Daily Journal

VERDICTS & SETTLEMENTS

FRIDAY, MARCH 2, 2012

PERSONAL INJURY

Medical Malpractice

Negligent Nursing Care

VERDICT: DEFENSE

CASE/NUMBER: *John Nigra v. Glendale Adventist Medical Center* / EC053384.

COURT/DATE: Los Angeles Superior Burbank / Feb. 2, 2012.

JUDGE: Hon. William D. Stewart.

ATTORNEYS: Plaintiff - Steven C. Glickman (Glickman & Glickman, Beverly Hills).
Defendant-Raymond L. Blessey (Taylor Blessey LLP, Los Angeles).

MEDICAL EXPERTS: Plaintiff - Pam Geyer, R.N., hospital nursing care, Valencia; Barbara Greenfield, R.N., B.S.N., C.C.M., life care planning, South Pasadena; Robert Lieberson, M.D., neurosurgery, Pleasanton; Ann T. Vasile, M.D., physical medicine and rehabilitation, Long Beach.
Defendant - Edwin C. Amos, III, M.D., neurology, Santa Monica; Margaret Armbruster, R.N., nursing care, Los Angeles; Frank J. Coufal, M.D., neurosurgery, Rancho Santa Fe; Amy M. Sutton, BSN, MA, PhD, CLCP, CRRN, life care planning, Long Beach.

TECHNICAL EXPERTS: Plaintiff - Darryl R. Zengler, M.A., forensic economics, Pasadena.
Defendant - Jennie McNulty, CPA, MBA, economics, Los Angeles.

FACTS: On July 7, 2009, plaintiff John Nigra, 78, was admitted to Glendale Adventist Medical Center for a lumbar spine decompression surgery. His medical history was positive for chronic lower back pain and in the recent months, his discomfort began to significantly interfere with his daily functional activities. Plaintiff had previously been diagnosed with an ischemic optic neuropathy and was found to be legally blind. However, his visual impairment did not interfere with his ability to live and function independently.

On Feb. 7, 2009, plaintiff underwent a decompression surgery at the L4 level without any complications. The following day, when he got out of bed to ambulate for the first time after surgery, he was noted to develop atrial fibrillation. Prior to this event, he was without a cardiac history. The attending cardiologist and the orthopedic surgeon agreed to place him on Lovenox in order to decrease the likelihood of clot formation and an embolic stroke.
On Feb. 10, plaintiff was transferred from the medical surgery floor to the Rehabilitation Unit located on the Glendale Adventist Medical Center campus. At the time of transfer to the Rehabilitation Unit, the orthopedic surgeon documented that plaintiff was stable and neurologically intact.

Plaintiff began to complain of leg pain, left greater than right, on the Rehabilitation Unit on July 11, 2009. His symptoms did not resolve over the course of the next few days, and on July 13, he asked to be seen by his orthopedic surgeon. His surgeon ordered a Doppler ultrasound study, which ruled out the presence of a deep vein thrombosis. He then ordered plaintiff to be seen by a pain management physician who, on July 15, administered an epidural injection at the L4-5 level after holding Lovenox for approximately 12 hours. Plaintiff was seen by his neurologist following the nerve block at which time he continued to complain of left leg pain. A CT scan was ordered and completed on July 16. This study revealed the presence of a fluid collection at L4-5 level suggestive of a hematoma versus seroma.

Plaintiff's left leg pain persisted up to and through Saturday, July 18, and, at times, was reported to be as high as level 8 out of 10. In addition, plaintiff again asked to be seen by his surgeon due to his persistent pain and his desire to discuss the CT scan results with him. The attending nurse telephoned plaintiff's orthopedic surgeon and left a message with his service to report plaintiff's request. Approximately five hours later, the attending nurse placed a second call to plaintiff's orthopedic surgeon since he did not respond to the initial call. At that time she spoke with the on-call surgeon who advised her he did not have staff privileges and therefore would not be able to come in to see the patient. The on-call surgeon recommended that plaintiff wait until Monday, July 20, to be seen by his surgeon. The next nurse on duty on July 18 noted for the first time a complaint of left leg weakness.

On July 19, the attending nurse contacted plaintiff's neurologist and reported that plaintiff wanted to be seen due to his persistent left leg pain. She left a message with the answering service of plaintiff's orthopedic surgeon reminding him that the patient wanted to discuss his symptoms and CT scan study with him.

On July 20, at 9:30 a.m. a copy of the CT scan result was faxed to the office of plaintiff's orthopedic surgeon at the surgeon's request. At 1:15 p.m., the physical therapist treating plaintiff reported that the patient's feet were numb and he demonstrated weakness in his left foot. This change in condition was reported to plaintiff's neurologist who ordered a second CT scan. He also decreased the dose of Lovenox at this time. At approximately 7:40 p.m., the attending nurse reported to the attending physical medicine physician that plaintiff was too weak to stand to urinate and had numbness in both feet. An order was issued to place a Foley catheter. At 8:40 p.m., the attending nurse contacted plaintiff's orthopedic surgeon and reported that the patient was weak, experiencing numbness and was unable to feel the Foley catheter insertion. An MRI Scan was ordered and orders were issued to place plaintiff on a "nothing by mouth" status in anticipation of an exploratory surgery to be done the next day to evacuate a presumed spinal hematoma.

On July 21, plaintiff underwent surgery to evacuate the hematoma and to further decompress the lumbar spine. Plaintiff remained in the hospital until Sept. 11. However, he never regained his full strength in his lower extremities or control of either his bowel or bladder function.

PLAINTIFF'S CONTENTIONS: Plaintiff alleged that by July 18th, there had been sufficient change in his condition to alert the nursing staff of the importance to ensure that he was seen by his orthopedic surgeon. His change in condition included progressive left leg pain and the acute onset of leg weakness. The fact that there was a "black box" warning for Lovenox when used for patients post acute spine surgery known to the nursing staff should have further heightened their concern. The standard of care under the circumstances required that the attending nurse, on July 18th, go up the chain of command to ensure that plaintiff's surgeon be advised of his change in condition. In the event his surgeon could not be located, another spine surgeon needed to be consulted. In addition, in the face of a changing neurological status in a patient at risk of an epidural hematoma, the attending nurse should not have given Lovenox without first clearing it with the surgeon or an attending physician.

Plaintiff contended that had the surgeon been contacted on July 18 and advised of his patient's status, the appropriate imaging studies would have been ordered and surgical intervention would have occurred prior to the onset of bladder impairment. To a reasonable medical probability, had the hematoma been evacuated prior to the onset of bladder impairment, plaintiff would not have suffered any permanent neurologic impairment.

DEFENDANT'S CONTENTIONS: Defendant contended that the nursing care on July 18th was reasonable and within the standard of care under the circumstances and that such care was not a substantial factor causing the permanent nerve damage suffered by plaintiff.

JURY TRIAL: Length, eight days; Poll, 9-3 (negligence); Deliberation, 4.5 hours

SETTLEMENT DISCUSSIONS: Plaintiff's counsel served no formal offer during the pendency of this matter.
Defendant's final pre-trial offer was $30,000. Plaintiff's final pre-trial offer was $450,000.

RESULT: Defense verdict.
Plaintiff had previously settled with two physicians involved in plaintiff's care for confidential amounts.

OTHER INFORMATION:
EXPERT TESTIMONY: Pam Geyer, R.N., testified that the nurse attending to plaintiff on July 18, 2009, fell below the standard of care by failing to go up the chain of command to contact the patient's surgeon when there was change in condition and a request by plaintiff to see his surgeon. In addition, plaintiff's expert was critical of the same nurse for failing to check with his surgeon or the attending physician before administering Lovenox on the 18th since she knew or should have known of the "black box" warning that this medication can result in a spinal hematoma in patients with recent spine surgery.

Dr. Robert Lieberson, M.D., neurosurgeon, opined that the change in plaintiff's condition post lumbar laminectomy was due to the development of a lumbar epidural hematoma that was compressing the spinal cord and the nerve roots at lumbar levels 4 and 5. In general, the sooner the surgeon evacuates the hematoma, the greater the chances are to prevent permanent nerve damage. Certainly by the time the patient developed bowel and bladder impairment it was too late to prevent permanent nerve damage. If the nurse been able to contact the surgeon on the Saturday, July 18, he would have evacuated the hematoma and prevented the onset of a cauda equina syndrome. However, the surgeon did not see plaintiff until July 20, 2009.

Dr. Ann Vasile, M.D., physical medicine and rehabilitation specialist, opined that plaintiff would need to have skilled nursing help for his bowel and bladder care, an electric wheelchair, home modifications and ongoing assessments by a urologist, internist and surgeon, as well as physical and occupational therapy.
Barbara Greenfield, R.N., life care planner, prepared a life care plan designed to address plaintiff's future care needs in conjunction with Dr. Vasile. Her primary role was to obtain costs for the services needed in the future.

Darryl Zengler, forensic economist, calculated the present cash value of the cost of plaintiff's future life care needs. He testified to figures ranging from $995,900 to $1,375,837, depending on the various options for plaintiff's living situation (residence versus facility). Plaintiff was also claiming approximately $200,000 in past medical expenses and past and future general damages.

Dr. Frank Coufal, M.D., neurosurgeon, opined that there was no evidence of a significant change in plaintiff's neurologic condition until the early afternoon of July 20, 2009, when he demonstrated objective changes in his lower extremity strength and numbness in his feet. He did not believe that there was an indication to surgically intervene on July 18th when plaintiff was requesting to see his surgeon and complaining of persistent pain and weakness.

Margaret Armbruster, R.N., felt the nursing care on the weekend of the July 18 and 19, 2009, was well within the standard of care. She opined that there was no significant change in plaintiff's neurologic status on the weekend in question and therefore, no need to go up the chain of command and no indication to hold the Lovenox therapy.
Dr. Edwin Amos, M.D., neurologist, performed the defense medical examination prior to trial. Based on his examination findings and review of the medical records, Dr. Amos provided his recommendations for plaintiff's future medical care needs.
Amy Sutton, Ph.D., R.N., along with Dr. Amos, developed a life care plan to address all of plaintiff's future medical care needs and assigned a cost to each item.
Jennie McNulty, CPA, MBA, opined that the present value of the future care costs was in the range of $285,000 to $420,000 depending on where plaintiff would end up residing. She also calculated an offset figure based on the costs of care required due to plaintiff's pre-existing visual impairment.

FILING DATE: June 21, 2010.