Nurses' delays led to amputation of boy's leg, suit alleged

Type: Mediated Settlement

Amount: $12,500,000

State: New Jersey

Venue: Essex County

Court: Essex County Superior Court, NJ

Injury Type(s):

- *other* - prosthesis; physical therapy; compartment syndrome
- *epidermis* - gangrene
- *amputation* - leg; leg (below the knee); toe
- *surgeries/treatment* - skin graft
- *mental/psychological* - anxiety; emotional distress; post-traumatic stress disorder

Case Type:

- *Medical Malpractice* - Nurse; Failure to Treat; Failure to Diagnose; Failure to Communicate

Case Name: Amanda Ocasio, as parent and guardian ad litem for Noah Ocasio; and Amanda Ocasio and Richard Ocasio, individually v. Timothy S. Yeh, M.D., Phuong M. Nghi, M.D., Karendeep Kandola, R.N., Jennifer M. Aranda, R.N. and Saint Barnabas Medical Center, No. ESX-L-002145-16

Date: March 11, 2020

Plaintiff(s):

- Noah Ocasio (Male, 5 Years)
- Amanda Ocasio
- Richard Ocasio

Plaintiff Attorney(s):

- Beth G. Baldinger; Mazie Slater Katz & Freeman, LLC; Roseland NJ for Amanda Ocasio, Richard Ocasio, Noah Ocasio
- David A. Mazie; Mazie Slater Katz & Freeman, LLC; Roseland NJ for Amanda Ocasio, Richard Ocasio, Noah Ocasio

Defendant(s):

- Phuong M. Nghi
- Timothy S. Yeh
- Karendeep Kandola
- Jennifer M. Aranda
- Saint Barnabas Medical Center

Defense Attorney(s):

- Lauren M. Strollo; Vasios, Kelly & Strollo, P.A.; Union, NJ for Phuong M. Nghi
- Joseph L. Garrubbo; Garrubbo & Capece, P.C.; Westfield, NJ for Timothy S. Yeh
- Douglas G. Ammerman; Hall Booth Smith, P.C.; Atlanta, GA for Timothy S. Yeh
- Julia A. Klubenspies; Marshall Dennehey Warner Coleman & Goggin, P.C.; Roseland, NJ for Karendeep Kandola, Saint Barnabas Medical Center
- Lauren Koffler O'Neill; MacNeill, O'Neill & Riveles, LLC; Cedar Knolls, NJ for Jennifer M. Aranda

Insurers:

- Lexington Insurance Co.
- Continental Casualty Co.
- CNA

Facts:

On June 4, 2015, plaintiff Noah Ocasio, 5, underwent amputations below the knee of his right leg and great left toe, in Philadelphia. His parents, plaintiffs Amanda Ocasio and Richard Ocasio, claimed that the amputations were a result of negligent care administered by physicians Timothy Yeh and Phuong Nghi, and by nurses Karendeep Kandola and Jennifer Aranda, all of Saint Barnabas Medical Center, in Livingston.

The Ocasios sued Yeh, Nghi, Kandola, Aranda and Saint Barnabas Medical Center. They alleged that the defendants failed in their standard of care toward Noah; they further alleged that their failure constituted medical malpractice.

On April 27, 2015, Noah underwent a tonsillectomy at Saint Barnabas Medical Center. During the surgery, emergent resuscitative measures had to be performed after Noah experienced complications. One of the measures included making punctures in both femoral arteries in an attempt to establish an arterial line. At 9 a.m., following the surgery, Noah was placed on a ventilator. He was then sedated and moved to a pediatric intensive care unit, where he came under the care of the defendants.

Since the medical staff knew the punctures that were made to Noah's femoral arteries presented a risk of blood clots developing and hindering circulation, the nurses were instructed to monitor Noah's circulation every hour. At about 2 p.m., Aranda called Yeh to report a decrease in pulse in Noah's legs, with his right leg cooler than the left. At about 4 p.m., Aranda noticed another decrease in leg pulse but failed to notify the physician on duty, the plaintiffs claimed. Despite no improvement in Noah's circulation over the next 12 hours, the nurses failed to notify Yeh or Nghi, according to the plaintiffs. Plaintiffs' counsel further claimed that Ocasio told the medical staff that the child's right leg was cooler than the left and that the top of his right foot was discolored, like a bruise, but that no measures were taken.

At about 11 p.m., Aranda called in Nghi to report that Noah was agitated and pulling out his breathing tube. Ocasio told the doctor she was concerned that Noah's right foot was now even colder, and the discoloration had grown darker and larger. She claimed that Nghi told her that there was no reason to be concerned.

On April 28, at about 2 a.m., there was no detectable pulse in Noah's lower right leg. At about 7 a.m. he underwent emergency vascular surgery, which failed to restore circulation to his right leg. The surgeon determined that the child would likely lose his right leg.

Noah was then airlifted to a children's hospital in Philadelphia, where the family had to wait several weeks for gangrene to stop spreading before the amputation could be performed. On June 4, 2015, doctors amputated the child's right leg and his great left toe.

Plaintiffs' counsel asserted that Yeh, Nghi, Kandola and Aranda failed to recognize the signs of acute compartment syndrome, where the risk of loss of limb increases as time passes without treatment. Noah experienced acute compartment syndrome for 12 hours before it was detected, plaintiffs' counsel maintained.

The defense maintained that there were no signs of acute compartment syndrome, and that the defendants acted swiftly in response to changes in the patient's condition.

Injury: On June 11, 2015, a week after the amputations, Noah underwent more surgery for skin grafts and wound closure. He was released almost a week later, on July 17.

Since the amputation, Noah has been using a prosthesis and sometimes requires a wheelchair when use of the prosthesis causes irritations and wounds. He was later diagnosed with post-traumatic stress disorder and separation anxiety. This has allegedly affected his social and educational functioning.

The plaintiffs sought damages for past and future pain and suffering.

Result: The parties negotiated a pretrial settlement. St. Barnabas' primary insurer agreed to pay $7 million, and its excess insurer agreed to pay $5 million. Kandola's insurer agreed to pay $500,000. The settlement's negotiations were mediated by Dennis Carey III of Tompkins, McGuire, Wachenfeld & Barry LLP.

Trial Information:

Judge: Dennis F. Carey III

Editor's Comment: This report is based on information that was provided by plaintiffs' counsel. Defense counsel did not respond to the reporter's phone calls.

Writer Aaron Jenkins

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

VerdictSearch

Lawsuit: ENT failed to ensure biopsy was performed

Type: Verdict-Plaintiff

Amount: $5,183,957

Actual Award: $1,814,385

State: Florida

Venue: Broward County

Court: Broward County Circuit Court, 17th, FL

Injury Type(s):

- *neck*
- *other* - death; scar tissue; reconstructive surgery
- *cancer* - metastatic
- *sensory/speech* - anosmia; speech/language, impairment of
- *pulmonary/respiratory* - respiratory

Case Type:

- *Wrongful Death*
- *Medical Malpractice* - Misdiagnosis; Failure to Test; Cancer Diagnosis; Delayed Diagnosis; Delayed Treatment; Ear, Nose & Throat; Failure to Diagnose; Negligent Treatment

Case Name: Ernest Hubler, and his wife, Carol Hubler, individually v. Walter Fingerer, M.D., Walter M. Fingerer, M.D., P.A., WMF Management Corp., Ignacio A. Rodriguez, M.D., South Florida ENT Associates, P.A., and South Florida ENT Associates, Inc., No. CACE19021921

Date: April 26, 2024

Plaintiff(s):

- Carol Hubler, (, 0 Years)
- Estate of Ernest Hubler, (Male, 66 Years)

Plaintiff Attorney(s):

- Jack P. Hill; Searcy Denney Scarola Barnhart & Shipley PA; West Palm Beach FL for Estate of Ernest Hubler
- Jordan A. Dulcie; Searcy Denney Scarola Barnhart & Shipley PA; West Palm Beach FL for Estate of Ernest Hubler

Plaintiff Expert (s):

- Andrew J. Doorey M.D.; Cardiology; Durham, NC called by: Jack P. Hill
- Andrew J. Bierhals M.D.; Radiology; St. Louis, MO called by: Jack P. Hill
- Eroston Price M.D.; Pathology; Dania, FL called by: Jordan A. Dulcie
- Michael Armstrong M.D.; Otolaryngology; Richmond, VA called by: Jordan A. Dulcie
- Richard J. Hirschman M.D.; Oncology; New York, NY called by: Jordan A. Dulcie

Defendant(s):

- Walter Fingerer
- WMF Management Corp.
- Ignacio A. Rodriguez
- Walter M. Fingerer M.D. P.A.
- South Florida ENT Associates Inc.
- South Florida ENT Associates P.A.

Defense Attorney(s):

- Michael E. Brand; Cole, Scott & Kissane, P.A.; Miami, FL for Ignacio A. Rodriguez, South Florida ENT Associates P.A., South Florida ENT Associates Inc.
- Tullio E. Iacono; Cole, Scott & Kissane, P.A.; Miami, FL for Ignacio A. Rodriguez, South Florida ENT Associates P.A., South Florida ENT Associates Inc.

Defendant Expert(s):

- Bert O'Malley M.D.; Otolaryngology; Baltimore, MD called by: for Tullio E. Iacono
- Jonathan Eisenstat M.D.; Pathology; Decatur, GA called by: for Tullio E. Iacono

Insurers:

- Medical Protective Co. (The)

Facts:

On May 15, 2017, plaintiff’s decedent Ernest Hubler, 66, retired, attended an appointment with otolaryngologist Dr. Ignacio Rodriguez.

Ernest Hubler previously saw another otolaryngologist, Dr. Walter Fingerer, in March 2017. Ernest Hubler, a former longtime smoker, had complained of a sore throat and trouble swallowing. Fingerer had diagnosed Ernest Hubler with inflamed tonsils.

Ernest Hubler then sought a second opinion from Rodriguez. Rodriguez noted Ernest Hubler had a hypopharyngeal mass. The doctor concluded that the mass appeared benign and diagnosed spastic dysphonia, then sent Ernest Hubler for a barium swallow test and speech therapy.

Ernest Hubler returned to Rodriguez in July 2017 and was again diagnosed with spastic dysphonia along with hoarseness and a hypopharyngeal mass. Ernest Hubler subsequently returned to Fingerer, who performed a tonsillectomy in October 2017.

The mass continued to grow, so Ernest Hubler underwent a neck CT in December 2018. A biopsy followed, and Ernest Hubler was diagnosed with stage 4 squamous cell carcinoma of the hypopharynx.

Ernest Hubler sued Fingerer, Rodriguez and their respective practices alleging both doctors negligently failed to provide a timely diagnosis of his cancer and that their practices were vicariously liable for their employees' actions.

Ernest Hubler died in 2021 and his estate was substituted as the plaintiff. Ernest Hubler's widow, Carol Hubler, served as the personal representative of the estate. The amended complaint alleged that the defendants' negligence led to Ernest Hubler's death.

The claims against Fingerer and his practice were resolved prior to trial. The case proceeded against Rodriguez and his employer, South Florida ENT Associates. Fingerer remained on the verdict form as a Fabre defendant.

Plaintiff's counsel argued that Rodriguez never performed a biopsy of the subject mass. Plaintiff's counsel alleged that Rodriguez falsely assumed Fingerer had done a biopsy that came back negative. However, Fingerer did not do a biopsy in 2017 either, plaintiff's counsel contended.

Plaintiff's counsel argued that Rodriguez should have contacted Fingerer to see if the latter doctor had done a biopsy. Rodriguez would have then realized that no biopsy was done and would have performed the procedure himself, plaintiff's counsel claimed.

Plaintiff's counsel conceded at trial that Fingerer was also partially liable for failing to do an earlier biopsy. However, plaintiff's counsel suggested that the jury assign at least 50 percent of the liability to Rodriguez.

The defense's otolaryngology expert opined that the mass was not cancerous in 2017 and that no biopsy was required at that time. The defense further maintained that if Rodriguez was negligent for failing to do a biopsy, then Fingerer should be held liable, as well.

Rodriguez did not testify at trial. In his deposition, he said that Ernest Hubler may have told him during the April 2017 appointment that another doctor had already done a biopsy on the mass. Plaintiff's counsel countered that Ernest Hubler did not mention any earlier biopsy on his intake form.

Injury:

In late 2018 or early 2019, Ernest Hubler was diagnosed with Stage 4 hypopharynx cancer with regional metastasis. Plaintiff's counsel contended that back in April 2017, the cancer was still Stage 1.

Per plaintiff's counsel, if the cancer had been diagnosed in April 2017, Ernest Hubler could have treated it with chemotherapy and radiation. However, by the time the cancer was diagnosed, the only viable treatment option was a complicated throat reconstruction surgery.

Ernest Hubler underwent this procedure, which included a laryngopharyngectomy, in March 2019. He was hospitalized for over a month and had multiple readmissions.

While the surgery successfully eliminated the cancer, the procedure also prevented him from speaking, smelling and tasting for the rest of his life. He had scar tissue in his neck and had to use a small stoma hole in his neck to breathe.

Ernest Hubler ultimately died in his home on April 19, 2021. Plaintiff's counsel argued that Ernest Hubler died from respiratory complications related to the 2019 throat surgery. Ernest Hubler left behind his wife and one adult child.

The estate sought recovery of past medical and funeral expenses, damages for Carol Hubler's lost support and services, and past and future damages for Carol Hubler's loss of companionship and protection, and her pain and suffering.

Alternatively, the estate sought recovery of damages Ernest Hubler sustained prior to his death. The estate would receive these damages if the jury determined that Rodriguez's negligence caused injury to Ernest Hubler but did not contribute to his death.

The defense disputed whether the throat surgery caused Ernest Hubler's death. The defense maintained that Ernest Hubler instead died from an unrelated acute myocardial infarction. The defense's pathology expert opined that there was a hemorrhage on the wall of Ernest Hubler's coronary artery. This was evidence that a clot was blocking the artery, the defense argued.

Plaintiff's counsel argued that there was no evidence of a coronary blockage. The estate's pathology expert did a post-mortem dissection of Ernest Hubler's coronary artery and found no significant stenosis. There was also no plaque, hemorrhages or clots in the artery, plaintiff's counsel contended.

The estate's counsel further noted that Ernest Hubler had previously received a pacemaker. Plaintiff's counsel argued that an acute myocardial infarction would have caused a tachycardia arrhythmia that would have then triggered the pacemaker. However, per plaintiff's counsel, the pacemaker did not register any tachycardia arrhythmias just prior to Ernest Hubler's death. Plaintiff's counsel argued that this was further evidence Ernest Hubler's death was not related to a myocardial infarction.

Result: The jury determined there was negligence by both Rodriguez and Fingerer that was a legal cause of Ernest Hubler's death. The jury assigned 65 percent of the liability to Fingerer and 35 percent to Rodriguez.

The jury awarded the estate $5,183,957.25. The comparative-fault reduction produced a net verdict of $1,814,385.04.

Carol Hubler

Estate of Ernest Hubler

$ 1,646,240.25 past medical and funeral expenses

$ 2,000,000 past damages for Carol Hubler's loss of companionship and protection, and her pain and suffering

$ 1,500,000 future damages for Carol Hubler's loss of companionship and protection, and her pain and suffering

$ 37,717 Carol Hubler's loss of support and services

$ 5,183,957.25 Plaintiff's Total Award

Trial Information:

Judge: Carol-Lisa Phillips

Demand: $2 million (to Rodriguez and South Florida ENT Associates)

Offer: $250,000 (from Rodriguez and South Florida ENT Associates; made at start of trial)

Trial Length: 10 days

Trial Deliberations: 4 hours

Jury Vote: 6-0

Jury Composition: 2 male, 4 female; 2 Black, 1 Hispanic, 3 white

Editor's Comment: This report is based on information that was provided by plaintiff's counsel. Additional information was gleaned from court documents. Defense counsel for Rodriguez and South Florida ENT Associates did not respond to the reporter's phone calls. Counsel for the remaining defendants was not asked to contribute.

Writer Melissa Siegel

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

VerdictSearch

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-Foreign Object

Type:	Verdict-Plaintiff
Amount:	$3,250,000
State:	New York
Venue:	New York County
Court:	New York Supreme, NY
Case Type:	• *Medical Malpractice* - Foreign Object
Case Name:	George and Elaine Berrios v. The New York Hospital, No. 114099/93
Date:	July 08, 1997
Plaintiff(s):	• George and Elaine Berrios (Male, 24 Years)
Plaintiff Attorney(s):	• Gerald Chiariello; Chiariello & Chiariello; Forest Hills NY for George and Elaine Berrios
Plaintiff Expert (s):	• Eric Munoz; General Surgery; Newark, NJ called by: • Dr. Richard Dwyer; Cardiology; Newark, NJ called by: • Dr. Richard Friedman Ph.D.; Psychology; Stony Brook, NY called by:
Defendant(s):	• The New York Hospital
Defense Attorney(s):	• Erik Kapner; Martin, Clearwater & Bell; New York, NY for The New York Hospital
Defendant Expert(s):	• Dr. Jose Corvalan; General Surgery; Manhattan, NY called by: for • Dr. Myles Schwartz; Cardiology; Manhattan, NY called by: for • Dr. Melvin Becker; Radiology; Manhattan, NY called by: for

Injury:

Pltf., then age 24, underwent emergency surgery for a bleeding ulcer at the Deft. Hospital in 1970. Prior to the surgery, Pltf. had never had any other surgical procedure other than a tonsillectomy when he was a child. Pltf. claimed that during his hospitalization at Deft.'s hospital in 1970, a venous pressure catheter was inserted into his body and was never removed. Hospital records indicate that when Pltf. was hospitalized in 1970, a central venous pressure catheter was introduced into his body for the purpose of monitoring his blood volume. Although the measure of central venous pressure is noted in several areas of the record, there was no notation concerning where in the body the catheter was inserted, or if it was removed. Pltf. testified that he remembered having a gauze dressing on his neck after the surgery, which his experts opined was one of the possible insertion points for the catheter.

In 1992, Pltf., then age 46, began experiencing episodes of dizziness and coughing fits. In April 1992, he presented to Central General Hospital after he fainted. Chest X-rays were normal. An echocardiogram revealed that an indwelling catheter, approximately 13 inches long, extended through Pltf.'s heart and pulmonary artery. He was transferred to St. Francis Hospital, where attempts to remove the catheter via arterial basket catheterization were unsuccessful. Pltf. underwent a sternotomy and the catheter was removed through an adjacent artery.

Pltf. testified that he never had any surgery during the intervening years, never recalled having any tubes or other catheter-like devices inserted into his body, and was never put under general anesthesia for any procedure other than routine colonoscopy. He stated that he had no other symptoms pertaining to the indwelling catheter during the 22-year period.

Deft.'s experts argued that the catheter was not placed during Pltf.'s 1970 hospitalization. Deft. called two physicians who took part in Pltf.'s surgery in 1970 who testified that the catheter could not have been left in during the 1970 surgery. Deft. contended that an X-ray taken before Pltf.'s discharge in 1970 did not record the presence of a CVP line. Deft. contended that the catheter could have been placed during at least one of Pltf.'s other hospitalizations during the intervening 22 years. Deft.'s expert contended that when Pltf. was treated for an anxiety attack and chest pains in 1978, a central venous catheter would have been inserted into his body. Deft. claimed that in 1992 a catheter was found extending from the left brachio-cephalic vein through the vena cava into the heart. The CVP line inserted at New York Hospital in 1970 had been inserted in the area of the jugular on the right side of the neck. Testimony indicated that Pltf., an NYPD narcotics detective, sustained many injuries, most of which required emergency room visits only. Due to the passage of time, however, several of those records, including the record of the anxiety attack, were unavailable for trial. Pltf. testified that he was only hospitalized for several hours in connection with the anxiety attack, and claimed that he underwent electrocardiac monitoring at that time.

After the surgical removal of the catheter via sternotomy, Pltf. was hospitalized on two subsequent occasions for heart-related complaints. He testified that he suffered anxiety attacks and experienced continued dizziness and a racing heartbeat, as well as depression and fear of engaging in his usual activities. He claimed that his life has changed as a result of the surgery to remove the catheter, and emphasized that he had no prior heart condition. Offer: $400,000; demand: $1,500,000; amount asked of jury: $3,000,000 to $5,000,000.

Result: $2,500,000 for George B. (5/1). Breakdown: $2,000,000 for past pain and suffering; $500,000 for future pain and suffering. $750,000 for Elaine B. for loss of services. Breakdown: $500,000 for past loss of services; $250,000 for future loss of services. The case settled for $1,000,000 pursuant to a $1,000,000/$300,000 high/low agreement. Jury: 3 male, 3 female.

Trial Information:

Judge: Alice Schlesinger

Trial Length: 2

Trial Deliberations: 2

Writer

VerdictSearch

Incomplete treatment led to fatal loss of blood, suit alleged

Type: Settlement

Amount: $2,200,000

State: New York

Venue: Kings County

Court: Kings Supreme, NY

Injury Type(s):
- *other* - death; dehiscence; dehydration
- *arterial/vascular* - exsanguination

Case Type:
- *Wrongful Death* - Survival Damages
- *Medical Malpractice* - Failure to Treat; Premature Discharge

Case Name: Rochelle Salliey as Administrator of the Estate of Allyson Engram, Deceased v. Noble Medical Associates, Inc Juraj George Braun, M.D., and The New York Eye & Ear Infirmary, No. 6033/10

Date: March 20, 2013

Plaintiff(s):
- Estate of Allyson Engram (Female, 31 Years)

Plaintiff Attorney(s):
- Allan Zelikovic; Weitz & Luxenberg P.C.; New York NY for Estate of Allyson Engram

Defendant(s):
- Juraj George Braun
- Noble Medical Associates Inc.
- New York Eye and Ear Infirmary

Defense Attorney(s):
- Jeffrey J. Cohen; Amabile & Erman P.C.; Staten Island, NY for Juraj George Braun
- None reported for Noble Medical Associates Inc., New York Eye and Ear Infirmary

Insurers:
- Medical Liability Mutual Insurance Co.

Facts: On March 15, 2008, plaintiff's decedent Allyson Engram, 31, a clerk, presented to The New York Eye and Ear Infirmary, in Manhattan. She reported that she was suffering dehydration, that her throat was painful and that she could not swallow. The symptoms were residual effects of a tonsillectomy that Engram had undergone on March 6, 2008. She was admitted to the hospital, where she was monitored by her surgeon, Dr. Juraj Braun.

Engram's condition was addressed via the administration of an antibiotic, fluids and painkillers. She was discharged after three days had passed, but she died after two additional days had passed. Her death was a result of bleeding that was caused by dehiscence of one of the surgical wounds that Braun had created.

Engram's estate sued the New York Eye and Ear Infirmary, Braun, and Braun's practice, Noble Medical Associates Inc. The estate alleged that Braun failed to timely address the dehiscence of Engram's wound, that the failure constituted malpractice and that the remaining defendants were vicariously liable for Braun's actions.

New York Eye and Ear Infirmary was dismissed via summary judgment, and the estate's counsel discontinued the claim against Noble Medical Associates. The matter proceeded against Braun.

The estate's counsel contended that Braun failed to properly address the dehiscence of the surgical wound that he created. He claimed that Braun's records indicated that Engram continued to report that she could not swallow, but that Braun approved a discharge. He contended that Braun indicated that readmittance would be approved if Engram's symptoms persisted.

Defense counsel claimed that dehiscence is one of a tonsillectomy's accepted risks, and he contended that Braun properly addressed the condition.

Injury: Engram suffered dehiscence of a surgical wound that had been created during a tonsillectomy that was performed on March 6, 2008. She became dehydrated; she developed soreness of her throat; and she could not swallow. She was hospitalized on March 15, 2008. During the ensuing three days, she underwent the administration of an antibiotic, fluids and painkillers. She was discharged on March 18, 2008, but she subsequently suffered fatal exsanguination.

Engram, 31, died March 20, 2008. She was survived by a 9-year-old son. Engram's estate sought recovery of wrongful-death damages that included damages for Engram's pain, her suffering and her son's loss of parental guidance.

Result: The parties negotiated a pretrial settlement. Braun's insurer agreed to pay $2.2 million.

Trial Information:

Judge: Marsha L. Steinhardt

Editor's Comment: This report is based on information that was provided by plaintiff's counsel. Braun's counsel did not respond to the reporter's phone calls, and the remaining defendants' counsel was not asked to contribute.

Writer Max Mitchell

VerdictSearch

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

VerdictSearch

Plaintiff claimed doctors overlooked two cancers in four months

Type:	Decision-Plaintiff
Amount:	$1,950,000
State:	New York
Venue:	Federal
Court:	U.S. District Court, Western District, NY

Injury Type(s):

- *neck*
- *other* - tongue; fatigue; dysphagia; acupuncture; gastrostomy; Mohs surgery; malnutrition; drug dependency; physical therapy; reconstructive surgery; decreased range of motion; scar and/or disfigurement; aggravation of pre-existing condition
- *cancer*
- *shoulder*
- *face/nose* - jaw
- *urological*
- *sensory/speech* - speech/language, impairment of
- *mental/psychological* - insomnia

Case Type:

- *Medical Malpractice* - Radiology; Pathologist; Radiologist; Failure to Test; Cancer Diagnosis; Delayed Treatment; Failure to Diagnose

Case Name: Gerald Culhane and Carol Culhane v. United States of America, No. 17-cv-00005

Date: December 28, 2020

Plaintiff(s):

- Carol Culhane
- Gerald Culhane (Male, 70 Years)

Plaintiff Attorney(s):

- John T. Loss; Connors LLP; Buffalo NY for Carol Culhane, Gerald Culhane
- Andrew M. Debbins; Connors LLP; Buffalo NY for Carol Culhane, Gerald Culhane

Plaintiff Expert (s):

- Marc D. Brown M.D.; Dermatology; Rochester, NY called by: John T. Loss, Andrew M. Debbins
- Thom Loree M.D.; Otolaryngology; Buffalo, NY called by: John T. Loss, Andrew M. Debbins
- Sarah G. Thompson M.D.; Internal Medicine; Batavia, NY called by: John T. Loss, Andrew M. Debbins
- Stuart Packer M.D.; Oncology; Bronx, NY called by: John T. Loss, Andrew M. Debbins
- Terence Harrist M.D.; Pathology; Cambridge, MA called by: John T. Loss, Andrew M. Debbins

Defendant(s):

- United States of America

Defense Attorney(s):

- Michael S. Cerrone; U.S. Attorney's Office; Buffalo, NY for United States of America
- Mary Pat Fleming; U.S. Attorney's Office; Buffalo, NY for United States of America

Defendant Expert(s):

- Gary Goldenberg M.D.; Dermatopathology; New York, NY called by: for Michael S. Cerrone, Mary Pat Fleming
- Barry L. Wenig M.D.; Otolaryngology; Chicago, IL called by: for Michael S. Cerrone, Mary Pat Fleming

Facts:

On March 3, 2015, plaintiff Gerald Culhane, a retiree in his 70s, learned that he was suffering cancer. He had undergone a biopsy that addressed a lesion of his forehead. On March 3, he was informed that the test's results revealed that the lesion was a malignant melanoma.

Culhane had previously undergone a CT scan that addressed a lesion of his neck. The interpreting radiologist opined that the test's results were negative. However, after Culhane had learned that his forehead's lesion was cancerous, he suspected that his neck's lesion may have been misdiagnosed. In May 2015, he underwent a contrast-dye CT scan of his neck's lesion, and the test's results revealed squamous cell carcinoma. The malignancy had originated in his left tonsil.

Culhane claimed that his neck's cancer should have been diagnosed in September 2013, when the original CT scan was performed. The original CT scan was administered at the Buffalo VA Medical Center, in Buffalo. The test was supposed to have been performed with and without the use of dye, but dye was not used. The interpreting radiologist opined that the test's results did not reveal a tumor. Culhane was told that further testing was not necessary.

On Dec. 3, 2013, Culhane's forehead's lesion was noticed by another doctor. Culhane was referred to Buffalo VA Medical Center's dermatological clinic. A resident opined that the lesion was benign. Cryotherapy was recommended. Culhane underwent the treatment, but another resident opined that it had failed. On April 18, 2014, the resident performed a punch-biopsy procedure that addressed the neck's lesion. A pathologist opined that the biopsy's results were negative.

In February 2015, a dermatologist noticed the lesion that occupied Culhane's forehead. The doctor performed three shave-biopsy procedures, and the tests' results revealed that the lesion was a malignant melanoma. Hence, Culhane pursued further testing of his neck's lesion, and those tests ultimately revealed the lesion's cancerous nature. Culhane claimed that neither cancer was timely diagnosed, and he further claimed that timely intervention would have diminished his cancer's residual effects.

Culhane sued the Buffalo VA Medical Center's operator, the U.S. government. The lawsuit alleged that the Buffalo VA Medical Center's staff failed to timely diagnose Culhane's cancer, that the staff's failure constituted malpractice, and that the U.S. government was vicariously liable for the staff's actions. The matter proceeded to a bench trial.

Culhane's counsel contended that Culhane's forehead's cancer was overlooked by the pathologist who interpreted the results of the April 2014 biopsy. Culhane's expert pathologist opined that the biopsy's results depicted indications of an early form of melanoma. The expert further opined that the pathologist should have recommended a shave-biopsy procedure.

Culhane's counsel also contended that Culhane's neck's cancer was overlooked by the radiologist who interpreted the results of the September 2013 CT scan. The defense conceded that the radiologist misinterpreted the CT scan's results, but it contended that the April 2014 biopsy's results were not misinterpreted. The defense's dermopathology expert opined that the biopsy's results did not depict a melanoma, that the results were properly read by the interpreting pathologist, and that a shave-biopsy procedure was not necessary.

Injury:

On March 3, 2015, Culhane learned that his forehead's lesion was a malignant melanoma. He underwent Mohs surgery, which involved incremental removal of the cancerous tissue. He subsequently underwent reconstructive surgery.

In May 2015, Culhane learned that his neck had developed a squamous cell carcinoma. The cancer had originated in his left tonsil.

Culhane developed residual effects that included malnourishment. In June 2015, he underwent a gastrostomy: surgical implantation of a tube that allows automatic feeding of a patient. He subsequently underwent 40 sessions of radiotherapy, and he also underwent seven weekly sessions of chemotherapy. His cancer entered remission, but his mouth and tongue developed recurrent pain. In 2017, he underwent a CT scan. The test's results revealed that his left tonsil had developed another mass. Subsequent tests revealed that the mass was cancerous. The cancer was deemed a recurrence of the left tonsil's prior cancer.

In March 2017, Culhane underwent a tonsillectomy. The procedure also included dissection of the left side of Culhane's neck.

Culhane claimed that he developed residual effects that included pain, insomnia, urinary retention, soreness of his jaw and throat, and dysphagia: impairment of the ability to swallow. He was prescribed opioid-based painkilling patches. He developed a dependency, and he subsequently experienced symptoms of withdrawal.

Culhane also claimed that his tonsillectomy aggravated preexisting impairment of his left shoulder. He claimed that he suffered residual diminution of the shoulder's functionality

and range of motion. He underwent physical therapy, but he claimed that his limitations persisted. In January 2018, he underwent replacement of his left shoulder. The surgery produced a good outcome.

Culhane retains a deformity of his tongue. He suffers resultant impairment of his speech and his ability to swallow. He also claimed that he has developed a persistent cough, that he suffers chronic fatigue, and that his neck remains painful. His neck's pain is being addressed via acupuncture and physical therapy.

Culhane further claimed that he previously enjoyed gardening, hunting and recreational walks, but that his residual effects greatly restrict his performance of those activities. He claimed that his residual effects limit his ability to maintain the large property that he owns, and he contended that those limitations will ultimately necessitate his sale of the property.

Culhane also claimed that he fears that his cancer will return. Plaintiff's counsel contended that the disease's prior recurrence increases the likelihood of another recurrence. Plaintiff's counsel claimed that the prior recurrence was a result of the failure to timely diagnose the cancer that originated in Culhane's left tonsil. The parties agreed that the cancer could have been diagnosed in September 2013, but it was not diagnosed until May 2015. Culhane's expert oncologist opined that the delay allowed 20 months of additional division of cancerous cells, and he contended that Culhane may have resultantly developed a mutation that could resist treatment. However, Culhane's counsel conceded that the delay did not contribute to Culhane's need for chemotherapy and radiotherapy.

Culhane sought recovery of damages for past and future pain and suffering. His wife, Carol Culhane, sought recovery of damages for loss of consortium and services.

The defense's expert otolaryngologist opined that Mr. Culhane was not harmed by the delayed diagnosis of the cancer that originated in the left tonsil. The expert contended that the delay did not allow advancement of the stage of the cancer, and he further contended that that particular cancer's survivability rate is great and not affected by the time of diagnosis.

The defense also contended that Culhane exaggerated the extent of his residual effects.

Result:

Judge Elizabeth Wolford found that Culhane's neck's cancer was not timely diagnosed, that the failure constituted malpractice, and that Culhane was resultantly injured. She rejected the claim that Culhane's forehead's cancer was not timely diagnosed.

Wolford determined that damages totaled $1.95 million.

Carol Culhane

$100,000 Personal Injury: loss of consortium and services

Gerald Culhane

$1,250,000 Personal Injury: Past Pain And Suffering

$600,000 Personal Injury: Future Pain And Suffering

Trial Information:

Judge:	Elizabeth Wolford
Editor's Comment:	This report is based on information that was provided by plaintiffs' counsel. Additional information was gleaned from court documents. Defense counsel did not respond to the reporter's phone calls.
Writer	Melissa Siegel

VerdictSearch

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

Doctor failed to obtain informed consent for tonsilllectomy

Type: Verdict-Plaintiff

Amount: $1,500,000

State: Pennsylvania

Venue: Luzerne County

Court: Luzerne County Superior Court, PA

Injury Type(s):
- *other* - ageusia
- *neurological* - nerve damage/neuropathy; nerve, severed/torn
- *mental/psychological* - emotional distress

Case Type:
- *Medical Malpractice* - Informed Consent; Ear, Nose & Throat

Case Name: Antonio Costagliola and Tiffany Costagliola v. Samuel V. Rizzo, M.D. and Ear, Nose, Throat Surgery, No. 2011-11472

Date: May 07, 2015

Plaintiff(s):
- Antonio Costagliola (Male, 34 Years)
- Tiffany Costagliola (Female)

Plaintiff Attorney(s):
- Edward J. Ciarimboli; Fellerman & Ciarimboli; Kingston PA for Antonio Costagliola, Tiffany Costagliola
- Molly D. Clark; Fellerman & Ciarimboli; Kingston PA for Antonio Costagliola, Tiffany Costagliola

Plaintiff Expert (s):
- John R. Bogdasarian M.D.; Otolaryngology; Fitchburg, MA called by: Edward J. Ciarimboli

Defendant(s):
- Samuel V. Rizzo, M.D.
- Ear, Nose, Throat Surgery

Defense Attorney(s):
- Kevin H. Wright; Kevin H. Wright & Associates, P.C.; Lansdale, PA for Samuel V. Rizzo, M.D., Ear, Nose, Throat Surgery

Defendant Expert(s):

- Lee D. Rowe M.D.; Otolaryngology; Philadelphia, PA called by: for Kevin H. Wright
- Richard L. Doty Ph.D.; Psychology/Counseling; Philadelphia, PA called by: for Kevin H. Wright

Insurers:

- Physicians Insurance Program Exchange (PIPE)

Facts:

On Sept. 1, 2009, plaintiff Antonio Costagliola, 34, a pizzeria-owner, presented to otolaryngologist Samuel Rizzo, of Pittston, because of episodes of recurrent tonsillitis (i.e., a sore throat), for approximately five years. During the examination, Rizzo noted that Costagliola had cystic tonsils, and determined that he would require a tonsillectomy.

On Sept. 14, Rizzo performed the tonsillectomy, during which he allegedly either crushed or severed Costagliola's glossopharyngeal nerve, which is attached to the posterior portion of the tongue and provides the sensation of taste. Costagliola claimed that he permanently lost his sense of taste.

Costagliola sued Rizzo and his practice (Ear, Nose, Throat Surgery), alleging that he negligently failed to provide appropriate care, constituting medical malpractice.

Costagliola's expert in otolaryngology faulted Rizzo for damaging his glossopharyngeal nerve during the procedure. The expert further faulted the physician for failing to inform the patient of the potential risk of the tonsillectomy, which according to medical literature, was a known risk.

Costagliola testified that Rizzo never told him about the risk of ageusia (loss of taste) as a result of the procedure. Costagliola's counsel cited Rizzo's testimony, in which he admitted that he did not inform Costagliola of this risk.

Rizzo claimed that he did not tell Costagliola about the potential severing of his glossopharyngeal nerve, because it was a rare risk.

Rizzo's expert in otolaryngology opined that the tonsillectomy was performed within the standard of care, even though the glossopharyngeal nerve was damaged.

Injury:

Rizzo referred Costagliola to a psychologist in otorhinolaryngology, who performed testing and affirmed Costagliola's ageusia. No treatment is reportedly available for the condition.

Costagliola claimed that all food tastes like "metal" to him. He reportedly was forced to end plans to open another pizzeria, and his wife had to take over his job as taste-tester.

Costagliola's counsel argued that his loss of taste had a devastating effect on Costagliola, not only as a restaurant owner but as someone who is of Italian descent, in which food is a central part of the culture. Costagliola claimed that he lost all enjoyment of food and only eats for sustenance. He sought damages for past and future embarrassment and humiliation and past and future loss of ability to enjoy life's pleasures. His wife sought damages for her claim for loss of consortium.

Result:	The jury found that Rizzo was not negligent, but failed to obtain Costagliola's informed consent prior to performing the tonsillectomy. Costagliola was determined to receive $1.5 million.

Antonio Costagliola

$1,500,000 Personal Injury: embarrassment and humiliation, loss of ability to enjoy life's pleasures

Trial Information:

Judge:	Richard M. Hughes III
Demand:	$975,000
Trial Length:	3 days
Trial Deliberations:	2 hours
Jury Vote:	12-0
Jury Composition:	5 male, 7 female
Editor's Comment:	This report is based on information that was provided by plaintiffs' counsel. Defense counsel did not respond to the reporter's phone calls.
Writer	Aaron Jenkins

VerdictSearch

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

VerdictSearch

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

Cancer was undiagnosed for a year, prisoner claimed

Type: Decision-Plaintiff

Amount: $1,156,149

Actual Award: $1,156,149

State: New York

Venue: Federal

Court: U.S. District Court, Eastern District, NY

Injury Type(s):

- *back* - stenosis
- *neck* - stenosis
- *cancer*
- *surgeries/treatment* - tracheostomy/tracheotomy

Case Type:

- *Government* - Prisoner Suit
- *Medical Malpractice* - Cancer Diagnosis; Delayed Diagnosis; Delayed Treatment

Case Name: Hernando Franco Lopez v. The United States of America, No. 03 CV 1729

Date: August 26, 2005

Plaintiff(s):

- Hernando Franco Lopez (Male, 48 Years)

Plaintiff Attorney(s):

- Fred Lichtmacher; ; New York NY for Hernando Franco Lopez
- Steven T. Halperin; Halperin & Halperin P.C.; New York NY for Hernando Franco Lopez

Plaintiff Expert (s):

- Andrew Rosenberg M.D.; Anatomic Pathology; Boston, MA called by: Steven T. Halperin
- Richard Fabian M.D.; Oncology; Boston, MA called by: Steven T. Halperin
- Wilfredo Talavera M.D.; Pulmonology; New York, NY called by: Steven T. Halperin

Defendant(s):

- United States of America

Defense Attorney(s):

- Nancy A. Miller; Assistant United States Attorney, United States Attorney's Office, Eastern District of New York; Brooklyn, NY for United States of America
- Zachary A. Cunha; United States Attorney's Office, Eastern District of New York; Brooklyn, NY for United States of America

Defendant Expert(s):

- Dr. Dennis Kraus; Otolaryngology; New York, NY called by: for Nancy A. Miller
- Margaret Brandwein-Gensler M.D.; Anatomic Pathology; New York, NY called by: for Nancy A. Miller

Facts:

In June 2000, plaintiff Hernando Franco Lopez, 48, an inmate incarcerated at the federal correctional institution located in Loretto, Pa., reported that he was suffering a nasal blockage and breathing difficulty. He was subsequently examined by several of the institution's physician's assistants.

On July 6, 2000, Lopez submitted an "inmate request to staff" form that requested an examination by an ear, nose and throat specialist. The request was denied. Lopez appealed the denial, but the jail warden denied the appeal.

During the period that spanned September 2000 and June 2001, Lopez repeatedly reported that he was suffering hoarseness, a sore throat, speaking difficulties and a dry cough. He was examined more than 13 times by the prison medical staff, which ultimately determined that Lopez was suffering recurrent pharyngitis--an infection or irritation of the pharynx or tonsils. Lopez was administered several different antibiotics.

During the period that spanned June 2001 and July 2001, Lopez was transferred three times. He was sent to the federal penitentiary in Lewisburg, Pa., to the federal transfer center in Oklahoma and, finally, to the federal detention center in Oakdale, La. At each stop, he repeated his complaints, was examined and was administered antibiotics.

On Oct. 24, 2001, Lopez was examined by Dr. Leslie Warshaw Jr., an ear, nose and throat specialist who was employed by the Federal Bureau of Prisons. Warshaw recommended performance of a CT scan and requested a follow-up examination of Lopez. He did not examine Lopez's larynx, but such an examination was performed during the follow-up examination, which occurred Jan. 22, 2002. During that examination, Warshaw observed a lesion that was located on Lopez's larynx. Warshaw recommended performance of a biopsy.

On Feb. 6, 2002, Warshaw performed a panendoscopy--an examination of the lining of the esophagus. He also performed a laser biopsy of the larynx lesion. He removed a mass legion that occupied the anterior two-thirds of Lopez's right true vocal cord. After the procedure, Warshaw determined that Lopez was suffering laryngeal cancer.

Lopez sued the Federal Bureau of Prisons and its operator, the United States of America. He alleged that the bureau's staff failed to timely diagnose and treat his cancer and that the failure constituted medical malpractice. The matter proceeded to a bench trial.

Lopez claimed that he repeatedly requested examinations by an ear, nose and throat specialist, but that his requests were denied. His counsel contended that the cancer was diagnosed during stage III, but that it could have been diagnosed in September 2000 or October 2000, when it was a stage-I condition. He also contended that Lopez's treatment did not begin until after March 1, 2002, when Lopez was released from the federal prison system.

Defense counsel contended that Lopez's cancer was timely diagnosed. They also contended that his medical history included a series of throat ailments that were unrelated to his cancer. They noted that one of the ailments necessitated performance of a tonsillectomy.

Injury:

Lopez claimed that he suffered stage-III laryngeal cancer that progressed to stage IV. He contended that his treatment did not begin until after March 1, 2002, when he was released from the federal prison system. His treatment comprised multiple surgeries, which included a permanent tracheostomy and a hemilaryngectomy--partial removal of the larynx. He also underwent nine months of chemotherapy and radiation treatment. The cancer recurred in 2003, but it was subsequently eradicated, and Lopez remains cancer-free.

Lopez claimed that his tracheostomy tube often causes coughing and that he cannot talk unless he covers the tube's opening. (He uses a finger to cover the opening.) He contended that he suffers esophageal stenosis--or narrowing--and that he will require additional surgical procedures. He also contended that his cancer has produced a 10-year shortening of his life expectancy. His counsel contended that the disease could have been diagnosed before or during stage-I status and that an earlier diagnosis would have produced a more favorable result.

Lopez's medical expenses totaled $18,149. They were paid by insurance, but a lien was pending. He sought recovery of the lien amount, his future medical expenses and damages for his past and future pain and suffering. His damages request totaled $6 million--the maximum allowed by the Federal Tort Claims Act.

Defense counsel noted that Lopez was a smoker and contended that his cancer may have fully or partially stemmed from damage caused by smoking. They also contended that his cancer-treatment choices might have fully or partially caused the residual conditions that he experiences. Specifically, they claimed that radiation therapy could have achieved a better result than the hemilaryngectomy. They contended that radiation therapy would have preserved his voice and that it would not have caused esophageal stenosis.

Defense counsel also contended that Lopez's cancer was diagnosed during stage II, that it was timely diagnosed and treated, and that an earlier diagnosis would not have altered the outcome of his treatment.

Defense counsel further noted that Lopez's incarceration included stays in three states and that it ended in Louisiana. They argued that Louisiana law should have been applied to this case and that, as such, Lopez's damages recovery should have been limited to that state's maximum: $500,000. In response, plaintiff's counsel argued that Pennsylvania law was applicable because a cancer diagnosis could have been made while Lopez was incarcerated in that state. Judge Charles Sifton accepted the latter argument.

Result:

Sifton rendered a plaintiff's decision. He found that the Bureau of Prisons failed to timely diagnose and treat Lopez's cancer and that the failures were a proximate cause of Lopez's damages. Lopez was awarded $1,156,149.

Hernando Franco Lopez

$18,149 Personal Injury: Past Medical Cost

$288,000 Personal Injury: Future Medical Cost

$400,000 Personal Injury: Past Pain And Suffering

$450,000 Personal Injury: Future Pain And Suffering

Trial Information:

Judge:	Charles P. Sifton
Demand:	$5,000,000
Offer:	$1,000,000
Trial Length:	6 days
Editor's Comment:	Plaintiff's counsel did not respond to a faxed draft of this report or a phone call.
Writer	Joanna Bonfiglio

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

Medical Malpractice - Narcotic Prescription - Fatal Overdose

Type: Settlement

Amount: $650,000

State: Michigan

Venue: Genesee County

Court: Genesee County, Circuit Court, Flint, MI

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

Case Name: Anonymous Male v. Anonymous Physician and Anonymous Pharmacy, No. WITHHELD

Date: September 01, 2009

Plaintiff(s):
- Anonymous Male (Male, 36 Years)

Plaintiff Attorney(s):
- Sandra J. Renard; ; Detroit MI for Anonymous Male
- David W. Christensen; ; Detroit MI for Anonymous Male
- Mary Pat Rosen; ; Detroit MI for Anonymous Male

Defendant(s):
- Anonymous Physician and Anonymous Pharmacy

Defense Attorney(s):
- Withheld upon request of the counsel.; Alexandria, VA for Anonymous Physician and Anonymous Pharmacy

Facts: An overdose of morphine for post-surgical pain management resulted in the death of a patient. Plaintiff sought damages from both the independent pharmacy who filled the prescription and the physician who wrote it. Defendants denied all allegations. The case settled for $650,000 prior to case evaluation.

Plaintiff's decedent was examined by a general surgeon and underwent a septoplasty uvulopalatopharyngoplasty and tonsillectomy for a significant history of obstructive sleep apnea, deviated nasal symptom and hypertrophic tonsils. Surgery was performed and the patient was discharged the following morning. A prescription was written for the discharge medications as follows: Morphine sulfate 15 milliliters p.o. every 3-4 hours for pain, signed by the physician. A second prescription was given, Tylenol with codeine, 15 milliliters p.o. every 3 hours for pain with one refill signed by the physician. The prescription was then filled by an independent pharmacy, which dispensed the morphine at a higher concentration than intended. Decedent was staying at this mother's home so she could monitor the medications. His mother gave the pain medication to her son for pain as needed. The next morning, decedent was found dead. An investigation into the death confirmed the amount of medication given to be consistent with that which the mother reported she provided to decedent, which was actually in lesser amounts than what had been prescribed. An autopsy was performed which concluded the cause of death to be morphine intoxication.

Plaintiff alleged that defendant physician failed to specify the concentration of morphine to be administered on the written prescription; negligently ordered an excessive amount of morphine and/or narcotics for a patient with a history of obstructive sleep apnea and recent surgery; and failed to consult with the pharmacy to clarify the concentration amounts regarding the prescriptions. Plaintiff also asserted that the pharmacy failed to clarify the morphine dose intended by the prescribing physician; failed to recognize that the dosage filled was inappropriate for this patient; and dispensed an excessive amount of narcotics to the patient.

Defendant physician asserted that his script was clear. Defendant pharmacy said it filled the prescription as written. Both defendants denied any violations in the standard of care.

Plaintiff's decedent was a 36 year old male who was a nursing student and musician.

Injury: Death as a result of morphine intoxication from prescription overdose. Decedent was survived by his mother and minor daughter.

Result: $650,000

Trial Information:

Judge: Withheld

Writer

VerdictSearch

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

VerdictSearch

Patient Dies During Bronchoscopy and Tonsillectomy

Type: Settlement

Amount: $440,000

State: California

Venue: Orange County

Court: Superior Court of Orange County, Santa Ana, CA

Case Type:
- *Medical Malpractice*

Case Name: Confidential v. Confidential, No. S98-06-08

Date: September 18, 1997

Plaintiff(s):
- Confidential (0 Years)

Plaintiff Attorney(s):
- Rodney E. Moss; Law Offices of Moss, Hovden & Lindsay; Whittier CA for Confidential

Plaintiff Expert (s):
- Dale Rice; Internal Medicine; Los Angeles, CA called by:
- Peter Formuzis; Economics; Santa Ana, CA called by:
- Ronald S. Katz M.D.; Anesthesiology; Los Angeles, CA called by:
- Richard Witten; Radiology; Burbank, CA called by:
- Jonathan L. Benumof M.D.; Anesthesiology; San Diego, CA called by:
- Parakrama Chandrasoma M.D.; Pathology; Pasadena, CA called by:

Defendant(s):
- Confidential

Defense Attorney(s):
- Confidential Confidential; Confidential for Confidential

Defendant Expert(s):
- Confidential; Expert Testimony; Confidential, CA called by: for

Facts:

10/12/95: Decedent, a 44-year-old secretary, suffered from recurrent sore throats, difficulty breathing, and sleeping. The Defendant ENT had x-rays and MRIs of the neck performed, which revealed hypertrophied tonsils which encroached upon the oropharyngeal airway. The ENT scheduled a bronchoscopy, tonsillectomy, and adenoidectomy at ROE hospital. The ENT knew that the oropharyngeal airway was encroached by the hypertrophied tonsils but never communicated that fact to anesthesiologist. The anesthesiologist claimed that she was called by the hospital at the last moment because of a scheduling change. She performed an inadequate pre-anesthetic evaluation and never made chart entries in the hospital record until after the procedure. She claimed she never saw the x-rays or MRI reports in the hospital record which revealed the oropharyngeal airway obstruction. The Defendant anesthesiologist failed to follow the American Society of Anesthesiologist protocol for difficult airway management cases which created the standard of care that proscribes an awake intubation so as to not to lose control of the airway in view of the fact that a difficult intubation was clearly foreseeable. She instead used a long-acting paralyzer, Atracurium, after which the ENT attempted a bronchoscopy in order to explore soft tissue neck mass and tonsillar enlargement before doing a tonsillectomy and adenoidectomy. The ENT did not use a fiberoptic bronchoscope and could not successfully pass the tube down. Thereafter, the Defendant anesthesiologist made multiple failed attempts to intubate the patient. Instead of abandoning and cancelling the procedure, she called in three additional anesthesiologists, who continued in their attempts to intubate the patient. By the time the fourth anesthesiologist successfully intubated the patient, it was too late as the patient was manifesting symptoms of negative pulmonary edema and was secreting sanguinous bloody material. The patient, before surgery, actually began decompensating and finally went into cardiac arrest. Approximately 2 1/2 hours after the procedure began she died on the operating table.

Plaintiffs claimed the ENT should have attempted further conservative care in dealing with sleep apnea by C-pap treatment. The ENT should not have attempted a bronchoscopy knowing that there was encroachment of the oropharyngeal airway by a enlarged tonsils. Rather he should have attempted outpatient surgical biopsy of the lymph nodes to rule out malignancy, if that was his concern. He failed to share information with the anesthesiologist dealing with the encroachment upon the oropharyngeal airway. He should have insisted on an awake intubation. Once the bronchoscopy failed and the first several unsuccessful intubation attempts were made, he should have foreseen that further attempts to intubate the patient would cause injury and should have canceled the procedure. The anesthesiologist failed to perform an adequate pre-anesthetic evaluation and failed to properly consult the hospital chart. She failed to perform an awake intubation. She used a long-acting, paralyzing drug, Atracurium, which was most inappropriate for a difficult airway management case. This usage deprived her of the ability to early on wake up the patient and abandon the procedure if she got into trouble. She made persistent misguided attempts to intubate the patient. The hospital scheduling of the procedure was somewhat chaotic, which precipitated the claimed last-minute scheduling change and assignment of this anesthesiologist. They failed to make sure that all pre-surgical diagnostic tests and reports were in the chart prior to the commencement of the surgery.

Defendant argued that the extent of the difficulty of intubating this patient was unforeseeable. The Decedent began to emit sanguineous bloody secretions early on, which made intubation absolutely necessary to save her life; therefore they exercised reasonable care. The Decedent suffered from pre-existing interstitial lymphocytic pneumonitis of the lung, myocarditis of the heart, and chronic hepatitis of the liver, all of which affected her

life expectancy. On the issue of damages, there is evidence that the 11-year-old would never have lived with the mother and, therefore, did not lose support, and that the 19-year-old"s economic dependency upon mother was limited; therefore, very little, if any, economic damages were provable.

Injury:

Injuries: Death, age 44; survived by daughters age 11 and 19.

Damages: $300,000 loss of support; the Decedent was a secretary making $28,000 a year. She had divorced her husband, the father of her two daughters, in 1991. Both daughters were awarded custody to the father, the 11-year-old was living with the father out of state at the time of the death and the 19-year-old came to live with her mother within six months prior to her death and was dependent on her for support. Evidence was that there were plans that the 11-year-old would move to the mother"s residence within a month or so of this incident.

Result:

Settlement:

$440,000 total; $220,000 from Defendant anesthesiologist, $145,000 from Defendant ENT and $75,000 from Defendant hospital. The second, third, and fourth anesthesiologists were dismissed. The settlement proceeds were equally divided between both daughters.

Note:

Settlement mediator was Hon. William Sheffield.

Trial Information:

Judge: John D. Watson

Trial Length: 0

Trial Deliberations: 0

Writer S Domer

VerdictSearch

Failure to Diagnose Cancer

Type: Settlement

Amount: $350,000

State: California

Venue: Orange County

Court: Superior Court of Orange County, Santa Ana, CA

Case Type:
- *Medical Malpractice*

Case Name: Doe Patient vs. Roe Medical Facility And Roe M.D., No. S97-06-16

Date: October 08, 1996

Plaintiff(s):
- Doe Patient (Female, 0 Years)

Plaintiff Attorney(s):
- Christopher J. Day; Day & Day; Tustin CA for Doe Patient

Plaintiff Expert (s):
- Roy L. Herndon; Internal Medicine; Orange, CA called by:
- Joel Sercarz M.D.; Otolaryngology; Los Angeles, CA called by:
- Frank Meyskens; Oncology; Orange, CA called by:
- Wayne Lancaster; Economics; Fullerton, CA called by:
- Steven A. Armentrout; Oncology; Los Angeles, CA called by:

Defendant(s):
- Roe M.D.
- Roe Medical Facility

Defense Attorney(s):
- Confidential Confidential; Confidential for Roe Medical Facility

Defendant Expert(s):

- Ted Vavoulis; Economics; Pasadena, CA called by: for
- Eric Waki; Otolaryngology; Fullerton, CA called by: for
- David Plotkin; Oncology; Los Angeles, CA called by: for
- Catherine Campion M.D.; Internal Medicine; Newport Beach, CA called by: for

Insurers:

- Confidential

Facts:

1/9/94: Plaintiff presented to Defendant Roe Medical Facility''s walk-in clinic complaining of a swollen gland on the right side of her neck, under her jaw, present for over two months. The Plaintiff also complained of ear pain and dizziness. The clinic''s doctor placed the Plaintiff on an antibiotic. On 1/13/94, the Plaintiff saw her primary care physician, Defendant Roe Doctor, complaining of the swollen gland. The Defendant Doctor prescribed ear drops and advised the Plaintiff to continue with the antibiotic. Over the next ten months, the Plaintiff was seen twice at the Defendant medical facility for complaints of continued swelling of the glands. On 11/17/94, the Plaintiff returned to the Defendant Doctor''s office where she was referred to a general surgeon. The Plaintiff was placed on antibiotics and ordered to return to the general surgeon''s office in two weeks. On 12/13/94, the Plaintiff returned to the general surgeon who again placed her on antibiotics. On 1/6/95, the Plaintiff had the Defendant Doctor recheck her glands. The doctor prescribed more antibiotics and told her to return in one month. On 2/3/95, the Plaintiff returned, complaining of continued swelling of her glands. On 3/27/95, the Plaintiff again went to the Defendant Doctor''s office for a recheck. At this time, lab work was ordered and the Plaintiff was finally referred to an otolaryngologist for a biopsy. The biopsy was performed on 5/3/95, revealing bilateral squamous cell carcinoma. On 5/6/95, an MRI was performed, revealing extensive adenopathy. On 5/15/95, the otolaryngologist performed bilateral cervical lymphadenectomies, direct laryngoscopy with biopsies, esophagoscopy and bilateral tonsillectomy. The Plaintiff was diagnosed as suffering from stage IV bilateral metastatic squamous cell carcinoma. Thereafter, the Plaintiff began seven weeks of radiation treatment. The Plaintiff''s cancer has since recurred.

PLAINTIFF CLAIMED the Defendants failed to timely order the appropriate follow-up tests and biopsies that the Plaintiff''s symptoms warranted. Cervical nodes enlarged for more than four weeks require a biopsy to comply with the standard of care. The Plaintiff''s enlarged nodes were only on the right side from 1/94 until 9/94.

DEFENDANT ARGUED that their employees did not commit any malpractice and acted within the standard of care. Any delay in diagnosis was the Plaintiff''s fault for not returning between January and November of 1994. The Plaintiff had bilateral disease in 1/94 and her course of treatment and prognosis was unchanged. Since it was undisputed the cancer was metastatic and no primary tumor was found, the Plaintiff''s result was exactly the same as it would have been in 1/94.

Injury:

INJURY: Failure to diagnose cancer for 16 months. Treatment: Radiation therapy. Residuals: Shortened life expectancy.

SPECIALS: Medical Costs: Collateralized; Loss of Earnings: $180,000 - $360,000 assuming a 5-10 year work life

Result: OFFER: Not firm

DEMAND: Not firm

RESULT: $350,000 (settlement)

Settled for $350,000

This matter settled after motions in limine and just prior to jury selection.

Trial Information:

Judge: Floyd H Schenk

Trial Length: 0

Trial Deliberations: 0

Writer S Domer