

VERDICTS, SETTLEMENTS & TACTICS

A PERSONAL INJURY LITIGATION REPORTER

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MEDICAL LIABILITY

ANESTHESIOLOGY

1. Defense Verdict In Suit Alleging Negligent Anesthesia

The plaintiff, Christopher Duffney, DOB: 11/24/69, was admitted to Saratoga Hospital on 02/18/14 and underwent spinal surgery (lumbar reconstructive surgery) by an orthopedic surgeon, Dr. Herzog. The plaintiff received general anesthesia for the surgery. The surgical procedure lasted approximately 5½ hours and the plaintiff was in the prone position throughout. Approximately one hour post surgery, the plaintiff complained of severe pain, swelling and severe disfigurement of his tongue. He was thereafter referred to a Dr. Barry Maisel (otolaryngologist) who ultimately performed abscess drainage and reconstructive surgery of the tongue. The plaintiff thereafter following with Dr. Maisel for approximately 6 months.

The plaintiff contended that the anesthesia services were performed negligently. Specifically, the plaintiff contended that the anesthesiologist and the nurse anesthetist were negligent as a result of the tongue being pinched by the endotracheal tube, which led to ischemia, loss of circulation, and the resultant injury to the tongue. Plaintiff further contended that this was an injury which would not have occurred without negligence. At the time of trial, the judge charged the jury with *res ipsa loquitur* charge.

The defendants contended that injury to the tongue is a recognized complication of general anesthesia. The defendants further contended that the plaintiff had a preexisting injury to his tongue.

General Injury: Disfigurement of his tongue. The plaintiff underwent postoperative surgery for the tongue on 02/28/14. Despite the postoperative surgery along with medical management by the otolaryngologist, the plaintiff's tongue remained disfigured and anesthetized. As a result of this injury, the plaintiff complained of altered speech, inability to eat certain foods, disfigurement of the anterior aspect of the tongue and permanent paresthesia/dysesthesia.

Result: Jury verdict in favor of the defendants.

Plaintiff's Expert Witness: Tom Mitros, M.D., anesthesiologist, Philadelphia, Pennsylvania

Defendant's Expert Witness: Vivek Moitra, M.D., anesthesiologist, New York, New York

Plaintiff's Attorney: David J. Taffany, Anderson, Moschetti & Taffany, PLLC, Latham, NY

Defendant's Attorney: Terence P. O'Connor, O'Connor, O'Connor, Bresee & First, P.C., Albany, New York

Duffney v. Anesthesia Group of Albany, P.C., Matthew Taylor, MB, BCh, BAO, C. Bourne, CRNA, No.: 2014-2713 (Saratoga Cty. Sup. Ct. N.Y. May 17, 2017)

2. Defense Verdict In Suit Alleging Negligent Anesthesia

On May 16, 2012, Theresa Marie Howsden, age 49, underwent an elective outpatient surgical procedure (endometrial ablation) at Bella Women's Care in Phoenix, AZ. This routine gynecological procedure was performed by Mani Tehranchi, M.D. The anesthesia for the procedure was provided by Christopher S. Ray, M.D. Sometime during the procedure Marie Howsden suffered hypoxemic respiratory failure long enough for her to sustain severe anoxic brain injury which led to her death on May 25, 2012.

Plaintiffs alleged that Dr. Ray negligently administered too high of a dose of an anesthetic and failed to appropriately monitor her breathing. Plaintiffs alleged that these deviations from the standard of care were the cause of Theresa Howsden's death.

Dr. Ray denied that he was at fault for medical negligence in this case and denied that anything he did caused harm to Theresa Howsden. Further, Dr. Ray alleged that Theresa Howsden was herself at fault for her death for not providing accurate medical history to him.

General Injury: Death.

Result: Jury verdict in favor of defendant.

Plaintiff's Expert Witnesses: Jonathan Benumof, M.D., Anesthesiologist, San Diego, CA; Neal Shadoff, M.D.

Defendant's Expert Witnesses: Steven Mandel, M.D., anesthesiologist, Los Angeles, California; Shephal K. Doshi, M.D., cardiologist, causation

Plaintiff's Attorney: W. Daniel Shelton, Goldberg & Osborne LLP, Tucson, Arizona

Defendant's Attorneys: Neil C. Alden, Curtis Bergen, Jardine, Baker, Hickman & Houston

Miller v. Ray, No. CV2014-008240 (Maricopa County Superior Court of Arizona, March 2, 2017)

3. Defense Verdict In Suit Alleging Negligent Post-Operative Care

On December 16, 2010, Mrs. Gilbert was admitted to Cedars-Sinai. During her hospitalization, Mrs. Gilbert was found to have sepsis. While still hospitalized at Cedars-Sinai, Mrs. Gilbert, beginning on the afternoon of January 4, 2011, had elective orthopedic surgery for a right hip replacement. The surgery was complicated by an intraoperative femur fracture. The operation lasted a number of hours, during which time Mrs. Gilbert was under the stress of general anesthesia for a prolonged period. Dr. Snibbe was the surgeon who performed the operation. Dr. Filsinger was the anesthesiologist for the surgery.

Following the operation and after Mrs. Gilbert had spent a relatively brief amount of time in the Post-Anesthesia Care Unit ("PACU"), Drs. Snibbe and Filsinger permitted Mrs. Gilbert to be returned to her room on the orthopedic floor in an unmonitored bed.

At approximately 4:30 a.m. on January 5, 2011, hospital staff at Cedars-Sinai initiated a code blue after finding Mrs. Gilbert unresponsive and without a pulse. Subsequently, doctors were able to obtain a pulse, but by then Mrs. Gilbert had sustained, among other things, massive brain damage. Mrs. Gilbert died the next day.

Plaintiffs alleged that, in obtaining Mrs. Gilbert's consent to the surgery, Dr. Snibbe, Dr. Filsinger and Cedars-Sinai, negligently failed to inform Mrs. Gilbert that (1) Mrs. Gilbert's hospitalization and medical conditions increased the risk of death from elective hip replacement surgery; (2) she could have postponed the elective surgery to a later date to minimize the effect of the hospitalization and her medical conditions; and, (3) shortly following surgery she would be returned to her room on the orthopedic floor in an un-monitored bed where she would receive only minimal care.

Plaintiffs further alleged that defendants negligently (1) monitored Mrs. Gilbert's vital signs; (2) performed laboratory and other testing; (3) managed her blood and fluids; (4) assessed Mrs. Gilbert's respiration (e.g. oxygen and carbon dioxide levels); (5) administered medication(s); and, (6) treated her for surgical complications and injuries. Additionally, in connection with the medical care Cedars Sinai provided Mrs. Gilbert, Cedars-Sinai negligently failed to train, supervise, and evaluate its hospital staff.

Defendants denied any violations of the standard of care.

General Injury: Death.

Result: Jury verdict in favor of Dr. Snibbe and Dr. Filsinger.

Plaintiffs' Expert Witnesses: Howard Rosen, M.D., Anesthesiologist; Thomas J. Grogan, M.D., orthopedic surgeon,

Defendants' Expert Witnesses: Richard Ruffalo, M.D., anesthesiologist; Kevin Dhrhart, M.D., orthopedic surgeon,

Plaintiff's Attorney: Harold J. Light, Law Offices Of Harold J. Light, Los Angeles, California

Defendants' Attorneys: Robert B. Packer, Law, Brandmeyer + Packer, LLP, Pasadena, CA (for Defendant, Jason C. Snibbe, M.D.); Richard D. Carroll, Carroll, Kelly, Trotter, Franzen, McKenna & Peabody, Long Beach, California (for Defendant Daren Filsinger, M.D.)

Gilbert v. Cedars-Sinai Medical Center, No.

BC481372 (Los Angeles County Superior Court of California Apr. 21, 2017)

CARDIOLOGY

4. Defense Verdict In Suit Arising From Coronary Artery Bypass Surgery

Joe Wilson, was an 82-year old male who was referred to Dr. Richard Declusin by Dr. Dennis Brooks for evaluation of severe mitral regurgitation, coronary artery disease and atrial fibrillation. He was first seen by Dr. Declusin on October 13, 2014. Because of Mr. Wilson's rapid restenosis (after a stenting procedure), severe mitral regurgitation and atrial fibrillation, Dr. Declusin recommended coronary artery bypass surgery and mitral valve surgery and a Cox-Maze IV procedure for the A-Fib. Dr. Declusin performed the procedures on November 3, 2014 without complication.

While Dr. Declusin was dissecting the Lower Anterior Descending Artery during the bypass graft procedure he made an incision through the wall of the right ventricle, which was repaired with a suture. For the first 48 hours postoperatively, Mr. Wilson did quite well; however, during a nurse's attempted removal of the Swan-Ganz catheter on the third postoperative day, a tear in the wall of the right ventricle occurred and Mr. Wilson suffered a cardiac tamponade caused by bleeding from his heart. He underwent cardiopulmonary resuscitation in the coronary care unit and was quickly taken to the operating room where he died while they were trying to repair the tear.

It was contended that the incident was related to the repair of the incision which occurred during the CABG procedure. A suture used to repair the incision may have entrapped the Swan-Ganz catheter inside the right ventricle, unbeknownst to Dr. Declusin.

During the removal of the catheter, the nurse (a preceptee, being supervised by another RN) felt resistance during retraction. The chart indicated the preceptor (supervising RN) attempted to confirm the resistance by retracting the catheter again, and Mr. Miller's blood pressure suddenly dropped, leading to the nurses

leaving the room to get a physician. It was assumed that the retraction of the catheter caused a tear in the heart because it was entrapped by the repair suture in the ventricle.

Plaintiff contended that Dr. Declusin violated the standard of care in four ways: Failure to remove the catheter before suturing; failure to check the catheter for entrapment after suturing; failure to document the repair in the medical record; and, delegating removal of the catheter to a nurse. Plaintiff also contended that the hospital nurses were negligent for attempting to remove the catheter while the patient was seated; retracting the catheter a second time after feeling resistance; and leaving the patient to get a physician.

The defense contended that at all times, Dr. Declusin complied with the standard of care in performing surgery on Mr. Wilson. The injury resulted from an unfortunate and extremely unusual circumstance which could not have been foreseen by Dr. Declusin. The surgery and repair was done properly.

St. John's Hospital settled with plaintiff because the nursing staff violated the standard of care and hospital procedures by retracting the catheter more than once, causing the tear in the ventricle. Defendants contended that the nurses were negligence and that was a cause of Mr. Wilson's death.

General Injury: Death.

Result: Jury verdict in favor of defendant.

Plaintiff's Expert Witness: Robert Shuman, M.D., Cardiac Surgeon, Long Beach, CA

Defendant's Expert Witness: Douglas R. Zusman, M.D., Cardiac Surgeon, Newport Beach, CA; Cindy Damboise, RN,

Plaintiff's Attorney: Walter J. Wabby, Law Offices of Walter J. Wabby, Woodland Hills, California

Defendant's Attorney: Benjamin F. Coats, Engle Carobini & Coats LLP, Ventura, CA

Wilson v. Declusin, No. 56-2015-00473770-CU-MM-VTA (Ventura County Superior Court of California February 23, 2017)

5. Defense Verdict In Suit Arising From Pacemaker Discontinuation Following Open Heart Surgery

Ms. Soon Park, age 72, died on August 24, 2012 at the University of Washington Medical Center (“UWMC”). In 2001 she successfully underwent aortic valve replacement surgery with a bovine valve, but the valve had severely stenosed over time and required replacement. Other than her cardiac issues, she enjoyed good health for her age.

Ms. Park was the matriarch of a close-knit Korean American family and very involved in the lives of her three children and grandchildren. At the time of her death, she lived with her daughter Soon Kim’s family. Her other daughter, Michelle Cho, lived nearby and their families interacted on a daily basis. Although her son, Huan Cho, lives in Korea, Ms. Park traveled there each year to spend a couple of months with Huan’s family.

The open heart surgery to replace her aortic valve was performed by Dr. Jack Sun at UWMC on August 22, 2012. Ms. Park survived the complex surgery without complications, only to die of preventable cardiac arrest 30 hours later after discontinuation of her temporary pacemaker and transfer from the cardiothoracic ICU (CTICU) to the telemetry floor.

Plaintiff alleged that Ms. Park was at high risk for cardiac arrhythmias her surgery and should have remained on a temporary pacemaker for at least 48 hours, and that had her pacing not been discontinued the day after her surgery, she likely would have survived.

It was UWMC’s position that because Soon was stable during the night and the next morning after her surgery, the decision to discontinue her pacing and transfer her to the step down unit was appropriate. UWMC further disputed that Ms. Park’s death was due to the failure of her heart electrical conduction system.

Plaintiff contended that Ms. Park was at high risk for the failure of her heart’s electrical conduction

system and that her death that was preventable with pacemaker protection based on the following:

1. She had a history of atrial fibrillation with chronic anticoagulation;
2. She had an aortic valve nodal reentry tachycardia (AVRNT) procedure performed in 2000;
3. The second aortic valve surgery, which required extraction of the deeply embedded old valve to replace it with a new one, was very difficult with a great deal of bleeding and trauma to the septum, resulting in a high risk of damage to the heart’s electrical conduction system;
4. She developed junctional rhythm in the CTICU after the surgery;
5. The 12-lead EKG performed the morning of 8/23 showed left axis deviation and first degree AV block, which was evidence of slow conduction;
6. During the code she developed junctional rhythm and then asystole (also known as flatline, a state of no electrical activity), but then went back into after receiving large doses of supplemental adrenaline, strongly suggesting a breakdown of her electrical conduction system; and
7. The autopsy found considerable hemorrhage and trauma to the septum as well as a suture that had pierced through the septum into the tricuspid valve, evidencing the degree of surgical trauma and damage in the area of the conduction bundle.

Result: Jury verdict in favor of defendant. The jury found that Dr. Mackensen was not negligent.

Plaintiff’s Expert Witness: Bruce Charash, M.D, cardiologist, New York, NY

Defendant’s Expert Witness: Dr. Tom Amidon, cardiologist, Bellevue, Wash.

Plaintiff’s Attorneys: Maria S. Diamond, Judy I. Massong, DiamondMassong, PLLC, Seattle, WA

Defendant’s Attorneys: Jake Winfrey, Todd W. Reichert, Fain Anderson Vanderhoef Rosendahl O’Halloran Spillane, PLLC, Seattle, WA

Cho v. State of Washington d/b/a University of Washington Medical Center, No. 15-2-25665-3 SEA (King County Superior Court of Washington, May 8, 2017)

6. Defense Verdict In Suit Arising From Anti-Coagulation Therapy

Dr. Garfunkel underwent a left coronary angiography, right coronary angiography, and left heart catheterization with ventriculography at Jefferson Hospital on May 8, 2013. Although discharged the following day, Dr. Garfunkel was re-admitted to Jefferson Hospital on May 12, 2013, with complaints of chest pain and dyspnea on exertion.

On May 15, 2013, while admitted to Jefferson Hospital, Dr. Garfunkel underwent a triple coronary artery bypass with reverse saphenous vein graphs. On May 17, 2013, Dr. Garfunkel began suffering rapid atrial fibrillation which was initially treated with medications, but eventually required a transesophageal echocardiogram with cardioversion performed on May 21, 2013.

During Dr. Garfunkel's admission to Jefferson Hospital Dr. Garfunkel was being cared for and supervised by Defendant Dr. Nimoityn. Under Dr. Nimoityn's supervision, Dr. Garfunkel was prescribed and administered Coumadin for anti-coagulation therapy. During his admission at Jefferson Hospital Dr. Garfunkel's Prothrombin Time ("PTT") and International Normalized Ratio ("INR") were tested numerous times per day in an attempt to determine a safe blood thinning regimen for Dr. Garfunkel.

Dr. Garfunkel was discharged from Jefferson Hospital on May 22, 2013 with instructions to discontinue taking Coumadin and to have his INR monitored. However, Dr. Garfunkel's blood was only monitored once, on May 23, 2013. On that date, Dr. Garfunkel's blood work revealed that his INR levels had decreased to a sub-therapeutic level. As a result, Dr. Nimoityn ordered that Dr. Garfunkel reinstitute Coumadin at a dosage of 2 mg. Defendants allegedly failed to have any additional blood work conducted on Dr. Garfunkel.

On May 28, 2013, Mrs. Garfunkel entered their bathroom and found Dr. Garfunkel's lifeless body in a pool of blood hemorrhaging from his rectum.

Defendants denied any violations of the standard of care.

General Injury: Death.

Result: Jury verdict in favor of defendants Philip Nimoityn, M.D. and Cardiovascular Medical Associates, P.C.

Plaintiff's Expert Witnesses: Dr. Bruce Charash, Cardiologist, New York, NY.; Dr. Joseph Kiss, Hematology/Oncology, Pittsburgh, PA; Dr. David Popper, Gastroenterology

Defendant's Expert Witness: Dr. Peter Kowey, cardiologist and pharmacologist, Wynnewood, PA

Plaintiff's Attorneys: Eric H. Weitz, Justin L. Groen, Messa & Associates, P.C., Philadelphia, PA

Defendant's Attorney: George L. Young, Jr., Young & McGilvery, P.C., King of Prussia, PA (for Philip Nimoityn, M.D. and Cardiovascular Medical Associates, P.C.)

Garfunkel v. Nimoityn, No. 140900689 (Philadelphia County Court of Common Pleas of Pennsylvania March 10, 2017)

7. Defense Verdict In Suit Alleging Negligent Care Of Cardiac Patient

James Micketts was 64 years-old at the time he presented to Abbott Northwestern Hospital ("Abbott") on August 23, 2012 with a three-day history of intermittent chest pain, which was moderate, intermittent, dull and sharp, located mid-sternally (in the middle of the sternum) and without radiation. He did not have any shortness of breath, nausea, diaphoresis or recent illness. His daily medications at home included Vitamin C, aspirin, Vitamin D3, Coenzyme Q10-Vitamin E, a multivitamin, simvastatin, and terazosin at bedtime. In the emergency department at Abbott, Mr. Micketts' blood pressure was 123/68, pulse 65, respira-

tions 16, and he had no fever. His troponin level—which was taken by a blood test that identifies and measures heart damage—was 0.02 ng/mL (normal ≤ 0.03).

Nathaniel S. Bowler, MD, a physician working in the emergency department at Abbott, met with Mr. Micketts at 11:34 a.m. to discuss diagnostic and treatment options. Dr. Bowler ordered and authorized an ECG (electrocardiogram) to look at heart activity details. He read the ECG as normal. Dr. Bowler also ordered a CT coronary angiogram imaging scan to look at the arteries of Mr. Micketts' heart, other lab tests, oxygen, a cardiac monitor, continuous oxygen monitoring, and ACS (acute coronary syndrome) drugs to improve blood flow through the vessels of his heart, treat chest pain, and prevent blood clots from forming in the heart's blood vessels. Dr. Bowler ordered an aspirin, Plavix, heparin, metoprolol, and nitroglycerin.

The CT coronary angiogram was performed at or around 1:57 p.m. that day. It showed the following stenoses and plaques: left main artery- no stenoses, calcified plaque; left anterior descending artery- no stenoses, mild plaque; first diagonal artery- moderate stenosis, moderate plaque; intermediate artery - no stenoses; circumflex artery - mild stenosis; and right coronary artery (RCA) - severe stenosis to total occlusion of the ostium (opening) of the posterolateral branch.

The conclusion was that Mr. Micketts had severe posterolateral branch (PL) stenosis with intermediate severity stenosis of the proximal right coronary artery (RCA).

The emergency department record indicated that Mr. Micketts was advised to return to the emergency department for increasing chest pain over the next 24 hours and to see his doctor for follow-up in the next two to three days. The emergency room record, however, also stated that Mr. Micketts was to be “urgently” treated with ACS medications (acute coronary syndrome medications mentioned above including aspirin, nitroglycerin, heparin, Plavix, and metoprolol) and admitted to the hospital. Mr. Micketts was given a choice at Abbott: either to follow up with his primary

care doctor in the next two to three days, or be admitted to Abbott for a coronary angiogram to take place the next morning. Mr. Micketts chose what appeared to be the “safer” route, which was to immediately take care of his cardiac issues with providers at Abbott.

Dr. Bowler ordered continuous oximetry (oxygen monitoring) and cardiac monitoring, continuous oxygen by nasal cannula, a peripheral IV solution, 325 mg of aspirin one time, Plavix 600 mg one time to prevent blood clots, and nitroglycerin 0.4 mg tablets as needed for chest pain. Dr. Bowler also ordered a nitroglycerin drip for pain. The latter medication is the same as the nitroglycerin tablet but it is administered through an I.V. on a continuous basis. The rate of the infusion of nitroglycerin could be adjusted according to Mr. Micketts' pain and could range from 1.5 to 36 mL/hour. To decrease clotting, Dr. Bowler ordered a heparin injection of 3,000 units and a heparin infusion. To improve the function of Mr. Micketts' heart and prepare him for the CT angiogram of his heart, Dr. Bowler ordered 100 mg of metoprolol.

At 3:20 p.m., Susan Shannon, RN started Mr. Micketts' nitroglycerin drip (50mg in 250 mL) at 0.1mL/hour.

Mr. Micketts had an echocardiogram—which shows a video of the heart's movement and function—at or around 4:32 p.m. It showed normal left ventricular size, borderline wall thickness, normal global systolic function with an estimated ejection fraction (EF) of 55-60 percent, borderline right ventricular size. All of these findings were either normal or not significant.

That same day—at or around 4:44 p.m. (16:44)—Defendant Craig Strauss, M.D., a cardiologist, evaluated Mr. Micketts at Abbott. Dr. Strauss documented that Mr. Micketts had no prior history of coronary artery disease. He also documented that Mr. Micketts had substernal (behind the sternum) chest pain that had been intermittent over the past two to three weeks that did not radiate and typically occurred when Mr. Micketts was driving or walking but not during exercise. Dr. Strauss documented that Mr. Micketts did not have lightheadedness, dizziness, syncope (a faint) or presyncope (a feeling as though one will faint but does not).

Mr. Micketts' blood pressure was 123/68 and pulse was 65. Dr. Strauss noted the CT angiogram findings of diffuse stenosis (narrowing) in the posterolateral branch of the RCA and a moderate proximal RCA stenosis.

Dr. Strauss diagnosed Mr. Micketts with unstable angina, and admitted him to telemetry (a monitoring unit of the hospital) for serial troponins, heparin infusion, an echocardiogram in the morning, and a coronary angiogram and possible percutaneous coronary intervention in the morning.

At 4:12 p.m. (16:12), Dr. Strauss wrote orders that Mr. Micketts receive continuous cardiac monitoring, continuous supplemental oxygen, vital signs per the unit protocol, "the ACS order set," and call the physician if; (1) heart rate is greater than 110 or less than 50; (2) systolic blood pressure greater than 170 or less than 100; (3) if medications were being held due to blood pressure or heart rate; or (4) for recurrent or unrelieved chest pain.

Also at 4:12 p.m. (16:12), Dr. Strauss ordered metoprolol 25 mg tablet every 12 hours (with an order to hold the medication for a systolic blood pressure less than 90 or a heart rate less than 60) and nitroglycerin tablets for chest pain.

Finally, and also at 4:12 p.m. (16:12), Dr. Strauss entered an order that allowed Mr. Micketts to be "up ad lib." This order meant that Mr. Micketts could be up out of bed as desired and walking around as he wished with no restrictions.

About 45 minutes later, Dr. Strauss entered an order for Mr. Micketts to receive terazosin 20 mg orally at bedtime at 4:57 p.m. (16:57).

Metoprolol is a beta-blocker medication that affects and slows the heart and circulation (blood flow through arteries and veins). Nitroglycerin is a medication that works by relaxing (widening) blood vessels to allow blood to flow more easily and to reduce the heart's workload and the amount of oxygen needed by the heart. Severe hypotension and shock may occur with even small doses of nitroglycerin. Terazosin is a medication that relaxes blood vessels to improve blood

flow and relaxes prostate and bladder muscles to improve urination.

Metoprolol, nitroglycerin and terazosin are medications with known side effects— particularly ordered together for one patient—or increasing the chance of a patient to become hypotensive, dizzy, lightheaded, faint and fall, particularly when getting up suddenly from a lying or sitting position or after urinating. The side effects of these medications increase the risk of patients to become hypotensive, dizzy, lightheaded, faint and fall.

Mr. Micketts' assigned nurse—Katelyn J. Pedersen, R.N.—cared for him in the mid-afternoon and evening that day.

At 6:51 p.m., medical records show that Mr. Micketts received education regarding nitroglycerin and expressed an "understanding to call health care provider if side effects occur." At 7:01 p.m., Nurse Pedersen gave Mr. Micketts metoprolol 25 mg orally. At 7:05 p.m., Nurse Pedersen gave Mr. Micketts his nitroglycerin drip (50 mg in 250 mL) at 1.5 mL/hour, titrated down from 10 mcg/minute (3mL/hour). At 7:42 p.m., Nurse Petersen made a note in the medical records about her evaluation of Mr. Micketts' fall risk. She documented that Mr. Micketts ambulated in room and tolerated it, had no safety precautions, and had no confusion, dizziness or vertigo. Per the Hendrich Model II Fall Risk Tool, Mr. Micketts could push up in one attempt on the Get Up and Go Test, and could return the demonstration of the call light. His score was a 2 (1 point for male gender, 1 point not explained). At 7:43 p.m., Nurse Pedersen gave Mr. Micketts his nitroglycerin drip (50 mg in 250 mL) at 3 mL/hour. At 10:09 p.m., Nurse Pedersen gave Mr. Micketts 20 mg of terazosin, which was his usual dose at bedtime.

At 11:03 p.m., Mr. Micketts stood up in his room and a nurse located outside of the room heard Mr. Micketts fall. He was found on the floor facing his door and appeared to be coming back from the bathroom. His face was bleeding and he was minimally responsive/unresponsive. Mr. Micketts was in pulseless electrical activity (PEA), which means that the heart has electrical activity but is not pumping blood

so that a pulse cannot be felt. Mr. Micketts had an asystolic pause (a brief period of no heart beat) followed by bradycardia (slow heart rate). Rhythm strips showed severe bradycardia without evidence of heart block with no ST-elevation on monitor. Mr. Micketts' EKG showed "no acute ischemic changes." Cardiopulmonary resuscitation was started and was successful. All of his drips were stopped (the heparin and nitroglycerin), and he was given bolus of normal saline fluid twice. He was placed in a neck brace and on a backboard. Jay Traverse, M.D., a cardiologist treating Mr. Micketts during the code, thought that the severe bradycardia/sinus arrest was "vagal" and secondary to going to the bathroom, volume depletion.

After being resuscitated, Mr. Micketts could not feel anything below his nipple line. He could not move his arms or legs and had increased tone in all fours. He went for a head and spine CT scan and imaging.

Mr. Micketts' cervical MRI revealed a "T2 signal consistent with cord contusion extending from C2-C5, presumably from recent trauma. . . Findings consistent with acute cord injury." Mr. Micketts also had a hematoma and laceration on his forehead.

Dr. Fred Lux, a neurologist, evaluated Mr. Micketts at Abbott Northwestern Hospital and documented his findings at 1:53 a.m. on August 24, which was about four hours after his fall. He wrote that Mr. Micketts had a normal level of consciousness, orientation, and speech articulation. Mr. Micketts' corneal reflexes were normal as were his facial movements, hearing, voice and swallow (intact cranial nerves). Mr. Micketts had, however, no movements of the shoulders on down his body. His sensory level was at the nipple area for pain. Dr. Lux concluded that Mr. Micketts had an anterior cord syndrome with motor dysfunction from the C5 level and sensory dysfunction from the T5 level "likely secondary to an acute traumatic spinal cord injury." Dr. Lux spoke with the neuroradiologist and confirmed the diagnosis of a spinal contusion with cord edema but no subdural hematoma.

Dr. Roman Melamed, of the critical care service at Abbott Northwestern Hospital, evaluated Mr. Micketts and documented his findings at 2:46 a.m. on August

24, 2012. He concluded that the fall was due to cardiac arrest with acute neurologic dysfunction "consistent with traumatic spinal cord injury."

Dr. Timothy Henry performed Mr. Micketts' coronary angiogram on August 27, 2012. It was the angiogram that was originally scheduled for the morning of August 24, 2012. It had to be delayed because of Mr. Micketts' fall and neck injury. At the procedure, Dr. Henry found a normal main coronary artery, mild irregularities in the left anterior descending artery, mild irregularities of the circumflex artery, and a 99 percent proximal to mid lesion in the right coronary artery. The left ventricular ejection fraction was normal (60-65 percent). The lesion in the right coronary artery was dilated with a balloon and a stent was inserted there to maintain an open blood vessel. Dr. Henry reported that the 99 percent stenosis was reduced to 0 percent. The posterolateral branch stenosis was also reduced with stenting from 100 percent to 0 percent.

With a diagnosis of tetraplegia, Mr. Micketts was transferred to Sister Kenny (now known as Courage Kenny Rehabilitation Institute), a rehabilitation facility now owned and operated by Defendant Allina Health System, on September 5, 2012. Quadriplegia/tetraplegia is a spinal cord injury causing paralysis of arms and legs; the muscles of the abdomen and chest are also impacted so that breathing and coughing are impaired. At Sister Kenny, Mr. Micketts required total assistance with eating, grooming, dressing, toileting, transfers, and bathing. He had bowel and bladder problems requiring intermittent bladder catheterization. A suprapubic catheter exiting his abdomen directly from his bladder was planned for long term management. His paralysis prevented him from breathing and coughing well, so he developed pulmonary problems and required therapy to work on his breathing. Mr. Micketts required leg wraps and an abdominal binder for hypotension because his paralysis caused him to lose muscular support in his abdomen and extremities making it difficult for blood to get back to his heart. His appetite was poor due to his paralysis and depression stemming from his quadriplegia/tetraplegia. Mr. Micketts had a major loss of upper extremity motion and strength; he had spasms, nausea and shortness of breath. He had diminished skin integ-

rity, deconditioning, weakness and impaired sensation. He did make some gains in upper extremity function, but he met none of his goals. It became apparent, during intensive rehabilitation therapy, that he would not be able to be discharged home.

Before his therapy could continue further at Sister Kenny, Mr. Micketts was transferred back to Abbott on September 30, 2012. He became hypotensive with a fever and tachycardia (rapid heart rate) as well as shortness of breath. The working diagnosis was possible sepsis. He was cultured for an infection, and his antibiotics were changed. Mr. Micketts' troponin testing—for the purposes of looking for a cardiac problem—was negative (normal).

Neurologist Dr. Fred Lux evaluated Mr. Micketts and noted that he was alert and appropriate, and he had no cognitive dysfunction. But his sensory level (paralysis level) had not changed since right after the fall and resulting trauma. Dr. Lux anticipated a long rehabilitation and the possibility of little functional gain.

Mr. Micketts died on October 3, 2012 at Abbott Northwestern Hospital of presumed sepsis (severe infection).

The Hennepin County Medical Examiner evaluated Mr. Micketts' cause of death. According to the death certificate, Mr. Micketts' immediate cause of death was complications of quadriplegia (also known as tetraplegia). The underlying cause of death was blunt force neck injury from a fall. (Other contributing conditions were Mr. Micketts' coronary artery disease, for which he had been stented, and his hyperlipidemia.)

General Injury: Death.

Result: Jury verdict in favor of defendant.

Plaintiff's Expert Witnesses: Emil Hayek, M.D., cardiology, Hudson, Ohio; Karen Marzlin, DNP, RN

Defendant's Expert Witnesses: Steven R. Goldsmith, M.D., cardiology, Minneapolis, Minn.; Thomas J. Davis, M.D., FACC, cardiologist, Minneapolis, Minnesota; Paul William Ament, Pharm.D.

Plaintiff's Attorneys: Robins Kaplan, Ltd., Minneapolis, MN

Defendant's Attorneys: Rebecca Egge Moos, Christine E. Hinrichs, Bassford Remele A Professional Association, Minneapolis, MN

Micketts v. Allina Health System d/b/a Abbott Northwestern Hospital and the Minneapolis Heart Institute, No. 27-CV-15-20377 (Hennepin County District Court of Minnesota May 17, 2017)

8. Defense Verdict In Suit Alleging Negligent Management Of Anti-Coagulation Therapy

Gary Tilleskjaer had a cardiac condition known as atrial fibrillation, which is the most common type of arrhythmia. Gary Tilleskjaer was referred by his cardiologist to undergo a catheter ablation, a procedure designed to correct the arrhythmia problem, to be performed by Defendant, Dr. Natale, a cardiologist/electrophysiologist, at Scripps Green Hospital in San Diego.

The catheter ablation procedure is known to cause blood clots, which can lead to the patient having a stroke. In order to greatly reduce this risk, patients are treated before and after the ablation procedure with medications, such as Coumadin, that work to prevent blood clots from forming.

The defendants began managing Mr. Tilleskjaer's anticoagulation therapy several weeks before the procedure that was scheduled for August 27, 2013. A blood test determines the level of clotting tendency of a patient's blood, whether it is likely to form a clot or not. The blood test measure the International Normalization Ratio level, commonly referred to as the INR level. The goal of the anticoagulation therapy is to have the patient's INR level between 2 and 3 for weeks before the procedure and for three to six months after the procedure. An INR level of 2-3 is considered to be a therapeutic state in which the blood is less likely to form a clot.

Gary Tilleskjaer began his anticoagulation therapy on July 10, 2013 by taking 4 milligrams, (mg), of Coumadin per day. His INR level was 1.2 on July 23,

2013 and his dosage was increased to 6mg per day. On August 14, 2013 his INR level was 1.5 and his dosage was increased to 8mg that day, 6mg the next day and 8mg for the next 4 days. His INR level was 1.6 on August 19, 2013. Defendants then changed the dosing schedule to 12mg for 2 days, then 10 mg. the following day. On August 21, 2013 his INR level was 2.4 and his dose was changed to 8mg. His INR on August 23 was 2.8, he continued taking 8mg and his INR level was 2.4 on August 27, 2013, the day of the ablation procedure. He took the Coumadin in the evening and the blood tests were typically drawn in the morning.

Defendants were aware that Gary Tilleskjaer was taking more than 30 over the counter supplements for a long period of time due to a chronic disabling back injury. Defendants were aware these supplements could have an adverse effect on the performance of the Coumadin in anticoagulating his blood. Per written instruction from the defendants he was told to continue to take his supplements up to but not including the day of surgery. He followed these instructions.

The procedure was successfully performed and there were no intra-operative complications. On the day following the procedure, August 28, 2013, his INR level was 3.3, slightly above the therapeutic level. The defendants discharged him from the hospital that day and advised him to stay in a hotel near the hospital until Friday August 31, 2013. He was also instructed to skip his Coumadin dose that day and then begin a daily dosage of 6 milligrams and to have his INR checked on September 3, 2013 in Tucson.

Gary Tilleskjaer remained in San Diego as instructed and he skipped his dose of Coumadin on August 28, 2013. He remained in San Diego as instructed and began a daily dosage of Coumadin on August 29, 2013. He returned home to Tucson on Friday August 31, 2013 and continued taking the daily dosage of 6mg.

In the afternoon on September 2, 2013 Gary Tilleskjaer was rushed to the hospital via ambulance where he was diagnosed with having suffered a stroke, an infarct in the left side of his cerebellum. His INR level on the day of the stroke was 1.46, dangerously below the therapeutic range.

Plaintiffs alleged a reasonable practitioner would have instructed Mr. Tilleskjaer to have his INR checked before he left San Diego in order to determine the proper dose of Coumadin during the days immediately following the ablation procedure to maintain a therapeutic level. The days following the procedure are of heightened risk of a clot forming.

Plaintiffs alleged that defendants breached the standard of care by failing to properly manage Gary Tilleskjaer's anticoagulation therapy. Plaintiffs alleged that the Defendants were required by the standard of care to strictly monitor his INR levels in the days immediately following the procedure.

Defendants denied any breach of the standard of care.

General Injury: Prior to suffering the stroke, Gary Tilleskjaer was disabled due to chronic low back pain. He was making improvements with his back pain just prior to the ablation procedure. The stroke has caused him to experience dizziness, nausea and ocular motor problems.

Result: Jury verdict in favor of defendant.

Plaintiff's Expert Witness: Dr. George Rodgers, cardiologist

Defendant's Expert Witnesses: Kalyanam Shivkumar, M.D., Ph.D. cardiologist and electrophysiologist, California; Dr. Raffi Simonian, Pharm. D.

Plaintiff's Attorneys: Mark B. Simowitz, Mark B. Simowitz A Professional Corporation, San Diego, CA; James Matthew Brown, James Matthew Brown, APLC, San Diego, CA

Defendants' Attorneys: Clark R. Hudson, David P. Burke, Neil, Dymott, Frank, McFall, Trexler, McCabe & Hudson, A Professional Law Corporation, San Diego, CA

Tilleskjaer v. Scripps Clinic Medical Group, Inc., No. 37-2014-00039876-CU-MM—CTL (San Diego County Superior Court of California, June 2, 2016)

EMERGENCY MEDICINE**9. Defense Verdict In Suit Alleging Failure To Diagnose Stevens-Johnson Syndrome**

On September 17, 2013, Ella Byrd saw Dr. Meinecke at Via Christi St. Francis Emergency Department, with a painful rash covering almost all of her body, cough, sore throat, headache, tachycardia, a fever over 104 degrees Fahrenheit, and eosinophils elevated at 26. Plaintiff alleged that, despite a clear chest x-ray, despite a recent prescription for Allopurinol, which is one of the most common causes of Stevens-Johnson Syndrome, and despite Stevens-Johnson Syndrome being the only diagnosis which explained all of these symptoms and findings, Dr. Meinecke diagnosed Mrs. Byrd as having pneumonia. Dr. Meinecke told Mrs. Byrd that she could be admitted, but did not tell her that she had a potentially deadly condition and that she would likely die if she went home. Moreover, when Mrs. Byrd said she wanted to go home, Dr. Meinecke allegedly breached the hospital AMA policy and discharged Mrs. Byrd, allowing Mrs. Byrd to go home not knowing that she had a potentially deadly condition.

On September 20, 2013, Mrs. Byrd went to see Dr. Ohaebosim, reporting that she was still was experiencing the painful rash and other symptoms. The painful rash had progressed to sores, knots and burning. Mrs. Byrd explained her emergency room visit and told the doctor how she was diagnosed with pneumonia and given fluids, antibiotics and a steroid. Dr. Ohaebosim allegedly did nothing to follow up on the “pneumonia” diagnosis, such as ordering a chest x-ray. Dr. Ohaebosim did not order any blood work. Dr. Ohaebosim diagnosed Mrs. Byrd as having poison oak.

On September 22, 2013, Mrs. Byrd’s daughter Gina found her in extreme pain and called an ambulance. EMS workers noted she had a raised rash from head to toe including in her mouth and throat. Mrs. Byrd was transported to Via Christi-St. Francis where she admitted to ICU. After being admitted to the ICU Mrs. Byrd’s skin became necrotic and started sloughing off,

she became septic, and was critically ill. Mrs. Byrd was diagnosed with Stevens-Johnson Syndrome, which is progressively less treatable the later it is identified.

Mrs. Byrd’s symptoms and blood-work should have pointed the Defendants to Stevens-Johnson Syndrome, but Defendants missed or ignored the signs. The Stevens-Johnson Syndrome was likely an allergic reaction to Allopurinol, a medication which Mrs. Byrd was taking for gout.

By the time Mrs. Byrd died on September 26, 2013, over 90% of her skin had sloughed off. Her death certificate lists the causes of death as acute respiratory failure, sepsis, toxic epidermal necrolysis and drug reaction.

According to Defendant Meinecke, Ella Mae Byrd came to the emergency department at Via Christi St. Francis on September 17, 2013 at 8:32 p.m. and was discharged at about 4:02 a.m. September 18. Dr. Meinecke noted she had a fever and a rash from head to toe. The rash was angry and scaly and had been there for about three days. It was non-petechial. She was given a full septic workup, plus a chest x-ray. The chest x-ray had a questionable loss of the right heart border, and was consistent with pneumonia.

Dr. Meinecke could not put together a clear clinical picture, and went to the family and told them he would like to admit her. He recommended admission for observation because he was not sure what was happening with the patient. He wasn’t sure that there was pneumonia, and he was waiting on a urinalysis result. Mrs. Byrd told him in this encounter that she could not be admitted to the hospital because she had to go home.

After that, the urinalysis result came back. Dr. Meinecke again met with the patient and advised her to be admitted, and she declined. He told her it was okay if she would go home only if she would follow-up with her primary care provider. She agreed to do so, rendering moot any requirement for documentation that she was leaving against medical advice.

Dr. Meinecke did not personally make a note of the patient’s decision to refuse his medical

recommendation. Dr. Meinecke worked that night with a scribe, Tarren Evans, who must have missed Dr. Meinecke's comment that he believed the patient should be admitted for observation. Tarren did note that the patient was stable for discharge, an important fact that was also true, and more relevant, because the patient had chosen to go home. She was stable for discharge.

Mrs. Byrd did not have a common condition, and in fact, based on hindsight, had a very rare condition in its very early, less diagnosable, stages. In these circumstances, when the patient is ill, has a fever, and has a clinically significant rash, the appropriate approach for an ER physician is to try to talk the patient into being admitted, even though there isn't a definitive diagnosis, or to strongly recommend close follow-up with the primary physician. Dr. Meinecke did exactly what any reasonable emergency physician would do under the circumstances. He offered the decedent the opportunity to be admitted to the hospital for diagnosis of the condition that he could not diagnose, and when the patient declined, he specifically requested and secured the patient's agreement to follow-up with the primary physician very soon.

On September 20, 2013, Mrs. Byrd went to Dr. Ohaebosim, her primary care provider, with similar problems to those reported to the emergency department on September 17. She told his nurse it was like her previous poison oak rash, even though she knew or had reason to know it was not, so Dr. Ohaebosim diagnosed her with poison oak rash. He gave her a Decadron injection and a prescription for topical steroids.

On September 22, Mrs. Byrd was admitted to the hospital with a raised purpuric rash from head to toe and in her mouth and throat. She was admitted to the hospital in intensive care in the burn unit. She died on September 26, 2013.

Stevens-Johnson Syndrome and/or toxic epidermal necrolysis is one of the most difficult diagnoses to make in an emergency department. In fact, on the date of admission to the hospital on September 22, four days after Dr. Meinecke saw Mrs. Byrd, the physician,

Dr. Stangl, despite the fact that Mrs. Byrd was in much worse condition clinically than on September 17/18 and September 20, and had a worse rash, did not make a definitive diagnosis of Stevens-Johnson Syndrome. There were several differential diagnoses, pending several specialty consultations.

General Injury: Death.

Result: Jury verdict in favor of defendant Dr. Meinecke.

Plaintiffs' Expert Witness: David Fairbanks, M.D., emergency medicine

Defendant's Expert Witnesses: Robert E. Holt, M.D., Family Medicine, Belleville, KS; Robert A. Schwartz, M.D., Dermatologist, Bayonne, NJ; David J. Ricketts-Kingfisher, M.D., emergency medicine, Topeka, Kansas

Plaintiff's Attorney: Matthew L. Bretz, Bretz & Young, L.L.C., Hutchinson, Kansas

Defendants' Attorneys: Mark R. Maloney, Hinkle Law Firm, L.L.C., (for Defendant Ohaebosim); Brian C. Wright, Wright Law Office, Chtd., Great Bend, Kansas. (for Defendant Meinecke)

Byrd v. Meinecke, No. 2015-CV-001714-TM (Sedgwick County District Court of Kansas April 2017)

10. Defense Verdict In Suit Alleging Failure To Diagnose Diverticulitis

Plaintiffs alleged that there was a delay in diagnosis and treatment of David Davitch's diverticulitis in late January and early February of 2013. Mr. Davitch was seen in the ER at Chestnut Hill Hospital on January 31, 2013, by David Jaslow, M.D., an Emergency Medicine physician, with complaints of left-sided abdominal pain, tenderness in the left lower quadrant and a history of fevers. Plaintiffs alleged that Dr. Jaslow breached the standard of care by failing to promptly order a CT of the abdomen or obtain a surgical consult based upon Mr. Davitch's symptoms.

Defendants denied any violations of the standard of care.

General Injury: Damage to a significant portion of the sigmoid colon requiring its removal and a colostomy, with ongoing, permanent and continued irreversible injuries.

Result: Jury verdict in favor of the defendants David Jaslow M.D., Chestnut Hill Hospital, Michael B. Rosen MD and Lafayette Hill Family Medicine P.C.

Plaintiffs' Expert Witnesses: Karen Jubanyik, M.D., Emergency Medicine, New Haven, CT; Michael Stanley Drew, M.D., General Surgery, Rego Park, New York

Plaintiff's Attorneys: Bernhardt, Rothermel & Siegel, P.C., Philadelphia, Pennsylvania

Defendants' Attorneys: Gregory S. Nesbitt, Laurie B. Shannon, Jorge L. Barroso IV, Kilcoyne & Nesbitt, LLC, Blue Bell, PA (for Defendant, David Jaslow, M.D.); Elaine M. Ross, Joann Giangliulio, McCumber, Daniels, Buntz, Hartig & Puig, P.A., Norristown, PA (for defendants, CHHS Hospital Company, LLC d/b/a Chestnut Hill Hospital and Chestnut Hill Health System, LLC); Richard S. Margulies, Michael A. Cavaliere, Christie & Young P.C., Philadelphia, PA (for defendants, Michael B. Rosen, M.D. and Lafayette Hill Family Medicine, P.C.)

Davitch v. HHS Hospital Company, LLC, et al. (Philadelphia County Court of Common Pleas of Pennsylvania February 14, 2017)

FAMILY PRACTICE

11. Defense Verdict On Causation In Suit Alleging Failure To Follow Up On Abnormal PSA Value

Defendants stipulated that Dr. Anton Posch was negligent in his treatment of Charles Richardson in failing to follow up on Mr. Richardson's abnormal Prostate Specific Antigen test results in April 2004 and

thereafter and that such failure caused a delay in the diagnosis of Mr. Richardson's prostate cancer.

Defendants disputed that Dr. Posch's breach of the standard of care proximately caused injury to Mr. Richardson. Defendants contended that in 2004 Mr. Richardson's cancer was not treatable for cure. Defendants also contend that Mr. Richardson has not otherwise been damaged by the delay as his cancer needed to be treated when it was discovered in 2015. Mr. Richardson is currently 82 years of age. Defendants further contend that Mr. Richardson's excellent response to this treatment makes it more likely he will not pass away as a result of complications of his prostate cancer. The only issues for trial were causation and damages.

Defendant, Anton Posch, M.D., was Mr. Richardson's family physician. During a Well-Adult visit in April of 2004, Dr. Posch ordered a Prostate Specific Antigen test ("PSA"). The results, dated April 5, 2004, were 4.5. Earlier PSA values were: 1998 - 1.5 and 1999 - 2.0. The test results were never reported to Mr. Richardson. They were not documented and Dr. Posch did not order any follow up tests. Defendants have admitted that this was a breach of the standard of care.

Dr. Posch saw Mr. Richardson many times between 2004 and 2015. The patient's medical history was significant for Type II Diabetes, obstructive sleep apnea, Stage III kidney disease, degenerative joint disease, hyperlipidemia, and hypertension. He had longstanding phimosis and periodic balanitis, which are problems related to his foreskin.

On August 21, 2015, when Mr. Richardson saw Dr. Jian Ma (urology) for phimosis. A PSA was ordered by Dr. Ma. His PSA was 130. Dr. Ma ordered a biopsy.

The prostate biopsy revealed adenocarcinoma with an assigned Gleason score of 4 + 3 = 7/10 and 9 of 12 positive cores. A CT August 28, 2015 revealed enlargement of the prostatic 5 mass extending into the left bladder, left seminal vesicle outflow and left pelvis with interval development of the left pelvis adenopathy. Oncology staged the cancer as T4N1M0 based upon a CT finding of an enlarged lymph node in the left pelvis. This was presumed to be evidence of

metastatic disease; but the node was not biopsied to prove metastatic disease. The bone scan of the same date revealed no evidence of bony metastatic disease.

Mr. Richardson's GHC radiation oncologist, Dr. Canning, recommended androgen deprivation therapy ("ADT"). ADT seeks to reduce or eliminate the production of male hormones, particularly testosterone. The theory of ADT is that without testosterone to "feed" the prostate cancer, the cancer may be reduced and spread may be limited. The stated goal with ADT was to bring his PSA down under 4 and ideally less than 0.2, which "may indicate a chance of localized disease." Mr. Richardson obtained second opinion at the University of Washington, which was consistent with Dr. Canning's.

Shortly after his consultation at the University of Washington, Mr. Richardson started ADT. By all accounts, both by his health care providers and the experts in this case, Mr. Richardson has had an extraordinary response to ADT. Three PSAs have been obtained since the diagnosis in 2015, which are as follows: April 6, 2016 0.02; June 21, 2016 0.03; March 20, 2017 0.06.

These PSA levels are so low they are often considered "undetectable" by urologists and oncologists. Plaintiffs' oncology expert, Dr. Goldberg, agreed that the minimal increases in PSA values could be attributed to lab error. He could not say on a more probable than not basis that additional treatment would be required, even if the PSA reached a level of 2.0. Dr. Goldberg's recommendations for treatment would depend largely upon whether Mr. Richardson was symptomatic, which he was not.

Radiographic imaging also confirmed Mr. Richardson's excellent response. An abdominal/pelvic CT taken on December 9, 2016 showed no evidence of disease. There was no longer evidence of an enlarged lymph node in the left pelvis. Plaintiffs' radiology expert, Randall Patten, M.D., conceded this at his deposition, going so far as to state that the regional metastatic disease he saw in the August 28, 2015 CT had "resolved."

Other than the side effects of ADT, Mr. Richardson's prostate cancer remained asymptomatic.

General Injury: Delay in treating prostate cancer.

Result: Jury verdict in favor of Defendants Dr. Posch and GHC on proximate cause.

Plaintiff's Expert Witnesses: Ronald Goldberg, Ph.D., M.D., oncologist; Geoffrey Sonn, M.D., urologist; Michael Shannon, M.D., endocrinologist

Defendant's Expert Witnesses: Dr. Michael Brawer, urologist; Dr. Marc Garnick, medical oncologist

Plaintiff's Attorneys: James L. Holman, Holman Law, PLLC, Tacoma, WA; John C. Galbraith, Law Office of John C. Galbraith, Tacoma, WA

Defendant's Attorneys: Patrick C. Sheldon, Natalie A. Heineman, Forsberg & Umlauf, P.S., Seattle, Washington

Richardson v. Posch, No. 16-2-10418-5 KNT (King County Superior Court of Washington, May 10, 2017)

GERIATRICS

12. Defense Verdict In Suit Alleging Failure To Monitor Patient's INR Levels

From August 4, 2011 through October 7, 2011, the plaintiff's decedent, Douglas Norris, was a resident at Alden-Wentworth Rehabilitation And Healthcare Center, Inc. in Chicago, Illinois. From August 4, 2011 to January 11, 2012, the defendant, Emmanuel Paintsil, M.D., was treating and caring for Douglas Norris. Plaintiff alleged that Dr. Paintsil negligently failed to properly test Douglas Norris' INR levels.

Defendants denied any violations of the standard of care.

General Injury: Death.

Result: Jury verdict in favor of defendant Dr. Paintsil.

\$500,000 settlement with Alden-Wentworth Rehabilitation and Health Care Center Inc.

Plaintiff's Expert Witnesses: Dr. Terrance Baker, geriatrics, Baltimore, MD; Dr. Paul Collier, vascular surgery, causation

Defendant's Expert Witnesses: Dr. Timothy McCurry, geriatrics, Chicago, Ill.; Dr. Bitran

Plaintiff's Attorneys: Kevin J. Golden, Marisa Schostok, Dudley & Lake, LLC, Chicago, IL

Defendant's Attorneys: Thomas R Mulroy III, Whitney S. Goldin, Hinshaw & Culbertson LLP, Chicago, IL

Norris v. Alden-Wentworth Rehabilitation and Health Care Center Inc., No. 2013L010806 (Cook County Circuit Court of Illinois May 2, 2017)

HOSPITALS

13. Defense Verdict In Suit Arising From Surgical Positioning

Mr. John Bruno, date of birth July 28, 1961 was diagnosed with rectal cancer in August of 2012. One month later, Mr. Bruno presented to one of the Colorectal Surgeons at Memorial Sloan Kettering Cancer Center, Larissa Temple, M.D. Dr. Temple confirmed the presence of a rectal mass at approximately 12 cms. She thereafter recommended to Mr. Bruno that he undergo pre-operative radiation and chemotherapy. The hope was that the chemotherapy and radiation would "shrink the tumor."

When the lesion was first discovered on colonoscopy, it was found to be approximately 4 cms. in size and was a friable sessile irregular mass within the rectum. The pathology was a poorly differentiated adenocarcinoma.

Because Mr. Bruno resided in Staten Island, he decided to have his chemotherapy and radiation done locally.

After Mr. Bruno completed his neoadjuvant chemo-

therapy and radiation, he returned to see Dr. Temple on January 9, 2013. Dr. Temple noted that Mr. Bruno had tolerated quite well the chemoradiation. Specifically, that the tumor had become smaller.

Dr. Temple instructed Mr. Bruno to return to her office in two weeks so that another proctoscopic examination could be performed. Specifically, Dr. Temple wanted to ascertain whether the tumor was completely eradicated.

On January 30, 2013, Mr. Bruno returned to Dr. Temple at MSKCC. During this consultation, an area of tumor was still present. Dr. Temple told Mr. Bruno and his wife that "Watchful waiting" was not a viable option.

During the office visit of January 30, Dr. Temple testified that she went into great detail concerning the functional alterations of a Lower Anterior Resection and the quality of life with an Abdominoperineal Resection. Mr. Bruno made it perfectly clear that he wanted to proceed with a Lower Anterior Resection as he did not want to have a permanent colostomy. Dr. Temple advised Mr. Bruno that with a Lower Anterior Resection he would have a temporary stoma which could turn out to be permanent.

On February 21, 2013, Mr. Bruno was admitted to Memorial Hospital for the purpose of undergoing a Low Anterior Resection of his rectum with a diverting ileostomy. The first part of the surgery, the mobilization of small intestine, was done laparoscopically. The second part of the operation, the resection and creation of a temporary stoma, was done using a DaVinci Robot.

The laparoscopic surgery proceeded uneventfully. The robotic surgery became complicated when the "Staple line did not hold." Dr. Temple testified that it was her opinion that Mr. Bruno's tissue was "too thick" for the staples to hold. It should be noted that at the time of surgery, Mr. Bruno was approximately 300 lbs.

When the universal stapler was fired across the distal rectum, and the staple line did not hold, a decision was then made to use the robot to perform a purse string closure around the rectal stump.

Dr. Temple testified that the surgery took longer than normal - about 9 hours. Typically, a surgery like this would take 6 hours +/- . Dr. Temple explained that when the staple line “did not hold,” the length of the procedure was extended because of the need to use the robot to attempt to effectuate a purse string closure around the rectal stump.

Defense counsel maintained that had Dr. Temple “taken the easy way out,” she would have simply completed the surgery by effectuating a permanent colostomy. This would have taken about 3 hours off the total surgical time of 9 hours.

At the time of surgery, Mr. Bruno had a BMI of 43.8 and was described as being morbidly obese. He was approximately 51 and a half years of age.

Of significance to this litigation, Mr. Bruno was placed in the lithotomy position throughout the procedure. It was plaintiff’s expert’s contention that at the 5 hour mark, Mr. Bruno’s legs should have been taken out of the stirrups and “moved around” so as to “restore the circulation.”

On Postoperative Day Two, at approximately 6:45 a.m., Mr. Bruno began to complain of severe pain localized to his right calf. He described the pain as being 9 out of 10 or 10 out of 10. The concern was that Mr. Bruno had developed a Compartment Syndrome of his right calf.

Compartment pressures were subsequently obtained and were noted to be moderately elevated. Thereafter, a decision was made to take Mr. Bruno to surgery so that a fasciotomy could be done.

After receiving consent for surgery, a decompression fasciotomy of Mr. Bruno’s left anterolateral compartment of his right leg, debridement of muscle and application of wound vac were effectuated. The Orthopedic Surgeon noted that, “The majority of the muscle was viable.” There were two subsequent debridements which yielded small amounts of necrotic tissue.

Mr. Bruno was discharged from Memorial Sloan Kettering Cancer Center on March 2, 2013. At the time

of discharge, Mr. Bruno was able to ambulate with a walker.

The MSKCC Orthopedic Surgeon, Patrick Boland, M.D., last saw Mr. Bruno on April 25, 2013. He noted that Mr. Bruno had “No complaints in his leg, a full range of motion and was able to walk without a limp.”

In August of 2013, Mr. Bruno underwent surgery in New Jersey by Dr. Cozzarelli, a Podiatrist. The surgery was described as “Decompression of the common peroneal nerve right leg.” Of significance, plaintiff’s orthopedic expert testified that he could find no justification for this surgery done in New Jersey. Also of interest, Mrs. Bruno testified that it was after the New Jersey surgery, that Mr. Bruno began to complain of right lower leg pain, once again.

Plaintiff’s counsel produced one expert witness at trial, an Orthopedic Surgeon, John Reilly, M.D. Dr. Reilly testified that the Staff at Memorial Sloan Kettering Cancer Center had departed from good and accepted surgical practice by not removing Mr. Bruno’s legs from the stirrups, once the surgery reached the 5 hour mark. Plaintiff’s expert went on to testify that had Mr. Bruno’s legs been “moved” or “repositioned” the compartment syndrome would not have occurred.

Plaintiff’s expert in Orthopedics also testified that there was a delay in diagnosing the compartment syndrome. However, he never connected the “delay” to “causation.” Accordingly, only one departure went to the jury.

Shortly after plaintiff rested, a Stipulation of Discontinuance, With Prejudice, as to Dr. Temple only, was entered into. That is, the case was now proceeding as to Memorial Sloan Kettering Cancer Center alone. Counsel for the defendant Hospital stipulated that Dr. Temple was an employee of the Hospital and that all of the care and treatment she rendered to Mr. Bruno was in the scope of her employment.

The defendants’ primary contentions were as follows:

- I. That there is no standard of care in America, or the World, requiring a surgeon to take a pa-

tient's legs out of stirrups, at the 5 hour mark, when the lithotomy position is being utilized.

- II. That plaintiff's expert in Orthopedic Surgery admitted that he had no knowledge as to the Standard of Care of Colorectal Surgeons in 2013.
- III. That there were multiple reasons to explain why Mr. Bruno continued to have pain and balance issues. Specifically, that Mr. Bruno had significant pathology in his lumbar spine, had undergone neurotoxic chemotherapy and that it was the "New Jersey surgery" that caused his present problems.

The defendant produced an expert in Colorectal Surgery and an expert in Orthopedic Surgery. Both experts testified unequivocally that there is no "Standard of Care in America" to remove a patient's legs from the stirrups, once they have been in the lithotomy position for a period of 5 hours.

General Injury: The plaintiff complained that he had difficulty with his balance and would often "lean to the right." Mr. Bruno also testified that he needed narcotic medications to help him control the pain in his right lower extremity.

Following the surgery that is the subject of this lawsuit, Mr. Bruno went on disability. He continues to be on disability. Mr. Bruno had been employed as an Elevator Mechanic for the City of New York. He was married and had one grown son.

Result: Jury verdict in favor of defendant.

Settlement Negotiations: Demand: \$850,000. Offer: 0.

Plaintiffs' Expert Witness: John Reilly, M.D., Orthopedic Surgery

Defendant's Expert Witnesses: Craig Johnson, M.D., Colorectal Surgery; Timothy Rapp, M.D., Orthopaedic Surgery

Plaintiff Attorney: Rodney Stilwell, Tracy Stilwell & Parrinello, P.C., Staten Island, NY

Defendant's Attorney: Glenn W. Dopf, DOPF,

P.C., New York, New York (for Defendants Memorial Hospital for Cancer and Allied Diseases, Memorial Sloan Kettering Cancer Center, and Larissa Temple, M.D.)

Bruno v. Memorial Hospital for Cancer and Allied Diseases, Memorial Sloan Kettering Cancer Center, and Larissa Temple, M.D., No. 150751/2014 (Richmond County Supreme Court, N.Y. May 30, 2017)

INTERNAL MEDICINE

14. Defense Verdict In Suit Alleging Failure To Diagnose Abdominal Infection

Plaintiff, Sylwia Calus, alleged that this Defendant, Dr. Rolek, failed to diagnose and treat an abdominal infection during Ms. Calus' admission to Alexian Brothers Medical Center from January 9, 2012 to January 11, 2012.

Plaintiff's claim of medical negligence against Dr. Rolek alleged two distinct deviations from the standard of care; namely, that Dr. Rolek discharged plaintiff from the hospital prematurely, and that Dr. Rolek failed to advise plaintiff to return to the hospital when she was informed in a telephone conversation with plaintiff on the early evening of January 13 that plaintiff's physical condition had worsened.

Dr. Rolek agreed that if she was told that plaintiff's condition had worsened, but failed to advise plaintiff to return to the hospital, she would have deviated from the standard of care. The parties disputed the substance of the conversation. Plaintiff contended that she informed Dr. Rolek that her condition had worsened and inquired whether it was safe for her to return to Poland the next day; defendant contended that plaintiff called to inquire about obtaining medical records and imaging studies, and did not recall that plaintiff mentioned her condition had worsened.

General Injury: Plaintiff claimed the alleged failure caused pain and suffering and necessitated subsequent surgical intervention in her native country of Poland. Ms. Calus underwent two surgeries in Warsaw,

Poland, at Baby Jesus Hospital. The first surgery was an open laparotomy performed on January 15, 2012. The second surgery was on January 18, 2012, and was an exploratory laparotomy in which the abdominal cavity was drained.

Result: Jury verdict in favor of Defendant Dr. Rolek.

Plaintiff's Expert Witness: Dr. Christopher Polen, internal medicine, Gastonia, NC

Defendant's Expert Witnesses: Dr. Jeffrey Fronza, surgeon, Chicago, Illinois; Dr. Steven Tureff, internal medicine, Des Plaines, Illinois

Plaintiff's Attorney: Robert B. Patterson, Law Offices of Robert B. Patterson, Ltd., Chicago, IL

Defendant's Attorneys: Vito M. Masciopinto, Kelly A. Pachis, Lowis & Gellen LLP, Chicago, Illinois

Calus v. Rolek, No. 2013L014119 (Cook County Circuit Court of Illinois April 11, 2017)

15. Defense Verdict In Suit Arising From Anticoagulation Therapy

In December 2008 and June 2010, Mr. Geagan had developed pulmonary emboli or blood clots in the lung, a medical condition which required chronic warfarin, an oral medication commonly known as a “blood thinner” or “anticoagulant.” The degree of anticoagulation with oral warfarin is measured by a laboratory test known as the INR. In Mr. Geagan's case, therapeutic anticoagulation is achieved when the INR is approximately 2.5 to 3.0. An INR over 3.0 increases the risk of internal bleeding which could cause serious morbidity or even death. Warfarin therapy must therefore be carefully monitored and the dose adjusted to prevent these serious complications.

On March 20, 2012, Mr. Geagan's INR was 3.1, indicating that the degree of Mr. Geagan's anticoagulation was mildly supra-therapeutic.

On March 20, 2012 Mr. Geagan agreed to undergo

an invasive procedure on his backbone to treat the pain of a steroid induced compression fracture of his spine, a procedure that required switching his anticoagulation from oral warfarin to intravenous heparin, a different type of “blood thinner” or “anticoagulant.” The process of switching a patient from oral warfarin to intravenous heparin is known as “bridging.” Since September 2008, Defendant BIDMC published “BIDMC Periprocedural Guidelines for the Management of Patients on Anticoagulant and Antiplatelet Agents” which specifically addressed the “bridging” process.

Intravenous heparin therapy should not be started in a patient who had been receiving oral warfarin therapy until the INR has fallen to 1.5 after discontinuation of oral warfarin. It may take up to five (5) days for the INR to fall sufficiently such that intravenous heparin may be started safely.

On March 20, 2012 at 14:12, even though Mr. Geagan's INR was 3.1 and mildly supra-therapeutic, Defendant Brondon ordered intravenous heparin according to “BIDMC HEPARIN DOSING GUIDELINES” which applied to patients who were not already supra-therapeutically anticoagulated with warfarin such as Mr. Geagan.

Defendant BIDMC failed to specifically train or instruct its employee, Defendant Brondon, not to start intravenous heparin, in a patient who has been receiving warfarin, until the PT has been documented to have fallen to a subtherapeutic level, usually less than or equal to 1.5.

The degree of anticoagulation with intravenous heparin is measured by a laboratory test known as the PTT. In Mr. Geagan's case, therapeutic anticoagulation with intravenous heparin would have been achieved when the PTT was approximately 60-100. A PTT over 100 increases the risk of internal bleeding which could cause serious morbidity or even death. Intravenous heparin therapy must therefore be carefully monitored by frequent measuring of the PTT and the heparin dose adjusted or discontinued to prevent these serious complications.

On March 20, 2012 at 22:31, six (6) hours after

Defendant Brondon ordered the intravenous heparin, Mr. Geagan developed a nosebleed. The PTT was measured as greater than 150 and the INR was measured as 3.3.

On March 21, 2012 at 08:05, the Hematology Laboratory notified Dr. Brondon that Mr. Geagan's PTT was still greater than 150. The Hematology Laboratory noted this in the medical record as: 150 IS HIGHEST MEASURED PTT, Reported to and read back by DR. BRONDON 0805T 03/21/12."

On March 21, 2012 the INR was 2.9 on a blood sample collected at 06:28.

During the morning of March 21, 2012, Defendant Brondon and a nurse both noted the presence of ecchymosis or bleeding into the skin throughout Mr. Geagan's body.

On March 21, 2012 at 09:26, a "Trigger," Defendant BIDMC's term for a medical emergency, was called for Mr. Geagan. Defendants Brondon and Cheng responded to the Trigger. During the "Trigger," Defendant Brondon noted that Mr. Geagan had tachycardia or fast heart rate, a symptom of serious internal bleeding. Defendant Brondon failed to consider that Mr. Geagan may have had serious internal bleeding and failed to order testing for internal bleeding despite the markedly elevated PTT. Defendant Brondon failed to discontinue the intravenous heparin and reverse Mr. Geagan's anticoagulation with medication or blood product transfusions. Defendant Cheng failed to consider that Mr. Geagan may have had serious internal bleeding and failed to order testing for internal bleeding despite the markedly elevated PTT. Defendant Cheng failed to discontinue the intravenous heparin and reverse Mr. Geagan's anticoagulation with medication or blood product transfusions. Despite the new findings of ecchymosis, the persistent tachycardia and the markedly abnormal coagulation studies, Dr. Brondon's care plan for Mr. Geagan on March 21, 2012 included, "cont[inue] heparin [drip] for anticoagulation."

On March 21, 2012 at 11:00, the medical record indicates that Defendant Avigan was "verbally" notified of the "Trigger." Despite being notified that Mr.

Geagan was in the midst of a "Trigger," Defendant Avigan failed to attend to his patient, failed to evaluate or examine Mr. Geagan, failed to review Mr. Geagan's laboratory results, failed to review Defendant Brondon's care plan, failed to order further testing and evaluation and failed to communicate his evaluation and recommendations to Mr. Geagan's family.

On March 21, 2012 at 13:15, a second "Trigger" was called for Mr. Geagan, who still had a fast heart rate, but now developed falling blood pressure, yet another sign of serious internal bleeding. Defendant Brondon responded to this second Trigger.

On March 21, 2012 at 15:40, the Hematology Laboratory again notified Dr. Brondon that Mr. Geagan's PTT was still greater than 150. The Hematology Laboratory noted this in the medical record as: 150 IS HIGHEST MEASURED PTT, Reported to and read back by DR. BRONDON 1540T 03/21/12." Testing done during this second "Trigger" indicated that Mr. Geagan's hematocrit or blood count had fallen from 33 to 26, a significant drop indicating severe internal bleeding.

On March 21, 2012 at 13:47, Dr. Brondon discontinued the intravenous heparin but did not order medication or blood products to reverse the anticoagulation effects of the intravenous heparin and previously administered warfarin.

On March 21, 2012 at 13:40, the medical record indicates that Defendant Avigan was "verbally" notified of the second "Trigger." Despite being notified that Mr. Geagan was in the midst of a second "Trigger," Defendant Avigan failed to attend to his patient, failed to evaluate or examine Mr. Geagan, failed to review Mr. Geagan's laboratory results, failed to review Defendant Brondon's care plan, failed to order further testing and evaluation and failed to communicate his evaluation and recommendations to Mr. Geagan's family.

Defendant Brondon ordered blood transfusions, but failed to expedite the administration of the blood transfusions to Mr. Geagan.

On March 21, 2012, during the over four (4) hours

between 13:15 and 17:30, Defendant Brondon failed to obtain testing to determine the source of the internal bleeding, failed to administer medications or blood products to reverse Mr. Geagan's anticoagulation or replace the blood he had lost internally and failed to transfer Mr. Geagan to an intensive care unit.

On March 21, 2012 at 17:31, a third "Trigger" was called for Mr. Geagan, when his blood pressure fell dangerously in the "70's - 80's" and he was found to be "pale," findings consistent with serious internal bleeding. Defendant Brondon responded to this third Trigger. Testing done during this third "Trigger" indicated that Mr. Geagan's hematocrit or blood count had fallen further to 23, a very significant drop indicating severe internal bleeding.

On March 21, 2012 at 17:45, the medical record indicates that Defendant Avigan was "verbally" notified of the third "Trigger." Despite being notified that Mr. Geagan was in the midst of a third "Trigger," Defendant Avigan failed to attend to his patient, failed to evaluate or examine Mr. Geagan, failed to review Mr. Geagan's laboratory results, failed to review Defendant Brondon's care plan, failed to order further testing and evaluation and failed to communicate his evaluation and recommendations to Mr. Geagan's family.

On March 21, 2012 at 18:20 a CT scan was performed which showed a significant accumulation of blood in the retroperitoneum, the space adjacent to the spine. After the CT scan, Mr. Geagan was returned to an intensive care unit. Once in the intensive care unit, the nurse raised the head of Mr. Geagan's bed only 30 degrees to make him comfortable. Mr. Geagan then developed dramatic postural hypotension (low blood pressure) which required chest compression. The nurse's note is explicit: "on first compression complained of pain." Chest compression in a patient with a known compression fracture of the spine, like Mr. Geagan had, can cause spinal cord injury and paraplegia.

On March 21, 2012 at 19:00, further testing showed that Mr. Geagan's hematocrit or blood count had fallen further to 20 despite receiving blood transfusion.

On March 22, 2012 at approximately 13:00, Mr. Geagan developed acute sensori-motor loss below the level of T5-T6 with loss of rectal tone and rectal incontinence. An urgent MRI was obtained which showed spinal cord compression in the area of the previously known compression fracture. On March 22, 2012 Mr. Geagan underwent emergent and extensive spinal cord surgery, but he never recovered any functional use of his legs.

In a letter dated May 15, 2012 to Dr. Adams, Mr. Geagan's primary care physician, Dr. White, the surgeon who operated on Mr. Geagan's spine on March 22, 2012, acknowledged that Mr. Geagan "suffered a spinal cord injury during a cardiac resuscitation on March 22, 2012." Dr. White evaluated Mr. Geagan again on June 5, 2014 and noted: "However he remains at very high risk for paraplegic related complications such as DVT, skin ulceration and pulmonary complications."

Mr. Geagan died from pneumonia, a pulmonary complication, on October 28, 2012.

Defendant denied any violations of the standard of care.

General Injury: Death.

Result: Jury verdict in favor of defendant.

Plaintiff's Expert Witness: Judith C. Lin, M.D., Internal Medicine—Hematology, physician in New York, New York

Plaintiff's Attorney: Domenic Paolini, Paolini & Haley, P.C., Woburn, MA

Geagan v. Brondon, No. 1581CV01579 (Middlesex County Superior Court of Massachusetts, May 19, 2017)

16. Defense Verdict In Suit Arising From Patient's Death From Alcohol Withdrawal

On October 13, 2009, Nicholas Thompson was admitted as a patient to Florida Hospital Celebration

and during that hospitalization, Dr. Navani became his treating physician.

On October 13, 2009, Nicholas Thompson underwent lumbar surgery without any significant complications. He was scheduled to be discharged from on October 15, 2009, but was not released because of one or a combination of the following: a low grade temperature, tachycardia, hypokalemia and hypomagnesemia and a low platelet count.

On October 16, 2009, Dr. Navani diagnosed Nicholas Thompson as suffering from alcohol withdrawal. Following this diagnosis of alcohol withdrawal, the standard Clinical Institute Withdrawal Assessment protocol was ordered by Dr. Navani, which included the administration of low dose Ativan every two hours as needed for agitation. Despite those orders and the continuing care and treatment provided by the nurses and nursing staff, Nicholas Thompson condition deteriorated and he began experiencing delirium tremens. His condition was complicated by hypokalemia, atrial fibrillation and an undiagnosed ileus. On October 18, 2009, he suffered an acute aspiration, respiratory failure and cardiac arrest causing an anoxic brain injury. This led to his ultimate death on October 24, 2009.

Defendant denied any violations of the standard of care.

General Injury: Death.

Result: Jury verdict in favor of defendant.

Plaintiff's Expert Witness: Peter G. Terry, M.D., intensivist, New York, NY

Plaintiff's Attorney: Thomas E. Duffy, Jr., Terrell Hogan, P.A., Jacksonville, Florida

Defendant's Attorney: Jennings L. Hurt, III, Rissman, Barrett, Hurt, Donahue, McLain & Mangan, P.A., Orlando, FL

Thompson v. Navani, No. 2012-CA-009623 (Orange County Circuit Court of Florida, April 7, 2017)

OB/GYN

17. \$3.4 Million Verdict In Suit Arising From Post-Hysterectomy Hemorrhage

On July 22, 2013, Decedent was pregnant and presented to Monterey Park Hospital for a scheduled cesarean section to be performed by her obstetrician, Dr. Nassir. Following a cesarean section delivery and a hysterectomy, Ms. Viera lost more than over 3 liters of blood intraoperatively with her pulse dropping to 40, blood pressure systolic down to 56, and hemoglobin down to 5.0. Plaintiff alleged that Dr. Nassir, obstetrician, Dr. Arroyo, pulmonologist, Monterey Park Hospital negligently failed to appropriately recognize, diagnose, monitor, and treat a hemorrhage during and after the cesarean section delivery. Decedent bled to death on July 23, 2013.

Defendants denied any violations of the standard of care.

General Injury: Death.

Result: \$3,438,566 jury verdict, consisting of \$12,372 funeral and burial expenses; \$87,606 Past household services; \$338,588 Future household services; \$1,000,000 past loss of Virginia Viera's love, companionship, comfort, care, assistance, protection, affection, society, and moral support; \$2,000,000 future loss of Virginia Viera's love, companionship, comfort, care, assistance, protection, affection, society, and moral support.

The jury found fault as follows: Albert Nassir, M.D. 50 %; Joel E. Arroyo, M.D. 40 %; Monterey Park Hospital Nursing Staff 10 %.

Prior to trial, Joel E. Arroyo, M.D. settled for \$200,000.00, and Monterey Park Hospital settled for an undisclosed amount.

Plaintiff's Expert Witness: Howard Mandel, M.D.

Defendant's Expert Witness: Michael Ross, M.D.,

obstetrics and maternal fetal medicine; James D. Leo, M.D., critical care

Plaintiff's Attorney: Gary M. Schneider, Law Offices of Gary M. Schneider, Los Angeles, California

Defendant's Attorney: Patrick W. Mayer, Schmid & Voiles, Los Angeles, Cal.

Viera v. Nassir, No. BC561041 (Los Angeles County Superior Court of California April 28, 2017)

18. \$5 Million Settlement In Suit Arising From Birth Injury

Jenifer Mochocki was a healthy full term VBAC (vaginal birth after cesarean) who entered Naval Hospital Jacksonville in labor. This was her second child, and her prior child was delivered via cesarean section. After several hours, her labor progressed and the EFM strips reflected variable decelerations. The labor team consisting of the Attending, a nurse-midwife, two family practice residents and a labor and delivery nurse, performed resuscitative measures appropriate for a Category II strip, and consulted with the on-call OB surgeon. The OB wrote a Plan of Care stating if there was a worsening of the decelerations, he was to be called and a C-Section delivery to be emergently performed. Despite a worsening of the decelerations, the OB was never contacted, and two hours later, the child was emergently delivered vaginally in three pushes. The baby was born with Apgars of 1/1/1 and had to be resuscitated.

General Injury: The child was diagnosed with HIE and CP. The child lives with a G tube, a J tube and a trach.

Result: \$5,000,000.00 settlement, consisting of a combination of cash and annuities.

Plaintiff's Expert Witnesses: Nathan Hirsh, M.D. (OB/GYN), Miami, FL; Stuart Brown, M.D. (Ped Neurology), Miami, FL; Laura Mahlmeister, RN (Nursing), San Francisco, CA; Caron Jones, MSN, CNM (Midwife), Pittsboro, NC; Ellen Fernandez (Life Care Planning), Melbourne, FL; Paul Mason, Ph.D. (Economics), TX

Defendant's Expert Witnesses: William McCool, Ph.D., CNM (Nurse Midwife), Philadelphia, PA; Lauren Beslow, M.D. (Neurology), New Haven, CT; Suneet Chauhan, M.D. (OB/GYN); Robert Shavelle, Ph.D. (Life Expectancy), San Francisco, CA; Robynne Cash-Howard (Life Care Plan), Seffner, FL; John Fahr, Ph.D. (Economics), Washington, D.C.

Plaintiff's Attorneys: Michael V. Nakamura, Shulman, Rogers, Potomac, MD; Sean Cronin, Cronin & Maxwell, Jacksonville, FL

Defendant's Attorney: Roberto Rodriguez, U.S. Attorney, Tampa, FL

Mochocki v. United States of America, (United States District Court for the Middle District of Florida March 2, 2017)

19. \$2 Million Verdict In Suit Arising From Shoulder Dystocia

Afolake Lawoyin obtained prenatal care during her pregnancy, some of which was at provided by Defendant Dr. Akere, as an agent of JIL Medical Consultancy, Ltd.

Afolake Lawoyin gained approximately fifty pounds during her pregnancy and was at risk for gestational diabetes. Plaintiff alleged that appropriate prenatal testing for gestational diabetes and other conditions was not ordered or performed by any of the Defendants. Plaintiff alleged that Defendant Dr. Akere, as an agent of JIL Medical Consultancy, Ltd., did not order or perform timely ultrasound or other screening tests to determine the adequacy of the pelvis and to ascertain the size of the baby.

On December 8, 2006, Afolake Lawoyin was admitted to St. Anthony Hospital for an elective induction of labor. On or about December 8, 2006, labor was induced with Pitocin. During labor on December 9, 2006, the fetal heart monitoring strips showed decelerations. During the delivery, Dr. Akere called in an obstetrician, Dr. Abdulghany Tabbara, to assist with the delivery. During delivery, Dr. Akere authorized the use of a vacuum extractor to deliver Oladasoyin.

Plaintiff alleged that during delivery, a shoulder dystocia was encountered, which Dr. Akere, as an agent of JIL Medical Consultancy, Ltd., failed to recognize. Plaintiff alleged that Dr. Akere applied excessive traction to complete the delivery of Oladasoyin Lawoyin.

Defendants denied any violations of the standard of care.

General Injury: Oladasoyin Lawoyin suffered injury to her brachial plexus nerves.

Result: \$2,000,000 jury verdict.

The jury found in favor of Oladasoyin Lawoyin, a minor, by her Parents and Next Friends, Lajide Lawoyin and Afolake Lawoyin, and against the Defendants Ayoade Akere, M.D. and JIL Medical Consultancy, LTD. on the counts of medical negligence and informed consent.

The jury awarded the following: \$500,000 disfigurement; \$250,000 disability experienced and reasonably certain to be experienced in the future; \$500,000 pain and suffering experienced and reasonably certain to be experienced in the future; \$400,000 reasonable expense of necessary medical care, treatment, and services received and the preset cash value of the reasonable expenses of necessary medical care, treatment and services reasonably certain to be received in the future; \$350,000 present cash value of the earnings reasonably certain to be lost in the future.

Plaintiffs' Expert Witness: Lawrence Borow, M.D., ob/gyn, Bala Cynwyd, PA

Defendant's Expert Witness: Robert Gherman, M.D., obstetrician-gynecologist, Cheverly, Maryland

Plaintiff's Attorneys: Kathryn L. Conway, Power Rogers & Smith, LLP; Pamela Pantages, The Becker Law Firm, Cleveland, OH

Defendant's Attorneys: Paul V. Esposito, Robert L. Reifenberg, Kathleen M. Klein, Clausen Miller P.C., Chicago, IL

Lawoyin v. Akere, No. 2013L001645 (Cook County Circuit Court of Illinois January 27, 2017)

20. Defense Verdict In Suit Arising From Shoulder Dystocia

Dr. Vetter began to see Tanya Lehfeltdt for her pregnancy with Karsen at the Dakota Medical Center. Tanya was 32 years old and her family history was significant for hemophilia, multiple births and diabetes. Her current pregnancy was positive for slight bleeding and a vaginal discharge, nausea and vomiting, constipation, headaches, and urinary complaints.

Dr. Vetter noted that Tanya Lehfeltdt was multiparous, had a history of second trimester fetal death, preterm labor and delivery, and had a history of gestational diabetes mellitus. She had also been able to vaginally deliver an 8 pound, 8 ounce infant. Following Dr. Vetter's initial exam, he assigned an estimated due date of 05/17/2005. Two ultrasounds, 11/01/2004 at 11-5/7 weeks and 01/13/2005 at 22-23 weeks, confirmed the due date.

Tanya Lehfeltdt entered Essentia Hospital on 5/5/2005, to deliver Karsen. Tanya was admitted for Pitocin induction for macrosomia, and electronic fetal monitoring. Her gestational age was 38+2 days with an estimated date of delivery as 5/17/2005. The membranes remained intact at 1645, and were artificially ruptured at 1830. The fluid was clear and the quantity was normal. An external tocometer monitored contractions, and an ultrasound externally monitored the fetal heart rate.

Pitocin was gradually increased to a maximum of 14 mu/mn. A labor epidural for pain management began at approximately 2000 and ended at 2030. The fetal monitor strip entries note that at 2139 Tanya was completely dilated. Karsen was born at 2216. The second stage of labor from complete dilatation to delivery took 37 minutes. Karsen weighed 4536 grams at birth. Karsen's Apgars were 6 and 8. He required the usual suction. He also required tactile stimulation and warming, blow by oxygen, and bag and mask ventilation with oxygen. His neck, face, and shoulder were bruised. He had petechiae (pinpoint bleeding into the skin) and decreased extremity movement. Tanya suffered a 4th degree perineal laceration requiring repair.

In Dr. Vetter's Labor and Delivery Summary which he completed two days after delivery, he identified Tanya's pregnancy as high risk. He documented her induction with Pitocin for impending macrosomia (weight greater than 4000 grams). When Tanya was completely dilated, Karsen's head was in the OA orientation (occiput anterior). After Karsen's head delivered his left shoulder (anterior shoulder) became stuck under the pubic symphysis (pubic bone). Dr. Vetter was unable to deliver the anterior shoulder with McRoberts, or "pubic" pressure. Dr. Vetter delivered Karsen's posterior shoulder "relatively easily" after he had been unable to deliver Karsen with other maneuvers. Karsen was born at 1017 and weighed 9#15oz. During delivery, Karsen suffered severe shoulder dystocia. At birth, Karsen's left neck was swollen and his face was bruised. His left arm was flaccid. He was taken to the NICU (neonatal intensive care unit).

Defendant denied any violations of the standard of care.

General Injury: Severe brachial plexus injury.

Result: Jury verdict in favor of defendant.

Plaintiff's Expert Witnesses: Edith Gurewitsch, M.D.; Robert Allen, PH.D., P.E.

Defendant's Expert Witnesses: Michele Grimm, Ph.D.; Robert Demott, M.D., obstetrician, Green Bay, WI; Dennis J. Lutz, M.D., obstetrician/gynecologist, Miles City, Montana

Plaintiff's Attorneys: Robins Kaplan LLP, Minneapolis, MN

Defendant's Attorneys: Angela E. Lord, Charlotte J.S. Rusch, Vogel Law Firm, Fargo, ND

Lehfelddt v. Vetter, No. 09-2015-CV-01306 (Cass County District Court of North Dakota, January 31, 2017)

21. Defense Verdict In Suit Arising From Shoulder Dystocia

Plaintiff alleged that shoulder dystocia was encountered during childbirth, and that Dr. Gof had applied excess downward traction to the fetal head and neck.

Defendant contended that the fact that the posterior arm was injured indicated that the injury occurred due to the endogenous forces of the delivery process, and not to physician-applied traction.

General Injury: Erb's palsy.

Result: Jury verdict in favor of defendant.

Plaintiff's Expert Witness: Russel D. Jelsema, M.D. obstetrician/gynecologist, Grand Rapids, Michigan

Defendants' Expert Witness: Dr. Joseph Ouzounian, obstetrics and maternal-fetal medicine, Keck School of Medicine, University of Southern California

Plaintiff's Attorney: Carol Forte, Blume, Donnelly, Fried, Forte, Zerres & Molinari, P.C., Chatham, New Jersey

Defendant's Attorney: Teresa C. Finnegan, Buckley Theroux Kline & Petraske, LLC, Princeton, N.J.

Demir v. Gof, No. PAS-L-3103-14 (Passaic County Superior Court of New Jersey, April 6, 2017)

22. \$33.8 Million Bench Verdict In Suit Arising From Birth Injury

Marla Dixon received prenatal care from Jessie Trice. Jessie Trice is a federally supported health center. The pregnancy was normal and without complication until the day of the birth. Dixon did not participate in formal pre-natal education, but she learned

about C-section and vaginal deliveries by watching YouTube videos.

On December 2, 2013, at approximately 1:00 a.m., Dixon went into labor. She presented at North Shore at approximately 2:00 a.m. Upon admission to North Shore, Dixon signed a consent form which acknowledged her general consent to treatment as well as her right to refuse any medical treatment. The consent form indicated that she was agreeing to a vaginal delivery as well as any other surgical procedures required in the course of delivery.

Yolande McCray, a nurse at North Shore, was assigned to provide care for Ms. Dixon during her labor and delivery once her shift began at 7:00 a.m. Dr. Atogho, who was offsite, was advised that Dixon was in labor and issued orders admitting Dixon and addressing her care, including continuous external fetal monitoring. He ordered a Low Dose Pitocin regime should contractions become irregular. The order required McCray to stop Pitocin if there was evidence of fetal distress.

Dixon's labor was uneventful until approximately 13:20 when fetal heart rate tracings showed deceleration of the baby's heart rate. Pitocin, which had been started at 9:46, was turned off at 13:30 because of a non-reassuring heart rate. At about 13:33, McCray charted her vaginal examination, revealing Dixon to be fully dilated (marking the end of Stage One, and beginning of Stage Two Labor) with the baby descended to +1 station. McCray notified Dr. Atogho on his cell phone of the deceleration and the conditions indicating that the baby was ready to be delivered.

Dr. Atogho arrived at Dixon's bedside for the first time at 13:49. Fetal monitoring indicated the baby had a non-reassuring heart rate indicative of hypoxia (oxygen deprivation). Dr. Atogho believed that the fetal monitoring indicated that Earl Jr. had a category 3 heart rate. Pitocin was restarted once Dr. Atogho arrived. Dr. Atogho continued infusing Pitocin into Dixon from 13:50 until 15:21, when Earl Jr. was delivered. The court found that pitocin was contraindicated because of the baby's non-reassuring heart rate, and further impaired the flow of blood and oxygen to

the baby. The court found that Dr. Atogho failed to use appropriate fetal resuscitation measures to correct the non-reassuring fetal heart rate. The court found that from 13:49 through 15:21 Dr. Atogho believed that Earl Jr. was in imminent danger of hypoxic injury, brain damage or death. The court found that nonetheless, he continuously left Dixon's room to treat another patient, and he delivered that other baby at 15:08, just minutes before Earl Jr. was born. The court found that during that same time, Dr. Atogho also made an eight-minute phone call to his financial advisor.

Between 13:49 and 15:21, Dr. Atogho used a Kiwi vacuum device on three occasions. At 15:21, Ms. Dixon delivered Earl Jr. vaginally. When Earl Jr. was delivered, he was blue and not breathing. Shortly after birth, the Neonatal Intensive Care Unit ("NICU") team was called and assumed care for the baby. Earl Jr. was transferred the following day to Nicklaus Children's Hospital, where he was later diagnosed with hypoxic ischemic encephalopathy and brain damage from oxygen deprivation.

The Plaintiffs alleged that Dixon requested a C-section several times, and that Dr. Atogho refused, telling her to "keep pushing."

The United States alleged that Dr. Atogho advised Dixon to undergo a caesarean section ("C-section"), but Dixon refused.

General Injury: Brain damage.

Result: \$33,813,495.91 bench verdict in favor of plaintiff. The Court awarded Plaintiff Earl Jr. the following damages: Past and future economic damages: \$21,788,495.9; Past and future non-economic damages: \$7,625,000; Total damages for Earl Jr. \$29,413,495.9. The Court awarded Plaintiff Marla Dixon the following damages: Past non-economic damages: \$300,000; Future non-economic damages: \$3,000,000. Total damages for Marla Dixon: \$3,300,000. The Court awarded Plaintiff Earl Reese Thornton the following damages: Past non-economic damages: \$100,000; Future non economic damages: \$1,000,000. Total damages for Earl Reese Thornton: \$1,100,000.

Plaintiff's Expert Witnesses: Martin Gubernick,

M.D., ob/gyn, New York, N.Y.; Harlan Giles, M.D., ob/gyn

Defendant's Expert Witnesses: Dr. Frank Ling, ob/gyn, Germantown, Tennessee; Dr. Michael Berkus, ob/gyn

Plaintiff's Attorneys: Richard B. Sharp, Mallard & Sharp, P.A., Miami, Fla.; Lauri Waldman Ross, Ross & Girtten, Miami, Fla.

Defendants' Attorneys: Charles S. White, U.S. Attorney's Office, Miami, Fla.; Joseph S. Jareau, U.S. Dept. of Justice, Washington, D.C.

Dixon v. United States, No. 15-23502-Civ-Scola (United States District Court Southern District of Florida April 28, 2017)

OPHTHALMOLOGISTS

23. \$5 Million Verdict In Suit Alleging Negligent Treatment Of Age Related Macular Degeneration

Beginning in 2006, Dr. Beck began treating Nancy for age related macular degeneration (AMD) in her left eye. This is a disease that, left untreated or not treated properly, can evolve into a serious condition that causes blindness in the eye. Blindness is preventable with proper treatment.

AMD can develop into what is known as "wet" AMD. This condition involves the growth of blood vessels behind the retina that release fluid and cause damage to the eye. Proper treatment involves the use of medication injected into the eye that arrests the blood vessels and prevents the damage to the eye. With proper care, wet AMD can actually be reversed and the eye's vision preserved.

Between 2006 and 2010, Dr. Beck gave only four injections into Nancy's left eye to treat her AMD. However, he performed two laser surgeries in her left eye. Plaintiff alleged that this treatment of Nancy's left eye was not consistent with the standard of care and as a result, Nancy lost vision in her left eye.

During the years 2006 through June 2012, Nancy's vision in her right eye was fine.

On June 12, 2012, Nancy sought treatment from Dr. Beck for decreased vision in her right eye. Upon examination, Dr. Beck determined that Nancy had very early wet AMD. To meet the standard of care, this finding requires medical treatment as soon as possible - within days. This is particularly true in a one eyed person. Nancy's left eye was already legally blind.

Dr. Beck did not treat Nancy's condition until July 3, 2012. On that day, Dr. Beck injected the drug used to treat early AMD. However, Dr. Beck combined the drug with Kenalog, a steroid, used to treat recalcitrant wet AMD and only after other more conservative treatment is unsuccessful. A common side effect of this combination therapy is glaucoma - a condition of high pressure in the eye that can be permanent. In Nancy's case, she already had a history of glaucoma so the use of a steroid as first line treatment for early AMD is a violation of the standard of care.

Nancy returned to Dr. Beck's office on July 6 with excruciating pain in her right eye. She was now experiencing nausea and vomiting. On examination, the pressure in Nancy's right eye was 46 - an emergency situation. Normal pressure is 21. In violation of the standard of care, Beck treated Nancy's right eye with eye drops for the next ten days.

On July 16, Dr. Beck undertook to do glaucoma surgery. This surgery was unsuccessful and rather than refer Nancy to Boston for treatment, he decided to proceed with a more aggressive surgery. Plaintiff alleged that Dr. Beck performed Ahmed Valve surgery on Nancy's right eye, in violation of the standard of care.

Nancy returned to Dr. Beck's office on September 7 and her vision in her right eye was legally blind. Nancy was now unable to live independently. Dr. Beck's office notes document that the fundus exam was abnormal, however, it records the retina as normal. Plaintiff alleged that Dr. Beck's and NEES records are inaccurate and incomplete and not in accordance with the standard of care.

Plaintiff alleged that the medical records docu-

mented by Dr. Beck and NEES staff did not meet the standard of care. NEES employees who provided care and treatment to Nancy were acting beyond the scope of their ability. As a result, Nancy did not receive standard of care eye treatment and related medical services and medical record documentation.

Nancy returned to Dr. Beck on September 11, 2012 and was diagnosed with having a total detachment of the retina in her right eye.

Nancy returned to Dr. Beck on September 14, 2012 and he attempted a highly specialized technical procedure. Essentially, he attempted to re-attach the retina in Nancy's right eye. Plaintiff alleged that Dr. Beck violated the standard of care and the procedure failed.

Nancy returned to Dr. Beck on January 7, 2013 and he again attempted surgery. By now, the right eye was damaged beyond repair. As a result, Nancy is blind in her right eye.

Nancy returned to Dr. Beck on March 11, 2013 and her vision was recorded as "bare light perception." This was near the end point of vision and very painful. The eye was red, inflamed and extremely painful. Plaintiff alleged that the care rendered by NEES, Beck and his technicians through March 2013 did not meet the standard of care.

Defendant denied any violations of the standard of care.

General Injury: Nancy is now blind in both eyes.

Result: \$5,029,142 jury verdict.

The jury found that the defendant deviated from the standard of care with respect to the defendant's treatment of Nancy's left eye but that did not cause her any damage. With respect to the defendant's treatment of Nancy's right eye, the jury found the defendant engaged in medical malpractice and awarded Nancy \$4,679,142.00.

They also awarded Joseph \$350,000 for loss of consortium.

Plaintiffs' Expert Witnesses: Michael J. Bradbury,

M.D., ophthalmologist, Worcester, MA; Nancy Bonachea, M.D., ophthalmologist, Bedford, New Hampshire

Plaintiff's Attorneys: Richard E. Fradette, Bellevue, Fradette & Gallant, P.A., Manchester, NH

Defendant's Attorneys: M. Kate Welti, John D. Cassidy, Ficksman & Conley, LLP, Boston, MA

Knox v. Beck, No. 2182014CV00249 (Rockingham County Superior Court of New Hampshire, December 9, 2016)

ORTHOPEDICS

24. \$0.744 Million Verdict In Suit Arising From Mumford Procedure

On Saturday, January 28, 2012, Dylan, a 16-year-old high school sophomore, injured his shoulder in a high school wrestling match. His father called South Bend Orthopedics on January 30 to schedule an appointment. Dylan presented to Dr. Jeff Yergler (the defendant's son) on Friday, February 6, 2012. An MRI was performed that day. Dylan was instructed to return on Monday for the MRI results. On Monday, February 9, 2012, Dylan returned to Dr. Jeff Yergler. The MRI report found "a low-grade acromioclavicular joint separation (grade 1)" in a "skeletally immature patient." Dr. Jeff Yergler prescribed ibuprofen for Dylan and instructed him to sit out of sports for three days.

After sitting out for three days, Dylan resumed his wrestling season. Following the season, with his shoulder still bothering him somewhat, he returned to South Bend Orthopedics for a follow up visit on April 4, 2012—his 16th birthday. This time he saw the defendant, Dr. Willard Yergler.

Dr. Willard Yergler did a brief physical exam of Dylan's shoulder and then looked at the February 6th MRI. Almost immediately, Dr. Yergler explained to Dylan that he had two choices: live with the pain or undergo a Mumford procedure. (A Mumford proce-

ture shaves off a portion of the distal clavicle.) Dr. Yergler explained to Dylan and his father that it's a simple surgery that he had performed thousands of times on Notre Dame football players. Trusting Dr. Yergler, Dylan and his father agreed to the surgery, which was performed on May 7, 2012.

In the months following the surgery, the pain from the grade-1 AC joint sprain went away. In its place was a constant, achy pain that was eventually diagnosed as being caused by surgical scar tissue. Dr. Willis Stevenson, an orthopedic surgeon who the Dixons sought to provide a second opinion, ordered another MRI in January of 2013 and explained to Dylan that he did not recommend surgery to "clean out" the scar tissue; it would inevitably return. Therefore, there was no remedy for Dylan's constant pain.

The claim was presented to a Medical Review Panel consisting of three orthopedic surgeons, none of whom knew Dr. Yergler nor Dylan Dixon. On May 6, 2015, the Panel issued its unanimous opinion: Dr. Willard Yergler violated the standard of care "and the conduct complained of was a factor of the resultant damages."

The Defendant waived mediation because there would be no money offered to settle the matter.

The trial began on May 15, 2017 and lasted three days. Plaintiff called one of the Medical Review Panel members as his expert. He testified that the Panel felt it was a violation for Dr. Yergler to perform the Mumford procedure on a skeletally immature 16-year-old, particularly because there was no significant conservative treatments ordered first. He testified that the injury would have more likely than not healed with conservative therapy. Therefore, any subsequent injury from the surgery is the result of the decision to perform it.

The Defendant's expert—an orthopedic surgeon from Richmond, Indiana—testified that it was not a violation of the standard of care to go directly to the Mumford procedure, and even if it were, Dylan did not suffer any damages as a result.

In closing argument, counsel for Plaintiff acknowledged that Dylan's shoulder pain was not a severe, unbearable injury; it was not debilitating. Rather, it

was a constant, achy soreness that he will have lived with for 62 years (according to the Life Expectancy Tables). It was argued that the value of the injury was entirely up to the jury, but \$10,000 per year seemed fair under the circumstances.

Injury: Permanent scar tissue, pain and reduced range of motion in his shoulder due to an unnecessary surgery.

Result: The jury returned a verdict of \$744,000—or \$12,000 per year for 62 years.

Plaintiff's Expert Witness: Dr. Edward Todderud, Indianapolis, Ind. (retired)

Defendant's Expert Witness: Dr. Christopher Neher, Richmond, Ind.

Plaintiff's Attorneys: Nathan M. Miller and J. Brad Kallmyer, M.D., Montross Miller Muller Mendelson & Kennedy, LLP

Defendants' Attorney: Edward Chapleau

Dixon v. Yergler, M.D. and South Bend Orthopedics Associates, Inc., No. 71D04-1506-CT-000239 (St. Joseph County Superior Court, South Bend, Indiana)

25. Defense Verdict In Suit Arising From Knee Replacement

On April 8, 2012, Plaintiff Michael Murphy, a 58-year-old smog technician, was working in his yard on a ladder when he was attacked and beaten by an 85-year-old neighbor wielding a hardwood cane. The attack was so severe that after approximately fifteen blows from the cane it literally broke in two over Mr. Murphy's body. As a result of the assault, Mr. Murphy sustained severe injuries to his head, forearm, wrist, left hand, and right knee.

Prior to the attack, Mr. Murphy had a long history of right knee pain. He also had a history of right knee surgery and injections. Immediately after the attack, he reported he was not able to work due to his injuries.

Following the assault, Mr. Murphy was seen by

providers in several specialties. For his right knee pain, he was referred to Dr. Gill in Fresno. His first visit with Dr. Gill's office was on May 8, 2012. At that time, he reported a number of physical limitations including, but not limited to, difficulty walking, climbing stairs, locking and popping of the right knee, inability to walk more than five blocks, trouble putting on socks, and night pain. He described his pain as moderate to severe and he was using pain medication and anti-inflammatories. Physical examination revealed limitations in the knee and x-rays showed narrowing and osteophytes formation throughout the knee.

An MRI of the right knee was performed in late May and the patient returned for another evaluation in Dr. Gill's office on June 12, 2012. Based on the patient's film studies, physical examinations, and ongoing complaints, Mr. Murphy was scheduled for a right total knee replacement. There is no dispute in this case that the right knee surgery was indicated. It is also undisputed that Mr. Murphy was told prior to this surgery that one of the risks of the procedure was that he may need a revision at a later date.

Dr. Gill performed surgery at Community Regional Medical Center on August 29, 2012. The surgery was a right total knee arthroplasty. In There were no complications noted during surgery.

Over the next several months, Mr. Murphy appeared to do well. He was seen in Dr. Gill's office in September and October of 2012 and was making good progress. On October 19, 2012, he reported that he was full weight-bearing on the right knee and he was feeling good. He was scheduled for a follow-up visit in five months.

Mr. Murphy returned to Dr. Gill's office on March 19, 2013. Dr. Gill noted Mr. Murphy's knee had good range of motion and x-rays confirmed his implants were in stable position. Dr. Gill concluded his chart note by stating Mr. Murphy was doing well and he should return in October for repeat x-rays.

Sometime in the late spring or early summer of 2013, Mr. Murphy began to experience increased pain and significant difficulties in the right knee again. He was seen in Dr. Gill's office on July 2, 2013, and he

reported an increase in symptoms over the prior few months. Film studies were performed and Mr. Murphy was also scheduled for lab studies to rule out a possible knee infection. The patient returned on July 9, 2013. The infection studies were normal. However, Mr. Murphy was still experiencing significant pain and now he had swelling in his knee. Subsequent x-rays showed what appeared to be a loosening of the femoral component only. Mr. Murphy was scheduled for a revision knee surgery to replace the femoral implant with a new one.

Mr. Murphy's revision surgery was performed on September 16, 2013, at the Fresno Surgery Center. During the course of that surgery, Dr. Gill found that cement used in the original surgery had bonded well to the implant. Yet he found the femoral component of the knee replacement was loose as there appeared to be little-to-no penetration of the cement to Mr. Murphy's femur. So he removed and replaced the femoral prosthesis. This time, he anchored the femoral prosthesis further up the femur. The surgery appeared to be without incident or complication. Plaintiff's expert, Dr. Graboff, expressed no criticisms of the revision surgery in September of 2013.

Mr. Murphy again appeared to do well in the post-operative period. He was seen in October and November of 2013 and was noted to be making good progress. He returned in April of 2014 and he was doing well at the time. This was the last visit with Dr. Gill's office regarding the patient's right knee.

General Injury: Mr. Murphy continues to experience significant post-operative pain, and he finds it difficult to exercise, kneel, walk long distances, or perform other activities of daily living. Mr. Murphy was unable to continue his career as a smog technician/mechanic..

Result: Jury verdict in favor of defendant.

Plaintiff's Expert Witness: Steven R. Graboff, M.D., Orthopedic Surgeon, Huntington Beach, CA

Defendant's Expert Witness: William Brien, M.D., orthopedic surgeon, Fresno, Cal.

Plaintiff's Attorney: Vonn R. Christenson, of the Christenson Law Firm, LLP.

Defendant's Attorney: Mark B. Canepa, of White | Canepa LLP, Fresno, California

Murphy v. Gill, No. 14 CECG 03613 (Fresno County Superior Court of California, September 12, 2016)

26. Defense Verdict In Suit Arising From Hip Replacement

Plaintiff alleged that on October 1, 2012 he first learned by reason of a consultation with Dr. William Hopkinson that the femoral component inserted by defendant on March 25, 2008 was loose because of retained cement in the femur and that his right hip would need revision surgery. Plaintiff consulted Dr. David Manning on October 16, 2012. He reviewed x-rays taken before and after the surgery of March 25, 2008, noting retained cement and evidence of fracture at the time of surgery. Plaintiff's hip was revised by Dr. Manning on December 12, 2012 at which time 16 centimeters of cement were removed from the proximal femur.

Plaintiff was a longstanding orthopedic patient of defendant. Defendant performed bilateral hip replacements for plaintiff; the right hip in 1995 and the left in 1997. Both original hip replacements were cemented constructs. Plaintiff's right hip became painful and defendant advised plaintiff he needed to have the hip revised because the femoral component was likely loose. He testified that a primary hip replacement is typically completed in an hour and one-half but a revision surgery can be six times longer, perhaps 4 or 5 hours, depending on whether the revision includes the acetabular cup as well as the femoral component. Defendant was not going to remove the acetabular cup if it was found to be stable as that would only add additional surgical time. During the surgery a cyst or bony defect was found behind the acetabular cup and, therefore, he decided the cup needed to be revised along with the loose femoral component. Defendant noted in his report that the cup was severely ingrown and was difficult to remove. With regard to the femoral

side, defendant noted that the cement in the femur was removed and that the "calcar" was eroded. He wrote that upon insertion, the 250 mm femoral component appeared to be breaking out through the anterior and lateral cortex, and that the excessive bowing of the femur was a major problem. Continuing, defendant noted that after further resection a 300 mm prosthesis was inserted under direct vision as it passed the orifice of fracture. It is noted that after surgery the patient was returned to the recovery room in satisfactory condition.

During the surgery, x-rays of the femur were obtained and later reviewed by a radiologist, Dr. Grewal. He noted in his report the presence of a comminuted fracture in the mid-diaphysis with extension of the anatomically aligned femoral prosthesis outside the cortex at the fracture site. It was further noted that subsequent x-rays showed repositioning of the component inside the cortex.

Defendant testified that he intentionally left cement in the lateral proximal femur for fear of damaging the trochanter bone behind the cement and because, he contended, bone does not grow in this area. Further, he testified that what he described as a fracture in his operative report is really a "window" or "trap door" or "controlled fracture" created for access to the mid-shaft femur. He testified that Dr. Grewal misinterpreted the x-rays taken during the surgery. Defendant testified the prosthesis as shown on the x-ray is lying on top of the femur - not inside the bone as Dr. Grewal described. Dr. Grewal was shown the report and the x-rays taken during the surgery and testified, to a reasonable degree of radiologic certainty, the prosthesis is in anatomic position inside the bone in its proximal aspect and outside the cortex in the distal aspect. Dr. Manning testified that no reasonably careful surgeon would leave the cement in the proximal femur because its presence precludes osseous integration of bone and prosthesis and predisposes to fracture upon insertion of the revision femoral prosthesis.

After being discharged from the hospital, plaintiff had follow-up visits with defendant in his office. On each occasion, defendant told him the x-rays showed he was healing well and things were looking good. By March of 2009 (one year post surgery), plaintiff was

pain free and considered the surgery a success even though he had not yet returned to all activities of daily living.

Plaintiff next saw defendant in February of 2010 because now his left hip was painful. Defendant recommended revision surgery which was performed on April 6, 2010 at Elmhurst Memorial Hospital.

Sometime during the latter months of 2010, plaintiff noticed a pain in his right leg just above the knee. Plaintiff had returned to work, which required a great deal of walking. He testified the pain started as intermittent but over time became more persistent by the end of a work day.

On May 10, 2011, plaintiff fell at a Target store and since he had already had four hip surgeries his wife encouraged him to be examined as a precaution to make sure he had not damaged his hips. Plaintiff called Trinity Orthopedics to schedule an appointment with defendant. He was told Dr. Sheehan had retired but Dr. Kris Alden would see him. Plaintiff saw Dr. Alden on May 11, 2011, at which time he told the doctor about his prior hip surgeries, his right knee pain and the fall in the Target store. Dr. Alden took x-rays and told plaintiff everything looked good. Dr. Alden's records indicated there was no evidence of fracture, dislocation, osteolysis, loosening or fracture of the right revision total hip arthroplasty. On this same date, May 11, 2011, the x-rays which were taken during the surgery of March 25, 2008 were digitally reproduced.

Plaintiff's next encounter with a physician for evaluation of his pain above of the right knee was with Dr. Victor Romano, defendant's former partner at Trinity Orthopedics. Plaintiff saw Dr. Romano on July 5th, July 19th, August 9th and September 6th of 2012. Dr. Romano's records of July 5th noted that plaintiff's pain was located just superior to his knee and sometimes radiates to the hip. His diagnosis on this date was "probable diagnosis of a stress fracture of the right distal femur." A CT scan and bone scan were ordered to rule out stress fracture, loosening or infection. These studies were inconclusive; however, stress fracture or loosening remained a consideration. On July 19th Dr. Romano's diagnosis was stress fracture of the distal

femur. Because of persistent pain secondary to arthritis of the right knee, Dr. Romano administered a steroid injection to the knee joint. Plaintiff was instructed not to bear any weight on the leg for three weeks. On August 9th, plaintiff reported a reduction of pain since he has been non-weight bearing, and x-rays were obtained. Dr. Romano believed the stress fracture was healing well. At the September 6th visit plaintiff reported an increase in pain with partial weight bearing. Dr. Romano's diagnosis remained "stress fracture" and he recommended referral to Dr. William Hopkinson for a second opinion for possible prophylactic open reduction and internal fixation of the distal femur.

Plaintiff saw Dr. Hopkinson on October 1, 2012, and he reviewed x-rays plaintiff brought for the appointment. Dr. Hopkinson manipulated plaintiff's right leg and told him the femur was loose and needed to be revised. Dr. Hopkinson showed plaintiff the retained cement in the proximal right femur which was "crumbling." Dr. Hopkinson recommended plaintiff see Dr. Paprosky for long stem revision with removal of additional cement.

The alleged negligence of defendant, Dr. Joseph Sheehan, occurred during surgical revision of plaintiff's right hip arthroplasty on March 25, 2008. Plaintiff alleged that during that surgery defendant negligently failed to remove the orthopedic cement placed in the femur when defendant performed the original or primary hip replacement in 1995. It was alleged that the presence of retained cement caused loosening of the femoral component and early failure of the revision surgery. It was further alleged that the presence of cement caused a fracture of plaintiff's femur at its isthmus when defendant attempted to insert the revision component down the channel formed by the previously inserted cement.

Defendant denied any violations of the standard of care.

General Injury: Complications from the procedure.

Result: Jury verdict in favor of Joseph Sheehan, M.D.

Plaintiffs Expert Witness: Dr. William Kennedy, orthopedist

Defendant's Expert Witness: Dr. James Kudrna, orthopedic surgeon, Glenview, Illinois

Plaintiff's Attorney: Patrick F. Bradley, Patrick F. Bradley, Ltd., Northbrook, Illinois

Defendant's Attorneys: Mary C. O'Connor, Robert J. Cheris, Hickey, O'Connor & Battle, LLP, Chicago, Illinois for Joseph Sheehan, M.D.

Miniscalco v. Sheehan, No. 2014L000559 (Cook County Circuit Court of Illinois April 21, 2017)

27. Defense Verdict In Suit Arising From Carpel Tunnel Surgery

On December 21, 2012 Dr. Tait performed carpal tunnel surgery ("CTS") on Mr. Whittacre's left wrist. On December 23, 2012 Plaintiff began experiencing trouble because of swelling and an electrical shock sensation that ran from his left hand to his elbow and occasionally his shoulder.

On December 26, 2012 Plaintiff returned to Dr. Tait for post operative treatment, complaining about the swelling of his left hand and the electrical shock waves sensation he was experiencing up and down his arm.

Mr. Whittacre voiced concern to Dr. Tait that his left hand was not healing like his right hand had. Dr. Tait assured him that these symptoms were not unusual and scheduled a follow up. On January 9, 2013 Plaintiff returned to Dr. Tait's office; again Dr. Tait assured him that what he was experiencing was normal. Dr. Tait referred Plaintiff to an physical therapist. On January 14, 2013 Plaintiff began treating with Select Physical Therapy and began performing hand exercises at home.

On January 29, 2013 Plaintiff had a follow-up appointment with Dr. Tait. He complained about the progress of his left hand. Dr. Tait scheduled a second operation on the left hand to determine what was causing the swelling and other issues. On January 31, 2013

Dr. Tait performed a second surgery on Plaintiff's left hand and wrist. Plaintiff continued experiencing extreme swelling and severe pain with electrical sensations in his arm. Additionally Plaintiff began experiencing numbness in his left thumb, index finger, and middle finger.

On February 6, 2013 Plaintiff returned to Dr. Tait for a follow-up appointment. Dr. Tait informed Plaintiff that he had Reflex Sympathetic Dystrophy (RSD). On February 11, 2013 Plaintiff resumed occupational therapy at Select Physical Therapy. On June 19, 2013 Plaintiff returned to Dr. Tait for a follow-up. Dr. Tait informed Plaintiff that his recovery had reached a plateau and that Dr. Tait would not be able to treat the hand any longer. Dr. Tait referred Plaintiff to a hand specialist.

On July 12, 2013 Plaintiff treated with James Vahey, M.D., a hand specialist at the Orthopedic Institute of Henderson. On July 22, 2013 Plaintiff treated with Loretta Metzger, M.D., Plaintiffs primary care physician. Dr. Metzger expressed concern regarding Dr. Tait's failure to have Plaintiff see a neurologist to test for nerve damage, and arranged an appointment with Leo Germin, M.D. On July 29, 2013 Dr. Germin performed a nerve damage test, which confirmed that Plaintiff's hand was permanently damaged.

On September 24, 2013 Plaintiff had an MRI of his left wrist performed at Nevada Imaging Center. The MRI showed damage at the median nerve, right at the location of the CTS. On October 14, 2013 Plaintiff saw Dr. Vahey who informed him that the MRI showed the median nerve had split at the wrist and was permanently damaged. Dr. Vahey recommended exploratory surgery and informed Plaintiff he would never do carpal tunnel surgery without a scope first.

Defendant denied any violations of the standard of care.

General Injury: Nerve damage.

Result: Jury verdict in favor of defendant.

Plaintiff's Expert Witnesses: Ramin Modabber, M.D, orthopedic surgeon, Santa Monica, CA

Defendant's Expert Witness: Dr. James Brody, Hand Surgery

Plaintiff's Attorney: Cliff W. Marcek, Cliff W. Marcek, P.C., Las Vegas, NV

Defendant's Attorney: Anthony D. Lauria, Lauria Tokunaga, Gates & Linn, LLP, Las Vegas, Nevada

Whittacre v. Tait, No. 14A696438 (Clark County District Court of Nevada, April 6, 2017)

PEDIATRICS

28. \$4 Million Settlement In Suit Alleging Failure To Diagnose Kawasaki Disease

A five-month-old child was taken by his parents to a family physician to assess the child's fevers, increased fussiness, rash and red eyes. The family doctor sent the child to St. Mary's Hospital in Decatur, Illinois for an overnight stay, and then transferred the boy to St. John's Hospital in Springfield, Illinois, so that a pediatrician could rule out atypical Kawasaki disease, which was suspected due to his symptoms and blood test results. The child was admitted to the hospital under the care of a pediatrician affiliated with SIU Physicians and Surgeons. The pediatrician at St. John's performed an exam, but ordered no further testing and sent the child home after five hours, diagnosing a viral infection.

The parents continued to visit their family physician, and lab tests revealed that the child had elevated blood markers. He was admitted to OSF St. Francis Medical Center in Peoria, Illinois, where he was diagnosed with Kawasaki disease after undergoing an echocardiogram. The child had suffered several coronary aneurysms over the three coronary vessels of his heart. He was placed on intravenous immunoglobulin treatment and aspirin therapy. Subsequently, he suffered from stenosis and blockage of two of the three vessels.

Plaintiffs alleged that the delay in diagnosis worsened the baby's symptoms, and made treatment less effective.

General Injury: At age 4, the child's heart health was comparable to that of a 60-year-old man, the plaintiff's cardiologist stated. He will require lifelong care, observation and testing, and is at an increased risk for a heart attack, cardiac stenting, bypass or heart transplant

Result: \$4 million settlement.

Plaintiff's Expert Witnesses: Dr. Steven Shore, pediatric infectious disease, Atlanta, Ga.; Dr. Riva Kamat, pediatric hospitalist, Falls Church, Virginia; Dr. Kevin Ferentz, family medicine Baltimore, Md.; Dr. Michael Carr, pediatric cardiology, Chicago, Ill.; Jan Klosterman, life-care planning, St. Louis, Mo.; Lane Hudgins, accounting, damages, economics, Murphysboro, Illinois

Defendant's Experts Witness: Dr. Aaron Miller, pediatric infectious disease, St. Louis, Mo.

Plaintiff's Attorneys: Rachel L. Roman and David Zevan, Zevan and Davidson, St. Louis, Mo.

Defendant's Attorneys: Adrian Harless and Tyler Robinson, Heyl, Royster, Voelker & Allen, Springfield, Illinois

Anonymous v. v. SIU Physicians and Surgeons Inc., No. 14-L-82 (Macon County Circuit Court, Illinois Sept. 21, 2016)

29. \$1.9 Million Settlement In Suit Alleging Failure To Diagnose Leukemia

Plaintiffs alleged failure to diagnose an enlarged spleen secondary to acute leukemia when six-year-old W.P. presented with a grotesquely swollen abdomen on February 21, 2014. Plaintiff contended that that W.P.'s distended abdomen and history of three weeks of off and on' constipation, fever and muscle aches and wanting to sleep a lot required a complete exam. Plaintiff alleged that had Defendant satisfied the standard of care, W.P. would not have suffered a white blood cell clot in her spinal cord, which clot caused paralysis.

Defendant contended that, even if W.P. had an enlarged liver and/or spleen at the time of the February 21, 2014 appointment, a failure to detect that potentially enlarged liver and/or spleen did not fall below the standard of care. An enlarged spleen and/or enlarged liver can be difficult to pick up in a pediatric patient, particularly a new patient, even with a proper abdominal examination.

General Injury: Paralysis.

Result: \$1.9 million settlement.

Plaintiff's Expert Witness: Dr. Jeffrey Bomze, pediatrics

Defendant's Expert Witnesses: Wendy Chabot, M.D., pediatrician, Mass.; Debra Friedman, M.D., Director of the Pediatric Hematology/Oncology Division of the Vanderbilt University School of Medicine and professor of pediatric medicine; James Jarvis, M.D., Chief of Family Medicine Service and Director of Family Medicine Residency Program at Eastern Maine Medical Center and professor of osteopathic medicine

Plaintiff's Attorneys: Terrence D. Garmey, Christian C. Foster, Terry Garmey & Associates, Portland, ME

Defendant's Attorney: John Osborn, U.S. Attorney's Office, Portland, ME

Cash/Przybylski v. United States, No. 1:15-cv-00518-JAW (United States District Court, D. Maine March 2017)

RADIOLOGY

30. Defense Verdict In Suit Alleging Failure To Diagnose Lung Cancer

Ms. Murphy was a 72 year old woman who died in June 2009 of advanced lung cancer. She had a prior smoking history significant for 1 1/2 pack per day for 30 years duration.

In July 2004, Ms. Murphy underwent a chest x-ray

for complaints of a cough. The report indicated that a 2 mm x 4 mm nodular type density was identified in the right upper lobe, "possibly unchanged" when compared to a 11/02 chest x-ray which was unremarkable. The radiologist suggested a chest CT scan to clarify the finding.

On 8/17/04, Ms. Murphy underwent a chest CT scan which was reported as, "findings most compatible with a small area of scarring in the RUL." The radiologist noted that an early malignancy could not be excluded. A three month follow up with chest CT scan was recommended.

On 11/1/04, a follow up CT scan was done and reported by Dr. Tower as, "interval decrease in the size of previously demonstrated irregular density in the RUL consistent with resolving inflammatory changes and possible residual scarring. Probable 3 mm nodule in the lateral aspect of the inferior right upper lobe laterally unchanged." Dr. Tower made no recommendations for a follow up study.

The medical records did not indicate that any additional chest imaging studies were done for over 3 1/2 years, until June 2008, at which time Ms. Murphy was sent for imaging to work up new onset back pain. A chest x-ray done on 6/5/08 showed, "irregular opacity overlying the right upper mid lung suspect for lung lesion." A CT scan was done on 6/17/08 and showed, "a new mass in the right upper lobe with irregular margins. Additional work up with PET CT on 6/24/08 showed metastatic disease in the spine, ribs and iliac bone. Ms. Murphy was diagnosed with stage IV, poorly differentiated non-small cell carcinoma. She underwent palliative chemotherapy and radiotherapy to the right chest wall but had further progression of her disease. She died on June 1, 2009.

According to the defense, the plaintiff underwent a number of imaging studies relevant to the 2004 study at issue. These included a chest x-ray dated January 8, 2000, read by Michael Owens, M.D., which showed evidence of mild COPD but no evidence of any acute process; a chest x-ray dated November 26, 2002, read by Paul Tower, M.D., which showed no evidence of any acute pulmonary disease; a chest x-ray dated July

30, 2004 which was compared to the November, 2002 examination and was read by Elizabeth Cua, M.D., and showed a small, nodular type density, right upper lobe, possibly unchanged, with a CT scan recommended; and a CT scan dated August 17, 2004 read by Kenneth Peele, M.D., which showed findings most compatible with a small area of scarring in the right upper lobe. A 3 month follow-up CT scan was recommended. Dr. Tower interpreted a CT scan on November 1, 2004 and found that such “showed an interval decrease in size of the previously demonstrated irregular density in the right upper lobe laterally consistent with the resolving inflammatory changes and possible residual scarring. Probable 3 mm nodule in the lateral aspect of the inferior right upper lobe laterally unchanged from the previous examination. Emphysematous changes. No other significant findings or interval change.”

Following Dr. Tower’s read, a chest x-ray on June 4, 2008 interpreted by Alan Pratt, M.D., showed an abnormal right lung or more likely, an anterior rib. Further views were recommended. A lordotic view x-ray was done on June 5, 2008, which was read by Dr. Tower and showed an “irregular opacity overlying the right upper mid-lung suspect for a lung lesion for which a CT scan of the chest is advised.” A CT scan from June 17, 2008 read by Dr. Elizabeth Cua showed a “new 2 cm mass, right upper lobe, with irregular margins worrisome for malignancy.” No enlarged nodes were seen. A CT guided biopsy of the right 10th rib on July 16, 2008, showed a poorly differentiated mucoepidermoid carcinoma.

General Injury: Death.

Result: Jury verdict in favor of defendant Paul S. Tower, M.D.

Plaintiff’s Expert Witnesses: Samson Munn, M.D., Radiologist, Lincoln, MA; Ron Allison, M.D., Radiation Oncology, Greenville, NC

Plaintiff’s Attorneys: Philip J. Crowe, Jr., Michael J. Harris, Crowe And Mulvey, L.L.P., Boston, MA

Defendant’s Attorneys: Peter C. Knight, Stephanie M. Simmons, Morrison Mahoney, LLP, Boston, MA

Graves v. Tower, No. 1181CV03524 (Middlesex

County Superior Court of Massachusetts, May 22, 2017)

31. Defense Verdict In Suit Alleging Negligence In Treating Brain Aneurism

This medical negligence claim alleged a failure to timely and appropriately treat 31 year-old, A’laa Walker’s giant brain aneurism in October 2012. Ms. Walker came under the care of Dr. David Bonovich, a neuro-interventional radiologist at Eden Medical Center, on the evening of Friday, October 19, 2012 after being diagnosed with a giant brain aneurism. The aneurism was at high risk for rupture and required treatment in the form of neuro-interventional stenting as soon as possible. Plaintiff alleged Dr. Bonovich admitted the patient to the hospital on Friday afternoon, but waited until Monday afternoon - nearly 72 hours later - to perform a diagnostic angiogram and then failed to properly determine the appropriate treatment course for the patient. As a consequence, Ms. Walker’s aneurism ruptured before she could be effectively treated resulting in her death and the death of her unborn fetus.

On October 12, 2012, A’laa Walker developed moderate to severe headaches and reported to the emergency department at Summit Medical Center in Oakland. She was 23 weeks pregnant and described right sided headaches which were associated with vomiting. She had a normal neurologic examination and the headaches were attributed to her pregnancy. She was discharged with nausea medication.

Ms. Walker continued to suffer from the same headache in the following days. On the night of October 16, 2012 and early morning of October 17, 2012, Ms. Walker’s headache worsened. Ms. Walker’s mother, Joyce Rawlins, brought her to the Summit ER where she checked in at approximately 1:42 a.m. Ms. Walker was triaged at 3:00 a.m. and described headaches which were 10/10 in severity. She was given morphine for pain and Reglan for vomiting. The medications improved her symptoms, but did not fully resolve the headache. She underwent a neurologic examination

which was normal. She was discharged home at approximately 8:00 a.m.

On October 19, 2012, Ms. Walker developed visual disturbances. Her right eyelid drooped and she had a disconjugate gaze. She went to the emergency room at Alta Bates Medical Center where she underwent an emergent non-contrast CT brain scan. The scan revealed a 2.2 cm cerebral aneurysm (i.e. a “giant aneurism”). Dr. James Hirschberg, a neurologist at Alta Bates, consulted on the case and recognized that the patient needed urgent transfer for a higher level of care.

Dr. Hirschberg contacted Eden Medical Center and spoke to defendant, Dr. David Bonovich to arrange transfer. Dr. Bonovich had limited experience treating patients with giant aneurisms and had never treated a patient with an aneurism as large as Ms. Walker’s. Nonetheless, Dr. Bonovich agreed to accept Ms. Walker as a patient to provide her with definitive surgical intervention for her aneurism.

Dr. Bonovich directed Dr. Hirschberg to order a brain MRI/MRA emergently at Alta Bates. The MRI/MRA was performed on an emergent basis and confirmed the presence of a giant aneurism. Immediately following the MRI/MRA, Ms. Walker was transferred by ambulance to Eden Medical Center where she arrived at approximately 6:30 p.m.

By 7:10 p.m. on Friday night October 19th, Dr. Bonovich had personally reviewed Ms. Walker’s MRI/MRA studies and made the determination that she had an unruptured giant aneurism (i.e. that her aneurism had not bled). He examined the patient and took a history of her symptoms that night. Dr. Bonovich confirmed during his history and physical that Ms. Walker’s symptoms had progressively worsened over a period of 7-10 days.

Given the development of her symptoms and nature of her radiologic findings, he suspected that her giant aneurism was growing - and therefore at high risk of rupture.

Dr. Bonovich decided on the night of October 19, 2012 that the first step in Ms. Walker’s definitive treatment plan was a diagnostic angiogram. Eden was

equipped to perform the angiogram on the night of October 19 or the following day. However, Dr. Bonovich did not schedule the angiogram emergently or even urgently. Instead, he admitted Ms. Walker to the hospital, ordered morphine for her pain and directed nurses to perform neurological checks. The patient did not receive definitive neurologic care on Saturday, October 20 or Sunday, October 21.

On Monday, October 22, 2012 Dr. Bonovich performed a diagnostic cerebral angiogram for Ms. Walker. The angiogram revealed that the aneurism had grown in size since the patient’s admission and now measured 2.4 cm x 2.3 cm x 2.2 cm. After completing the angiogram, Dr. Bonovich determined that Eden Medical Center did not have the necessary surgical facility to treat the aneurism.

On Tuesday, October 23, 2012 Dr. Bonovich contacted facilities in an effort to transfer Ms. Walker. He contacted UCSF and then Kaiser Redwood City, which agreed to accept Ms. Walker in transfer. An ambulance was called and Ms. Walker was driven from Oakland to Redwood City. Ms. Walker arrived at Kaiser at approximately 8:44 p.m. on October 23. Kaiser planned a team meeting the following morning to decide on a treatment plan for the patient, but the notes reflected that they were considering treatment with placement of a Pipeline Stent.

At approximately 11:00 p.m., Ms. Walker’s aneurism ruptured. She became non-responsive and started twitching. A full code was called and the patient was rushed to the surgical room for emergent treatment. Maximum life-saving procedures were provided including surgical placement of a ventricular drain, but the damage caused by the rupture was too severe.

Ms. Walker was declared brain dead the following day. She was kept on a ventilator for three days in an effort to save the 24 week-old fetus she was carrying. On October 28, 2012, physicians lost the fetal heart-beat and the fetus was delivered stillborn.

General Injury: Death.

Result: Jury verdict in favor of defendant David Bonovich, M.D.

Plaintiffs' Expert Witness: Dr. Avery Evans, interventional neuroradiologist and neurosurgeon, University of Virginia

Defendant's Expert Witnesses: Robert Dodd, M.D., Ph. D., cerebrovascular neurosurgeon, Stanford; Laurence Shuer, M.D., neurosurgeon, Stanford

Plaintiff's Attorneys: Michael A. Kelly, Conor M. Kelly, Walkup, Melodia, Kelly & Schoenberger, San Francisco, California

Defendant's Attorneys: Ronald Goldman and Mary Sackett of the Goldman Law Firm

Doty v. Bonovich, No. RG14738936 (Alameda County Superior Court of California, February 16, 2017)

REHABILITATION

32. Defense Verdict In Suit Alleging Negligent Discharge

Samuel Taub, age 91, resided independently in his own apartment. In April and May of 2011, he had been checked into the Hampton Post Oak for a short stay to receive physical therapy following a hospitalization for chest pain, acute renal failure, and urinary retention. During his short stay at Hampton Post Oak, during which time he was under the care of Defendant Dr. Victor Narcisse, Samuel Taub was prescribed with numerous psychotropic medications which he did not normally take.

Plaintiff alleged that Samuel Taub became dehydrated and contracted a serious infection which was evident in bloodwork done, but left uncultured and untreated for at least a period of five (5) days before he was discharged from the facility on May 16, 2011 without the infection having been treated at all.

The next day, May 17, 2011, Plaintiff Ellen Taub had to call an ambulance to take her father, Decedent Samuel Taub, to St. Luke's Hospital where he was immediately placed into ICU. Samuel Taub died shortly thereafter on May 27, 2011, of "urosepsis," and kidney

failure as an alleged result of the failure of the Defendants' to treat his infection.

Plaintiff contended that Defendant, Dr. Narcisse, deviated from the standard of care as follows by prescribing multiple medications, and over-medicating Mr. Taub, failing to reassess the drug-drug interactions and monitor changes in condition, and discharging the patient with an elevated WBC consistent with infection and probably UTI with sepsis.

Defendant denied any violations of the standard of care.

General Injury: Death.

Result: Jury verdict in favor of defendant Victor Narcisse, M.D.

Plaintiff's Expert Witness: Harvey Gross, M.D., Dr. Keith Xavier

Defendant's Expert Witnesses: Stacey L. Hail, M.D., Emergency Medicine, Dallas, TX; Brian J. Miles, M.D., Urology, Houston, TX; Robert E. Jackson, MD, Internal Medicine, Houston, TX

Plaintiff's Attorney: Nicola Thompson Drake, The Drake Law Firm PC, Houston, Texas

Defendant's Attorneys: Richard M. Law, Rainy D. Gibbs, Law Feehan Adams LLLP, Houston, Texas

Taub v. Narcisse, No. 2013-41311 (Harris County Judicial District of Texas, April 20, 2017)

SURGERY

33. Defense Verdict In Suit Arising From Spinal Surgery

On January 31, 2007, plaintiff underwent an anterior lumbar interbody fusion at the L5-S1 level performed by defendant, Sagi Kuznits, M.D. When plaintiff awoke in recovery, he was in excruciating pain. After ongoing continued complaints and deficits, a CT scan was ordered several days after the surgery. The CT scan revealed multiple abnormalities. Additionally, following the surgery, plaintiff had issues concerning vision of his right eye.

Plaintiff alleged that Dr. Kuznits was negligent and deviated from the accepted standard of care in his failure to properly review and interpret Mr. Bashore's preoperative diagnostic studies and obtain a proper diagnosis of Mr. Bashore's problem. The MRI performed on November 16, 2006 demonstrated moderate to severe bilateral neural foraminal stenosis at L3-4. There was also mild central spinal stenosis. At L4-5, there was also moderate right and mild left neural foraminal stenosis. At L5-S1, there was also bilateral lateral recess and neural foraminal stenosis.

Prior to seeing Dr. Kuznits, Mr. Bashore had been evaluated by Dr. Howard Richter, a neurosurgeon. Dr. Richter reviewed the MRI and noted the degenerative conditions. In Dr. Richter's opinion, Mr. Bashore had discogenic pain secondary to discs at L3-4 and L4-5 with herniations at those two levels. It was clear that Mr. Bashore had multilevel lumbar degenerative disc disease. Plaintiff alleged that, given Mr. Bashore's preoperative condition, a posterior lumbar decompression and fusion extending from L3-S1 should have been performed by Dr. Kuznits. Plaintiff alleged that the anterior lumbar interbody fusion was not indicated and, therefore, was a deviation from the standard of care. Plaintiff also alleged that the interbody cages that were inserted by defendant were improperly positioned causing a fracture of the inferior endplate of L5 with bone fragments projecting posterior to the left with retropulsion into the left lateral recesses impingement on the left S nerve. As a direct result of the allegedly improperly placed cage at L5-S 1, Mr. Bashore suffered an injury to the L5 and S1 nerve root. Because of the injury, a posterior lumbar decompression and fusion was done on February 5, 2007. This procedure required nine and a half hours in the prone position which caused ischemic optic neuropathy causing vision problems as well for Mr. Bashore.

Defendant denied any violations of the standard of care.

General Injury: Mr. Bashore has problems with his vision as well as permanent restrictions to sedentary work.

Result: Jury verdict in favor of defendant.

Plaintiff's Expert Witness: Sanford Davne, M.D., Orthopedic Surgeon, Newtown Square, PA

Plaintiff's Attorney: Thomas F. Sacchetta, Sacchetta & Baldino, Media, PA

Bashore v. Kuznits, No. 2009-02086 (Montgomery County Court of Common Pleas of Pennsylvania, March 2, 2017)

34. Defense Verdict In Suit Arising From Laparoscopic Cholecystectomy

On May 28, 2009, Ms. Lindsey Barr ("Plaintiff" or "Ms. Barr") underwent a laparoscopic cholecystectomy to remove her gallbladder and gallstones, performed by Dr. Douglas Cook. On March 26, 2014, Ms. Barr was rushed to the emergency room at St. Agnes Medical Center with severe, sharp abdominal pain, sweats with pain, and vomiting. Tests revealed that she had gallstones and that her gallbladder had not been removed. An emergency cholecystectomy was performed the following day during which the gallbladder and gallstones were removed.

Result: Jury verdict in favor of defendant.

Plaintiffs Expert Witness: Lawrence Way, M.D., General Surgery, San Francisco, California

Defendant's Expert Witness: Kenneth B. Deck, M.D., F.A.C.S., general surgery, Laguna Hills, CA

Plaintiff's Attorney: Vonn R. Christenson, Christenson Law Firm, LLP, Porterville, California

Defendant's Attorneys: Dennis R. Thelen, Kevin E. Thelen, Law Offices of Lebeau • Thelen, LLP, Bakersfield, California

Barr v. Cook, No. 14 CE CG 03917 (Fresno County Superior Court of California, April 25, 2017)

35. Defense Verdict In Suit Arising From Sclerotherapy Embolization

This is a medical negligence case brought by Sara Nelson against the State of Washington through the University of Washington Medical Center. Plaintiff, a 28-year-old escrow closer, alleged that Dr. Meissner and Dr. Vaidya to properly perform a sclerotherapy embolization of the fourth digit of Ms. Nelson's right hand. Plaintiff alleged that this failure caused Ms. Nelson's finger to become gangrenous. Ms. Nelson had the majority of her fourth digit on her right hand amputated. After amputation of the gangrene, the remainder of her finger and hand was sutured to her groin for three weeks to preserve blood flow.

Plaintiff had a past medical history of congenital venous malformations occurring on her back, arms, and hands and right ring finger. She previously had her venous malformations on her back treated with laser therapy with success during her childhood.

In early 2013, Ms. Nelson was evaluated by a plastic surgeon at Harborview Medical Center who specialized in cranio-facial plastic reconstruction for potential surgical excision of a venous malformation on her fourth digit of her dominant right hand. He referred her to University of Washington Medical Center for a consultation on whether she would be a candidate for embolization of her venous malformation. Ms. Nelson was evaluated by Dr. Sandeep Vaidya at the University of Washington Medical Center Vascular Anomalies clinic on January 29, 2013. Dr. Vaidya explained to Ms. Nelson that sclerotherapy was a simple injection done under anesthesia, and that she would be able to return to work the next day. He indicated that the worst outcome Ms. Nelson could have associated with the procedure would be swelling of her finger. Ms. Nelson agreed to the procedure, which took place on May 14, 2013.

The defense argued that Drs. Meissner and Vaidya acted in accordance with the standard of care.

General Injury: Amputation of a portion of Ms. Nelson's ring finger.

Result: Jury verdict in favor of defendants Mark Meissner, MD and Sandeep Vaidya, MD

Plaintiff's Expert Witnesses: Dr. Brian Parrett, hand surgeon, Sutter Pacific Medical Foundation in San Francisco, California; Dr. Darwin Eton, vascular surgeon; Dr. Scott Resnick, interventional radiologist, Northwestern Memorial Hospital in Chicago, Illinois.

Plaintiff's Attorney: Jessica Holman Duthie, Holman Law, PLLC, Tacoma, WA

Defendant's Attorney: Bruce W. Megard, Jr., Law Offices, Bennett Bigelow & Leedom, P.S

Nelson v. State of Washington, No. 15-2-06079-1 SEA (King County Superior Court of Washington May 26, 2017)

36. Defense Verdict In Suit Alleging Negligence In Treating Patient's Pancreatitis

On 4/11/11, Doris Mzid died at age 59 from complications related to pancreatitis, namely, abdominal compartment syndrome and subsequent multisystem organ failure (renal and hepatic failure, ARDS, ischemic bowel injury).

On 4/8/11 at approximately 6:47 p.m., Ms. Mzid presented to MetroWest Medical Center with severe, 10 out of 10 abdominal pain. Dizziness, weakness, nausea and vomiting were also noted. She had no significant past medical history, although there was a question of a remote history of alcohol abuse. Her vitals at 7:00 p.m. were blood pressure 121/79, pulse of 73, respiratory rate of 18, temperature of 97, and pulse ox of 96% on room air. An EKG was noted to be borderline showing her in normal sinus rhythm with no acute ST-T wave changes, PR interval of 118, QT interval of 474, and QRS duration of 100. Lab results included a lipase of 1968(k) (n1 0-60), as well as a WBC of 5.4, hemoglobin of 14, hematocrit of 41.6, platelets of 298, sodium of 141, potassium of 3.4, chloride of 97, bicarb 29, glucose of 175, BUN of 15, creatinine of .61, GFR greater than 60, calcium 9.4, anion gap of 15, total protein of 7.0, albumin of 4.7,

total bilirubin of 0.6, AST of 48, ALT of 30, and ALK phos of 70. In the Emergency Department, Ms. Mzid (ht 5'4," 128 lbs) was administered fluids, Zofran, a GI cocktail, and Dilaudid.

She was diagnosed with pancreatitis and orders to admit to floor were given. An admission physical was performed by hospitalist and admitting physician, WolfWeiyang Wang, M.D. Upon examination, Dr. Wang noted that the ultrasound was pending but that the clinical picture was consistent with acute pancreatitis, likely alcohol induced. Her abdomen was noted to be soft, non-distended, tender to palpation at upper abdomen, without guarding or rebound. Ms. Mzid was made n.p.o., with orders to continue IV fluids, and continue nausea, vomiting and pain control. She was to be "monitored very closely for any signs of a complicated pancreatitis, especially if [she] becomes hemodynamically unstable."

At 9:34 p.m. she was administered Unasyn 1.5 mg. A right upper quadrant ultrasound showed a small amount of free fluid, mild dilatation of the intrahepatic bile ducts, thickened gall bladder wall and small amount of edema surrounding the gall bladder, and moderately dilated common bile duct. With respect to the pancreas, the head, neck and body of the pancreas appeared normal and the rest was obscured by bowel gas. The cause of the moderately dilated bile duct was not identified as the distal portion was obscured by gas.

At 11:00 p.m., Dr. Wang ordered a GI consult noting that she had a dilated common bile duct and needed further testing. At 11:51 p.m. she was noted to be lethargic and slow to respond.

On 4/9/11, on or around 12:53 a.m., she was transported from the Emergency Department to the floor. At 1:40 am, her vitals were blood pressure of 102/64, respiratory rate of 20, pulse of 99, pulse oximetry of 95% on 2L, and temperature of 98.5. She was given 2 mg of Dilaudid for 10 out of 10 abdominal pain.

On 4/9/11 at 1:50 a.m., a call was placed to Gastroenterologist, Khalid Aziz, M.D. requesting a consult. At 2:00 a.m., Ms. Mzid was noted to be lethargic, restless and slow to respond. Her abdomen was noted to be non-distended. She was on alcohol withdrawal

precautions. On or around 5:30 a.m. she was given another 2 mg of Dilaudid for severe pain. IV fluids were maintained at 75 cc/hr and no urine outputs are recorded in any of the nursing charting done in the early morning and morning of 4/9/11.

On the morning of 4/9/11, on or around 7:30 a.m., her vitals were blood pressure of 90/52, pulse of 100, respiratory rate of 24, and pulse oximetry of 95% on 2L. Nursing noted that Dr. "Krisnah" was aware of her low blood pressure and elevated heart rate. Ms. Mzid was still noted to be sedated and drowsy.

Despite her low blood pressure, and elevated heart rate, when compared to her admission numbers, and severe pain, Ms. Mzid was not evaluated by a physician on the morning of 4/9/11. There are no orders for bolus IV fluids to be given for the hypotension or elevated heart rate that was documented in the nurses notes at 8:09 a.m. on 4/9/11. Dr. Krishnaprakash noted in the discharge summary after transfer, that he saw Ms. Mzid at 8:00 a.m. and that she was resting comfortably so they planned to reevaluate her, presumably at a later time. There were no progress notes documenting a physician visit from the time she arrived on the floor on or around 1:00 am. until sometime around 12:12 p.m. when she was found by nursing to be profoundly hypotensive with marked respiratory distress leading to the Rapid Response Team (RRT) being called to her bedside. The RRT did not document any interventions being taken other than notifying Dr. Krishnaprakash at 12:12 p.m.

Once seen by Dr. Krishnaprakash, between 12:15 p.m. and 12:30 p.m., Ms. Mzid was put on a rebreather mask, given a liter bolus of normal saline over 2 hours and one dose of Narcan was administered. The Narcan was given for possible opiate overdose. Ms. Mzid was transferred to the ICU at or around 12:50 p.m.

In a note timed 12:30 p.m., gastroenterologist, Dr. Aziz noted that Ms. Mzid's pulse was 104, blood pressure 78/52, and oxygen sat 80-92% on 100% rebreather. Her pulse on cardiac monitoring was noted to be 116. At that time her abdomen was noted to be massively distended and markedly tender to touch. His assessment was acute pancreatitis, peritonitis, hypoten-

sion, and hypoxia. Dr. Aziz noted that most probably she had gallstone pancreatitis although no gallstones were seen. He noted that she had deteriorated since admission with hypotension, respiratory distress and worsening abdominal pain with signs suggestive of peritonitis. He questioned the possibility of perforated viscus, massive fluid third spacing, and abdominal compartment syndrome. He indicated that Ms. Mzid needed fluid resuscitation, pressors, chest x-ray to rule out perforation, antibiotics, IV PPI, intra-abdominal pressure (IAP) to rule out compartment syndrome, and abdominal CT.

The critical care team was identified as attending Dr. Alan Fine, Resident Dr. Bonilla, and Intern Dr. Papakosaj. Critical care orders at 12:50 p.m. included an order for an abdominal CT with contrast, but the order was not for a STAT abdominal CT and there was no order for measurement of IAP.

At 12:51 p.m. her pulse was noted to be 115 and her blood pressure was 94/32. At 12:54 p.m., her blood pressure was 84/27, and her pulse rate was 111. A blood gas drawn around this time showed Ms. Mzid to have a base deficit of -7, primarily on the basis of increased pCO₂, implying hypoventilation. At 1:05 p.m. her blood pressure was 71/54. Her oxygen was increased. At 1:33 p.m. she had a pulse of 105, blood pressure of 65/33, and respiratory rate of 12, and pulse oximetry of 95% on NRB. A Foley urinary catheter was placed just after 1:30 p.m. but never used for measurement of intra-abdominal pressure, although the need to assess that is mentioned several times in the record. Being that a “homemade” system can utilize the standard 2-way Foley to measure bladder pressure with a readily available arterial line transducer, it is unclear why Ms. Mzid had to be transferred to a higher level of care to have the IAP assessed, it was alleged.

In a nursing note timed 1:48 p.m., Ms. Mzid was noted to have been transferred from 2nd floor in acute respiratory distress with a respiratory rate ranging from 10-16, and a blood pressure in the 60's. She was on 100% and 6L NC with an oxygen saturation of 96% but still complaining of air hunger. Her abdomen was noted to be distended, firm and very tender to touch.

This assessment was confirmed by Dr. Fine, who described the abdomen as rigid and having peritoneal signs. She was on IV fluids wide open and was still hypotensive.

Due to hypotension not adequately responsive to IV fluids, Ms. Mzid was started on phenylephrine drip, and then Levophed, and Dr. Alan Fine, pulmonology/critical care physician, was notified. Dr. Douglas Peebles (Anesthesia) was consulted for intubation, although Dr. Peebles note states that he was asked only to “help with the A-line.” According to nursing, intubation was deferred but an A-line was placed with some difficulty due to low blood pressure.

Abdominal x-ray done around 1:30 p.m. demonstrated a dilated transverse colon, gaseous distention of the stomach, large amount of stool within the ascending and descending colon, no definitive free air, and bilateral densities reflecting a combination of pleural fluids and atelectasis.

Chest x-ray (report transcribed at 2:07 p.m.) showed focal density at the right lung base consistent with large pleural effusion and adjacent atelectasis, and a lucency following the contour of the right hemidiaphragm. Free air could not be excluded.

A central line was placed by a surgical resident around 2:00 p.m., and a NG tube was placed as well. Central line placement was confirmed by x-ray. Dr. Aziz came in to see the patient. Ms. Mzid's blood pressure was still low and Levophed was started.

Upon examination (untimed) by Dr. Alan Fine, Ms. Mzid was noted to have no bowel sounds, diffuse tender abdomen, which was rigid and positive for peritoneal signs. Her extremities were noted to be cold. Dr. Fine's recommendations included STAT CT scan, surgical consult, antibiotics and IV PPI. The order for the IV PPI at was written at 4:00 p.m.

Ms. Mzid had an extended period of hypotension throughout the afternoon despite pressor support.

Ms. Mzid was seen by surgical resident, Christopher Dodgion, M.D. in the afternoon and he authored a note timed at 3:00 p.m. The abdominal CT scan was noted to be pending. Dr. Dodgion noted that Ms. Mzid had

increased tenderness to palpation, with voluntary but no involuntary guarding. He noted Ms. Mzid's steadily increasing serum creatinine since admission. Dr. Dodgion's assessment was that pancreatitis was less likely due to the ultrasound of the pancreas showing no abnormalities. Recommendations from surgery included CT scan to further evaluate for perforated viscus, and aggressive resuscitation. According to the surgical note, the "plan was discussed with Dr. Moradi who agreed." No IAP was obtained by surgery. Her ABG drawn at 3:35 p.m. revealed a PH of 7.05 and a PCO₂ of 66.

At 4:00 p.m. Ms. Mzid was intubated for profound respiratory acidosis and hemodynamic instability by Dr. Peebles.

Ms. Mzid was taken to CT scan at or around 4:30 p.m. The abdominal CT scan revealed complete collapse of the right lower lobe, and a portion of the middle lobe as well as a large portion of the left lower lobe. It was noted that pneumonitis could not be excluded. CT scan also showed a small amount of pericardial fluid or pericardial thickening; small to moderate volume ascites with a large amount of fluid surrounding the pancreas which is nonspecific but can be seen with pancreatitis; no free air; segmental mural thickening involving the jejunum extending from the level of the ligament of Treitz. Radiology noted that while this is nonspecific it can be seen in the setting of inflammatory and ischemic causes of enteritis. Radiology findings were discussed with Dr. Fine.

Results were reviewed by house staff, surgical resident and Dr. Fine. At or around 5:00 p.m., Ms. Mzid's right hand was noted to be colder and darker. House staff and surgical resident were in to see Ms. Mzid. The A-line was removed by house staff.

At 5:30 p.m., in an addendum to the surgical consult, Dr. Dodgion noted that there was no free air on CT scan and no need for surgical intervention at this time. He also noted however that there were slightly elevated peak respiratory pressures, that they could not rule out compartment syndrome, and that Ms. Mzid may need to be transferred to higher level of care where they could measure bladder pressures.

At 5:33 p.m., Ms. Mzid's PH was 7.15. Her picture was now one of mixed respiratory and metabolic acidosis, suggesting the onset of intestinal ischemia given her worsening abdominal exam.

Decision was made to transfer Ms. Mzid to Finard ICU at Beth Israel Deaconess Hospital (B.I.) via Boston MedFlight. In a note timed 5:51 p.m., respiratory therapist Maura Mann noted that Ms. Mzid will be transferred to B.I. per Dr. Fine and that she will need surgery due to compartment syndrome and pancreatitis. There was also a concern over the placement of her A-line which was repositioned.

At 7:53 p.m. it was noted that patient was to be transferred to B.I. soon. The Boston MedFlight team noted Ms. Mzid's bladder pressure was up to 200 mm Hg. Ms. Mzid was detoured to the emergency department at B.I. for evaluation for emergency surgery. Her diagnoses upon arrival at B.I. were shock, pancreatitis and abdominal compartment syndrome. She had profound hemodynamic instability in the setting of severe pancreatitis. Her abdomen was noted to be firm, tense, dilated, distended, diffusely tender with severe guarding and brawny edema. Her skin was cool and she had mottled extremities. She was anuric.

The O.R. was set up at 9:47 p.m., and Ms. Mzid was taken to the OR for emergent decompressive laparotomy. Surgical incision time was noted to be 10:17 p.m. Surgical findings included a tremendous amount of pressure within the abdominal cavity when the peritoneum was opened, dusky of the entire intestine with the descending colon and ascending colon seeming to be more dusky, amber colored fluid within the abdominal cavity, heavily edematous retroperitoneum, a kidney that looked almost black with edema within Gerota's fascia, and edema in front of the pancreas as well.

Post-operatively, Ms. Mzid continued to require 3 pressors and had serum lactate levels ranging from 6 to 9. She had rising LFTs which were consistent with shock liver and her abdominal pressures continued to be in the upper twenties despite her open abdomen.

On 4/11/11, Ms. Mzid was taken back to the O.R. and she was found to have ischemia of her entire colon,

ileum and large segments of the jejunum. Ms. Mzid underwent excision of her colon, the majority of the small bowel, and debridement of a small area of necrotic pancreas. She was made comfortable with measures only and passed at 4:19 p.m.

Gross findings at autopsy performed at B.I. were significant for necrosis of the remaining small bowel, central necrosis of the liver and hemorrhagic necrosis of the pelvic organs, all consistent with compartment syndrome and subsequent hypotension/shock, as well as pleural and pericardial infection with sepsis.

General Injury: Death.

Result: Jury verdict in favor of Jayanthi Krishnaprakash, M.D. and Christopher Dodgion, M.D.

Plaintiff's Expert Witness: Charles Goldman, M.D., Surgery, West Des Moines, IA

Defendants' Expert Witnesses: Jeffrey M. Rothchild, M.D., MPH, internal medicine and critical care medicine, Newton, MA; Eric D. Libby, M.D., gastroenterology, Winchester, MA; Stephen J. Ferzoco, M.D., general surgery and specialization in gastrointestinal surgery, Dedham, MA; Christopher Dodgion, M.D., general surgery and critical care surgery, Milwaukee, WI; Nicholas S. Hill, M.D., Internal Medicine, Boston, MA; Kevin F. O'Donnell, M.D., surgeon, Boston, Massachusetts

Plaintiff's Attorneys: Andrew C. Meyer, Krysia J. Syska, Lubin & Meyer, P.C., Boston, Massachusetts

Defendants' Attorneys: Edward T. Hinchey, Timothy B. Sweetland, Sloane and Walsh, LLP, Boston, Massachusetts (for Jayanthi Krishnaprakash, M.D., VHS Acquisition Subsidiary Number 9, Inc. D/B/A/ Metrowest Medical Center, and Christopher Dodgion, M.D.); James J. Barry, McCarthy, Bouley, Barry & Morgan, P.C., Waltham, Massachusetts (for Alan Fine, M.D.); Peter C. Knight, Morrison Mahoney, LLP, Boston, Massachusetts (Iradj Moradi, M.D.)

DiPadua v. Krishnaprakash, No. 1481CV01776 (Middlesex County Superior Court of Massachusetts May 4, 2017)

MOTOR VEHICLES

37. \$1.265 Million Settlement In Suit Against California Highway Patrol For Leaving Tow Truck Driver Without Protection

On Jan. 28, 2014 at 1 a.m., two California Highway Patrol officers pulled over a motorist on Cedar Avenue near the 10 freeway in Bloomington and arrested him for driving under the influence. The officers called for a tow truck to impound the vehicle, and Ricardo Valdez, 39, responded to that call. Because the vehicle to be impounded was located in a lane of traffic, Valdez had to load the vehicle on to his flatbed tow truck in that location. While loading and securing the vehicle, a drunk driver, defendant Maria Ochoa, struck Valdez who suffered fatal injuries.

Plaintiffs are the decedent's mother (age 66 at the time of the settlement) and two daughters, who are 10 and 15 years old.

Plaintiff's Contentions: The video footage from the CHP vehicle showed that, approximately three minutes after Valdez arrived on scene, the officers left with the suspect. Valdez had to finish loading and securing the suspect's vehicle with no traffic control in place. Approximately 10 minutes after the officers left, Ochoa traveled down Cedar Avenue towards Valdez' location. At that moment, Valdez was at the rear of the tow truck, performing the final steps of securing the car to the bed of the truck. Ochoa testified that she was following another car in front of her, that the other car suddenly swerved to the left and that she applied her brakes, but she could not stop in time. Valdez was crushed between the front of Ochoa's car and the rear of the tow truck and was declared dead a few hours later.

Plaintiffs contended that because the CHP officers called Valdez to the scene and placed him in harm's way, as he was in the middle of an active traffic lane, they had a special relationship with him and owed him a duty to provide reasonable protection. The officers

breached that duty by leaving the scene promptly after Valdez' arrival. The CHP's own procedures regarding special relationships allow the officers to leave only if there is an emergency elsewhere, they have been relieved by other law enforcement officers or they have been ordered to leave by a superior officer.

Plaintiffs contended that had the officers stayed on scene, with their vehicle parked behind the suspect's vehicle, the drunk driver would have, at worst, struck the rear of the CHP vehicle and caused some property damage. Valdez would have been uninjured.

Defendants' motions for summary judgment on this issue were denied after the tentative ruling was in their favor.

Defendants contended that there was no special relationship between the officers and Valdez and that getting struck by a motorist is simply an inherent risk of working as a tow truck driver. Defendants also contended that most or all of the fault for the crash rested with Ochoa, the drunk driver, who had consumed two shots of tequila and four to five beers at the bar where she worked. Ochoa fled the scene after the crash, and when the police finally tested her blood alcohol level approximately eight hours later, it was .08 percent. Defendants' toxicologist opined that her BAC would have been approximately .21 percent at the time of the crash. Defendants argued that it was Ochoa's intoxicated condition that prevented her from seeing and avoiding the bright, flashing lights of the tow truck, which were visible from 350 feet away.

In addition, defendants contended that the officers had a legitimate reason to leave the scene because Valdez allegedly told them he did not need their assistance and because their CHP office was shorthanded that night. Defendants argued that Valdez' employer bore a significant share of the fault because he allowed Valdez to perform towing operations for the CHP without having obtained CHP certification. Defendants' tow truck expert opined that it was unsafe for Valdez to stand at the rear of his truck to secure the suspect's car and that the safer practice was to perform that task from the side of the truck.

General Injury: Death.

Valdez lived with his mother at the time of the incident. Plaintiffs contended that the mother was financially dependent on her son, on account of the \$300 per month that he contributed towards the mortgage payment, and that this established her wrongful death standing under CCP 377.60(b). Defendants disputed that there was financial dependence, and this likely would have been an issue for the jury at trial.

Valdez had not lived with his daughters since 2008 and was never married to their mother. However, he did see his daughters almost every day. Because Valdez earned just over minimum wage and because it would have been extremely difficult to estimate the amount of money that he contributed to his daughters, plaintiffs chose not to seek economic damages. The only damages sought at trial would have been non-economic damages for the loss of plaintiffs' relationship with the decedent.

Result: \$1,265,000 settlement.

At the mediation, the CHP agreed to pay \$1,250,000 to settle the case, and plaintiffs agreed to dismiss the individual officers. Of the total settlement amount, \$100,000 was allocated to decedent's mother and \$575,000 each to decedent's two daughters. The children's money is being placed into annuities, which will pay out \$670,000 to the elder daughter and \$707,000 to the younger daughter over the course of the next 30 years. Prior to the mediation, the insurance carrier for the drunk driver, Ochoa, agreed to pay its \$15,000 policy limits. This money was used to resolve the entire workers' compensation lien, which totaled \$278,438.

Plaintiffs' Expert Witnesses: Charles Dickerson, accident reconstruction, Mesa, Ariz.; Jesse Enriquez, tow truck standards, Los Angeles; Mark S. Sanders, Ph.D., human factors, Encino, Cal.; Alvin Yamaguchi, law enforcement practices, Chino Hills, Cal.

Defendant's Expert Witnesses: Stein Husher, M.S., accident reconstruction, Camarillo, Cal.; David Krauss, Ph.D., ergonomics/human factors, Los Angeles; Arlan White, tow truck standards, Colton, Cal.; Craig Klein, law enforcement practices, Moopark, Cal.; Richard J. Geller, M.D., toxicology, Fresno, Cal.

Plaintiffs' Attorneys: Roger E. Booth, Carly L. Sanchez of Booth & Koskoff, Torrance, Cal.

Defendant's Attorneys: Heather E. Paradis, Lee H. Roistacher, Daley & Heft LLP, Solana Beach, Cal. (for CHP); William L. Cummings, James J. McGarry, McGarry & Laufenberg, El Segundo, Cal. (for individual CHP officers)

Valdez v. State of California, et al., No. CIVDS1416659 (San Bernardino Cty. Superior Ct. Cal. March 1, 2017)

38. \$1.375 Million Verdict In Suit Arising From Injuries Sustained By Good Samaritan

On May 14, 2013, the plaintiff, age 59, was acting as a good Samaritan who pulled up to a red light behind a car that had stalled in traffic unexpectedly. Other cars were going around the stalled vehicle and through the light; when the plaintiff reached it, he decided to stop to help. He put his vehicle in park and turned on his hazard lights. The plan was to push her vehicle a few feet to the right, on a shoulder area and out of traffic. As he was standing behind the vehicle ready to push it, his vehicle was rear-ended by an inattentive driver. This collision pushed his vehicle into him and pinned him between the two vehicles.

Defense argued liability, because the plaintiff could have moved his vehicle off to the shoulder. Defense also argued the plaintiff failed to mitigate his damages.

General Injury: Serious vascular injury (femoral artery, femoral vein and sciatic nerve) to the left leg. Surgeons were able to save the leg, but the recovery was complicated by infection and development of deep vein thrombosis in both legs. He also had a separate knee injury. He is left with chronic pain, swelling, fatigue of his legs. He also developed post traumatic depression and adjustment disorder.

Result: \$1,375,000 jury verdict, consisting of the following: Past medical expenses: \$250,000; Future medical expenses: \$250,000; Past wages: \$25,000; Past pain and suffering: \$500,000; Future pain and suffering: \$350,000.

Plaintiff's Attorneys: Benjamin Wagner and Molly Lavin, Habush Habush & Rottier S.C.

Defendant's Attorney: Rick E. Hills, Hills Legal Group Ltd.

Browarski vs. Country Preferred Insurance Company et al., No. 2016CV000189 (Milwaukee Cty. Cir. Ct. Wis. June 14, 2017)

PRODUCTS LIABILITY

AUTOMOTIVE PRODUCTS

39. Settlement In Suit Alleging Defective Airbag

Plaintiffs, Linda K. Thomas and Garold D. Thomas, were the owners of a 2007 Chrysler Town & Country, which they purchased used. On September 29, 2013, plaintiff Linda K. Thomas was driving the 2007 Chrysler Town & Country, with passenger Kristy Bolejack, eastbound on Hickman Road (US Highway 6) in Des Moines, Iowa. A westbound vehicle driven by Ms. Elizabeth Hines pulled into oncoming traffic while attempting a left-hand turn at the intersection of Hickman Road and 63rd Street (State Highway 28), and was struck by Ms. Thomas' vehicle. The inflatable knee blocker ("IKB") in the subject vehicle deployed during the accident.

Plaintiffs, Linda K. Thomas and Garold D. Thomas, filed this lawsuit against FCA US LLC. Plaintiffs' Petition asserts causes of action against FCA US for design defect, failure to warn and breach of implied warranty.

General Injury: Ms. Thomas sustained injuries to her left leg.

Result: Settled for an undisclosed amount.

Plaintiffs' Expert Witnesses: James Weaver, Mechanical Engineer, Jerry Hall, Mechanical Engineer, Ames Forensic Engineers, Ames, Iowa,

Defendant's Expert Witness: John Hinger

Plaintiff's Attorney: Jason S. Rieper, Rieper Law Office, Des Moines, IA

Defendant's Attorneys: Terrence C. Thom, Susan K. Allen, Stafford Rosenbaum LLP, Milwaukee, WI; Richard A. Stefani, Gray, Stefani & Mitvalsky, P.L.C., Cedar Rapids, IA

Thomas v. FCA US LLC, No. 4:15-cv-424 (United States District Court, S.D. Iowa March 2017)

40. Settlement In Suit Alleging That Pontiac Grand Am Was Uncrashworthy

This product liability case arose out of a motor vehicle accident that occurred on May 22, 2013 at the intersection of Headland Avenue and Murray Road in Dothan, Alabama. Ms. Bridgette Neal was driving her 2002 Pontiac Grand Am east on Murray Road approaching the intersection at Headland Avenue. At the same time, Bobby Etheridge was driving his 2005 Sierra pickup north on Headland Avenue. According to Ms. Neal, as she approached the intersection, her traffic light changed from red to green and she proceeded across the intersection. Ms. Neal was almost across the intersection when the two vehicles collided in the intersection. Ms. Neal's minor daughters, 13-year-old BB and 10 year-old ALB, were in the back of the car at the time of the wreck. All three occupants were wearing their seatbelts. The crash forces and the principle direction of force caused the occupants to move forward and toward the right front corner of the Grand Am.

Plaintiffs alleged that the Grand Am was manufactured by GM in such a way that the structural back of the seat where ALB was seated was made of plastic. During the crash, a flat tire in the trunk moved forward and broke through the plastic seat-back where ALB was seated. According to GM's Accident Reconstructionist Brent Benson, the tire impacted the rear seat-back at either 34 or 24 mph. ALB was caught between the intruding tire/seatback and her seatbelt. Following the crash, photographs taken while the vehicle was still at the scene reveal that the seat-back was displaced.

Closer inspection after the crash revealed that the lower anchor points of the plastic seat were completely broken.

ALB, who was removed from the rear seat by a City of Dothan police officer, was unconscious and required CPR at the scene. She was still wearing her seatbelt when Officer Kauffman removed her from the Grand Am. ALB had "a knot" on her back at the scene. Dr. James Johnston, a neurosurgeon at Children's Hospital in Birmingham, who operated on ALB to stabilize her broken spine, diagnosed ALB with an L1 flexion-distraction with spinal cord injury. Dr. Johnston testified her type injury is caused (1) by a blow to the back where the spinal bones push and hit the spinal cord, or (2) in a flexion/distraction injury, the spine was in a flexed position and could have been overloaded from the back.

General Injury: ALB is paralyzed and will live in a wheelchair for the rest of her life.

Result: Settled for an undisclosed amount.

Plaintiff's Expert Witnesses: Larry Sicher, seat design, Kelly Kennett, injury causation; Bryant Buchner, Accident Reconstruction

Defendant's Expert Witnesses: Michael E. Klima, P.E., Design Research Engineering; Brent R. Benson, Ph.D., P.E., Benson Engineering, L.C.

Plaintiff's Attorneys: D. Michael Andrews, Jere L. Beasley, J. Greg Allen, J. Cole Portis, Beasley, Allen, Crow, Methvin, Portis & Miles, P.C., Montgomery, Alabama

Defendant's Attorneys: Robert R. Baugh, Jaime C. Erdberg, Sirote & Permutt, P.C., Birmingham, AL; Brad J. Robinson, Hartline Dacus Barger Dreyer LLP, Dallas, Texas

Neal v. General Motors, LLC, No. 2:14-CV-00633-WKW-GMB (United States District Court, M.D. Alabama June 2017)

FORKLIFTS

41. Pallet Truck Manufacturer Not Liable For Worker's Injuries

Plaintiff was hired in June 2013 at Bozzuto's, Inc., a wholesale distributor in Connecticut. After a few days of orientation and safety training, he began work as a goods "selector." This work required him to use a pallet truck that was manufactured by defendant to move around the freezer area of the Bozzuto's warehouse, picking up loads of items and moving them to the warehouse bay doors, where they could be transferred to trucks for distribution.

The model of pallet truck operated by plaintiff was a Crown Equipment Corporation PE 3540-80. The truck has a pair of forks that extend to carry a pallet load. On the opposite side of the truck from these forks is a platform on which the truck's operator may stand. Facing that platform is the "control handle," which is used to operate the truck and to apply power by means of a hand-controlled throttle, which can be rotated in either direction to propel the truck forward or backward. The "control arm" in turn connects the control handle to the body of the truck. Next to the base of the control arm on the body of the truck is a "coast selector" switch. This is a manually activated switch for a "coasting" feature that allows the truck to coast or glide along without further application of power by the operator at the control handle. If the "coast selector" switch is not activated, then the truck will not glide or coast once an operator stops applying power.

Also on the main body of the truck, to the left of the control arm, is the "key switch," which is an ignition switch that uses a key in order to turn the truck "on" or "off" for operation. The truck is battery powered, and it has a "power disconnect" handle on the main body of the truck to the right of the control arm that can be used to cut the power to the battery. If the truck has been turned on at the key ignition switch, then its power can still be controlled by means of either plugging in or pulling out the power disconnect handle.

On June 20, 2013, approximately two weeks into his employment at Bozzuto's, plaintiff parked his pallet truck outside the break room in the warehouse. After taking a break, plaintiff returned to the truck, and he reconnected the truck's battery using the "power disconnect" handle. According to plaintiff, the truck was already turned on, because the key had been snapped off while in the "on" position in the ignition switch. As plaintiff then attempted to mount the platform, his left foot slipped off, and he started to fall. To catch himself he grabbed the control handle and pulled at it in such a way that the truck suddenly moved toward him and hit into his right leg, crushing it against the wall.

Plaintiff's expert, Paul L. Dreyer, submitted a report alleging two defects in the design of the truck. The first alleged defect was that the key in the truck could be removed from the ignition switch while the ignition was still in the "on" position. This alleged defect caused plaintiff's accident, because it resulted in the truck already being turned on before plaintiff could safely mount the operator's platform. The second alleged defect was that the "coast activator" switch was designed and located in a way that made it too easy to activate by accident. This alleged defect caused the accident because plaintiff may have accidentally activated the coast feature during his fall, allowing the truck to move freely and hit him.

Defendant denied liability.

General Injury: Right foot and ankle injury.

Result: The trial court granted defendant's motion for summary judgment, ruling that there was no genuine fact issue to support a conclusion that either of the alleged defects caused plaintiff's injury.

Plaintiff's Expert Witness: Paul I. Dryer, of Dreyer Consulting, Allentown, PA

Plaintiff's Attorney: Aldrey D. Medd of Lyncu Schwab & Gasparini, PLLC, Brewster, New York

Defendant's Attorneys: Kevin M. Smith, Wiggin and Dana LLP, New Haven, CT; Thomas J. Cullen, Jr., Sarah L. Scott, Goodell, DeVries, Leech & Dann, LLP, Baltimore, MD

Garrett v. Crown Equipment Corporation, No. 3:15-cv-00942-JAM (United States District Court, D. Connecticut June 22, 2017)

HOUSEHOLD PRODUCTS

42. Settlement In Suit Against Manufacturers Of Electric Heated Throw And Heating Pad

The lawsuits in this consolidated action arise out of a fire that occurred December 22, 2013 at the home of Norma Albin and Carolyn (Dee) Albin in Greencastle, Indiana. The Albins claimed that the fire was caused either by a Sunbeam electric heated throw or a Conair heating pad. The Albin Plaintiffs alleged that the “Sunbeam electric blanket suddenly, without warning, lit on fire, causing a fire in the Albin home” or in the “alternative, the Conair heating pad, suddenly, without warning, lit on fire, causing a fire in the home.”

The defense contended that the Sunbeam heated throw product in this case is of the current state-of-the-art technology that has been used by Sunbeam in all its PTC bedding products since May 1, 2000. The Albin heated throw product complied with the UL (Underwriters Laboratories) 964 Standards for Safety for Electrically Heated Bedding Products at the time of its manufacture and was UL listed at that time. The design of Sunbeam heated throw products comply with all other industry safety standards and voluntary or mandatory safety requirements for electrically heated bedding products.

General Injury: Unspecified personal injuries.

Result: Settled for an undisclosed amount.

Plaintiffs’ Expert Witness: Fred Hackett, fire investigation Mid-West Forensics LLC, Brownsburg, IN; Paul Thogersen, PE, DCEI, Wolf Technical Services, Inc., Indianapolis, IN

Defendant’s Expert Witness: Mark Svare, P.E., Int.P.E., electrical engineering, MSD Engineering

Plaintiff’s Attorney: Tyler M. Nichols, Taylor,

Chadd, Minnette, Schneider & Clutter P.C., Crawfordsville, Indiana

Defendant’s Attorneys: Jeffrey J. Mortier, Blake N. Shelby, Frost Brown Todd LLC. Indianapolis, IN; Logan C. Hughes, Reminger Co., LPA, Indianapolis, IN (for Defendants, Hook-Superx, LLC d/b/a CVS Pharmacy and Conair Corporation)

Albin v. Jarden Corporation, Sunbeam Products Inc., Nos. 2:16-cv-00024-JMS-DKL, 2:16-cv-00025-WTL-DKL (United States District Court, S.D. Indiana, May 2017)

INDUSTRIAL PRODUCTS

43. Settlement In Suit Against Manufacturer Of Rebar Fabricating Machine

On October 26, 2011, Plaintiff, acting within the scope of his employment as a metal fabricator, was operating the Taeyeon steel reinforcing-bar spiral bending machine, when it ensnared his ungloved right hand, by catching portions of his hand which caused his hand to be pulled into the pinching, crushing, rotating exposed mechanism intended for bending steel rebar up to 1-inch in diameter. Subsequently, the unguarded, exposed, moving, rotating parts of the Taeyeon machine crushed and/or cut and/or amputated and/or otherwise damaged portions of his hand.

Plaintiff was unable to shut off the motor from his position since there was no emergency stop button located close to him. There was also no dead-man (aka hold-to-run) footpedal switch for stopping the motor upon release of the foot pedal switch. Plaintiff was unable to reverse the motor and release his hand from the pinch point since this model did not have a motor that was wired to go in reverse. Some Taeyeon machines did come with a reversible motor, but the machine of concern did not have the reverse function. In addition, there was no foot pedal for reversing the drive motor on the machine of concern.

Plaintiff contended that Defendant failed to provide effective and adequate guards, warning labels and

operators manual. An effective and efficient safety cover was never provided by the factory because there was no evidence for a tapped hole and/or holes in the machine plates. Defendant failed to provide effective and/or efficient guards for exposed rotating parts at the point of entry and/or pinch point of the rebar bending machine of interest. Defendant failed to provide and maintain safety warning labels about the imminent risk of amputation at the pinch point.

Defendant denied liability.

General Injury: Crushed hand.

Result: Settled for an undisclosed amount shortly before trial was scheduled to begin.

Plaintiff's Expert Witness: Gerard C. Gambs, P.E., mechanical engineering, Abington, PA

Plaintiff's Attorney: Daniel Kenneth Snyder, Aronbero, Kouser, Snyder & Lindemann, P.A., West Cherry Hill, New Jersey

Defendant's Attorney: Sukjin Henry Cho, Fort Lee, New Jersey

Sherman v. Taeyeon Machinery Company, Ltd., No.: 1:13-Cv-06032-Jhr-Amd (United States District Court For The District Of New Jersey May 2017)

MEDICAL PRODUCTS

44. \$2.1 Million Verdict In Suit Against Pelvic Implant Manufacturer

On September 20, 2006, Mrs. Sharon Beltz, then 34 years old, had an Ethicon Prolift device and an Ethicon TVT-O device implanted in her pelvis by Dr. Heather Van Raalte, a urogynecologist, to treat her pelvic organ prolapse and stress urinary incontinence.

Ethicon provided a description of the Prolift and TVT-O devices, the implant procedures, the attributes of the Prolift and TVT-O mesh, and the warnings, adverse events, indications, and contraindications for the Prolift and TVT-O devices to physicians in the Instructions for Use. Ethicon also provided informa-

tion about the Prolift and TVT-O's benefits, risks, and adverse events to physicians and patients in the patient brochures.

Following her implant surgery, Mrs. Beltz began reporting pain with intercourse. Beginning on December 15, 2006, Mrs. Beltz complained of pain with intercourse on the right side with deep penetration, an area known as the right vaginal fornix. On March 30, 2007, a pelvic exam was performed, and Dr. Van Raalte's office found a painful, palpable knot in that area. Mrs. Beltz was given her first trigger point injection to help relieve some of her pain.

On June 22, 2007, Mrs. Beltz returned to Dr. Van Raalte's office, reporting a dull pain in her pelvic region, as well as pulling and throbbing with intercourse. It was noted that Mrs. Beltz felt that the last trigger point injection helped relieve some pain, although she had tenderness in the right vaginal cuff on examination. Mrs. Beltz received another trigger point injection at that visit.

On July 18, 2007, Mrs. Beltz had her annual exam and her physician noted her anterior and posterior mesh was palpable, meaning it could be felt through the tissue in her vagina.

On September 21, 2007, she returned to Dr. Van Raalte with similar complaints of pain with sex as well as urinary urgency. She also reported pain with urination, a need to urinate that woke her at night, and pain in her right lower quadrant that came with walking. The knot was still palpable on the right side of her vagina in the location of her mesh arms, and she was given another pain injection, again relieving her pain.

On January 4, 2008, Mrs. Beltz returned to see Dr. Van Raalte and reported soreness at her bladder with sex. Notably, at this visit, she had no tenderness with palpation of the mesh or arms, suggesting the trigger point injections had solved the majority of her pain problems.

Mrs. Beltz returned again to Dr. Van Raalte's office on October 24, 2008 and reported that her pain with sex was improving, and she had only some soreness at her bladder.

She continued to see her Ob/Gyn group in November of 2008 and March of 2009, and then went to St. Luke's Obstetrics and Gynecology in October of 2009, where she reported pain with sex and generalized pelvic tenderness. The doctor was able to feel the mesh in her anterior compartment through her vaginal tissue, and noted her uterus was tender. The doctor noted that Mrs. Beltz attributed the pain she experienced to her pelvic organ prolapse surgery, not to her Ethicon mesh implants. There is no indication her physician ever suggested the Prolift and/or TVT-O devices she had were defective and/or the source of her symptoms, nor is there any evidence that Mrs. Beltz was told her problems were anything other than normal surgical risks associated with having had pelvic surgery.

Mrs. Beltz did not see a physician for her symptoms from that time until March 1, 2011. As Mrs. Beltz explained, her dyspareunia had been relieved with the trigger point injections, and she and her husband could make positional changes during this time so they could have enjoyable sex during that time period.

On March 1, 2011, Mrs. Beltz reported to her family doctor that she had persistent back pain and urinary discomfort. She followed up with Dr. Van Raalte on April 29, 2011, and complained that she now had intermittent pain, dyspareunia, pressure, and recurrent prolapse. She was diagnosed with a Stage 1 rectocele, perineocele, and uterovaginal prolapse incomplete stage 2.

She consented to have a revision surgery, and on November 9, 2011, she had a laparoscopy hysterectomy or removal of her uterus, and rectocele repair using a Y-shaped mesh that was placed abdominally. Dr. Van Raalte also resected the tension on her mesh, meaning she cut the arms of the mesh she had implanted in 2006. Mrs. Beltz testified that she believed the pain was caused by the tension on the arms of the mesh because of their placement, a condition she was led to believe was a surgical risk of the procedure.

Mrs. Beltz' condition only declined after this revision surgery. She returned to see Dr. Van Raalte in 2012, and was found to have tenderness on the right arm of her mesh. On February 1, 2011, March 1, 2011,

December 31, 2012, and October 16, 2014, she sought treatment from her family practitioner for recurrent urinary tract infections.

On October 22, 2015, Mrs. Beltz went to see urogynecologist Dr. Valerie Riley. She reported having constant pelvic pain since her surgery in 2011, along with urge incontinence, urinary retention, and pain with sex. Dr. Riley was able to palpate her Prolift mesh, and felt it was rigid and tight along its edges. She additionally noted that palpation of the mesh recreated Mrs. Beltz' pain symptoms, and suggested that Mrs. Beltz may require another revision surgery to further release tension on her mesh.

Plaintiff alleged that, as a result of the Prolift and TVT-O implantation, Mrs. Beltz suffers from constant pelvic pain and dyspareunia that is so bad that she rarely engages in intercourse with her husband. Mrs. Beltz also currently experiences vaginal spotting and radiating pain in her pelvic area when she stands or sits for an extended period of time.

Dr. Michael T. Margolis, plaintiffs' expert in female pelvic medicine and reconstructive surgery, explained in his report that while the surgical removal of the Prolift and TVT-O could be attempted, they cannot be removed completely, and Mrs. Beltz will continue to suffer from lifelong pelvic pain and dyspareunia.

Defendant denied liability.

General Injury: Pelvic pain and dyspareunia.

Result: \$2,160,000 jury verdict (compensatory damages).

The jury found in favor of defendants on plaintiffs' claim for punitive damages.

Plaintiffs' Expert Witnesses: Dr. Daniel Elliott urology and reconstructive surgery, Rochester, Minnesota; Prof. Dr. med. Uwe Klinge, biomaterial science; Peggy Pence, Ph.D., Food and Drug Administration ("FDA") regulations; Michael Thomas Margolis, M.D., urogynecologist, California; Bruce Rosenzweig, M.D., urogynecology, Chicago, Illinois

Defendants' Expert Witness: Dr. Elizabeth Kavalier,

Plaintiff's Attorneys: Thomas R. Kline, Kila B. Baldwin, Kline & Specter, P.C., Philadelphia, PA

Defendants' Attorneys: Kenneth A. Murphy, Molly E. Flynn, Drinker Biddle & Reath LLP, Philadelphia, Pa; Julie Callsen, Tucker Ellis LLP, Cleveland, Ohio; Kat Gallagher, Beck Redden, Houston, TX; Nils Burton Snell, Butler Snow LLA, Fort Washington, Pa; Tracy J. Van Steenburgh, Nilan Johnson PA; Minneapolis, MN; Dimitri Portnoi, O'Melveny & Myers LLP, Los Angeles, CA

Beltz v. Ethicon Women's Health And Urology, A Division of Ethicon, Inc., et al., No. 1306003835 (Philadelphia County Court of Common Pleas of Pennsylvania 5/26/17)

45. Manufacturer Of Merci Retriever Not Liable For Patient's Injuries

During a March 9, 2010 procedure by co-defendant Howard Riina, M.D. to treat an aneurysm in Ford's brain, a coil escaped and migrated further into Ford's neurovasculature. Riina attempted to retrieve the coil using a device called an alligator and device called a snare. These attempts failed and Riina resorted to a device called a Merci Retriever. Riina first used a V Series Merci Retriever size 2.0. Riina was able to capture the migrated coil using this Merci Retriever but the retriever fractured when Riina attempted to retract it. Riina then used a V Series Merci Retriever size 2.5, which was larger than the size 2.0, in an attempt to retrieve the fractured Merci Retriever and the coil. The second Merci Retriever also fractured. Riina was then able to capture the size 2.5 Merci Retriever using a snare but could not capture the first Merci Retriever and coil. Ford was ultimately brought for an emergency craniotomy and suffered a major stroke that rendered him severely brain damaged. By stipulation, plaintiff and Concentric, the manufacturer of the Merci Retriever, agreed that plaintiff's claims against Concentric would be limited to defects in design, inadequate or improper warnings and/or instructions and breach of implied warranty.

General Injury: Severe brain damage.

Result: The trial court granted Concentric Medical, Inc.'s motion for summary judgment.

The claim against Dr. Riina remains pending.

Plaintiff's Expert Witnesses: Karl Puttlitz, Ph.D., metallurgist/materials science; David H. Frakes, Ph.D., biomedical engineer

Defendant's Expert Witnesses: Matthew J. Gounis, Ph.D., a bioengineer; Tudor G. Jovin, M.D., neurologist; Brad James, Ph.D., engineer

Plaintiff's Attorneys: Dankner Milstein & Ruffo, PC, New York, NY

Defendant's Attorneys: Judi Abbott Curry, Kelly E. Jones, Marina Plotkin, Harris Beach PLLC, New York, NY

Ford v. Riina, M.D., New York Presbyterian Hospital and Concentric Medical, Inc., No. 805242-2012 (New York County Supreme Court of New York May 2, 2017)

PHARMACEUTICAL PRODUCTS

46. \$15 Million Verdict In Suit Against Manufacturer Of Depakote

This lawsuit involved the prescription medication Depakote, manufactured, marketed and sold by Defendant Abbott Laboratories Inc. ("Abbott"). Depakote ER is prescribed for persons with bipolar disorder.

This action has been brought on behalf of a minor child, E.G. Plaintiffs claimed that E.G.'s mother, Christina Raquel, was prescribed and took Depakote ER during her pregnancy with E.G. Plaintiffs claimed that E.G. was born with birth defects as a result.

Plaintiffs claimed that Abbott failed to provide an adequate warning to Christina Raquel's physicians regarding the risks of Depakote. Plaintiffs seek recovery of damages from Abbott for the injuries and harm suffered by E.G. in connection with his alleged birth defects.

Abbott claimed that it adequately warned Christina Raquel's physicians about the risks of Depakote during pregnancy. Abbott further claimed that Plaintiffs have not proved that the content of the warning caused E.G.'s injuries or that E.G.'s injuries were caused by Depakote ER.

Raquel was taking the drug, which is used to treat epilepsy, bipolar disorder and other conditions, when she became pregnant with E.G. in 2006. He was born with spina bifida. None of the doctors she saw while seeking treatment for her severe bipolar disorder knew about studies that showed the risk of spina bifida associated with the drug was above 10 percent, plaintiffs alleged. They were only aware of the 1 to 2 percent rate the label accompanying Depakote listed, plaintiffs alleged.

Abbott argued the doctors were well aware of the connection between spina bifida and Depakote's active ingredient, valproic acid, and a decision was made about whether Raquel's need for Depakote outweighed the risk to a potential baby.

General Injury: Spina bifida.

Result: \$15 million jury verdict (compensatory damages).

The jury found in favor of defendant on plaintiff's claim for punitive damages.

Plaintiff's Expert Witnesses: Cynthia Curry, M.D.; David Kessler, M.D.; Ira Lott, M.D.; Kenneth McCain; Godfrey Oakley, Jr., M.D., M.S.P.M.; Valerie Parisi

Defendant's Expert Witnesses: David Feigal, Jr., M.D., M.P.H.; Lisa Thornton, M.D.; Christopher Ticknor, M.D.

Plaintiffs' Attorneys: John E. Williams, Jr., John T. Boundas, Williams Kherkher Hart Boundas LLP, Houston, Texas

Defendant's Attorneys: Joel H. Smith, Bowman And Brooke LLP, Columbia, SC; Dan H. Ball, Bryan Cave LLP, St. Louis, Missouri

E.G. v. Abbott Laboratories Inc., No. 15-Cv-702-

Njr-Scw (United States District Court For The Southern District Of Illinois June 9, 2017)

47. Defense Verdict In Suit Against Manufacturer Of Xarelto

In February 2014, Dr. Maurice St. Martin prescribed Xarelto in a 20 milligram dose for Mrs. Sharyn Orr, to treat her atrial fibrillation. Her dose was subsequently reduced to 15mg on July 25, 2014. Given Mrs. Orr's medical profile and the allegedly dangerous characteristics of the drug, Plaintiffs contended that Mrs. Orr should not have been placed on Xarelto to treat her condition. Plaintiffs further alleged that a different course of medication treatment for Mrs. Orr more likely than not would have been followed, had Dr. St. Martin, or a reasonable physician in his circumstances, been provided by Defendants with adequate information before prescribing Xarelto for a patient such as Sharyn Orr.

Sharyn Orr suffered a brain hemorrhage on April 24, 2015, an event which Plaintiffs alleged was due to the effects of Xarelto. She was seen that same evening in the emergency room of Ochsner Main Campus by a neurosurgeon, Dr. Cuong Bui, who was consulted in order to address her life-threatening condition. The standard of care for a patient in Ms. Orr's condition is to immediately proceed to surgery in order to relieve pressure in the brain and to minimize tissue death. Time is of the essence in such an emergent situation. But since Mrs. Orr was indicated to be on a Xarelto prescription, Dr. Bui waited twelve hours before surgically inserting ventricular drainage tubes to relieve the pressure in Mrs. Orr's skull caused by her brain hemorrhage. Mrs. Orr died despite this surgery.

Plaintiffs did not criticize Dr. Bui in any way for his treatment of, or for the delay in surgically treating, Mrs. Orr. Rather, Plaintiffs alleged Defendants failed to inform Dr. Bui that a routine simple blood test, that was actually performed, has meaning to patients taking Xarelto. The test was actually ordered and done when Mrs. Orr presented in the in the emergency room

that evening, and the test result revealed that she was not then anticoagulated and it was safe to proceed to surgery.

It was Plaintiffs' contention that Defendants failed to provide warnings and instructions to Dr. Bui that would have advised him to refer to this test result in order to assess the actual amount of Xarelto in Mrs. Orr's system at the time she needed surgery. Plaintiffs further alleged that Defendants not only failed to warn about the usefulness of a simple blood test, but affirmatively misled doctors like Dr. Bui to believe that no such test is available. Dr. Bui was under the false impression that no test to assess coagulation status on Xarelto is available. Plaintiffs claimed that, with this information, Dr. Bui would have been in a position to perform surgery sooner, and that the Defendants' failure to provide information about the available measurement of Xarelto in Mrs. Orr's system to Dr. Bui, or to a reasonable surgeon and Dr. Bui's circumstances, more likely than not would have either prevented Mrs. Orr's death, or would have increased her chances of surviving.

Defendants denied liability.

General Injury: Death.

Result: Jury verdict in favor of defendant.

Plaintiff's Expert Witnesses: Frank Smart, M.D., cardiologist; Peter Liechty, M.D., neurosurgeon; Suzanne Parisian, M.D., regulatory expert

Defendants' Expert Witnesses: Dr. Colleen Johnson, New Orleans, LA; Dr. Najeeb Thomas, Metairie, LA

Plaintiffs' Attorneys: Brian Barr of Levin Papantonio, Andy Birchfield of Beasley Allen, Leonard Davis of Herman, Herman & Katz, Roger Denton of Schlichter Bogard & Denton, Brad Honnold of Goza & Honnold, LLC, Emily Jeffcott of The Lambert Firm, PLC, Gerald Meunier of Gainsburgh Benjamin, Michael Weinkowitz of Levin Sedran & Berman, and Neil Overholtz of Aylstock, Witkin, Kreis & Overholtz, PLLC

Defendants' Attorneys: Beth Wilkinson of Wilkin-

son Walsh & Eskovitz, David Dukes of Nelson Mullins Riley & Scarborough LLP, Andrew Solow of Arnold & Porter Kaye Scholer LLP, Kevin Newsom of Bradley Arant Boult Cummings LLP, and John Olinde of Chaffe McCall LLP for Bayer; Susan Sharko of Drinker Biddle, and Jim Irwin of Irwin Fritchie Urquhart & Moore LLC

In Re: Xarelto (Rivaroxaban) Products Liability Litigation, No. 2:14-MD-02592 (U.S. District Court, Eastern District of Louisiana June 12, 2017)

WORKPLACE PRODUCTS

48. Settlement In Suit Alleging Defective Safety Equipment

On January 8, 2015, Michael Jason Homer was injured while employed by Union Carbide Corporation when he fell 22 feet from a pipe rack onto a concrete floor and became paralyzed from the waist down. At the time of his fall, Mr. Homer was wearing a full body safety harness with attached double lanyards, but neither component of his fall arrest system was connected to an anchor. The full body safety harness was manufactured by Capital Safety, and the double lanyard was manufactured by Sellstrom Manufacturing Company. Mr. Homer alleged that he tripped over one of the lanyards, causing his fall.

Mr. Homer alleged that Capital Safety's full body safety harness was unreasonably dangerous because of an inadequate warning and instruction regarding the tripping hazard created by double lanyards that were being used with it, and regarding where to store an unanchored lanyard on the harness.

Capital Safety denied Plaintiffs' allegations that its full body harness was unreasonably dangerous, and asserted that its warnings and instructions regarding its full body safety harness were adequate and in compliance with all applicable industry standards and specifications. Capital Safety also contended that the harness was free of all defects and would have performed as expected if used properly. Capital Safety also asserted that Mr. Homer's failure to attach his

double lanyard to an anchor point was the proximate cause of his fall, and further that his use of the full body safety harness by not having it connected to an anchor point was not a reasonably anticipated use of the harness. Finally, Capital Safety asserted that it owed no duty to warn Mr. Homer or Union Carbide regarding the alleged hazards created by an un-hooked lanyard attached to its harness because they were sophisticated users of this equipment.

General Injury: Unspecified personal injuries.

Result: Settled for an undisclosed amount at pre-trial settlement conference.

Plaintiff's Expert Witness: Robert E. Borison, Total Safety Services, Inc., Pass Christian, Mississippi; Shael Wolfson, Ph.D.; Dr. James R. Bartkus, New Orleans, LA

Defendant's Expert Witnesses: David Schlangen, P.E. Capital Safety, Red Wing, MN; Jubal Hamernik, PhD, P.E., Boulder, CO; Steven Arndt, PhD, CHFP, warnings, Deer Park, IL

Plaintiff's Attorneys: Gilbert V. Andry, IV, The Andry Law Firm, LLC, New Orleans, LA

Defendant's Attorneys: Christopher O. Massenburg, Kevin R. Sloan, Manion Gaynor & Manning, L.L.P., New Orleans, Louisiana; Jerry W. Blackwell, Gerardo Alcazar, Blackwell Burke P.A., Minneapolis, MN (for Defendant DB Industries, LLC d/b/a Capital Safety USA)

Homer v. DNOW L.P., Sellstrom Manufacturing Company, RTC, A Subsidiary of SELLSTROM Manufacturing Company, Capital Safety, USA/DBI SALA, and Hagemeyer North American, Inc., No. 2:16-CV-01210 (United States District Court, E.D. Louisiana, May 2017)

49. Settlement In Suit Against Manufacturer Of Electrical Meter

On May 15, 2014, Plaintiff Donald Robert Williams was a fire protection system repair technician em-

ploied by Atlanta Sprinkler Inspection. On that day, Plaintiff Williams was repairing a fire protection system at an office building in Norcross Georgia. In the course of performing the repair, Plaintiff Williams used an Ideal 61-310 Multimeter to determine whether electricity was running through a fire pump controller. As Plaintiff Williams touched the test leads of the Ideal 61-310 multimeter to the fire pump controller, Plaintiff Williams was burned when an arc blast electrical explosion occurred. At the time of the incident, the test leads of the Ideal 61-310 were connected to the 10 Amp and common port.

From the mid-2000s until 2013, Ideal designed, tested, and sold the "Ideal Resi-Pro 61-310" - a meter that measures electrical voltage and current. Most meters on the market have a "high energy fuse" safety feature; this meter did not. Instead of fusing, Ideal relied on customers to understand a "Category" rating warning system.

Plaintiff alleged that Ideal knew that its customers did not understand Category ratings, that some customers would mistakenly insert meter test leads into the incorrect meter ports, and that when the incorrect ports were used on an electrical system outside a certain Category rating, there would be an arc flash / blast explosion. Plaintiff alleged that despite this knowledge, Ideal brought the defective meter to market with no fuse protection and the useless Category warning system.

Defendant denied liability.

General Injury: Burns.

Result: Settled for an undisclosed amount.

Plaintiff's Expert Witnesses: H. Landis Floyd II, Electrical Engineer, University of Alabama Birmingham; Jeffrey W. Barnes, engineer, Cal.

Plaintiff's Attorneys: Matthew B. Stoddard, The Stoddard Firm, Atlanta, GA

Defendant's Attorneys: Thomas J. Mazziotti, Richard J. Valladares, Greenberg Traurig, LLP, Atlanta, Georgia

Williams v. Ideal Industries, Inc., No. 1:14-cv-

02883-LMM (United States District Court, N.D. Georgia June 27, 2017)

MISCELLANEOUS PRODUCTS

50. Settlement In Suit Alleging Defective Walking Stick

On August 23, 2014, the Plaintiff, Michael Flanagan's wife purchased a Hurrycane for \$39.99 from Bed Bath & Beyond. Hurrycane is a foldable walking cane that has a pivoting base that sits a top three small supported feet. The Plaintiff's wife returned to their residence and the cane's re-fabricated pieces were snapped together, which is the extent and proper manner of the assembly required to utilize the Hurrycane. The Plaintiff then began to utilize the Hurrycane in a manner that was consistent with its intended and foreseeable purposes and/or uses. As he was leaving his home, descending the two exterior stairs, suddenly and without warning, the subject cane collapsed causing the Plaintiff to fall violently down the steps, ultimately landing on his knees, causing him to sustain a right quadriceps tear and fractured his left kneecap.

Plaintiff contended that since only a few pounds of force are required to separate the individual sections of

the cane to prepare it for folding and storage, the design of the subject cane is prone to unexpected collapse as a result of inadvertent separation of the sections of the cane if the base of the cane is restrained. Plaintiff contended that the key deficiency in the design of the subject cane is the lack of any means to mechanically lock the individual three sections of the cane together to prevent their separation during the course of normal use.

Defendant denied liability.

General Injury: Right quadriceps tear and fractured his left kneecap.

Result: Settled for an undisclosed amount.

Plaintiff's Expert Witness: David Bizzak, mechanical engineer

Defendant's Expert Witness: Charles S. Fleishman, PE, Rimkus Consulting Group, Inc.

Plaintiff's Attorneys: Monte J. Rabner, Fred G. Rabner, Ashley M. Cagle, of Rabner Law Offices, P.C

Defendant's Attorney: Michael R. Abbott, Cipriani & Werner, Blue Bell, PA

Flanagan v. Martfive, LLC, 2:16-cv-01237 (United States District Court, W.D. Pennsylvania April 2017)

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