CASE INFORMATION SHEET
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COUNTY AND COURT:

Brevard County Circuit Court

NAME OF CASE:

CORINA CHRISTENSEN, individually and as Personal Representative of the Estate of MATTHEW CHRISTENSEN,

Plaintiffs,

v.

EVERETT C. COOPER, M.D., and COASTAL PHYSICIAN SERVICES OF ORLANDO, INC.,

Defendants

CASE DOCKET NO.: 05-2000-CA-13703 **JUDGE:** Tonya B. Rainwater

PLAINTIFF(S) ATTORNEY(S)/TRIAL COUNSEL [full names, firm and city]:

John A. Shipley, Esquire
Searcy, Denney, Scarola, Barnhart & Shipley
West Palm Beach, FL

DEFENDANT(S) ATTORNEY(S)/TRIAL COUNSEL [full names, firm and city]:

Jennings L. Hurt III, Esquire
Henry W. Jewett II, Esquire
Rissman, Barrett, Hurt, Donahue & McLain, P.A.
Orlando, FL

AGE/SEX/OCCUPATION OF PLAINTIFF OR DECEDENT [at time of accident or occurrence]:

Decedent's name: Matthew Christensen

Date of Birth: May 14, 1969
Date of Death: June 9, 1998
Age at time of death: 29 years

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

Surviving spouse: Corina Christensen

Date of Birth: July 20, 1971
Age at time of incident: 26 years
Age at time of trial: 38 years

DATE, TIME AND PLACE OF ACCIDENT OR OCCURRENCE:

This case involved the care and treatment rendered to Matthew Christensen at the Emergency Department at Cape Canaveral Hospital in Cocoa Beach, Florida on June 8 and 9, 1998.

CAUSE OF INJURY: [factual description including allegations and defenses on liability]:

At approximately 10:24 p.m. on June 8, 1998, Matthew Christensen and his wife, Corina Christensen, were involved in a motor vehicle accident on North Courtenay Parkway in Merritt Island, Florida. Mr. and Ms. Christensen were riding a large Honda motorcycle northbound on Courtenay Parkway. They broadsided a car which had entered Courtenay Parkway from a side street after failing to stop at a stop sign.

Both Mr. and Ms. Christensen were thrown from the motorcycle. The paramedics estimated that Ms. Christensen was thrown 30 feet and Mr. Christensen was thrown 20-30 feet.

The paramedics arrived around 10:30 p.m. Mr. Christensen was awake, alert, oriented x3 and was even joking with the paramedics. Ms. Christensen appeared confused, could not recall the accident or her age, and could not tell the paramedics whether she had lost consciousness.

Mr. Christensen was morbidly obese. There was no conclusive evidence of Mr. Christensen's exact weight, but it appeared that he weighed between 350-390 lbs.

Mr. Christensen appeared to have fractures of his left and right forearm and his right femur. Splints were applied to those extremities.

The paramedics were unable to obtain a blood pressure from Mr. Christensen since they did not have a cuff large enough to go around his left leg, his only unsplinted extremity. However, Shannon McNally, the paramedic, testified that he estimated Mr. Christensen's systolic blood pressure to be between 80 and 90 since Mr. Christensen was awake and alert and had a strong carotid pulse. The paramedics also could not start Mr. Christensen on any I.V. fluids in the field.

Both Mr. and Ms. Christensen qualified as "trauma alert" patients. At the time, though, there was no trauma center in Brevard County. The nearest trauma center was at Orlando Regional Medical Center (ORMC) which was at least an hour away from the accident scene by ground ambulance.

Mr. McNally testified that he did not feel at the time that helicopter transport was a valid option since Mr. Christensen probably would not have fit into any available helicopter because of his obesity and his splinting.

Thus, the paramedics decided to transport both Mr. and Ms. Christensen to the emergency department at Cape Canaveral Hospital, which was the nearest emergency department to the accident scene.

Ms. Christensen was transported first. She left the scene at 10:47 p.m. and arrived at the hospital at 11:02 p.m. Mr. Christensen left the scene at 10:57 p.m. and arrived at the hospital at 11:09 p.m.

Mr. Christensen's delay in transport from the scene was due in large part to his size. Mr. McNally and his paramedic partner, Michael Zocchi, testified that it took six firemen to load Mr. Christensen into the ambulance. Because of his size and his splinting, he had to be loaded into the ambulance backwards.

Upon their respective arrivals, Ms. Christensen's vital signs appeared to be slightly worse than that of Mr. Christensen. Ms. Christensen's pulse was 138, respirations were 34, blood

pressure was 111/69, and her oxygen saturation was 92% on 100% oxygen with a non-rebreather mask.

Mr. Christensen's vital signs upon arrival were a pulse of 128, respirations of 28, blood pressure 108/72, and 96% oxygen saturation on two liters of oxygen via nasal cannula.

Mr. Christensen's blood pressure on arrival was an important factor in the case because it showed that he was not significantly hypotensive. Since Mr. Christensen had received no I.V. fluids from the paramedics, Mr. Christensen's relatively normal blood pressure on arrival 45 minutes after the accident weighed against any significant internal bleeding.

The Cape Canaveral Hospital Emergency Department was staffed at the time by defendant, Dr. Everett Cooper. He was assisted by Bill Cross, a physician assistant, and several nurses.

The Cape Canaveral Hospital ED was a community hospital ED and not a trauma center. Consequently, at that time of night, there was no surgeon, anesthesiologist, OR team, interventional radiologist or CT technician in the hospital. If any of these persons were needed to evaluate or treat a trauma patient at this time of night, they had to be called from home.

Upon Dr. Cooper's initial evaluation, it appeared that Ms. Christensen had the more potentially life-threatening injuries. It was undisputed that Ms. Christensen was confused, indicating a potential head injury. Further, she complained of significant chest pain, with several witnesses testifying that they heard Ms. Christensen screaming about the pain in her chest.

The initial x-ray of Ms. Christensen's chest showed changes consistent with bruising of the lungs, plus a potential injury to her mediastinum. This raised the possibility of an injury to her thoracic aorta, which can cause a patient to die within a very short period of time. In contrast, Mr. Christensen continued to be awake and alert, indicating good perfusion to his brain. Overall, Mr. Christensen appeared to be hemodynamically stable.

On physical examination, Dr. Cooper found Mr. Christensen had bruising, scrapes, and tenderness in his upper abdomen and lower chest. Ms. Christensen had bruising and scrapes in the same areas.

Dr. Cooper also suspected that Mr. Christensen had a pelvic fracture. Mr. Christensen complained of pain on pelvic rocking. However, because of Mr. Christensen's large size, Dr. Cooper could not be sure of a pelvic fracture.

Dr. Cooper ordered CT scans of the head, cervical spine, chest, abdomen and pelvis for both Mr. and Ms. Christensen. However, since Cape Canaveral Hospital only had one CT scanner, Dr. Cooper had to decide which patient to send to the CT scanner first.

Dr. Cooper chose to send Ms. Christensen first because she appeared to have the more potentially life-threatening injuries than Mr. Christensen. Further, it appeared Mr. Christensen was stable enough to wait on the CT scan. Finally, Dr. Cooper was concerned that Mr. Christensen's weight might exceed the CT scanner's weight limit.

Ms. Christensen was sent to the CT scanner at 11:55 p.m. She did not return to the ED until 1:00 a.m. The CT scan of Ms. Christensen's chest showed an anterior mediastinal hematoma. The radiologist, Dr. Douglas Gordon, reported that an acute aortic traumatic injury could not be excluded, given Ms. Christensen's history of severe trauma. Dr. Gordon recommended thoracic aortography for further evaluation.

Dr. Gordon subsequently attempted a thoracic aortogram to rule out an aortic tear. He was unable to pass the catheter into the ascending aorta. Dr. Gordon's inability to pass the catheter was strongly suggestive of an aortic tear.

Consequently, Dr. Cooper, Dr. Gordon, and Dr. Matthew Lube, the on-call general surgeon, decided to transfer Ms. Christensen to Orlando Regional Medical Center for further workup concerning the potential thoracic aortic tear. She was transported by helicopter at 4:50 a.m. Subsequent testing at ORMC showed that Ms. Christensen did not have an injury to her thoracic aorta.

In the meantime, Mr. Christensen continued to be awake, alert, and hemodynamically stable. Dr. Cooper had ordered tests to determine whether Mr. Christensen had suffered any injuries to his internal abdominal organs and whether there was any blood within his abdomen. These tests included the CTs of the abdomen and pelvis, as well as blood tests such as CBC, hepatic and renal panels, and amylase and lipase (pancreas). The pelvic CT was also intended to address the potential pelvic fracture.

Dr. Cooper had ordered a standard I.V. fluid challenge for Mr. Christensen in accordance with the Advanced Trauma Life Support Guidelines. At 11:10 p.m., an I.V. was placed in Mr. Christensen's right shoulder, and a liter of normal saline was started, wide open. At 11:25 p.m., a second I.V. was placed in Mr. Christensen's left shoulder, with a liter of D5LR, wide open.

At 12:00 a.m., another liter of normal saline was started in the right shoulder after the first liter had been completed. At 12:10 a.m., the liter of D5LR into the let shoulder had been completed, and that I.V. site was hep-locked.

Thus, within an hour of Mr. Christensen's arrival at the ED, he had received more than two liters of I.V. fluid. He remained awake, alert and hemodynamically stable, indicating that he had responded well to the I.V. fluid challenge.

Mr. Christensen's blood pressure was being monitored by a cuff on his lower left leg. In order to obtain a more reliable blood pressure, Dr. Cooper ordered an arterial line placed in Mr. Christensen's right radial artery. The A-line was placed at 12:00 a.m. and at 12:10 a.m., it showed a blood pressure of 110/43, which was within normal limits. This was further evidence that Mr. Christensen was responding well to the I.V. fluid challenge.

Additionally, beginning at 12:00 a.m., Mr. Christensen began drinking oral contrast in preparation for his CT scans. This indicated that Mr. Christensen was awake, alert and able to follow commands, which further indicated that his brain was receiving adequate perfusion.

At 12:14 a.m., Mr. Christensen's condition suddenly and unexpectedly began to change. Despite an oxygen saturation of 98%, Mr. Christensen began to report that he was having trouble breathing. He also began thrashing, requiring the staff to hold him down.

Dr. Cooper was at bedside at this time. It was not clear to Dr. Cooper what was occurring with Mr. Christensen. Dr. Cooper ordered the administration of a sedative, Droperidol, to calm Mr. Christensen. This was administered at 12:25 a.m.

Shortly thereafter, Mr. Christensen became unresponsive, bradycardic and hypotensive. Dr. Cooper then began to resuscitate Mr. Christensen, starting with the placement of an

endotracheal tube. After Mr. Christensen was intubated, Dr. Cooper then attempted to place a central line for the delivery of fluids. However, because of Mr. Christensen's obesity, the central line was not placed successfully until 12:50 a.m.

Around this time, Dr. Cooper spoke with Dr. Lube, the on-call physician, by phone. Dr. Lube then came to the emergency department, arriving at bedside around 1:10 a.m. As Mr. Christensen was no longer stable and was incapable of going to the CT scanner, Dr. Lube performed a diagnostic peritoneal lavage (DPL), which was grossly positive for blood.

Dr. Lube then ordered the OR team to be assembled for an emergency trauma laparotomy. It took an hour for the team to assemble at the hospital. Mr. Christensen was then taken to the OR at 2:10 a.m.

Dr. Lube reported that the trauma laparotomy was technically difficult because of Mr. Christensen's obesity. Upon entry into the abdomen, he found between 2.5 and 4.0 liters of blood. He also found a large retroperitoneal hematoma, presumably from the pelvic fracture.

Dr. Lube was unable to immediately assess Mr. Christensen's spleen because Mr. Christensen's stomach was quite distended. The anesthesiologists were unable to decompress the stomach using an NG tube, so Dr. Lube had to cut the stomach open and suction its contents.

Dr. Lube was able to access the spleen, which he described as a "Grade V" fracture. Dr. Lube performed a splenectomy and ligated the splenic vessels. He also removed a section of Mr. Christensen's small bowel due to an injury in the blood supply to that section of bowel.

Dr. Lube did not address Mr. Christensen's pelvic fracture or the retroperitoneal hematoma. His plan was to have Dr. Gordon, the interventional radiologist, perform angiography and possible embolization of the pelvic arteries, if necessary. However, Mr. Christensen's condition was so poor that these procedures never took place before Mr. Christensen died at approximately 9:00 a.m. on June 9, 1998.

PLAINTIFFS' LIABILITY AND CAUSATION CLAIMS:

This case was controlled by the (1999) Florida Good Samaritan Act, Section 768.13(2)(b), ***Fla. Stat.*** Consequently, the

standard applied to Dr. Cooper's actions was "reckless disregard" as defined in the statute, and not ordinary medical negligence.

According to the statutory definition, a physician acts with "reckless disregard" if he knew or should have known at the time of his treatment that his conduct would likely cause injury or harm to the patient. Plaintiff conceded that Dr. Cooper did not have actual knowledge at the time that the treatment would likely cause Mr. Christensen's death. Plaintiffs proceeded under the "should have known" part of the definition.

Dr. Frank Baker, Plaintiffs' emergency medicine expert, testified that Dr. Cooper had acted with "reckless disregard" in the following areas:

a. Within 10-15 minutes of Mr. Christensen's arrival at the ED, Dr. Cooper should have concluded that Mr. Christensen had a splenic injury that required surgical intervention. Thus, Dr. Cooper should have called a surgeon within that period of time. Dr. Cooper acted with reckless disregard when he did not call the surgeon at that time.

b. Dr. Cooper should not have ordered CT scans of Mr. Christensen's abdomen and pelvis. Instead, Dr. Cooper should have either performed a DPL himself, or had a surgeon do it. Dr. Baker said Mr. Christensen was too unstable to go to the CT scanner, and that a DPL was the only diagnostic tool available to determine whether Mr. Christensen was bleeding from injuries to abdominal organs.

c. Dr. Cooper should have begun transfusing Mr. Christensen with "universal donor" blood immediately after his assessment of Mr. Christensen.

d. Dr. Cooper should not have administered Droperidol after Mr. Christensen began agitated. Instead, Dr. Cooper should have paralyzed Mr. Christensen and intubated him.

Dr. Kenneth Swan, Plaintiffs' trauma surgery expert, testified as to causation. Dr. Swan said that if Dr. Cooper had called a surgeon within 10-15 minutes of Mr. Christensen's arrival, the surgeon would have not only agreed to come to the ED to see Mr. Christensen, but he would have arrived within ten minutes. The surgeon would have then performed a DPL and decided to take Mr.

Christensen to surgery. Dr. Swan said that Mr. Christensen would have then survived, more likely than not.

DEFENDANTS' LIABILITY AND CAUSATION CASE:

Dr. Cooper and **Dr. William Spangler**, Defendants' emergency medicine expert, both testified that Dr. Cooper's care was reasonable and appropriate and certainly not reckless disregard. During the first hour of Mr. Christensen's admission to the ED, he was hemodynamically stable, as evidenced by the fact that he was awake, alert and responding well to the I.V. fluid challenge.

Because Mr. Christensen was hemodynamically stable during his first hour in the ED, Dr. Cooper and Dr. Spangler testified that there was no reason for Dr. Cooper to call a surgeon. Based on their experience in community hospital EDs, the surgeon probably would not have agreed to come to see Mr. Christensen until after the CT scan was performed.

Dr. Michael Cheatham, the defendants' trauma surgery expert, agreed that if Dr. Cooper had called a surgeon within 10-15 minutes of Mr. Christensen's arrival, the surgeon probably would not have come to the ED to see Mr. Christensen. Dr. Cheatham actually trained Dr. Lube during Dr. Lube's general surgery residency at Orlando Regional Medical Center. Dr. Cheatham said that even if Dr. Lube had been called by 11:25 p.m., he probably would not have agreed to see Mr. Christensen in the ED until the CT scans had been performed.

Further, Dr. Cheatham testified that even if Dr. Lube had agreed at 11:25 p.m. to see Mr. Christensen in the ED, he would not have arrived within ten minutes. More likely than not, a reasonable general surgeon like Dr. Lube would not have come in for another 30-45 minutes.

Dr. Cheatham then testified that even if a reasonable general surgeon such as Dr. Lube had arrived in the emergency department by 11:35 p.m., as contended by Plaintiffs' experts, the surgeon still would have waited on a CT scan since Mr. Christensen was hemodynamically stable and able to wait on the CT scan. Dr. Cheatham said that a reasonable general surgeon would certainly not have performed a DPL on Mr. Christensen at that time.

Dr. Cheatham, Dr. Cooper and Dr. Spangler all testified that a DPL is never performed on a hemodynamically stable patient if a CT scan is available. DPL is a non-specific test that does not

identify the source of the blood within the abdomen, nor the extent of any injuries to the internal organs. In contrast, a CT scan is very specific as to identifying the injured internal organs, the degree of injury to the internal organs and the amount of bleeding.

Dr. Cheatham, Dr. Cooper and Dr. Spangler all explained that surgery is to be avoided if at all possible, particularly on patients such as Mr. Christensen who are morbidly obese and have pelvic fractures. Thus, so long as the patient is awake, alert, and hemodynamically stable, the reasonable general surgeon will wait on a CT scan and not perform a DPL.

Dr. Cheatham then testified that even if a surgeon had decided at 11:45 p.m. to take Mr. Christensen to surgery for a trauma laparotomy, it would have taken at least an hour to assemble an OR team, and Mr. Christensen's sudden and unexpected collapse at 12:14 a.m. would not have been avoided.

Dr. Cooper, Dr. Spangler and Dr. Cheatham all testified that it would have been improper to administer blood to Mr. Christensen during the first hour in the ED, contrary to Dr. Baker's testimony. The ATLS protocols state that a patient should receive an I.V. fluid challenge, and if the patient responds positively to the challenge, then blood is not to be given. Dr. Cheatham testified that giving blood during the first hour would not have changed the outcome of the case.

Dr. Cooper and Dr. Spangler testified that giving Mr. Christensen Droperidol in response to his agitation at 12:14 a.m. was reasonable and appropriate since Mr. Christensen needed to be sedated. Dr. Cooper, Dr. Spangler and Dr. Cheatham testified that using any other sedative would have resulted in the same outcome.

Dr. Cooper, Dr. Spangler and Dr. Cheatham testified that paralyzing and intubating Mr. Christensen in response to his agitation would have been inappropriate. Mr. Christensen would have definitely stopped breathing had he been paralyzed. Mr. Christensen's obesity indicated, in foresight, that he might have been difficult to intubate. Dr. Cheatham testified further that paralyzing Mr. Christensen would have worsened his hemorrhagic shock because Mr. Christensen's body would have relaxed, thereby removing any remaining ability to maintain his blood pressure.

Dr. Cheatham also testified that Mr. Christensen would have died regardless of the treatment that he received at Cape Canaveral Hospital given the nature of his injuries and the services available at Cape Canaveral Hospital that evening. In fact, Dr. Cheatham testified that Mr. Christensen probably would not have survived even if he had been taken to ORMC's Level I trauma center.

Dr. Cheatham testified that Mr. Christensen's large "open book" pelvic fracture meant that the bleeding from that pelvic fracture was probably Mr. Christensen's primary problem. Calling a general surgeon to perform a splenectomy would not have addressed the bleeding from the pelvic fracture. An interventional radiologist would have still been needed to stop the acute bleeding.

Finally, Dr. Cheatham testified that due to Mr. Christensen's morbid obesity, he was at significant risk for potentially fatal post-operative complications, even if he could have been successfully treated surgically.

NATURE OF INJURY [please be specific concerning injuries, treatment and medical testimony]:

Mr. Christensen died on June 9, 1998 of multi-organ shock caused by blood loss.

PLAINTIFF'S EXPERT WITNESSES [include full name, degree, specialty and city]:

Frank J. Baker, M.D. - emergency medicine
St. Luke's Medical Center, Rush Medical College
89 Timber Court
Oakbrook, IL 60523

Kenneth Swan, M.D. (by video) - trauma surgery
University of Medicine & Dentistry of New Jersey
90 Bergen Street
Newark, NJ 07103

Patricia Pacey, Ph.D. - forensic economist
Pacey Economics, Inc.
6688 Gunpark Drive
Suite 200
Boulder, CO 80301

DEFENDANT'S EXPERT WITNESSES [include full name, degree, specialty and city]:

William Spangler, M.D. – emergency medicine
216 East Cowan Drive
Houston, TX 77007-5024

Michael Cheatham, M.D. – trauma surgery
86 W. Underwood St.
Suite 201
Orlando, FL 32806

CHECK APPROPRIATE SPACE:

_____X_____ Defense Verdict

DATE OF VERDICT: January 25, 2010

VERDICT AMOUNT

Not Applicable

COMPARATIVE NEGLIGENCE [if applicable]:

Not Applicable

JUDGMENT:

Pending.

DATE OF JUDGMENT:

Pending.

DEFENDANT'S OFFER:

No offer to settle was made on behalf of Dr. Cooper and Coastal Physician Services.

PLAINTIFF'S DEMAND:

Plaintiffs' last demand before trial was $750,000 in a Proposal for Settlement on March 10, 2008. At trial, Plaintiffs asked for $2.45 million in damages, consisting of $1 million in economic damages and $1.45 million in non-economic damages.

ATTORNEY'S COMMENTS:

Plaintiffs have agreed to not appeal the defense verdict in exchange for the defense's agreement to waive any claims for fees and costs.

This was the fourth time this case had been to trial. A mistrial had been declared in September 2004 because of Hurricane Fran. The second trial in December 2005 ended with a directed verdict for the defense after the trial court ruled that the Plaintiffs' emergency medicine expert at the time, Dr. James Niemann, had improperly equated reckless disregard under the Good Samaritan Statute with ordinary negligence.

The 5th DCA subsequently reversed the defense judgment in ***Christensen v. Cooper***, 972 So. 2d 207 (Fla. 5th DCA 2007). The 5th DCA ruled that because Dr. Niemann had used the "magic words" in testifying that Dr. Cooper had acted with reckless disregard, the case should have gone to the jury.

The trial was started a third time in April 2009, but a mistrial was declared during jury selection because one of the potential jurors knew Dr. Cooper and spoke favorably of him. At that point, there was not enough time to pick and empanel another jury, and then have the case tried before the end of the trial docket.

Submitted By: **Jennings L. Hurt III**
Henry W. Jewett II

Date: February 5, 2010

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

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