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LAWYERS WEEKLY

MICHIGAN LAWYERS WEEKLY 25 YEARS 1986 · 2011

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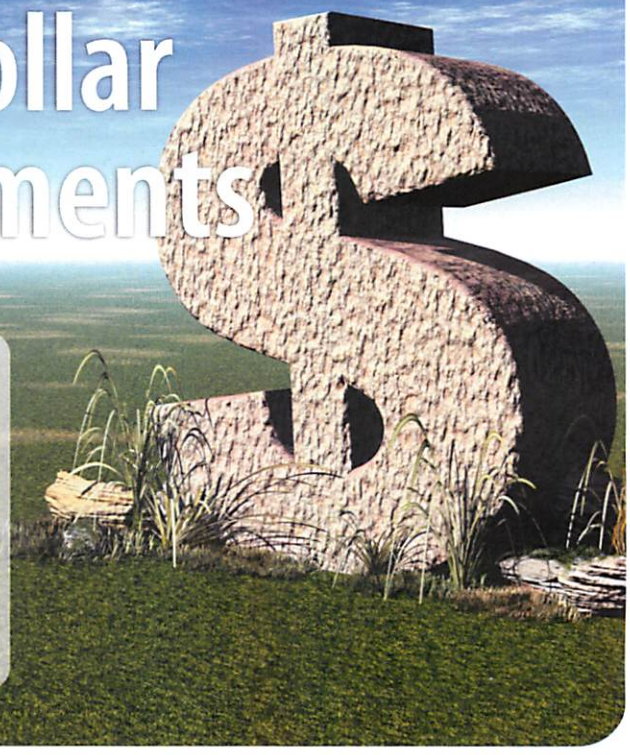
2011 Million-Dollar Verdicts & Settlements



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LARGEST SETTLEMENTS

#1

Two-hour delivery delay results in cerebral palsy

OB should have responded sooner while fetus in distress, plaintiff says

$6.25 million

In a confidential lawsuit, plaintiff next friends to plaintiff minor sought compensatory damages from defendant medical center and defendant OB physician on claims of cerebral palsy, spastic quadriplegia and developmental delay following birth.

Approximately 30 minutes following admission to the hospital, the mother, having been placed on a fetal heart monitor, was seen by the first-year OB resident, who discovered meconium staining and severe variable decelerations. The OB resident was discovered to have been practicing without supervision of a senior resident.

McKeen

Shortly thereafter, the attending OB was contacted by phone, but didn't call back until 30 minutes later. At that time, there were late fetal heart-rate decelerations developing. The first-year resident then discussed the case with the senior fourth-year resident, and a decision to deliver by C-section was made over the phone. However, from the time of decision to delivery by C-section, it took nearly two hours to deliver the child.

Discovery revealed the defendant attending on-call OB apparently had child care issues that compelled her to choose to stay home while the fetus was in distress.

At birth, there was tight nuchal cord. Plaintiff's neonatology and child neurology experts testified the child sustained hypoxic-ischemic injury during the two-hour delay, immediately prior to delivery. The child displayed multi-organ dysfunction following birth, despite a cord Ph above 7.0.

Plaintiff was able to explain how the child's severe hypoxia-is-

LARGEST SETTLEMENTS

chemia at birth was not inconsistent with a cord Ph above 7.0 by testimony of a world-renowned expert/author in the field of umbilical cord blood gases.

The child is now 4 years old with spastic quadriplegia and developmental delay.

Defense contended this was not a case of acute infrapartum asphyxia, and the cord Ph above 7.0 was inconsistent with a severe acute hypoxic ischemic insult just prior to birth. The defense argued there was no scientific evidence delivery two to three hours earlier would have changed the outcome.

The matter settled for $6.25 million.

Types of actions:
Birth trauma, medical malpractice

Types of injuries:
Cerebral palsy, spastic quadriplegia, developmental delay

Name of case: Confidential

Court/Case no./Date:
Confidential; Aug. 25, 2011

Name of judge: Withheld

Settlement amount: $6.25 million

Insurance carrier(s): Withheld

Attorneys for plaintiff:
Jeffrey T. Meyers, Brian J. McKeen, Terrance J. Cirocco

Attorney(s) for defendant: Withheld

#2

Induction with Pitocin blamed for asphyxia

Mother testifies asking obstetrician about C-section long before delivery

$6 million

In a confidential lawsuit, plaintiff next friend (mother) to plaintiff minor sought compensatory damages from defendant obstetrician, defendant nurse and defendant hospital on claims of birth trauma and medical malpractice resulting in hypoxic-ischemic encephalopathy, cerebral palsy and developmental delay.

On Dec. 28, 2007, the mother was admitted to defendant hospital under the care of defendant obstetrician and defendant nurse for induction of labor with Pitocin. The mother was at term, and her prenatal course had been uneventful.

Despite steadily increasing Pitocin, it was noted to be difficult to determine the uterine contraction pattern. Four hours later, a terminal bradycardia developed, and the obstetrician called for a C-section; delivery was accomplished 17 minutes later, but the child was asphyxiated prior to delivery.

The asphyxia was so severe that it caused hypoxic ischemic encephalopathy, which evolved into a permanent static encephalopathy. In addition, the child has been diagnosed with spastic cerebral palsy, and will require lifelong attendant care and supervision.

Plaintiff's counsel contended that Pitocin is a synthetic form of oxytocin, a naturally occurring hormone which stimulates uterine contractions. It increases the resting tone of the uterus, strength and frequency of uterine contractions. Each contraction results in a temporary interruption of blood flow through the uterus.

In every labor augmented with Pitocin, the standard of care requires continuous electronic fetal heart rate monitoring (EFM). EFM involves recording fetal heart rate and maternal uterine activity. The purpose of fetal monitoring is to allow clinicians to recognize patterns consistent with fetal hypoxia and intervene in order to avoid needless neurologic injury.

McKeen

Dawes

The birth trauma claim asserted combined negligence of defendant obstetrician and defendant in first creating fetal distress in plaintiff minor by injudicious use of Pitocin, then delaying in timely performing a C-section in the face of mounting evidence that the child was not tolerating the stress of labor and needed to be delivered.

It was further contended that, as a result of the defendants' joint and several negligence, plaintiff minor sustained an acute near total asphyxia in the minutes prior to delivery. Plaintiff retained multiple experts who have testified in support of that fact, and the mother testified that she asked defendant obstetrician about a C-section long before the terminal bradycardia.

The matter settled for $6 million.

Types of actions:
Birth trauma, medical malpractice

Types of injuries:
Hypoxic-ischemic encephalopathy, cerebral palsy, developmental delay

Name of case: Confidential

Court/Case no./Date:
Confidential; Nov. 21, 2011

Name of judge: Withheld

Settlement amount: $6 million

Insurance carrier(s): Withheld

Attorneys for plaintiff:
Brian J. McKeen, Terry A. Dawes

Attorney(s) for defendant: Withheld

LARGEST SETTLEMENTS

#2

Improper blood glucose monitoring at hospital leads to hypoglycemia

Plaintiff contended it was known that newborn was at an increased risk

$6 million

McKeen

Dawes

In a confidential medical-malpractice lawsuit, plaintiff next friend to plaintiff minor sought compensatory damages from defendants hospital and pediatricians on claims of catastrophic brain damage due to a prolonged period of hypoglycemia (low blood glucose).

The child was born Aug. 18, 2003, as a term newborn, but had a significant risk factor for hypoglycemia. At 4 pounds 13 ounces, he was found to be small for gestational age (SGA); he had decreased fat stores and decreased glycogen in his liver, both risk factors for development of hypoglycemia.

On the first and second day of life, the child's assigned was defendant Pediatrician A. Due to persistent low blood glucose, an IV of dextrose solution was started Aug. 19, 2003 at 5:40 p.m. The child's response was normal, as his blood glucose went up and stayed above 50 during the time he was given supplemental dextrose via IV.

The next day at 10 a.m., an order was written to begin reducing the amount of supplemental dextrose child was given, to be sure if the child can maintain a safe glucose level (above 50) on oral feedings alone with or without oral supplementation.

It was asserted that the nursing staff at defendant hospital negligently failed to appropriately wean the child's IV, and to consistently check pre-prandial blood glucose after the IV was discontinued, as his post-prandial blood glucose dipped into the 40s throughout the day, and the nursing staff only checked minor child's blood glucose five times. In addition, it was contended that the nursing staff failed to perform a blood glucose for the last 7 hours and 45 minutes the child remained in the hospital

Given this information, it was asserted that it was imperative that Pediatrician B (the pediatrician responsible for the child's care on the day of discharge) and the nursing staff restart the dextrose IV, continue to monitor Minor child's pre-prandial blood glucose, and refrain from discharging him.

After being discharged, the next morning the mother found that the child was cold and clammy, not moving, and bluish in color. Upon arrival at the emergency department, he was noted to be profoundly hypothermic and hypoglycemic with no detectable blood glucose. Permanent brain injury had occurred in the hours after the discharge and before the child was returned to the hospital. The child will never walk or talk normally, live on his own, or work, and will require lifelong 24-hour nursing care for the rest of his life.

Plaintiff asserted that defendants knew the child was at increased risk for hypoglycemia due to his SGA status. It was further contended that if the defendants had kept the child in the hospital, consulted with a neonatologist, and worked the child up, they would have easily identified the congenital lack of cortisol and growth hormone as another risk for hypoglycemia.

One of plaintiff's pediatrician experts opined that Pediatrician A was negligent in failing to consult a neonatologist to come in and evaluate minor child and ensure that his blood glucose was properly monitored; and, more importantly, to ensure that he was not discharged until such time that it was established that minor child could maintain his blood glucose on oral feedings alone.

The matter settled for $6 million.

Type of action: Medical malpractice

Type of injuries:
Permanent brain injury due to severe hypoglycemia

Name of case: Confidential

Court/Case no./Date: Confidential; Feb. 25, 2011

Name of judge: Withheld

Settlement amount: $6 million

Insurance carrier(s): Withheld

Attorneys for plaintiff:
Terry A. Dawes, Brian J. McKeen,

Attorney(s) for defendant: Withheld

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LARGEST SETTLEMENTS

#3

Mom: C-section should have happened sooner

Plaintiff asserts fetal distress signs were not heeded by defendants

$4.5 million

In a confidential lawsuit, plaintiff next friend (mother) to plaintiff minor sought compensatory damages from defendant OB/GYN medical center and defendant hospital on claims of birth trauma and medical malpractice resulting in hypoxic-ischemic encephalopathy and cerebral palsy.

On March 23, 2005, the mother was scheduled for a prenatal visit with her obstetrician at defendant OB/GYN medical center. She was 35 weeks pregnant. The mother reported that she had, the previous day, perceived a decrease in fetal movement. Child's mother's blood pressure was also slightly elevated; therefore, the obstetrician instructed the mother to proceed directly to defendant hospital for evaluation and monitoring.

Upon arrival, the mother was taken to the OB triage area, where a nurse took vital signs and hooked the mother up to a fetal monitor. The mother's blood pressure was elevated (133/99) and a urinalysis showed 2+ protein. A repeat blood pressure confirmed hypertension (130/90), and the findings were suggestive of preeclampsia. No further blood pressure checks were done before the child was born.

The initial external fetal monitor strip, applied from 9 a.m. to about 9:24 a.m., showed decreased variability suggesting that the child may not be tolerating the intrauterine fetal environment. Due to the non-reassuring fetal heart tones, a first-year OB resident performed a biophysical profile (BPP) from

MCKEEN

DAWES

LARGEST SETTLEMENTS

about 9:25 a.m. through 9:50 a.m. which is why there is no recording of fetal heart rate during that time.

Following the BPP, the resident documented that the mother was remote from delivery, fetal heart tones were non-reassuring, and she would continue to monitor the non-reassuring heart tones.

It was asserted that, rather than recognize that the unborn child was at increased risk for permanent neurologic injury and needed to be delivered by emergency C-section, the obstetrician ordered an oxytocin challenge test (OCT).

When fetal monitoring resumed at about 9:51 a.m. variability appeared worse. Despite this, no effort was made to stimulate the child in an effort to elicit acceleration in heart rate. The obstetrician arrived at the hospital at about 10:45 a.m. to evaluate the patient, and decided the baby needed to be delivered by stat C-section. The child was born a full half-hour after the obstetrician arrived at the hospital.

The child's discharge summary from defendant hospital indicates he was diagnosed with hypoxic-ischemic encephalopathy. He also has been diagnosed with cerebral palsy, more pronounced on the left side. He receives occupational therapy, physical therapy, and speech therapy. Because of his spastic muscles, the child has been injected with Botox; given Baclofen, an oral medication; and wears ankle foot orthotics on each leg. He will require these treatments for life.

Plaintiff asserted that the attending obstetrician, the first-year resident, and the nursing staff of defendant hospital failed to recognize impending fetal distress and failed to emergently deliver the minor child, via C-section.

The matter settled for $4.5 million.

Types of actions: Birth trauma, medical malpractice

Types of injuries: Hypoxic-ischemic encephalopathy, cerebral palsy

Name of case: Confidential

Court/Case no./Date: Confidential; Jan. 31, 2011

Name of judge: Withheld

Settlement amount: $4.5 million

Insurance carrier(s): Withheld

Attorneys for plaintiff: Brian J. McKeen, Terry A. Dawes

Attorney(s) for defendant: Withheld

#7

Patient's quadriplegia blamed for delayed MRI, lack of checking

Spinal cord compression detected too late for 41-year-old to be saved

$3.36 million

In a confidential lawsuit, plaintiff patient sought compensatory damages from defendant hospital on medical-malpractice claims that resulted in quadriplegia.

On Jan. 6, 2006, plaintiff, 41, went to the hospital with complaints consistent with spinal epidural abscess (SEA), an infection in the epidural space. He had no neurological deficits upon admission.

Based on his complaints and lab tests, the emergency department physicians immediately concluded that SEA was top on the differential diagnosis. A stat MRI was ordered, but due to plaintiff's excruciating pain in the spin, he was unable to lie still long enough to allow the test to be done, despite the use of conscious sedation.

The MRI was still ordered, but was not performed over the next few days. On Jan. 8, a second MRI was attempted, this time with less sedating medicine ordered. Because of this, plaintiff could not lie flat, and the test was not completed..

McKeen

Dawes

On Jan. 9, the internist was told that no anesthesiologist was available to do a consultation on a Monday afternoon. The head of the department of anesthesia testified that no request for anesthesia was made. However, plaintiff's anesthesiology experts testified that an anesthesiologist should have been available to consult on the patient to allow the then-three-day-old MRI order to be completed.

Before leaving for the day Jan. 9, the attending internist wrote orders for a post-void residual and for neurochecks on plaintiff ever four hours; the orders illustrated that there was concern plaintiff might develop neurological deficits.

The medical records reflected that at 6:45 p.m. Jan. 9, plaintiff had a post-void residual of 800cc, which plaintiff asserted was clear evidence of urinary retention and new-onset neurological deficit. Despite this finding, it was contended that the nurse caring for plaintiff neither notified a doctor nor did the ordered neurochecks.

Plaintiff was later noted to have numbness and inability to move his legs, and the nurse who noted this again failed to notify a physician. A physician was contacted at 1 a.m. Jan. 10, six hours after the post-void residual results were known.

The MRI was finally done 11:30 a.m. Jan 10, and showed an SEA with significant spinal cord compression. Plaintiff was immediately taken to surgery, where a multi-level decompression and evacuation of the abscess was done. However, the delay in di-

LARGEST SETTLEMENTS

agnosis and treatment resulted in permanent quadriplegia.

Plaintiff asserted that the order for a stat MRI should not have taken four days to be fulfilled, thus breaching the standard of care. It also was contended that the failure of the nursing staff to do neurochecks and report new onset neurological defects breached the standard of care.

The matter settled for $3.36 million.

Type of action: Medical malpractice

Types of injuries: Spinal cord injury, quadriplegia

Name of case: Confidential

Court/Case no./Date: Confidential; May 16, 2011

Name of judge: Withheld

Settlement amount: $3.36 million

Insurance carrier(s): Withheld

Attorneys for plaintiff: Brian J. McKeen, Terry A. Dawes

Attorney(s) for defendant: Withheld

#13

Plaintiff says standard of care was breached before and after birth

It's argued that C-section delivery should have been ordered sooner

$2.6 million

In a confidential lawsuit, plaintiff next friend of plaintiff minor sought compensatory damages from defendants physicians and medical centers for birth trauma-related injuries.

Plaintiff next friend presented to labor and delivery with complaints of painful contractions and possible rupture of membranes. Initial electronic fetal monitor strips showed a nonreactive tracing. Based on the nonreactive strip, the mother was admitted to the hospital. Initial impression upon admission included a nonreactive non-stress test (NST) coupled with a complaint of decreased fetal movement.

Plaintiff asserted that, given these findings, the standard of care required close monitoring and further evaluation of fetal well-being, and that the very first note indicates a biophysical profile (BPP) may be needed if the tracings continue to be nonreactive. Given that the mother was over 38 weeks gestation, there was no risk of complications of prematurity if the baby needed to be delivered via C-section.

Plaintiff's obstetric nursing experts testified that the nurses assigned to care for the mother were negligent in failing to, starting at 2:50 p.m., request the obstetrician come to the bedside and evaluate a tracing that was suggestive of fetal intolerance to the intrauterine environment.

When the obstetrician was at the bedside at 5:20 p.m., plaintiff contended the standard of care required nursing staff to advocate for a change in the plan of care for the patient, and, if their request was rebuffed by the obstetrician, the standard of care required that the nursing staff invoke the chain of command to insure that the safety of mother and the unborn child were adequately addressed. In addition, it was contended, the nursing staff should have taken steps to insure NICU staff attended the delivery.

McKeen

Dawes

Upon delivery, the child was noted to be neurologically depressed as evidenced by his APGAR scores of 4 at one minute and 5 at five minutes. He was transferred to the NICU due to respiratory distress. Given the fetal monitor strips the standard of care required that the obstetrician request that staff from the NICU attend the delivery and immediately attend to plaintiff minor. As it happened, no one from the NICU arrived until five minutes of life.

At the age of 13, it was asserted, plaintiff minor's cognitive function is equivalent to that of a 2-year-old child. The child will never work, never live independently, and will require round-the-clock supervision and care for the remainder of his life.

Plaintiff contended that an obstetrician and obstetric nurses failed to properly manage labor and failed to expedite delivery via C-section due to increasingly abnormal electronic fetal monitor tracings. As a result of that negligence, plaintiff minor sustained an acute hypoxic-ischemic injury to his brain prior to delivery.

In addition, it was asserted, additional health care providers, neonatal nurse practitioners, and neonatologists failed to timely and properly treat hypotension and seizures the child had following delivery, which resulted in additional injury to his brain. This resulted in cerebral palsy and global developmental delay.

The matter settled for $2.6 million.

Types of actions: Birth trauma, medical malpractice

Types of injuries: Hypoxic-ischemic encephalopathy, cerebral palsy, developmental delay

Name of case: Confidential

Court/Case no./Date: Confidential; Dec. 12, 2011

Name of judge: Withheld

Settlement amount: $2.6 million

Insurance carrier(s): Withheld

Attorneys for plaintiff: Brian J. McKeen, Terry A. Dawes

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LARGEST SETTLEMENTS

#16

Plaintiff asserts wrong procedure took place for abdominal pain

Woman suffers pancreatitis, is put near death after a duct ruptures

$2.25 million

In a confidential lawsuit, plaintiff patient sought compensatory damages from defendant CRNA, defendant gasteroenterologist and defendant hospital for pancreatic duct injuries.

The patient, a 38-year-old mother of two and sole breadwinner, had been experiencing diffuse abdominal pain. The gastroenterologist suspected sphincter of Oddi dysfunction (the sphincter of Oddi serves as one of the valves that controls the release of caustic pancreatic enzymes into a person's intestines).

The gastroenterologist recommended an endoscopic retrograde pantography (ERCP) with manometry, a procedure where the pancreas is injected with dye, and pressure measurements are taken of the sphincter of Oddi. However, that procedure was never performed; instead, the gasteroenterologist performed an interventional ERCP, where he cut the pancreatic sphincter (another valve adjacent to the sphincter of Oddi) and lodged a stent into the patient's pancreatic duct.

McKeen

Garvey

Plaintiff asserted that, prior to the procedure, there was no evidence that a surgical "time-out" — a protocol recommended by the World Health Organization (WHO) and other regulatory bodies to prevent sentinel events, such as incorrect procedures and wrong-site surgeries — was performed.

It was further contended that, despite the fact that the patient consented to a ERCP with manometry only, a time-out was never performed, allowing the wrong procedure to take

LARGEST SETTLEMENTS

place. The defendant CRNA, in her deposition, testified that no one at defendant hospital paid attention to the WHO time-out protocols.

The procedure resulted in injury to the patient's pancreatic duct. The placement of a "pig tail" stent in the pancreatic duct resulted in the rupture of the pancreatic duct (the channel that delivers pancreatic enzymes to the digestive system). The rupture of this duct resulted in the highly caustic enzymes being spilled into the patient's abdomen. All of the damage to the patient's pancreatic duct was photographed interoperatively, and sent to a radiologist for review.

Radiology, however, did not spot the gross extravasation of contrast dye from the patient's pancreas, and dictated a normal report. The patient, in the ICU, began to suffer from a severe necrotizing pancreatitis.

Subsequently, another radiologist, a general surgery consultant, and a hospitalist failed to spot the iatrogenic injury. More importantly, it was asserted, there was no communication between different members of the treatment team, which likely would have prevented the two weeks of necrotizing pancreatitis and near death of the patient.

When the patient was near death, her husband sent her CT scans to his brother-in-law, a Kentucky radiologist. Upon review, the brother-in-law immediately contacted surgeons at defendant hospital and described the findings over the phone. After nearly two weeks of delay, repair surgery was performed within 24 hours.

The patient subsequently spent nearly six months in the hospital, and incurred more than $1 million in medical expenses. She spent nearly two years receiving all nutrition by IV.

Defense contended that all of the damages occurred as a normal risk and result of an ERCP.

The matter settled for $2.25 million.

Type of action: Medical malpractice

Types of injuries: Iatrogenic injury to pancreatic duct during endoscopic retrograde pantography (ERCP), followed by failure to diagnose injury based upon radiological evidence and clinical symptoms, resulting in severe sepsis and permanent disability

Name of case: Confidential

Court/Case no./Date: Confidential; Oct. 20, 2011

Name of judge: Withheld

Settlement amount: $2.25 million

Insurance carrier(s): Withheld

Attorneys for plaintiff: Brian J. McKeen, Robert F. Garvey, Phillip B. Toutant

Attorney(s) for defendant: Withheld

#21

Child born with birth defects after mom is in motor-vehicle accident

Injuries would have been avoided with a timely delivery, experts say

$1.8 million

In a confidential medical-malpractice/birth-trauma lawsuit, plaintiff conservator, on behalf of plaintiff minor, sought compensatory damages from defendant hospital on claims of negligence in delaying recognition of a placental abruption and addressing profound hypotension and anemia following delivery.

On July 17, 2001, the minor's mother was involved in a motor-vehicle accident. According to records, the EMS unit called the defendant hospital indicating that they were en route to with a pregnant female with bilateral pelvic and leg pain. She denied loss of consciousness, and her vital signs were within normal limits. An IV line was established and fluids administered as a precautionary measure while en route to the hospital.

At the hospital, it was noted that she had a contusion on her right lower quadrant, as well as tenderness and pain in her femurs bilaterally. The only other indication of trauma was a small laceration to her forehead, which had no active bleeding.

It was asserted that cervical spine and femur X-rays taken thereafter reflected pelvic fractures that would preclude the occurrence of a vaginal delivery, and that a Caesarean section delivery would be required.

McKeen

Dawes

Plaintiff's obstetrical experts asserted that obstetrical staff who assessed plaintiff minor's mother in the emergency department were negligent in failing to bring an electronic fetal monitor to the emergency department until 30 minutes later; failing to immediately perform an assessment of fetal well-being; and failing to immediately recognize the presence of an abruption and the need for a stat C-section.

Plaintiff minor was born with severe cerebral palsy and mental retardation, and today has spastic quadriplegia and a seizure disorder. She requires around-the-clock supervision, is in a wheelchair, requires a feeding tube, has been in and out of physical and occupational therapy, and is fully dependent on others for all of her basic needs.

Plaintiff asserted that a motor vehicle accident is a major risk factor for placental abruption, and that the standard of care requires the baby be promptly evaluated. Also, pediatric neuroradiology expert opined that the pattern of injury seen on plaintiff minor's neuroimaging studies is consistent with intrapartum hy-

LARGEST SETTLEMENTS

poxic-ischemic injury.

In addition, plaintiff's pediatric neurology expert testified that timely delivery of plaintiff minor would have spared her devastating neurological injuries.

Defendant contended that the standard of care requires the baby only be evaluated after the mom has been stabilized.

Plaintiff, however, asserted that, because the minor's mother was stable, evaluation of her unborn child should have been undertaken concurrently with the examination of minor's mother.

The matter settled for $1.8 million.

Types of actions: Birth trauma, medical malpractice

Types of injuries: Hypoxic-ischemic encephalopathy, cerebral palsy, developmental delay

Name of case: Confidential

Court/Case no./Date: Confidential; June 16, 2011

Name of judge: Withheld

Settlement amount: $1.8 million

Insurance carrier(s): Withheld

Attorneys for plaintiff: Brian J. McKeen, Terry A. Dawes

Attorney(s) for defendant: Withheld

#22

Estate asserts surgeons' handling of vascular procedure killed patient

It's contended that one doctor had interpreted symptoms as urological

$1.55 million

McKeen

In a wrongful-death and medical-malpractice lawsuit filed in Marquette County Circuit Court, plaintiff Frances Colucci-Hill, as personal representative for the Estate of Robert Hill, sought compensatory damages from Dr. Joel A. Johnson, Dr. James H. Mering III and Marquette General Hospital, Inc., on claims of a delay in performing vascular surgery, resulting in death from severe hypotension.

Robert Hill, 44, was participating in the UP Golf Tournament on Aug. 12, 2005, when he suddenly collapsed. He was rushed to St. Francis Hospital in Escanaba. There, a radiologist correctly diagnosed his right common iliac artery tear, and the emergency department physician had him transferred to Marquette General Hospital, the only Upper Peninsula hospital with a vascular surgery service.

Prior to Hill's arrival, a note was made in the Marquette General chart stating that the OR would be prepared and ready to perform surgery immediately upon Hill's arrival.

He was seen at Marquette General by Joel Johnson, a vascular surgeon. It was asserted that, instead of ordering a radiological consultation, calling the radiologist in Escanaba, or simply deferring to the diagnosis of the staff at St. Francis, Johnson elected to review the CT scan from St. Francis himself. After looking at the films, it was contended that he erroneously suspected Hill was suffering from a urological issue. Thus, he consulted Mering, a urologist.

It was asserted that, between the two of them, the decision was made that Hill should not be taken to surgery, but kept under observation instead. Hill was put on Mering's service.

The next morning, Mering took the CT films from St. Francis down to the radiology suite for a "curbside consult," an informal, reading of an imaging study that the consulting radiologist does not dictate and add to the patient's chart. Though the curbside consult was not revealed to plaintiff's counsel until opening statements, Mering was informed by the radiologist that Hill did not have a urological problem, but rather a vascular problem. It was contended that Mering chose not to make a note of this consultation anywhere in the patient's chart, and did not obtain further vascular surgery consultation.

On the afternoon of Aug. 13, Hill's condition suddenly worsened. A general surgery consultation was obtained, and the decision was made to take him to surgery for what was determined to be a vascular bleed. When surgery was commenced, Hill was described as "in extremis," or near death.

Though the surgeons did identify and repair Hill's right common iliac artery tear, they chose to ligate his inferior vena cava, which allows for blood return from the lower extremities. Hill became severely hypotensive and died when the physicians removed the clamp from his aorta, which sends blood down to the lower extremities.

Plaintiff argued that the delay in performing decedent's surgery was a cause of his death, because surgery could have been performed when he was stable, and likely to survive the operation. Plaintiff also argued that the ligation of his vena cava was a cause of his death.

Defendants argued that, contrary to autopsy findings, genetic testing, and clinical criteria, plaintiff's decedent suffered from a rare genetic disease known as Ehlers-Danlos syndrome, type IV; it is associated with exceedingly friable arteries, resulting in ar-

terial ruptures that happen frequently and unexpectedly, and a life expectancy of 44 years.

Plaintiff countered that, consistent with the autopsy diagnosis, the decedent suffered from a condition known as fibromuscular dysplasia, which can cause arterial rupture, but is not systemic; arteries are easily repaired; and patients who have it have a normal life expectancy.

The case was argued to a Marquette County jury until the parties agreed to a $1.55 million settlement.

Types of actions: Wrongful death, medical malpractice

Types of injuries: Delay in performing vascular surgery, resulting in death from severe hypotension

Name of case: *Estate of Hill v. Marquette General Hospital, et al.*

Court/Case no./Date: Marquette County Circuit Court; 07-45013-NH; May 26, 2011

Tried before: Jury (until settlement was reached)

Name of judge: Thomas L. Solka

Settlement amount: $1.55 million

Insurance carrier(s): Withheld

Attorneys for plaintiff: Brian J. McKeen, Phillip B. Toutant

Attorneys for defendant: Ralph F. Valitutti Jr., Daniel R. Corbet, Gregory A. Elzinga, Jonathan C. Martin

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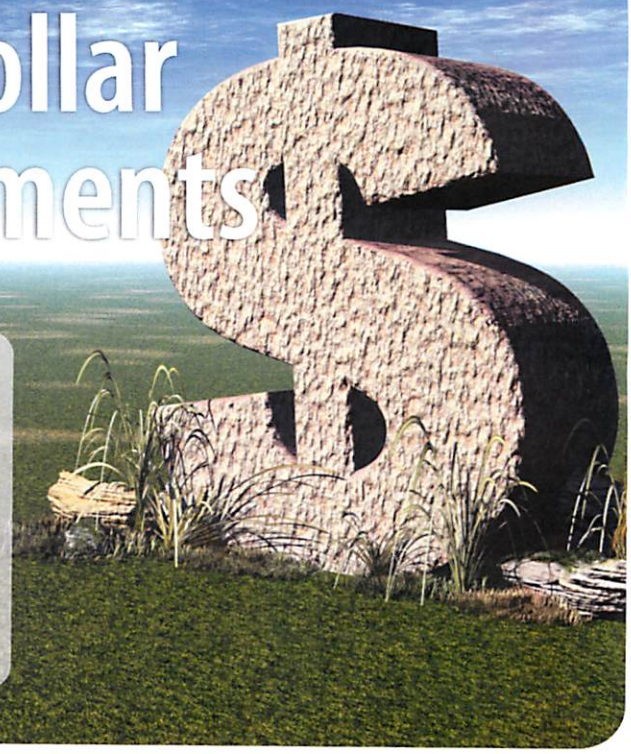
2011 Million-Dollar Verdicts & Settlements



ABOUT THIS SECTION

This section includes verdicts and settlements of $1 million or more obtained in a Michigan court in 2011 that were reported to *Michigan Lawyers Weekly* and verified on or before Dec. 22, 2011.

We would like to thank the attorneys who submitted their reports to *Lawyers Weekly* throughout 2011. While many of these reports were published in the "Verdicts & Settlements" section of the newspaper, others appear in this section for the first time.

Lawyers Weekly acknowledges that there have been other verdicts and settlements of $1 million-plus reached in 2011. This section, however, includes only those verdicts and settlements properly reported to us and verified by deadline.

If you have any questions, please contact Douglas J. Levy at (248) 865-3107 or douglas.levy@mi.lawyersweekly.com.

LARGEST SETTLEMENTS

#23

Aneurysm procedure, diminished cognitive capacity are disputed

Plaintiff says that given woman's age, other surgery was appropriate

$1.5 million

In a confidential medical-malpractice lawsuit, plaintiff patient sought compensatory damages from defendant neurosurgeon and defendant medical center on claims of severe neurological damage following an intracranial aneurysm clipping procedure.

In October 2007, plaintiff, a 70-year-old woman, was referred by her primary-care internist to a neurologist for complaints of dizziness. On Oct. 31, 2007, plaintiff underwent a magnetic resonance angiography of the brain. The study reportedly demonstrated a 4 mm right-middle cerebral-trifurcation aneurysm.

On Jan. 3, 2008, plaintiff underwent CT angiography. The study reportedly confirmed the presence of a 4mm intracranial aneurysm as well as a 2.7 mm wide-necked aneurysm. The radiology report indicated that the aneurysms were amenable to an endovascular coiling procedure.

McKeen

Plaintiff was immediately referred to defendant neurosurgeon, who recommended surgical clipping over endovascular coiling and over conservative management with observation. Although the neurosurgeon claimed he offered the patient conservative treatment and observation of her aneurysms, he repeatedly told plaintiff that the aneurysms could rupture at any time if she didn't have the clipping procedure performed.

Brackon

On Feb. 19, plaintiff underwent a right frontotemporal craniotomy and clipping of right-middle cerebral-artery aneurysm; and exploration for right-internal carotid-artery aneurysm. Though the operation seemed to take place without incident, in the

LARGEST SETTLEMENTS

hours that followed the surgery, plaintiff cognitively deteriorated.

Finally, on Feb. 20, plaintiff underwent a CT of the head that demonstrated a large subarachnoid hemorrhage. After further deterioration, another CT was performed that demonstrated "increasing prominence of a right frontal infarct with hemorrhagic transformation." Ultimately, a third CT was performed that demonstrated a "frontal intraparenchymal hemorrhage with increasing/large midline shift," and a craniotomy was performed to evacuate the intraparenchymal hemorrhage.

Plaintiff remained in the hospital and rehabilitation unit for several months. She currently requires 24-hour care and assistance at her residence.

Plaintiff asserted that, given the age of the patient, as well as the size and location of the aneurysms, an aneurysm clipping should not have been performed. It also was contended that she should have been managed conservatively or possibly considered for an endovascular coiling procedure.

Defendants asserted that the clipping procedure was proper; that the plaintiff consented to the procedure and, therefore, defendants were absolved from liability; and that plaintiff's diminished cognitive capacity was a result of dementia, not the intracranial bleed.

It was further contended that plaintiff had a limited life expectancy due to arthritis of the neck, chronic neck and back pain, gait dysfunction, a history of falls, peripheral vascular disease, hypertension, and a 40-year history of heavy smoking.

The matter settled for $1.5 million.

Type of action: Medical malpractice

Type of injuries: Severe neurological damage following intracranial aneurysm clipping

Name of case: Confidential

Court/Case no./Date: Confidential; Nov. 23, 2011

Name of judge: Withheld

Settlement amount: $1.5 million

Insurance carrier(s): Withheld

Attorneys for plaintiff: Brian J. McKeen, Derek J. Brackon

Attorney(s) for defendant: Withheld

#25

Malpractice is claimed for ruptured aneurysm

Decedent's estate: Wrong-sided craniotomy results in delay to fix it

$1.3 million

In a confidential wrongful-death/medical-malpractice lawsuit, plaintiff's decedent's estate sought compensatory damages from defendants hospital, neuroradiologist and neurosurgeon following the handling of an aneurysm.

On Aug. 6, 2007, plaintiff's decedent (patient) presented to the emergency department of a local hospital with an acute subarachnoid bleed. An interventional neuroradiologist proposed to do a cerebral angiogram with possible coiling of an aneurysm.

McKeen

Dawes

The day next, after identifying the location, the radiologist spoke with a neurosurgeon about treatment of the aneurysm, saying that because of the wide neck of the aneurysm, balloon assistance would probably be required. However, both decided that the radiologist would proceed with an attempted coiling of the aneurysm.

The radiologist then informed the operating room team that he would proceed with embolization of the aneurysm. The Hyperform balloon was reinflated, and it was noted that the patient was acutely hypertensive and bradycardic. The radiologist then informed the operating room team that the neurosurgeon needed to be notified, and a second operating room needed to be available for a possible emergent craniotomy.

An initial contrast dye injection showed diffuse spasm of the artery with slow flow throughout the left internal carotid artery, with no definitive aneurysm rupture or extravasation. The radiologist asked the operating room team to contact the neurosurgeon stat for an emergency craniotomy for aneurysm rupture.

Upon entry into the second operating room, for reasons unknown, it was erroneously determined that a right-sided craniotomy would be done, which plaintiff's estate asserted was in error, as the aneurysm was on the left side. After the craniotomy and durotomy was finished, the neurosurgeon asked the radiologist to come into the second operating room and asked which side the aneurysm was on.

According to the radiologist's dictated procedure note, he "restated" to the neurosurgeon that the aneurysm was on the left side. At that point, the right-sided craniotomy and durotomy were closed, and the patient was prepped for the left-side craniotomy. The neurosurgeon then performed clip occlusion of the aneurysm. Performance of the attempted coiling caused iatrogenic rupture of the aneurysm.

Plaintiff's estate asserted that the failure to correctly identify the proper side for the craniotomy resulted in needless delay in performing the operation that the patient desperately needed to control the bleeding into her brain due to the aneurysm.

It was added that, as a result of the delay and not properly doing the proper-sided surgery, the patient sustained permanent brain injury; it left her with permanently impaired cognitive capacity. The patient remained in this condition until her death Dec. 8, 2008.

The matter settled for $1.3 million.

Types of actions: Wrongful death, medical malpractice

Types of injuries: Brain injury, coma, death

Name of case: Confidential

Court/Case no./Date: Confidential; June 3, 2011

Name of judge: Withheld

Settlement amount: $1.3 million

Insurance carrier(s): Withheld

Attorneys for plaintiff: Brian J. McKeen, Terry A. Dawes

Attorney(s) for defendant: Withheld