CALIFORNIA

HOSPITAL

Emergency Room — Wrongful Death — Anesthesiology

Cardiac evaluation would have prevented death, family alleged

VERDICT	**Defense**
CASE	Anita Reyes; Alvaro Reyes; Mario Reyes; Louis Reyes; Juan Reyes v. Beverly Hospital; Healthcare Partners; Ariel Malamoud, M.D.; Kumar Ghai, M.D., No. BC324439
COURT	Superior Court of Los Angeles County, CA
JUDGE	Aurelio N. Munoz
DATE	3/19/2007
PLAINTIFF ATTORNEY(S)	**Rolando Hidalgo**, Law Offices of Manuel Hidalgo, Los Angeles, CA
DEFENSE ATTORNEY(S)	**Raymond L. Blessey**, Taylor Blessey LLP, Los Angeles, CA

FACTS & ALLEGATIONS On Nov. 2, 2003, plaintiffs' decedent, Alvaro Reyes, 78, was admitted to Beverly Hospital via the emergency room after "collapsing" from abdominal pain at his home.

The emergency room physician diagnosed cholecystitis and admitted him to the hospital.

Reyes had a past medical history, including congestive heart failure, mitral valve and aortic valve replacements, chronic atrial fibrillation, hypertension, diabetes mellitus type II and prostate cancer. His history also included aortic valve replacements, inguinal hernia repair, cataract surgery and prostate cancer. The emergency room evaluation done at Beverly Hospital noted these multiple conditions.

After admission, Reyes was seen by a general surgeon who discussed the need for possible emergency surgery. Reyes was allegedly not willing to undergo surgery and insisted on medical management only.

Reyes' bilirubin increased by Nov. 4. A GI consult was ordered to evaluate the patient for a possible endoscopic retrograde cholangiopancreatography (ERCP) because of the suspicion that the patient had an obstruction in the biliary tract.

Ariel Malamud, M.D., was the gastroenterologist who performed the ERCP on Nov. 4, in order to rule out choledocholithiasis. After Malamud began the procedure advancing the scope as far as the common bile duct, Reyes became hypoxic. His oxygen saturation dropped temporarily into the 60's. The scope was withdrawn, Reyes was turned to the supine position and he was ventilated using an AMBU bag. His oxygen saturation returned to 100%, but he became bradycardic with a heart rate in the 40's. A code blue was called.

Reyes never regained consciousness after the ERCP and eventually died on Nov. 12, after his family decided to take him off the ventilator. The death certificate listed the cause of death as acute cardio respiratory arrest leading to anoxic encephalatopy.

On his behalf, Reyes' family members sued Beverly Hospital, Healthcare Partners, Malamud and Kumar Ghai, M.D., for medical malpractice. Prior to trial, all plaintiffs except the decedent's wife, Anita, dismissed their complaint against Malamud. Beverly Hospital, Healthcare Partners and Ghai were also dismissed.

The plaintiffs claimed their decedent would not have died if he had undergone a cardiac evaluation prior to the ERCP and if an anesthesiologist had been present during the procedure.

At trial, the plaintiffs' expert anesthesiologist, Phillip Larson, testified that he had performed a total of three ERCP procedures in the last five years and fewer than 10 during his 50 years of medical practice. His area of concentration involved orthopedic, urologic and neuro surgery under general anesthesia. He testified that the defendant fell below the standard of care by not recognizing that he needed cardiac clearance for the procedure. The defendant was also negligent in failing to have an anesthesiologist present for the procedure. According to Larson, an anesthesiologist would have provided constant monitoring of the patient during the procedure; had been better able to determine the appropriate medications, dose and frequency; bag ventilate the patient during the respiratory distress; and to intubate the patient when indicated.

Larson claimed that the decedent suffered an 8-9 minute episode of oxygen deprivation during the procedure before it was terminated which led to anoxic encephalopathy which in turn led to death. Had an anesthesiologist been present for the ERCP, the decedent would have survived without any problems.

The plaintiffs did not call their gastroenterology expert.

The defense contended that the ERCP was both appropriate and necessary. Malamud appropriately evaluated the patient in light of his cardiac history. The use of Versed and Demerol without the assistance of an anesthesiologist was within the applicable standard of care and did not cause or contribute to any injury to the decedent. Reyes suffered anoxic brain damage due to decreased perfusion of the brain secondary to a slow heart rate and low blood pressure after the code blue team took over the decedent's care.

Malamud contended that his care and treatment complied with the applicable standard of care and did not cause or contribute to the decedent's death or injury to the plaintiff.

The defense's expert anesthesiologist, Don Mills testified that Reyes suffered anoxic brain damage due to decreased perfusion of the brain secondary to a slow heart rate and low blood pressure that was noted after the code blue team took over Reyes' care. The doses of conscious sedation (Versed and Demerol) used by Malamud were low and to a reasonable medical probability did not cause either respiratory or cardiac impairment.

According to Mills, the decedent did not experience an extended period of time with a dangerously low saturation level. The persistent normal heart rates and blood pressures in the 10 minute period in which Larson claimed the patient was not receiving enough oxygen were evidence that the patient did not experience a prolonged period of low oxygen.

The defense also called expert gastroenterologist, Carl Blau, who is board certified with extensive experience administering anesthesia, having performed over 12,000 procedures during which he used conscious sedation. Blau testified that Malamud's pre-ERCP assessment in terms of the indications for the study and evaluation of the patient's cardiopulmonary status was reasonable. This is confirmed by Ghai's findings, the internist and pulmonologist and the surgeon.

Malamud's procedure was appropriately carried out, according to Blau, including the use of conscious sedation. It is not uncommon for patients to develop transient desaturation during an ESRP unrelated to conscious sedation. Malamud timely recognized the patient's hypoventilation and took the necessary actions to reverse the decreased oxygen level. The standard of care did not require cardiac clearance for the decedent prior to the ERCP given his stable clinical status and the findings of Ghai. It was not necessary to have an anesthesiologist present during the ERCP.

INJURIES/DAMAGES *death*

The decedent's family members did not put forth any evidence of special damages. The plaintiffs sought $250,000 from the jury.

RESULT The jury returned a defense verdict.

DEMAND $259,804.13
OFFER Waive costs and malicious prosecution

TRIAL DETAILS Trial Length: 5 days
Trial Deliberations: 1.2 hours
Jury Vote: 11-1

PLAINTIFF EXPERT(S) **Phillip Larson, M.D.**, anesthesiology, Los Angeles, CA

DEFENSE EXPERT(S) **Carl Blau**, gastroenterology, Encino, CA
Don Mills, M.D., anesthesiology, Los Angeles, CA

EDITOR'S NOTE This report is based on information that was provided by the plaintiffs' and defense counsel.

–Michael Rehak