Medical Malpractice

Verdicts, Settlements & Experts

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ANESTHESIOLOGY

Dehydration Blamed for Paralysis During Surgery — $9.13 Million Minnesota Verdict. The plaintiff, a forty-seven year-old mechanic, presented to the hospital on February 22, 2012, dehydrated, septic, hypertensive, and with flu-like symptoms. He began receiving fluids and was diagnosed with a perforated bowel. Defendant determined he would need surgery to repair the perforation. Prior to surgery, plaintiff received an epidural. Throughout the surgery, plaintiff's blood pressure continued to drop, which resulted in more fluids and administration of phenylephrine. On February 23, nurses realized that plaintiff was unable to move his lower extremities. He underwent an MRI, and no lesion or hematoma was detected on the spinal cord. Plaintiff was finally diagnosed with an ischemic spinal-cord injury Plaintiff claimed he was severely dehydrated going into the surgery and was not given adequate fluids. Plaintiff alleged dehydration caused him to suffer a prolonged period of low blood pressure after anesthesia was administered, which resulted in a critical lack of blood flow to his spinal cord, permanently damaging the cord and leaving him paralyzed. Plaintiff's expert in anesthesiology opined that it was necessary for plaintiff to be properly rehydrated before surgery. The expert faulted the anesthesiologist for plaintiff's injuries, in giving an epidural to a patient who was severely dehydrated and septic. Plaintiff's neurology expert opined that the combination of the low blood pressure and the epidural caused a stroke on plaintiff's spinal cord. The anesthesiology expert for the defense opined that it was appropriate for plaintiff to receive an epidural prior to surgery, and that he received a proper amount of fluids during surgery.. The jury awarded plaintiff $9,137,000 in damages. **Plaintiff's Experts:** Linda Graham, RN, Minneapolis, MN; Charise Petrovitch, M.D., anesthesiology, Washington, DC; Michael McGarvey, M.D., neurology, Philadelphia, PA. **Defendant's Experts:** James Watson,M.D., neurology, Rochester, MN; Joseph Neal, M.D., anesthesiology, Seattle, WA. **Joseph W. Lakoskey v. Anesthesiology P.A.** Hennepin County (MN) Circuit Court No. 26-CV-14-8112. Colin F. Peterson, Brandon Thompson and Robins Kaplan, Minneapolis, MN for plaintiff. David C. Hutchinson and Mark W. Hardy, Geraghty, O'Loughlin & Kenney, St. Paul, MN for defendant

Aberrant Heart Rate Was Ignored Prior to Shoulder Surgery — Death — $2.5 Million New Jersey Settlement. The plaintiff's decedent was a fifty-seven-year-old man who presented to the defendant surgical center for elective right-shoulder surgery. Three hours after surgery, the decedent died. The cause of death was a tumor that secretes large amounts of adrenaline-like substance into circulation. The plaintiff asserted that the defendant anesthesiologist was responsible for monitoring the patient's vital signs and intervening if anything appeared abnormal before the surgery. The plaintiff asserted that the decedent had an aberrant heart rate prior to surgery and that the defendant deviated from the standard of care when he allowed the surgery to go on. During the surgery, when the defendant treated the decedent's wide complex tachycardia, his treatment deviated from the standard of care when he failed to treat the decedent's condition with the proper medications, and failed to appreciate the severity of the situation despite the problems with oxygenation and discoloration of the skin, and delayed having the decedent taken to the nearest hospital. The defendant argued that there was no reason to suspect a tumor, and therefore no reason to postpone the surgery. The defendant contended that there was no reason to believe the decedent was cyanotic after the surgery and there was no delay in calling for EMS to transfer the decedent. The case settled for $2,500,000. **Plaintiff's Experts:** Jill Fong, M.D., anesthesiology, New York, NY. Edward Julie, M.D., cardiology, Clifton, NJ. Anthony Heaney, M.D., endocrinology, Los Angeles, CA. **Defendant's Experts:** Frank Kern, anesthesiology, Long Island, NY. Normal Ertel, endocrinology, Newark, NJ. Richard Epstein, anesthesiology, Philadelphia, PA. **Carleen E. Perricone, Executrix of the Estate of Gerald J. Perricone v. Kareem Eltaki, M.D., Northern Valley Anesthesia, PA, Bloomfield Surgi Center LLC, doing business as Ambulatory Center of Excellence,** Hudson County (NJ) Superior Court, Case No. HUD-L-351-14. Daryl L. Zaslow, Eichen Crutchlow Zaslow & McElroy, Edison, NJ for the plaintiff. R. Scott Eichhorn, Marshall Dennehey Warner Coleman & Googin, Roseland NJ, for Kareem Eltaki, M.D. and Northern Valley Anesthesia, PA; Heather M. LaBombardi, Giblin Combs & Schwartz, Morristown, NJ for Bloomfield Surgi Center, LLC; defendants.

Alleged Failure to Prevent Movement During Eye Surgery — Loss of Vision — Illinois Defense Verdict. The plaintiff, a sixty-eight year-old retiree, underwent vitrectomy on his right eye on November 24, 2010, to address a macular hole in the right eye. The defendant anesthesiologist administered general anesthesia for the eye surgery. However, plaintiff moved during the procedure while under anesthesia, causing a choroidal hemorrhage to the right eye. Plaintiff alleged defendant failed to properly keep her under anesthesia, failed to use the appropriate amount of muscle relaxant to prevent her from moving, and failed to perform proper Train-of-Four monitoring so he could have predicted and prevented the movement that occurred. Plaintiff required two hospitalizations in December 2010 to remove the blood from her eye. She alleged the choroidal hemorrhage caused scarring, inflammation, recurrence of the macular hole, vision loss in the right eye, and total legal blindness because she had previous vision loss in her left eye. The defense contended that moving can occur under general anesthesia even during eye surgery. Defendant contended that proper anesthetic agents and dosages were administered, the plaintiff was properly monitored during the procedure, she had risk factors for moving, the incident did not cause the macular hole to return, and her continued vision loss was due to the returned macular hole. The jury returned a defense verdict. **Plaintiff's Experts:** Dennis Doblar, M.D., anesthesiology, Birmingham, AL; Michael A. Rosenberg, M.D., ophthalmology, Shirley Daugherty, RN. **Defendant's Experts:** Ira Garoon, M.D., ophthalmology; Charles E. Laurito, M.D., anesthesiology; Jack A. Cohen, M.D., ophthalmology. **Kathleen O'Rourke**

v. Michael J. Hruskocy, M.D., Park Ridge Anesthesiology Associates Ltd. Cook County (IL) Circuit Court No. 12L-13214. Craig S. Galasso and Vincent B. Browne, Kent M. Lucaccioni Ltd for plaintiff. William J. Rogers and Megan E. Donohue, Swanson, Martin for defendants.

CARDIOLOGY

Quicker Intervention Could Have Saved Eyesight Following Open-Heart — Anemia, Permanent Blindness — $6,844,543 Texas Verdict. The plaintiff, a fifty-year-old man, underwent open-heart surgery performed by defendant at defendant clinic. The next day, the plaintiff slowly started losing his vision in the right eye. It progressed to his left eye until he was completely blind. The defendant critical care doctors and nurses thought the plaintiff was having a reaction to his medication or anesthesia, or that he had suffered a brain stroke. Tests showed no evidence of a stroke in the brain, and an ophthalmology consult was requested. The hospital did not have an ophthalmologist on staff and one had to be credentialed just for the plaintiff. The ophthalmologist determined that the vision loss resulted from a stroke of the optic nerves. This condition can result from blood loss during surgery, anemia, and low blood pressure, and the ophthalmologist ordered immediate transfusions to correct the plaintiff's anemia and raise his blood pressure. The plaintiff's vision did not return. The plaintiff alleged that the nurses failed to make accurate and timely reports of his deteriorating vision and that the critical care doctors failed to respond to the reports in a timely manner to consult an ophthalmologist. The plaintiff claimed that the standard of care required an urgent consultation with an ophthalmologist as soon as the plaintiff's vision changed. The plaintiff alleged that if his complaints had been addressed timely, his blindness could have been stopped and even reversed by timely blood transfusions. The defense argued that the plaintiff's condition is rare, and one with which critical care doctors are generally not familiar. The defense contended that faced with a patient's vision problem, a critical care doctor is trained to look to the brain, not the eyes, as the source of the problem, and that the condition the plaintiff experienced is untreatable and once it begins, the vision loss cannot be reversed. A $6,844,543 verdict was returned, including $250,000 for past loss of consortium, $250,000 for future loss of consortium, $822,964 for future lost earning capacity, $1,000,000 for past physical pain and mental anguish, $50,000, past care and assistance expenses, $205,000 for future physical pain and mental anguish, $3,731,003 for future care and assistance expenses, and $409,996 for past lost earning capacity. **Plaintiff's Expert(s):** John Kress, M.D. critical care, Chicago, IL. Lori Hinton, R.N., life care planning, Houston, TX. Susan Bamason, nursing, Lincoln, NE. Alfredo Sadun, M.D., Ph.D., neuro-ophthalmology, Pasadena, CA. **Defendant's Expert(s):** Carl Dahlberg, M.D., critical care, Houston, TX. Nancy Newman, M.D., neuro-ophthalmology, Atlanta, GA. Michael Blackmon, R.N., nursing, Plano, TX. **Ronald Fortner and Pam Fortner v. Texas Heart Hospital of the Southwest, LLP d/b/a The Heart Hospital Baylor Plano, Gary E. Erwin Jr., M.D., Jeff E. Taylor, M.D.; Gregory Messner, D.O.; and Health Texas Provider Network d/b/a Dallas Diagnostic Association-Plano; James S. Rellas, M.D., P.A., d/b/a HeartFirst Cardiology Center; and Medical Edge HealthCare Group, P.A., d/b/a The Texas Clinic at Prestonwood,** Dallas County (TX) District Court, Case No. DC-10-02994. Kenneth B. Chaiken, Robert L. Chaiken, and Carrie P. Kitner, Chaiken & Chaiken, Plano, TX; and Jeffrey S. Levinger; Levinger, Dallas, TX, for the plaintiffs. John A. Scully and Cory M. Sutker, Cooper & Scully, Dallas, TX for Texas Heart Hospital of the Southwest LLP; Stan Thiebaud, Thiebaud Remington Thornton Bailey, Dallas, TX for Jeff E. Taylor, M.D., Gary E. Erwin Jr., M.D., Health Texas Provider Network; Susan C. Cooley and Lisa M. Wilson; Schell Cooley, Addison, TX for James S. Rellas, M.D., P.A., Medical Edge HealthCare Group P.A.; and Joel J. Steed, Steed Dunnill Reynolds Murphy Lamberth, Rockwall, TX for Gregory Messner, D.O.; defendants.

Cardiac Condition Misdiagnosed — Unnecessary Cardiac Defibrillator — $1.75 Million Arkansas Verdict. Tthe plaintiff underwent cardiac testing which revealed below the normal average. Defendant diagnosed plaintiff with peripheral vascular disease and congestive heart failure. Plaintiff underwent a nuclear stress test, and a month later underwent a cardiac catheterization, which showed no lesions or blockages in the vessels. Four months later plaintiff underwent another echocardiogram, which reaffirmed a diagnosis of congestive heart failure. She was admitted to the hospital a month later and an automatic internal cardiac defibrillator was implanted. Plaintiff alleged defendant misdiagnosed her with congestive heart failure and unnecessarily implanted her with a cardiac defibrillator. Plaintiff's cardiology experts opined that defendant's findings were incorrect. Both experts concluded that plaintiff did not have congestive heart failure and was therefore not a candidate for an internal cardiac defibrillator. Plaintiff's expert cardiologist opined defendant failed to adjust her medication dosages to optimize her cardiac repair. The defense contended that defendant's treatment of plaintiff met the standard of care, and that the defibrillator was necessary. Plaintiff's expert in electrophysiology opined that there are risks of unnecessarily implanting a defibrillator and extracting it. He concluded that extracting the defibrillator was not an option since it could be fatal. The jury awarded plaintiff $1.75 million. **Plaintiff's Experts:** Morton Rinder, MD, Chesterfield, MO; Heather Bloom, MD, Atlanta, GA. **Angelia Thornton v. Shabbir Dharamsey, M.D., Cardiac and Vascular Center of Arkansas, et al.** Jefferson County (AR) Circuit Court No. CV-2012-640-2. Gene E. McKissic, Pine Bluff, AR; Jackie B. Harris, Pine Bluff, AR for plaintiff. R.T. Beard III; Mitchell, Williams, Selig, Gates & Woodyard, Little Rock, AR for defendants.

CHIROPRACTIC

Delay in Brain Injury Diagnosis — Subdural Hematoma, Total Disability — $6 Million Washington Verdict. The plaintiff, a forty-nine-year-old man fell at work; injuring his head, neck, back, and lost consciousness. The defendants treated him for six months through L&I. The plaintiff alleged that he informed the defendants of his symptoms of a brain injury, but was never referred to a medical doctor, despite his requests or the requests of his L&I representative. L&I finally ordered their own IME, which showed a large subdural hematoma. A $6,291,380 verdict was returned. **Plaintiff's Experts:** Martha Glisky, Ph.D., neuropsychology, Bellevue, WA. **Defendant's Experts:** Dawn Ehde, Ph.D., neuropsychology, Seattle, WA. **Robert Harmon v. C. Michael Hughes, D.C.; Rita Hughes, D.C.; and Meridian Valley Chiropractic Clinic, P.S.,** King County (WA) Superior Court, Case No. 15-2-00152-3KNT. Kenneth Friedman and Sean Gamble, Friedman Rubin, Bremerton & Seattle, WA; and Elizabeth Quick and Matthew Quick, Quick Law Group, Kirkland, WA; for the plaintiff. Craig McIvor and Melinda Drogseth, Lee Smart, Seattle, WA for the defendants.

Adjustments Allegedly Causef Acute, Permanent Spinal Injury — Florida Defense Verdict. The plaintiff, a seventy-four-year-old woman, received a number of chiropractic adjustments of the lumbar spine by defendant chiropractors. The plaintiff claimed that the last adjustment caused an acute spinal injury with ischemic findings in the conus medularis, resulting in a severe and permanently disabling spinal injury. The plaintiff alleged that the defendants were negligent in failing to consider her medical history when planning her course of treatment. The defendants denied that their chiropractic treatment was responsible for the plaintiff's injury. A defense verdict was returned. **Plaintiff's Experts:** Nizam Razak, M.D., FACS, neurosurgery, Orlando, FL. Salvatore D. LaRusoo, D.C., chiropractic medicine, Wellington, FL. L. Stuart Cody, life care planning, Orlando, FL. Christopher M. Leber, M.D., physical medicine and rehabilitation, Gainesville, FL. **Defendant's Experts:** Clayton Woods Hopkins, D.C., DABFP, chiropractic medicine, Pinellas Park, FL. Albert Mitsos, M.D., ABFM, ABFE, AAETS, BCFT, forensic medicine, Long Grove, IL. **Ana M. Alejandro v Total Health Chiropractic Solutions, Inc., Esther Pichardo, D.C., and Ahitsha Ortiz, D.C.,** Orange County (FL) Circuit Court, Case No. 2014-CA-008689. Tiffany M. Faddis and Eric H. Faddis, Faddis & Faddis, Orlando, FL for the plaintiff. Philip J. Crowley, Macfarlane Ferguson, et al., Tampa, FL for the defendants.

DENTAL/ORAL SURGERY

Untimely Diagnosis of Cancerous Lesion Led to Patient's Death — $1.47 Million Michigan Verdict. The plaintiff's decedent was evaluated by a general dentist on May 29, 2011 for a large yellow spot on the left side of her tongue. The dentist attributed the lesion to biting her tongue. He rendered no treatment and wrote a note to check it at the patient's next visit. On March 19, 2012 decedent presented to the dentist with a yellow and white patch on the left side posterior tongue and the tip of the tongue. She was referred to defendant oral surgeon. Defendant saw decedent on April 4, 2012, at which time he noted the patient's past medical history as a cigarette smoker and prescribed Kenalog in Orabase. Defendant recommended in a letter to patient's dentist that the lesion be observed at her regular cleaning appointments and if it became large, he would recommend removing it in the hospital. Defendant neither biopsied the lesion nor scheduled a follow-up appointment. In March 2012 decedent called defendant and reported that she was in extreme pain and that the sore was eating away her tongue. Defendant called her in a prescription for Kenalog in Orabase. She called again May 1, 2013, and defendant consented to see her. He referred her to an ENT, but did not indicate that it was urgent. She was not able to see an ENT until June 5, 2013. Decedent's husband contacted an ENT on May 8, 2013, and he was able to see her immediately. A biopsy of decedent's tongue was performed, and a CT/PET scan of the neck was also performed. His impression was that she had an ulcerative mass on the left side of her tongue, which was suspicious for squamous cell carcinoma. On May 15, 2013, the cancer diagnosis was confirmed. Decedent underwent surgery on May 21, 2013 for a left hemiglossectomy with left partial neck dissection. Decedent returned to the hospital the next day for surgery to control significant postoperative bleeding from the tongue. Decedent began a course of radiation treatment, but became dehydrated and suffered radiation burns for which she had to be hospitalized. By February 2014, the radiation proved unsuccessful. She underwent an aspiration of a right neck mass, which revealed that the cancer had metastasized to the lymph nodes on the right side of her neck. She resumed treatment but gradually weakened and endured great pain before her death on October 5, 2014. Plaintiff's oral surgeon expert opined that defendant should have biopsied the lesion on April 4, 2012. The jury awarded plaintiff $1,476,031.00 apportioning fault at 40% plaintiff and 60% defendant. **Plaintiff's Experts:** Michael Krell, oral surgery; Richard Chesbrough, M.D., radiologyt; Carolyn Bradford, M.D., ENT specialist**. Joseph Jager for the estate of his wife, Sandra Jager, deceased v. Paul Flynn, M.D. Oral Surgeon.** Ingham County (MI) Circuit Court 14-577-NH. Matthew L. Turner and Lisa Esser, Weidenfeller for plaintiff. Dale L. Arndt for defendant.

Failure to Obtain Informed Consent for Dental Restoration — $200,000 Texas Verdict. The plaintiff, a sixty-eight year-old landscaper, underwent a full mouth restoration in December 2011, the purpose of which was to improve and whiten his smile. Throughout the restoration, plaintiff developed severe complications, including pain and bite problems. He saw defendant and

various specialists at least forty times over two years before finally switching to another dentist. Plaintiff's general dentistry expert opined that defendant violated the standard of care by failing to obtain informed consent for the restoration; failed to advise plaintiff of the risks of the restoration; failed to advise plaintiff of other options besides the restoration; and failed to perform the restoration, including root canals and bite adjustments. Defendant denied any negligence or wrongdoing. Defendant contended that he informed plaintiff of the risks and that, when complications arose, he treated them appropriately, and timely referred plaintiff to appropriate specialists as needed. Plaintiff alleged defendant's negligence resulted in dental pain, bit problems, broken teeth and lost crowns and veneers. The jury awarded plaintiff $200,000 in damages. **Plaintiff's Experts:** Robbie Henwood, D.D.S., general dentistry, San Antonio, TX; James Person, D.D.S., general dentistry, McAllen, TX. **Defendant's Expert:** Joseph Boyle, D.D.S, general dentistry, San Antonio, TX. **Ralph Ruby v. Rocky L. Salinas, D.D.S. and RGV Smiles by Rocky L. Salinas D.D.S. P.A., Both Individually and d/b/a RGV Smiles and RGV Smiles, Individually.** Hidalgo County (TX) District Court No. C-1313-15-C. Aizar J. Karam, Jr., McAllen, TX for plaintiff. Richard C. Woolsey, Corpus Christi, TX for defendant.

Wisdom Teeth Removal Brings Fractured Jaw, Metal Piece Left in Jaw — $75,000 Washington Settlement. The plaintiff, a twenty-two-year-old woman, saw defendant oral surgeon for removal of her wisdom teeth. The plaintiff contended that during the surgery, the defendant fractured her jaw and left a metal piece of dental instrument in her jaw. The plaintiff continued to see the defendant following the surgery with complaints of severe pain and swelling. The defendant failed to refer the plaintiff to a specialist. The case settled for $75,000. **Plaintiff's Expert:** Fred Quarnstrom, DDS, dentist, Seattle, WA. **Defendant's Expert:** Ralph Zech, DDS, dentist, Woodinville, WA. **Kelsie Nickerson v. Adam Cramer, DDS,** Thurston County (WA) Superior Court, Case No. 14-2-00393-2. Ann Rosato, Peterson Wapold Rosato Luna Knopp, Seattle, WA for the plaintiff. Jake Winfrey, Fain Anderson VanDerhoef Rosendahl O'Halloran Spillane, Seattle, WA for the defendant.

Plaintiff Allegedly Not Ready for Dental Implants — Infection, Additional Surgery — Illinois Defense Verdict. The plaintiff, a thirty-five-year-old woman, presented to defendant dentist for a consultation and second opinion after her regular dentist recommented dental implants to replace a decayed front tooth. The plaintiff had a history of dental problems, including decaying or missing teeth, and she told the defendant, through a translator, that she wanted to fix her entire mouth. The defendant recommended extractions and implants. The plaintiff agreed and signed the consent form. The defendant performed the procedure, but one implant failed to properly integrate, so the defendant replaced it with a new one. The second defendant treated the plaintiff and restored the implants, but the plaintiff complained of bleeding and swelling around the implants for the next few months. Another dentist diagnosed infected implants and severe bone loss. The implants were removed, and the plaintiff is unable to receive new ones. The plaintiff alleged that the defendants were negligent in failing to treat periodontal disease before placing the implants, failing to advise her of all the risks involved, and in negligently replacing the implants, therefore exacerbating the problem. The defense asserted that the implants were appropriately placed, the plaintiff gave informed consent, the work was properly done, and the reason the implants failed is because the plaintiff continued to smoke after the surgery. A defense verdict was returned. **Plaintiff's Expert:** Louis B. Scannicchio, D.D.S., prosthodontist. **Defendant's Experts:** Gary A. Morris, D.D.S., prosthodontist, Buffalo Grove, IL. Frank A. Maggio, D.D.S., periodontist. **Halina Panszczyk v. A Center for Dental Implants, ACDI – Orland Park LLC, James V. D'Alise, D.D.S., Eric G. Jackson, D.D.S.,** Cook County (IL) Circuit Court, Case No. 11L-8216. Christopher L Lufrano, Lufrano Law, Oak Park, IL, for the plaintiff. Anne M. Oldenburg and Anthony G. Joseph, Hay & Oldenburg for A Center for Dental Implants, ACDI – Orland Park LLC, D'Alise; James E. Abbott and Paul A. Ruscheinski, Litchfield, Cavo for Jackson; defendants.

Dental Implant Allegedly Caused Nerve Damage — Illinois Defense Verdict. The plaintiff, a fifty-six year-old construction company owner, underwent dental implant surgery at defendant's dental office. Defendant placed four implants into the lower jaw of the plaintiff. He returned one week later with complaints of numbness in his right lower lip and chin. Defendant continued to treat plaintiff until July 30, 2007, including restoring the implants with bridgework. Defendant claimed plaintiff's numbness had resolved at that time, while plaintiff alleged the numbness was ongoing. Plaintiff alleged plaintiff improperly inserted implant #29 into the right mandibular nerve, causing him to frequently bite his lip and cheek, forcing him to limit his diet to soft foods, and affecting his ability to kiss his wife. Plaintiff's dental expert opined that defendant deviated from the standard of care because plaintiff's jawbone was too small to accommodate the size of the dental implant, causing the implant to breach the nerve canal. The defense contended plaintiff was never tested for nerve injury by his subsequent treating dentists or his own expert. The jury returned a defense verdict. **Plaintiff's Experts:** Gary Hosters, D.MD., periodontics; Martin Lapidus, D.D.S., dentistry; Brian Herman, M.D., radiology, Chicago, IL. **Defendant's Experts:** Donald Kalant, D.D.S,., oral surgery; Joel Meyer, M.D., radiology. **Lester Osmak v. Joseph F. Orrico, DDS, Illinois Implant Dentistry Ltd.** Cook County (IL) Circuit Court NO. 12L-10658. Edward L. Osowski for plaintiff. John M.Green and Patrick O. Quinn, Green Law Offices for defendants.

DERMATOLOGY

Alleged Failure to Monitor Blood and Liver Functions Blamed for Cirrhosis of Liver/Death — Georgia Defense Verdict. The plaintiff's decedent, a fifty-nine year-old, woman was taking Methotrexate for severe and debilitating psoriasis of her hands, torso, legs, and head, and slightly elevated liver enzymes. The defendant dermatologist placed decedent on Methotrexate in December 2005 until October 2008 for her psoriasis. The drug relieved decedent's suffering from psoriasis and defendant lowered her dosage and subsequently switched her to another drug after concluding her liver enzymes were elevated. A year after decedent stopped seeing defendant, she was diagnosed with non-alcoholic cirrhosis of the liver. Decedent's treating physicians attributed the development of cirrhosis to liver damage caused by Methotrexate. She died a year after being diagnosed with liver disease. Decedent's husband alleged that defendant had not properly monitored the blood and liver functions of the patient and that the patient should have had blood and liver function tests before being prescribed Methotrexate. The defense contended that decedent had multiple other potential causes of her liver failure and that it was unlikely to have been caused by the Methotrexate. The defense also contended decedent was informed of the risks of the drug and that the decedent had no insurance and was non-compliant in not getting the tests done as ordered by defendant. The defense noted that decedent was only treated intermittently at the clinic, with periods where she went for months without treatment or the Methotrexate. The jury returned a defense verdict. **Plaintiff's Experts:** Steven R. Feldman, M.D., dermatology, Winston-Salem, NC; Fred C. Fowler, M.D., Charlotte, NC; **Defendant's Experts:** David J. Cohen, M.D., dermatology, Macon, GA; James Spivey, M.D., Atlanta, GA. **Bobby Henderson Daniel v. John Chung, Joe Langshaw and Skin Cancer & Cosmetic Dermatology, Inc.** Gordon County (GA) Superior Court No. 12CV61236. Richard Kopelman and Clint W. Sitton, Atlanta, GA for plaintiff. Duane L. Cochenour and Robert C. Martin, Jr., Hall, Booth, Smith, Columbus, GA for defendant.

DIAGNOSIS ERRORS

Cancer Diagnosed as Sciatic Pain —$1 Million Massachusetts Settlement. The plaintiff's primary care physician allegedly failed for years to fully investigate and treat the cause of the plaintiff's sciatic pain. The plaintiff alleged that the defendant diagnosed simple sciatic pain, even though that diagnosis was ruled out by imaging studies. The defendant simply prescribed narcotic pain medications and blamed the patient for not showing up for appointments, although records showed that she encountered the plaintiff over thirty times over the period in question. The defendant contended that because of the rarity of the cancer, the patient's death was inevitable and that anything they did or did not do would not make a difference. The plaintiff asserted that regardless of the nature of her cancer, she had a right to a timely diagnosis and should not have had to suffer in pain. The case settled for $1,000,000. **Anonymous v. Anonymous Primary Care Provider,** _____ County (MA) Superior Court, Case No._____. David J. Hoey and Krzysztof Sobczak, Law Offices of David J. Hoey, N. Reading, MA for the plaintiff.

X-Rays Allegedly Misread — California Defense Verdict. The plaintiff, a nineteen-year-old man, fell from a ladder approximately eight feet while stocking inventory. He landed on his feet, and complained of immediate pain to the right foot and ankle. He was taken to a nearby medical group, where the defendant emergency medicine specialist, ordered X-rays and interpreted the films to be negative for a fracture. The defendant diagnosed the plaintiff with a severely sprained right ankle, and told him to use crutches, keep the foot elevated, take Naprosyn with regular ice baths, and to return to the office in one week. Seven days later, the defendant saw the plaintiff for a second visit, during which the plaintiff complained of severe pain. The defendant took additional X-rays of the right foot and ankle, and again interpreted the films to be normal, and diagnosed a severely sprained right ankle. In the next two months, the defendant was seen several more times and underwent physical therapy. The plaintiff maintained that his ankle remained severely dysfunctional. The plaintiff was approved to return to work, but he returned to the defendant two weeks later, again complaining of severe pain. An MRI was ordered and showed a severe longitudinal fracture of the calcaneus with extension into the subtalar joint and a displaced fracture fragment distal to the end of the fibula. The plaintiff was immediately placed on a non-weight-bearing basis and, ultimately required fusion surgery a few months later. The plaintiff alleged that the defendant failed to properly interpret the X-rays and failed to timely diagnose the fracture. The plaintiff alleged that if the calcaneal fracture had been diagnosed on a timely basis, he would have had the injury fixed with an open-reduction-and-internal-fixation-type surgery, rather than fusion, which was the only surgical option available after the delay in diagnosis. Defendant denied that he misread the X-rays and argued that the plaintiff did not have a fracture when he saw him. The defendant asserted that the plaintiff could rise to a vertical position from a full squat without pain, he could also heel-toe walk with normal range of motion, and there was no swelling. The medical chart also noted that the plaintiff said he was feeling better. The defendant argued that the plaintiff's fracture must have occurred after the defendant saw the plaintiff. A defense verdict was returned. **Plaintiff's Expert(s):** Kenneth Ferra, M.S., C.R.C., vocational rehabilitation, Bakersfield, CA. Michael Gillman, M.D., orthopedic surgery, Orange, CA. Stephen Ross, M.D., general practice, Santa Monica, CA. **Defendant's Expert(s):** Rick Sarkisian, vocational rehabilitation, Fresno, CA. Richard Johnson, family medicine, Pacific Palisades, CA. **Christian Vargas v. Mark Kasow, M.D.,** Kern County (CA) Superior Court, Case No. S-1500-CV-284149. Richard C. Brenneman;

Brenneman, Juarez & Adam, Santa Maria, CA, for the plaintiff. Dennis R. Thelen, LeBeau-Thelen, Bakersfield, CA, for the defendant.

DRUGS AND DEVICES

Acupuncturist's Needle Broke in Plaintiff's Body - Surgeries, Physical Therapy — $104,575 New York Verdict. The plaintiff was a thirty-nine-year-old woman who underwent acupuncture performed by defendant acupuncturist. During the first phase of the treatment, a needle was inserted in the rear side of the plaintiff's right shoulder. The needle should have been removed before the defendant began the second phase of treatment, but he overlooked the needle. When the massage phase began, the plaintiff, who was lying on a table, experienced a severe contraction and spasm of a muscle. She quickly stood up, and the defendant tried to remove the needle. The needle broke, and a portion remained in the plaintiff's body. The plaintiff required surgical removal of the needle, and she claimed that she suffers ongoing residual effects. The plaintiff alleged that the defendant failed to timely remove the needle that he had inserted, and that the needle was defectively manufactured by the defendant manufacturer. The defendant asserted that the accident was caused by the plaintiff's act of getting up before the needle could be removed, and the break was the fault of the defect in its manufacture. A $104,575 verdict was returned; including $3,575 for past medical costs, $26,000 for past lost earnings capability, and $75,000 for past pain and suffering. **Plaintiff's Expert:** Robert MacDonald, MS, LAc., LMT, acupuncture, Hartsdale, NY. **Sun Jackie Huh v. Daniel Yi and Dong Bang Acupuncture, Inc.,** New York County (NY) Supreme Court, Case No. 100648/12. Eric W. Berry Berry Law, New York, NY, for the plaintiff. John J. Hopwood, Marks, O'Neill, O'Brien, Doherty & Kelly, New York, NY, for Daniel Yi; William Lee Kinnally Jr, Gibney, Anthony & Flaherty, New York, NY, for Dong Bang Acupuncture Inc.; defendants.

EMERGENCY MEDICINE

Versed Allegedly Caused Twin Infant's Death — $5.07 Million Illinois Verdict. The plaintiff's twins were born on March 21, 2008, with the baby boy suffering from a severe congenital heart defect known as hyperplastic left heart syndrome. He underwent surgery four days later, with another one planned in six months and a third surgery to be done when he was two or three years old. On April 18, the baby was readmitted three times over the next few weeks. On May 5, 2008, plaintiff called the treating pediatric cardiologist, to report that the baby was constantly crying and not feeding well. They were told to take the baby to the ER, where he was given the sedative Versed. He was then transferred to a different hospital for four days to stabilize his condition. On May 15, 2008, plaintiff's called the twins' pediatrician, who came to their home that night and examined the baby boy, and determined that he was fine. A few hours later, the plaintiffs called the cardiologist to report the baby was grunting, continued abnormal feedings, and diarrhea. The cardiologist told them to take him to the ER. The defendant ER physician called the cardiologist, who recommended the mother swaddle the baby, discontinuing attempts to insert an IV, give him Pedialyte, insert a nasogastic tube to hydrate the baby, and administer Versed if he continued to cry. The parents' alleged defendant immediately ordered the administration of Versed as soon as he got off the phone with the cardiologist. Within ten minutes of receiving the Versed, the baby's heart rate dropped and he suffered a fatal cardiac arrest at eight weeks of age. The plaintiffs alleged that defendant was negligent in failing to following the cardiologist's recommendations, failed to examine the infant before administering Versed, failed to realize he was dehydrated with insufficient volume to absorb and tolerate the Versed, giving the Versed when it was unnecessary because he had stopped crying, and failed to timely intervene after his heart rate deceased, causing his death. The defense denied the Versed contributed to the baby's death. Defense contended that the baby's congenital condition was among the worst of babies who survive the first surgery as evidenced by his multiple hospitalizations, and he was in very severe end-stage heart failure. The jury awarded plaintiff's $5,072,030. **Plaintiff's Experts:** Tarek Husayni, M.D., pediatric cardiology; Zeina Kalache, M.D., pediatrics; Alison Galanopoulos, M.D., pediatrics; Holly Benjamin, M.D., pediatrics; Joseph Tobias, M.D., pediatric anesthesiology; Robert Achtel, M.D., pediatric cardiology; Daniel Corboy, M.D., emergency medicine, Wilmette, IL. **Defendant's Experts:** Frank Kern, M.D., anesthesiology; John Zautcke, M.D., emergency medicine; Linda H. Cripe, M.D., pediatric cardiology, Columbus, OH. **Estate of Eli G. Haig, deceased minor v. David Mayor, M.D., Emergency Health Care Physicians, Advocate Christ Hospital & Medical Center, Adventist Hinsdale Hospital.** Cook County (IL) Circuit Court No. 09L-9934. Jerry Latherow and Bridget C. Duignan for plaintiff. David C. Burtker and Sarah A. Rodak, Cunningham, Meyer for defendants.

Failure to Evaluate/Treat Fever Origin — Spinal Epidural Abscess — $1.05 Million Virginia Settlement. The plaintiff, a thirty-three year old Spanish speaker, presented to the ER with complaints of pain in his right buttocks after falling at work. An X-ray revealed no fracture, and the plaintiff was sent home on Ibuprofen. Four days later on November 30, 2013 plaintiff presented to the same ER with complaints of pain in his lower back radiating down his leg uncontrolled by pain medication. His

vital signs showed he had a new symptom of fever of 101.8 which was documented in his chart. Defendant emergency medicine physician conducted a physical exam which showed the plaintiff was tender to palpitation over the sacrum/coccyx area. Prior to his exam, a physician's assistant ordered certain lab studies including CBC with diff and urinalysis to evaluate the plaintiff for an infection. However, the studies were cancelled by the defendant. The defendant ordered a CT of the pelvis without contrast. The CT revealed no evidence of fracture and moderate facet arthopathy at L4-L5 on the left with a facet joint cyst extending into the central canal. The radiologist suggested this could be better evaluated by MRI of the lumbar spine if clinically indicated. Defendant discharged plaintiff home with a clinical impression of cocoygeal contusion. He instructed plaintiff to take Motrin for pain, take Percocet for severe pain and follow up with his primary care physician in two days. Two days later plaintiff returned to the ER unable to walk or urinate. An MRI revealed an extensive lumbar epidural abscess that extended from the L5-S1 level to the thoracic level. Plaintiff underwent surgery for evacuation of the epidural abscess, which along with antibiotics, successfully treated plaintiff's spinal infectious process. However, plaintiff was left with lower extremity weakness, nerve pain, neurogenic bladder and bowel dysfunction. Plaintiff's standard of care experts opined that defendant failed to appreciate the significance of plaintiff's fever on presentation on November 30. Plaintiff alleged defendant also failed to order lab tests in the presence of fever. Plaintiff alleged defendant failed to consult with a neurosurgeon. Plaintiff's neurosurgeon expert opined that the extensive lumbar epidural abscess as seen on the December 3 MRI increased in size over the two days, but would have still been appreciable on MRI imaging on November 3. The parties settled for $1.05 million. **Anonymous thirty-three year-old Spanish speaker v. Anonymous emergency room physician.** ___ County (VA) Circuit Court No. ____. Charles J. Zauzig and Melissa G. Ray, Woodbridge for plaintiff.

Alleged Failure to Diagnose Blood Clot — Above-the-Knee-Amputation — Washington Defense Verdict. The plaintiff, an eighty-three-year-old man, was a patient at the defendant's emergency room. The plaintiff alleged that the emergency room physician was negligent in failing to diagnose a blood clot in the common femoral artery, resulting in amputation above the knee. A defense verdict was returned. **Plaintiff's Expert:** Benjamin Starnes, M.D., vascular surgeon, Seattle, WA. **Defendant's Experts:** Mark Morasch, M.D., vascular surgeon, Billings, MT. John Moorhead, M.D., emergency medicine, Portland, OR. **Gary Winston as Personal Representative of the Estate of Harry Winston v Highline Medical Center,** King County (WA) Superior Court, Case No. 14-2-19388-2SEA. Mark Johnson & Michael Sprangers, Johnson Flora, Seattle, WA for the plaintiff. Jake Winfrey & Todd Reichert, Fain Anderson VanDerhoef Rosendahl O'Halloran Spillane, Seattle, WA for the defendant.

Alleged Mismanagement of Wound Blamed for Deep Joint Infection, Surgery, Hospitalization — Louisiana Defense Verdict. The plaintiff sustained an open and compound ankle fracture and was taken to the ER. He was treated by defendant ER physician who set the fracture and sutured the wound. He discharged the plaintiff with instruction to follow up in a few days with an orthopedist. The plaintiff followed up with an orthopedist three days later, and his ankle was severely swollen. The orthopedist diagnosed an infection and immediately took the plaintiff in for surgery to control the infection. The deep joint infection was resistant to antibiotics, and the plaintiff remained in the hospital for twelve days. The plaintiff claimed that the defendant failed to properly manage the wound while in the ER, and he should have immediately called for a surgical consult. The defendant contended that the met the standard of care and the plaintiff's issues were as a result of the original injury. A defense verdict was returned. **Plaintiff's Expert:** Robert West, M.D., emergency expert. **Defendant's Expert:** James LaLonde, M.D., orthopedics, Baton Rouge, LA. **Purvis v Dietrich,** Jefferson Parrish, (LA) District Court, Case No. 643635. R. Glenn Cater and David J. Foshee, Cater & Associates, New Orleans, LA for the plaintiff. Harvey J. Godofsky, Batiza Godofsky Schroeder & Coles, Metairie, LA for the defendant.

Alleged Failure to Treat Blood Clot — Death — New Jersey Defense Verdict. Plaintiff's decedent, a forty-five-year-old man, was seen at the ER of the defendant medical center, with complaints of pain behind his left knee. Defendant physician examined the knee and suspected a blood clot. Two and a half months later, the decedent returned to the ER with complaints of shortness of breath and chest pain. A chest x-ray was performed, and the decedent was released. Twelve days later, the decedent died from a massive pulmonary embolism. The plaintiff alleged negligence in failure to performed diagnostic testing during the decedent's initial ER visit to determine if his suspicions were correct, and that the x-ray results showed deep vein thrombosis, and the defendant physician was negligent in not informing the decedent of the results of it, or the radiologist's recommendation of a CT scan to rule out pulmonary embolism. The plaintiff further alleged negligence in failing to record a proper medical history or recognize the symptoms of deep vein thrombosis. The defendant denied liability and maintained that the initial knee exam was sufficient, and the standard of care was met. A defense verdict was returned. **Plaintiff's Experts:** Alan Schechter, M.D., emergency medicine, Manalapan Township, NJ. Monroe Karetzky, M.D., pulmonary/respiratory diseases, Newark, NJ. Elizabeth Ridgely, M.D., standard of care, Telford, PA. **Defendant's Experts:** David Shank, emergency medicine, Harrisonburg, VA. David Karras, emergency medicine, Philadelphia, PA. **Sally Kelly and the Estate of John Kelly v. Atlantic Health System Inc., Morristown Medical Center, Emergency Medical Associates of NJ & PA, Steven Gohsler, MD, Alfredo Tapia, MD / Sally Kelly and the Estate of John Becker Walker v. Morristown Medical Center, Emergency Medical Associates of NJ & PA EDIMS LLC, Ann Griswold, RN, Gery McKenna, RN, Brad Robbins, RN,** Morris County (NJ) Superior Court, Case No. 2862/11:2546/12. Denise Campbell, Campbell Legal Associates, Manasquan, NJ for the plaintiff. Anothony Cocca, Bubb

Grogan & Cocca, Morristown, NJ for Ann Griswold, RN, Brad Robbins, RN, Gery McKenna, RN, Alfredo Tapia, MD, Morristown Medical Center, Atlantic Health System Inc.; Paul F. Schaaff Jr, Orlovsky, Moody, Schaaff & Gabrysiak, West Long Brach, NJ for EDIMS LLC, Steven Gohsler, MD Emergency Medical Associates of NJ & PA; defendants.

Administration of Medication for High Blood Pressure Too Rapidly Allegedly Led to Stroke — Wyoming Defense Verdict. The plaintiff, a sixty year-old man, was found lying on the floor next to a piece of machinery at work with a large laceration across his forehead. EMTs were called and he was transported to a hospital. Plaintiff's laceration was sutured, a CT scan ordered, and he was administered medication to treat his critically high blood pressure of 246/132. On the way home, his condition worsened, and he returned by ambulance to the hospital, under the care of the same ER physician. Plaintiff was diagnosed with a closed head injury, and admitted to the hospital under the case of a general surgeon. The next morning plaintiff was diagnosed with a probable stroke. He was transferred to a different hospital the following day and a vertebral artery dissection leading to a stroke was confirmed on MRA. Plaintiff alleged the ER physician failed to diagnose the VAD and thus actually caused the stroke by lowering his blood pressure too abruptly on the second emergency room visit. Defense contended the defendant s were not negligent in their care of the plaintiff. Defense contended that the use of tPa was contraindicated on the product data sheet because of the head trauma and severe laceration suffered by plaintiff. The jury returned a defense verdict. **Plaintiff's Experts:** David Wheeler, M.D., neurology, Casper, WY; Ingram Eugene DuQuette, M.D., emergency medicine, Casper, WY; Charles Bowkley, III, M.D., diagnostic radiology, Casper, WY. **Defendant's Experts:** Neil Schwartz, M.D., neurology, Palo Alto, CA; David Newman, M.D., emergency medicine, New York City, NY. **Jackson Lee v. Riverton Memorial Hospital.** Park County (WY) District Court No. 38526. T. Thomas Metier, Ft. Collins, CO; Todd Ingram, Ingram, Olheiser, Casper, WY for plaintiff. John M. Fitzpatrick, Wheeler, Trigg, O'Donnell, Denver, CO for defendant.

Intoxicated Woman Falls From Ambulance — Head and Facial Injuries — Illinois Defense Verdict. The plaintif,f a forty-eight year-old woman, was a patron at a restaurant//bar. She admitted she consumed enough alcohol to reach the point of intoxication. As she was leaving the bar and heading to another bar, she walked into a concrete column and fell to the ground. Emergency personnel were called and responded to the scene. Defendants transported her to the ER. Plaintiff alleged the defendants failed to secure her in a wheelchair and left her unattended inside the back of the ambulance at the ER triage entrance. Plaintiff fell out of the chair and vehicle when she either slumped over or tried to stand, causing her to land on her head on the pavement below. She suffered head lacerations, facial bruising/swelling, a chipped front tooth, four broken ribs, and soft tissue injuries to her shoulders. The defense denied plaintiff was left unattended and unsecured in a wheelchair in the back of the ambulance. The jury returned a defense verdict. **Plaintiff's Experts:** Farah Turk, M.D., family practice; Allison Hunter, RN. **Brenda Brecheen v. City of Chicago, Luis J. Vazquez, Ryan Antonik.** Cook County (IL) Circuit Court No. 13L-9505. David J. VanderPloeg, Jr. and Paul K. Hanna for plaintiff. Yi Sun and Thomas J. Lawler, Chicago Corporation Counsel for defendants.

Alleged Failure to Properly Treat Diabetic Ketoacidosis in Minor — Death — Florida Defense Verdict. The plaintiff's decedent, a twelve year-old girl, was taken to the ER in a state of diabetic ketoacidosis. She was treated by the defendant physician and air-lifted to a different hospital, which had a pediatric ICU. She died two days later at the hospital. The plaintiffs, parents of the deceased minor, alleged that their daughter was given insulin and fluids at the first hospital in amounts appropriate for an adult rather than a small child. Plaintiff alleged that such fluids led to her cerebral edema and brainstem herniations, ultimately leading to her brain death. The defendant physician was dismissed with prejudice. A defense verdict was returned. **Plaintiff's Experts:** Michael Tunik, M.D., pediatric emergency medicine, New York, NY; Craig A. Alter, M.D., pediatric endocrinologist, Philadelphia, PA; Harold Linde, Psy.D., psychology, Tampa, FL; Jose G. Diaz, M.D., pediatric critical care medicine, Fort Myers, FL. **Defendant's Experts:** Ronnie S. Fuerst, M.D., emergency medicine, Lexington, SC; Richard K. High, RN, Franklin, TN; Nicole Glaser, M.D. pediatric endocrinology, Davis, CA. **Terrence Kelly and Sandra Kelly, as Co-Personal Representatives of the estate of Shannon Kelly, deceased v. Indian River Memorial Hospital and Dudley Teel, M.D.** Indian River County (FL) Circuit Court NO. 31 2010 CA 073141. John F. Romano, West Palm Beach, FL; Elizabeth A. Zwibel, Swope, Rodante, Tampa, Fl for plaintiffs. Lee M. Cohen, Cole, Scott, et al., West Palm Beach, FL (Dudley Teel, M.D.); John E. Hall, Jr., Duane L. Cochenour, and Denise L. Dawson, Hall, Booth, et al, North Palm Beach, FL; Roy R. Watson, Adams, Coogler, et al, West Palm Beach, FL (Indian River Memorial Hospital) defendants.

GASTROENTEROLOGY

Delayed Diagnosis of Metastatic Colon Cancer — $716,549 Ohio Verdict. The plaintiff, a forty-seven-year-old woman, presented to her primary care physician after she felt a mass in her rectum the size of a grape. The physician performed an examination and confirmed the mass. The plaintiff was referred to the defendant gastroenterologist who performed a colonoscopy and biopsy. The defendant determined the biopsy's results were benign and the mass consisted of normal bowel tissue. The results were forwarded to the plaintiff's primary care physician. After two weeks, the plaintiff called her primary care physician

and was told the results of the tests were normal and she should not be worried. Seven months later, the plaintiff suffered an episode of rectal bleeding and was referred to a colorectal surgeon by her primary care physician. The appointment for the surgeon was made the following month. The plaintiff however suffered additional bleeding and was rushed to the emergency room where she underwent an exam and CT scan. The tests showed a 6.4 cm mass and the plaintiff was diagnosed with anal cancer. She underwent radiation and chemo treatments, and was found to be cancer free. Three years later, doctors discovered that the cancer had metastasized to some of the lymph nodes outside the original area of treatment. The plaintiff's cancer was Stage IV, with a fifteen percent chance of a five-year survival. The plaintiff claimed that her chance of survival would have been greater than five years had the cancer been detected earlier. She also claimed that a portion of the mass being biopsied was beneath the lining of the bowel, and that portion of the mass was not tested. The plaintiff asserted that the defendant should have known that lumps like this one are known to yield false normal results and should have been tested further. The defendant contended that nothing they did or failed to do contributed to the plaintiff's prognosis. The defendant claimed that his actions were in the scope of his knowledge and training. A $716,549 verdict was returned, including $51,549 future medical costs and $665,000 non-economic damages. **Plaintiff's Experts:** Megan L. DeHaan, M.D., radiation oncology, Columbus, OH. Stephen Goldstone, M.D., general surgery, New York, NY. **Defendant's Experts:** Lowell B. Anthony, M.D., FACP, oncology, Lexington, KY. Mark Arnold, M.D., colon & rectal surgery, Columbus, OH. Step P. Martin, M.D., gastroenterology, Fairfield, OH. **Linda Lemley v. Laurence K. Entsuah M.D., Mt. Carmel St. Ann's Hospital; Digestive Medical Services Inc.; Jane/John Does; Mt. Carmel Health System; His Grace Medical LLC and Olugbenga F. Tolani M.D.,** Franklin County (OH) Court of Common Pleas, Case No. 13-CV-004290. David A. Shroyer, Colley, Shroyer & Abraham Company, Columbus, OH for the plaintiff. Mark L. Schumacher, Freund, Freeze & Arnold, Columbus, OH for Laurence K. Entsuah M.D., Digestive Medical Services, Inc.; Frederick A. Sewards, Hammond Sewards & Williams, Columbus, OH, for His Grace Medical LLC and Olugbenga F. Tolani, M.D.; defendants.

GYNECOLOGY

Burns During Urethral Sling Surgery — New Jersey Defense Verdict. The plaintiff was a thirty-nine-year-old woman who was admitted to the defendant surgical center to undergo urethral sling surgery performed by defendant ob-gyn in order to alleviate symptoms of incontinence. During surgery, the plaintiff was burned on the inside of her left thigh after her skin came into contact with the heat-source of a cystoscope tool, causing a third degree burn. The plaintiff claimed that the defendant was negligent in burning her skin. The defendant denied liability. He argued that if the plaintiff's burn was caused by the cystoscope, it would have been the fault of the nurse. The defendant asserted that the cystoscope was not giving off intense heat when he was using it, and he was not using it near the thigh. A defense verdict was returned. **Plaintiff's Experts:** Gary Conner, M.D., ob-gyn, Dayton, OH. Paul Saccone, M.D., plastic surgery/reconstructive surgery, Maplewood, NJ. **Defendant's Expert:** Daniel Small, M.D., ob-gyn, Lawrenceville, NJ. **Keisha Taylor-Hill v. Suresh Thani, M.D. and American Surgical Center,** Essex County (NJ) Superior Court, Case No. 1340/13. Neil S. Weiner, Lynch, Lynch, Held & Rosenberg, Hasbrouck Height, NJ, for the plaintiff. Vincent E. Reilly, Coughlin Duffy, Morristown, NJ, for American Surgical Center; James Sharp, Schenck Price Smith & King, Florham Park, NJ, for Suresh Thani, M.D.; defendants.

Allegedly Unnecessary Hysterectomy Blamed for Bladder Perforation, Surgery, Incontinence — Illinois Defense Verdict. Plaintiff, a forty-five-year-old woman, underwent a hysterectomy performed by defendant obgyn. Plaintiff claimed that during the surgery, she suffered a bladder perforation which led to surgery, prolonged hospitalization, pneumonia, and incontinence. The plaintiff alleged that the surgery was unnecessary. The defendant argued that the plaintiff was properly advised of the various alternatives based on her clinic presentation and diagnostic test results. He explained the risks and benefits of each alternative and the hysterectomy was properly performed based on her informed choice of that procedure. A defense verdict was returned. **Plaintiff's Expert:** Fred Duboe, M.D., ob/gyn. **Defendant's Experts:** Carla Carpenter, D.O., ob/gyn, Willowbrook, IL. Michael D. Moen, M.D., urogynecology. **Laurie Evola v. Dr. Mark A. Kijek,** Grundy County (IL) Circuit Court, Case No. 10L-57. Michael J. Radtke, Radtke & NusBaum, Chicago, IL for the plaintiff. Kevin J. Vedrine and Christopher J. Solfa, Cunningham, Meyer, Warrenville, IL for the defendant.

Bladder Allegedly Perforated During Hysterectomy — Arizona Defense Verdict. The plaintiff, a thirty-two year old medical record clerk, underwent an abdominal hysterectomy. She claimed the hysterectomy was performed through a long open incision and all organs in the pelvis were in clear view. Plaintiff alleged defendant gynecologist negligently perforated her bladder during the procedure. She also alleged defendant failed to recognize or repair the two centimeter perforation in the back wall of the bladder. Defendant denied falling below the standard of care. Defendant contended that a perforated bladder was a known complication of the surgical procedure. Plaintiff alleged that because of defendant's negligence, she required a second surgical procedure to repair the perforated bladder. The jury returned a defense verdict. **Gomez v. Mesa Obstetricians and Gynecologists; Mechelke, D.O.** Maricopa County (AZ) Superior Court No. CV 2014-012773.

HOSPITALS

Incorrect Heparin Dosage After Hip Replacement Injures Brain — $1.5 Million Missouri Settlement. The plaintiff was a seventy-one-year-old woman who was recovering from a total hip replacement when a nurse gave her a large dose of heparin due to a pharmacist's mistake. Because of the mistake, the plaintiff experienced internal bleeding for seven hours and suffered a heart attack. During efforts to resuscitate her, the staff allegedly halted their efforts to revive her, and three minutes passed before a nurse noticed her grasping for breath. The plaintiff was transferred to a large hospital where she regained her liver and kidney function but remained comatose for two weeks. The plaintiff has a low percentage of a working memory and her senses of taste and smell are altered. The plaintiff alleged that the hospital staff failed to respond properly to her signs of distress while she was bleeding. A settlement was reached in the amount of $1,500,000. Plaintiff's Experts: Bernard Abrams, M.D., neurology, Kansas City, MO. Dan Bagwell, life care planning, San Antonio, TX. David Altman, M.D., neurology, San Antonio, TX. **Anonymous Seventy-One-Year-Old Woman v Confidential Defendant(s), _____County (MO) Circuit Court, Case No. _____.** Robert D. Kingsland, Jr., Jason P. Osteen and Bradley L. Akins, Dempsey & Kingsland, Kansas City, MO, for the plaintiff.

Bariatric Surgery Leads to Feeding Tube Accident — Infection, Surgery, Hospital Stay — $1 Million Washington Settlement. The plaintiff, a sixty-three-year-old woman, underwent a revision bariatric surgery. Because of post-operative complications, the plaintiff was put on a feeding tube. The plaintiff accidently pulled the tube out a slightly while washing her hair, and contended that the defendant's medical staff manually pushed the tube back in, though a staple line, causing an infection. The case settled for $1,000,000. Plaintiff's Expert: Katherine Werth NPC, nurse/bariatric coordinator, Omaha, NE. Defendant's Expert: Mary Lough, Ph.D., RN, nurse, San Francisco, CA. **Linda Hughes and Dale Hughes v Swedish Health Services**, King County (WA) Superior Court, Case No. 15-2-10284-2SEA. Ralph J. Brindley, Luvera Law Firm, Seattle WA, for the plaintiff. Rando B. Wick, Johnson Graffe Keay Moniz & Wick, Seattle, WA for the defendant.

Failure to Secure Emergency Medical Assistance Resulted in Seizure and Cardiac Arrest — $700,000 Virginia Settlement. The plaintiff's decedent, a forty-two year-old man, suffered from a seizure disorder. On March 27, 2015, at a tax exempt community rehabilitation program workshop, decedent had a severe, continuous and convulsive seizure. The seizure lasted more than 15 minutes before the staff called 911. The defendant staff contended they called 911 approximately 17 minutes after the seizure occurred. However, evidence revealed the staff waited as long as 25 minutes before calling. By the time medical personnel arrived, evidence showed that the decedent had been seizing for more than 30 minutes. EMT's were able to stop the seizure, but the decedent went into cardiac arrest. CRP was administered and a heart beat was restored, however, by the time the decedent was admitted to the hospital, there was no brain activity. The decedent died three days later when life support was discontinued. The decedent's parents alleged that the defendant was guilty of gross negligence as well as claims for negligent hiring and retention. Settlement was reached through mediation for $700,000. **Donald J. Louque, Jr., administrator of the estate of James Robert Louque v. NW Works Inc.** Frederick County (VA) Circuit Court No. CL-15000519-00. Mark D. Obenshain and Justin M. Wolcott, Harrisonburg for plaintiff.

Failure to Timely Remove IVC Filter — $231,922 Montana Verdict. The plaintiff, a twenty-eight year-old man, was injured when he fell off a metal roof. He was taken to the ER and diagnosed with an L1 burst fracture and bilateral heel fractures. An orthopedic surgeon advised that plaintiff would need an IVC filter, to prevent blood clots in the lungs. The selection of the OPTEASE filter was not the radiologist's selection: it was what was on the shelf. Neither the plaintiff, the radiologist, nor the surgeon was supplied with the package insert. Plaintiff was placed on Coumadin and underwent pool therapy. A nurse discontinued the Coumadin two months after the IVC filter placement. Plaintiff was never informed that the filter needed timely removal until four moths later. Plaintiff returned to the hospital several times for x-rays and diagnostic studies. On August 10, 2011 plaintiff presented to the orthopedic surgeon and underwent an x-ray. The orthopedist was surprised that the filter was still there. He ordered its removal. A surgeon attempted to remove the filer on August 16, 2011 and discovered that it had embedded in the wall of the IVC, and could not be removed by conventional means. Plaintiff returned to the hospital on 8/19, 8/22, and 8/29 with abdominal, pelvic, and groin pain. An ultrasound revealed a DVT in his right leg and extension of the large cot to the filter. He underwent treatment and was transferred to a different hospital for removal of the filter. The filter removal was unsuccessful. On November 10, 2011 plaintiff was admitted to the hospital for laser removal of the filter. The procedure was successful for the most part, but a fragment of the catheter was fractured. Plaintiff recovered from his injuries and was able to return to work. Plaintiff alleged defendant fell below the standard of care in his treatment. Defendants denied the allegation and contended its care and treatment did not cause or result in his injuries. The jury awarded plaintiff $231,922. **Eric Horn v. St. Peter's Hospital, L&C Co.** Clark County (MT) District Court No. BDV-13-695. Neel Hammond, Missoula; Eric Rasmusson, Missoula for plaintiff. David McLean & Ryan Willmore, Missoula for defendants.

Physical and Occupational Therapy Allegedly Resulted in Pulmonary Embolism, Death — Illinois Defense Verdict. The plaintiff's decedent, an eighty-one-year-old woman, fell and fractured her pelvis and hip. Following surgery, the decedent was transferred to defendant health care facility for physical and occupational rehab. A few days later, the decedent began having symptoms of low oxygen levels including shortness of breath, a symptom of pulmonary embolism. Her symptoms worsened, and she was readmitted to the hospital, where she died a day later. The estate alleged that the decedent should have notified the decedent's doctor, and she should have been transferred to the hospital earlier, preventing her death. The defendant asserted that the decedent's drop in oxygen levels were not indicative of a pulmonary embolism, and she developed a blood clot in her lungs, and when it was discovered, she was transferred to the hospital. A defense verdict was returned. Plaintiff's Experts: Michelle Myers-Glover, R.N., nursing. David M. Systrom, M.D., pulmonology. Defendant's Experts: Diane Brown-Bell, R.N., nursing. Caitriona Buckley, M.D., pulmonology. Miledones Eliades, M.D., rehab/physical medicine. **Estate of Betty J. Spotts, deceased v. Providence Health Care South Holland, Dr. Ahmed Elgamal**, Cook County (IL) Circuit Court, Case No. 13L-1450. Milo W. Lundblad and Cole H. Munvez, Brustin & Lundblad for the plaintiff. Terrence S. Cardin, III and Patricia Cruz Montalvo, Myers, Carden for Providence Health Care South Holland; and James J. Stamos and Benjamin F. Klimek, Stamos & Trucco for Elgamal; defendants.

Alleged Lack of Fall-Risk Assessment and Plan —Death — New Jersey Defense Verdict. Plaintiff's decedent, a woman in her seventies, suffered an aortic aneurysm requiring a stent placement. She underwent placement of an abdominal aortic stent and femoral bypass graft and was transferred to defendant rehabilitation for recovery and physical therapy. The next month, she fell twice over a period of three days and her bypass graft ruptured. Decedent also suffered a pseudo-aneurysm, and had multiple corrective hear surgeries to repair and protect the graft from infection. Following the surgeries, the decedent died from multi-system failure, sepsis, COPD, and congestive heart failure. The plaintiff alleged that the bypass graft ruptured as a results of the decedent's falls, and led to her death; and the decedent's falls we a result of the defendant's failure to perform a fall-risk assessment and follow a fall-risk plan. The defendant argued that the decedent was responsible for her falls because she failed to following instructions and use her bell instead of leaving her bed. The defendant asserted that the decedent's death was unrelated to the falls, but rather due to unrelated health issues. A defense verdict was returned. **Plaintiff's Experts:** Rose Valentine, RN, nursing police & procedures, Yardley, PA. Peter Scalia, MD, cardiothoracic surgery, Ocean Township, NJ. Anthony Squillaro, MD, cardiothoracic surgery, Ocean Township, NJ. **Defendant's Expert:** Roger Rossi, physical medicine, Edison, NJ. **Estate of Dolores Karanasos v. Meridian Health, Meridian Sub Acute Rehabilitation, Carol Morgan, RN, Nicole Mollema, RN, Tara Hanley, RN, Ruth Kearny, RN and Yong Shi, MD,** Monmouth County (NJ) Superior Court, Case No. 4274/11. Jack Sanders, Shebell & Shebell, Shrewsbury, NJ for the plaintiff. Joseph K. Cooney, Widman, Cooney & Wilson, Oakhurst, NJ for Yong Shi, MD, Ruth Kearny, RN, Tara Hanley, RN, Nicole Mollema, RN, Meridian Sub Acute Rehabilitation; Teresa K. Gierla, Ronan Tuzzio & Giannone, Tinton Falls, NJ for Carol Morgan, RN; defendants.

Alleged Failure to Diagnose and Treat Intracranial Bleed — Arizona Defense Judgment. The plaintiff's decedent, a forty-nine year-old man, died as a result of an intracranial bleed. Plaintiff alleged that the defendant hospital's staff fell below the standard of care when they discharged decedent prematurely. Plaintiff also alleged that decedent, who had suffered an intracranial bleed, required neurosurgical intervention and should not have been discharged. Plaintiff claimed that the hospital's nursing staff fell below the standard of care when they failed to advocate for decedent and against his discharge. The defendants denied falling below the standard of care. The defense contended that decedent had suffered a traumatic brain injury; he was stable and was not a surgical candidate. Defendants also contended that there were no new findings that the nursing staff should have reported to trauma service in order to prevent decedent's discharge. The court found that plaintiff had not met her burden of proof, and granted a defendant's motion for judgment. **Plaintiff's Experts**: Robert E. Lieberson, M.D., neurosurgeru, Pleasanton, CA; Beth Brower, R.N. **Defendant's Experts:** Martin H. Weiss, M.D., neurology, Los Angeles, CA; Carol S. McCleary, psychologyt; Deborah A. Mills, R.N. **Stevens v. Banner-University Medical Center, Tucson Campus.** Pima County (AZ) Superior Court No. CV 2014-0625.

MEDICINE

Failure to Obtain Consent for Unnecessary ECRP — $1.53 Million Maryland Verdict. The plaintiff, a seventy-five year-old retired woman, was evaluated by her primary care physician. Plaintiff had suspicious elevated blood levels that were indicative of pancreatic cancer. She was referred to a gastroenterologist for follow-up. The defendant specialist labeled the suspicious areas with tumor and mass, although there was no tumor or mass, which he relayed to plaintiff's primary care physician. Defendant recommended plaintiff undergo an ERCP with cytology brushing. Following the ERCP, plaintiff developed necrotizing pancreatitis, causing death of the pancreas and resulting in Type 1 diabetes. Plaintiff alleged defendants were negligent in obtaining an informed consent. Plaintiff alleged that the ERCP with brushing was unnecessary and that defendant recommended the procedure despite an MRI, ultrasound and endoscopic ultrasound all being negative for pancreatic cancer. Plaintiff claimed

defendant failed to discuss the probability of success or explain that the probability of finding pancreatic cancer after the prior testing was very low, while the risk of pancreatitis was 6 to 20 percent. The defense contended that the ERCP with brushing was appropriate and necessary to assess the pancreas, chronic gallstones and abnormal labs. The defense further claimed that plaintiff was properly informed of all the risks and signed the appropriate consent forms. Plaintiff suffered necrotizing pancreatitis, resulting in Type I diabetes. She required blood checks five times a day, the use of insulin and enzymes in order to eat, and also suffered from chronic diarrhea. The jury returned a $1,535,000 verdict, which was reduced to $1,249,193, which took into account the statutory cap on non-economic damages and reduction for reduced medical payments. **Wanda Saffer v. Mark Noar, M.D., Endoscopic Microsurgery Associates PA and Mark D. Noar M.D. & Associates.** Baltimore County (MD) Circuit Court No. 03C15000350. Rodney M. Gaston and Laura Greeves Zois, Miller & Zois, Baltimore, MD for plaintiff. Neal M. Brown and Saamia H. Dasti, Waranch & Brown, Lutherville, MD for defendant.

Alleged Failure to Diagnose Babesiosis — Blood Transfusion Rquired — New York Defense Verdict. The plaintiff, a sixty-five-year-old man, presented to a medical clinic and was evaluated by defendant physician. The plaintiff complained that his throat was sore, and he also was experiencing post-nasal drip. He was diagnosed with bronchitis. After nine days had passed, the plaintiff returned to the clinic having developed a cold sore. The defendant recommended medication. The plaintiff again returned to the clinic with a cough. Defendant physician also diagnosed the plaintiff with bronchitis, and prescribed an antibiotic. Five days later, the plaintiff returned to the clinic with improved respiration, but he claimed that he was suffering night sweats. The defendant prescribed further monitoring of the plaintiff's condition. Three days later, the defendant called the plaintiff and the plaintiff informed the defendant that his condition had declined. The defendant prescribed an antibiotic. After three days had passed, the plaintiff was examined by another physician. The doctor ordered a study of plaintiff's blood, and the test results revealed that the plaintiff was suffering babesiosis. He underwent a transfusion, and he claimed that his recovery lasted 12 months. The plaintiff claimed that his disease should have been diagnosed upon his first visit, and that a timely diagnosis would have greatly reduced the length of his recovery. He alleged that his disease was a result of being bitten by a tick, and that both defendants knew this. The plaintiff also alleged that he reported that he was suffering flu-like symptoms, and those symptoms are common with a tick bite, and this should have prompted the defendants to immediately test the plaintiff's blood, since tick bites are common in the area. The defendants contended that 28 days may pass before babesiosis' symptoms become active and diagnosable, therefore the disease could not have been diagnosed during the first few evaluations. The defendants contended that the plaintiff did not report that he had been bitten by a tick, that he did not report that he was suffering flu-like symptoms, and that his symptoms suggested that he was suffering bronchitis. The defendants claimed that they appropriately addressed the plaintiff's symptoms. The defendants maintained that a blood study was recommended to the plaintiff during the earliest consultation, but that the plaintiff did not heed the recommendation. The defendants' records indicate supported the claim. A defense verdict was returned. **Plaintiff's Expert:** Yoram Puius, M.D., Ph.D., infectious diseases, Bronx, NY. **Defendant Expert(s)**: Gary Wormser, M.D., infectious diseases, Hawthorne, NY. Horan Bruce Farber, M.D., infectious diseases, Manhasset, NY. Morello Preston Winters, M.D., internal medicine, White Plains, NY. **William Ryan v. William Blakely Kerr, M.D., and Ilona Polak, M.D.**, Suffolk County (NY) Supreme Court, Case No. 35725/12. Lewis J. Saul and Edward A. Coleman; Lewis Saul & Associates, New York, NY, for the plaintiff. Elizabeth A. Horan, McHenry, Horan & Pilatsky, Oyster Bay, NY for Ilona Polak; Stephen V. Morello, Chesney & Nicholas, Syosset, NY for William Blakely Kerr; defendants.

Alleged Failure to Timely Diagnose and Treat Aortic Dissection — Death — Georgia Defense Verdict. The plaintiff's decedent, a fifty-seven year-old IT technician, presented to the ER with complaints of chest pain on April 11, 2012. He was evaluated and sent home with instructions to see his primary care physician the next day. The following morning he was referred to an internist, for follow-up care, because his primary care physician was not able to see him. The defendant internist prescribed decedent a GI cocktail. He reportedly felt better and was sent home. Two days later, defendant received the ER chest X-ray, which suggested bilateral pneumonia. He called decedent, who presented to defendant's office the same day. Decedent was admitted directly to the hospital on the evening of April 13 and underwent an EKG and repeat chest X-ray, which revealed acute pericarditis. Defendant continued to treat the patient for pneumonia because he did not believe the pericarditis diagnosis from the computer evaluation of the EKG. On April 15 defendant believed the patient's condition had worsened. He ordered a CT scan to be done the next morning. The CT scan showed an aortic dissection, which was treated as an emergency. A cardiothoracic surgeon was consulted and took over the patient's care. A trans-thoracic echocardiogram and transesophogeal echocardiogram confirmed the dissection. While undergoing surgery on April 16, the dissection ruptured and patient coded. Decedent suffered significant brain damage due to oxygen deprivation. He was removed from life support and died ten days later. Decedent's wife, on behalf of decedent's estate, alleged that the defendants failed to timely diagnose and treat decedent's aortic dissection, resulting in his wrongful death. Plaintiff alleged defendant beached the standard of care on the basis that he mismanaged the EKG on April 13, which allegedly revealed acute peridcarditis. Plaintiff alleged that defendant failed to properly read the April 15 chest X-ray, which reflected widening of the mediastinum, and should have alerted defendant of the emergent condition. Defense contended that the review of the chest X-ray was appropriate and that defendant's care and treatment of the patient was reasonable and within the standard of care. A defense verdict was returned. **Victoria Hull, for the Estate of Cary Hull, deceased v. Lanier Medcare, PC, Song H. Na, M.D., Jani Widjaja, M.D. and North Metro Radiology Associates.**

Gwinnett County (GA) State Court No. 12-C-07755-S5. John G. Mabrey, Atlanta, GA for plaintiff. Daniel J. Huff and Taylor C. Tribble, Huff, Powell & Bailey, Atlanta, GA; Jeffrey A. Peters and Jonathan C. Peters, Peters & Monyak, Atlanta, GA for defendants.

NURSING

Allegedly Misplaced IV — Loss of Thumb Function, Loss of Fingernail — Massachusetts Defense Verdict. The plaintiff, a woman in her thirties, was in a local hospital being treated with nausea medication. The defendant R.N. administered the medication through an IV placed in the plaintiff's thumb. IV infiltration occurred, and as a result, the plaintiff claimed she lost function in the thumb and lost her fingernail. The plaintiff alleged that the defendant negligently administered an unnecessary medication through the IV into an inappropriate site in her thumb. The plaintiff claimed that she was screaming as the defendant administered the medication and the defendant jammed the medication through the syringe, exhibiting improper nursing judgment. The defendant contended that she was following orders to administer the nausea medication, the only access for the IV was through the plaintiff's thumb, and infiltration is a known risk of the procedure. A defense verdict was returned. **Kimberly Elridge v. Hannah Stone, R.N.,** Plymouth County (MA) Superior Court, Case No. 1283CV01282. Charlotte E. Glinka, Keches Law Group, Milton, CT for the plaintiff. John P. Faggiano, Faggiano & Associates, Brookline, MA for the defendant.

NURSING HOMES

Alleged Improper Wound Care Blamed for Gangrene, Necrosis, Amputation — Virginia Defense Verdict. The plaintiff, an eight-seven-year-old woman, was transferred to defendant retirement community for long-term care following a below-the-knee amputation of her right leg. A week later, the doctor who performed the surgery examined the plaintiff and diagnosed her with gangrene, and amputated her leg above the knee five days later. The plaintiff alleged that the defendant facility staff and doctor failed to properly monitor the surgical wound, and recognize signs of infection in a timely manner and refer her back to her surgeon. The defendant contended that the wound was properly monitored and there were no signs of infection. At the first sign of vascular compromise to the wound site, the plaintiff was promptly sent back to her surgeon. The defendant argued that the plaintiff's poor blood supply was the cause of her negative healing. A defense verdict was returned**. Plaintiff's Experts: Joanne Biddix, R.N., nurse practitioner, Richmond, VA.** Stanley Crossland, M.D., cardiovascular surgery, Reston, VA. **Defendant's Experts:** Jeff Brown, M.D., cardiovascular surgery, Richmond, VA. Joseph Farr, M.D., vascular surgery, Manassas, VA. Carolyn Hasson, R.N., nursing, Richmond, VA. Angela Mattocks, R.N., nursing, Upper Marlboro, MD. Dennis O'Neill, M.D., internal medicine, Newport News, VA. Gary Simon, M.D., infectious disease, Washington, DC. **Martha Aughavin v. Watermark Retirement Communities, Inc. d/b/a The Fountains at Washington House and Ashok Chauhan, M.D.,** Alexandria City (VA) Circuit Court, Case No. CLI 3000-2310. David Charles Masselli, David Charles Masselli, Arlington, VA and Sean W. O'Connell, Law Office of Sean W. O'Connell, Arlington, VA for the plaintiff. M. Richard Coel and Gerald F. Ragland, Jr., LeClair Ryan, Alexandria, VA for Watermark Retirement Communities Inc.; Kristina Lewis and Byron J. Mitchell, Rawls McNelis & Mitchell, Fredericksburg, VA for Ashok Chauhan M.D.; defendants.

OBSTETRICS

Infant's Skull Fractured By Forceps — Death — $10.2 Million Texas Verdict. The plaintiff, a woman in her mid-twenties, gave birth to the decedent while under the care of defendant doctor at defendant medical center. After the plaintiff had been in labor most of the day, fetal heart monitor indicated that the baby was distressed. However, the defendant disagreed with the head delivery nurse that the baby was in distress. This prompted the nurse to go to her supervisor, who, two hours later, confronted the defendant, telling him that the distressed monitoring strips were a serious concern and necessitated the cessation of the oxytocin begin given the plaintiff. The defendant disagreed, and ordered another nurse to increase the dosage. About three hours later, with the fetal monitoring strip showing severe distress to the decedent, the defendant decided to deliver the decedent, and half an hour later attempted to complete delivery. For approximately seventeen minutes, the defendant used forceps three times to extract the baby, all of which were unsuccessful. On the second attempt, cracking noises were heard. After forceps failed to deliver the baby, a c-section was ordered, and the baby was born limp, lifeless and unresponsive. She was diagnosed with hypoxic ischemic encephalopathy, and taken off life support. The autopsy stated that the defendant's hypoxic ischemic encephalopathy was caused by skull trauma. Plaintiff claimed that the defendant and the nursing staff should not have continued to administer oxytocin when the baby was clearly in distress. The plaintiff asserted that the supervising nurse should have contacted her supervisor and continued up the chain of command until the defendant stopped the oxytocin and the issue was resolved. According to the plaintiff, the defendant was so reckless in using the forceps that it caused one of the fractures to depress into the baby's brain matter. The plaintiff cited literature that prohibited physicians to use their leg muscles when applying the forceps,

gentle application was critical. During one of his forceps attempts, the defendant had his leg on the bed to increase the force he was using. During the delivery the defendant tried to turn the baby using the forceps, which is outside the standard of care because of the risk of rotary injuries like the one sustained by the decedent. The defendant denied the allegations, blaming the bleed and resulting traumatic skull injuries to the plaintiff pushing over a long labor, although a mother's pushing efforts rarely cause such damage to a baby. A $10,200,575 verdict was returned, including $575 for funeral burial expense, $100,000 for past physical pain, $3,000,000 for past loss of society companionship, $3,000,000 for future loss of society companionship, and $4,100,000 for past mental anguish. **Plaintiff's Expert:** Mark Akin, M.D., ob-gyn, Austin, TX. **Defendant's Expert(s):** Joellen Klohn, R.N., obstetrics nursing, San Antonio, TX. Cooksey Stephen Nelson Jr., pediatric neurology, Metairie, LA. Timothy Bohan, M.D., pediatric neurology, Houston, TX. Ferdinand Plavidal, M.D., ob-gyn, Houston, TX. **Rachel Ann Melancon, individually and as representative the Estate of Olivia Marie Coats v. George Backardjiev, M.D. and The Medical Center of Southeast Texas L.P.,** Jefferson County (TX) District Court, Case No. B0195944. M. Malachi Daws, The Daws Law Firm, Beaumont, TX, for the plaintiff. Curry L. Cooksey, Cooksey & Marcin, The Woodlands, TX, for The Medical Center of Southeast Texas L.P.; Mary Kathleen Evans, Luccia & Evans, Houston, TX, for George Backardjiev, M.D.; defendants.

Failure to Timely Deliver Baby Via C-Section Led to Child's Cerebral Palsy — $8.4 Million Wisconsin Settlement. The plaintiff, a thirty-year old woman who was 40 weeks pregnant and weighed 300 pounds, was admitted to the hospital for delivery of a baby girl. On March 20, 2012 she was given Oxytocin for labor induction. Within 30 minutes of the administration of Oxytocin, her baseline started to climb, accelerations ceased, and late decelerations commenced. The drug was steadily increased throughout the morning and early afternoon. The baby was not tolerating the contractions, so the nurse discontinued the oxytocin. The attending physician ordered that Oxytocin be restarted after giving the baby an opportunity to recover. Plaintiff requested a C-section be done. Defendant ob/gyn refused to do a C-section, contending that he was concerned that due to her excessive weight and prior heart surgery, a C-section would be risky. His shift ended later that day and care of the plaintiff was provided by his partner. On March 21 the on-call nurse noticed that the baby's heart rate had climbed to 160 beats per minute. Plaintiff still had not progressed with labor. The defendant ob/gyn physician ordered terutaline to help labor progress. However, he did not come to plaintiff's bedside to examine her. An hour after the administration of the medication, the baby's heart rate dropped. The defendant immediately did an emergency C-section. The baby girl was born severely depressed and lifeless. Plaintiff's expert ob/gyn opined that defendants should have performed an emergency C-section on the afternoon of March 20. Plaintiff's obstetrics nurse faulted the nurses for not being more assertive in recommending a C-section on March 20. The defense expert opined that the fetal monitoring strips on March 20 were not as non-reassuring as plaintiff claimed, and that a C-section was not warranted. An MRI done at 23 days of life showed that the baby girl had distinct hypoxic ischemic injury. She was diagnosed with cerebral palsy, as she is non-ambulatory and with significant impaired cognitive abilities. Plaintiff's expert in pediatric neurology opined that the baby's hypoxic injury occurred within 30 minutes of delivery, and that the injury could have been prevented had a C-section been performed earlier. The parties settled during mediation for $8.4 million. **Plaintiff's Experts:** Gary Yarkony, M.D., Elgin, IL; Robert Dein, M.D., ob/gyn, Plymouth Meeting, PA; Stephen Glass, M.D., pediatric neurology, Bothell, WA; Patricia Spier, RN, Loma Linda, CA. **Defendant's Experts:** George Macones, M.D., ob/gyn, St. Louis, MO; Judith Poole, R.N., labor & delivery, Charlotte, NC; Carolyn Salafia, M.D., placental pathology, Bronx, NY; Charles Fitz, M.D., radiology, Pittsburgh, PA; Richard Katz, M.D., physical medicine, St. Louis, MO; Richard Colan, M.D., pediatric neurology, Oak Creek, WI. **Nevaeh Crowe, a minor by Jerome Hierseman, her Guardian ad Litem, and Jennifer Hall v. Wheaton Franciscan Health Care, Joseph Wilczynski, M.D., Gregory Pae, M.D., et al.** Racine County (WI) Circuit Court No. 2013-CV-000929. Jeffrey M. Goldberg and Adam T. Peterson, Jeffrey M. Goldberg Law Offices, Chicago, IL for plaintiff. Barrett J. Corneille, Green Bay , WI; Mary K. Wolverton, Peterson, Johnson & Murray, Milwaukee, WI; Michael P. Russart, Hinshaw & Culbertson, Milwaukee, WI for defendants.

Improper Treatment During Pregnancy Blamed for Stillborn Twins — $4.25 Million Pennsylvania Settlement. The plaintiff, a twenty-nine year-old woman, was pregnant with twins when she suffered an eclamptic seizure at 33.4 weeks. The baby twins were allegedly stillborn. Plaintiff alleged that defendant failed to properly treat her pre-eclampsia between December 9, 2008, and February 27, 2009. She alleged that the seizure forced her to suffer hypovolemic shock, tachycardia and massive hemorrhaging, and required her to undergo an emergency hysterectomy and removal of her fallopian tube and ovaries. Plaintiff has no children, and was rendered unable to conceive children at age 29. Plaintiff filed a petition seeking to apportion 60 percent of the settlement proceeds to her distress claim and 20 percent each to the wrongful-death and survival claims. She also sought to bar the twins' biological father from sharing in the recovery due to his abandonment of the twins. Plaintiff agreed to receive 65 percent of the wrongful-death and survival funds, with 35 percent going to the father. Plaintiff was awarded $4.25 million. **Jo Ann Page v. Moses Taylor Hospital.** Lackawanna County (PA) Court of Common Pleas No. 11 CV-1402. Matthew Casey and Joshua Van Naarden, Ross, Feller, Casey, Philadelphia, PA for plaintiff. Timothy Foley, Foley, Comerford & Cummins, Scranton; Mark T. Perry and Christian A. Owens, Perry Law Firm, Scranton for defendants.

Baby's Weight Underestimated Before Delivery — Shoulder Dystocia, Permanent Brachial Plexus Injury — Illinois Defense Verdict. The plaintiff was delivered by defendant ob-gyn at defendant hospital. The plaintiff contended that the defendant failed to read an ultrasound report that was performed five days earlier. The defendant allegedly failed to suspect fetal macrosomia based on the comparison of the fetal head circumference and fetal abdominal circumference. Instead, the defendant relied on the estimated fetal weight of under eight pounds when he decided to proceed with a vaginal delivery. The baby girl's actual birth weight was ten and one half pounds. As a result of the baby's large size, her should became lodged behind her mother's pubic bone after the head was delivered via vacuum. The defendant delivered the shoulder, but the plaintiff sustained permanent brachial plexus injury. The plaintiff maintained the defendant cause the dystocia and injury by failing to diagnose the macrosomia and improperly using the vacuum extractor when it is contraindicated for macrosomia babies. The defendant denied any responsibility and asserted that his reliance on the estimated weight was within the standard of care. A defense verdict was returned. **Plaintiff's Experts:** Julian Ullman, M.D., ob-gyn. Gary Yarkony, M.D., rehab/physical medicine. **Defendant's Experts:** Scott MacGregor, M.D., ob-gyn. Richard Lazar, M.D., neurologist. **America Camacho, minor v Dr. Sonya L. Thomas, Norwegian American Hospital,** Cook County (IL) Circuit Court, Case No. 12L-12459. Guy Delson Geleerd, Jr., Geleerd Trial Law and Christopher Bargione, Collins, Bargione for the plaintiff. Catherine Coyne Reiter and Jennifer A. Heydemann, Hughes, Socol for the defendants.

Ectopic Pregnancy Misdiagnosed — Unnecessary Abortion — Kentucky Defense Verdict. The plaintiff was six weeks pregnant and suffering pain in her lower abdomen. She reported to her obstetrician, who was off that day, and was instead seen by his partner, the defendant. The defendant performed an ultrasound and could not find the fetus. The plaintiff's Hcg levels were highly suggestive of an ectopic pregnancy. The next day the defendant performed a laparoscopic surgery and found no evidence of an ectopic pregnancy, but did remove the plaintiff's appendix. The defendant continued to be concerned about the possibility of an ectopic pregnancy and recommended that the plaintiff terminate the pregnancy. The next day, the defendant gave the plaintiff Methotrexate to halt the development of the fetus. A week later, an ultrasound revealed not an ectopic pregnancy, but a developing fetus, properly planted, and with a beating heart. Because of the methotrexate, the likelihood of birth defects was high, so the defendant again suggested terminating the pregnancy, which the plaintiff did one month later. The plaintiff alleged that the defendant should have completed the pathology from the appendix and repeated the ultrasound before rushing into advising the plaintiff to abort her baby. The defendant said that she acted reasonably based on the plaintiff's symptoms. **Plaintiff's Expert:** Philip Cohen, M.D., ob-gyn, Winter Park, FL. **Defendant's Experts:** Michael Baggish, M.D., ob-gyn, San Francisco, CA. Carl Wingo, M.D., ob-gyn, Nashville, TN. **Cope v. Savells,** Marshall County (KY) Circuit Court, Case No. 12-554. Thomas L. Osborne and J. Boone Reed, Osborne-Reed Law Firm, Paducah, KY for the plaintiff. James R. Coltharp, Jr., Whitlow Roberts Houston & Straub, Paducah, KY for the defendant.

Alleged Failure to Resolve Dystocia — Nebraska Defense Verdict. Plaintiff received an ultrasound that showed that her fetus was unusually large, and because of the baby's large size, the plaintiff was admitted to defendant hospital for induction of labor. During the delivery, shoulder dystocia occurred, and the infant plaintiff sustained a multitude of injuries, including the brachial plexus injury, a strained C5 disc, ruptured C6, C8 and T1 discs, and an avulsion of C7. The plaintiff claimed the defendants negligently failed to resolve the obstetrical complication of shoulder dystocia to deliver the infant plaintiff without trauma. Had they done so, the child would not have sustained injuries at birth, which will likely impact her life forever. The plaintiff also accused the defendants of failing to inform her regarding the child's brachial plexus injury. The defendant hospital denied that any injury the infant plaintiff sustained was due to factors that were in their control. The defendant hospital claimed that the cause of the plaintiff's injuries were her underlying medical conditions. The defendant clinic denied deviating from the accepted standards of medical care, maintaining that the procedures performed were necessary. The defense claimed that the child's arm injury was exceedingly rare and unforeseeable, thus it was appropriate that she was not informed of that being a potential risk. A defense verdict was returned. **Plaintiff's Experts:** Amos Grunebaum, M.D., ob-gyn; New York, NY. Scott Kozin, M.D., orthopedic surgery, Philadelphia, PA. **Defendant's Experts:** Andrew Robertson, perinatology, Omaha, NE. Robert DeMott, obstetrics; Green Bay, WI. **Dawn Lawrey, Mother and Next Friend of Aubree Lawrey, A Minor v. Good Samaritan Hospital, Kearney Clinic, P.C., and Dawn M. Murray, M.D.**, _____ County (NE) District Court, Case No. 11-CV-00063. Kenneth M. Levine and Sheila Mone, Kenneth M. Levine & Associates; Brookline, MA, and Christopher P. Welsh and James R. Welsh, Welsh Law Firm; Omaha, NE, for the plaintiffs. James A. Snowden and Joseph M. Aldridge, Wolfe, Snowden, Hurd, Luers & Ahl, Lincoln, NE, for Dawn M. Murray, M.D., Kearney Clinic, P.C.; Mark A. Christensen and Susan K. Sapp, Cline, Williams Law Firm; Lincoln, NE, for Good Samaritan Hospital; defendants.

Alleged Delay in Treatment and C-Section Blamed for Infant Death — Michigan Defense Verdict. The plaintiff underwent weekly non-stress tests due to excess amniotic fluid until the fluid returned to normal. Near the end of her pregnancy, the plaintiff noticed a decrease in fetal movement and called the defendants. She was told to perform a fetal kick count and go to the ER if the count was abnormal, but the plaintiff fell asleep. In the morning, she presented to the defendant's office and was sent to the hospital for an emergency C-section which wasn't performed until two and a half hours later. The infant was born in distress and died eight hours later. The plaintiff alleged that the defendants should have continued weekly tests even after the fluid levels

returned to normal, they should have sent her to the ER when she initially called about the decreased fetal movement, and the C-section should have been performed immediately upon arrival to the hospital. The defense asserted that further testing was unwarranted, the phone advice was appropriate, the delay in C-section was out of their control, and the outcome would have been the same regardless of their actions. A defense verdict was returned. **Plaintiff's Experts:** Roger Kushner, M.D., ob/gyn, Livonia, MI. Robert Dock, M.D., ob/gyn, Livonia, MI. **Defendants' Experts:** Timothy Wilcox, M.D., ob/gyn, Petoskey, MI. Harvey Kilman, pathology, New Haven, CT. Stephen DeVoe, M.D., ob/gyn, Columbus, OH. Wes Beemer, M.D., ob/gyn, Ypsilanti, MI. William Roberts, maternal fetal medicine, Signal Mountain, TN. **Neebin Genereaux, deceased by her personal representative Gabriel Genereaux v. Elaine du Plessis, M.D., Nancy Herta, M.D., and Mid-Michigan Physicians, P.C.,** Ingham County (MI) Circuit Court, Case No. 13-000953-NH. Fallon Yaldo, Bloomfield Hills, MI for the plaintiff. Michael W. Stephenson and Marcy Matson, East Lansing, MI for the defendants.

OPHTHALMOLOGY

Alleged Failure to Diagnose Retinal Tears and Refer — Detached Retina, Vision Impairment — Massachusetts Defense Verdict. The plaintiff, a man in his fifties, visited his ophthalmologist on four or five occasions during a three-month period, complaining of blurred vision. The plaintiff claimed that despite his complaints upon every visit, the defendant ophthalmologist failed to appreciate the breaks and tears to the retina of his eye. The defendant failed to dilate the plaintiff's eye on the final visit, and had he done so, he would have discovered the retinal tears and referred him to a specialist. The plaintiff claimed that one week after his last visit with the defendant, he suffered a detached retina, requiring surgery and resulting in permanent vision problems. The defendant contended that he performed the appropriate exam and tests, and that he had dilated the plaintiff's eye during prior visits, and there was no change in the plaintiff's eyes that warranted another dilation or referral to a specialist. The defendant asserted that when the plaintiff called with vision changes, he was referred to a specialist. A defense verdict was returned. **Plaintiff's Expert:** Bernard Spier, M.D., ophthalmology, South Orange, NJ. **Defendant's Experts:** Steven Berger, M.D., ophthalmology, Springfield, MA. Nancy D. Efferson Bonachea, M.D., retinal detachment, Bedford, NH. **Frank Staffier and Patricia Staffier v. Jack V. Greiner, D.O. and Charles River Partners Groups, LLC, d/b/a Charles River,** Middlesex County (MA) Superior Court, Case No. 1181CV00595. Benjamin R. Novotny, Lubin & Meyer, Boston, MA for the plaintiff. J. Peter Kelley, Bruce Kelley Law, Burlington, MA for the defendant.

ORTHOPEDICS

Scoliosis Screws Impinge on Organs — $2.55 Million Louisiana Verdict. The plaintiff, a twelve-year-old girl, underwent scoliosis repair surgery performed by defendant orthopedist. The defendant inserted screws and rods into the plaintiff's spin to correct its curvature. Following the surgery, the plaintiff continued to have spinal problems. She saw another physician who discovered that the screws were improperly inserted and were in danger of impinging internal organs or nerves in her spine. The doctor performed a serious, complex, and life-threatening surgery to repair the issues. After that surgery, the plaintiff had a spinal fluid leak and remained in the hospital for a week. The plaintiff claimed that the defendant improperly placed the screws, and their location endangered the life of the plaintiff, which necessitated the second, more dangerous surgery. The plaintiff alleged that the defendant should have identified the screw placement problem in post-surgical x-rays. The defendant asserted that the care was appropriate and that the plaintiff simply suffered a complication in that her spine's curvature progressed, and she needed revision surgery. A $2,550,000 verdict was returned, including $400,000 in medicals; $800,000 in future care; $1,000,000 for pain and suffering; and $350,000 for mental anguish. **Plaintiff's Expert:** Lawrence Glorioso, M.D., radiology. **Thomas v Warren,** Orleans Parrish (LA) District Court, Case No. 12-4208. Tamara Kluser Jacobsen and Robert G. Harvey, Sr., New Orleans, LA for the plaintiff. Robert H. Wall and Adam P. Gulotta, Adams & Reese, New Orleans, LA for the defendant.

Silk Tie Left in Place During Surgery — Arm Amputation — $2 Million Massachusetts Settlement. The plaintiff, a twenty-three-year-old man, was involved in a motorcycle accident. He was transferred to the defendant hospital and diagnosed with a fracture of the left distal humerus and radial styloid. The plaintiff underwent an operation for irrigation and debridement, and Doppler pulses of the arteries were strong. Three days later, another orthopedic surgery team performed another irrigation and debridement along with an open reduction of the left distal humerus, radial styloid and a wound VAC application. Over the next few days, the plaintiff experienced a lack of motor and sensory function in his left extremity. Three days later, he underwent a third procedure, and the surgeon noted that the plaintiff had no pulses, and his left hand was mottled and cold, without sensation and motor function. The surgeon also noted that there was a traumatic laceration to the artery of that arm. During the exploration to locate the source of the laceration, a silk tie was found that had been left from a previous surgery. Three days later, the plaintiff underwent a below-elbow amputation. The case settled for $2,000,000. **Anonymous Twenty-Three-Year-Old Man v. Anonymous Surgeon,** _____County (MA) Superior Court, Case No. _____. Max Borten and Sidney Gorovitz, Gorovitz & Borten, Waltham, MA for the plaintiff.

ORIF Left Patient Unable to Ambulate — $819,651 California Verdict. The plaintiff, a sixty-nine year-old retiree, presented to the defendant orthopedic surgeon for treatment o f a comminuted fracture of the right distal femur. She had previously sought treatment at various facilities for a number of serious health issues, including progressive dementia. On May 30, 2012, plaintiff fell and fractured her right leg. She presented to the defendant the next day and underwent open reduction and internal fixation surgery. She followed up with defendant at his office for three visits. During her fist office visit, defendant observed an internal rotation of her leg and ordered gently PT. On the third office visit, defendant informed plaintiff and her family that union of the bone had not been attained and that he recommended a revision surgery with a bone graft. However, plaintiff's dementia had worsened, and her family did not return her for further care with defendant. Plaintiff eventually underwent a revision procedure on January 29, 2013, at which time union of the bone was ultimately achieved. Plaintiff claimed she was unable to ambulate due to her leg condition until it was resolved in January 2013. However, by that time, her comorbidities left her bedridden and on a tracheostomy. Plaintiff alleged defendant was negligent in the performance of the May 2012 surgery. Plaintiff's counsel alleged that during the first surgery, defendant negligently placed the plate and screws in a way that caused plaintiff's leg to be fixed in an internally rotated position. Defense contended that the surgery was appropriate and defendant timely diagnosed the internally rotated leg. The defense orthopedic surgery expert opined that the internal rotation of the leg occurred after the surgery and was a result of polymyositis. Plaintiff alleged that she remained bedridden for an extended period of time as a result of not being able to walk on her leg and that she untimely developed a severe case of pneumonia, which ultimately necessitated her permanent admission to a nursing home. The jury awarded plaintiff $819,651.00. **Plaintiff's Expert:** Clive M. Segil, M.D., orthopedic surgery, Los Angeles, CA. **Defendant's Expert:** Christopher J. Woodson, M.D., orthopedic surgery, Los Alamitos, CA. **Leanese Brown v. Mohamed Zareem Lameer, M.D., and Does 1through 50.** Los Angeles County (CA) Superior Court No. BC527852. Allison R. Bracy, Ivie, McNeill & Wyatt, Los Angeles, CA for plaintiff. Angela S. Haskins, Haight, Brown & Bonesteel, Los Angeles, CA for defendant.

Alleged Failure to Diagnose Postop Infection Blamed for Sepsis, Knee Replacement — Illinois Defense Verdict. Auxiliary Nerve Transected During Shoulder Surgery — Pain, Limited Range of Motion — $525,000 Tennessee Verdict. The plaintiff, a sixty-three-year-old woman, underwent laparoscopic surgery on her left shoulder performed by defendant orthopedic surgeon. During the surgery, the defendant transected the plaintiff's auxiliary nerve. The plaintiff now suffers with pain and limited range of motion. The plaintiff alleged that the defendant failed to protect the nerve and then transected it. The defendant asserted that transection is a known risk of the procedure. The plaintiff maintained that if even transection is a known risk, the defendant's error is not excused. A $525,000 verdict was returned, including $250,000 for permanent injury; $200,000 for past and future loss of enjoyment of life; $50,000 past suffering; and $25,000 for future suffering. **Plaintiff's Expert:** Robert Karsch, M.D., orthopedics, Atlanta, GA. **Defendant's Expert:** Claude Mooreman, M.D., orthopedics, Durham, NC. **Scott v Brady,** Knox County (TN) Circuit Court, Case No. 1-647-12. Robert E. Pryor, Jr., Pryor Priest Harber Floyd & Coffey, Knoxville, TN for the plaintiff. James H. London and Libba Bond, London & Amburn, Knoxville, TN for the defendant.

The plaintiff, a forty-three-year-old man, underwent bilateral arthroscopic knee surgery for a torn meniscus in each knee. The procedure was performed by defendant orthopedic surgeon. The next day, the plaintiff was transported by ambulance to the emergency room with complaints of severe pain in both knees. The next day, the defendant aspirated large amounts of fluid from both knees, but did not send the fluid off for testing. Two days later, the plaintiff was diagnosed with bilateral knee infections, which led to additional surgeries, septic arthritis, permanent joint damage, and eventual knee replacements. The defense asserted that testing the fluid was not necessary because there was no reason to suspect infection that soon after surgery, and that the cause of the injury might be attributed to the plaintiff's running errands the day after surgery. A defense verdict was returned. **Plaintiff's Experts:** J. Scot Player, M.D., orthopedics. Fred A. Zar, M.D., infectious disease. **Defendant's Expert:** Richard S. Sherman, M.D., orthopedics. **Michael Hurrle, Cindy Hurrle v. Dr. John Lombardi, DuPage Medical Group Ltd.,** Cook County (IL) Circuit Court, Case No. 11L-6460. Clifford Lee Gunter, Lee Gunter, Joliet, IL for the plaintiff. Scott A. Herbert and Timothy F. Dobry, Cunningham, Meyer, Warrenville, IL for the defendant.

Failure to Prescribe Antibiotic Allegedly Led to Sepsis and Death — Missouri Defense Verdict. The plaintiff's decedent, an eighty-nine year old woman, developed sepsis more than two years after a knee replacement. Plaintiff alleged defendant physician drained fluid from decedent's swollen left knee on February 17, 2012. Plaintiff alleged defendant negligently failed to prescribe an antibiotic or provide other treatment pending a follow-up visit scheduled for three days later. Upon her return, decedent was rushed to the hospital for treatment of the spreading infection. She remained hospitalized for more than one month. She returned to the hospital after a week in a rehabilitation center. She was discharged less than two weeks later and admitted to a nursing facility under hospice care. She died on there on April 13, 2012. The jury returned a defense verdict. **Plaintiff's Experts:** Barry Bast, M.D., Manitowoc, Wisconsin; Richard Levy, M.D., internal medicine, San Francisco, CA. **Defendant's Experts:** Morton Rinder, M.D.,internal medicine, Chesterfield, MO; Craig Della Valle, M.D., orthopedics, Chicago, IL. **Wallace A. Anderson Jr., individually and as a personal representative of the estate of Elizabeth E. Anderson, deceased v. William C. Schroer, M.D., and SSM Orthopedic, Inc.** St. Louis County (MO) Circuit Court No. 14SL-CC00398. Lawrence D. Mass, Clayton for plaintiff. Peter Spataro and Sarah Cahill, Brown & James, St. Louis for defendants.

Sciatic Nerve Allegedly Cut During Hip Replacement — Wisconsin Defense Verdict. The plaintiff, a sixty-four year-old retired schoolteacher, underwent hip posterior approach replacement surgery. During the procedure, plaintiff alleged that her sciatic nerve was cut approximately three- quarters through. The following day the damage was noticed. Plaintiff underwent another surgery to repair the nerve, but it failed. Plaintiff alleged that she has permanent plantar flexion, causing foot drop. Plaintiff's orthopedic expert opined that the damage to plaintiff's sciatic nerve was caused by the negligent use of a surgical saw. The defense orthopedic expert opined that nerve damage is not uncommon in such a procedure. Plaintiff claimed she must wear a brace for the rest of her life to attain a normal gait. The jury returned a defense verdict. **Plaintiff's Expert:** Steven Woolson, M.D., orthopedic surgery, Milwaukee, WI. **Defendant's Expert:** Richard Glad, M.D., orthopedic surgery, Madison, WI. **Carlyn Hulbert v Joel Wallskog, M.D.** Brown County (WI) Circuit Court No. 10-CV-1162. John C. Cabaniss, Milwaukee, WI for platiniff. Todd M. Weir and Neal S. Krokosky, Otjen, Van Ert, Lieb & Weir, Milwaukee, WI for defendant.

OTOLARYNGOLOGY

Orbital Wall Fractured During Sinus Surgery — Decompression Surgery, Double Vision, Headaches — New Jersey Defense Verdict. The plaintiff, a man in his twenties, underwent functional endoscopic sinus surgery to treat breathing problems related to a deviated septum. The procedure was done at defendant surgicare facility by defendant otolaryngologist. During the surgery, the bone around the plaintiff's right eye was fractured by an instrument. The defendant continued the surgery and removed fat blocking the sinus in the orbital wall. The plaintiff claimed that the defendant departed from the standard of care by removing the fat after the orbital fracture, which pulled on the eye muscle, causing vision impairment, leading to the need for orbital decompression surgery. The plaintiff also alleged negligence because the defendant failed to call an ophthalmological surgeon. The defendant asserted that the surgery had been performed correctly, and an orbital fracture was a known complication of the procedure. A defense verdict was returned. **Plaintiff's Experts:** Shannath Merbs, M.D., ophthalmology, Baltimore, MD. Jacqueline Jones, M.D., otolaryngology, New York, NY. **Defendant's Experts:** Edmund Pribitkin, otolaryngology surgery, Philadelphia, PA. Jacqueline Carrasco, ophthalmology, Wynnewood, NJ. **Mina Farag v. Bergen Hudson ENT LLC and Babak Behin, M.D.,** Hudson County (NJ) Superior Court, Case No. 5604/13. Jeff S. Korek, Gersowitz, Libo & Korek, New York, NY for the plaintiff. Sam Rosenberg, Rosenberg Jacobs & Heller, Morris Plains, NJ for the defendant.

Alleged Failure to Intubate Before Condition Worsens — Death— Georgia Defense Verdict. The plaintiff's decedent, a fifty-six year-old painter with a history of myelodysplasia, was admitted to the ICU after he had presented to the hospital the previous day with complains of swelling and right-sided neck pain. Decedent underwent a consultation with defendant otolaryngologist, defendant pulmonologist, and a critical care physician. Defendants determined that based on decedent's multiple risk factors, he was not a candidate for intubation by nose or mouth at that time. Defendants decided to monitor the decedent in the ICU by critical care specialist and ICU nurses. Decedent's oxygen saturation levels had significantly decreased and he was intubated. During the intubation, decedent went into cardiac arrest. He was resuscitated and placed on life support. A culture report showed decedent *had pseudomonas aeruginosa bacteremia*. Four days later, decedent was taken off life support and he died. The cause of death was determined to be sepsis induced by pseudomonas aeruginosa and multisystem organ failure. Decedent's wife, as administrator of her husband's estate, alleged that the defendants' actions constituted delayed treatment, causing decedent's wrongful death. Plaintiff's counsel alleged decedent should have been intubated immediately after he was evaluated upon admission to the ICU. Plaintiff alleged that, by the time the decedent was intubated, his airway was completely occluded. Plaintiff's otolaryngology expert opined that defendant failed to perform an endoscopic evaluation of decedent's airway during the ICU evaluation. The defense contended the defendants' decision not to intubate the decedent was based on multiple health risk factors. The defense also claimed that decedent required mechanical ventilation due to his decreasing oxygen saturation level, which declined as a result of the infection/sepsis. The defense pulmonology expert opined that the standard of care did not require defendant to perform airway intervention upon admission to the ICU, and it was reasonable for defendant to have performed a clinical exam and closely monitor the patient's condition due to the risk factors present. Defenses' oncology expert opined that decedent had a six-month survival prognosis at the time of his death. The jury returned a defense verdict. **Plaintiff's Experts:** Allan L. Goldman, M.D., pulmonology, Tampa, FL; Scott Graham, M.D., otolaryngology, Iowa, City, IA; John C. Schaefer, M.D., infectious diseases, Norfolk, VA. **Defendant's Experts:** J. Allen D. Coper, Jr., M.D., pulmonology, Birmingham, AL; Douglas Mattox, M.D., otolaryngology, Atlanta, GA; Daniel M. Musher, M.D., infectious diseases, Houston, TX; Wendy L. Wright, M.D., neurosurgery, Atlanta, GA. **Sandra Harper, for the estate of Kenneth Glenn Harper, deceased v. Michael Lamar Vick, M.D., Wellstar Physicians Group ENT, LC d/b/a ENT Associates of North Georgia, Paul Zolty, M.D., and Georgia Lung Associates, P.C.** Fulton County (GA) State Curt No. 08EV005552. William Q. Bird and Jennifer A. Kurle, Atlanta, GA for plaintiff. Henry D. Green, Jr. and Daniel J. Moriarty, Green, Sapp & Moriarty, Atlanta, GA; Roger E. Harris and Drew C. Timmons, Swift, Currie, McGhee & Hiers, Atlanta, GA for defendants.

PAIN MANAGEMENT

Doctors Continued to Use Meds Following Recall — Spinal Fungal Infections, Death — Michigan Defense Verdict. The various plaintiffs were patients of defendant physicians at the defendant rehabilitation group. The defendants performed fluoroscopically-guided injections for pain management on the plaintiffs. The defendants' practice began buying a preservative-free steroid from an out of state compound pharmacy. The defendants preferred the preservative-free version because the alternative preparations may result in nerve damage. A voluntary recall of the steroid was issued, and the plaintiffs allegedly were harmed by the recalled medication. The defendants claimed to be unaware of the recall and claim to have acted reasonably in selecting the steroid they used, and argued that the doctors and practice acted reasonably in relying on federal and state boards to monitor pharmacies bringing prescriptions into the state. The defendants further argued that it would be unreasonable to expect them to try and practice medicine while also trying to police the licensing of the pharmaceutical companies they use. A defense verdict was returned. **Plaintiff's Experts:** Frank J. Falco, M.D., physical medicine, Bear, DE. Anurag Malani, M.D., infectious diseases, Ann Arbor, MI. Lloyd Saberski, M.D., pain management, New Haven, CT. **Defendant's Experts:** Stephen Andriese, M.D., physical medicine, Traverse City, MI. Rajesh Iyer, M.D., physical medicine, Troy, MI. James Mackenzie, M.D., physical medicine, Traverse City, MI. **June Gallivan as Personal Representative for the Estate of Loren Gallivan, Vernon Duff, Phyllis Briggs, et al. v Neuromuscular and Rehabilitation Associates of Northern Michigan (DBMJ Rehabilitation Services), Stephen Andriese, M.D., Richard Ball, M.D. and James MacKenzie, M.D.,** Grand Traverse County (MI) Circuit Court, Case No. 14-30499-NO. Mark R. Dancer and Ashley Wilson, Dingeman & Dancer, Traverse City, MI; Lisa Esser-Weidenfeller and Robert B. Sickels, Sommers Schwartz, Southfield, MI; and Daniel O. Myers, Law Offices of Daniel O. Myers, Traverse City, MI for the plaintiffs. Randall A. Juip and Kim J. Sveska, Foley Baron Metzger & Julip, Livonia, MI; and Timothy J. Dardas, Hackney Grover Hoover & Bean, East Lansing, MI for the defendants.

PHLEBOTOMY

Phlebotomist Allegedly "Fished" Around for Vein — Complex Regional Pain Syndrome — Nevada Defense Verdict. The plaintiff, a twenty-two-year-old man, underwent a blood draw performed by a phlebotomist employed by the defendant. The plaintiff alleged that the phlebotomist used improper techniques and "fished" around with the needle looking for a vein, while ignoring the plaintiff's complaints of pain during the blood draw. The plaintiff claims that he now suffers from complex regional pain syndrome. The defendant denied fallowing below the standard of care. The defendant asserted that the plaintiff's records show a routine and successful blood draw, and that if the plaintiff was injured, it was not because of any negligence. A defense verdict was returned. **Plaintiff's Experts:** Steven M. Sertich, R.N., nursing standards and practices. Daniel L. Burkhead, M.D., pain management. **Defendant's Experts:** Catherine A. Ernst, R.N., P.B.T, A.S.C.P., nursing standards and practices expert. Floyd D. Fortuin, M.D., neurologist, San Francisco, CA. **Garcia v Valley Health System, L.L.C., dba Centennial Hills Hospital Medical Center,** Clark County (NV) District Court, Case No. CV A684898. Clark Seegmiller and Karla M. Gabour, Seegmiller & Associates for the plaintiff. Casey W. Tyler and Tyson J Dobbs, Hall, Prangle & Schoonveld for the defendant.

PODIATRY

Failure to Treat Foot Ulcer Led to Infection and Amputation — $400,000 Defense Verdict. The plaintiff, a sixty-six year-old retired man, suffered from Type 2 diabetes with neuropathy, peripheral arterial disease, and prior left foot ulcers. He was referred defendant podiatrist for his left foot ulcer. Defendant performed an in-office surgical procedure to remove the sesmoid bone on January 18, 2012. Plaintiff developed symptoms of infection in the left foot. His foot developed necrotic tissue and gangrene of his big toe that spread, exposing bone and tendon. Defendant treated plaintiff's foot almost every day, for a total of twenty-eight times, which included weekends. Defendant referred plaintiff to non-party infectious disease specialist, who saw plaintiff on February 22. The specialist amputated plaintiff's left big toe and administered IV antibiotics and diagnosed osteomyelitis. A non-party vascular surgeon performed an abdominal aortogram and peripheral runoff study to determine plaintiff's blood flow before amputation surgery. A partial ray amputation was performed on March 29. Plaintiff then underwent six weeks of IV antibiotics and wound care. The wound did not fully close after months of care. Plaintiff presented to his primary care physician, who cultured the wound, which returned positive for methicillin-resistant staphylococcus aureus. Plaintiff presented to a plastic surgeon that diagnosed him with osteomyelitis. He underwent hyperbaric oxygen therapy for ninety minutes per day for ninety days, wound debridement and additional IV antibiotics. The wound still did not heal. In May 2013, plaintiff underwent an exploratory incision and drainage surgery. A suture that had likely been left following plaintiff's original partial ray amputation in March 2012 was found in the wound site. The suture was removed and within two weeks, plaintiff's wound had healed. Plaintiff alleged defendant podiatrist and non-party vascular surgeon fell below the standard of care during their treatment of plaintiff. Plaintiff's podiatrist expert opined that he should have been referred to a specialist by January 30, because his infection

was not improving. Plaintiff's infectious diseases expert opined that plaintiff's toe was unsalvageable by February 10, and the toe and partial ray amputation were required after that date. He also opined that earlier IV antibiotics would have saved the toe and prevented the need for amputation. Defendant denied falling below the standard of care and claimed that plaintiff had poorly controlled diabetes, and that plaintiff was comparatively at fault. Defendant argued plaintiff's disease was the sole reason his wound would not heal, and that he was a non-compliant patient that did not always follow up with his primary care physician visits. Defendant alleged plaintiff failed to disclose that he had suffered ulcers in the same location at least three prior times. Defendant's infectious diseases expert opined that earlier IV antibiotics would not have saved the toe. He further opined that plaintiff's outcome was inevitable due to his other diseases, which overwhelmingly caused the non-healing wound. Plaintiff alleged that his gait was affected by the ray amputation, which resulted in a limp and the need for a walker. He further alleged that as a result of this impaired gait and underlying preexistent arthritis, he developed pain in the spine, hips, and knees. The plaintiff was awarded $400,000 in damages. **Plaintiff's Experts:** Alexander M. Reyzelman, D.P.M., San Francisco, CA; Larry W. Rumans, M.D., infectious diseases. **Defendant's Experts:** Lewis H. Freed, D.P.M., podiatry; Ngozi A. Osondu, M.D., infectious disease; Rimma Finkel, M.D., plastic surgery. **Wagner v. Farrel, D.P.M.** Pima County (AZ) Superior Court No. CV 2014-00023.

Spider Vein Treatment Leaves Scars — – Multiple Revision Procedures — $250,000 Virginia Verdict. The plaintiff was a sixty-one-year-old woman who underwent spider vein treatment performed by defendant podiatrist. The plaintiff developed multiple scars on both legs following the treatment, and had to undergo multiple scar revision procedures to improve the look of the scars. A $250,000 verdict was returned. **Plaintiff's Experts:** Victoria Vastine, M.D. Jason Bailey, PA-C. **Stephanie Breeden v. Thomas Thang Tran, DPM., PC.,** Rockingham County (VA) Circuit Court, Case No. CL15-1114. Russell W. Updike and Jennifer K.M. Crawford, Covington, VA for the plaintiff.

Tendon Cut During Bunion Surgery —South Dakota Defense Verdict. The plaintiff, a fifty year-old laborer at a manufacturing plant, presented to the defendant podiatrist on November 2008 with complains of increased pain and discomfort in his right foot. Plaintiff underwent a bunionectomy on December 12. Plaintiff continued to have pain in his foot and had trouble walking. He underwent a second bunionectomy on March 20, 2009. Plaintiff claimed he lost use of his foot, and alleged that the invasive surgery was unnecessary. Plaintiff also claimed that the bunionectomy involved the removal of the bunion and cutting a tendon between the big toe and the little toe. He maintained that the cutting of the tendon was unnecessary. It was alleged that defendant failed to warn plaintiff of what could happen as a result of the surgery. The defense contended that the surgery was appropriate, and denied negligence. Plaintiff alleged he continues to have pain throughout the bottom of his right foot, which is exacerbated by activity. He claimed that his foot condition limited his ability to walk and made it impossible for him to be employed in anything other than a sedentary position. Defense contended that plaintiff was suffering from a degenerative form of arthritis and suffered for years with foot pain before going to see defendant. The jury returned a defense verdict. **Plaintiff's Expert:** David Cornell, D.P.M., podiatry, Omaha, NE. **Defendant's Expert:** Vincent Mandracchia, D.P.M., podiatry, Des Moines, IA. **Gordon Downing v. Chad Stapp, M.D.** Brown County (SD) Circuit Court No. 11-350. Seamus Culhane, Turbak Law Office, Watertown, SD for plaintiff. Reed A. Rasmussen, Siegel, Barnett & Schutz, Aberdeen, SD for defendant.

PSYCHIATRY

Alleged Failure to Monitor Psychiatric Unit Blamed for Rape — Virginia Defense Verdict. The plaintiff alleged she was raped while a patient at a mental health hospital. She alleged that defendant hospital failed to prevent her alleged rape by another patient because staff failed to conduct 15-minute patient checks. Plaintiff alleged a fellow patient came into her room and sexually assaulted her. The defendant contended that its staff had complied with the standard of care in its monitoring and treatment. The defense claimed that plaintiff had formed a relationship with a male patient and snuck him into her room. When she realized she had been caught, she was worried her husband would find out. Therefore, she claimed she had been raped. The jury returned a defense verdict. **Plaintiff's Experts:** H. Chip Walls, Ph.D., toxicology; Lisa E. Gaulard, RN; Jeffrey Schlichter, Ph.D., psychology **Defendant's Experts:** Heather A. Borek, toxicology; Sarah S. Saoud, RN; Kehill Sheorn, M.D., psychiatry. **Anonymous alleged rape victim v. Anonymous Mental Health Hospital.** Pinellas County (VA) Circuit Court No. ___. Jodi B. Simopoulos and Thomas F. Hancock IV, Glen Allen, VA for defendants.

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RADIOLOGY

Failure to Diagnose Benign Brain Tumor — Loss of Eyesight — $2 Million New Jersey Settlement. The plaintiff, a forty-nine year old woman, alleged that defendant physician failed to diagnose a congenital brain tumor when she had a CT scan taken of her head in September 2012. Eight months later the tumor was discovered when it had grown larger and caused a loss of eyesight. Plaintiff claimed the tumor was visible on her CT scan, but the defendant did not diagnose it. Plaintiff underwent surgery

to remove the tumor but she lost all vision in her left eye and 70 percent in her right eye, and is unable to work. The defense contended that an earlier discovery would not have helped to preserve the plaintiff's vision. A $2million settlement was reached. **Sharon Fisahn v. Ling Lai Lam, M.D.** _____ County (NJ) Superior Court No._____. Robert Adinolfi, Gill & Chamas, Woodbridge for plaintiff. Sam Rosenberg, Rosenberg, Jacobs & Heller, Morris Plains, for defendant.

Internal Bleeding Remains Untreated for Two Days — Death — $1.27 Million Illinois Verdict. The plaintiff's decedent, a seventy-three year-old man, fell ten feet from a ladder while trimming trees in his yard and landed on his right hip. He was taken to the ER, where x-rays of his hip and lumbar spine were ordered. The x-rays revealed a compression fracture of the L-2 vertebra and a burst compression fracture at L-4. He was admitted to the hospital and an orthopedic surgeon consultation was requested by the ER physician. The defendant radiologist read decedent's CT scan of his hip and pelvic area. There was no fracture, but defendant saw an abnormality in the retroperitoneum. Defendant recommended a non-emergent CT of the abdomen for further evaluation. While decedent was awaiting spinal surgery, he complained of an upset stomach and was transferred to the ICU due to changes in his vital signs. Later that evening, he experienced a drop in blood pressure, increased respiration and heart rates, and arrhythmia. A code blue was called an hour later, but he could not be resuscitated. An autopsy determined his death was due to severe lacerations of the grater omentum and transverse mesocolon, with 1800cc of blood in the abdominal cavity. Plaintiff alleged the lacerations were caused by the ladder fall, and that they bled slowly for two days. Plaintiff alleged defendant was negligent for failing to review the spinal x-ray which would have helped her recognize that the infiltration was blood. Plaintiff alleged defendant failed to diagnose bleeding and failed to recommend a STAT abdominal CT. The ER physician denied the standard of care required her to order a STAT CT and trauma surgery consult because there was no indication that the patient hit his abdomen in the fall, and his vital signs were stable in the ER. The radiologist contended that she did not know decedent had fallen from a height, she was only asked to rule out a hip fracture. The defense claimed that the internal lacerations were caused by aggressive CPR after the cardiac arrest in the ICU. The jury awarded plaintiffs $1.27 million in damages. **Plaintiff's Experts:** Manuel Montez, M.D., pathology; Jack Perlmutter, M.D., orthopedics; Jeffrey Kopin, M.D., internal medicine; Arthur P. Sanford, M.D., trauma surgeory; Michael Federle, M.D., radiologiy,, Stanford, CA; Eric A. Gross, M.D., emergency medicine, Sacramento, CA. **Defendant's Experts:** David M. Anderson, M.D., orthopedics; Amy Wlodek, RN; David Bova, M.D., radiology, Maywood, IL; Matthew J. Sorrentino, M.D., cardiology; Robert Lawrence Reed, M.D., trauma surgeon; Mark E. Cichon, D.O. **Estate of Daniel B. Spillane, deceased v. Catherine B. Montalbano, M.D., Wellington Radiology Group S.C., Linda L. Davis, Linda Libbey Davis, M.D. Ltd.** _____ County (IL) Circuit Court No. 13L-843. Joseph E. Kolar and Brian J. Lewis, Baizer, Kolar, Highland Park, IL for plaintiff. Mary Kay Scott and Joshua C. Bell, Brenner, Monroe, Chicago, IL; Mary M. Cunningham and Lisa M. Green, Kominiarek, Bresler, Chicago, IL for defendants.

Alleged Failure to Treat Neurological Changes Before Stroke — Washington Defense Verdict. The plaintiff suffered a sub-arachnoid hemorrhage on March 22, 2009, and was immediately transferred to a hospital. Plaintiff was found to have an extensive F3 SAH and was diagnosed as a Hunt-Hess Grade 3 critically ill patient. Eight days later, plaintiff began to experience vasospasms causing further neurological symptoms. Defendant, an interventional neuro- radiologist, was able to perform angioplasty of the left and right M1 sections of the middle cerebral arteries. Because of their size, however, he could not do an angioplasty on the M2 segments. The plaintiff was under the care of a neurosurgeon and hospital employees following the procedure. They thought plaintiff was stable until the next morning when she showed evidence of a stroke. Plaintiff alleged the interventional neuro-radiologist deviated from the standard of care by not using vasodilators in the M2 branches of the left and right middle cerebral arteries. Plaintiff also alleged the neurosurgeon and hospital employees deviated from the standard of care by failing to monitor the plaintiff and failed to note the significance of certain neurological changes. Plaintiff suffered left and right brain infarcts and was unable to return to work. She is also in need of around the clock care. The jury found in favor of the defense. **Plaintiff's Expert:** Matthew Berlet, M.D., Tampa, FL; Kevin Sheth, M.D. **Defendant's Experts:** Ajith Thomas, M.D., Boston; Avery Evens, M.D., UVA; Felipe Albuquerque, M.D., Phoenix; Jesse Hall, M.D., Chicago, IL. **Anonymous sub-arachnoid hemorrhage patient v. Anonymous interventional neuro-radiologist.** _____ County (WA) Superior Court of the District of Columba No. 2012 CA 005254 M. Stephen Altman and Andrew Spence, Fairfax; James Gleason and Rachel Viglianti, Rockville, MD; Dan Costello and Tim Fisher, Annapolis, MD for defendants.

SURGERY

Fatal Cardiac Arrhythmia Four Hours Post-Surgery — $7.75 Million Illinois Verdict. The plaintiff's decedent, a fifty-six yea old man with a history of diabetes, hypertension, obesity, sleep apnea, and coronary artery disease, with insertion of five coronary stents since 1997, underwent two-level cervical disc replacement surgery on November 24, 2008, due to long-standing back pain from herniated discs at C3-4 and C5-6 with spinal cord compression. After being transferred to a general surgical floor, he complained of burning in his chest. The defendant physician was notified and ordered a cardiology consult. The cardiologist found abnormalities in the decedent's cardiac monitor strips and ordered a transfer to the ICU. However, decedent developed

severe ventricular arrhythmia before the transfer and before the consultation was completed. He died despite resuscitative efforts. An autopsy revealed recurrent severe atherosclerosis with significant stenosis of three major arteries. The estate alleged defendant physician negligently failed to obtain pre-operative cardiac clearance from a cardiologist and improperly proceeded with elective surgery without a full cardiac workup. The estate claimed that defendant cardiologist failed to properly interpret an abnormal EKG done three days before surgery and failed to order a full cardiac workup including a stress test. The estate alleged the defendant anesthesiologist and CRNA failed to perform an adequate pre-op assessment, failed to obtain cardiac clearance, and failed to cancel the elective surgery. The defendant physician maintained cardiac clearance was not necessary. The defendants contended that defendant physician informed them that there was cardiac clearance, and defendant physician claimed the EKG was correctly interpreted and reported. The jury awarded plaintiff's $7.75 million. **Plaintiff's Experts:** Marc Levin, M.D., neurosurgery; John W. Schweiger, M.D., anesthesiology; Neal Shadoff, M.D., cardiology; Pamela Gill, CRNA, Ruskin, FL. **Defendant's Experts:** William G. Soden, M.D., anesthesiology; Thomas Correll, CRNA, Morris, IL; Morris Marc Soriano, M.D., neurosurgery; Dan J. Fintel, M.D., cardiology; Jay Alexander, M.D., cardiology. **Estate of Jon Munden, deceased v. Continental Anesthesia Holdings LLC, Continental Anesthesia LLC, et al.** Cook County (IL) Circuit Court No. 10L-10241. Keith A. Hebeisen, Bradley M. Cosgrove and Susan A. Capra, Clifford Law Offices for plaintiffs. John V. Smith, II and Brian C. Sundheim, Pretzel & Stouffer; Kevin J. Glenn, Foran, Glennon; Julie A. Ramson, McKenna, Storer for defendants.

Small Bowel Obstruction Performed Negligently and Without Specialty Consult — $2.7 Million Indiana Verdict. The plaintiff was a seventy-year-old woman who went to the ER with complaints of severe abdominal pain, nausea, and vomiting. She was admitted to the hospital and diagnosed with a small bowel obstruction, mild dehydration, elevated protein, hypercalcemia, and chronic pain syndrome. The plaintiff underwent a CT scan and the following day, the defendant surgeon was brought in for a consult. Two days later, the defendant performed an exploratory laparotomy, removal of internal scar tissue, a small bowel resection, and an aseptic decompression of the small bowel. After the surgery, the plaintiff continued to complain of abdominal pain and constipation, and underwent further CT scans and x-rays, but was discharged from the hospital almost a month after she arrived. The plaintiff continued to see the defendant for her post-surgical care, but continued to have abdominal pain and abnormal bowel movements. Over the next several months, the plaintiff underwent more CT scans, x-rays, surgery and hospital stays. The plaintiff alleged that the defendant negligently performed the small bowel resection, sutured the bowel incorrectly, and failed to refer her to a specialist. The defendant denied any breach of the standard of care. A $2,700,000 verdict was returned. **Plaintiff's Expert:** Donald Pesavento, M.D., surgery, Crown Point, IN. **Defendant's Experts:** Jeff Allen, M.D., surgery, Louisville, KY. Wayne DeVos, colorectal surgery, Reading, PA. **Estate of Roddy v Uwidia,** Lake County (IN) Superior Court, Case No. 45D03-1106-CT-6. John M Kopack, John M. Kopack & Associates, Merrillville, IN for the plaintiff. Kirk D. Bagrowski and Kathleen E. Freeman, Eichhorn & Eichhorn, Hammond, IN for the defendant.

Gallbladder Remnants Left in Peritoneum — $1.8 Million Virginia Settlement. The plaintiff underwent a laparoscopic cholecystectomy performed by defendant general surgeon. When the plaintiff was discharged the defendant did not disclose or note that gallbladder remnants were left in the peritoneum. The next day, the plaintiff suffered nausea, intense abdominal pain and general malaise. Two days later, the plaintiff returned to the hospital. The defendant was called and reported a normal, uneventful surgery. The plaintiff's condition continued to degrade significantly, and she was airlifted to another facility. The plaintiff went into exploratory surgery, but because of rapid blood pressure decline, they had to abort the procedure and resume later. Three days later the surgery was performed again, and a remnant of the gallbladder neck was found. The patient was septic. The defendant's failure to disclose the remnant left in the patient is the direct cause of the sepsis. The sepsis led to poor circulation and a partial removal of all ten fingers and both feet. The case settled for $1,800,000. **Anonymous Patient v. Anonymous General Surgeon,** _____ County (VA) Circuit Court, Case No._____. Mark J. Favaloro, Virginia Beach, VA for the plaintiff.

Both Kidneys Removed By Mistake — $1.2 Million Virginia Settlement. The plaintiff had a hydronephrotic left kidney due to an obstruction and underwent a Nuclear Medicine (NM) scan to estimate how well each kidney functioned. The blocked left kidney functioned at about twenty percent and the right kidney at about eighty percent. Instead of draining and preserving the left kidney, the defendant surgeon decided to perform a left nephrectomy. Before the surgery, both the radiologist and surgeon failed to notice the NM study showed a horseshoe shaped kidney, meaning both the right and left kidneys were joined. The plaintiff alleged that a left nephrectomy was inappropriate because a repair would have restored function. Not only did the defendant chose to remove the kidney instead, he removed both kidneys believing it was one. As a result, the plaintiff was on dialysis for over a year while waiting on a transplant, suffered a stroke, as well as multiple infections. The defendant denied having removed the right kidney, and documented a shape resembling a kidney on ultrasound, and assumed it was the right kidney. It never occurred to the defendants that both kidneys could have been removed as one. The case settled for $1,200,000. **Plaintiff's Experts:** Stanley Kogan, M.D. Theonia Boyd, M.D. Douglas Gibson, M.D. **Anonymous v. Anonymous Surgeon(s),** _____ County (VA) Circuit Court, Case No. _____. Judith M. Cofield, Virginia Beach, VA for the plaintiff.

Failure to Obtain Informed Consent to Decompression Procedure — Amputation — $1 Million California Verdict. The plaintiff, a forty-nine year old woman, became a left-sided, below-the-knee amputee due to an automobile accident when she was 20 years old. She underwent a left piriformis release surgery for the relief of severe a debilitating pain in her left buttocks from pressure on the sciatic nerve area. The same day, she also underwent decompression surgery on the left peroneal nerve for the relief of pain radiating into her left residual limb. Plaintiff alleged the surgery was ineffective and that defendant surgeon was negligent, as her pain persisted post-surgery and she had to undergo a repeat surgery of the left piriformis release surgery a year later. She further alleged that she never consented to the second procedure and that defendant committed medical battery by performing the left peroneal nerve decompression without her consent. Plaintiff alleged defendant committed fraud by deceiving her and concealing his intent to perform the second procedure for the purpose of monetary gain. Plaintiff claimed defendant returned to the surgery center after she had discovered her left residual leg had been incised, and immediately apologized to her for not discussing the additional procedure with her. In addition, plaintiff alleged that defendant had negligently performed the surgical procedure. Plaintiff's neurosurgery expert testified that she had no sensation in the area enervated by the peroneal nerve. Plaintiff alleged defendant was negligent for not removing the piriformis muscle to relieve the entrapped sciatic nerve. Defendant contended that the peroneal nerve decompression surgery was discussed with plaintiff during his initial consultation with her. Defendant also contended he performed a pre-op exam on plaintiff and that he had fully discussed the peroneal nerve decompression procedure with plaintiff and that plaintiff consented. He presented a signed copy of the surgical center's informed consent form, which was signed by plaintiff and which identified both surgical procedures to be performed on that date. Plaintiff claimed that she did not see or talk to defendant before the surgeries. She also denied signing the surgery center's surgical consent form for the peroneal nerve decompression. A surgical nurse contended that she did not hear defendant make any apology statement to plaintiff after the surgery. The jury awarded plaintiff $1 million in damages. **Plaintiff's Experts:** Patricia A. Ahearn, M.D., San Juan Capistrano, CA; Janos P. Ertl, M.D., orthopedics, Indianapolis, IN; Chad R. Marquis, prosthetics, Orange, CA; Nader Pouratian, M.D., neurosurgery, Los Angeles, CA. **Defendant's Expert:** Aaron G. Filler, M.D., neurosurgery, Santa Monica, CA. **Nadine Froesch v. Israel P. Chambi and OC Multispecialty Surgery Center.** Orange County (CA) Superior Court NO. 30-2013-00680714-CU-MM-CJC. John C. Adams, III, Hunt & Adams, Santa Ana, CA; Thomas D. Rowley, Laguna Hills, CA for plaintiff. Michael A. Zuk, Herzfeld & Rubin, Los Angeles, CA for defendant.

Alleged Failure to Perform Posterior Stabilization During Lumbar Surgery Necessitated Further Surgery — MRSA, Death — Nevada Defense Verdict. The plaintiff's decedent injured his spine, and three months later, tripped again and was transported to the hospital where defendant treating physician met him and diagnosed several lumbar vertebral fractures. The defendant recommended spinal surgery. Following the surgery, decedent was unable to walk or get out of bed on his own, and his condition continued to deteriorate. X-rays revealed the internal hardware had dislodged and the vertebrae was fractured. About fifteen days later, the defendant performed revision surgery to include a redo of the anterior fusion and a posterior fixation. Following the second surgery, the decedent's condition continued to deteriorate, and he suffered renal failure, a bowel obstruction, and anemia. A CT scan showed the decedent had free fluid in his pelvis, a distended stomach, and the beginnings of pneumonia. Within a few days the collection of urine was displacing the decedent's kidney. Five days later, a urologist attempted to stent the left ureter, but the procedure was aborted because the ureter was completely severed from the renal pelvis. A nephrostomy tube was inserted into the decedent's kidney. He became confused, required the use of a ventilator, and lost the ability to eat. Within a month, he had persistent leukocytosis, fever, E coli, and UTIs. The decedent continued to deteriorate, developing pneumonia, a collapsed lung, diverticulosis, and required intubation. He died five months later. The plaintiffs claimed that the defendant fell below the standard of care when he failed to perform a posterior stabilization of the decedent's lumbar spine, failed to properly relieve decedent's spinal stenosis, and that negligence cause the decedent to undergo a second lumbar surgical procedure which resulted in complications, including MRSA, which lead to his death. The defendant denied falling below the standard of care. A defense verdict was returned. **Plaintiff's Experts:** John G. Frazee, M.D., neurology, Agoura Hills, CA. Daniel P. Flanigan, M.D., vascular surgery, Orange, CA. Peter R. Wolfe, M.D., infectious disease, Los Angeles, CA. **Defendant's Expert:** Robert Wagmeister, M.D., vascular surgery, Santa Monica, CA. **Moore; Kimball; and Kimball, Estate of v. Capanna, M.D.,** Clark County (NJ) District Court, Case No. CV A628199. William R. Brenske, Jennifer R. Andreevski and Ryan D. Krametbauer, Brenske & Christensen, for the plaintiff. Amanda L. Ireland, Mandelbaum, Ellerton & Associates, and Marc A. Benjoya, Cassidy Schade, Libertyville, IL for the defendant.

Alleged Failure to Diagnose and Repair Punctured Bowel During Appendectomy — Illinois Defense Verdict. The plaintiff, a fifty year-old man, presented to the ER with severe abdominal pain on November 11, 2009. The defendant general surgeon diagnosed h acute appendicitis and performed an appendectomy. Plaintiff remained hospitalized in stable condition over the next few days; although there was suspicion he may have suffered from a post-op ileus and interruption of peristalsis. Four days after surgery, plaintiff underwent a CT scan, which showed the presence of free air inside the abdomen. Plaintiff underwent an exploratory laparotomy that same day by a different surgeon. Massive amounts of green bowel contents in the abdominal cavity were discovered, along with a 12-mm hole in the ileum about eighteen inches from the appendectomy surgical site. The surgeon performed a resection of the ileum with creation of an ileostomy. Plaintiff alleged defendant's failure to diagnose and repair the ileum perforation caused him to suffer sepsis and peritonitis, requiring hospitalization for over a month on a ventilator, subsequent

treatment at an acute rehabilitation facility and eventual surgery several months later to reverse the ileostomy. Plaintiff claimed he suffers daily from frequent episodes of explosive diarrhea. The defense contended that some injury did occur during the original surgery, but the injury was only a small or partial thickness injury which was not visible. The defense also contended that plaintiff's current complaints were actually due to diabetic diarrhea and were not related to the ileum resection. The jury returned a defense verdict. **Plaintiff's Experts:** Thomas L. Michalsen, D.O.; Michael Beirele, M.D., general surgeryn; Ralph Silverman, M.D., colorectal surgery, St. Louis, MO; Michael Uzer, M.D., gastroenterologiy. **Defendant's Experts:** Morris Marc Soriano, M.D., neurosurgeryn; Anatoly Rozman, M.D., rehab/physical medicine; W. Gregory Ward, M.D., general surgery; Greg S. Cohen, M.D., gastroenterology. **Lonnie Waugh, Deborah Waugh v. Andrew P. Hoffman, M.D.** ____ County (IL) Circuit Court No. 10L-382. Matthew I. Baker, Sandman, Levy, Chicago, IL for plaintiff. Michael J. Denning and Douglas J. Pomatto, Heyl, Royster, Rockford, IL for defendant.

Anastomotic Leak After Gastric Bypass — Death — Texas Defense Verdict. The plaintiff's decedent, a sixty-six year-old retired man, underwent gastric bypass surgery. He then developed complications consistent with a contained anastomotic leak. Decedent's condition did not improve, and when defendant performed exploratory surgery, he identified and repaired a contained anastomotic leak. Decedent's condition continued to deteriorate and he died just five days after surgery. His cause of death was systemic immune response syndrome and an anastomotic leak. Decedent's estate alleged that he would have survived if defendant had performed the second operation as soon as he suspected a leak. Plaintiff's expert in general surgery opined that defendant violated the standard of care, and that performing the second surgery right away would have been consistent with the guidelines of the American Society for Metabolic and Bariatric Surgery. Defendant denied negligence. His expert surgeon opined that the decision whether to put off the second surgery was a judgment call, and that defendant made the right decision. The physician who performed the autopsy testified that, decedent's SIRS were not caused by the anastomotic leak or any infection. Rather, it was caused by a non-bacterial pneumonia that resulted from aspiration of material during or shortly after the surgery. The physician contended that the autopsy report was not complete until after he had signed the death certificate. The jury returned a defense verdict. **Plaintiff's Expert:** Garth Davis, M.D., general surgery, Houston, TX. **Defendant's Experts:** Dewitt Davenport, M.D., pathology, Harlingen, TX; Charles M. Richart, M.D., general surgery, Edinburg, TX; Manish Singh, M.D., general surgery, Edinburg, TX. **Maria Guerra, individually and as surviving spouse of Isidro Guerra Gonzalez, deceased, et al v. Robert Alleyn, M.D.** Hidalgo County (TX) District Court No. C-5871-13-J. Aizar J. Karam, Jr., McAllen, TX for plaintiff. Ronald G. Hole, Hole & Alvarez, McAllen, TX for defendant.

UROLOGY

Rectal Wall Punctured During Penile Implant — Impotence — $400,000 Arkansas Verdict. The plaintiff, a sixty-year old man, underwent a second penile implant surgery on April 3, 2008. He had been impotent since his early 40s, and his first implant had become infected. Defendant removed the previous implant. Plaintiff alleged that during the second penile implant, defendant punctured his rectal wall. He alleged that prior to his discharge from the hospital; he completed a bowel movement and discovered blood in the toilet. Plaintiff informed the nurse, and he was examined by a resident physician, who documented that blood appeared to come from his scrotum. Plaintiff alleged that defendant was negligent for not detecting the perforation post-surgery. Plaintiff alleged that he was unable to receive another implant and was permanently impotent. Plaintiff's expert in urology opined that the bleeding was from his punctured rectal wall. The expert opined that defendant could have detected this by performing a rectal exam, which in turn would have dramatically changed the course of plaintiff's outcome. The expert opined that plaintiff's implant was complicated, due to his excessive scar tissue. The defendant contended that nothing happened in the surgery to make him believe that he perforated the rectal wall. He claimed that performing a digital rectal exam would have been extremely painful for plaintiff. According to the defense, plaintiff presented to defendant with complaints of pain and defendant inserted a camera through his urethra and discovered infection and erosion. Defendant removed the penile implant and found part of the implant in plaintiff's rectum. Plaintiff underwent a debridement to remove the necrotizing flesh from his penis and address scar tissue that had developed. No further treatment was performed. Plaintiff's expert in urology opined that plaintiff's damage prevents him from ever having another penile-implant and that he is permanently impotent. The plaintiff was awarded $400,000 in damages. **Plaintiff's Expert:** Michael Brodherson, M.D., New York, NY. **Defendant's Expert:** John Mulcahy, M.D., urology, Madison, AL. **Robet E. Zolliecoffer and Malona Zolliecoffer v. John R. Delk II, M.D.** Pulaski County (AR) Circuit Court No. 60 CV-12-2849. Phil Votaw, Fort Smith, AR; A. Powell Sanders, Sexton & Sanders, Fort Smith, AR for plaintiff. Ken Cook and Megan Hargraves, Mitchell, Williams, Selig, Gates & Woodyard, Little Rock, AR for defendant.

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