where the bowel leak was, in fact, created. Apparently there was no provable allegation of deviation on behalf of the surgeons involved for creation of the bowel leak, primarily because there was no particular evidence indicating a deviation in bringing about the bowel leak, which was deemed to have occurred by the very nature of the procedure itself and not by any provable deviation from acceptable standards of practice on behalf of the surgeons at whose hands the bowel leak originally occurred.

Practitioners are again reminded by this aspect of the case that where an untoward event occurs by the very nature of a surgical procedure itself and not through any particular provable deviation in the performance of the procedure that brought about that offending poor result, the practitioners involved in that poor result will not normally be assessed liability unless it can be proven that they were responsible for a deviation in bringing about the poor result. It is the provable deviation in the course of the performance of any procedure that brings about liability to the surgeon or physician involved and not simply the fact that an adverse event occurred through the very nature of the procedure itself, as it was apparently deemed to be involving the surgeons in this particular case. However, liability was sustained against the radiology group for their failure to timely interpret the small bowel study and their other negligence in failing to timely diagnose and treat the bowel leak.

Practitioners should be aware of another important phase of liability that may well have existed in this case, even against the surgeons initially involved in the bringing about the bowel leak in the absence of any particular deviation. In this regard, practitioners are reminded that where an adverse event occurs with sufficiency frequency during a particular procedure to be considered a risk of that procedure or surgical intervention, then there may conceivably be a deviation on behalf of the surgeons or physicians involved in failing to obtain an informed consent indicating the possibility of the occurrence of this complication even where it can and does occur in the absence of negligence, which may well have been the situation in this case.

In this regard, practitioners are reminded that when they perform a particular procedure that carries with it a known risk which can and does occur in the absence of deviation in the performance of the procedure by the very nature of the procedure itself, they can conceivably incur liability on the basis of a failure of informed risk where they fail to advise the patient prior to the procedure of the possibility of the occurrence of this risk so that they can make a reasonable judgment as to whether or not to proceed with the surgical intervention.

Practitioners are further reminded that where there is a finding of a failure of informed consent, they can be held responsible for all the poor results of the procedure, which might otherwise not have been undertaken had there been a valid and appropriate informed consent advising of the risks of the particular occurrence. The recoverable poor results can also include the costs of any corrective treatment, financial damages, and any permanent injury to the patient that may have occurred.

EXPERTS

Plaintiff's general surgery expert: Leonard Milewski, M.D. from Rosemont, PA. Plaintiff's radiology expert: Seth Glick, M.D. from Philadelphia, PA. Defendant's infectious disease expert: Michael McIllroy from Detroit, MI. Defendant's radiology expert: Barry Bates, M.D. from OH.

REFERENCE

Shiawassee County, MI. Apsey vs. Memorial Hospital. Case no. 01-007289-NH; Judge Gerald D. Lostracco. Attorney for plaintiff: Frank Malfrice of Malfrice & Associates in Southfield, MI.

$2,500,000 VERDICT - WRONGFUL DEATH AND SURVIVAL ACTION - FAILURE TO DETECT BOWEL LACERATION DURING INCISIONAL HERNIA REPAIR SURGERY - NEGLIGENT POST-OPERATIVE CARE - PERITONITIS - SEPSIS.

CASE SUMMARY

The estate of the 74-year-old female plaintiff contended that the defendant general surgeon negligently failed to detect a bowel laceration during surgery to repair an incisional hernia. The plaintiff also alleged that employees of the defendant hospital deviated from the required standard of care in failing to appreciate the decedent's post-operative signs and symptoms of bowel leakage, leading to her ultimate death from sepsis. The defendant doctor argued that he did not detect bowel leakage at the time of surgery and that the cause of the plaintiff's subsequent symptoms was unclear. The defendants maintained that the bowel leakage was diagnosed as soon as possible. Several other physicians involved in the plaintiff's care were voluntarily dismissed from the case prior to trial.

CASE DETAILS

The decedent was admitted to the defendant hospital for elective surgery to repair an incisional hernia. The laparoscopic repair surgery was performed by the defendant general surgeon on April 29, 2004. The plaintiff's surgical expert testified that the defendant was negligent in failing to perform a post-operative re-examination of the plaintiff's bowel at the end of the surgery to ensure that there were no leaks. Such an examination would have revealed that a bowel laceration had occurred during the surgery, according to the plaintiff.

The defendant surgeon was not working at the hospital over the weekend following the decedent's surgery. The plaintiff claimed that the decedent exhibited several signs and symptoms of bowel leakage, which were not appreciated by the hospital physicians in charge of her care and that these physicians administered pain management only. In addition, the plaintiff's expert opined that the plaintiff's diagnostic tests, including a so-called "shift to the left", indicated a high white blood count and developing infection which was not appreciated by the hospital physicians.

Four days post-operative, on May 4, 2004, the decedent was being moved for a repeat CAT scan, when the plaintiff contended that fecal contents spilled out of her surgical wound. The plaintiff was diagnosed with two perforations or enterotomies in the bowel which the plaintiff claimed was caused by a bowel laceration during the surgery. The decedent underwent additional surgery to repair the bowel and the wound remained unclosed. Peritonitis and overwhelming sepsis resulted in her death eight months post-operatively.

The defendant surgeon testified that he checked for bowel leakage during the procedure and he did not believe that it was necessary to check again at the end of the procedure because if a leak were present, he would have seen it. The defense contended that the decedent's medical presentation was complicated and that the physicians who were treating her acted reasonably in considering differential diagnosis, including a hematoma. The defense argued that there was not sufficient evidence to diagnose a bowel injury during the time in question.

After a five day trial, the jury found for the plaintiff in the amount of $2,500,000. The award included $1,500,000 for the wrongful death claim and $1,000,000 for the survival claim. The addition of delay damages increased the plaintiff's judgment to $2,859,795. Post-trial motions are pending.

MEDICAL LIABILITY ANALYSIS

This was a sizable $2.5 million damage award in a case involving a very sad and agonizing death of a 74-year-old woman eight months after undergoing elective surgery to repair an incisional hernia. The crux of the plaintiff's case hinged on the allegation that the defendant surgeon, and hospital physicians who cared for the decedent in the surgeon's absence, failed to detect a bowel laceration which occurred during the operation and allowed her condition to progress beyond the point from which she could recover. There was no informed consent count in the complaint and experts seemed to agree that such a bowel injury could occur in the absence of negligence.

However, the defendant's expert made an important concession, during cross examination, that the standard of care requires a re-checking of the bowel at the conclusion of surgery and that he instructs his students and interns to follow that practice. The defendant surgeon admitted that he did not perform such a post-surgical check, but steadfastly asserted that it was not necessary to do so. The decedent was transferred to another medical facility closer to her family following spillage of fecal matter from her surgical wound and additional surgery to repair the bowel laceration.

The jury apparently related to the moving fact that the decedent was never able to go home again following what was believed to be a relatively minor procedure. The plaintiff introduced graphic photographs showing the decedent in her hospital bed with an open abdominal wound during the eight months between surgery and her ultimate death from overwhelming sepsis.

It was stipulated that the defendant surgeon was acting as an agent of the defendant hospital at the time in question.

RISK MANAGEMENT ADVISORY

It was successfully alleged in this case that the defendant general surgeon acted negligently in failing to detect a bowel laceration during surgery to repair an incisional hernia. The plaintiff's expert surgeon successfully opined that the defendant surgeon was negligent in failing to perform a re-examination of the plaintiff's bowel at the end of the surgery to ensure that there were no lacerations or leaks. Such an examination would have revealed that a bowel laceration had occurred during the surgery, according to this expert. The jury agreed with these contentions and rendered a verdict against the surgeon defendant in this case.

The plaintiff had also successfully contended that the employees of defendant hospital deviated from the required standard of care in failing to appreciate in a timely manner the decedent's post-operative signs and symptoms of bowel leakage which ultimately contributed to his death from sepsis. Significantly, there was no specific allegation that the laceration of the bowel occurred as a result of a deviation from acceptable standards of practice in the performance of the procedure itself, rather the focus was on the failure of the surgeon to identify the laceration prior to closing.

Practitioners are reminded by this aspect of the case that in situations where an untoward event occurs during the course of a surgical intervention, or any medical procedure for that matter, even if such an occurrence is considered a known risk which occurs in the absence of deviation, as it may well have been in this case, if there is a failure to appropriately react to such an occurrence that brings about injury to the patient, then there can indeed be liability for that failure. Furthermore, where a physician so involved fails to appropriately examine the patient during the surgical intervention, or even post-surgically, for signs of the occurrence of an untoward event, such as the bowel laceration in this case, liability can be assessed for failing to appropriately examine the patient to determine whether or not the particular adverse circumstance had occurred in accordance with the acceptable standard of care.

In addition, in situations where a particular untoward event occurs, liability can also be assessed against medical personnel for failing to timely and appropriately appreciate and react to signs and symptoms of an adverse circumstance such as an ongoing post-surgical infection. A failure to appropriately and timely treat the infection can in itself also be considered a deviation from acceptable standards of practice.

In this case, there was no allegation made of a failure of informed consent, probably because of the clear deviation involved in the failure to appropriately check for a bowel leak at the end of the surgery which was enumerated to be the standard of care in this case. Therefore, there was no necessity for the development of an informed consent issue. Practitioners are reminded, however, that where an adverse event occurs by the very nature of the procedure itself, if the untoward event occurs with sufficient frequency to be considered a known risk of the procedure, then the failure to inform a patient of this fact could create liability. Proper informed consent would require that the patient be advised of the possibility of this adverse circumstance that can be one of the risks involved in the procedure.

Furthermore, the failure of informed consent does not depend upon deviation in the performance of the particular procedure involved, rather it is based upon the fact that the particular untoward event can occur in the absence of deviation with sufficient frequency to be considered a known risk of the procedure. In that situation, the failure to inform the patient appropriately that he or she was undertaking the risk of that event by undergoing the procedure is what creates liability for lack of informed consent. However, in this case, there was sufficient deviation in the failure to appropriately check for the bowel leak as well as other events during the procedure, that the undertaking of an allegation of failure of informed consent, which may well have existed, was deemed unnecessary in this wrongful death action.

EXPERTS

Plaintiff's general surgeon expert: David Befeler from Stockton, NJ. Defendant's general surgeon: Guy Voller from Memphis, TN.

REFERENCE

U.S. District Court, Eastern District of Pennsylvania. Kurchner vs. Harbison and Temple University Hospital. Case no. n/a; Judge Cynthia Rufe, 1-16-09. Attorneys for plaintiff: Normal Perlberger and Eliot H. Lewis of Pomerantz, Perlberger & Lewis in Philadelphia, PA. Attorney for defendants: Robert C. Pugh of Kane, Pugh, Knoell, Troy & Kramer in Norristown, PA.

$1,750,000 VERDICT - OB/GYN - NEGLIGENT USE OF FUNDAL PRESSURE DURING SHOULDER DYSTOCIA - BRACHIAL PLEXUS INJURY - ERB'S PALSY - VERDICT RENDERED FOR MAXIMUM AMOUNT UNDER STATE MALPRACTICE CAP.

CASE SUMMARY

In this medical malpractice action, the plaintiff contended that the defendant ob/gyn utilized contraindicated fundal pressure when shoulder dystocia occurred. The plaintiff contended that as a result, the impaction of the shoulder worsened, resulting in the baby sustaining a brachial plexus injury that manifested in moderate to severe right sided Erb's Palsy. The defendant did not dispute that shoulder dystocia had been encountered or that fundal pressure was utilized. The defendant denied, however, that the use of fundal pressure was a deviation, or that the method of delivery contributed to the brachial plexus injury.

CASE DETAILS

The defendant passed away before discovery. The nurse who was present testified that when shoulder dystocia was encountered the defendant gave an order for the use of "pressure." The nurse indicated that she was about to begin using suprapubic pressure entailing the use of a closed fist above the pubic bone and pushing in an inward and downward motion to allow the baby's shoulder to go under the pubic bone and deliver. The nurse related that as she began, the defendant redirected her to use fundal pressure, entailing pushing downward from an area immediately below the breast bone.

The plaintiff contended that the use of fundal pressure constituted a deviation. The plaintiff's expert ob/gyn maintained that the use of such fundal pressure resulted in worsening of the impaction, which required the defendant to use excessive force, causing a widening of the angle between the head and shoulder. The plaintiff's expert ob/gyn and treating pediatric neurologist, who had worked with numerous children suffering Erb's Palsy, contended that although it was essential to complete the delivery as soon as possible to avoid a deprivation of oxygen once shoulder dystocia was encountered, the use of fundal pressure heightened the impaction, and that it was clear that excessive traction was applied to the baby's head, causing the nerve injury. The nurse's notes reflected that the physician had ordered fundal pressure and not suprapubic pressure. The plaintiff maintained that once shoulder dystocia occurs, the physician can utilize a number of accepted maneuvers, such as the use of suprapubic pressure, The McRobert's maneuver (in which the mother's legs are flexed toward her shoulders as she lays on her back), or the Woods corkscrew maneuver, that entails the turning the shoulder of the baby by placing fingers behind the shoulder and pushing in 180 degrees.

The defendant denied that such fundal pressure continues to be considered a deviation and contended that the medical literature is evolving and that there is no evidence that such pressure causes injury. The defense maintained that Erb's Palsy generally occurs in utero and is not related to the maneuvers during delivery.

The plaintiff confronted one of the defense experts, who denied during the subject trial that the use of fundal pressure was a departure, with a transcript from his testimony in a prior case in which he testified that if he saw a nurse giving fundal pressure, it would be his duty to stop him or her. The plaintiff maintained that in view of this testimony, the defendant's position should clearly be rejected.

The plaintiff contended that the baby suffered brachial plexus injuries at the C5,C6 and part of the C7 levels that resulted in moderate to severe right sided Erb's palsy. The child was three and a-half years of age at the time of time of trial. The plaintiff's maintained that the child will permanently suffer a severe loss of use, a cosmetic deficit and that surgery would not be helpful. The physician related that the child used his right leg to kick a ball that was rolled to him and that he could determine thereby, that the child was naturally right handed and that the injury was sustained on the dominant side.

The plaintiff contended that the jury should consider that as the child ages and goes through various stages of life, he will experience very extensive embarrassment and will be frustrated in attempting to engage in the various activities of daily living. The plaintiff argued that the jury should take into account that when he is in grade school, he will probably be picked on by other children, and will probably be the last person chosen to be on a team. The plaintiff maintained that the jury should also consider that the when in high school and attempting to date, he will also suffer very significant impediments, including attempting to use his right arm to dance. The plaintiff also contended that the infant plaintiff will continuously be reminded of the injury each time he attempts to perform a simple task, such as turning on a lamp or reaching for a doorknob.

The jury found for the plaintiff and awarded $250,000 for past pain and suffering and $1,500,000 for future pain and suffering.

MEDICAL LIABILITY ANALYSIS

The case was subject to Virginia's medical malpractice cap, which is determined by the year the injury was sustained. The subject birth occurred in 2005 and the cap controlling the case was $1,750,000. The jury rendered the full amount and accepted the plaintiff's counsel's suggestion of awarding $250,000 for past pain and suffering and $1,500,000 for future pain and suffering. It is thought that when discussing the lengthy life expectancy through which the infant plaintiff will suffer the effects of the Erb's Palsy, the plaintiff effectively depicted the myriad of day to day difficulties which will be faced by the child as he goes through various stages of life. This enabled the jury to better appreciate the manner in which such day to day impediments warrant very significant compensation. In this regard, the plaintiff stressed that the child will have to deal with the injury and be reminded of the Erb's Palsy every time he engaged in activities otherwise taken for granted, such as opening a door or turning a door knob.

Regarding liability, the defendant, who did not dispute that fundal pressure was utilized, denied that the use of this technique constituted a departure. The plaintiff productively confronted one of the defendant's experts with a transcript from a prior case in which the expert indicated that if he saw a nurse using fundal pressure, he would feel duty bound to stop him or her from continuing.

RISK MANAGEMENT ADVISORY

In this case, the plaintiff successfully contended that the defendant ob/gyn utilized contraindicated fundal pressure after a shoulder dystocia occurred during the delivery. The plaintiff further contended that as a result, the impaction of the shoulder became more severe, resulting in the infant sustaining a brachial plexus injury manifesting in significant right-sided palsy. Although the defendant did not dispute that a shoulder dystocia had been encountered or that fundal pressure was utilized, the defendant denied that the use of such fundal pressure constituted a deviation or that the method of delivery contributed to the brachial plexus injury. Unfortunately, the plaintiff's expert physicians, an ob/gyn and a pediatric neurologist with extensive experience in treating children with Erb's palsy, successfully opined that the use of fundal pressure, rather than suprapubic pressure, was, in fact, a deviation from acceptable standards of practice and caused the infant plaintiff's permanent injury.

In this regard, the plaintiff's experts explained to the satisfaction of the judge and jury that the use of such fundal pressure resulted in a worsening of the impaction, which required that the defendant use excessive traction to extricate the baby, caused a widening of the angle between the head and shoulder. Both experts agreed that although it was essential to complete the delivery as soon as possible to avoid a deprivation of oxygen once the shoulder dystocia was encountered, the use of fundal pressure heightened the impaction and that it was clear that excessive traction was applied to the baby's head, causing the nerve injury involved. In addition, the nurses' notes in this case actually reflected that the defendant physician had ordered fundal pressure and not the suprapubic pressure that the plaintiff's experts and most of the authorities seemed to indicate was the appropriate maneuver in this situation.

The generally accepted maneuvers, as testified to by the plaintiff's experts, that should have been utilized to avoid injury to the baby once the dystocia occurred would be either the McRobert's maneuver, in which the mother's legs are flexed toward her shoulders as she lays on her back, or the Wood's corkscrew maneuver. which entails turning of the baby's shoulder by placing fingers behind the shoulder and pushing in 180 degrees. The evidence indicated that neither of these maneuvers were utilized in accordance with the proven appropriate standard of care involved in this situation.

Although the defendant admitted that the method and manner of the delivery he performed may have previously been considered a deviation from acceptable standards of practice in accordance with the medical literature, it was his personal opinion that his delivery method was no longer a deviation because the prevailing literature is in the course of evolving and, therefore, there is no clear standard to have failed to comply with in this particular situation. In this regard, the defendant indicated that compliance with what he considered to be an existing, but old standard, was not essential or necessary to avoid liability because of the evolving, changing medical literature which now seems to indicate the possibility that the prevailing opinion enunciated in the literature used to establish the standard is not actually mandating compliance because such literature has been questioned by some authorities and, therefore, may not necessarily be binding upon physicians such as himself, who are following their own opinion regarding what is appropriate and what is not.

Practitioners are once again strongly reminded by this aspect of the case that as licensed physicians, they have a non-equivocable duty to comply with the acceptable standards of practice followed by most physicians in the particular circumstance or situation involved, and they also have the responsibility to continue to comply to such standards despite the fact that the prevailing standards may have come under question from a limited number of authorities, but not the prevailing majority of authorities on the subject. Practitioners should be aware that where they decline to follow the prevailing opinion of appropriate texts and authorities in their medical practice in any particular situation, they may well be assessed liability despite the fact that they do not necessarily agree with those authorities. In this regard, practitioners are indeed reminded that although they are entitled to their personal opinion on any medical subject matter, they cannot interpose that personal opinion and also avoid liability when they fail to follow the prevailing existing standard of care followed by most physicians in the particular situation and where such a failure to do so results in injury to their patient. In addition, although their opinion and judgment does not necessarily have to be infallible, where they render an opinion inconsistent with the prevailing existing standard of care relevant to the particular opinion or judgment being rendered, they cannot avoid liability on the basis of the fact that they were exercising their medical judgment in doing so at the time.

Of further significance in this case was the situation created when plaintiff's counsel confronted one of the defense experts, who denied during the trial that the use of fundal pressure was a departure from acceptable standards of practice, with the transcript of testimony he had given in a prior case in which he testified

that to the contrary, if he saw a nurse using fundal pressure, it would be his duty to stop him or her. Plaintiff's counsel argued to the jury that in view of this conflicting testimony, this expert physician's opinions should clearly be rejected.

Practitioners would do well to remember the importance of maintaining the credibility of the testimony and opinions proffered by experts in medical malpractice litigation. Where an expert is produced on behalf of a defendant who then gives testimony or an opinion that is clearly inconsistent with an opinion rendered by that same expert in some other matter, then the expert at that point can be considered to not only have impaired his own credibility beyond repair, but may well have also impaired the credibility of the entire defense in the malpractice case involved. Jurors in medical malpractice trials may sometimes accept certain inconsistent statements made due to lapses in memory which are not particularly material to the situation involved, but they will seldom forgive an outright statement made by a proffered expert or defendant which is clearly inconsistent with what they have testified to under oath in some other similar litigation.

In this regard, practitioners should be aware of the serious impairment of credibility that can be caused by a proffered professional produced as an expert in a medical malpractice litigation whose testimony and opinion is subsequently impeached, which can conceivably not only fatally impair the credibility of that expert, but which can also impair the credibility of the entire defense for having offered that testimony in the first place. Care should, therefore, be taken to avoid such impairment by close questioning of proffered experts as to whether or not there exists any conceivable inconsistencies between what they are now contending and what may have contended on a prior occasion and recorded in that prior litigation.

EXPERTS

Plaintiff's ob/gyn expert: Jeffery Soffer from NJ. Plaintiff's treating pediatric neurologist expert: Ralph Northam from Norfolk, VA.

REFERENCE

Circuit Court, Norfolk, Virginia. Williams vs. Jones, et al. Case no. CL07-6370; Judge Junius P. Fulton III, 5-09. Attorneys for plaintiff: Preston J. Douglas of Gurfein Douglas, LLP in New York, NY and Stanley Sacks of Sacks & Sacks in Norfolk, VA.

$1,000,000 GROSS VERDICT - PRIMARY CARE - NEUROLOGY - FAILURE TO DIAGNOSE STROKE - JURY FINDS CONTRIBUTORY NEGLIGENCE BY PLAINTIFF FOR PRE-TREATMENT SMOKING HABIT.

CASE SUMMARY

This medical malpractice case involved a now 62-year-old woman permanently neurologically injured as a result of a stroke. The plaintiff claimed that she had risk factors for stroke, such as high blood pressure, high cholesterol and smoking, and that she had symptoms of TIAs, precursors to stroke. The plaintiff further claimed that the defendants, her primary care physician and the neurologist to whom she was referred, overlooked the risk factors and the symptoms, failed to order proper testing and misdiagnosed her symptoms as those of migraine headaches, directly resulting in a debilitating stroke. The defendant neurologist denied awareness of the plaintiff's symptoms and history. The defendant primary care physician asserted that it was the responsibility of the defendant neurologist to order proper tests.

CASE DETAILS

In 2001, the plaintiff was 54 years old. For a number of years she had had migraine headaches that presented as headache and visual disturbance. In July 2001, she developed unilateral weakness, facial numbness and aphasia. Her primary care doctor ordered an MRI of the brain, but no study of the carotids. The primary care physician also referred the plaintiff to the defendant neurologist. At the time, the plaintiff did not have health insurance.

The neurologist saw the patient six weeks after the PCP. By then, the brain MRI had been performed. The plaintiff claimed that the radiologist's interpretation revealed abnormalities consistent with TIAs. Neither of the defendants ordered a carotid artery ultrasound which would have revealed the nearly totally occluded vessels. 17 days after the neurology visit, the plaintiff suffered a large right sided stroke which has left her neurologically compromised on the left side of her body. After her stroke, physicians at Boston's Beth Israel Hospital properly diagnosed the blockages in the plaintiff's carotids, placed a stent to open up the blocked artery and restored blood flow to the plaintiff's brain. She has not had another stroke, or interestingly, another migraine, since.

The defendant primary care physician testified that she informed the neurologist of the TIA symptoms in a telephone call some six weeks before the patient's neurology appointment. The defendant primary care physician testified that she called the defendant neurologist in advance of the appointment to be sure that the neurologist would see a patient without insurance. At trial, the PCP testified that in such a call she would have told the neurologist of the patient's history and presentation. The neurologist denied ever getting this call. The defendant neurologist claimed that he was unaware of the plaintiff's symptoms of unilateral arm and leg weakness and aphasia and that he was aware of only her history of headaches. The defendant neurologist testified that the plaintiff's MRI was normal.

The jury found against the neurologist, awarding a $1,000,000 verdict, reduced by 40% due to the plaintiff's contributory negligence, for a net award of $600,000.

MEDICAL LIABILITY ANALYSIS

The jury deliberated for four and a-half hours and returned a verdict for the plaintiff against to the neurologist. In a highly unusual move, the jury also attributed 40% fault to the plaintiff herself. Plaintiff's counsel noted that it is atypical for a jury to attribute contributory negligence in a medical malpractice case. Plaintiff's counsel believed that the jury attributed fault to the plaintiff because she continued to smoke long after receiving a diagnosis of high blood pressure and other diagnoses indicating a risk of stroke.

RISK MANAGEMENT ADVISORY

This case presents a highly unusual determination by a jury in a medical malpractice case. The jury decided to reduce the plaintiff's verdict based upon the patient's own contributory negligence, where such contributory negligence was founded upon the patient's personal habit of smoking, which was determined to have contributed to her diverse medical condition for which she went to the accused physicians in the first place. Furthermore, there was no indication in the record that the patient was advised by the defendant physicians to discontinue smoking, or that the treatment being rendered to her could be adversely affected by her continuing to smoke. In fact, the subject of smoking was never brought up at any time in accordance with the records in this case by either of the accused physicians.

The attributing of the plaintiff's actions to contributory negligence was not explained by any of the experts nor by the jury's determination, which went unexplained as to how and why they arrived at that conclusion. Plaintiff's counsel indicated that although he is not aware of what the jury had in mind in this regard, he believed that the jury attributed fault to the plaintiff because she continued to smoke long after receiving a diagnosis of high blood pressure and other diagnoses indicating a risk of a stroke. However, this conduct by the patient that the jury found to be contributory negligence all occurred prior to either defendant physician undertaking treatment of the patient.

Despite the outcome of this case, practitioners are reminded that a finding of contributory negligence in medical malpractice litigation is fairly rare and is usually found when the patient's own negligence is proven to have contributed to the poor result caused by deviation on the part of the defendant physician involved. In most jurisdictions, a patient's habits and behavior that brought the patient to the physician in the first place for treatment cannot be considered as contributory negligence. Contributory negligence normally only involves the patient's own conduct in failing to appropriately follow the advisements of a physician which can be proven to have contributed adversely to the patient's recovery.

Said another way, the contributory negligence of a patient for their own conduct cannot be attributed, in most jurisdictions, to the patient's poor health habits and lack of concern for their own health and well-being prior to treatment being rendered by an accused physician in medical malpractice litigation. In this regard, the practitioner is deemed to accept the patient as they find them with all of their infirmities and pre-existing habits that brought about the necessity for treatment in the first place and to render the appropriate treatment for a patient in that particular condition determined by the practitioner as a basis for the patient undergoing treatment. Therefore, a patient's prior habits such as smoking that may have deteriorated their health cannot be considered as contributory negligence because the physician who undertook to treat that patient accepted the patient with all of their pre-existing infirmities and habits that brought them to the physician in the first place.

Also in this case, the primary care physician testified at the trial that she had called the referred-to neurologist on the telephone prior to her appointment with the patient and told the neurologist of the patient's history and presentation, including the telltale TIA symptoms some six weeks before the patient's neurology appointment, as well as the radiologist's interpretation having revealed abnormalities consistent with TIAs. However, the defendant radiologist denied ever receiving this phone call or of receiving this particularly significant information. The jury exonerated the primary care physician, apparently believing her testimony over that of the neurologist's.

Practitioners are reminded by this aspect of the case of the importance, when referring a patient to a specialist for evaluation, of not only communicating directly with the referred-to physician, but also reducing all referral requests to written form so as to establish having provided the specialist with any appropriate and necessary findings of other physicians or their own findings for which the specialty evaluation is being requested. This written documentation should also include copies of all appropriate medical records and reports within the referring physician's file, as well as all prior tests performed or any radiological interpretations which might have a bearing on the specialist's evaluation. This information should be supplied in addition to any telephone communication that may also be involved in advising the specialist as to the referring physician's impressions pre-existing the specialist's examination.

Furthermore, physicians responsible for the appropriate referral of patients to specialists might also, from a safe practice point of view if not necessarily from a liability standpoint of view, immediately review the report from the referred-to specialist for any indications that the specialist failed to appropriately evaluate or appreciate the situation in accordance with the symptomatology that the referring physician believed formed the basis for the referral. If any questions should arise upon this review, the re-

ferring physician should communicate directly with the specialist to determine why the specialist's findings do not comport with the kind of conclusion or finding expected by the referring physician. Furthermore, written documentation of all communication between the referring physician and specialist can go a long way in avoiding any liability that may be involved by the failure of the specialist to appreciate all the necessary facts and circumstances that brought about the referral in the first place.

Practitioners are once again reminded of the importance of not only having written communication with the referred-to specialist containing all the relevant documentation, prior reports and conclusions, but also communicating the impressions of the referring physician through direct verbal communication with the referred-to specialist. Practitioners are also reminded by this case of the significance and importance of questioning the findings of the specialist if they appear to be inconsistent with the reasons for the referral or that may, by its very nature, create a suspicion that the specialist was not considering all of the important relevant evidence and symptomatology that necessitated the referral in the first place.

Practitioners should also be reminded that where they refer a matter to a specialist for evaluation, particularly in potentially serious situations where the specialist's response appears not to have possibly considered all of the elements in the case, then they should question it directly with the specialist and, if necessary, order another evaluation by either that specialist or by some other specialist.

REFERENCE

Plymouth County, MA. Jordan vs. Ronan, et al. Case no. PLCV2004-01282. Attorney for plaintiff: Suzanne C. M. McDonough of Lubin & Meyer in Boston, MA.

Medical Malpractice by Specialty

Dental

$275,000 VERDICT - Negligent administration of anesthetic during endoscopic procedure - Paresthesia.

The plaintiff, in his mid 40s, contended that the defendant dentist negligently failed to avoid the inferior alveolar nerve as he was administering an anesthetic during an endoscopic procedure. The plaintiff also maintained that the defendant negligently failed to immediately remove the needle when he complained of an electric shock sensation, heightening the injury.

The plaintiff maintained that he suffered permanent paresthesia to the lower left lip and that he will permanently experience numbness, difficulties eating, some difficulties with drooling and a speech impediment. The defendant maintained that any injury was the result of a known complication and denied administering the anesthetic in a negligent manner.

The defendant's expert dentist denied that the needle could cause the claimed damage. The plaintiff contended that in view of the apparent inconsistency between this conclusion and the defendant's testimony, the defendant's position should be rejected. The defendant maintained that if the plaintiff sustained injury, it was not as severe as claimed.

The jury found for the plaintiff and awarded $275,000.

REFERENCE

Bronx County, NY. DeCoro vs. Dr. W. Index no. 301338/07; Judge Norma Ruiz, 03-25-10. Attorney for plaintiff: Albert W. Chianese of Albert W. Chianese & Associates in Rockville Centre, NY. Attorney for defendant: Costello Shea & Gaffney, LLP in New York, NY.

DEFENDANT'S VERDICT - Alleged trigeminal neuralgia as result of teeth extraction - Pharmacological treatments, injection of alcohol into nerve and injections of anesthetics and glycerol - Neurectomy and Gamma Knife surgery.

The plaintiff presented at the defendant Albee Dental Care Clinic with complaints of dental pain. On August 15, 2000, the third-party defendant, an oral surgeon engaged by the defendant, performed extractions of teeth 20 and 21. The plaintiff alleged that as a result of these extractions, she suffered neuralgia. Specifically, she alleged that the oral surgeon injured the plaintiff's metal nerve which caused trigeminal neuralgia. The defendant argued that there was no evidence of any mental nerve damage subsequent to the extractions even when the nerve was exposed and examined by a treating physician. The defendant further contended that trigeminal neuralgia is not caused by dental treatments.

Following the extractions, the plaintiff continued to experience dental pain. She consulted several dentists and was diagnosed with trigeminal neuralgia, a very painful swelling of the trigeminal nerve that delivers feeling to the face and surface of the eye. She was treated with pharmacological treatments, injection of the nerve with alcohol to kill part of the

nerve, as well as injections of anesthetics and glycerol. She also underwent a neurectomy wherein a section of her mental nerve was removed. When these treatments were ineffective, the plaintiff underwent Gamma Knife surgery which alleviated her shooting pains and left her with a mild burning.

The defense experts opined that trigeminal neuralgia is not caused by dental treatments and that while the cause is not known for certain, the most likely cause is a blood vessel touching the trigeminal nerve within the skull. The defendant introduced a radiological study that showed a vascular loop to the plaintiff's trigeminal nerve within her skull.

The plaintiff was 56 years old at the time of the extractions and worked as a food service worker in a hospital.

After an eight day trial and after deliberating for one hour, the jury returned a verdict in favor of the defendant.

EXPERTS

Plaintiff's prosthodentistry expert: Susha Halberstam from Forest Hills, NY. Defendant's neurology expert: Steven Sparr from New York, NY. Defendant's oral surgery expert: Earl Clarkson from Brooklyn, NY.

REFERENCE

Kings County, NY. Shirley Boodoo vs. Albee Dental Care. Index no. 046184/2002; Judge Michelle Weston, 04-27-10. Attorneys for plaintiff: Raskin & Raskin in Brooklyn, NY. Attorney for defendant: Ryan Burns of Rawles & Henderson in New York, NY.

Hospital Negligence

$410,000 RECOVERY - Negligent appendectomy - Failure to timely diagnose post-operative bleeding - Sepsis - Death.

In this matter for medical malpractice, the plaintiff argued that the defendant's failure to diagnose post-operative bleeding led to a patient's death. The defendant generally denied the allegations and strongly contested the amount of damages alleged.

The decedent, a 46-year old man, was admitted to the defendant hospital with a diagnosis of acute appendicitis. At that time, he was taken immediately to the operating room where doctors performed a laparoscopic appendectomy. Following the surgery, the decedent was admitted to the PACU where his blood pressure dropped, his pulse increased, his temperature increased and his pain increased. These clinical signs were communicated to the attending doctor who ordered narcotics.

Nevertheless, the decedent's blood pressure continued to fall and a rapid response team was called. When lab work returned abnormal results, an attending physician concluded that the decedent was suffering from sepsis and was possibly suffering from internal bleeding. As a result, the decedent was transferred to the ICU for a CT-scan. The CT-scan revealed a hemorrhage in the abdomen and pelvis and the decedent's file indicated that these findings were discussed with the physician responsible for the decedent's care.

Despite receiving blood over the next several hours, the decedent's clinical condition did not improve and, ultimately, the decedent suffered cardiac and respiratory arrest. Resuscitation was not successful. The autopsy report concluded the decedent died from exsanguinations due to intra-abdominal bleeding.

Prior trial, the plaintiff's experts opined that the decedent's caregivers were negligent in their care and treatment of the decedent's condition. Specifically, experts targeted their negligent response to the decedent's post-operative bleeding which was compounded by their failure to timely respond to evidence of the decedent's deterioration.

Meanwhile, the defense strongly contested damages based on the decedent's truncated life-expectancy and the fact that he was not economically responsible for any dependents. In essence, the defense pointed out that the decedent's underlying health issues (i.e., diabetes, coronary artery disease, hypertension, and hyperlipidemia) significantly shortened his life expectancy. The defense also highlighted the fact that the decedent was not married and that his children were economically independent adults.

Ultimately, in April 2010, this matter settled prior to trial in the amount of a $410,000 recovery for the plaintiffs.

REFERENCE

Northern County, MN, C.P., as Trustee for D.P., deceased vs. Health System. 04-21-10. Attorney for plaintiff: Peter A. Schmit of Robins, Kaplan, Miller & Ciresi, LLP in Minneapolis, MN.

DEFENDANT'S VERDICT - 58-year-old ICU patient suffers decubitus ulcers requiring surgery.

In this medical malpractice matter, the plaintiff alleged that the defendant's staff was negligent in turning him while he was in the intensive care unit, resulting in bedsores which required surgical removal. The defendant denied the allegations and disputed that there was any deviation from acceptable standards of care in their treatment of the plaintiff.

On February 14, 2008 the 58-year-old male plaintiff was admitted to the defendant's hospital with a severe crush injury due to a work related incident. He was in the defendant's intensive care unit for six weeks as a result. The plaintiff alleged that during his stay, he developed bedsores as a result of the failure of the defendant's staff to care for him and the poor design of the hospital bed. The plaintiff intended to demonstrate that the

bed sores were as a result of not being turned frequently by the staff and in being in a rotating bed, which contributed to the development of the sores. The plaintiff alleged that he had to undergo surgery to repair the bedsores he developed.

The defendant denied the allegations. The defendant maintained that the plaintiff was turned frequently. The defendant maintained that the bedsores were friction injuries and were not pressure sores from not being properly turned. The defendant denied that there was any deviation from acceptable standards of care.

EXPERTS

Plaintiff's internal medicine expert: Lige B. Rushing, M.D. from Dallas, TX.

REFERENCE

Jefferson County County, TX. Ronald Lee Lewis vs. Christus St. Elizabeth Hospital. Case no. A183940; Judge Robert Wortham, 8-18-10. Attorney for plaintiff: Brett S. Thomas of Roebuck & Thomas P.C. in Beaumont, TX. Attorney for defendant: Curry L. Cooksey and Casey P. Marcin of Orgain Bell & Tucker in Houston, TX.

Ob/Gyn

$89,033 VERDICT - Failure to remove mesh following surgical procedure - Infection - Failure to timely diagnose cause of infection - Abscess necessitating additional surgery - Lost earnings.

In this medical malpractice matter, the plaintiff alleged that the defendant ob/gyn failed to remove mesh from the plaintiff following a surgical procedure, which led to an infection. The plaintiff contended that the defendant failed to timely diagnose the foreign object as the cause of the infection, resulting in injury to the plaintiff.

The female plaintiff was a patient of the defendant ob/gyn and her practice. The plaintiff underwent an IVS Tunnel/vaginal slip procedure at the hands of the defendant on January 28, 2005. In the month following the procedure, the plaintiff was seen by the defendant in follow-up and prescribed Flagyl for complaints consistent with a vaginal infection. The plaintiff alleged that during the next year she was given additional prescriptions for the same medication without any further follow-up or office visits with the defendant or anyone in her office.

The plaintiff alleged that the defendant ob/gyn failed to follow-up or to determine the cause of the infection which the plaintiff learned in 2007 was a foreign object, namely mesh left in her vagina during the procedure two years earlier. The foreign object caused an infection and later an abscess which required surgical intervention.

The plaintiff brought suit against the defendant, alleging negligence on the part of the defendant ob/gyn for failing to remove the mesh during the procedure and in failing to determine the cause of the infection. She also sued the defendant's practice alleging that they were negligent in prescribing the medication to the plaintiff without any follow-up office visits to assess her condition.

The defendants denied negligence and maintained there was no deviation from acceptable standards of care. Further, the defendants disputed the nature and extent of the plaintiff's injuries.

The matter proceeded to trial. At the conclusion of the trial, the jury found in favor of the plaintiff and against the defendants. The jury awarded the plaintiff the sum of $89,033, which consisted of $5,000 for past and future loss of normal life, $5,000 for past and future pain and suffering, $74,883 for medical expenses and $4,200 for lost earnings.

EXPERT

Plaintiff's ob/gyn expert: Brett Vassallo, M.D. from Park Ridge, IL.

REFERENCE

Cook County, IL. Wendy Salas vs. Female Heath Care Associates, Ltd., et al. Case no. 07L13714; Judge William J. Haddad, 08-31-10. Attorney for plaintiff: Charles V. Falkenberg, III of Karlin & Fleisher in Chicago, IL.

DEFENDANT'S VERDICT - Plaintiff contends that defendant surgeon negligently nicked the plaintiff's bowel during tubal ligation surgery - Permanent scarring and flatulence.

In this medical malpractice case, the plaintiff, in her 30s, presented to the defendant for a tubal ligation. The plaintiff contended that the defendant negligently nicked the plaintiff's bowel during the surgery. The defendant denied any violation of the standard of care and contended that the plaintiff insisted on a laparoscopic procedure which carries more surgical risks.

The plaintiff required an open procedure to repair the bowel. The plaintiff claimed she was left with permanent scarring and excessive flatulence. The plaintiff contended that her relationship was affected by her scarring.

At trial, the plaintiff called a gynecological surgeon who testified that everything the defendant did was within the standard of care except for the use of the wrong kind of surgical knot which caused

the opening of the plaintiff's bowel. The plaintiff opined that, if the perforation had happened at the beginning of the surgery or during the procedure, it would not have comprised malpractice because bowel perforation is a known risk of laparoscopic surgery. The plaintiff's expert testified that, because the perforation occurred at the end of the surgery due to a knot, it was negligent.

The defendant argued that he reviewed with the plaintiff all the risks of the laparoscopic tubal ligation procedure and recommended other procedures that had lower risks with the same results. The defendant maintained that the plaintiff insisted on laparoscopic surgery with the knowledge of the risk of nicking the bowel. The defendant argued that everything he did during the surgery was correct, including the way the surgical knot was tied.

The defendant also pointed to the fact that he immediately brought the plaintiff in as soon as he was aware there was an issue. He then performed CAT scans and repaired the bowel. The defendant called an obstetrician/gynecology expert who testified that the defendant performed the surgery correctly and there was no way he could have avoided the plaintiff's outcome.

The jury found no negligence and returned a verdict in favor of the defendant.

EXPERTS

Defendant's gynecological surgery expert: Steven Rosenman from CT.

REFERENCE

Norfolk County, MA. Tringali vs. Dr. S., et al. Case no. NOCV2007-00125, 03-08-10. Attorney for defendant: William J. Davenport of Gervais & Davenport in Medford, MA.

DEFENDANT'S VERDICT - Alleged failure to diagnose ovarian mass - Surgical removal of ovary and appendix - Supposed reduction in fertility.

In this obstetrical malpractice action, the plaintiff alleged the defendant negligently failed to appreciate a large right ovarian dermoid cyst during a routine gynecological exam, necessitating a major salpingo-oophorectomy and appendectomy, rather than a minor laparoscopic procedure had the cyst been diagnosed at the earlier time. The plaintiff also claimed substantial internal injuries and reduced fertility as a result. The defendant argued that the abdominal mass had not presented on the date in question and the examination did not deviate from the standard of care.

The evidence revealed that on June 19, 2002, at Montefiore Medical Center Institute for Women's Health, Genetics and Human Reproduction in Larchmont, New York, the then 22-year-old plaintiff visited the defendant ob/gyn for a routine gynecological examination. The defendant documented a normal exam. One year later, after finding "abdominal fullness," the plaintiff's primary care physician referred the plaintiff for a pelvic sonogram. The report of the pelvic sonogram described a "huge mass" arising in the pelvis.

The plaintiff underwent a right salpingo-oophorectomy and appendectomy on August 13, 2003, at New York-Presbyterian Hospital. Surgical pathology described a mature cystic teratoma measuring 30 x 20 x 10 centimeters and weighing 3200 grams [over seven pounds]. The plaintiff contended that had the cyst been diagnosed a year earlier by the defendant, she could have avoided major surgery and undergone an ovary-saving laparoscopic surgery instead.

The defendant argued the plaintiff's abdominal mass was not appreciable in the summer of 2002 and the failure to diagnose, especially in the absence of abdominal complaints by the plaintiff, was not a deviation from the standard of care. The defendant's expert testified that the mass was likely not palpable during defendant's examination because cystic teratomas have a rapid growth rate. Therefore, according to the expert, it was probable that the mass significantly grew from June of 2002 to its detection in June of 2003.

The defendant's arguments were supported by the fact that the plaintiff's primary care physician had not appreciated a mass in the plaintiff's abdomen just weeks before she was initially seen by defendant. The primary care physician noted a normal abdomen on April 2, 2002 and May 22, 2002. Moreover, the plaintiff reported no abdominal complaints to her physician just four months prior to being diagnosed with the abdominal mass in June of 2003.

The plaintiff alleged injuries included adhesions requiring an appendectomy, free fluid in the abdomen, an abdominal scar, and severe pain and suffering. She also contended that she would not have lost the ovary, as a cyst removal could have been performed, and that she has decreased fertility as a result. Finally, she argued that she also suffered significant abdominal adhesions as a result of the necessity to cut through the abdominal muscles to remove the large mass.

The defendant argued that any delay in diagnosis and treatment of the ovarian dermoid cyst caused no harm to the plaintiff. The defendant's expert testified that the alleged one-year delay in diagnosis made no difference in the treatment course or outcome because a laparotomy would have been required in 2002. Had the cyst been removed laparoscopically, defendant's expert testified that given the large size of the cyst and its contents, the plaintiff would have been at a greater risk for adhesions and/or infection.

Moreover, the defendant's expert testified that because the plaintiff had an ovarian dermoid cyst, she would have lost her ovary no matter when the diagnosis was made. In addition, the loss of the plaintiff's ovary was trivial due to the fact that only one ovary ovulates each month and the plaintiff still maintained a good ovary tube. The defendant's expert continued that the plaintiff's appendix was removed only as a prophylactic measure and the plaintiff conceded that there was no activity that she could not engage in as a result of her surgery.

The plaintiff, who claimed loss of income in the amount of $3,400, asked the jury to award her $1,300,000. The plaintiff's demand of $300,000 was met with a defense offer of $20,000. FOJP Service Corporation is the insurance company for both defendants.

The multi-racial jury made up of five females and one male deliberated for approximately four hours before returning a unanimous verdict in favor of the defendants.

EXPERTS

Plaintiff's obstetrics and gynecology expert: Robert Breitstein, M.D. from NY. Defendant's obstetrics and gynecology expert: Carmel J. Cohen, M.D. from New York, NY.

REFERENCE

Bronx County, NY. Cara Tocci vs. Klugmontefiore Medical Center Institute for Women's Health, Genetics and Human Reproduction, and S.D., MD. Index no. 21091/04; Judge Alan Saks. Attorney for plaintiff: Russel McHugh, Esq. of Alpert & Kaufman, LLP in New York, NY. Attorney for defendant Montefiore Medical Center: Andrew S. Kaufman, Esq. of Kaufman, Borgeest & Ryan, LLP in New York, NY.

Orthopedics

$230,000 CONFIDENTIAL RECOVERY - Incorrect procedure performed - Persistent pain at site of incision - Continued pain from DeQuervain's tendonitis.

The plaintiff alleged that the defendant was negligent in performing the wrong procedure on her, causing her injury and failing to alleviate her pain. The defendant surgeon admitted that he performed the wrong surgery, but it was the procedure that was scheduled by the medical group's employee and was not his fault. Further, the defendants disputed the nature and extent of the plaintiff's alleged injuries.

The 59-year-old female plaintiff, a homemaker, developed pain at the base of her right thumb on the dorsum of the hand in June, 2008. She underwent conservative care which did not relieve her symptoms. She then came under the care of the defendant orthopedist. The initial treatment consisted of anti-inflammatory medication and cortisone injections, but still the plaintiff did not have any relief from her complaints.

She was diagnosed by the defendant with DeQuervain's tendonitis of her right thumb. She was scheduled for surgery on May 20, 2009 to relieve the tendonitis. Somehow, the procedure was scheduled as a carpal tunnel procedure instead of a DeQuervain's tendonitis surgery. During the pre-operative visit, the plaintiff maintained that the defendant surgeon realized the error in the scheduling. Supposedly the defendant instructed one of his employees to contact the hospital and schedule the proper procedure for the DeQuervain's tendonitis.

When the plaintiff arrived for the surgery, it was still listed mistakenly as a carpal tunnel release. During the surgery, despite the state mandated "time out" procedure, the plaintiff alleged that the defendant orthopedist still performed the incorrect procedure. The plaintiff followed up with the defendant orthopedist on May 27th. At that juncture it was determined that the defendant had performed the wrong procedure on the plaintiff's hand.

The plaintiff alleged that she continues to experience pain at the site of the incision and continues to experience the same symptoms and discomfort in connection with the DeQuervain's tendonitis that she experienced prior to the surgery. The plaintiff brought suit against the hospital, the medical group and the surgeon, alleging negligence in performing the wrong procedure and in failing to correct the scheduling of the wrong procedure prior to the procedure itself.

The defendants collectively took the position that the plaintiff's transient pain attributed to the incorrect procedure should have resolved itself within 60 to 90 days post-operative. The defendant surgeon maintained that while he did perform the incorrect surgery, he did so because it was improperly scheduled by some employee of the medical group and when the employee was to correct the error, it was not done. The defendant surgeon testified that during the pre-operative visit he had realized the error and directed the medical group employee to call and schedule the correct procedure.

The defendant medical group alleged that the defendant surgeon incorrectly instructed its employee as to the procedure and disputed what the defendant surgeon testified occurred during the pre-operative visit. The defendant hospital disputed any liability to the plaintiff.

The matter was resolved prior to trial for the total settlement of $230,000. The defendant surgeon paid the sum of $225,000 and the defendant medical group and the defendant hospital each contributed $2,500 to the settlement.

EXPERTS

Plaintiff's nursing expert: Lynda Mansfield, R.N. from Westminster, CA. Defendant's nursing expert: Lila Cheney, R.N. from Pasadena, CA. Defendant's orthopedic surgery expert: George Macer, Jr., M.D. from Long Beach, CA. Defendant's orthopedic surgery expert: Kendall Wagner, M.D. from Fullerton, CA.

REFERENCE

Orange County, CA. Plaintiff vs. Defendant orthopedist. 08-25-10. Attorney for plaintiff: Daniel Hodes of Hodes Millman, LLP in Irvine, CA. Attorney for defendant Orthopedist: Gabriele Prater of DiCaro Coppo & Popcke in Carlsbad, CA. Attorney for defendant Medical Group: Raymond McMahon of Bonne Bridges Mueller O'Keefe & Nichols in Santa Ana, CA.

Orthopedic Surgery

DEFENDANT'S VERDICT - Alleged negligent performance of open reduction/internal fixation following wrist fracture - Tendon rupture.

The plaintiff, in her early 40s, who had suffered a radius fracture on the dominant side that was treated by way of ORIF, contended that the defendant orthopedic surgeon negligently placed the screws too deeply, resulting in the screws, which attached he plate to the palmer side of the wrist, protruding through the dorsal side and the plaintiff suffering a rupture of the EPL tendon controlling the thumb approximately ten weeks after the surgery was performed. The plaintiff maintained that she will suffer permanent reduced use despite surgery.

The plaintiff contended that proper fixation should have been obtained while keeping the sharp screws flush with the bone. The defendant maintained that it is necessary to insert the screws as deeply as was done in this case in order to obtain needed fixation. The defendant contended that damage to the tendon or other soft tissue structures are a known risk.

The evidence disclosed that several weeks after the defendant's surgery, the plaintiff relocated to Michigan and upon difficulties moving the thumb, went to a non party physician, who was not an orthopedist. This physician opened the patient, noted the rupture and since he was not an orthopedist, closed her and referred her to the subsequent, non-party orthopedist. This physician did repair surgery and the plaintiff maintained that too much time had elapsed to obtain more than limited improvement of movement.

The defendant contended that the jury should consider that neither physician who provided treatment in Michigan was critical of the defendant.

The demand of $425,000 was not met with an offer. The jury found for the defendant.

EXPERTS

Plaintiff's orthopedist expert: Mark Appel, M.D. Defendant's orthopedist expert: Russell Cecil, M.D.

REFERENCE

Saratoga County, NY. Demars vs. Dr. S., et al. Index no. 3988/07, 10-22-10. Attorney for defendant: Kevin P. Burke of Burke, Scolamiero, Mortati & Hurd, LLP in Albany, NY.

DEFENDANT'S VERDICT - Orthopedic surgery - Alleged sciatic nerve damage during total hip replacement surgery - Permanent foot drop allegedly leads to fall three years later.

In this medical malpractice case the plaintiff, Carmen Perez, contended that she suffered permanent disability due to the defendant surgeon's negligence during hip surgery. She additionally claimed that she suffered a fall three years later as a result of that disability. The defendant orthopedic surgeon countered that he met the standard of care under the circumstances.

On March 1, 2006, Brian Parsley, M.D. performed a left total hip replacement surgery on Carmen Perez at The Methodist Hospital in Houston. Mrs. Perez had diminished motor responses in her left leg in the recovery room and shortly thereafter a total absence of dorsiflexion. Dr. Parsley immediately returned her to surgery for exploration of the surgical area. Mrs. Perez alleged that she suffered a permanent foot drop that caused her to fall and break her femur three years later.

At the time of trial, she was using a cane to assist her with walking. Mrs. Perez sued for medical malpractice, alleging that Dr. Parsley negligently injured her sciatic nerve during the hip surgery and that the sciatic nerve injury caused her to fall and break her femur in 2009, requiring three additional surgical procedures.

In his operative report, Dr. Parsley documented that, when he explored the surgical area, he released a suture, allowing the sciatic nerve to drop back into the posterior fossa "without incident." Mrs. Perez was discharged from the hospital with absent dorsiflexion. Subsequent EMG testing confirmed that the peroneal division of the sciatic nerve was substantially injured, but that the tibial division was only minimally affected. Mrs. Perez's treating neurologist wrote in the medical records in the fall of 2007 that Mrs. Perez had 50% return of the strength to the muscle that dorsiflexes her left foot, but still had very little ability to rotate her foot outwards and no ability to pick up the big toe.

On August 24, 2009, Mrs. Perez fell in her kitchen and suffered an acute comminuted, displaced fracture of the distal left femur that required three subsequent surgeries and for her to be non-weight bearing for about three months. She was off from work for seven months. She alleged that her sciatic nerve injuries caused her to fall.

The plaintiffs' independent orthopedic surgeon, Dr. Larry Greenway, testified that the standard of care required dissecting and visualizing the sciatic nerve during hip replacement surgery. In addition, the plaintiffs contended that Dr. Parsley's technique of reattaching the quadratus femoris muscle to the femur at the end of the hip replacement procedure was an unnecessary step that caused the sciatic nerve to be injured. Both Dr. Greenway and defendant's independent orthopedic surgeon testified that they did not generally reattach the quadratus femoris muscle, but that it was within the standard of care to do so.

The defense counsel countered that the standard of care did not require the sciatic nerve to be visualized and that inspecting the position of the sciatic nerve by palpation was within the standard of care. Dr. Parsley, called as an adverse witness by

the plaintiff, testified that he palpated the sciatic nerve injury during the procedure prior to cutting the quadratus femoris muscle, and that when he reattached the quadratus femoris muscle to the femur, he sutured it back to the femur no more than three millimeters closer than the position it was in before he cut it. The plaintiff contended that he pulled the quadrates femoris much closer to the femur than it had originally been, thus stretching the sciatic nerve in the process.

Mrs. Perez sought recovery for past medical expenses in excess of $300,000, along with seeking $960,000 in past and future physical pain, mental anguish, physical impairment and physical disfigurement. The plaintiff called the defendant's independently retained neurology expert adversely and he testified that Mrs. Perez's sciatic nerve fibers had re-grown based upon his review of the medical records and principles of basic anatomy, but conceded that Ms. Perez still has weakness in the affected muscles.

The trial lasted five days. The jury, composed of ten men and two women, deliberated for 45 minutes before unanimously finding that Dr. Parsley was not negligent and not liable for Mrs. Perez's injuries.

EXPERTS

Plaintiff's orthopedic surgeon expert: Larry Greenway, M.D. from Austin, TX. Defendant's neurologist expert: Raymond Martin, M.D. from Houston, TX. Defendant's neuroradiology expert: Brian Parsley, M.D. from Houston, TX. Defendant's orthopedic surgeon expert: Thomas Greider, M.D. from Houston, TX.

REFERENCE

Harris County District Court, TX. Carmen Perez and Victor Perez vs. Baylor College of Medicine, et al. Case no. 2008-08423; Judge Reece Rondon, 07-30-10. Attorneys for plaintiff: Andy Rubenstein of Vickery, Mallia & Waldner in Houston, TX and Ron Estafan in Houston, TX. Attorneys for defendant: Jeffrey B. McClure and Laura Trenaman of Andrews Kurth LLP in Houston, TX.

Pathology

DEFENDANT'S VERDICT - Surgical sponge left inside decedent after laparoscopic hysterectomy allegedly contributes to her death - Pathologist performing autopsy allegedly conceals true cause of death by removing or chopping up internal organs.

The plaintiffs, in this combined medical malpractice and desecration of a body case, claimed the defendant physicians who authorized and performed the requested autopsy on their mother were involved in a conspiracy to cover-up the true cause of her death. The family alleged their mother died from a surgical sponge that was left inside her during a hysterectomy, which caused her health to deteriorate in the months following, until her death. The family claimed emotional distress, burial expenses and past medical costs relating to the death of their mother. The defendants argued the decedent's death was the result of numerous underlying health conditions unrelated to the surgical sponge.

The defendants further alleged that a cover-up never existed, as evidenced by the fact that the family was immediately informed of the retained surgical sponge and that the medical examiner was initially contacted to perform the autopsy. The defendants maintained the autopsy was performed by the defendant hospital only after the medical examiner waived jurisdiction. The defendants contended the standard of care had not been breached and that the plaintiff's claims were unfounded.

The 68-year-old retired decedent presented to Sharp Grossmont Hospital in San Diego in April 2007 with a large mass in her pelvis. A laparoscopic vaginal hysterectomy was performed and following the surgery she developed an infection and was later diagnosed with peritonitis and an incarcerated hernia. 11 days later the decedent underwent a procedure to reduce the hernia and to address the infection. At this time, a surgical sponge was discovered and removed. The decedent slowly healed and was discharged.

In July 2007, the decedent presented at Alvarado Hospital where she died of kidney failure. The decedent's nine children, the plaintiffs in this case, claimed their mother's decline began with the hysterectomy and the surgical sponge that was retained inside the decedent for ten days.

The defendants presented evidence that the overweight decedent had been ill for a long period of time previous to her death and that while her health began to deteriorate, she did improve after being discharged in the spring of 2007. The defendants argued that underlying health issues, such as high blood pressure and diabetes, contributed to her death.

The decedent spoke briefly with the defendant physician just prior to her death on July 12, 2007, and upon her death, the defendant requested an autopsy be done pursuant to the family's request. The co-defendant testified he phoned the medical examiner's office to inquire as to the office's intent to perform the autopsy. The medical examiner corroborated this testimony at trial, testifying that upon reviewing the decedent's medical records, his office waived jurisdiction on the basis that his office found no evidence of wrongdoing. The co-defendant pathologist then performed the autopsy at Alvarado Hospital.

In the co-defendant's autopsy report, he noted the retained surgical sponge found after the hysterectomy, but concluded it had no connection to the cause of the decedent's death. Upon receiving this report, the plaintiff's exhumed their mother's body and ordered a second autopsy with another pathologist. The physician who performed this autopsy claimed he was unable to find all the decedent's organs. Thus, the plaintiffs contended their mother's body was

desecrated during the initial autopsy, which they claimed was evidenced by organs that were missing or evulsed.

The defendant's presented evidence that it is industry standard to keep some portions of the internal organs during an autopsy due to microscopic testing that is sometimes later performed on the organs. The defendant's argued that upon exhumation, the internal organs quite possibly could have seemed congealed together due to the embalming process in which the organs are generally placed in a plastic bag inside the body cavity. Therefore, in accordance with industry standard, the internal organs would not be anatomically correct.

At trial, the plaintiffs presented pictures taken during the second autopsy, but the defendants argued the pictures were inconclusive and that they were provided no opportunity to perform their own post-exhumation examination. The defendants argued the plaintiffs failed to provide motive for a cover-up involving a procedure done at a competing hospital. The decedent underwent the hysterectomy at Sharp Grossmont Hospital and the autopsy was performed at the nearby Alvarado Hospital. The defendants argued the implausibility that they would risk their careers to attempt at covering up a malpractice at a competing hospital. Additionally, they contended the fact that the family was immediately notified of the sponge and that the sponge was noted in the autopsy report was evidence enough that a cover-up did not exist.

The hospital where the hysterectomy was performed and the defendant physician who performed the surgery settled the case, and the defendant was found not guilty on a non-suit dismissal. The co-defendant physician was found not guilty of malpractice after a ten day trial and two and a-half hours of jury deliberation.

EXPERTS

Plaintiff's pathologist expert: Dr. Marvin Pietruszka, M.D. from Reseda, CA. Defendant's hospitalist-internist expert: Dr. William Wayne Hooper, M.D. from San Diego, CA. Defendant's pathologist expert: Dr. Bernard S. Change, M.D. from San Diego, CA.

REFERENCE

San Diego County, CA. Minyon Hamilton, LaVida Johnson, et al., individually and Successors in Interest to Margaret Griffin vs. Grossmont Hospital, et al. Case no. 37-2008-00084918-CU-MM-CTL; Judge Timothy B. Taylor, 08-01-10. Attorneys for plaintiff: Joel G. Selik of Selik Law Offices in Encinitas, CA and Suzanne Mindlin in Carlsbad, CA. Attorneys for defendant: Hugh A. McCabe and Andrew Chivinski of Neil, Dymott, Frank, Harrison & McFall APLC in San Diego, CA.

Plastic Surgery

DEFENDANT'S VERDICT - Capsular contracture requiring multiple revision surgeries following breast augmentation surgery.

In this medical malpractice action, the plaintiff contended that the defendant failed to evacuate a post surgical hematoma, leading to capsular contracture. The defendant argued that it followed all recommended procedures with regard to treatment and that the plaintiff knew a hematoma was a possible complication of this procedure.

The plaintiff presented to the defendant surgeon for an elective breast augmentation. Post surgery, the plaintiff suffered a capsular contracture requiring additional revision procedures. The plaintiff contended that her final outcome resulted in a deformity of the breast that impacts significantly on her life. The plaintiff maintained that she will require future additional procedures and that she experienced significant pain and suffering. The plaintiff also made a substantial claim for past and future medical expenses.

At trial, the plaintiff called a plastic surgeon who testified that there was a significant hematoma requiring surgical evacuation and the defendant's failure to do so was the cause of the plaintiff's subsequent capsular contracture. The defendant argued that the hematoma, if it existed, was so minimal it did not require surgical evacuation because transumbilical surgery, such as the plaintiff underwent, creates a natural drain.

Further, the defendant argued that capsular contracture is a common complication of breast augmentation and the plaintiff was aware of the risk prior to the elective surgery. The defendant asserted that there is a five to eight percent chance of developing a capsular contracture even if the surgery is performed perfectly. At trial, the defendant presented an expert plastic surgeon from Los Angeles who testified that if there was a hematoma, it was insignificant and because it was an umbilical procedure, surgical evacuation was not necessary due to the natural drain created by the surgical approach. The defendant's expert opined that the capsular contracture did not exist because of any failure to evacuate the hematoma.

The jury found no negligence by the defendant.

EXPERTS

Defendant's plastic surgery expert: Dr. Neal Handel from Los Angeles, CA.

REFERENCE

Palm County, FL. Joanne Robles vs. Dr. A. Case no. 2008 ca 034722, 01-25-10. Attorneys for defendant: Barry Postman and Lee M. Cohen of Cole, Scott & Kissane, PA in West Palm Beach, FL.

Rehabilitation Center Negligence

$300,000 VERDICT - Substance abuse center negligence - Failure to properly monitor and treat alcohol withdrawal - Failure to follow-up on abnormalities identified on EKG and lab results - Cardiac arrhythmia and death.

In this medical malpractice case, the plaintiff's decedent allegedly died due to the negligence of the defendant substance abuse physician and center. The plaintiff asserted that the decedent was not properly examined and that abnormal test results were ignored. The defense denied liability, arguing that they met the standard of care for alcohol withdrawal treatment.

The plaintiff's decedent, a single 55-year-old male, sought treatment for alcohol dependency from the Keys to Recovery Substance Abuse Center, located at Holy Family Medical Center on October 8th, 2003. Prior to his arrival, the decedent reported drinking four quarts of vodka over the previous 72 hours. Upon admission, his blood alcohol content was 0.224. The defendant attending physician issued a telephone order for the decedent's care on the night of October 8th, including an EKG and lab work. The nursing staff at Keys to Recovery started valium for withdrawal symptoms and monitored the decedent's vital signs.

On October 9th, 2003, the decedent suffered cardiac arrhythmia and died. The plaintiff alleged that the defendant physician failed to properly monitor and treat the decedent's alcohol withdrawal and failed to follow up on abnormalities identified on the EKG and lab results. The plaintiff further alleged that the defendant negligently failed to examine the decedent on the morning of October 9th. The evidence showed that the defendant's discharge summary stated that he never saw the decedent alive.

The defendant testified in his deposition and at trial that he performed a physical examination of the decedent on October 9th, but did not document the exam. The defense argued that the decedent's condition was typical for a patient experiencing alcohol withdrawal, that the EKG and lab results were normal for a patient in alcohol withdrawal, and that no additional treatment was required by the standard of care.

The plaintiff was survived by an adult brother.

The jury found for the plaintiff estate and awarded $300,000.

EXPERTS

Plaintiff's cardiologist expert: Joel Kahn, M.D from West Bloomfield, MI. Plaintiff's family practice & sports medicine expert: John E. Hocutt, M.D from Wilmington, DE. Defendant's addiction medicine specialist expert: Gregory Teas, M.D. from Elk Grove Village, IL. Defendant's cardiologist expert: Gary Schaer, M.D. from Chicago, IL.

REFERENCE

Cook County, IL. Estate of Jay Shlofrock, deceased vs. Dr. L. and Clinical Associates S.C. Case no. 05L-10264; Judge Suriano. Attorney for plaintiff: David G. Pribyl & Matthew L. Williams of Salvi Schostok & Pritchard P.C in Waukegan, IL. Attorney for defendant Clinical Associates, S.C.: Mark Smith of Lowis & Gellen, LLP in Chicago, IL.

Surgery

$7,000,000 VERDICT - Alleged hip replacement surgery mistake results in one leg longer than the other - Retrial on damages only.

This medical malpractice case, tried on damages only, involved a hip replacement surgery that allegedly left the 50-year-old female plaintiff with a significant leg-length discrepancy. The plaintiff maintained that the condition has caused her to suffer spinal issues due to her altered gait. The defendant claimed the cause of the problem was a preexisting degenerative condition.

The evidence revealed that the plaintiff initially presented to a resident for her hip complaints and hip replacement surgery was recommended. The plaintiff first met with the defendant surgeon on December 20, 1998, the day the plaintiff underwent right hip replacement surgery, which was performed by the defendant at the Montefiore Medical Center. The plaintiff remained in the hospital for eleven days and then received out-patient physical therapy for nearly a year. She was prescribed a shoe lift for her right foot and was taught how to walk again. She ambulated with assistance initially by using a walker, then crutches, and then a cane.

The plaintiff claimed that the leg-length discrepancy resulted over time in her suffering scoliosis and listing. The plaintiff's maintained that this condition is directly related to the excessive leg length discrepancy that resulted from the right hip replacement surgery. The plaintiff sought damages for past pain and suffering from the date of the surgery to the present, future pain and suffering for a period of twenty years, and loss of enjoyment of life. The plaintiff, who is unemployed, made no loss of income claims.

The defendant contended that the plaintiff's current condition was caused by a preexisting degenerative arthritic condition of the hip and that the surgery performed complied with the standard of care.

This case was initially tried to verdict in January 2007, where the jury found liability and damages against the defendant. The plaintiff argued that the examinations before surgery and the surgery itself were improper and that no alternative treatment was given to the plaintiff. In the original case, the damage award totaled $3.4 million. The defendant made post-trial motions,

among other things, to set aside the verdict on damages as excessive and contrary to the weight of the evidence. These were granted by the court to the extent that a new trial on damages was ordered unless the plaintiff agreed to reduce the entire award to a total of $630,000. The plaintiff elected for a new trial on damages and the subject trial was scheduled.

The jury in this retrial on damages only awarded the plaintiff a total of $7,000,000, over double the original damages amount. The award included $2,000,000 for past and pain and suffering, $1,000,000 for medical specials, and $4,000,000 for future pain and suffering.

EXPERTS

Plaintiff's orthopedic surgeon expert: Sanford Davne, M.D. from Bala Cynwyd, PA. Defendant's examining physician - orthopedic expert: Melvin Adler, M.D. from New York. Defendant's orthopedic surgeon expert: Kenneth Seslowe, M.D. from New York, NY. Defendant's treating physician - orthopedic surgeon expert: Marvin Gilbert, M.D. from NY.

REFERENCE

Bronx County, NY. Sharon Clay vs. E.H., M.D. Index no. 14240/01; Judge Geoffrey Wright, J.S.C.. Attorney for plaintiff: David J. Pierguidi, Esq. of The Pagan Law Firm, P.C. in New York, NY. Attorney for defendant: Sylvere Hyacinthe, Esq. of Mary A. Bjork Law Office in NY.

DEFENDANT'S VERDICT - Bowel perforation during laparoscopic hernia repair surgery - Failure of surgeons to determine bowel perforation prior to completion of surgery - Additional surgery required - Emotional distress alleged.

In this medical malpractice matter, the plaintiff alleged that the defendants were negligent in failing to determine a bowel perforation had occurred before completing the surgery requiring the plaintiff to undergo additional surgical procedures. The defendants denied that there was any deviation from the applicable standard of care.

On June 15, 2006 the female plaintiff underwent a laparoscopic repair for multiple hernias. The plaintiff had undergone six prior abdominal procedures. The plaintiff had been advised of the risks of procedure, one of which was damage to internal organs. The plaintiff consented to the surgery. During the procedure, the defendant surgeon noted a large volume of adhesions and scar tissue from the plaintiff's prior procedures.

The plaintiff alleged that the defendants failed to check the bowel for perforations and failed to notice a bowel perforation. After the surgery, the plaintiff developed complications and ultimately had to undergo another surgical procedure for what was later determined to be a perforated bowel. The plaintiff brought suit against the defendants, alleging negligence in failing to determine the bowel perforation prior to the completion of the surgery.

The defendants denied the allegations. The defendants maintained that there was no deviation from acceptable standards of care. The defendants maintained that the plaintiff had been advised that there was a risk of damage to an internal organ and she had given informed consent. The defendants further argued that the surgeon made every effort to evaluate the plaintiff to check for defects prior to the completion of the surgery. No defects were located and the surgery was completed.

The matter was tried over a period of five days. The jury deliberated for one hour and returned its verdict in favor of the defendant and against the plaintiff.

EXPERTS

Plaintiff's general surgery expert: Kenneth Deck, M.D. from Los Angeles, CA. Defendant's surgery expert: Sunil Bhoyrul, M.D. from San Diego, CA.

REFERENCE

Imperial County, CA. Maria Hernandez vs. El Centro Regional Medical Center, et al. Case no. ECU03689; Judge Joseph W. Zimmerman, 05-18-10. Attorney for plaintiff: Scott S. Harris of Law Offices of Scott S. Harris, APLC in San Diego, CA. Attorney for defendant: Hugh A. McCabe of Neil Dymott Frank Harrison & McFall APLC in San Diego, CA.

$1,300,000 VERDICT - Alleged surgical error in the repair of a superior labral anterior-posterior tear - Subsequent failure to diagnose.

In this medical malpractice suit, the plaintiff contended that the defendant surgeon negligently performed the placement of an anchor on his glenoid surface during a repair procedure for a shoulder tear that later tore again. The plaintiff claimed the consequential injury was the fault of the defendant team doctor for failing to diagnose and worsening the condition by allowing the plaintiff to continue playing football. The plaintiff also brought suit against the doctor's corporation and the hospital associated with the surgery for being vicariously liable. Before trial, the hospital of the surgery was dismissed from the action.

The background evidence explained that the plaintiff, a 16-year-old student, injured his right arm and shoulder during the 2002 football season, when he arm-tackled another player. The defendant team doctor then diagnosed the injury as shoulder instability, prescribed physical therapy, and permitted him to play the remainder of the football season. The plaintiff's mother was present at the game, was aware of the injury, and of the doctor's diagnosis. In March 2003, an MRI arthrogram was performed, which revealed the plaintiff had a torn labrum and was advised to have an arthroscopy for definitive diagnosis and

repair. A month later, the surgery was performed. The post-operative report described a repair of a superior labral anterior-posterior tear (SLAP) with one absorb-able suture anchor and repair of a bankart lesion (anterior labral tear) with two anchors.

The defendant team doctor in August 2003 cleared the plaintiff to play another season of football, and two months later, the "new onset" of pain was reported. The defendant team doctor prescribed a steroid dose-pack and allowed the plaintiff to continue playing football without performing an MRI. The defendant noted in his records on that date that the repair may have failed and there may be a loose anchor on the joint.

Finally in February 2004, an MRI was performed which revealed an anchor in the joint space and damage to the articular surface of the humeral head and glenoid socket. The plaintiff received subsequent treatment by a second orthopedist, who diagnosed his condition as severe osteoarthritis of the shoulder, and performed arthoscopic repair of the torn labrum and removed loose foreign bodies including the anchor fragment. The operative report described the damage to the articular surface corresponding to "anchor placement" one centimeter onto the glenoid surface.

The plaintiff argued a departure from accepted standards of care by the defendant surgeon in negligently placing the anchor on the glenoid surface, and by the defendant team doctor for failure to recommend x-rays, an MRI or an arthroscopy to identify the cause of the shoulder instability on October 13, 2003. The plaintiff's expert opined that the latter departure was the cause of the plaintiff's worsened condition and subsequent surgery.

The plaintiff sought $1M for past pain and suffering, $2M for future pain and suffering and sought $50K for the cost of future joint replacement surgery. The estimated amount includes hospitalization, physician fees, and rehabilitation.

Following a ten-day trial, the jury found that the defendant team doctor was liable for failing to order an MRI in October 2003, which was a substantial contributing factor to the plaintiff's subsequent injury. However the jury decided that neither of the defendant doctors were liable for misplacing an anchor during the April 2003 arthroscopy. The jury found no comparative fault on the plaintiff patient's part. The jury then awarded the plaintiff $1,300,000.

EXPERTS

Plaintiff's orthopedic surgery expert: Gregory Shankman, M.D from Utica, NY. Defendant's orthopedic surgery expert: Jonathan Ticker, M.D from Massapequa, NY.

REFERENCE

Suffolk County, NY. Anthony Salzano vs. Brookhaven Orthopedic Associates, M.D., P.C., Brookhaven Memorial Hospital Medical Center, Inc., et al. Index no. 22088/2005; Judge Arthur G. Pitts. Attorney for plaintiff Anthony Salzano: David S. Pollack of Duffy & Duffy, Esqs. in Uniondale, NY. Attorney for defendant. Richard A. Ritter, M.D., Barry C. Kleeman, M.D: Peter C. Kopff of Kopff, Kopff, Nardelli & Dopf, LLP in New York, NY.

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