CASE INFORMATION SHEET
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COUNTY AND COURT: Collier County, Circuit Civil

NAME OF CASE: Wilner Joram, individually and as Guardian of Cassandra Cadet-Joram, an incapacitated person v. Rebecca Johnson, M.D., Emergency Physicians of Naples, Jody Alexander, M.D., Wallace McLean, M.D. & Naples Community Healthcare System d/b/a North Collier Hospital

CASE DOCKET NO.: 08-9222-CA **JUDGE:** Cynthia A. Pivacek

PLAINTIFF(S) ATTORNEY(S)/TRIAL COUNSEL:

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Attorney for Naples Community Hospital

AGE/SEX/OCCUPATION OF PLAINTIFF OR DECEDENT:

Cassandra Cadet-Joram was 30 years old at the time of the incident. She was a nursing school student. Her husband, Wilner Joram, was 40 years old and brought the claim on behalf of his incapacitated wife. The couple had 3 children ages 10, 5 and 3 days at the time of the incident.

FOR WRONGFUL DEATH CASES, PLEASE GIVE AGE AND RELATIONSHIP OF SURVIVORS:

DATE, TIME AND PLACE OF ACCIDENT OR OCCURRENCE:

May 15, 2008 at Naples North Collier Hospital, Naples, Florida.

NATURE OF INJURY:

Ms. Cadet-Joram suffered anoxic brain injury as a result of cardiopulmonary arrest that occurred at Naples Community Hospital on May 15, 2008. She is incapacitated to the extent that she requires 24 hour around the clock care. She is essentially unable to speak and unable to walk or care for her children. She has severe cognitive and motor dysfunction which requires 24 hour assistance for all of her activities of daily living for the remainder of her normal life expectancy estimated by Plaintiff's experts to be 45.7 years.

Past medical expense lien at trial from Blue Cross and Blue Shield was $229,971.70 in addition to the North Collier Hospital bill of $465,786.06.

CAUSE OF INJURY:

Ms. Cadet-Joram was admitted to North Collier Hospital on May 12, 2008 under the care of Dr. Alexander to undergo an elective C-Section delivery of her 3rd child. At the time of the delivery of her second child in 2003, Ms. Cadet-Joram had experienced postpartum congestive heart failure which required hospitalization and care in the intensive care unit. With knowledge of this history, Dr. Alexander placed Ms. Joram on a regular floor as opposed to the cardiac care unit following the birth of her third child on May 12, 2008.

The pertinent medical care records reflect that on May 14, 2008 (two days post delivery) at approximately 7:00 p.m., the patient was experiencing shortness of breath and that Dr. Alexander was aware of the condition. Ms. Cadet-Joram was complaining of shortness of breath while getting out of the bed to go to the restroom. At 9:15 p.m., Ms. Cadet-Joram reported having shortness of breath while sitting in the bed. Dr. McLean, who was covering for Dr. Alexander, was notified and additional orders were received. These included a chest x-ray which showed evidence of developing pneumonia. By 10:40 p.m. that evening, Dr. McLean ordered oxygen for the patient as well as antibiotic therapy.

By 6:40 a.m. on May 15, 2008, nursing notes reflected that the patient was spitting up copious amounts of pink-tinged, foamy sputum intermittently. Dr. McLean testified he was never notified of these facts and was never notified about the prior history of congestive heart failure with the 2003 delivery. Had

he known those facts he would have come to the hospital to examine the patient.

The specific events of that morning were in dispute at trial. The nursing notes in the medical record, according to the hospital computer system, were created more than three hours after the patient's cardiopulmonary arrest that morning. The computer system showed some of the notes made by nurses were entered around 10:00 a.m. on the 15th documenting events as far back as 7:00 p.m. the night before. The credibility of these notes documenting the timing of the symptoms experienced by Ms. Cadet-Joram was the major subject of the trial.

It was essentially undisputed that the respiratory therapist was summoned to the room shortly before 7:00 a.m. the morning of the 15th and began breathing treatments. Additionally, respiratory therapy ordered the BiPap machine and requested that the SWAT team be called. The SWAT team consisted of respiratory therapy and an ICU nurse per hospital protocol. Respiratory therapy also requested that a physician come to the bedside to assist with necessary orders.

Dr. Rebecca Johnson was the emergency room physician who had reported for work at approximately 6:45 that morning. Some time soon after 7:00 a.m., she received a request for assistance on the post-partum floor. When Dr. Johnson arrived at approximately 7:15 a.m. the patient was being cared for by respiratory therapists as well as the ICU nurse. Dr. Johnson gave orders for 2 milligrams of Morphine and ordered a STAT portable chest x-ray and EKG. She also ordered blood gases to be performed. She spoke with the patient and increased the BiPap to 100% oxygen.

The charting at this time was sparse and a point of contention for Plaintiff throughout the trial. A significantly elevated blood pressure was noted over 200 in the medical chart during the time Dr. Johnson was present. During the brief time that Dr. Johnson was present, she, along with the other nurses, testified that the patient's condition improved clinically and that there was no spitting up of the pink frothy secretions.

At approximately 7:30 a.m., Dr. Johnson consulted critical care and ordered transfer of the patient to the ICU. Dr. Johnson specifically spoke with Dr. Lawrence Albert, the covering critical care specialist, who agreed with the decision to transfer the patient to the ICU. Dr. Albert indicated that he was on his way into the hospital and would see the patient shortly. Dr. Johnson also called Dr. Alexander and informed Dr.

Alexander of the intention to transfer her patient to the ICU. Dr. Alexander indicated that she was on her way into the hospital.

Dr. Johnson then informed the respiratory therapist and ICU nurse of the decision to transfer the patient and began to head back to her responsibilities in the emergency room. Prior to leaving the patient, Dr. Johnson gave an order for 25 milligrams of Phenergan. The records reflect that the Phenergan was administered at 7:50 a.m. and that the transfer of the patient to the ICU began at 7:52 a.m. By this time Dr. Johnson had returned to the emergency room.

At 7:55 a.m., the patient suffered a cardiopulmonary arrest in the corridor on the way to the ICU. A code was called and Dr. Johnson responded to the code. Dr. Johnson appeared in the ICU and attempted to intubate the patient. Dr. Johnson did not receive confirmatory readings on the capnography of proper ET tube placement and therefore she decided to extubate the patient.

Because of significant pink frothy secretions as a result of the chest compressions that were ongoing, Dr. Johnson was unable to intubate the patient on two subsequent tries. She consulted anesthesiology and Dr. John Nolan responded and successfully intubated the patient. The patient was essentially pulseless for 17 minutes before a pulse was found. Resuscitation continued and the patient was eventually stabilized, but had suffered a hypoxic/anoxic brain injury leaving her permanently functionally impaired.

Prior to trial, Drs. Alexander and McLean, and Naples Community Hospital all settled.

PLAINTIFF'S EXPERT WITNESSES:

Paul K. Bronston, M.D.
Emergency Room Medicine
1 Jib Street, Suite 202
Marina Del Rey, CA 90292

Dr. Bronston offered testimony that Dr. Johnson fell below the standard of care in the following ways:

a) Dr. Johnson should have never left the bedside. The patient was unstable and in respiratory distress. Dr.

Johnson should have stayed with her throughout transport to the ICU.

b) The order of Phenergan was contraindicated for the patient. The patient had already been given Morphine and other narcotic medication which suppressed respiratory function. This was contraindicated for a patient in respiratory distress. The patient suffered her cardiopulmonary arrest within 5 minutes of the administration of the Phenergan.

c) The order of Lasix given by Dr. Johnson in response was an insufficient dosage to assist with the significant overload and congestive heart failure occurring.

d) Dr. Johnson was negligent in failing to obtain a history from the nursing staff of the vomiting of copious amounts of pink frothy secretions.

e) Dr. Bronston was critical of Dr. Johnson's failure to timely intubate the patient in the ICU. The delay in the intubation caused additional harm and there was no reason for Dr. Johnson to be unable to intubate this patient.

Kenneth Desser, M.D. (Cardiology)
Banner Good Samaritan Regional Medical Center
Department of Cardiology
1111 E. McDowell Road
Phoenix, AZ 85006

Dr. Desser offered causation opinions concerning the case as follows:

a) Dr. Desser felt that the failure by Dr. Johnson to stay with the patient's bedside delayed care once the Code was called. Had Dr. Johnson stayed at the patient's bedside, she could have instituted aggressive medical care that was delayed by her failure to be present.

b) Dr. Desser offered the opinion that Dr. Johnson's delay intubating the patient led to additional delay in providing sufficient oxygenation to the patient.

c) Dr. Desser offered the opinion that the Phenergan that was ordered was contraindicated and caused the arrest to occur in a respiratory depressed and distressed patient. The effects of Phenergan can be seen in a matter of minutes and the patient's arrest occurred 5 minutes after it was administered.

d) Dr. Desser felt that the failure to transfer the patient earlier to the ICU resulted in the patient failing to get the appropriate care from ICU qualified physicians and nursing staff which would have prevented her Code.

Cathlin Vinett, R.N. (Life Care Plan)
Care Management Consultants
214 Overlook Circle, Suite 100
Brentwood, TN 37027

Nurse Vinett prepared a life care plan in which she indicated that the Plaintiff's remaining life expectancy of 45.7 years would require 24 hour supportive care for all of her activities of daily living. She offered three plans which included the option of CNA assisted activities, a live-in assistant or an extended care facility. The present value cost of those plans range from $5.4 million to $6.8 million.

DEFENDANT'S EXPERT WITNESSES:

Peter Hill, M.D. (emergency medicine)
Johns Hopkins Medicine
Department of Emergency Medicine
600 North Wolfe Street
Marburg B186
Baltimore, MD 21287

Dr. Hill testified that Dr. Johnson complied with the standard of care. It was his opinion that the initial assessment by Dr. Johnson appropriately noted the patient to be in respiratory distress and that it was appropriate to consult critical care medicine. The initial orders for resuscitation and support were within the standard of care and the decision to transfer the patient to ICU complied with the standard of care.

Dr. Hill did not believe that the order of Phenergan was inappropriate and in fact felt that it complied with the standard of care because of the risk of aspiration. Dr. Johnson was within the standard of care by communicating the pertinent information concerning the patient to the critical care specialist and in returning to the emergency room. Further, her efforts at attempting to resuscitate the patient during the emergency situation within the ICU complied with the standard of care. Her inability to intubate given the fulminate pink, frothy secretions did not fall below the standard of care.

John Luce, M.D. (critical care medicine)
Department of Medicine and Anesthesia
University of California, San Francisco
1001 Potrero Avenue
Room 5K1
San Francisco, CA 94110

Dr. Luce testified that the management by Dr. Johnson, including the medications prescribed, did not cause or contribute to the patient's cardiopulmonary arrest. Rather, the condition was appropriately managed but unfortunately, due to the fact that the patient's condition had deteriorated to such an extent prior to Dr. Johnson's arrival, made the subsequent arrest irreversible. Once the patient was removed from the BiPap for transport to the ICU, she arrested due to significant pulmonary edema.

CHECK APPROPRIATE SPACE: ___X__ Verdict

DATE OF VERDICT: March 17, 2010

VERDICT:

Defense verdict as to Dr. Johnson and Emergency Physicians of Naples.

COMPARATIVE NEGLIGENCE:

N/A

JUDGMENT: Final judgment for Dr. Johnson and Emergency Physicians of Naples. Entry of cost judgment pending.

DATE OF JUDGMENT: July 1, 2010

DEFENDANT'S OFFER: None.

PLAINTIFF'S DEMAND: Last demand $2,000,000.

ATTORNEY'S COMMENTS:

By Richard Mangan:

Plaintiff argued that the obstetricians involved should never have placed Ms. Joram on a regular post-partum floor. Once those defendants settled, Plaintiff then began to focus the case against the hospital and Dr. Johnson for the monitoring of the patient and the response to the respiratory distress. The hospital then settled leaving the Plaintiff to focus on the only physician to see the patient on May 15, 2008. Plaintiff argued that Dr. Johnson's failure to appropriately diagnose and treat the developing respiratory distress led to the cardiopulmonary arrest and subsequent brain damage.

Plaintiff was critical of the orders provided, the monitoring of the patient and, in particular, the order of Phenergan which, combined with the other respiratory depressant medications, provided the impetus for the arrest. Plaintiff argued that the Phenergan was administered less than five minutes before the arrest occurred and was, in essence, the final straw leading to the arrest.

With the settlement of the co-defendants, Dr. Johnson amended her affirmative defenses to allege Drs. McLean and Alexander as well as the hospital as ***Fabre*** defendants. Dr. Johnson did not present any evidence at trial of the negligence of those co-defendants but rather relied upon the testimony of Plaintiff's own experts to establish the negligence of those individuals.

Dr. Johnson withdrew her ***Fabre*** defenses and simply argued that her care was appropriate and did not seek to apportion fault to any of the former defendants.

Plaintiff requested leave of Court at the jury charge conference to place the settling defendants on the verdict form. Over the Defendants' objection, Plaintiff placed the hospital as well as Drs. McLean and Alexander on the verdict form and asked the jury to assign 1% fault to each of them with the remaining 97% of responsibility to be placed on Dr. Johnson.

In a ruling immediately preceding the trial, the trial court granted that Defendants' motion in Limine to prohibit any evidence concerning losses sustained by Ms. Cadet-Joram's three children (ages 12, 7 and 2 at time of trial) as a result of her injuries. They were not permitted to recover for any loss of parental companionship because the complaint had failed to allege specific claims for those children.

In closing, Plaintiff asked the jury to return a verdict in favor of the Plaintiff for economic damages from $5.4 to $6.8 million as set forth in the life care plan. The Plaintiff also asked for recovery of non-economic damages suggesting to the jury that that number was uniquely within their ability to decide on the exact value. The defense countered that the only appropriate verdict was for Dr. Johnson and that her care and treatment was appropriate. The defense did not address the issue of damages.

The jury returned a defense verdict for Dr. Johnson and Emergency Physicians of Naples after 37 minutes of deliberations.

Submitted By: **Richard B. Mangan, Jr.** **Date: October 18, 2010**

Firm: **Rissman, Barrett, Hurt, Donahue & McLain, P.A.**

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