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Summaries with Trial Analysis

$7,000,000 RECOVERY EMERGENCY DEPARTMENT – DEFENDANT DOCTORS FAIL TO APPRECIATE SIGNS OF SYMPTOMS OF SEVERE INFECTION AND DISCHARGE INFANT MINOR WHO REQUIRED HOSPITALIZATION – SEPSIS – MENINGITIS – SEVERE MITRAL VALVE REGURGITATION REQUIRING SURGERY – CORTICAL BLINDNESS – CEREBRAL PALSY

Bucks County, PA

In this medical malpractice action, the mother of an infant male maintained that she presented her son to the defendants on several occasions with a high fever and flu-like symptoms, only to be discharged on each occasion with prescriptions. The infant was suffering from occult bacteremia, which went undiagnosed and the minor developed sepsis, which resulted in cerebral palsy. The defendants denied all allegations of negligence, and argued that the minor was treated in accordance with medical standards.

Between January 3, 2006 and January 13th, 2006, the eight month old minor plaintiff presented to the defendant hospital's emergency room three times, and was seen and treated by the three defendant doctor's on each visit. On the first visit, the minor was seen by the defendant, Ndu-Lawson, the second the minor was seen by the defendant, Rapp, and on the third visit, the minor was seen by the defendant, Shannon. Each doctor diagnosed the minor with either an ear infection, upper respiratory infection, or resolving fever, and treated the minor with antibiotics, fever reducers, and cough medicines. Following each visit to the ER, the minor was discharged a short time later. On January 15, the minor returned to the defendant hospital, where this time, he was diagnosed with sepsis and emergently transferred to the local Children's Hospital, where he remained for about three months. The plaintiff's allegations against the three ER doctors were failing to recognize the signs and symptoms of both, occult bacteremia and sepsis, as well as failing to do the following: Admit the minor for further observation and treatment, diagnose the minor's bacterial infection, and order proper diagnostic tests. In addition, the plaintiff alleged that the defendant hospital and doctors group were vicariously liable for acts of doctors.

As a result of the defendants negligence, the minor plaintiff suffered sepsis, meningitis, endocarditis, severe mitral valve regurgitation requiring mitral valve repair, bacteremia, hydrocephalus, cortical blindness, cerebral palsy, seizures, and neurological dysfunction. All defendants denied all allegations of liability and vigorously defended their stance that the minor was treated in accordance with all medical standards.

The parties settled their dispute for $7,000,000.

REFERENCE

Elijah Jackson a minor by and through his png Vera Jaryee vs. Ovunda Ndu-Lawson D.O., EPA Physicians Er Physician Group, Lower Bucks Hospital, Kadisha Rapp M.D., and Anne Warden Shannon M.D. Case no. 2011-06896; Judge Susan Devlin Scott, 08-18-14.

Attorney for plaintiff: Thomas Kline of Kline & Specter, P.C. in Philadelphia, PA. Attorney for defendant: Joan Orsini Ford of Marshall Dennehey in King of Prussia, PA. Attorney for defendant: John F.X. Monaghan of Harvey Pennington in Philadelphia, PA. Attorney for defendant: Mary Reilly of Post & Schell, P.C. in Philadelphia, PA. Attorney for defendant: William Pugh of Kane, Pugh, Knoell, Troy & Kramer LLP in Norristown, PA.

COMMENTARY

Pretrial documents in this case revealed that the parties argued over both the defendants alleged breach of standards of care, and the plaintiff mother's decision not to follow discharge instructions provided by the defendant Lawson and see her primary care physician the day after discharge from the emergency room.The plaintiff presented testimony that the defendants failed to order a complete blood count and urinary analysis during the minor's initial visit to the emergency room. The plaintiff maintained that his was a breach in the standard of care and argued that had the tests been performed, they would have been abnormal and required further work up which would have led to a proper diagnosis. The defense countered that the infant was a nontoxic patient who presented with fever, cough, corzya, abnormal ear exam, and increased heart and respiratory rate, which improved during the emergency room visit with standard therapies. The defense further argued that the discharge instructions clearly recommend that the infant be seen by his family doctor, as the plaintiff mother failed to comply with the recommendation.

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$6,900,000 GROSS VERDICT – MEDICAL MALPRACTICE – 10-MONTH DELAY IN DIAGNOSIS OF BREAST CANCER – METASTASIS – DEATH 8 YEARS AFTER DIAGNOSIS

Hartford County, CT

This was a medical malpractice action involving a then 40-year-old patient who contended that in August, 2000, the defendant radiologist negligently interpreted a mammogram spot compression and lateral views. The plaintiff maintained that because of the negligence, there was an approximate ten month delay in diagnosis, and the cancer progressed from a very treatable case to a stage III cancer, spreading to six out of 24 lymph nodes. The plaintiff died from the cancer in July of 2009 at the age of 49. She left a husband and two teenaged children.

The evidence disclosed that when the decedent had a mammogram on August 2, 2000, the non-party radiologist noted two areas of increased density on the outer aspect of the right breast, and a letter was sent the plaintiff advising her to return for a sonogram. The patient returned less than a week later, on August 8, 2000, for the sonogram. Rather than perform the sonogram as requested by the non-party radiologist, the defendant radiologist took another mammogram with spot compressions and lateral views. The plaintiff contended that this defendant negligently determined, based on a comparison with a mammogram taken several years earlier, that no suspicious changes were present. The plaintiff asserted that she was advised to return in one year.

The defendant maintained that despite his findings of a normal mammogram, he told the plaintiff to return in four months for a further mammogram on her right breast. The defendant contended that he mentioned in his report that he would recommend that the plaintiff return in four months. The defendant was unable to produce copies of any correspondence sent to the plaintiff advising her to follow-up. The records of the non-party ob/gyn who had referred the plaintiff to the defendant reflected that she, the ob/gyn, received the defendant's mammogram report and sent a copy to the plaintiff with a handwritten note, recommending her to follow-up. The plaintiff denied receiving any copy of the report or handwritten note. The plaintiff also established that under federal law, the defendant was required to send her written letter in lay language, advising her of the mammogram results. The plaintiff contended that no such letter was sent, and the defendant could not produce any copy of such a letter, or any other documentation at trial, showing that such letter was sent. The defendant contended at trial that the records were probably lost.

The defendant contended that the plaintiff was negligent in failing to return in four months, and that if the plaintiff had returned in four months, there was an increased chance that the cancer would have been found before it metastasized to six nodes.

The plaintiff visited her non-party family physician in late May, 2001, approximately ten months after the mammogram, and he felt a lump on the outer aspect of the right breast. The plaintiff was referred for a sonogram, then a mammogram and biopsy, and on June 6, 2001, the plaintiff was diagnosed with Stage III invasive ductal carcinoma. She underwent a mastectomy, and removal of 24 lymph nodes in July 2001. Six lymph nodes were found to be positive for metastatic cancer. The evidence also reflected that the cancer was estrogen and progesterone positive, and rendered the cancer more aggressive due to Plaintiff being premenopausal.

The plaintiff indicated that after she did research and learned of anticipated poor outcome from chemotherapy and radiation treatment in patients similar to her, and after considering the toxic effects of chemotherapy and radiation, she opted to decline those treatments and pursue treatment through alternative medicine.

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The defendant contended that the decedent failed to mitigate her damages by refusing to undergo chemotherapy and/or radiation treatments, and by undergoing alternative treatments.

The plaintiff elicited testimony from experts that as of the time of the diagnosis, studies showed that toxic chemotherapy offered an approximately 10% absolute benefit in a patient such as plaintiff. The plaintiff elicited testimony from a defense expert that literature at the time showed that radiation treatment offered a zero percent net increase in life expectancy in patients such as herself. The plaintiff maintained that the decedent's decisions to decline chemotherapy and radiation, and to follow an alternative medicine type program, was, therefore, reasonable and enabled her to live longer, and with a better quality of life than what was available with chemotherapy and radiation. The plaintiff elicited from defendant's expert in alternative medicine that the vast majority of the alternative remedies taken by the plaintiff were beneficial to her, and that none of them caused her any harm.

The decedent was an entrepreneur who had started, owned, and then sold a successful payroll business for a substantial profit. She was in the process of several other business ventures at the time of the diagnosis. The plaintiff offered economic expert testimony that the death caused income loss which was as much as $3,000,000.

The decedent left a husband as well as a son and a daughter, both of whom were in their teens.

The jury found the defendant 50% negligent, the decedent 50% comparatively negligent, and rendered a gross award of $6,900,000, including $3,000,000 for economic loss, and $3,900,000 for non-economic loss. The jury further found that the plaintiff failed to mitigate her damages and reduced the net award by an additional 13.5%, resulting in a net verdict of $2,984,250.

REFERENCE

Plaintiff's economic expert: Gary Crakes, PhD from Cheshire, CT. Plaintiff's internal medicine, alternative complimentary medicine expert: H. Robert Silverstein, M.D. from Hartford, CT. Plaintiff's radiological expert: R. James Brenner, M.D from San Francisco, CA. Defendant's alternative/complimentary medicine expert: David Rosenthal, M.D., from Stanford, CT. Defendant's oncological expert: Richard S. Zelkowitz, M.D. from Norwalk, CT. Defendant's radiological expert: Robert D. Russo, M.D from Bridgeport, CT.

Sawicki vs. Mandell & Blau, MD, PC. Case no. HHD-CV-Xo7-CV 02-081629-S; Judge Kevin Dubay, 05-02-14.

Attorney for plaintiff: Danielle George, pro hac vice of Phillips & Paolicelli, LLP in New York, NY. Attorney for plaintiff: Oliver Dickins in Simbsbury, CT.

COMMENTARY

The plaintiff argued that the defendant could not document the alleged advisements for the plaintiff to return in four months after the mammogram, and could not establish that it complied with federal law that required a written report be sent to the patient. The plaintiff also argued that irrespective of the issues regarding such advisement, any delay should have been avoided, and the defendant radiologist should have properly interpreted the mammogram, and conducted the sonogram as requested by his partner in Aug., 2002. Although the plaintiff was able to obtain a gross award, the jury found the decedent 50% comparatively negligent, and further reduced the net award by 13.5% for failure to mitigate. It is felt that the jury may have believed that an individual showing such a strong independent tendency that she would decline chemotherapy in favor of alternative approaches, should have been more aggressive during the delay in diagnosis, and that had she been so, the cancer would have been confirmed earlier.

$3,500,000 VERDICT MEDICAL MALPRACTICE – HOSPITAL NEGLIGENCE – PLAINTIFF DEVELOPS SEVERE PRESSURE SORES FOLLOWING LUMBAR DECOMPRESSION AND FUSION SURGERY – FAILURE TO PROPERLY REPOSITION PLAINTIFF POST OPERATIVELY – PRESSURE SORES – OSTEOMYELITIS – AMPUTATION OF FOOT

Allegheny County, PA

In this medical negligence case, the plaintiff alleged that the defendant hospital's staff was negligent in their care of the plaintiff following his surgery to treat Cauda Equina Syndrome. Post operatively, the plaintiff developed pressure sores on his buttocks and heel. These sores required over 18 surgical procedures and resulted in the eventual amputation of the plaintiff's foot. The defendant argued that the plaintiff was treated properly and in accordance with all standards of care. The 68-year-old male plaintiff presented to the defendant hospital on April 2, 2010 with complaints of severe back pain. He was seen and discharged with pain medication. The next day the plaintiff, again, presented to the defendant ER with worsening back symptoms, and was diagnosed with Cauda Equina Syndrome and admitted for surgery. Surgery was performed on April 4 without incident, and the plaintiff was transferred to the Neuro Critical Care Unit and scheduled for upcoming rehabilitation expected to last 10-14 days. On April 7, while still a patient in the NCCU, a nursing note indicates that the plaintiff had developed a deep tissue injury to his coccyx as a result of being placed on a bed pan for an indeterminate amount of time. By April 9, when the plaintiff was transferred to rehabilitation, he had three pressure sores on his body that required several debridement procedures over the next few weeks. By May of 2010, the plaintiff's continued diarrhea was preventing the coccyx wound from healing and the plaintiff was required to have a colostomy. Over the next few months, the plaintiff's wounds failed to heal and

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did not respond to surgeries and treatment. The plaintiff developed a MRSA infection, and eventually the plaintiff required a below the knee amputation of his right leg as a result of the heel pressure sore he developed at the defendant hospital. The plaintiff maintained that the defendant hospital was negligent in allowing unskilled or untrained individuals to care for the plaintiff, allowing the plaintiff to become malnourished, compromising the plaintiff's recovery from pressures ulcers, failing to properly turn and reposition the plaintiff in order to prevent pressure sores, and failing to provide the plaintiff with necessary and appropriate treatment. As a result, the plaintiff suffered multiple stage IV pressure wounds on the buttocks and on the heel. These wounds led to a MRSA infection, osteomyelitis, 19 surgeries, amputation of the right foot, colostomy, and renal dialysis caused by wound infection and antibiotic therapy. The defendant argued that the care plan established at the plaintiff's admission indicated he was at a high risk of skin breakdown due to his extensive medical history, including a 37 year history of diabetes. Unfortunately, despite proper medical care, the plaintiff developed pressure ulcers that required intensive medical treatment.

The jury found that the defendant was negligent, and that their negligence was a factual cause of harm to the plaintiff. The plaintiff was awarded $1,060,000 for noneconomic damages, including $1,413,350, and the plaintiff's wife was awarded $1,026,650 for loss of consortium.

REFERENCE

Plaintiff's nursing expert: Dorothy McDonnell Cooke from Clayton, MO.

John and Sylvia Scrima vs. University of Pittsburgh Medical Center Mercy. Case no. GD-11-019474; Judge Paul F. Lutty, 09-16-14.

Attorney for plaintiff: Michael T. Collis of Wilkes & McHugh in Pittsburgh, PA. Attorney for defendant: Richard Federowicz of Dickie, McCamey & Chilcote in Pittsburgh, PA.

COMMENTARY

The plaintiff presented expert nursing testimony that revealed that the defendant's own standard of care for treating patients at risk for skin breakdown was not met by their own staff. This expert testified that the protocol for patients like the plaintiff required daily exams of the skin for signs and symptoms of pressure sores. This expert stated that by the time the heel lesion was discovered for some time, revealing that the skin exams were not performed daily. In addition, the defendant's own protocol called for the plaintiff's heel to be elevated off the mattress or other surface, this too was obviously not done, since the plaintiff developed a pressure sore on the heel. Further, this expert testified that the defendant's protocol for patients at risk of pressure sores calls for the patient to be repositioned every 15 minutes. Nursing notes indicate that the patient remained in the same position for one to two hours.

$3,000,000 PLAINTIFF'S ARBITRATION AWARD – MEDICAL MALPRACTICE – OPTHALMOLOGY NEGLIGENCE – FAILURE TO PROPERLY TREAT ANGLE-CLOSURE GLAUCOMA – LOSS OF VISION

Withheld County, MA

In this medical malpractice matter, the plaintiff alleged that the defendant opthalmologist was negligent in failing to properly treat the plaintiff's angle-closure glaucoma following a car accident, which resulted in the plaintiff losing his vision. The defendant denied any negligence, and maintained that the plaintiff was unconscious at the time, and was unable to undergo surgery to his eyes due to the other injuries he sustained in a motor vehicle accident.

The 65-year-old male plaintiff, a nature photographer, was involved in a motor vehicle collision and sustained serious injuries, including possible eye injuries. The defendant ophthalmologist dilated the plaintiff's eyes to perform a routine examination while the plaintiff was still unconscious. The dilation caused the plaintiff to suffer angle-closure glaucoma. The defendant failed to treat the plaintiff's glaucoma in a timely manner, which would include regular monitoring of the plaintiff's intraoccular pressure with laser or traditional surgery to treat the pressure in the eye. As a result of the failure to properly monitor and treat the plaintiff's condition, the plaintiff lost his vision. The plaintiff brought suit against the defendant ophthalmologist, alleging negligence.The defendant denied the allegations and maintained that there was no deviation from acceptable standards of care. The defendant argued that surgery or a laser procedure was not possible due to the plaintiff's medical condition following the trauma of the collision.

The matter was submitted to arbitration. After a three day arbitration hearing, the arbitrators awarded the plaintiff the sum of $3,000,000 in damages. The damages consisted of $2,450,000 for loss of enjoyment of life, and $550,000 for past and future medical expenses.

REFERENCE

Plaintiff Outdoor Photographer vs. Defendant Opthalmologist., 07-18-14.

Attorney for plaintiff: Kevin Donius of Sbrogna & Brunelle in Worcester, MA.

COMMENTARY

The plaintiff presented medical evidence through his expert that the defendant ophtalmologist should have immediately taken steps to lower the plaintiff's intraoccular pressure as soon as he was diagnosed with the angle-closure glaucoma. The plaintiff maintained that the defendant failed to reg-

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ularly monitor the eye pressure, and should have performed either a laser irrodotomy procedure or surgical irridectomy on the plaintiff as soon as feasible. The plaintiff also maintained that the plaintiff was not properly followed by the defendant.

The defendant's experts refuted the plaintiff's allegations, maintaining that it was not possible to perform any type of laser or surgical procedure on the plaintiff, since he was unconscious and medically unstable, given his other injuries, which included multiple fractures to his arm, wrist, spine, rib, and face.

The surgery was performed on the plaintiff 39 days after the incident, but the plaintiff's vision had already been lost.

$1,260,000 ARBITRATION AWARD – MEDICAL MALPRACTICE NEGLIGENCE – NURSING HOME NEGLIGENCE – FAILURE TO CARE FOR PLAINTIFF RESULTING IN STAGE III AND STAGE IV PRESSURE SORES – DEBRIDEMENTS – COLOSTOMY – SKIN GRAFTING

Withheld County, MA

In this nursing home negligence action, the plaintiff alleged that the defendant nursing home was negligent in permitting the plaintiff, who was recovering from a stroke, to develop Stage III and Stage IV pressure ulcers, which impeded his continued recovery from a stroke. The defendant nursing home denied liability, and maintained that the development of the pressure sore was unavoidable, due to the plaintiff's co-morbidities.

The 67-year-old male plaintiff was admitted to the defendant nursing home following a stroke. Less than two weeks into his stay at the defendant's facility, the plaintiff developed a Stage III pressure ulcer on his sacrum. He was, thereafter, emergently transported to the hospital, and diagnosed with severe dehydration, as well as clinically starved. He was diagnosed with a Stage IV pressure ulcer, including septic shock. The pressure sore was 16 cm and protruded through the plaintiff's skin, muscle, fat, and bone. The plaintiff was required to undergo numerous procedures related to the pressure sore, including 30 hyperbaric oxygen treatments, a colostomy, skin grafting procedures, wound care, and administration of antibiotics. As a result of the defendant's negligent care of the plaintiff, he lost all progress he had previously made in stroke rehabilitation, and was rendered totally bedridden. He died in February 2013, approximately two years following his stroke.

The plaintiff brought suit, alleging that the defendant nursing home was negligent in failing to properly care for the plaintiff, and failing to adhere to acceptable policies and procedures for the care and treatment of patients at risk for developing pressure ulcers.

The defendant nursing home denied the allegations and disputed liability. The defendant contended that the development of the pressure sore was unavoidable, given the plaintiff's co-morbidities and lack of response to nutrition at a cellular level. The defendant also disputed the nature and extent of the plaintiff's injuries and damages, including any applicable offsets.

The matter was arbitrated. The arbitrator determined that the defendant had violated the standard of care in leaving the patient on his back for extended periods of time, without providing the plaintiff with any repositioning to avoid the development of pressure ulcers. The arbitrator awarded the plaintiff the sum of $400,000 for conscious pain and suffering, but maintained that only one-half of the plaintiff's medical bills resulted from the pressure ulcers. As requested by the defendant, the arbitrator declined to allow consideration of collateral offset reimbursement. Following reconsideration requested by both parties, the award total $1,260,000.

REFERENCE

Plaintiff Patient John Doe vs. Defendant Nursing Home., 04-29-14.

Attorneys for plaintiff: Abigail R. Williams and Erin A. Atwater of Abigail Williams & Associates in Worcester, MA.

COMMENTARY

Prior to the stroke, the plaintiff had lived independently and had no skin issues. Prior to the actions of the nursing home, the plaintiff was intended to return home following a short term stay at the defendant's facility for rehabilitation.

The issue of collateral source reimbursement under Massachusetts law was a key issue. The defendant argued that it should apply and reduce the damages potentially awarded to the plaintiff, and the plaintiff maintained that it was not applicable since the plaintiff did not file a complaint, and the arbitrator's decision did not qualify as a "verdict." Application of the collateral source rule would result in a devastating result for the plaintiff, since the the potential award would be less and the plaintiff would lose protection against third party lien holders, resulting in a "double whammy" to the plaintiff's damages. Both parties asked for a reconsideration of the arbitration award, the plaintiff seeking the full medical specials, and the defendant seeking application of the collateral source rule to reduce its exposure. The arbitrator reconsidered and awarded the plaintiff the full medical expenses, instead of only 50 percent. Additionally, the arbitrator continued to decline to apply the collateral source rule.

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$1,500,000 VERDICT – MEDICAL MALPRACTICE – INITIAL DEFENDANT PSYCHIATRIST NEGLIGENTLY WITHDRAWS LITHIUM TAKEN FOR BIPOLAR DISORDER WITHOUT ADEQUATELY MONITORING PATIENT – DECEDENT SURVIVES INITIAL SUICIDE ATTEMPT AND THEN COMES UNDER CARE OF SECOND DEFENDANT PSYCHIATRIST WHO CHANGES PRESCRIPTION TO LEXAPRO – DECEDENT COMMITS SUICIDE BY HANGING APPROXIMATELY ONE WEEK LATER

Essex County, NJ

This was a psychiatric malpractice case involving a 54-year-old decedent, who had been successfully treated with Lithium for bipolar disorder for 25 years. During this period, the decedent worked as a successful landscape architect, and was earning approximately $100,000 per year at the time of his death. The decedent had been treated by the for some nine years, and in Jan., 2008, blood tests disclosed kidney difficulties, which can be associated with Lithium use. The initial defendant took the patient off Lithium, and prescribed a number of alternative medications. In June, 2008, the decedent attempted suicide by hanging, but was found by his wife, who administered CPR, and had him admitted to the hospital. The initial defendant psychiatrist settled during trial for $420,000. The decedent recovered from the suicide attempt, and shortly after his discharge, came under the care of the second defendant psychiatrist. The second psychiatrist's chart reflected his concern that much of the difficulties suffered by the decedent stemmed from the decedent's relationship with his wife, with whom the second defendant believed was impossible to live. The plaintiff maintained that, although the chart also reflected that the second defendant was concerned that this factor might interfere with his ability to treat the decedent, the second defendant did not discuss these concerns with the decedent. This defendant provided treatment for approximately five weeks when he changed the prescription to Lexapro, which the plaintiff stressed has not been approved for treatment of bipolar disorder. The decedent committed suicide by hanging approximately one week later. At the time of the settlement with the initial defendant, the plaintiff also entered into a $250,000/$1,000,000 high/low agreement with the second defendant psychiatrist.

The plaintiff contended that prior to taking the decedent off Lithium, which had been successful for many years, the initial defendant psychiatrist should have closely monitored the blood results, and only change medication if it ultimately became absolutely necessary. The plaintiff contended that the chances of suicide on the part of bipolar suffers are very high, and that in view of this factor, and the long term success of Lithium with the treatment of the decedent, the medication should not be withdrawn unless and until all it is absolutely necessary to do so. The plaintiff also contended that once a decision to the withdraw the Lithium was made, the first defendant should have provided especially careful monitoring of the patient. The plaintiff further maintained that once the initial suicide attempt was made, the chances of another attempt rose extensively, and that the initial defendant failed to call the decedent and ask him to come in. The plaintiff also supported that in view of the entries in the chart in which the second defendant psychiatrist wondered if he could effectively treat the decedent because of the second defendant's hostile feelings towards the wife, he clearly should have had a discussion with the decedent regarding his continued treatment. The plaintiff further contended that this second defendant psychiatrist was clearly negligent in changing the decedent's medication to Lexipro, when it hasn't been approved for the treatment of bipolar disorder.

The plaintiff maintained that in view of the 25 years of effective treatment, the testimony of the decedent's son regarding the high quality of guidance and advice derived from his father should be given especially great weight.

The jury found the initial defendant psychiatrist, who settled during trial, 50% negligent, the second defendant psyhciatrist 30% negligent, and attributed 20% to the pre-existing bipolar disorder under Scaffidi. The jury then rendered a gross award $1,500,000, The net award of $453,922 against the second defendant psychiatrist fell within the parameters of the high/low agreement, and together with the $420,000 settlement by the first psychiatrist, provided a net judgment to the plaintiff of $873,922.

REFERENCE

Movitz vs. Sostowski, et al.; Judge James Rothschild, 07-00-14.

Attorney for plaintiff: Bruce H. Nagel of Nagel Rice,LLP in Roseland, NJ.

COMMENTARY

It is thought that of especially great significance in this case are the proximate cause issues in medical malpractice cases relating to the interplay between the concept of substantial factor and the reduction of any award, because of the pre-existing condition under Scaffidi. In this regard, the plaintiff argued that, unless the jury is sufficiently instructed regarding the two separate concepts, juror confusion is especially likely. The court, in its instructions, endeavored to clarify this issue for the jury, and accepted the plaintiff's arguments that they should be charged that even a finding as low as 3% would be sufficient to establish such a substantial factor.

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DEFENDANT'S VERDICT – MEDICAL MALPRACTICE – PRIMARY CARE NEGLIGENCE – WOMAN SUES DOCTOR AFTER BREAKOUT OF FACIAL BLISTERS – PAIN AND SUFFERING DUE TO BREAKOUT

Harris County, TX

In this case, a woman accused her doctor of prescription malpractice. The defendant denied this, and the case was decided by a Harris County jury.

On August 16, 2010, the 50-year-old plaintiff, Rosetta R., visited the office of defendant, Dr. H., her long-time primary care physician, to be treated for fever blisters, as well as a refill of her medications. The patient had a history of eczema, fever blisters, and facial acne. After examination, the plaintiff was given refills on her prescriptions for Clindamycin 1% lotion for her acne, Halobetasol 0.05% ointment for her eczema, and Zovirax 5% cream and Valcyclovir 500mg tablets for her fever blisters. The plaintiff had these prescriptions filled on this same day. Several months later, in January and February 2011, the plaintiff suffered a severe breakout of blisters on her face. Due to her condition, she was unable to leave her home, and was too embarrassed to work for two weeks. The plaintiff filed suit against her doctor in the 281th District Court of Harris County, accusing the defendant of breaching the standard of care by the prescription of Halobetasol to treat facial acne, and otherwise engaging in "polypharmacy," by prescribing multiple medications at once. The plaintiff sought recovery of pain and suffering damages. The defendant denied breaching the standard of care. At trial, the plaintiff argued that her doctor negligently wrote the prescription of Halobetasol, a heavy strength steroid cream, with instructions to use it on her face, causing her to suffer a severe breakout of facial blisters. The defendant denied this, asserting that the Halobetasol was not prescribed for her face, but for the eczema on her elbows. They argued that plaintiff had confused her medications, and used the wrong prescription on her face. The plaintiff admitted having thrown away the prescription information leaflets from her August visit. Further, the defense pointed out that in December 2010, the plaintiff received large amounts of prescription steroids to treat a sinus infection from a different doctor. They argued that the breakout could have been caused by the large influx of additional steroids into her system, as well as the impropriety of her applying Halobetasol to her face.

The jury found the defendant was not negligent, and that the plaintiff, herself, was 100 percent responsible for the occurrence in question.

REFERENCE

Plaintiff's Dermatology expert: Boris Zaks. Plaintiff's Internal Medicine expert: Anthony Zollo. Defendant's Internal Medicine expert: Hugh Poindexter.

Rosetta Ross vs. Yaa Amoah-Honny, M.D.; Judge Sylvia A. Matthews, 09-17-14.

Attorneys for plaintiff: Roy J. Elizondo, III of Elizondo Law Firm in Houston, TX. Attorney for defendant: James B. Edwards, Donald S. Stevens & Stacy T. Garcia of Edwards & Stephens in Stafford, TX. Attorney for defendant: Bradford G. Leigh of Leigh Law Firm in Woodlands, TX.

COMMENTARY

The plaintiff's expert, Dr. Anthony Zollo, testified that the defendant should not have prescribed multiple medications at the same time. The plaintiff's dermatology expert, Dr. Boris Zaks, testified that defendant breached the standard of care by prescribing Halobetasol to treat facial acne. However, under cross-examination, Dr. Zaks acknowledged that Halabetasol was appropriate for use in treating eczema on the elbows. Dr. Poindexter testified as an expert for the defense that it was clearly within the standard of care to prescribe different medications for different medical issues at the same time, as long as the prescriptions did not interact. He further testified that use of Halobetasol for eczema is within the standard of care, and that it is recommended that patients keep eczema medication available to them for unexpected flare-ups of the rash.

DEFENDANT'S VERDICT MEDICAL MALPRACTICE – ANESTHESIOLOGY – PLAINTIFF SUFFERS HYPOXIC BRAIN INJURY DURING CARDIAC SURGERY WHEN DEFENDANT ATTEMPTS TO SWITCH PLAINTIFF'S ENDOTRACHAEL TUBE DURING SURGERY – NEUROLOGICAL DEFICITS – BLINDNESS IN RIGHT EYE.

Montgomery County, PA

The plaintiff, in this medical malpractice action, alleged that he suffered serious and permanent brain damage when he was without proper oxygen during cardiac surgery. The plaintiff sued the anesthesiologist, alleging she failed to properly place the central line, and negligently attempted to change the endotracheal tube from a double line to a single line. The defendant denied being negligent, and denied that the plaintiff's injuries were related to any anesthesia services, and were instead related to post-operative complications.

On February 25, 2009, the 58-year-old male plaintiff underwent heart surgery for severe aortic stenosis, after suffering a fainting episode at his home earlier in the week, in which he fell and struck his head. During the procedure, for which the defendant provided anesthesia services, the plaintiff's position was changed, and it was noted that he had severe swelling of the neck and head. Upon seeing this, the defendant anesthesiologist

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attempted to exchange the plaintiff's endotrachael tube from a double to a single, but encountered difficulty placing the tube due to the immense swelling. The plaintiff maintained that during the time the tube was dislodged, the plaintiff was without oxygen and suffered an anoxic brain injury. The plaintiff blamed the incident on the negligence of the anesthesiologist, arguing that she failed to properly insert and secure the central venous catheter which dislodged and caused the swelling, failure to leave the original endotracheal tube in place in the setting of massive head and neck swelling, and negligently attempting to replace the endotracheal in light of the severe swelling in the plaintiff's neck. The plaintiff maintained that the lack of oxygen caused an anoxic brain injury with neurological impairment, near total loss of vision in right eye, memory deficits, impaired judgment, and an altered gait. The plaintiff now requires constant supervision. The defendant denied that the central line dislodged and caused the swelling, arguing that the line remained intact and in place, and that the cause of the swelling is undetermined. The defendant further argued that it was the joint decision of both the defendant and the surgeon to change the endotracheal tube in light of the swelling, and although the new tube could not be placed, the defendant quickly applied a mask airway. The defendant argued that the plaintiff's injuries were the result of post-surgical complications, including nasal hemorrhaging, and were not related to the cardiac surgery.

The jury found that the defendant's care and treatment of the plaintiff was proper, and in accordance with standards.

REFERENCE

Defendant's cardiac anesthesiology expert: Daniel Nyhan M.D. from Baltimore, MD.

John and Joyce Koniewicz vs. Shyla Banvi M.D. and Lankenau Hospital. Case no. 2011-04583; Judge Carolyn T. Carluccio, 09-19-14.

Attorney for plaintiff: Steven Barrett of Hamburg, Rubin, Mullin, Maxwell & Lupin in Landsdale, PA. Attorney for defendant: John Filoreto of Eckert Seamans Cherin & Mellott, LLC in Norristown, PA. Attorney for defendant: James Kilcoyne of Law Offices of Kilcoyne & Nesbitt, LLC in Plymouth Meeting, PA.

COMMENTARY

The defendant was able to provide expert medical testimony from a board certified cardiac anesthesiologist with over 25 years' experience who testified that the defendant's actions during the cardiac surgery were proper, and in accordance with all medical standards. This expert maintained that the medical records from the cardiac surgery indicated that the plaintiff's oxygen saturation levels never fell below 93%, which proves that the defendant never "lost the plaintiff's airway," so that the plaintiff could not have suffered a hypoxic brain injury from oxygen deprivation. This expert also testified that the decision to go from a double lumen tube to a single was appropriate in light of the swelling that was seen at the conclusion of the surgery when the plaintiff's position was changed. When the defendant attempted to place the single lumen tube and was unsuccessful due to the swelling, she immediately placed a laryngeal mask airway on the plaintiff, successfully oxygenating and ventilating the plaintiff.

Verdicts by Specialty

Ambulance Service Negligence

$400,350 GROSS VERDICT

Negligent ambulance transport – Plaintiff dropped from stretcher – Hip fracture – 25% comparative negligence found.

Miami-Dade County, FL

The plaintiff was a 69-year-old female being transported home from the hospital by the defendant transport service after undergoing left hip replacement surgery. The plaintiff alleged that the defendant's employees negligently dropped her while transferring her from the stretcher to her bed.

The plaintiff called her daughter and granddaughter who supported the plaintiff's claim that she was dropped from the stretcher by the defendant's employees. The plaintiff claimed that she sustained a fracture of the (non-operative) right hip as a result of the incident, and that she required rehabilitative therapy.

The defendant maintained that the plaintiff's transfer was routine without incident. The defense argued that there was no report of the alleged incident, and the plaintiff made no complaints to the defendant. It was the defendant's position that the plaintiff's left hip injury occurred before the date of this claimed incident and was part of her prior hip injury. The defense also contended that the plaintiff was given a walker on release from the hospital, as she was walking prior to discharge, but the plaintiff failed to use the walker upon arrival at home.

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The jury found the defendant 75% negligent, and the plaintiff 25% comparatively negligent. The plaintiff was awarded $400,350 in total damages, reduced accordingly. The defendant has filed an appeal.

Attorney for plaintiff: Paul A. McKenna of Paul A. McKenna & Associates in Coral Gables, FL. Attorney for defendant: Michael S. Kaufman of Michael S. Kaufman in Miami, FL.

REFERENCE

Lozano vs. MCT Express, Inc. Case no. 13-06462-CA-42; Judge Victoria S. Sigler, 06-10-14.

Cardiology

1,750,000 RECOVERY

Failure to recognize signs and symptoms of stroke after cardiac catheritization – Hemianopsia

Cook County, IL

This case involved a plaintiff in her late 40s who was admitted to the defendant hospital on June 6, 2011 for a cardiac catheterization procedure. The evidence reflected that after a cardiac catheterization, a patient is at an increased risk for a stroke because plaque can be loosened from blood vessel walls and travel to the brain, or an air embolus can be released from the catheter tipm and also travel to the brain. The plaintiff argued that shortly after waking up from the procedure, she complained of nausea, a severe headache, and loss of vision. The plaintiff contended that she was exhibiting signs and symptoms of a stroke that were not timely identified and treated. The following morning, the plaintiff was airlifted to a stroke treatment center where she was diagnosed with a right occipital lobe infarct, resulting in left sided hemianopsia (total visual field loss on the left of the vertical midline in each of her eyes).

The plaintiff maintained that because of the delay in diagnosis, physicians could not perform interventions to lessen or reverse the visual effects of the stroke.

The case settled prior to trial for $1,750,000, including $1,000,000 from the hospital, and $750,000 from the cardiologist performing the catheterization.

REFERENCE

Males vs. Adventist Glenoaks Hospital, et al. Case no. 2012 L 011998, 02-21-14.

Attorneys for plaintiff: John J. Perconti and Jordan S. Powell of Levin & Perconti in Chicago, IL.

$500,000 VERDICT

Cardiothoracic surgeon places pacemaker leads in wrong chamber of heart – Mistake noticed upon routine testing one year later – Plaintiff must now take Coumadin permanently and remains at risk of clotting and internal bleeding

Mercer County, NJ

The plaintiff, 64-years-old at the time, and 70 at trial, underwent surgery in which a pacemaker was installed, and contended that the defendant cardiothoracic surgeon negligently placed the leads in the wrong chamber of the heart.

The mistake was not discovered until routine testing showed it approximately one year later, and due to the passage of time, the wire could not be removed. The plaintiff supported that she remains at risk for clotting, necessitating Coumadin, and that because of the need for the blood thinner, she is also at increased risk for internal bleeding, and must be especially careful to avoid injury. The defendant maintained that the chance of clotting is small. The plaintiff countered that the complication involving the free floating wire in the wrong heart chamber is so rare, that the actual extent of the risk is not known with certainty. The plaintiff maintained that, in addition to the physical risk itself, the emotional consequences are great. The defendant pointed out that the plaintiff had been taking Plavix at the time, which was ultimately discontinued, and argued that the need to take a different blood thinning medication was of limited consequence. The plaintiff countered that the risks associated with Coumadin are much greater.

The jury found for the plaintiff and awarded $500,000.

REFERENCE

Rothman vs. Cole. Docket no. MER-L-2268-11; Judge William Anklowitz, 09-15-14.

Attorney for plaintiff: Richard Grungo, Jr. of Archer & Greiner, PC in Haddonfield,, NJ.

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Chiropractic

DEFENDANT'S VERDICT

Defendant chiropractor performs unwarranted contraindicated lumbar maneuver on plaintiff – Failure to obtain informed consent – Herniated L4-5 disc.

Trenton County, NJ

In this chiropractic malpractice action, the plaintiff maintained that the defendant chiropractor performed manipulations on the plaintiff's lumbar spine that was unwarranted, causing injury to a lumbar disc. The defendant doctor, as well as the doctor's practice, both denied all allegations of negligence, and argued that the plaintiff was properly treated in accordance with medical standards.

On July 19, 2010, the female plaintiff first presented to the defendant, at the defendant medical facility, for an evaluation of her scapular area with complaints of pain. The defendant obtained x-rays of the plaintiff's thoracic and lumbar spine. The plaintiff was treated by the defendant several times in July and August of 2010, and despite having no complaints of low back pain, the defendant performed several lumbar manipulations on the plaintiff, causing injury to the plaintiff's spine. At some point, subsequent to the defendant's treatment of the plaintiff in July and August of 2010, the defendant abandoned the plaintiff, and instructed her and her husband to cease any communication with him and the defendant facility. The plaintiff's complaint alleged that the defendant doctor failed to: Take, and perform, an adequate history and evaluation of her underlying conditions, document his impressions, including a diagnosis and plans of action, provide treatment in accordance with accepted medical and chiropractic standards, as well as obtain informed consent from the plaintiff.

The plaintiff alleged that as a result of the defendant's negligent treatment, the plaintiff suffered a herniated disc at L4-L5, a denervation of the bilateral S1, and other nerve roots, bilateral S1 radiculitis, a central disc protrusion, and an inability to safely complete a pregnancy and deliver a child. The defendant denied all allegations of negligence, and argued that he provided care that was at all times in accordance with all medical standards.

The jury found that the defendant deviated from the standard of care, but that his deviation did not cause any factual harm to the plaintiff. The jury also found that the defendant did obtain the plaintiff's informed consent before he performed any manipulations on the plaintiff's lumbar spine.

REFERENCE

Casey and Samuel Rothschild vs. Howard S. Tornopsky, D.C., Adelphia Chiropractic Center. Docket no. 12-cv-03901; Judge Tonianne J. Bongiovanni, 07-23-14.

Attorney for plaintiff: Elliot Elo in New York, NY. Attorney for defendant: Jeffrey B. Randolph in Glen Rock, NJ.

Dental

$287,500 RECOVERY

Instrument breaks during root canal and is left in tooth when sealant applied –Instrument found and removed by non-party subsequent treating dentist several months later – Plaintiff contends she continues to suffer severe trigeminal pain and that such pain will continue permanently – No actual diagnosis of trigeminal neuralgia

Westchester County, NY

The plaintiff, in her late 20's at the time, contended that the defendant dentist negligently broke a file into tooth no. 5 as he was performing root canal, and failed to remove it before sealing the tooth. The plaintiff contended that such events would not occur in the absence of negligence. The plaintiff related that she returned to the defendant on a number of occasions in the ensuing few weeks, and was told that she was simply suffering normal pain following root canal. The plaintiff supported that several months after the root canal, she visited the subsequent treating non-party dentist who took an x-ray, and discovered the instrument, and removed the instrument. The plaintiff contended, however, that she continues to suffer severe trigeminal pain, and the plaintiff maintained that such pain will continue permanently. There was no actual finding of trigeminal neuralgia.

The case settled prior to trial for $287,500.

REFERENCE

Plaintiff's Dental expert: Richard Strauss, DDS from Long Island, NY.

Plaintiff dental patient vs. defendant dentist., 10-15-14.

Attorneys for plaintiff: Richard L. Giampa and Zachary Giampa of R Giampa,PC in Bronx, NY.

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DEFENDANT'S VERDICT

Alleged improper height of crown placed during full mouth restoration – Alleged excessive height of crown caused an asymmetrical increase to the vertical dimension and resulted in TMJ dysfunction

Westchester County, NY

The plaintiff, who was undergoing a full mouth restoration that was to entail the ultimate placement of fixed bridges and crowns, contended that the defendant placed an improperly sized crown on tooth no. 18 , the second left lower molar. The plaintiff maintained that as a result, the vertical dimension of the mouth was improperly altered, and that the resulting pressure caused TMJ dysfunction, which will permanently cause pain and difficulties opening his mouth and eating hard foods. The defendant denied that an improperly sized crown was used on tooth 18. The defendant contended that a temporary crown on tooth 18 and a temporary partial anterior denture, caused a slight, 1mm increase in the vertical dimension, and maintained that such a slight increase is a known risk that can occur in the absence of negligence. The defendant also contends that plaintiff did not suffer a TMJ injury as a result of the dental treatment, but that he was predisposed of the condition due to his extensive medical history. The alleged negligence occurred approximately 1/3 of the way through the course of treatment, and the plaintiff did not continue with the defendant after this point.

The jury found for the defendant.

REFERENCE

Hart vs. Avenzato, DDS. Index no. 52325/11, 07-00-14.

Attorney for defendant: John Polinsky of Rende Ryan & Downes,LLP in White Plains, NY.

Hospital Negligence

DEFENDANT'S VERDICT

Following bowel obstruction surgery, decedent develops tachycardia and increased respiration, which the defendants fail to investigate and address – Failure to appreciate decedent's symptoms – Wrongful death of 74-year-old male.

Philadelphia County, PA

In this medical negligence action, the plaintiff maintained that the defendant doctor and hospital staff failed to appreciate the decedent's symptoms of tachycardia and increased respiration following bowel obstruction surgery performed by the defendant doctor. The defendants denied all allegations of negligence, and argued that the decedent's death was caused by preexisting comorbidities, and not negligence.

On October 6, 2010, the male decedent presented to the defendant hospital's ER with complaints of two days of nausea and vomiting. The decedent's history was significant for obesity and hypertension, and was diagnosed with a bowel obstruction. An exploratory laparotmy was performed by the defendant doctor on October 8. The following day, the decedent experienced an increase in respiration. Nursing notes over the next 24 hours indicate the decedent was tachycardic with increased respirations. Despite these concerning symptoms, no work up was ordered by the defendants. On October 11, 2010, the decedent developed severe shortness of breath. The rapid response team was called, however, the decedent became unresponsive and died a short while later from a pulmonary embolism. The plaintiff maintained that the defendants were negligent in improperly assessing the decedent's risk for pulmonary embolism, improperly administering heparin prior to bowel obstruction surgery, failing to order proper diagnostic tests, and failing to appreciate the significance of increased respirations and tachycardia. The defendants denied all allegations of negligence, and argued that the decedent was provided care that was in accordance with all medical standards. In addition, the defendants maintained that it was the decedent's comorbidities that caused his death, and not negligence.

The jury found for the defendants.

REFERENCE

Estate of Malcolm Wilson by Stephanie Snipes Wilson vs. Aria Health and Dr. Jan Olenginski. Case no. 120201970; Judge Albert Snite, 06-02-14.

Attorney for plaintiff: Briggs Bedigian of Gilman & Bedigian, LLC in Lutherville-Timonium, MD. Attorney for defendant: Michael McGilvery of Young & McGilvery, P.C. in King of Prussia, PA.

DEFENDANT'S VERDICT

Defendants fail to diagnose plaintiff with Cauda Equina Syndrome – Failure to appreciate plaintiff's complaints and symptoms – Permanent neurological damage to lumbar nerve roots.

Philadelphia County, PA

In this medical malpractice action, the plaintiff maintained that the staff at the defendant

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hospital failed to appreciate the plaintiff's symptoms and complaints, and failed to diagnose the plaintiff's with Cauda Equina Syndrome, which is a surgical emergency. The defendants denied being negligent, and maintained that care provided to the plaintiff was proper and in accordance with medical standards.

On February 23, 2010, the female plaintiff presented to the defendant hospital with complaints of severe pain in her low back radiating down both legs. In addition, she had decreased sensation in both legs and decreased sensation urinating. The plaintiff informed the defendant of her significant history over the past few months of severe low back pain with a diagnosis of a large L4-5 disc herniation, parasthesia, muscle spasms, and inability to bear down and have a bowel movement. The defendant discharged the plaintiff with instructions to follow-up with a back specialist. Two weeks later, the plaintiff saw a specialist who diagnosed the plaintiff with Cauda Equina Syndrome, and a L4-5 disc surgery was performed on March 2, 2010. The plaintiff suffers permanent physical and neurological injuries from the defendant's failure to diagnose Cauda Equina Syndrome. The plaintiff maintained that the staff at the defendant hospital was negligent in failing to adequately, properly, and timely diagnose the acute Cauda Equina syndrome, failing to order a follow-up MRI to look for a worsening of the L4-5 disc herniation, failing to appreciate the plaintiff's complaint, failing to perform emergent testing, and failing to appreciate the significance of the bladder scan, indicating retention of the bladder. As a result, the plaintiff suffered Cauda Equina Syndrome, numbness from right foot up to right pelvis, complete pelvic and perineal numbness, difficulty with bladder and bowel movements, and balance and intimacy issues. The defendant denied all allegations of negligence, and argued that the plaintiff was provided care that, at all times, was in accordance of the proper standard of care.

The jury found that the defendant was negligent, but that their negligence was not a factual cause of harm to the plaintiff.

REFERENCE

Quadina Bonilla vs. Jeanes Hospital. Case no. 120105051; Judge John M. Younge, 06-20-14.

Attorney for plaintiff: Todd Miller of Todd S. Miller & Associates in Allentown, PA. Attorney for defendant: Ira Bushman of Dolchin, Slotkin & Todd, P.C. in Philadelphia, PA.

$48,750 RECOVERY

Hospital staff fails to properly recognize, record, and communicate findings significant for a urinary tract infection – Decedent develops sepsis from UTI and dies – Wrongful death of 81-year-old male

Allegheny County, PA

In this medical negligence action, the estate of the decedent alleged that the defendant hospital staff failed to properly diagnose and treat urinary retention and infection, which caused sepsis and death of the decedent. The defendant denied all allegations of negligence.

The 82-year-old male decedent was admitted to the defendant long-term care facility on May 6, 2010. Prior to his admission, he had been hospitalized for several months for bilateral pneumonia with complications. His history was significant for an enlarged prostate and urinary tract infections. Beginning on May 31, 2010, the decedent started complaining of lower abdominal pain. Nursing notes over the next two weeks indicate a distended stomach, thick urine, decreased urine output, and a blockage of the catheter. The decedent's doctors were not made aware of these nursing findings. The decedent complained of discomfort with the catheter, and it was removed per doctor's orders on June 7, 2010. Over the next 24 hours, the decedent developed a fever. His stomach was distended, and there was a change in his mental status. Nursing records do not indicate that the staff was monitoring the decedent's urine output after the catheter was removed. At 7:00 am on June 9, the decedent was taken to a local hospital for his continued fever and hardened abdomen. He was diagnosed with a urinary tract infection and sepsis. He developed renal failure and respiratory distress. His condition continued to deteriorate despite treatment, and he died on July 5, 2010. The allegations of negligence against the defendants were failing to prevent the decedent from the following: Developing urinary retention, prevention from a urinary tract infection and sepsis, adequately tract the decedent's vitals, monitor the decedent's hydration and output, and to adhere to the decedent's care plan. The defendant denied all liability and injury. The defendant argued that the decedent's medical outcome was the result of pre-existing, or naturally occurring progression, and not the result of any negligence.

The parties settled their dispute for $48,750.

REFERENCE

The estate of William Carver Sr. by William Carver Jr. vs. Commons at Squirrel Hill. Case no. GD-12-007910; Judge Ronald Folino, 04-02-14.

Attorney for plaintiff: Elizabeth Chiappetta of Robert Peirce & Associates, P.C. in Pittsburgh, PA. Attorney for defendant: Anthony Williott of Marshall Dennehey Warner Coleman & Goggin, P.C. in Pittsburgh, PA.

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SUMMARY JUDGMENT FOR DEFENDANT

Claimed negligent performance of surgery to remove abdominal tumor – Laceration of vena cava – Wrongful death.

Hillsborough County, FL

The plaintiff claimed that the decedent, a 69-year-old female, sustained a negligently-caused laceration of the vena cava, causing her death during surgery to remove an abdominal tumor at the defendant hospital. The defendant hospital argued that the plaintiff could not maintain a case against the hospital, and moved for summary judgment. The physicians involved in the plaintiff's treatment settled for an undisclosed sum.

The plaintiff's complaint alleged medical negligence on the part of the defendant hospital under theories of agency, apparent agency, and non-delegable duty. The plaintiff argued that the surgeons were agents of the defendant hospital, and that the defendant hosptial failed to properly notify the patient of its delegation of duties and responsibilities of the surgical services to the surgeons. The plaintiff also claimed the defendant hospital had both a contractual and federal obligation to provide non-negligent surgical medical services to the decedent.

The defendant hospital relied on Florida Statute Section 1012.965 for the plaintiff's agency claims. That Statute states in pertinent part: "An employee or agent under the right of control of a university board of trustees who, pursuant to the university board's policies or rules, renders medical care or treatment at any hospital or health care facility.... shall not be deemed to be an agent of any person other than the university board in any civil action resulting from any act or omission of the employee or agent while rendering said medical care or treatment."

Regarding the plaintiff's non-delegable duty claims the defendant cited Tarpon Springs Hospital Foundation v. Reth. In that case, the Appellate court reversed the denial of a hospital's motion for directed verdict, and stated that the "applicable statutes and rules do not impose a nondelegable duty to provide anesthesia services to surgical patients."

The court granted the summary judgment motion as to all counts against the defendant hospital following a two-hour hearing. The plaintiff has appealed the ruling.

REFERENCE

Godwin vs. Tampa General Hospital. Case no. 12-CA-000017 Division B; Judge Martha J. Cook, 04-01-14.

Attorneys for defendant: Paula J. Parisi and Robert J. Murphy of Cole, Scott & Kissane in Tampa, FL.

Nursing Home Negligence

$200,000 RECOVERY

Alleged failure to provide adequate supervision to nursing home resident – 78-year old plaintiff slips and falls on snow on deck as she is having cigarette – Failure to take x-rays and diagnose leg fractures for several days

Essex County, NJ

The plaintiff, a 78-year-old plaintiff nursing home resident, who had been admitted with dementia and assessed at being at high risk for falls, contended that the defendant was negligent and violated the Nursing Home Statute by failing to provide adequate supervision of the resident, and by failing to provide timely medical care. The plaintiff pointed out that a finding of a violation of the statute would give rise to an award for attorney fees, and also supported that the defendant negligently failed to have the deck adequately cleared after a snow storm. The plaintiff contended that as she was on the deck having a cigarette, she slipped and fell on ice. The defendant maintained that the deck was properly cleared and further contended that appropriate supervision was provided, and that an employee, and the plaintiff, were on the deck together.

The fall occurred on December 5, and the plaintiff contended that the defendant failed to take an x-ray until December 8. The x-rays showed a fracture of the tibia and fibula, and the plaintiff underwent an open reduction and internal fixation. The plaintiff developed an infection that was treated medically and lengthened her hospitalization.

The plaintiff contended that she will suffer permanent pain and limitations, and that the result is worse than it would have been if the fracture had been detected in a timely manner.

The case settled after the completion of discovery for $200,000.

REFERENCE

Plaintiff's geriatrics expert: Perry Starer, MD from Elmhurst, NY. Plaintiff's nursing expert: Jennifer Graney, RN from Allentown, PA.

Plt nursing home resident falling on deck vs. Deft nursing home., 08-04-14.

Attorney for plaintiff: Stacey Selem-Antonucci of S Selem-Antonucci,LLC in Union, NJ.

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DEFENDANT'S VERDICT

Plaintiff decedent falls from shower bench at defendant facility and suffers fatal injuries – Failure to properly supervise decedent – Wrongful death of 69-year-old female.

Philadelphia County, PA

In this nursing home negligence action, the estate of the decedent maintained that the staff at the defendant facility failed to properly supervise the immobile decedent while she was on a showering bench at the facility on July 27, 2011. The decedent was left unattended, and was found unconscious on the floor of the bench. She never regained consciousness and died three days later as a result of the incident. The defendant argued that the decedent suffered a natural death, and did not die as a result of negligence.

The decedent was a resident of the defendant care facility. She had become a resident of the facility due to a fall she suffered in 2008, which left her wheelchair bound and unable to care for herself.

The decedent is survived by her mother, who is in her 90's. The estate alleged that the defendant was negligent in failing to do the following: Properly supervise the decedent, hire competent staff, properly train staff, and take reasonable precautions to eliminate and prevent unreasonable risk of harm to the decedent. The defendant denied all allegations of negligence, and argued that the decedent suffered a natural cardiac episode, which caused her death.

The jury unanimously found no negligence on the part of the defendant.

REFERENCE

Estate of Carolyn Coleman by Mary and Marvin Coleman vs. Maplewood Nursing and Rehabilitation Center. Case no. 120403416; Judge Rosalyn Robinson, 05-05-14.

Attorney for plaintiff: David Brooks in Glenside, PA. Attorney for defendant: Robert Dillon of Naulty, Scaricamazza & McDevitt, LLC in Philadelphia, PA.

Ob/Gyn

$3,250,000 CONFIDENTIAL RECOVERY

Failure to timely perform Cesarean section when Infant showed signs of distress – Hypoxic ischemic encephalopathy

Withheld County, MA

In this medical malpractice matter, the plaintiffs, a mother and infant, allege that the defendants, an ob/gyn, resident, and nurse were negligent in failing to deliver the child who was in distress in a timely manner via Cesarean section. As a result, the child suffered a brain injury. The defendants disputed any deviation from acceptable standards of care.

The female plaintiff presented to the hospital in labor at 2 p.m. The infant's heart rate at the time of admission was normal. Almost three hours later, the infant's heart rate was a baseline of 160-165 with persistent, but mild, decelerations. Still later, the plaintiff mother was diagnosed with a fever, but the defendant physicians failed to order antibiotics for another three hours. Despite these worrisome issues, the physicians failed to initiate a Cesarean delivery. At 10:05 p.m. the infant was experiencing fetal tachycardia, and approximately 35 minutes later, the membrane was ruptured by the defendants, and thick meconium was present, yet still, no emergency delivery was performed. The defendants still failed to undertake any emergency delivery of the infant, despite a notation in the medical record that the infant was experiencing moderate fetal distress, and may require an operative delivery. By midnight, there was distinct evidence that the infant was suffering persistent late decelerations with decreased baseline variability and tachycardia, which was all consistent with hypoxia. A Cesarean section was not ordered until 1:30 a.m., and the child was not delivered until 2:14 a.m., 45 minutes after the emergency Cesarean section was ordered. The child had a heart rate at birth in the 50s, was blue and apneic, with Apgar scores of 1, 7, and 9. She was diagnosed with hypoxic ischemic encephalopathy. The plaintiff brought suit against the defendants, alleging negligence in the care of the plaintiff and infant during the labor, including a delay in the delivery of the child when it was very apparent that the infant was in fetal distress.

The defendants denied that there was any deviation from acceptable standards of care, and disputed the nature and extent of the plaintiff's injuries and damages. The defendants maintained that any brain injury occurred prior to the plaintiff's arrival at the hospital.

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The parties agreed to mediate the plaintiff's claim, and agreed to resolve the claim for the sum of $3,250,000 in a confidential settlement arising from the mediation.

REFERENCE

Plaintiff Mother and Infant Doe vs. Defendant Family Practitioner, et al., 06-04-14.

Attorneys for plaintiff: Elizabeth N. Mulvey and David W. Suchecki of Crowe & Mulvey in Boston, MA.

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$675,000 RECOVERY

Bladder negligently sutured to vaginal cuff at conclusion of total abdominal hysterectomy – Vessico-vaginal fistula – Need for four subsequent surgeries – Extended bed rest causes DVT and PE that is treated medically

Morris County, NJ

The 46-year-old plaintiff, who underwent a total abdominal hysterectomy that was performed by the two defendant ob/gyns, contended that the bladder was negligently sutured when the defendants closed the vaginal cuff. The plaintiff maintained that one of the defendants was negligent in failing to properly retract the bladder when the vaginal cuff was closed, and that the other negligently placed the suture into the bladder. The plaintiff maintained that she developed a vessico-vaginal fistula, and that she required four subsequent surgeries before the fistula was resolved.

The plaintiff supported that she was left with permanent moderate scarring and permanent stress incontinence, in which she feels the need to void much more frequently than would otherwise be the case. The plaintiff also contended that because of the need for extended bed rest, she suffered DVT and a PE. The embolus was treated medically. The plaintiff, however, required surgery to install a Greenfield filter into the inferior vena cava. The plaintiff will also permanently require Coumadin. The defendant denied negligence and contended that the plaintiff suffered a known complication. The defendant also maintained that the non-party urologist handled the subsequent care improperly.

The case settled prior to trial for $675,000.

REFERENCE

Plaintiff's ob/gyn expert: Victor Borden, MD from Teaneck, NJ. Plaintiff's urological expert: Jerry Blavis, MD from New York, NY.

Plaintiff undergoing abdominal hysterectomy vs. Defendant ob/gyns.

Attorney for plaintiff: John B. Collins of Bongiovanni Collins & Warden,PC in Denville, NJ.

$1,000,000 CONFIDENTIAL RECOVERY

Failure to document prior shoulder dystocia – Failure to inform plaintiff of increased risk of permanent damage to infant due to increased risk – Brachial plexus injury

Withheld County, MA

In this medical malpractice matter, the plaintiff mother alleged that the defendant obstetrician was negligent in failing to properly document the plaintiff's history of shoulder dystocia, and failure to inform the plaintiff of the risks associated with a vaginal birth given a prior history. As a result, the infant suffered a brachial plexus injury. The defendant denied the allegations, and disputed liability, damages and causation.

The plaintiff mother had a history of shoulder dystocia. This was not documented in the plaintiff's medical records. The plaintiff contended that since it was not documented, the defendant also failed to advise the plaintiff of the high incident that it would occur with the present pregnancy, thereby depriving her of the option of undergoing a Cesarean delivery, instead of putting the child at risk. The plaintiff infant suffered shoulder dystocia, and was diagnosed with a permanent brachial plexus injury following the vaginal birth. The plaintiff brought suit against the defendant doctors, alleging that they were negligent in failing to properly document her medical file, and in failing to properly advise her, regarding the increased risk for recurring shoulder dystocia, as well as the associated injuries, including permanent brain damage. The plaintiff maintained that had she been properly informed, she would have opted for a Cesarean delivery. The defendants' failure to properly inform her of all the risks associated with a vaginal birth in light of her medical history was a deviation from acceptable standards of care.The defendants denied the allegations and disputed liability and damages.

The parties agreed to resolve the plaintiff's claim for the sum of $1,000,000 in a confidential settlement agreement.

REFERENCE

Plaintiff Mother Doe vs. Defendant Ob/Gyn Roe et al., 04-01-14.

Attorneys for plaintiff: Kenneth M. Levine and Sheila E. Mone of Kenneth Levine & Associates in Brookline, MA.

$225,000 CONFIDENTIAL RECOVERY

Patient was not properly attended to, and suffered a large laceration when he was dropped by the defendant's staff – Deep laceration to leg

Withheld County, MA

In this rehabilitation facility negligence, the plaintiff alleged that the defendant was negligent in failing to properly attend to the patient who was at a high risk for falls and needed two people to attend to him. One nursing assistant was attempting to move the patient by herself and dropped him, causing a deep leg laceration that required

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the patient to be taken to the hospital. The defendant denied the allegations, and disputed the nature and extent of the patient's injuries and damages.

The 92-year-old male patient was admitted to the defendant's rehabilitation facility following a hospital stay for lower leg problems. He was assessed at a high fall risk, and was unable to ambulate without assistance. His plan of care required that two people assist, due to his high fall risk, including his unsteady gait and leg problems. On the date of this incident, a nursing assistant ignored the care plan and attempted to transfer the patient alone. She dropped the patient, and he sustained a large 4 x 4 centimeter deep laceration to his left shin area. He was transferred to the hospital and treated. Due to the nature of the location of the wound, it was not able to be sutured, and the wound took a very long time to heal since it was deep. The patient died of unrelated medical issues prior to this settlement. The plaintiff brought suit against the defendant facility, alleging negligence in its failure to properly attend to and treat the patient who was at a high risk for falling.The defendant denied liability, and disputed the nature and extent of the plaintiff's injuries and damages, citing that the patient's wound had healed without incident. The parties agreed to resolve the plaintiff's claim for the sum of $225,000 in a confidential settlement.

REFERENCE

Plaintiff Estate of Patient Doe vs. Defendant Rehabilitation Facility., 06-13-14.

Attorney for plaintiff: Robert Shuman of Robert A. Shuman & Associates in Sharon, MA. Attorney for plaintiff: David J. Hoey and Richard Bromby of Law Offices of David J. Hoey, P.C. in North Reading, MA.

Physical Therapy

DEFENDANT'S VERDICT

Defendant therapists maneuvers plaintiff's foot during physical therapy and causes injury – Failure to perform therapy in the manner prescribed by the doctor – Nonunion of talonvicular articulation – Complex regional pain syndrome.

Philadelphia County, PA

The plaintiff, in this medical malpractice action, had just undergone successful foot fusion surgery. She was sent to the defendants for therapy following the surgery. During a therapy session, the defendant painfully maneuvered the plaintiff's foot, causing injury to the plaintiff. The defendants denied all allegations of negligence, and argued that the nonunion was not caused by therapy.

On November 6, 2009, the female plaintiff underwent foot fusion surgery performed by a non party doctor. This doctor sent the plaintiff to the defendants for physical therapy. The doctor prescribed specific instruction to the defendants, including limitations and restrictions of the fuse foot. On December 2, 2009, the plaintiff was undergoing therapy by the defendant Smith, when Smith started applying too much pressure on the plaintiff's foot. The plaintiff informed the defendant that the therapy was too much, and still, the defendant continued to move the foot in extreme positions. The defendant applied so much force in an up and down maneuver that she caused the plaintiff extreme pain and a nonunion. The plaintiff alleged that the defendants were negligent in failing to perform therapies in the manner prescribed by the doctor, failing to follow and adhere to the standard of care involving patients with foot fusions, improperly performing physical therapy on the plaintiff's foot, and exerting too much pressure on the fusion area. As a result, the plaintiff suffered a nonunion of the talonvicular articulation, complex regional pain syndrome, L5 radiculopath, and right sural neuropathy. The defendant denied all liability and injury, and argued that the therapy was not related to the nonunion.

The jury found no negligence on the part of any defendant.

REFERENCE

Maritza Araya vs. Mariann Smith, Mark Human, and Novacare Rehabilitation Center. Case no. 101103675; Judge Leon Tucker, 05-29-14.

Attorney for plaintiff: Feeda Musitief of Fine and Staud in Philadelphia, PA. Attorney for defendant: Paul Troy of Kane Pugh Knoell Troy & Kramer LLP in Norristown, PA.

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Primary Care

DEFENDANT'S VERDICT

Defendant doctor fails to appreciate complaints of chest pains and a racing heart to plaintiff patient, and continues to prescribe Ritalin – Negligently and improperly prescribing Ritalin over a number of years – Massive stroke with severe cognitive deficits.

Philadelphia County, PA

The plaintiff, in this medical malpractice action, is the power of attorney for the now incapacitated patient. They claim that the defendant regularly prescribed Ritalin to the plaintiff without performing regular physical exams, and that the excessive Ritalin in the plaintiff's system caused, or contributed, to a massive stroke. The defendant denied that the stroke was related to the prescription.

The plaintiff began treating with the defendant doctor in 2002 for narcolepsy and pain. The defendant prescribed Ritalin to be taken three times a day. The plaintiff was only required to come in for yearly checkups, and the defendant, and his office, continued to prescribe the plaintiff Ritalin every month through 2009. The plaintiff complained over the phone to the defendant of chest pains and a racing heart, still the defendant did not require the plaintiff to come in for an exam, or send the plaintiff to the ER. On December 31, 2009, the plaintiff suffered a massive stroke. The plaintiff's complaint alleges that the defendant was negligent in failing to perform appropriate physical examinations, failing to anticipate and prevent the untoward condition of the plaintiff, improperly prescribing Ritalin over a number of years, improperly prescribing Ritalin over a number of years without performing a physical exam, and failing to run blood tests. As a result, the plaintiff suffered a massive left hemisphere stroke with catastrophic neurological defects, and a need for rehabilitation, home care, and skilled nursing. The defendant denied all liability and injury, and maintained that the stroke was unrelated to treatment. In addition, the defendant argued that the plaintiff was provided care that at all times was in accordance with the standard of care.

The jury found no negligence on the part of the defendants.

REFERENCE

Wilma Ingui as Power of Attorney for John Ingui vs. James Bonner M.D. and Physical Therapy Physicians PC. Case no. 111002391; Judge Angelo Foglietta, 06-19-14.

Attorney for plaintiff: Derek Layser of Layser & Freiwald, P.C. in Philadelphia, PA. Attorney for defendant: Paul Troy of Kane Pugh Knoell Troy & Kramer LLP in Norristown, PA.

Radiology Negligence

DEFENDANT'S VERDICT

Alleged failure to detect breast cancer

Miami-Dade County, FL

In this matter, a woman suffering from breast cancer sued her radiologist. The matter was resolved through a jury verdict after the defendant denied liability.

On July 14, 2008, the 41-year-old plaintiff, Hortensia M., went for a routine mammogram screening, which was interpreted by the defendant, Dr. Jorge S., a radiologist. The mammography report identified a "nodule" in the plaintiff's right breast. Approximately one year later, the plaintiff developed metastasized cancer, which spread from her breast to her lymph nodes, and ultimately to her vertebrae. The defendant was insured by Lancet Indemnity RRG, a physician owned and directed professional liability insurance carrier.

The plaintiff filed suit in the 11th Judicial Circuit for Miami-Dade County, Florida for medical malpractice, accusing the defendant, Dr. S., of breaching the standard of care by failing to detect her cancer. The plaintiff sought over $26,000,000 in damages, including $5,316,940 in lost earnings, past and future medicals, and $20,985,000 in pain and suffering. The defendant denied the accusation. By the time of trial, the plaintiff's cancer had progressed further, and testimony given to the court gave her a life expectancy of less than two years. The plaintiff's primary care doctors were also named as co-defendants, but ultimately were dismissed prior to trial.

At trial, it was uncontroverted that the plaintiff's primary care doctor never met with the patient, nor informed the plaintiff of the results. The alleged truth was further disputed that the plaintiff subsequently presented to a second primary care doctor complaining of breast pain. The plaintiff argued that the defendant, Dr. S., knew that there was cancer on the film in 2008, but failed to indicate it in his report. The plaintiff brought as evidence a videotaped deposition, taken in 2013, in which defendant admitted to being aware of cancer in July of 2008. However, the defendant subsequently recanted the testimony in a

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later deposition, claiming that he was confused at the earlier deposition.

The defense called both primary care doctors as adverse witnesses. The first primary care doctor admitted that it took four months for him to fax the plaintiff a copy of her mammography report. The second primary care doctor testified that, although she saw the plaintiff on four occasions, she did not review the mammography report at all. The defense also called Kevin Inwood, M.D., a board certified internal medicine specialist of Jupiter, Florida, who testified that the primary care doctors breached the standard of care by failing to refer the plaintiff for a surgical consult and/or surgical biopsy. Expert testimony offered by both parties agreed that, had a surgical biopsy been ordered within a year of the original finding, the plaintiff's cancer would have likely been detected before it metastasized.

The jury returned a finding for the defendant, rejecting the plaintiff's theory of liability against the defendant doctor.

REFERENCE

Hortensia Martin vs. Jorge Jose Sowers, M.D.; Judge Peter Lopez, 09-30-14.

Attorney for plaintiff: Maria Rubio in Miami, FL. Attorney for defendant: Steven L. Lubell of Lubell & Rosen, LLC in Syosset, NY.

DEFENDANT'S VERDICT

Defendant's fail to properly read and interpret the decedent's MRI which showed a glioma of the brain in 2009 – Negligently reporting the MRI as negative when it was positive – Wrongful death.

Philadelphia County, PA

The plaintiff, in this medical malpractice action, maintained the defendants failed to properly read and interpret a brain MRI taken in 2009, which the plaintiff claims actually showed a glioma. The glioma was diagnosed a year later, and despite therapy for the glioma, the decedent died from issues related to the ailment in 2011. The defendants denied that the glioma was present on the MRI. and argued that even it were it would not have altered the decedent's medical course or outcome.

On March 27, 2009, the plaintiff's decedent presented to the defendant radiology group for an open MRI which had been ordered following the decedent's complaints of neck pain and headaches, after he was involved in a motor vehicle accident. The MRI was interpreted by the defendant, Liem, and read as "negative brain MRI with mild cerebral atrophy." A report was generated by the defendants and sent to the decedent, the decedent's doctor, and the plaintiff, stating that the impression of the MRI was negative. On April 1, 2010, the decedent presented to a non-party radiology group for MRI of the brain, following continued complaints of headaches and a change in vision. The MRI revealed a 3 x 9 x 5.6 cm glioma in the right temporal lobe. Removal of the glioma was done in April 2010, followed by radiation and chemotherapy. Unfortunately, the decedent died from complications of the glioma on March 12, 2011. The plaintiff maintained that the defendants were negligent in their performance, interpretation, and reporting of the decedent's MRI, and negligently reported the MRI as negative when the MRI showed a lesion. The defendant's denied all allegations negligence, and argued that glioma was not present in the 2009 MRI, and that even if the glioma had been detected earlier, it would not have changed the decedent's medical outcome.

The jury found that the defendants were not a factual cause of harm to the plaintiff, and rendered a defense verdict.

REFERENCE

Estate of James Cole by Carol Cole vs. Marina Liem M.D and Tri State Imaging Consultants. Case no. 120105121; Judge Angelo Foglietta, 06-06-14.

Attorney for plaintiff: Harry Roth of Cohen Placitella & Roth in Philadelphia, PA. Attorney for defendant: Dean Murtagh of German, Gallagher & Murtagh in Philadelphia, PA. Attorney for defendant: Raymond McGarry of Wynn McGarry LLC in King of Prussia, PA.

Surgeon's Negligence

$3,034,000 VERDICT

Doctor gives barium CT to plaintiff with perforated bowel – Failure to diagnose

Philadelphia County, PA

In this action, a soccer player sued his surgeon and the hospital, after the surgeon perforated his bowel, including a missed diagnosis, that landed him in a hospital for a month. The defendants denied breaching the standard of care, and the matter was resolved by a Philadelphia jury.

The 27-year-old plaintiff, Juan D., was a soccer player set to play professionally in Colombia. Prior to leaving for Colombia, the plaintiff began experiencing pain in his left groin. He consulted the defendant, Dr. William M., who recommended him for a surgical procedure developed by the doctor to treat groin pain. The plaintiff was assured that he'd be fully healed and ready to play within three weeks. The plaintiff was discharged from Hahnemann University Hospital the evening after

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his surgery, where he immediately began experiencing severe abdominal pain. Juan D. called Dr. M several times, and the doctor called in a prescription for pain medication. When the pain continued, Juan returned to Hahnemann's ER the afternoon following. Dr. M sent his resident, a Hahnemann employee, to evaluate Juan's condition.

The resident ordered a CT scan with oral barium contrast, which is absolutely contraindicated if there is any chance of a bowel perforation. If barium leaks into the abdomen, it causes massive inflammation, severe infection, and scarring. The scan revealed a bowel perforation with spread of intestinal contents and barium throughout the plaintiff's abdomen. The plaintiff, thereafter, required a month-long hospital stay, multiple surgeries, and placement of drains to clear recurrent infected abscesses.

The plaintiff filed suit against the hospital and Dr. M. in the Philadelphia Court of Common Pleas, accusing both of breaching the standard of care. The plaintiff sought recovery of his future medical expenses, as well as damages for pain and suffering. The defendants denied breaching the standard of care.

At trial, the plaintiff asserted that his condition upon returning to the hospital clearly indicated a perforated bowel. Despite this, the plaintiff was given barium contrast and showed that the hours of waiting at the hospital without diagnosis, followed by improper administration of barium, caused him to develop barium peritonitis, resulting in the formation of dense scar tissue in his abdomen. Immediately before the verdict, the hospital offered $1,500,000 to settle the case. The plaintiff rejected that offer. At the conclusion of trial, the jury returned a verdict for the plaintiff, concluding that both the hospital, and Dr. M., breached the standard of care. The jury awarded $3,034,000 in damages.

REFERENCE

Juan Duque vs. Hahnemann University Hospital, et al., 07-10-14.

Attorneys for plaintiff: Alisa Marion and Bradley Beckman of Beckman & Marion in Philadelphia, PA.

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