

# Medical Law Reporter

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2007 Med LR .....

## NATIONAL CONSUMER DISPUTES REDRESSAL COMMISSION, NEW DELHI

1. **Kurien Abraham and Others**  
vs.  
**Dr. Omana Jacob and Others** 3
  2. **Shridevi Hospital and Shridevi  
Diagnostic & Research  
Centre, Tumkur**  
vs.  
**P. Subhash** 4
  3. **Dr. Arul Raj**  
vs.  
**N. Ramanathan and Others** 5
  4. **Dr. Balagopal Perinthalmanna**  
vs.  
**K.V. Radhakrishna Menon & Others** 6
- GUJARAT STATE CONSUMER DISPUTES  
REDRESSAL COMMISSION, AHMEDABAD**
- 5 **Dr. Yogendra A. Pandya and Another**  
vs.  
**Mrs. Harshaben C. Patel and Others** 7

## USA JUDGMENTS

- |    |                    |    |
|----|--------------------|----|
| 6  | CARDIOLOGY         | 9  |
| 7  | EMERGENCY MEDICINE | 9  |
| 8  | HOSPITALS          | 9  |
| 9  | MEDICINE           | 10 |
| 10 | SURGERY            | 10 |

### **ANAESTHESIA**

- Anaesthetist leaving operation theatre immediately after extubation – Surgeon allowing Anaesthetist to go without verifying that patient was really out of anaesthesia or not – Patient remained unconscious and ultimately died – Deficiency-in-service.

### **APPENDISECTOMY**

- Wrongly diagnosing ailment – Second surgery to remove gangrene to rectify obstructions in the intestine – Death of patient – Refusal to give treatment records – Deficiency-in-service – Award of compensation of Rs. 1,50,000.

### **CARDIOLOGY**

- Failure to Diagnose Coronary Artery Dissection – Death-\$1 Million Massachusetts settlement.

### **DELIVERY OF CHILD**

- No Doctor attending on patient resulting in her death – Deficiency-in-service – Hospital directed to pay Rs. 2,70,000 along with interest to complainants .

### **EMERGENCY MEDICINE**

- Failure to Properly Evaluate Abdominal Pain and Admit to Hospital – Mesenteric Vein Thrombosis With Need for Small Bowel Resection Results in Short Bowel Syndrome – Colorado Defense Verdict.
- Failure to Property Treat Woman With Low Blood Pressure Despite History of High Blood Pressure – Death Next Day – \$195,000 California Settlement.
- Failure to Diagnose Early Stages of Heart Attack and Use Thrombolytic Therapy – Death – \$500,000 Massachusetts Settlement.

### **FRACTURE OF LEG**

- Vascular Injury – Failure of doctors in the diagnosis and treatment of the injured – Not conducting Doppler test and not referring the patient to vascular surgeon – Amputation of leg as gangrene had set in – Neither discharge summary nor copies of case records given to the patient by the hospital – Award of compensation of Rs. 2,25,000.

6

### **HOSPITALS**

- Failure to Properly Monitor Woman in ICU- Self Extubation With Cardiac Arrest and Death- \$ 1 Million Illinois Verdict.

### **INTENSIVE CARE UNIT**

- Non-supply of oxygen to patient who was on ventilator – Oxygen got exhausted – No spare cylinder in ICU – Wastage of time in getting it replenished – Death of patient – Deficiency-in-service.

### **MEDICINE**

- Failure to Refer to Cardiologist and Provide Testing for Coronary Disease during Treatment of Gastroesophageal Reflux Disease – Death From Heart Attack – \$ 1.6 Million Net Verdict in Ohio.
- Failure to Inform Patient of Elevated PSA Test Result – Prostate Cancer Diagnosed Two Years Later After Spreading to Spine – \$1.7 Million New York Settlement.

### **SURGERY**

- Performance of Colostomy Removal and Anastomosis Performed Too Soon After Colectomy and Hartmann Pouch Procedure – Anastomotic Leak Not Timely Diagnosed – Death – \$1.47 Million Massachusetts Settlement.

**2007 Med LR 189**  
**NATIONAL CONSUMER DISPUTES REDRESSAL COMMISSION,**  
**NEW DELHI**

**Hon'ble Justice Mr. S.N. Kapoor, Presiding Member**

**Hon'ble Mr. B.K. Taimni, Member**

First Appeal No. 528 of 1997

Decided on 17-10-2006

***Kurien Abraham and Others***

**vs.**

***Dr. Omana Jacob and Others***

**MEDICAL NEGLIGENCE – DELIVERY OF CHILD – No Doctor attending on patient resulting in her death – Deficiency-in-service – Hospital directed to pay Rs. 2,70,000 along with interest to complainants.**

**SUMMARY OF FACTS**

The patient, aged 27 years, on getting pregnant for the first time, being under care of first respondent, attending gynaecologist from the beginning, was admitted in the hospital for the delivery of child. The patient was removed to the labour room at 8.30 a.m. but the doctor was not seen after that either by the patient or by her relatives. A baby was delivered but the mother having developed certain complications after the delivery died on the same evening. The relations of the patient filed a complaint alleging deficiency in rendering medical service, claiming compensation of Rs. 15 lakhs. The State Commission holding the hospital medically negligent for absence of the attending gynaecologist from the beginning directed it to pay Rs. 25,000 along with cost of Rs. 2,000 to the complainants. No appeal filed by the doctors or the hospital. However, in appeal filed by the complainants, the National Commission enhanced the amount of compensation to Rs. 2,70,000 considering that the deceased patient was a young lady, aged 27 years who was a qualified 'graduate High School teacher', earning Rs. 3,000 per month in year 1995.

**HELD [NATIONAL COMMISSION]**

*Leading allegation amounting to medical negligence is related to the non-attendance of the first respondent Dr. Omana Jacob from 8.00 a.m. on 17.11.1995 onwards as she was the attending gynaecologist from the beginning as far as the deceased was concerned. The material brought on record clearly shows that no doctor was available to take care of the deceased till late in the afternoon, when she was attended to by the second respondent Dr. Jossetta. Ld. State Commission.*

*As per material on record, the second respondent Dr. Jossetta one of the Sr Gynaecologists admitted before the State Commission that on 17-11-1995, she had 'Theatre duty' and went to the labour room where the patient was lying only after she was informed of the condition of the deceased at the post-delivery stage and after serious complications had arisen, which resulted in the death of the patient. According to both respondents 1 and 2 it was Dr. Laila George who was on duty yet there was no reference to this in the written version filed by them before the State Commission or in the material on record, thus, clearly leading the State Commission to conclude that from the time the deceased was moved into labour room and till the time she had serious complications there was no doctor attending on the deceased which as rightly held by the State Commission is a clear case of deficiency resulting in the death of the deceased.*

*In the above circumstances, State Commission, in our view, rightly held the 5th respondent guilty of medical negligence. No appeal has been filed by the respondents which reassure us that they had accepted their medical negligence.*

*This is a case of death by negligence on the part of the respondents and appeal has been filed by the appellants/complainants for enhancement of compensation. We also see in the complaint filed before the State Commission they had asked for a compensation of Rs. 15 lakhs, of which they have not given any break-up and State Commission has also shown no ground based on which they have arrived at a figure of Rs. 25,000 awarding as compensation for loss of life of 27 years old lady who was a qualified 'graduate High School teacher' and there is no material brought on record to rebut this. In such circumstances, we find that the State Commission has not awarded the compensation commensurate with the loss caused to the appellants. In view of above, in our view, the deceased who was a qualified graduate High School teacher would be earning Rs. 3,000 per month way back in 1995. 50% is set off as expenditure and balance 50% would be Rs. 1500 per month, meaning thereby for a year she would be contributing/saving Rs. 18,000 using*

*a multiplier of 15, the appellants would be entitled to a sum of Rs. 2,70,000 in all, as she died at a young age of 27 years. We have not taken into calculation possible revision in pay-scales/career advancement in future.*

#### **IMPORTANT LAW POINT**

**+ Where from the time the pregnant lady was moved into labour room and till the time she had serious complications resulting in her death there was no doctor attending on the deceased patient, it was rightly held as a clear case of deficiency-in-service.**

#### **ORDER**

*\* For details of Order See Medical Law Reporter*

**2007 Med LR 314**

**NATIONAL CONSUMER DISPUTES REDRESSAL COMMISSION,  
NEW DELHI**

**Hon'ble Mr. Justice K.S. Gupta, Presiding Member**

**Hon'ble Dr. P.D. Shenoy, Member**

Revision Petition No. 1991 of 2004 and

Revision Petition No. 2395 of 2004

Decided on 19-1-2007

***Shridevi Hospital and Shridevi Diagnostic & Research Centre, Tumkur***

**vs.**

***P. Subhash***

**MEDICAL NEGLIGENCE – FRACTURE OF LEG – Vascular Injury – Failure of doctors in the diagnosis and treatment of the injured – Not conducting Doppler test and not referring the patient to vascular surgeon – Amputation of leg as gangrene had set in – Neither discharge summary nor copies of case records given to the patient by the hospital – Award of compensation of Rs. 2,25,000.**

#### **SUMMARY OF FACTS**

The complainant, a minor suffered serious injuries to his left leg and was taken to Shridevi Hospital. After about three days, the doctor there advised the father of the injured to shift his son to Bowring Hospital where he was examined by an Orthopaedic Surgeon who informed the father of the injured that gangrene had set in and the left leg was required to be amputated to save the life of the injured. He was told that if the injured had been treated for vascular injury soon after the accident, the left leg could have been saved.

The complainant claimed compensation of Rs. 5 lakhs alleging criminal negligence on the part of the doctors at Shridevi Hospital in the diagnosis and treatment of the injured. The District Forum directed the concerned doctors at Shridevi Hospital to pay jointly and severally compensation of Rs. 1,75,000 to the complainant. In appeals filed by the parties, the State Commission enhanced the compensation from Rs. 1,75,000 to Rs. 2,25,000. Both District Forum and State Commission concurrently held the three doctors negligent in treating the patient. The National Commission upheld the findings recorded by the fora below considering that as the DP Pulse and post tibial pulse of the injured were feeble, the doctors should have performed Doppler examination to find out whether there was any vascular insufficiency and whether there was any serious threat to the vascularity of the leg.

#### **HELD [NATIONAL COMMISSION]**

*In the present case it is evident that the D P Pulse and post tibial pulse were feeble. That being so, the respondent No. 2 should have performed Doppler examination to find out whether there was any vascular insufficiency and whether there is any serious threat to the vascularity of the leg.*

*This amply makes it clear that in such cases every medical man should be able to recognize the presence of severe vascular trauma in limb injuries so that urgent steps should be taken to shift the casualty to proper hospitals and save the limbs.*

*As against this the hospital authorities or treating doctors have failed to produce any extract of any medical text to support their contention. This shows clear negligence on the part of Dr. Tyagaraju in not conducting the Doppler test and not referring the patient to vascular surgeon. As can be seen from the case*

records of the hospital, there is no proof of evidence produced before us to show that copies of the Shridevi Hospital records were not handed over to the complainant's father. Even the discharge summary was not given to him.

Neither the discharge summary nor copies of the case records were given to the patient or to his father by the Shridevi hospital. This is not generally done by any responsible hospital. Further a perusal of the case records indicates that the signature of the father of the complainant was taken only on the case record pertaining to 13.05.2000 but there is no signature of the treating surgeon after the above case record. On other days why signatures were not taken is baffling.

The State Commission has re-appreciated his evidence and observed that if really the said Sound Doppler Test had been conducted on 13.05.2000 it should have been mentioned in the case sheet dated 13.05.2000, but this has been mentioned only on 14.05.2000. We feel that such an important occasion cannot miss the attention of the doctors and they would have definitely mentioned it in the case sheet if the test was done on 13th. We fail to understand why the respondent No. 3 gave a letter to the father of the injured referring the name of Dr. Ramesh of Bowring Hospital only on 15th and why he did not hand over all the case sheets and discharge summary to the father of the injured. Hence, looking from any angle it is difficult to assail concurrent findings of the fora below that the respondent hospital and the treating doctor/surgeons were negligent.

Now coming to the claim of the complainant that compensation should be enhanced. Though there appears to be some merit in this claim we are not in a position to accede to this request as fora below have awarded a fairly high rate of interest i.e. 12% per annum from the date of the complaint i.e. 12.07.2000.

#### **RESULT**

Complaint Allowed.

#### **BOOKS REFERRED**

'Fractures' in Children Volume (3) Fourth edition

#### **COUNSELS**

**For the Petitioners:** Shri B. Vishwanath Bhandarkar, Advocate.

**For the Respondents:** Shri Byendra Singh, Advocate.

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#### **IMPORTANT LAW POINT**

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+ In cases of injuries to the lower and upper limb fractures, the medical man should be able to recognize the presence of severe vascular insufficiency in limb injuries so that urgent steps should be taken to shift the casualty to proper hospitals and save the limbs.

#### **ORDER**

\* For details of Order See Medical Law Reporter

**2007 Med LR 655**  
**NATIONAL CONSUMER DISPUTES REDRESSAL COMMISSION,**  
**NEW DELHI**

**Hon'ble Mr. B.K. Taimni, Presiding Member**

Revision Petition No. 350 of 2007

Decided on 27-2-2007

**Dr. Arul Raj**

**vs.**

**N. Ramanathan and Others**

**MEDICAL NEGLIGENCE – INTENSIVE CARE UNIT – Non-supply of oxygen to patient who was on ventilator – Oxygen got exhausted – No spare cylinder in ICU – Wastage of time in getting it replenished – Death of patient – Deficiency-in-service.**

## **SUMMARY OF FACTS**

Wife of the complainant suffering from severe pain in stomach and chest was admitted in the hospital and kept in Intensive Care Unit and was on oxygen continuously. At 5.00 p.m. on 9.12.1998 the oxygen cylinder got exhausted, as there was no spare oxygen cylinder provided in the ICU, the second cylinder was rushed from the ground floor but it was found to be defective. Meanwhile, the patient was gasping due to lack of oxygen supply and she died around 6.30 p.m. on 9.12.1998. A complaint filed alleging medical negligence against the doctor was allowed. The doctors were directed to pay Rs. 3,00,000 as compensation.

## **HELD [NATIONAL COMMISSION]**

*There is a concurrent finding of the fact on the point of non-supply of the oxygen to the deceased. The patient was on ventilator in the ICU. The oxygen got exhausted. There was no spare cylinder in the ICU and when the spare cylinder being brought to second floor the lift did not stop there and finally when the cylinder did come it was found to be defective and oxygen did flow out. Both the lower fora have held this to be a clear case of medical negligence.*

## **RESULT**

Complaint Allowed.

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## **IMPORTANT LAW POINT**

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**+ Non-supply of the oxygen to the patient resulting in her death when she was on ventilator in the Intensive Care Unit, for non-availability of any spare cylinder in the ICU is medical negligence.**

## **ORDER**

*\* For details of Order See Medical Law Reporter*

**2007 Med LR 657**

**NATIONAL CONSUMER DISPUTES REDRESSAL COMMISSION,  
NEW DELHI**

**Hon'ble Mr. Justice K.S. Gupta, Presiding Member**

**Hon'ble Dr. P.D. Shenoy, Member**

Revision Petition No. 1368 of 2000

Decided on 21-2-2007

***Dr. Balagopal Perinthamma***

**vs.**

***K.V. Radhakrishna Menon & Others***

**A. MEDICAL NEGLIGENCE – MEDICAL RECORDS – Refusal to give any treatment records either to the patient or even to the District Forum – Adverse inference can be drawn against the doctor and the Nursing Home.**

**Paras 1 & 7**

**B. MEDICAL NEGLIGENCE – APPENDISECTOMY – Wrongly diagnosing ailment – Second surgery to remove gangrene to rectify obstructions in the intestine – Death of patient – Refusal to give treatment records – Deficiency-in-service – Award of compensation of Rs. 1,50,000. – Paras 5 & 7**

## **SUMMARY OF FACTS**

A patient with a complaint of abdominal pain had gone to a Doctor wherein he performed exploratory laparotomy and removed the appendix. Subsequently the patient had to be re-admitted in the same Nursing Home but as the situation did not improve she was taken to the District Hospital where surgery was performed for removing the gangrene and to rectify all the obstructions in the intestine and the patient died after about a month. A complaint was filed alleging medical negligence stating that the doctor did not even get the consent from the patient before conducting the first surgery and that he did not properly diagnose the

disease. The doctors having failed to produce the consent form and also the detailed records of treatment in their Nursing Home, an adverse inference was drawn in favour of the complainants.

#### **HELD [NATIONAL COMMISSION]**

*It is clear from the records that OPs have failed to produce the consent form and they even failed to produce the detailed records of treatment in their Nursing Home despite the fact that she stayed in the Nursing Home on two different spells. If the patient was relieved of her pain on the date of her discharge i.e. 20.9.1996 why she had to be re-admitted in the hospital poses a serious question. Further, it is not the case of the revision petitioner that the patient was relieved of her pain and hence she was discharged on 4.10.1996. The State Commission refers to a letter about the condition of patient from the opposite party's hospital wherein Dr. Balagopal stated that the post-operative period was stormy and she had paralytic ileus. It is also clear from the records that she had to be re-admitted with pain and vomiting on 29.9.1996.*

*Despite complainants petition to produce the records before the fora below, the treatment records were not produced by the Ops.*

#### **RESULT**

Complaint Allowed.

#### **COUNSELS**

**For the Petitioner:** Shri K. Rajeev, Shri Alex Joseph, Advocates.

**For the Respondent:** Ms. Bina Madhavan, Shri Hemal Sheth, Advocates.

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#### **IMPORTANT LAW POINT**

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**+ When the doctors have failed to produce the consent form and they even failed to produce the detailed records of treatment in their Nursing Home despite the fact that the patient stayed in the Nursing Home on two different spells, adverse inference about medical negligence has to be drawn against the treating doctor and the Nursing Home.**

#### **ORDER**

*\* For details of Order See Medical Law Reporter*

**2007 Med LR 486**

**GUJARAT STATE CONSUMER DISPUTES REDRESSAL COMMISSION, AHMEDABAD**

**Hon'ble Mr. Justice M.S. Parikh, President**

**Hon'ble Dr. M.K. Joshi, Member**

**Hon'ble Mrs. Leenaben P. Desai, Member**

Appeal No. 113/03 & 8/03

Decided on 22-1-2004

***Dr. Yogendra A. Pandya and Another***

**vs.**

***Mrs. Harshaben C. Patel and Others***

**MEDICAL NEGLIGENCE – ANAESTHESIA – Anaesthetist leaving operation theatre immediately after extubation – Surgeon allowing Anaesthetist to go without verifying that patient was really out of anaesthesia or not – Patient remained unconscious and ultimately died – Deficiency-in-service.**

#### **SUMMARY OF FACTS**

The patient having hernia was operated under general anaesthesia. The operation was completed at 1 p.m. but his breathing was stopped soon after operation. Doctors continued the treatment till 1 p.m. but the patient remained unconscious and his condition did not improve. He was referred to another Hospital where he died. There was nothing to show that the patient was fully conscious at the time of extubation but the Anaesthetist had left the operation theatre immediately after extubation and surgeon had allowed him to go without verifying that patient was really out of anaesthesia or not. Complaint filed by wife and children of the patient was allowed. The State Commission held it a case of gross deficiency in service.

## **HELD [STATE COMMISSION]**

*At the outset, it is important to note that even as per the medical record the surgery was completed at 1.00 p.m. and extubation was also done at the same time. However, there is nothing on record how the induction of general anaesthesia was done, which gases or drugs were used, how the patient was maintained during surgery, what were his vital signs like pulse, B.P. or respiration rate during surgery and what was the condition of the patient at the end of the surgery. In other words there is nothing on record to show that patient was fully conscious at 1.00 p.m. i.e. at the time of extubation.*

*Now according to the medical record itself the air-way was obstructed either by secretion and/or tongue fall because of untimely extubation. In this context it is to be noted that O.P.2 (Anaesthetist) left the operation theatre immediately after extubation at 1.00 p.m. and O.P. 1 (Surgeon) allowed him to go without verifying that patient was really out of anaesthesia or not. The duty of the anaesthetist does not end till the patient fully recovers from the effect of anaesthesia. For practical purpose it is the duty of the anaesthetist also to see that patient is shifted to the ward and kept there in proper position and carry out last clinical examination there before he leaves the hospital. As per the record respiratory depression was noticed at 1.10 p.m. (it does not mean that it developed at that time), then cyanosis and cardiac arrest which ultimately resulted in death of the patient.*

*Everything happened in four walls of the operation theatre just after surgery. The anaesthetist left the theatre at least with implied consent of the surgeon. The patient was not monitored for vital 10 minutes i.e. from 1.00 p.m. to 1.10 p.m. The complications were first noticed at 1.10 p.m. then anaesthetist was called again and patient was re-intubated at 1.22 p.m. (such specific, timings are rarely seen in medical record). Thus, what was the condition of patient at the time of extubation, what happened after surgery and extubation, why patient was not shifted to ward, why anaesthetist left before shifting the patient to ward, who monitored the patient during that period, what steps were taken for prevention are the questions which remained unanswered. These are the facts which are within the special knowledge of the opponents and they have failed to explain them in any manner and this certainly amounts to deficiency in medical service on the part of the opponents.*

## **RESULT**

Complaint Allowed.

## **COUNSELS**

**For the Appellants:** Mr. R.M. Shah, Advocate.

**For the Opponent No. 1:** Mr. H.M. Bhagat, Advocate.

**For the Original Opponents No. 2 & 3:** Mr. H.J. Bhatt, Advocate.

## **IMPORTANT LAW POINT**

**+ The duty of the anaesthetist does not end till the patient fully recovers from the effect of anesthesia. The anaesthetist leaving the operation without verifying whether that patient was really out of anaesthesia or not amounts to gross deficiency in service on his part.**

## **ORDER**

*\* For details of Order See Medical Law Reporter*

## **USA JUDGEMENT**

### **CARDIOLOGY**

#### **Failure to Diagnose Coronary Artery Dissection – Death-\$1 Million Massachusetts settlement.**

The plaintiff's decedent, age fifty-one was treated by the defendant cardiologist for symptoms that included hypotension, bradycardia and angina. The decedent subsequently presented to an emergency room, where she died from cardiogenic shock. The plaintiff claimed that the decedent died from a coronary artery dissection, which was the cause of the symptoms the plaintiff was being treated for by the defendants. The plaintiff argued that the dissection was visible on fluoroscopy and that the defendants failed to recognize the dissection or its hallmark signs. The defendants contended that there was no dissection on the film and that the plaintiff died of long-standing coronary artery disease. The defendant pointed to the fact that the autopsy did not list any evidence of coronary artery dissection. A \$1 million settlement was reached.

### **EMERGENCY MEDICINE**

#### **Failure to Properly Evaluate Abdominal Pain and Admit to Hospital – Mesenteric Vein Thrombosis With Need for Small Bowel Resection Results in Short Bowel Syndrome – Colorado Defense Verdict.**

The plaintiff was seen by the defendant in an emergency room, which was her second emergency room visit in as many days. The plaintiff complained of worsening abdominal pain. The plaintiff was sent home with instructions to return immediately if she worsened. The plaintiff returned two days later and was then admitted. She was eventually diagnosed with mesenteric vein thrombosis (MVT). The plaintiff claimed that the MVT resulted in a large amount of small bowel resection and she claimed to suffer from short bowel syndrome. The defendant argued that an appropriate evaluation was made and appropriate diagnostic testing was performed and that there was no reason to suspect MVT or any other serious condition. The defendant argued that the plaintiff had delayed in returning when she worsened. According to published Reports a defense verdict was returned.

#### **Failure to Property Treat Woman With Low Blood Pressure Despite History of High Blood Pressure – Death Next Day – \$195,000 California Settlement.**

The plaintiff's decedent, age seventy-two, went to the emergency room in March 2004 with complaints of having fallen and hip pain. Her blood pressure was 87/41, despite the fact that the decedent had a history of high blood pressure. She was administered morphine and she was discharged after a couple of hours. She was found unresponsive at home a few hours later. She died of heart failure the next day. The plaintiffs claimed that the defendants failed to provide adequate treatment. The plaintiffs claimed that morphine was contraindicated and that her blood pressure was not checked after the administration of the morphine. The defendant doctor denied being told of the blood pressure reading. According to a published account a \$ 195,000 settlement was reached.

#### **Failure to Diagnose Early Stages of Heart Attack and Use Thrombolytic Therapy – Death – \$500,000 Massachusetts Settlement.**

The plaintiff's decedent, age thirty-eight, went to the emergency room with complaints of chest pain and diaphoresis. He was hyperventilating and felt numbness in his arm. The defendant emergency medicine physician ordered an EKG, which indicated ST fiber elevations. The cardiac enzymes were within normal limits. The defendant administered one milligram of Ativan. When the defendant returned to check on the patient several minutes later, he was unresponsive, cyanotic and foaming at the mouth. Attempts to resuscitate him were unsuccessful. The plaintiff claimed that the defendant failed to diagnose the early stages of a heart attack and mistakenly diagnosed an anxiety attack. The plaintiff claimed that thrombolytic therapy should have been started immediately, which would have avoided the death. According to a published report the defendant's insurance carrier ceased doing business and made a one-time non-negotiable offer of \$ 500,000, which was accepted.

### **HOSPITALS**

#### **Failure to Properly Monitor Woman in ICU- Self Extubation With Cardiac Arrest and Death- \$ 1 Million Illinois Verdict.**

The plaintiff's sixty two year old decedent suffered a seizure at home and was admitted to the ICU with respiratory distress. She was intubated with an endotracheal tube. Her prior medical history included chronic obstructive pulmonary disease, congestive heart failure, myocardial infarction, stroke, hypertension, seizure disorder and dependence on home oxygen. While in the ICU she extubated herself. She was given a respiratory depressant sedative and four minutes later was found unresponsive. Despite resuscitation efforts

she died. No autopsy was performed. The plaintiff claimed that the defendants failed to take appropriate measures to prevent self-extubation, including timely application of wrist restraints and sedation when the decedent became agitated, failed to properly evaluate and monitor the decedent after self-extubation and failed to timely reintubate, leading to respiratory arrest that progressed to cardiac arrest. The defendants maintained that they acted appropriately in taking measures to prevent self-extubation, including timely application of wrist restraints and sedation, but that the decedent self-extubated by coughing and shaking her head. The defendants argued that the decedent was properly assessed following self-extubation and was placed on an oxygen mask rather than immediately reintubated because she was breathing well on her own. The defendants argued that the decedent had an unrelated cardiac arrest due to arrhythmia. According to a published Report a \$ 1 Million verdict was returned.

### **MEDICINE**

#### **Failure to Refer to Cardiologist and Provide Testing for Coronary Disease during Treatment of Gastroesophageal Reflux Disease – Death From Heart Attack– \$ 1.6 Million Net Verdict in Ohio.**

The plaintiff's decedent, age forty, treated with internist Dr. Tolentino five times over the course of two and one-half years prior to his death. He had a family history of coronary artery disease, including the death of his father from the disease at age forty one. The plaintiff also had a recent history of Gastroesophageal reflux disease. During the first visit with the defendant the decedent complaint of chest pain and indigestion. At the final visit before his death the decedent's spouse was present and asked if the decedent should be seen by a cardiologist. The defendant said a cardiologist wasn't necessary because the decedent's complaints were from gastroesophageal reflux disease. The decedent died while operating a snow blower eight months later. The official coroner's report indicated that the decedent died of an arrhythmia as a result of coronary artery disease. The plaintiff claimed that the decedent had a total blockage of his left anterior descending coronary artery and an eighty percent blockage of the right coronary artery for two years prior to his death. The plaintiff claimed that the occlusion could have been stented and the decedent would have survived. The plaintiff argued that the defendant should have referred the decedent for a stress test. The defendant contended that the decedent was young and had no other history of cardiac problems and that the decedent's Gastroesophageal reflux disease may have masked the cardiac symptoms. The defendant also claimed that there was no way to show that any artery occlusion existed at the time of the defendant's last visit with him. The defendant also claimed that the death was due to scarring on the heart muscle, which disrupted the electrical function of the heart. According to Ohio Trial Reporter a \$ 1,798,000 verdict was returned, but ten percent comparative negligence was assessed, making the net verdict \$, 618,200.

#### **Failure to Inform Patient of Elevated PSA Test Result – Prostate Cancer Diagnosed Two Years Later After Spreading to Spine – \$1.7 Million New York Settlement.**

The plaintiff, In his fifties, went to defendant Dr. Roth, his family physician in March 2002 for a routine physical. A prostate specific antigen test (PSA- test was performed). The plaintiff was seen by Dr. Roth on about seven more occasions. Two years after the initial PSA test another PSA test was performed, which showed high levels. The plaintiff was referred to a urologist and he was diagnosed with prostate cancer. The cancer spread to his L2 vertebra before diagnosis. He underwent radiation, decompression surgery and spinal fusion. The plaintiff was cancer free at the time of settlement. The plaintiff claimed that Dr. Roth never informed him of an elevated PSA on the March 2002 test, which should have prompted a referral to a urologist. Dr. Roth claimed that the plaintiff had been advised of the test results and advised to see a urologist. The defendant claimed that his records reflected this. According to a published account a \$1.7 million settlement was reached.

### **SURGERY**

#### **Performance of Colostomy Removal and Anastomosis Performed Too Soon After Colectomy and Hartmann Pouch Procedure – Anastomotic Leak Not Timely Diagnosed – Death – \$1.47 Million Massachusetts Settlement.**

The plaintiff's decedent, age forty-two, underwent a sigmoid colectomy and Hartmann pouch performed by a non-party surgeon. During his follow-up care, the treating surgeon reportedly recommended that the decedent wait at least three months before having any additional procedures so his body would have time to recovery, limiting complications. The defendant surgeon assumed the decedent's care two months later. The defendant performed a second surgery forty-nine days after the initial procedure. This surgery included a laparotomy, Colostomy removal and colonic resection, and an Anastomosis. The decedent developed multiple post-operative complications, including a high fever and confusion. The defendant took no action to locate the origin of the complications. A severe anastomotic leak and sepsis was eventually diagnosed. Surgery was immediately performed and both ends of the colonic Anastomosis were found to have fallen

apart and fecal material was present in the peritoneal cavity. The patient could not be stabilized and the decedent suffered cardiac arrest and died the next day. The plaintiff claimed that the defendant disregarded the recommendation of the primary surgeon and performed the second procedure despite the risks and warnings. The plaintiff also claimed negligence in failing to perform emergency surgery when the decedent showed distress. The plaintiff claimed that the defendant should have drained the abdominal cavity of the fecal material and that the failure to remove the fecal material led to a septic infection, which was the primary cause of the decedent's death. The defendant contended that his treatment was reasonable and appropriate. According to a published report a \$ 1.47 million settlement was reached.