Medical Malpractice - Tonsillectomy - Hypoxic Injury

Type: Settlement

Amount: $5,335,000

State: Michigan

Venue: Oakland County

Court: Oakland County, Circuit Court, Pontiac, MI

Case Type:
- *Domestic Relations*
- *Medical Malpractice*

Case Name: Anonymous Male v. Anonymous Otolaryngologist A, B and C and Anonymous Anesthesiologist, No. WITHHELD

Date: December 01, 2007

Plaintiff(s):
- Anonymous Male (Male, 3 Years)

Plaintiff Attorney(s):
- Norman D. Tucker; ; Southfield MI for Anonymous Male
- Robert B. Sickels; ; Southfield MI for Anonymous Male

Defendant(s):
- Anonymous Otolaryngologist A, B and C and Anonymous Anesthesiologist

Defense Attorney(s):
- Withheld upon request of the counsel.; Cleveland, OH for Anonymous Otolaryngologist A, B and C and Anonymous Anesthesiologist

Facts:

Complications following a routine tonsillectomy resulted in permanent brain damage to a 3 year old boy. Defendant physicians denied violating the standard of care, but settled plaintiff's claims for $5,335,000. All defendants contributed to the settlement.

Plaintiff toddler had a history of chronic infections and ultimately underwent a tonsillectomy performed by Defendant Otolaryngologist A. The surgery was uneventful, but plaintiff coughed up blood clots four days later. His mother took him to the emergency

room where small blood clots were found in the pharynx, but there was no active bleeding at that time. A telephone consult with Defendant Otolaryngologist B resulted in plaintiff being hydrated and discharged with instructions to follow-up with Otolaryngologist A.

Two days later, plaintiff's mother consulted with Otolaryngologist A, who was out of town. Although there were no other signs of bleeding, she told the doctor that the child was lethargic. No follow-up was ordered. Several days later, plaintiff coughed up 1.5 cups of blood and was returned to the emergency room. Treaters found fresh clots in the back of the child's throat and contacted Defendant Otolaryngologist C, who was on-call. Otolaryngologist C advised that plaintiff be kept overnight and, if his hemoglobin was low the following morning, he would be transfused with a unit of packed red cells. Otolaryngologist C did not personally examine the child. The child was transfused in the morning and sent home as there were no clots present at that time. However, at 1:30 a.m., plaintiff coughed up a copious amount of clotted and fresh blood and was immediately returned to the emergency room. Otolaryngologist C was again on-call and summoned to the hospital. Plaintiff was prepared for surgery and examined by Defendant Anesthesiologist. Plaintiff claimed Otolaryngologist C and the anesthesiologist failed to discuss options for the child's airway if he began bleeding again. The boy began to bleed at about the time rapid sequence induction was begun. Oral intubation was attempted and failed at least twice. Otolaryngologist C was in the operating room, but not yet participating when defendant anesthesiologist attempted a cricothyroidotomy procedure with a Quicktrach kit, a procedure he had never attempted on a human. He was unable to access the trachea and plaintiff's oxygen reserves dropped. The anesthesiologist abandoned the cricothyroidotomy. Otolaryngologist C began an emergency tracheotomy, but the proper tray was not in the operating room and had to be retrieved from central supply.

Plaintiff arrested and resuscitation efforts began as his blood pressure bottomed out. Without blood pressure, the bleeding stopped and the anesthesiologist was able to orally intubate as the tracheotomy tray appeared. Plaintiff's vitals returned to normal upon intubation and the bleeding in the tonsil fossa vessel was cauterized. However, plaintiff was transferred to a regional center where he developed seizure activity within 48 hours and required sedation. He eventually recovered from the tonsillectomy, but had permanent brain damage as a result of the hypoxic event.

Plaintiff alleged Defendants A, B and C failed to appropriately treat the boy, despite repeated presentations at the emergency room. Plaintiff claimed that, had defendants timely diagnosed his bleeding process, it could have been corrected without residuals. Plaintiff argued that Defendants Anesthesiologist and Otolaryngologist C were negligent in failing to coordinate their efforts or discuss a plan in case of an emergency, or have an emergency tracheotomy kit available. Plaintiff also claimed the anesthesiologist should not have attempted a cricothyroidotomy.

Defendant Otolaryngologists contended that watchful waiting was the appropriate response to plaintiff's symptoms and he was treated within the standard of care. Defendant anesthesiologist argued that he was faced with a sudden emergency when the initial intubations failed and he provided the best care he could under the circumstances.

Plaintiff was a 3 year old male.

Injury: Hypoxic brain damage as a result of complications from a tonsillectomy. Plaintiff was able to ambulate with assistance of a reverse K-walker and was a second grade student in a private school at the time of settlement. He required special needs programs, as well as physical and occupational therapy three times a week. Plaintiff claimed that, considering his age, his communications skills and mental impairments were good. However, he would not progress beyond the level of a fourth or fifth grader according to his treaters and would always require home or residential facility supervision.

Result: $5,335,000 with contribution from all defendants.

Trial Information:

Judge: Withheld

Editor's Comment: Due to a confidentiality agreement, the court location was chosen at random.

Writer

Lack of Oxygen After Surgery Causes Brain Damage

Type: Verdict-Plaintiff

Amount: $4,312,192

State: California

Venue: Los Angeles County

Court: Superior Court of Los Angeles County, Central, CA

Case Type:
- *Medical Malpractice*

Case Name: Devante Rashad, a minor, by and through his Guardian ad Litem, Billie Johnson v. Thomas Mitchell, M.D., No. BC 198 261

Date: September 18, 2000

Plaintiff(s):
- Billie Johnson (Female, 0 Years)
- Devante Rashad (Male, 3 Years)

Plaintiff Attorney(s):
- Bruce G. Fagel; Law Office of Bruce G. Fagel And Associates; Beverly Hills CA for Devante Rashad, Billie Johnson

Plaintiff Expert (s):
- Stan Schultz; Economics; Pasadena, CA called by:
- Henry Bribram M.D.; NeuroRadiology; Irvine, CA called by:
- Peter Formuzis; Economics; Santa Ana, CA called by:
- Sharon Kawai; Pediatric Psychiatry; Fullerton, CA called by:
- Elliott Krane M.D.; Pediatric Anesthesiology; Stanford, CA called by:
- William Goldie; Pediatric Neurology; Ventura, CA called by:
- Nicholas Bircher M.D.; Anesthesiology; Pittsburgh, PA called by:

Defendant(s):
- Thomas Mitchell, M.D.

Defense Attorney(s):
- Marshall Silberberg; La Follette, Johnson, DeHass, Fesler, Silberberg & Ames; Los Angeles, CA for Thomas Mitchell, M.D.

Defendant Expert(s):

- Ted Vavoulis; Economics; Pasadena, CA called by: for
- Barry D. Pressman; NeuroRadiology; Los Angeles, CA called by: for
- David Frankville M.D.; Pediatric Anesthesiology; Davis, CA called by: for
- Diane Casuto R.N.; Nursing; San Diego, CA called by: for
- Perry Lubens; Pediatric Neurology; Long Beach, CA called by: for

Insurers:

- St. Paul's Insurance Co.

Facts:

July 28, 1998, plaintiff, a 3-year-old boy, underwent a tonsillectomy/adenoidectomy surgery at Los Angeles Metropolitan Hospital. Defendant Dr. Thomas Mitchell was the assigned anesthesiologist. He assigned an ASA category III based on a history of obstructive sleep apnea, asthma, and anemia. There were no problems or complications during the surgery. After the surgery, Dr. Mitchell removed the ET tube and continued to observe the plaintiff in the OR while he was breathing spontaneously with an oxygen saturation of 100%. The surgeon and the OR nurse accompanied Dr. Mitchell while the plaintiff was transferred to the recovery room. During attachment of the monitors in the recovery room, the recovery room nurse noted the plaintiff was not breathing and she notified Dr. Mitchell who was standing at the desk next to the plaintiff. Dr. Mitchell immediately returned to the bedside together with another anesthesiologist and began CPR with an Ambu bag ventilation, chest compressions, medications and re-intubation. When the ET tube was replaced, 10 cc of blood was suctioned out of the trachea, and a chest X-ray showed an aspiration. The resuscitation lasted 3-5 minutes until there was a return of pulse and blood pressure. Plaintiff remained in coma and was transferred to Los Angeles Children's Hospital where he remained in a coma. On August 29, 1998, he was discharged home and has remained in a persistent vegetative state with 16-hour LVN care provided by MediCal.

Plaintiff contended that Dr. Mitchell used an excessive amount of anesthesia for this surgery. He used a 5.5 ET tube, which may have caused swelling after removal in the OR. In the recovery room, Dr. Mitchell failed to act when the oxygen saturation dropped to 88% allowing further hypoxia, which led to the plaintiff's cardiac arrest.

Defendant contended that his anesthesia care during and after surgery complied with the standard of care. In the recovery room, Dr. Mitchell responded immediately when the nurse stated the plaintiff was not breathing and the oxygen saturation monitor then showed 88%. Because of "coupling" between the respiratory and cardiac system in children, the plaintiff went into cardiac arrest very quickly. The respiratory arrest was due to a complete blockage of the airway by 10 cc of blood, and the hypoxia was not corrected until the plaintiff was re-intubated. The outcome was an unfortunate complication of the surgery.

Injury: Injuries: Brain damage due to lack of oxygen (air obstruction caused by blood in trachea) after surgery.

Residuals: Persistent vegetative state with feeding gastrostomy and tracheostomy. Specials:

Medical to date $327,000 (MediCal lien). Future medical $3,000,000 annuity cost per plaintiff; $2,100,000 annuity cost per defendant (total future cost of $4,200,000 over 10 years). Future wage loss $708,000 per plaintiff; $506,000 per defendant (present cash value).

Result: Demand $1,000,000 CCP 998 before first trial; $1,000,000 CCP 998 before second trial. Offer $1,000,000 policy limit just prior to first trial (rejected by the plaintiff); None raised to $900,000 raised to $1,000,000 before second trial (rejected by the plaintiff).

Result: $5,610,809 gross, $4,312,192 net; $327,000 past care costs, $3,027,192 present cash value (annuity cost) for future care costs ($4,200,409 total future care costs for 10 years), $708,000 present cash value for future loss of earnings, $375,000 noneconomic reduced to $250,000 per MICRA. 12-0 negligence, 11-1 causation/damages.

Note: Plaintiff reports that this was a re-trial after a mistrial (hung jury at 8-4 in favor of Dr. Mitchell), which was held in Bellflower Superior Court in November 1999. Defendant has requested a hearing to enter a periodic payment judgment, which the plaintiff opposes until Dr. Mitchell can show adequate insurance. Plaintiff is also requesting prejudgment

interest of $700,000 plus costs. Los Angeles Metropolitan Hospital entered into a

confidential settlement with the plaintiff just prior to the second trial.

Trial Information:

Judge: Irving S. Feffer

Trial Length: 10 days

Trial Deliberations: 1.5 days

Writer S Domer

Medical Malpractice - Drug Overdose - Fatality

Type: Verdict-Plaintiff

Amount: $4,002,227

State: Ohio

Venue: Lucas County

Court: Lucas County, Court of Common Pleas, Toledo, OH

Case Type:
- *Wrongful Death*
- *Medical Malpractice* - Hospital

Case Name: Estate of Bailey Scherf v. St. Charles Hospital, No. CI99-3983

Date: January 24, 2001

Plaintiff(s):
- Estate of Bailey Scherf (Female, 2 Years)

Plaintiff Attorney(s):
- Jack M. Lenavitt; ; Toledo OH for Estate of Bailey Scherf
- James M. Tuschman; ; Toledo OH for Estate of Bailey Scherf

Defendant(s):
- St. Charles Hospital

Defense Attorney(s):
- Timothy D. Krugh; Toledo, OH for St. Charles Hospital

Defendant Expert(s):
- Gary Brewer; Securities/Commodity Futures & Options; Columbus, OH called by: for

Insurers:
- St. Charles Hospital

Facts: Plaintiff decedent, who was 2 years old, presented to Defendant St. Charles Hospital for a tonsillectomy. The procedure was performed at 9:30 a.m. and later that day, decedent was given too much Phenergan and then later an overdose of the wrong pain medication by members of defendant's nursing staff. Decedent went into arrest at 12:30 p.m., was then transferred to another hospital and died at approximately 2:30 a.m. Defendant admitted liability and the case proceeded on the issue(s) of proximate cause and damages.

Plaintiff alleged that the family of decedent was entitled to recover $25,000,000 for their pain and suffering, grief and loss of consortium.

Defendant contended that plaintiffs should recover $1,500,000 for the wrongful death of decedent.

Injury: Wrongful death. Decedent was survived by her parents and a sibling.

Result: $4,002,227

Trial Information:

Judge: William J. Skow

Trial Deliberations: 2 hours

Writer

Medical Malpractice - Wrongful Death - Twins Die

Type: Verdict-Plaintiff

Amount: $2,000,000

State: Ohio

Venue: Union County

Court: Union County, Court of Common Pleas, Marysville, OH

Case Type:
- *Wrongful Death*
- *Domestic Relations*
- *Medical Malpractice*

Case Name: Jennifer Legge, Administratrix, et al. v. Union County Hospital Association d//a Memorial Hospital of Union County and Fred R. Leess, IV, M.D., No. 09CV0278

Date: August 06, 2010

Plaintiff(s):
- Jennifer Legge

Plaintiff Attorney(s):
- Gerald S. Leeseberg; ; Columbus OH for Jennifer Legge
- Anne M. Valentine; ; Columbus OH for Jennifer Legge
- Walter J. Wolske; ; Columbus OH for Jennifer Legge

Plaintiff Expert (s):
- Kim Collins M.D.; Pathology; Charleston, SC called by:
- Deborah Schwengel M.D.; Pediatric Anesthesiology; Baltimore, MD called by:
- Laurence Tom M.D.; Pediatric Otolaryngology; Philadelphia, PA called by:

Defendant(s):
- Union County Hospital Association d//a Memorial Hospital of Union County and Fred R. Leess, IV, M.D.

Defense Attorney(s):
- Frederick A. Sewards; Columbus, OH for Union County Hospital Association d//a Memorial Hospital of Union County and Fred R. Leess, IV, M.D.

Defendant Expert(s):

- David Applegate M.D.; Pathology; Marysville, OH called by: for
- Saeed Jortani Ph.D.; Toxicology; Louisville, KY called by: for
- Charles Myer M.D.; Otolaryngology; Cincinnati, OH called by: for
- Laureen Marinetti Ph.D.; Toxicology; Dayton, OH called by: for

Insurers:

- Doctor's Company

Facts:

A medical malpractice suit was brought after identical twins died following a tonsillectomy and adenoidectomy. The children's mother brought suit and alleged the children were negligently released from the hospital following surgery. The defendants denied negligence, but a Union County jury found for the plaintiff and awarded a $2,000,000 verdict.

Plaintiffs' decedents, Anthony and Joshua Legge, were 3-year-old identical twins. They underwent a tonsillectomy and adenoidectomy on April 18, 2006, and were under the care of Defendant Fred R. Leess, IV, M.D. They were discharged from Defendant Memorial Hospital of Union County following the surgery. Both children suffered respiratory distress in the middle of the night of April 19. They were transported to Memorial Hospital. Anthony was declared dead on arrival. Joshua was ultimately transferred to Nationwide Children's Hospital, where he died two days later.

Plaintiffs alleged that defendants fell below the standard of care in their respective treatment of the twins by improperly discharging them and/or failing to admit them overnight for observation following their tonsillectomy and adenoidectomy. Plaintiffs argued that admission was warranted given their age, size and diagnosis of sleep apnea, as well as their persistent somnolence at the time of discharge, and defendants' negligence was a direct and proximate cause of the boys' deaths.

Defendants denied liability and contended that the children died from codeine toxicity, which was indicated by the coroner's office. Defendants maintained they acted within the standard of care.

Decedents were 3-year-old males. They were identical twins.

Injury:

Respiratory and cardiac arrest, resulting in the post-surgical deaths of twins.

Result:

$2,000,000

Trial Information:

Judge:

David C. Faulkner

Trial Deliberations:

6 hours

Editor's Comment: Per plaintiff's counsel, the verdict has been paid.

Writer

Parents: Doctor's negligence caused baby's brain damage

Type: Verdict-Plaintiff

Amount: $1,686,170

State: Pennsylvania

Venue: Dauphin County

Court: Dauphin County Court of Common Pleas, PA

Injury Type(s):
- *leg*
- *brain* - brain damage
- *other* - physical therapy
- *sensory/speech* - speech/language, impairment of
- *mental/psychological* - cognition, impairment

Case Type:
- *Medical Malpractice* - Failure to Monitor; Negligent Treatment

Case Name: Reginald Graham and Tykeisha Metz, parents and natural guardian of Keonte Graham, a minor v. Andrew M. Shapiro M.D. and Associated Otolaryngology of Pennsylvania, No. 2009-CV-14003-MM

Date: June 19, 2012

Plaintiff(s):
- Keonte Graham (Male, 11 Years)
- Tykeisha Metz (Female)
- Reginald Graham (Male)

Plaintiff Attorney(s):
- Terry S. Hyman; SchmidtKramer; Harrisburg PA for Reginald Graham, Tykeisha Metz, Keonte Graham

Plaintiff Expert (s):
- Anna Messner M.D.; Pediatric Otolaryngology; Palo Alto, CA called by: Terry S. Hyman
- Terry P. Leslie; Vocational Assessment; Landisville, PA called by: Terry S. Hyman
- Hilary B. Berlin M.D.; Physical Medicine; Great Neck, NY called by: Terry S. Hyman

Defendant(s):	• Andrew M. Shapiro M.D. • Associated Otolaryngology of Pennsylvania
Defense Attorney(s):	• Andrew H. Foulkrod; Foulkrod Ellis; Camp Hill, PA for Andrew M. Shapiro M.D., Associated Otolaryngology of Pennsylvania • Darlene K. King; Foulkrod Ellis; Camp Hill, PA for Andrew M. Shapiro M.D., Associated Otolaryngology of Pennsylvania
Defendant Expert(s):	• James Reilly M.D.; Pediatric Otolaryngology; Palo Alto, CA called by: for Andrew H. Foulkrod, Darlene K. King
Insurers:	• The Doctors Company

Facts:

In November 2007, co-plaintiff Tykeisha Metz brought her 11-month-old son Keonte to Camp Hill-based pediatric otolaryngologist Andrew Shapiro, reportedly due to concerns that the boy was having trouble breathing while sleeping. Shapiro performed a sleep study and observed the baby's apnea-hypopnea index (AHI) to be at a 43 -- roughly four times higher than what is typically considered a severe level. A tonsillectomy and adenoidectomy were subsequently performed.

According to Metz, the child's sleep-study results showed that he was at an increased risk of postoperative respiratory complications. Despite this, Metz claimed, Shapiro ordered the pediatric nurses in the pediatric ward of the hospital where the surgery was performed to monitor Keonte as they would any other patient -- about once every four hours. Keonte's parents claimed that one in four children who have an AHI in the 40s and oxygen desaturation below 80 have some type of respiratory problem. The younger the child, the greater the risk of a respiratory problem, it was argued.

According to the parents, Shapiro took off the child's pulse oximeter (the finger-mounted device used to measure blood oxygen) and ordered placement of a heart and respiratory rate monitor. The parents claimed that the boy was last seen by a healthcare professional at 4:00 a.m.; allegedly, there was no record of his oxygen saturation for the next hour and forty-five minutes. Keonte reportedly stopped breathing at 6:40 a.m.; it was alleged that his brain was without oxygen long enough to cause demonstrable anoxic brain injury that was observable via MRI.

Keonte's parents sued Shapiro and his practice group (Associated Otolaryngology of Pennsylvania), alleging that Shapiro's treatment of the boy had fallen below accepted standards of medical care, and that his practice was vicariously liable for his negligent treatment. Plaintiffs' counsel argued that Shapiro had failed to tell nurses who were caring for the baby about, and how to care for, the boy's enhanced risk for respiratory failure, and that he had failed to ensure that Keonte was monitored by continuous pulse oximetry. The latter assertion was bolstered by a pediatric otolaryngology expert, who testified that, had Shapiro kept the baby on an oximeter, he would have observed Keonte's oxygenation going down before his heart stopped, an observation that arguably would have allowed him to effect a timely intervention.

Shapiro denied the allegations. In court papers, the defense argued that Shapiro had recognized that the child's preoperative sleep study showed that he was driven to breathe by decreased blood oxygen saturation, which was noted as being typical in patients with obstructive sleep apnea. The defense maintained that the American Academy of Otolaryngology dictates that admission to an intensive care unit is not the appropriate standard of care in cases such as Keonte's.

Shapiro asserted that treating nurses did not observe signs of respiratory distress, and that no alarms sounded until the child arrested. The defense's pediatric otolaryngology expert opined that the baby likely arrested as a result of hypoglycemia and/or an acute aspiration, which the expert argued would not have been identified by blood oxygen saturation.

Injury: In their pretrial memorandum, the plaintiffs claimed that "immediately prior to his surgery, [Keonte] was a normal child, who could say 'mama', eat finger foods, and was just on the verge of walking." After his anoxic incident, they claimed in court papers, "[he] was like a newborn. He could not lift his head or sit up. He could not talk. He could not move." Keonte, who was 5 at the time of trial, allegedly suffers from an cognitive difficulties; experiences an impaired gait, as he walks with a wide step; has balance issues; and is unable to run. He undergoes continued physical, occupational and speech therapies.

A non-treating pediatric physiatrist retained by plaintiffs' counsel testified that given Keonte's young age, it is difficult to assess how much progress he eventually will make in his recovery, as he could reach nearly 100 percent, or half of that. Keonte's parents' suit sought $686,170 in damages for future lost earning capacity, and an unspecified amount of damages for past and future pain and suffering. No future medical costs were presented by the plaintiffs. The parents also sought damages in their own right.

Result: The jury found that Shapiro had been negligent with respect to his treatment of Keonte. Keonte and his parents were awarded damages totaling nearly $1.7 million.

Keonte Graham

$686,170 Personal Injury: FutureLostEarningsCapability

Reginald Graham

$500,000 Personal Injury: non-economic damages

Tykeisha Metz

$500,000 Personal Injury: non-economic damages

Trial Information:

Judge: Scott Evans

Trial Length: 6 days

Trial Deliberations: 1 days

Editor's Comment: This report is based on an article that was previously published by The Legal Intelligencer, a fellow ALM publication, and on information that was provided by plaintiffs' counsel. Defense counsel declined to contribute.

Writer Aaron Jenkins

Child's Tonsillectomy-Related Death Suit Settles for $1.4 Million

Type: Settlement

Amount: $1,450,000

State: Missouri

Venue: Jackson County

Court: Jackson County Circuit Court, 16th, MO

Case Type:
- *Negligence*
- *Wrongful Death*
- *Medical Malpractice*

Case Name: Michael E. Smith, et al. v. Heartland Regional Medical Center, No. 00CV217290

Date: May 14, 2001

Plaintiff(s):
- Joyce F. Smith (Female, 0 Years)
- Michael E. Smith (Male, 0 Years)

Plaintiff Attorney(s):
- W. William McIntosh; McIntosh Law Firm; Kansas City MO for Michael E. Smith, Joyce F. Smith
- Diane Fair; McIntosh Law Firm; Kansas City MO for Michael E. Smith, Joyce F. Smith
- Andrew McCue; McIntosh Law Firm; Kansas City MO for Michael E. Smith

Plaintiff Expert (s):
- David Wellman M.D.; emergency medicine; Durham, NC called by: W. William McIntosh
- Steven Handler M.D.; pediatric otolaryngology; Los Angeles, CA called by: W. William McIntosh

Defendant(s):
- Heartland Regional Medical Center

Defense Attorney(s):

- William Lynch; Blackwell Sanders Peper Martin; Kansas City, MO for Heartland Regional Medical Center
- Scott Martin; Blackwell Sanders Peper Martin; Kansas City, MO for Heartland Regional Medical Center

Insurers:

- American International Specialty Lines
- Missouri Hospital Plan
- PIE

Facts:

Ashley Smith was 6 in January 1996 when she underwent a tonsillectomy and adenoidectomy that ultimately resulted in her untimely death.

Injury:

Her parents, Michael and Joyce Smith, sued the hospital where Ashley was taken for emergency treatment when complications arose. They claimed the hospital's trauma center was negligent in failing to have blood immediately available for a transfusion. The surgery was performed on Jan. 19, 1996 at Children's Mercy Hospital in St. Joseph. When Ashley was taken home on Jan. 22, she began to hemorrhage. Hemorrhaging is a known complication in 8 to 15 percent of tonsillectomies.

Because of ambulance regulations that require trauma patients to be taken to the nearest trauma center, the child was transported by ambulance to Heartland Regional Medical Center in St. Joseph, despite requests from her parents that she be taken to Children's Mercy. Ashley was admitted to the pediatric unit at 10:30 p.m. and died at 4 a.m. the next morning.

Result:

Trial Averted. Heartland avoided trial by settling the case, agreeing to pay the Smiths $1,450,000.

Trial Information:

Judge: Jon R. Gray

Trial Length: 0

Trial Deliberations: 0

Writer S Sissom

Medical Malpractice - Anesthesia - Fatality - Minor

Type: Settlement

Amount: $1,250,000

State: Georgia

Venue: Cobb County

Court: Cobb County, State Court, GA

Case Type:
- *Wrongful Death*
- *Domestic Relations*
- *Medical Malpractice*

Case Name: Payne v. Snellville Anesthesia Services and Alfonso Dampog, M.D., No. 89A09542-3

Date: July 01, 1991

Plaintiff(s):
- Payne (Male, 2 Years)

Plaintiff Attorney(s):
- Joel O. Wooten Jr.; ; Columbus GA for Payne

Plaintiff Expert (s):
- John Patton M.D.; Anesthesiology; Jackson, WY called by:

Defendant(s):
- Snellville Anesthesia Services and Alfonso Dampog, M.D.

Defense Attorney(s):
- John A. Gilleland; Atlanta, GA for Snellville Anesthesia Services and Alfonso Dampog, M.D.

Insurers:
- MAG

Facts: Decedent, a twenty-month-old boy, underwent a tonsillectomy. Defendant anesthesiologist administered a 3% dose of halothane for more than five minutes. He subsequently left the operating room, leaving a nurse in charge. Decedent's blood pressure and other vital signs dropped significantly. Decedent subsequently suffered cardiac arrest and lapsed into a coma. He died three days thereafter.

Plaintiff alleged that defendant anesthesiologist was negligent in administering an excessive dose to the decedent, which resulted in cardiac arrest, and in leaving the operating room with only a nurse in charge.

Defendant contended that: (1) he was not negligent; (2) the nurse was adequately supervised; and (3) decedent's death was unexplainable.

Injury: Wrongful death of 20-month-old boy.

Result: Structured settlement with present cash value of $1,250,000.

Trial Information:

Judge: None

Writer

Airway fire occurred in plaintiff's mouth during tonsillectomy

Type: Verdict-Mixed

Amount: $748,738

State: California

Venue: Santa Clara County

Court: Superior Court of Santa Clara County, Santa Clara, CA

Injury Type(s):
- *brain* - brain damage
- *other* - carbon monoxide poisoning
- *mental/psychological* - depression; post-traumatic stress disorder

Case Type:
- *Medical Malpractice*
- *Products Liability* - Design Defect; Failure to Warn

Case Name: Andrew Garcia and Paul Garcia v. Douglas Phan, M.D., ConMed Corporation, San Jose Medical Center, Alice Tsao, M.D., Associated Anesthesiology Medical Group, Mallinckrodt Inc., No. 1-04-CV023354

Date: December 17, 2008

Plaintiff(s):
- Paul Garcia (Male)
- Andrew Garcia (Male, 8 Years)

Plaintiff Attorney(s):
- Joshua S. Markowitz; Carcione, Cattermole, Dolinski, Okimoto, Stucky, Ukshini, Markowitz & Carcione, LLP; Redwood City CA for Andrew Garcia, Paul Garcia
- Joseph W. Carcione; Carcione, Cattermole, Dolinski, Okimoto, Stucky, Ukshini, Markowitz & Carcione, LLP; Redwood City CA for Andrew Garcia, Paul Garcia

Plaintiff Expert (s):

- John H. Menkes M.D.; Neurology; Beverly Hills, CA called by: Joshua S. Markowitz, Joseph W. Carcione
- Vyto Babarauskas; Fire Damage; New York, NY called by: Joshua S. Markowitz, Joseph W. Carcione
- Joseph F. Dyro M.D.; Biomedical; Setauket, NY called by: Joshua S. Markowitz, Joseph W. Carcione
- Thomas Naidich M.D.; Neuroradiology; New York, NY called by: Joshua S. Markowitz, Joseph W. Carcione
- Charles Myer III; Pediatric Otolaryngology; Cincinnati, OH called by: Joshua S. Markowitz, Joseph W. Carcione
- Gilbert Kliman M.D.; Child Psychiatry; San Francisco, CA called by: Joshua S. Markowitz, Joseph W. Carcione
- Patrick F. Mason Ph.D.; Economics; San Francisco, CA called by: Joshua S. Markowitz, Joseph W. Carcione
- Patricia C. Sullivan Ed.D.; Vocational Rehabilitation; San Francisco, CA called by: Joshua S. Markowitz, Joseph W. Carcione

Defendant(s):

- Alice Tsao, M.D.
- Mallinckrodt Inc.
- ConMed Corporation
- Douglas Phan, M.D.
- San Jose Medical Center
- Associated Anesthesiology Medical Group

Defense Attorney(s):

- Michael C. Osborne; Shook, Hardy & Bacon L.L.P.; San Francisco, CA for Mallinckrodt Inc.
- Bradford J. Hinshaw; Hinshaw, Draa, Marsh, Still & Hinshaw; Saratoga, CA for Douglas Phan, M.D.
- Robert J. Allan; Allan Law Group; Malibu, CA for Associated Anesthesiology Medical Group
- Genese K. Dopson; Sedgwick, Detert, Moran & Arnold LLP; San Francisco, CA for ConMed Corporation
- John Quincy Brown III; Hardy Erich Brown & Wilson, APLC; Sacramento, CA for San Jose Medical Center
- Dennis E. Raglin; Sedgwick, Detert, Moran & Arnold LLP; San Francisco, CA for ConMed Corporation
- David A. Sherman; Sherman & Ziegler; San Francisco, CA for Alice Tsao, M.D.

Defendant Expert(s):

- John M. Luce M.D.; Pulmonology; San Francisco, CA called by: for Bradford J. Hinshaw, Genese K. Dopson, Dennis E. Raglin
- Peter Koltai; Otolaryngology; Palo Alto, CA called by: for Bradford J. Hinshaw
- Rowena Korobkin M.D.; Pediatric Neurology; Napa, CA called by: for Bradford J. Hinshaw, Genese K. Dopson, Dennis E. Raglin
- Michael Shore Ph.D.; Neuropsychology; San Francisco, CA called by: for Bradford J. Hinshaw, Genese K. Dopson, Dennis E. Raglin
- Michael O'Brien; Vocational Rehabilitation; Sacramento, CA called by: for Bradford J. Hinshaw, Genese K. Dopson, Dennis E. Raglin
- Patrick Barnes M.D.; Pediatric Neurology; Palo Alto, CA called by: for Bradford J. Hinshaw, Genese K. Dopson, Dennis E. Raglin

Insurers:

- Chubb & Sons Insurance
- The Doctors Company

Facts:

On April 18, 2003, plaintiff Andrew Garcia, age 8, underwent a tonsillectomy at San Jose Medical Center. Treating physician Douglas Phan used a hand-held electrode that was powered by an electrosurgical unit -- and was manufactured by ConMed Corporation -- to perform the tonsillectomy. While the electrode was in Andrew's mouth, an airway fire occurred.

Individually and on his son's behalf, Andrew's father sued Phan for medical malpractice and Conmed for products liability.

Before trial, the plaintiffs settled with the medical center for a confidential amount; with Alice Tsao, another physician at the medical center, for $30,000; with the Associated Anesthesiology Medical Group, which administered the anesthetic, for $30,000; and with Mallinckrodt Inc., which makes endotracheal devices associated with the electrode that was used in the subject procedure, for $10,000.

Garcia argued that ConMed's device was negligently designed because it could allow two active electrodes to be powered at once, even though Phan and the surgical technician testified that two electrodes were not in Andrew's mouth at the time of the fire. Garcia alleged that someone in the operating room accidentally stepped on a foot pedal, causing the device to produce current and then start the fire. Garcia also argued that the electrosurgical unit's warnings regarding the risk of fire in electrosurgery were insufficient, and that ConMed had a duty to retrofit or recall the device. Plaintiff's counsel argued that Phan allowed two electrode devices (capable of being electrified) to be placed inside Garcia's mouth during the surgery, which would fekk below the standard of care. Plaintiff's counsel argued that one of the electrodes then was electrified accidentally by someone stepping on a foot switch, and that the tip of that electrode then made contact with the endotracheal tube, which ignited.

Plaintiff's counsel also argued that once Phan saw the flame, he poured saline into the throat to extinguish it, but did not immediately remove the endotracheal tube (it was eventually removed by an anesthesiologist but there is a debate about the length of time that elapsed before removal). The failure to immediately remove the tube was below the standard of care and counsel argued that the fire was still burning inside the tube, which in turn allegedly sent soot into plaintiff's lungs.

ConMed contended that the device was similar in design to those of all major manufacturers of electrosurgical units, that it was designed in conformity with industry-wide design criteria, that it met national and international engineering standards, and that it had been cleared for marketing under a 510(k) submission to the U.S. Food & Drug Administration.

At trial, ConMed submitted evidence which showed that eletrocautery risks have been taught for decades in medical school and were well known to Phan before the surgery, and that the warnings on the device were virtually identical to those listed by other product manufacturers.

Phan testified he only had one electrode in the mouth, not two. He also denied that fire burned inside the endotracheal tube, resulting in soot in the plaintiff's lungs.

Injury: Andrew alleged carbon monoxide poisoning, severe lung injuries and lifelong brain damage from the airway fire.

Plaintiff's counsel argued for about $850,000 in expected costs, which included a special boarding school for learning disabled kids that totaled $350,000, psychological counseling and medication for depression and post-traumatic stress disorder. Additionally, Garcia sought $30,000 in medical expenses and $27 million in future medicals and emotional distress.

The plaintiffs asked for a seven-figure verdict, but felt that an eight-figure verdict was more appropriate.

The defense disputed the damages.

At the close of evidence and after denying ConMed's motion for a nonsuit, the court granted its directed verdict as to punitive damages.

Prior to trial, the medical center paid Andrew's medical expenses of about $130,000, representing the initial treatment after the fire and then intensive care unit treatment at (Stanford University) Lucille Packard Children's Hospital.

Result: The jury found that Phan was negligent, but returned a defense verdict for ConMed. The jury awarded $748,738.

Trial Information:

Judge: Richard J. Loftus Jr.

Trial Length: 7 weeks

Trial Deliberations: 3 days

Post Trial: The plaintiffs moved for a new trial.

Editor's Comment: This report includes information from plaintiffs' counsel, defense counsel and a Daily Journal article. Attorneys Sherman, Allan and Osborne were not asked to contribute, as they were added after deadline.

Writer Priya Idiculla

Hospital Negligence - Respiratory Difficulty - Treatment

Type: Settlement

Amount: $600,000

State: Ohio

Venue: Cuyahoga County

Court: Cuyahoga County, Court of Common Pleas, Cleveland, OH

Case Type:
- *Wrongful Death*
- *Domestic Relations*
- *Medical Malpractice* - Hospital

Case Name: Renee Fitzgerald, Indiv. and as Admx. of Est. of Brian Pierre Fitzgerald v. MetroHealth Medical Center, et al., No. 225388

Date: June 01, 1993

Plaintiff(s):
- Renee Fitzgerald, Indiv. and as Admx. of Est. of Brian Pierre Fitzgerald (Male, 4 Years)

Plaintiff Attorney(s):
- Martin L. Sandel; ; Cleveland OH for Renee Fitzgerald, Indiv. and as Admx. of Est. of Brian Pierre Fitzgerald

Plaintiff Expert (s):
- Mervynn Jeffries M.D.; Anesthesiology; New York, NY called by:

Defendant(s):
- MetroHealth Medical Center, et al.

Defense Attorney(s):
- James L. Malone; Cleveland, OH for MetroHealth Medical Center, et al.

Insurers:
- MetroHealth Medical Center

Facts: Plaintiff's decedent, a four-year-old boy, underwent an elective tonsillectomy and adenoidectomy procedure at Defendant Cleveland MetroHealth Medical Center. He was hospitalized overnight. During the early morning hours decedent developed respiratory difficulty. The nursing staff repeatedly telephoned the physician on call requesting him to examine decedent. When the physician did not arrive, the nursing staff called Pediatric Intensive Care where the staff declined to send another physician because "protocol" had to be followed. Decedent developed adult respiratory distress syndrome due to aspiration of gastric contents and died approximately three weeks thereafter.

Plaintiff alleged that defendants were negligent in failing to monitor decedent and in failing to have decedent examined by a physician when his condition warranted it.

Defendants settled with plaintiff.

Injury: Wrongful death. Decedent was survived by his mother and step-brother.

Result: $600,000

Trial Information:

Judge: Timothy E. McMonagle

Writer

Medical Malpractice - Surgery - Minor Burned

Type: Settlement

Amount: $100,000

State: Michigan

Venue: Wayne County

Court: Wayne County, Circuit Court, Detroit, MI

Injury Type(s):
- *burns* - burns

Case Type:
- *Domestic Relations*
- *Medical Malpractice*

Case Name: Shenita Olison, Individually and as Next Friend of C.B., a minor v. Detroit Medical Center, Children's Hospital of Michigan, Michigan Pediatric ENT Associates PLLC, Walter Belenky, M.D., and Angie Phipps, D.O., jointly and severally, No. 04-407577-NH

Date: February 14, 2008

Plaintiff(s):
- C.B.
- Shenita Olison (Female, 43 Years)

Plaintiff Attorney(s):
- Geoffrey N. Fieger; ; Southfield MI for C.B.
- Todd J. Weglarz; ; Southfield MI for C.B.

Defendant(s):
- Detroit Medical Center, Children's Hospital of Michigan, Michigan Pediatric ENT Associates PLLC, Walter Belenky, M.D., and Angie Phipps, D.O., jointly and severally

Defense Attorney(s):
- William D. Chaklos; Detroit, MI for Detroit Medical Center, Children's Hospital of Michigan, Michigan Pediatric ENT Associates PLLC, Walter Belenky, M.D., and Angie Phipps, D.O., jointly and severally
- R. Scott Glover; Detroit, MI for Detroit Medical Center, Children's Hospital of Michigan, Michigan Pediatric ENT Associates PLLC, Walter Belenky, M.D., and Angie Phipps, D.O., jointly and severally

Insurers:

- self-insured ($5 million)

Facts:

A child allegedly sustained third degree burns during a tonsillectomy/adenoidectomy procedure. Defendants denied all allegations of malpractice, but settled plaintiffs' claim for $100,000 prior to trial.

Plaintiff C.B., a minor, was taken to Defendant Detroit Medical Center by her mother, Plaintiff Shenita Olison, in September 2001. She had complaints of nasal obstruction, mouth breathing and loud snoring. Upon examination, defendant's physicians recommended removal of the minor's tonsils and adenoids. Two weeks later, surgery to remove same was performed by Defendants Walter Belenky, M.D., an otolaryngologist, and Angie Phipps, D.O., with assistance from nurses and other medical staff at Detroit Medical Center. Plaintiff Shenita claimed her minor daughter sustained third degree burns on the inside of her mouth as a result of the procedure, allegedly caused by an electrocautery device.

Plaintiffs alleged the procedures performed by defendant doctors were unnecessary, the procedure was performed with a defective electrocautery device or the device was used improperly. Plaintiffs claimed vicarious liability against the hospital for the actions of its employees, staff and defendant doctors. Plaintiffs asserted that the minor child sustained mouth scarring and experienced emotional distress as a result of the incident.

Defendants denied all allegations and contended that the child's injuries were caused by plaintiffs' own negligence or third-party negligence. They maintained that plaintiffs failed to mitigate their damages. Defendants also disputed the extent of the child's injury.

Plaintiff Shenita Olison was a 43 year old female. Plaintiff C.B. was a minor female whose age was not available for publication.

Injury:

Third degree burns (bilateral oral commissure burns) on the inside of Plaintiff C.B.'s mouth and on the corners of her mouth and lips caused by an electrocautery device.

Result:

$100,000

Trial Information:

Judge:

Michael E. Sapala

Editor's Comment:

Information for this summary was obtained from another published source.

Writer

Flash Fire Sparked in Child's Throat During Tonsillectomy

Type: Settlement

Amount: $0

State: Texas

Venue: Tom Green County

Court: Tom Green County District Court, 51st, TX

Injury Type(s):
- *burns*

Case Type:
- *Products Liability* - Medical Devices
- *Medical Malpractice* - Surgeon; Anesthesiology
- *Civil Practice* - Settlement

Case Name: Juanita Trejo, Individually and as Next Friend of Andrea Trejo v. Shannon Medical Center, United States Surgical and Shannon Clinic, No. A-03-0016C

Date: February 04, 2003

Plaintiff(s):
- Andrea Trejo (Female, 9 Years)
- Juanita Trejo (Female)

Plaintiff Attorney(s):
- Rick DeHoyos; Ratliff, Edwards & DeHoyos; San Angelo TX for Andrea Trejo
- Richard Hubbert; Sims, Hubbert & Wilson; Lubbock TX for Juanita Trejo, Andrea Trejo

Defendant(s):
- Shannon Clinic
- Shannon Medical Center
- United States Surgical

Defense Attorney(s):

- George S. Finley; Smith, Rose, Finley, Harp & Price; San Angelo, TX for Shannon Clinic
- Ken Patterson; Patterson & Wagner; San Antonio, TX for Shannon Medical Center
- David A. MacDonald; McCauley, MacDonald & Devin; Dallas, TX for United States Surgical
- Charles J. Wittenburg; Davis, Hay, Wittenburg, Davis & Caldwell; San Angelo, TX for Shannon Medical Center
- Jennifer D. Liebhauser; McCauley, MacDonald & Devin; Dallas, TX for United States Surgical

Insurers:

- Medical Protective

Facts:

Plaintiff Andrea Trejo, 9, suffered a burn injury during a routine tonsillectomy. Her mother, Juanita Trejo, on Andrea's and her own behalf sued Shannon Clinic, which employed the surgeon and anesthesiologist, Shannon Medical Center, where the procedure took place, and Connecticut-based United States Surgical which made the cauterizing device used in the procedure.

The injury occurred as the anesthesiologist was administering oxygen to Andrea through a tube in her trachea. During cauterization, the gas ignited, causing a flash fire in her otopharyngeal area.

The plaintiffs alleged that the cauterizing device was defective and that doctors operated the device negligently and admininistered the oxygen negligently.

The defendants denied any defect or negligence. The equipment was tested after the incident and was found to be in good working order, they claimed. The doctors contended that cauterization was necessary to control bleeding, and that it was necessary for Andrea's lungs to have air with a high concentration of oxygen.

Injury:

Andrea Trejo suffered injuries to her otopharyngeal area, which included the back of the mouth, the base of the tongue and the tonsil area. She to spend a few extra days in the hospital. Her mother, Juanita Trejo, claimed past medical bills of about $12,000.

The child was later given a clean bill of health.

The defense contended that any injuries she suffered were extremely minor and short-lived.

Result:

The parties reached a confidential settlement. The hospital simply agreed to waive any amounts due, said its attorneys, adding that the hospital had already been paid in part by the plaintiff's health insurer.

A friendly suit was filed, and the judge approved the settlement on Feb. 4.

Rick DeHoyos was the guardian ad litem.

The plaintiff's attorney declined to comment on the case.

Trial Information:

Judge: Barbara L. Walther

Writer John Schneider

Medical Malpractice - Outpatient Surgery - Death

Type: Verdict-Defendant

Amount: $0

State: Massachusetts

Venue: Bristol County

Court: Bristol County, Superior Court, Fall River, MA

Case Type:
- *Wrongful Death*
- *Domestic Relations*
- *Medical Malpractice*

Case Name: Nancy Medeiros (Personal Representative) for the Estate of Faith Smith v. Judy Carvalho and William O'Connor, M.D., No. brcv1994-01941

Date: January 25, 2001

Plaintiff(s):
- Nancy Medeiros (Personal Representative) for the Estate of Faith Smith (Female, 7 Years)

Plaintiff Attorney(s):
- Brian R. Cunha; ; Fall River MA for Nancy Medeiros (Personal Representative) for the Estate of Faith Smith

Plaintiff Expert (s):
- Swan Thung M.D.; Pathology; New York, NY called by:
- Dominic Cannovo M.D.; Anesthesiology; New York, NY called by:

Defendant(s):
- Judy Carvalho and William O'Connor, M.D.

Defense Attorney(s):
- Christopher C. Trundy; New Bedford, MA for Judy Carvalho and William O'Connor, M.D.

Defendant Expert(s):
- Hugh Reilly M.D.; Otolaryngology; Falmouth, MA called by: for
- Herbert Everett M.D.; Anesthesiology; Taunton, MA called by: for
- Richard Fitton M.D.; Otolaryngology; Fall River, MA called by: for

Insurers:

- ProMutual

Facts:

Plaintiff, a 7 year old girl, underwent a tonsillectomy/adenoidectomy at a hospital in Fall River. The procedure, done at 10 am as an outpatient, was uneventful and she was released later in the day. By 8:00 pm, she became ill and lost consciousness. EMT was called, she suffered cardiac arrest from which she was revived, but died several days later. Pathology reports indicated decedent suffered from an undiagnosed, preexisting liver disease causing a toxic reaction to the anesthesia. Decedent's medical records indicated a risk of sleep apnea because of her obesity (130 pounds), although it was never diagnosed.

Plaintiff alleged that: (1) because of the sleep apnea risk, decedent should have been admitted for the surgery and kept overnight; (2) there may have been an airway obstruction from the surgery; and (3) had decedent been in the hospital, her death could have been prevented.

Defendants contended that: (1) there was never a sleep apnea diagnosis; (2) there was no reason to keep decedent overnight; (3) decedent's liver disease was unknown; and (4) the surgery was necessary and decedent's airway improved immediately after surgery.

Injury:

Death from acute drug injury to decedent's liver (toxicity from anesthesia).

Result:

Defense verdict

Trial Information:

Judge:

David A. McLaughlin

Trial Deliberations:

2 hours

Writer

Child died during surgery for tonsil and adenoid removal

Type: Settlement

Amount: $0

State: Texas

Venue: Potter County

Court: Potter County District Court, 320th, TX

Injury Type(s):
- *brain* - encephalopathy
- *other* - death
- *cardiac* - cardiac arrest
- *epidermis* - edema
- *pulmonary/respiratory* - anoxia; hypoxia

Case Type:
- *Wrongful Death* - Survival Damages
- *Medical Malpractice* - Surgeon; Anesthesiology; Failure to Treat; Delayed Diagnosis; Failure to Detect; Negligent Treatment

Case Name: Elvia Lugo and Crecencio Aguayo, Individually and as Representative of the Estate of David Aguayo, Deceased v. Northwest Texas Surgery Center; Amarillo Ear, Nose and Throat Associates, P.L.L.C.; Lone Star Anesthesia Consultants, P.L.L.C., Dr. Michael D. Guttenplan; and Dr. Chuck Alan Duke, No. 88-856-D

Date: August 21, 2003

Plaintiff(s):
- Elvia Lugo (Female, 30 Years)
- Crecencio Aguayo (Male, 30 Years)
- Estate of David Aguayo (Deceased) (Male, 9 Years)

Plaintiff Attorney(s):
- Nick C. Nichols; Abraham, Watkins, Nichols, Sorrels, Matthews & Friend; Houston TX for Elvia Lugo, Crecencio Aguayo, Estate of David Aguayo (Deceased)
- Benny Agosto Jr.; Abraham, Watkins, Nichols, Sorrels, Matthews & Friend; Houston TX for Elvia Lugo, Crecencio Aguayo, Estate of David Aguayo (Deceased)
- C. F. "Jeb" Waite; Abraham, Watkins, Nichols, Sorrels, Matthews & Friend; Houston TX for Elvia Lugo, Crecencio Aguayo, Estate of David Aguayo (Deceased)

Plaintiff Expert (s):

- G. Paul Laursen M.D., DDS, FACE; Otolaryngology; San Antonio, TX called by: Benny Agosto Jr.
- Paul B. Radelat M.D.; Pathology; Houston, TX called by: Benny Agosto Jr.
- Tareq O. Khan; Anesthesiology; Houston, TX called by: Benny Agosto Jr.

Defendant(s):

- Chuck Alan Duke M.D.
- Lone Star Anesthesia PLLC
- Michael D. Gutterplan M.D.
- Northwest Texas Surgery Center
- Amarillo Ear, Nose & Throat Associates LLP

Defense Attorney(s):

- Charles E. Moss; Peterson, Farris, Doores & Jones; Amarillo, TX for Lone Star Anesthesia PLLC, Chuck Alan Duke M.D.
- Thomas C. Riney; Gibson, Ochsner & Adkins; Amarillo, TX for Northwest Texas Surgery Center
- Kristi R. Weaber; Peterson, Farris, Doores & Jones; Amarillo, TX for Lone Star Anesthesia PLLC, Chuck Alan Duke M.D.
- Jim Hund; Hund & Harriger; Lubbock, TX for Amarillo Ear, Nose & Throat Associates LLP, Michael D. Gutterplan M.D.

Defendant Expert(s):

- Martin L. Schneider M.D.; Neurotology; Amarillo, TX called by: for Charles E. Moss, Thomas C. Riney, Kristi R. Weaber, Jim Hund
- Geoffrey L. Wright M.D.; Otolaryngology; Amarillo, TX called by: for Charles E. Moss, Thomas C. Riney, Kristi R. Weaber, Jim Hund

Facts:

The plaintiffs' decedent, David Aguayo, 9, a student, was admitted to the Northwest Texas Surgery Center in Amarillo on June 7, 1999, for a tonsillectomy and adenoidectomy performed by otolaryngologist Michael D. Guttenplan of the Amarillo Ear, Nose and Throat Associates. Shortly after the start of the surgery, Guttenplan allegedly notified the attending anesthesiologist, Chuck Alan Duke of the Lone Star Anesthesia Consultants, that David's blood appeared to be abnormally dark and dusky. Monitor readings allegedly indicated that David was acceptably stable, and Guttenplan continued with the procedure. Near the completion of the tonsillectomy, Guttenplan allegedly informed Duke that David "looked quite dusky and his color looked rather poor.: When the surgical drapes were removed, David's entire body was observed to be abnormally dusky. David then went into cardiopulmonary arrest. CPR was initiated, a spontaneous heartbeat was re-established but David suffered severe anoxia and had to be placed on life support. He died the next day.

David's parents, Elvia Lugo, 30s, a homemaker, and Crecencio Aguayo, 30s, a truck driver, individually and as representatives of David's estate, sued Northwest Texas Surgery Center; Amarillo Ear, Nose and Throat Associates PLLC; Lones Star Anesthesia Consultants PLLC; Guttenplan and Duke for medical malpractice.

The plaintiffs alleged that rather than terminate the procedure to determine the cause of the dark, dusky blood, the doctors continued with the procedure. They maintained that by relying on monitoring devices, rather than on observation and examination, the defendants failed to timely commence medical intervention and resuscitation measures that may have prevented his untimely death.

Injury: David suffered a cardiac arrhythmia, acute pulmonary edema, cardiac arrest and anoxia. He was transported to a hospital and treated for hypoxic encephalopathy and acute pulmonary edema. When David's parents were informed that David had suffered brain death with no hope of recovery, they donated his organs for transplantation. David died on June 8.

The plaintiffs sought damages for the physical pain and mental anguish which David allegedly suffered from the time of the incident until the time of his death as well as reasonable and necessary medical expenses and funeral expenses. They also sought damages for their own past and future severe mental anguish and for the termination of the parent-child relationship. They also sought exemplary damages, alleging that the defendants' negligent acts and omissions demonstrated a conscious disregard for David's rights, welfare and safety.

Result: The Northwest Texas Surgery Center was nonsuited. The remaining parties settled for a confidential amount.

Trial Information:

Judge: Don Emerson

Writer B. K. Silva

Boy suffered fatal secondary bleed after tonsillectomy

Type: Verdict-Defendant

Amount: $0

State: New York

Venue: Dutchess County

Court: Dutchess Supreme, NY

Injury Type(s):
- *other* - death; loss of services

Case Type:
- *Medical Malpractice* - Surgeon; Failure to Treat; Failure to Diagnose
- *Wrongful Death* - Survival Damages

Case Name: Richard Quesada & Tina Quesada, as Administrators of the Goods, Chattels and Credits Which Were of Richard Matthew Quesada, Deceased v. Orange Otolaryngology a/k/a Hudson Valley Ear, Nose & Throat, P.C.; Horton Medical Center; Lawrence Gordon, M.D.; Richard R. DeMaio, M.D., No. 2614/01

Date: April 06, 2004

Plaintiff(s):
- Tina Quesada (Female)
- Richard Quesada (Male)
- Richard Matthew Quesada Estate of (Male, 7 Years)

Plaintiff Attorney(s):
- Michael J. Taub; Julien & Schlesinger P.C.; New York NY for Richard Matthew Quesada Estate of, Richard Quesada, Tina Quesada

Plaintiff Expert (s):
- Robert Elliot Pickard M.D.; Otolaryngology; South Miami, FL called by: Michael J. Taub

Defendant(s):
- Richard DeMaio
- Lawrence Gordon
- Horton Medical Center
- Orange Otolaryngology

Defense Attorney(s):

- Robert R. Sappe; Feldman, Kleidman & Coffey L.L.P.; Fishkill, NY for Orange Otolaryngology, Lawrence Gordon, Richard DeMaio
- Richard F. Liberth; Drake, Sommers, Loeb, Tarshis, Catania & Liberth PLLC; Newburgh, NY for Horton Medical Center

Defendant Expert(s):

- Tim Siglok M.D.; Otolaryngology; Hopewell Junction, NY called by: for Robert R. Sappe

Insurers:

- Medical Liability Mutual Insurance Co.

Facts:

On Sept. 1, 1999, plaintiff's decedent Richard Matthew "Ricky" Quesada, 7, underwent an adenoidectomy and tonsillectomy at Horton Medical Center in Middletown. The procedure was performed by Dr. Lawrence Gordon. The surgery was originally scheduled as a single-day procedure, but Ricky was retained until the following day because Gordon believed that he was not consuming enough fluids. Intravenous fluids were administered throughout that evening.

The following day, the nursing staff noted that Ricky was exhibiting improved tolerance of fluids. Gordon was informed via telephone, and he approved the boy's discharge.

During his trip home, Ricky expectorated a small amount of bright red blood--enough to create a 3-inch or 4-inch stain on a paper towel. His father telephoned Gordon and reported the incident, but Gordon, upon hearing that the bleeding was a brief, one-time incident, prescribed rest and cough medicine, which was intended to sooth the boy's throat.

The next morning, Sept. 3, Ricky expectorated more bright red blood. His father telephoned Gordon, but Gordon was not in the office. Ricky's father was told that the boy could be examined by Gordon's associate, Dr. Richard DeMaio, in DeMaio's Middletown office.

DeMaio examined Ricky and detected a clot at the base of the boy's left tonsil bed. He also observed serosanguineous discharge emanating from Ricky's adenoids, but there was no active bleeding. DeMaio remove the clot and applied a small amount of a cauterizing agent. He prescribed rest and soft foods, and told Ricky's father to follow-up with Gordon after one week.

During his trip home, Ricky expectorated more bright red blood and vomited some older, darker blood. Ricky's father called DeMaio's office again. He was informed that DeMaio was in transit to his Newburgh office, and that he would examine Ricky there.

DeMaio examined Ricky in Newburgh, but he did not observe any clots or active bleeding, though adenoidal discharge was still present. He prescribed Neosynephrine spray to constrict the blood vessels in Ricky's nose and throat. He also reiterated his prescriptions of rest and soft foods, and reminded Ricky's father to follow-up with Gordon after one week.

Ricky did not bleed or vomit again until six days later, during the early morning hours of Sept. 9, when he awoke bleeding profusely from his throat and vomiting blood. His mother called for an ambulance, but Ricky was in cardiac arrest by the time the

ambulance arrived. Ricky was revived after 45 minutes of CPR, but he began bleeding again. He was taken to Vassar Brothers Hospital in Poughkeepsie, where surgeons performed a ligation of his exterior carotid artery. The bleeding stopped, but Ricky was brain-dead. Life support was terminated the following day. An autopsy revealed that Ricky's bleeding stemmed from an open artery in his left tonsil bed.

Ricky's parents, Richard and Tina, commenced a wrongful-death action against DeMaio, Gordon and their practice group, Orange Otolaryngology. Horton Medical Center was also included in the suit, but it was discontinued prior to the trial.

The Quesadas claimed that Ricky was bleeding at the time of his discharge, that the bleeding continued until that afternoon, and that his blood's bright red color indicated a "sentinel" or "early warning" bleed that signaled an artery in need of ligation.

The Quesadas contended that Gordon was negligent for failing to perform pre-operative blood work, for discharging Ricky without performing an examination, and for failing to examine Ricky on Sept. 2, after Ricky's father reported the child's first bleeding episode.

The Quesadas also claimed that DeMaio should have hospitalized Ricky on Sept. 3, and that he should have checked Ricky's hematocrit and hemoglobin levels. They contended that such blood work would have indicated the extent of the bleeding. They alleged that DeMaio also failed to recognize Ricky's sentinel bleeding.

Gordon contended that healthy patients don't need pre-operative blood work. He also contended that tonsillectomy patients can be discharged without a discharge-day examination--provided that the patient's extended hospitalization stemmed entirely from the need for additional fluids. He added that Ricky's Sept. 2 bleeding incident was too brief to necessitate a personal examination.

DeMaio contended that he performed adequate evaluations of Ricky, and that no further treatment was necessary because no active bleeding was observed.

Both doctors contended that Ricky's Sept. 9 bleeding episode was unrelated to his Sept. 2 and Sept. 3 bleeding episodes. They claimed that the earlier bleeds stemmed from an arteriole--a minute artery--that opened during the surgery. They contended that the Sept. 9 bleed was a secondary bleed of a larger artery that was opened during sloughing of eschar, which is the dead matter formed during cauterization. They argued that arteries can be exposed during the sloughing process, and that secondary bleeds cannot be predicted.

Injury:

Ricky became brain-dead on Sept. 9, 1999, at age 7. Life support was terminated the following day. Ricky is survived by his father and mother.

The Quesadas sought recovery for Ricky's pre-death pain and suffering. They also presented loss-of-services claims. The jury was asked to award $1 million.

Result:

The jury rendered a defense verdict.

Trial Information:

Judge:	Thomas J. Dolan
Demand:	$350,000
Offer:	None
Trial Length:	2 weeks
Trial Deliberations:	2 hours
Jury Composition:	4 male, 2 female
Editor's Comment:	Plaintiffs' counsel did not respond to a faxed draft of this report or a phone call.
Writer	John Hadler