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**SUPERIOR COURT OF THE STATE OF CALIFORNIA FO THE COUNTY OF LOS ANGELES - CENTRAL DISTRICT**

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| Plaintiff,  vs.  Defendants. | ) ) ) ) ) ) ) ) ) ) ) ) ) ) )  ) | Case No. BC503410  [Assigned for all Purposes to the Hon. Teresa A. Beaudet, Department 97]  **PLAINTIFF'S MEDIATION BRIEF**  Date: July 27, 2015  Time:10:00 a.m.  Judicate West, Jay C. Horton, Esq.  Date Action Filed: 3/20/2013  Trial Date: 6/29/2016 |

PARTIES AND COUNSEL

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| Plaintiff | GARY N. STERN |

INTRODUCTION/SUMMARY

Plaintiff is a tracheotomy dependent quadriplegic due to the negligence of the defendants in this case in failing to diagnose and promptly treat a Spontaneous Cervical Epidural Hematoma that, under Defendants' watch, slowly compressed and eventually irreversibly damaged his spinal cord at C3-C6. He became a quadriplegic over the course of one day spent in the Emergency Department (ED) at \*\*\* Medical Center, January 13, 2012. The day before, he was a normal high school student, age 17, looking forward to college and the type of rich, rewarding life that this young man of Honduran descent was working toward, earned and deserved. Because the health care providers he never met prior to January 13, 2012 failed to provide the prompt and competent medical interventions he sought on an emergency basis on January 13, 2012, by January 14, 2012, he faced life as a wheelchair dependent, tracheotomy assisted quadriplegic human being.

Plaintiff arrived at the Emergency Department (ED) of \*\*\* Medical Center (CHMC) via ambulance at 9:26 a.m. He remained undiagnosed and untreated for over 10 hours. Defendants in this case failed to follow, implement or seemingly care about standards of care for what was a neurosurgical emergency from the moment Jose arrived in the Emergency Department. Plaintiff’s presentation suggested that a life threatening space occupying lesion had to be at the top of the differential list and thus the patient required an immediate MRI yet one was not done for 8 hours.

A series of negligent acts and omissions to act on the part of an emergency room doctor, nurse, consulting neurologist, radiologist and hospitalist combined to cause Plaintiff to become a permanent quadriplegic with a tracheotomy. All of these health care practitioners were chosen by MC to care for Jose and thus MC is also responsible for their negligence. See Mejia v. Community Hospital of San Bernardino (2002) 99 Cal.App.4th 1448; Whitlow v. Rideout Memorial Hospital - filed June 9, 2015, Third District, Cite as 2015 S.O.S. 2896.

STATEMENT OF THE CASE

Plaintiff, age 17 in January 2012, was an excellent student at \*\*High School, quiet, serious, studious and popular among his peer group. He was an artistic young man, who had played a bit of soccer and occasionally skateboarded, but otherwise enjoyed school, his friends and most of all his family.

In 2011, he experienced some minor, transient neck pain. On a couple of occasions in 2011, he presented to his primary care clinic at the MC, but by the time he arrived at the clinic, the pain had subsided. He was basically told that his pain was likely muscle strain caused by long periods of time carrying a student backpack. On January 13, 2012, Plaintiff woke up in the middle of the night with severe neck pain that this time did not go away. He had not experienced any recent trauma. He had not been ill. He had not been suffering from any form of infection. His mother decided to take him to the urgent care clinic at Hudson. He independently showered, dressed, ate breakfast, walked downstairs unassisted to his mother's car, then got in the back seat to stretch out. On the drive to the clinic, he complained of increasing, debilitating neck pain. His mother pulled over and called an ambulance which took him to Medical Center where he had not previously sought any health care. The EMT records noted the severe pain, but no other findings. The EMT's both testified that if there was any indication of an inability to move; any suggestion of paralysis, they would have noted it in their records. No such observation was made by the EMT's, who recorded a maximum, normal Glasgow Coma Scale. All they said in their EMS record, a copy of which was given to the MC ED staff was "complains of neck and back pain, no visible trauma; patient found sitting in car, stated been having pain for some time, no fall or injury, dispatched as...non-emergency, non-traumatic back pain." The paramedics of course were not trained with the "worst first" mantra that is the hallmark of emergency room care, but what they did know is that Plaintiff exhibited absolutely no signs of paralysis as he arrived at Medical Center.

P arrived at MC at 9:26 a.m. with no attention paid to him until 9:39 a.m. He was assigned as a Emergency Department Level 4 patient (5 being of least concern, 1 being of greatest concern). The Level 4 assignment was in direct violation of MC's own ED admission priority protocols. The Level 4 assignment was never amended despite the obvious serious symptoms that manifested throughout Jose's over 10 hours in the Emergency Department.

P was triaged at 9:39 a.m. by a MC RN with severe neck pain, but no findings suggesting any paralysis or developing reduction in sensory or motor function. He was not seen further by anyone until 10:25 am. The Emergency Department record contains an entry at that time by an ER doctor who saw P in the hallway. This was the defendant \*\*\*, M.D. She wrote: "He states neck pain worse with ROM (but moves neck without distress), and has now developed total body weakness en route in car with mother...Reflexes trace but intact bilat LE. Pt. not moving UE or LE to command, not withdrawing to pin pricks..." The ER doctor did not again see the patient until 11:37 a.m.

A CT scan of the cervical spine was ordered and blood work was ordered. The CT scan of the neck was completed at about 10:45 a.m. and read as negative, even though it turns out that the actual films in fact reveal the existence of a cervical epidural hematoma at C3-6, a life threatening space occupying lesion. Defendant radiologist Dr. B either missed it completely or never actually looked at the films

At 12:58 p.m., an MRI was ordered. But then at 1:02 p.m., Dr. F conferred by telephone with a neurologist, Defendant Dr. L, who recommended a lumbar puncture and that the MRI was not emergent and could wait. Dr. L never sought to review the chart, never sought to review the blood work, never sought to personally review the radiographs, never sought to meet or examine the patient. He also made it clear in recent deposition testimony that the CT scan was the first priority test and that its negative reading placed "space occupying lesion" down on the differential list. This despite the overwhelming acceptance in the medical community that the standard of care for this patient's presentation of unexplained, non-trauma based severe neck pain was the immediate performance of an MRI, not a CT scan.

Dr. F and Dr. L both agreed that every order for a patient in the ER was a "stat" order. Yet the 12:58 MRI order was not carried out until 5:31 p.m. Then, no doctor sought to learn the results of that MRI until after 6:45 p.m. Dr. F wrote a note shortly after 7:00 p.m. saying she had to go to Radiology herself to look at the film since no one had reported to her as yet. The MRI was read as showing a C3-C6 spinal mass, rule out hematoma. A neurosurgeon, Dr. L, was called in and ordered emergency decompression surgery to try to save the spinal cord from the pressure that had been building on the spinal cord since about 1 hour AFTER the patient arrived at the ER.

But the evening of January 13, 2012 was too late. Furthermore, postoperatively, P required a tracheotomy which remains in place. He will live the rest of his life as a quadriplegic.

P and his family (mother, two brothers) have testified in deposition that P tried not to move his body during the day in order to prevent the neck pain from getting worse. P said that in the early afternoon, in the presence of others, he made the sign of the cross with regard to a prayer for recovery. The testimony by Plaintiff and his family calls into question the credibility and accuracy of the computerized emergency department chart entries,

CONTENTIONS/SPECIAL LEGAL PRINCIPLES

DEFENDANT MC

P's presenting history required a "worst first" approach to differential diagnosis in which a space occupying lesion involving the spinal cord had to be at the top of the differential list. In that instance, an immediate spinal MRI was the standard of care.

The urgency of P's presenting condition was not recognized by the medical staff at MC, the first of so many violations of the standard of care. It was unconscionable to allow this young man with severe, non-traumatic neck pain and no prior illness history to wallow on a gurney in the hallway of the ED for one hour following his arrival at the MC emergency department. Of note is that he was triaged at 9:39 a.m. by a MC nurse and found to have no sensory or motor deficits in his arms or legs. But the mystery of the neck pain should have led the hospital health care team to have "space occupying lesion" at the top of the differential list, requiring an immediate MRI and preparation of the OR for emergency surgery, with the recognition that time would be of the essence. Instead, P was then not seen by any doctor until 10:25 a.m. when Defendant Dr. F saw P in the hallway. Her observations are noted above. She then ordered the wrong imaging, a CT scan, which, nevertheless, DID happen to show, clearly and explicitly, the evidence of a cervical epidural hematoma. The CT scan was performed at about 10:45 a.m. and either was never actually read by the radiologist Defendant Dr. B (an agent of the hospital and an agent of Defendant Medical Group) or woefully misread as negative.

As for the MRI that should have been immediately ordered following triage, a series of chart entries in this case demonstrate a serious and outrageous breach of protocol and standards of care.

* P's reported neck pain complaints were noted as 10 out of 10 at 9:40 a.m. and again at 12:21 p.m.; the very next pain complaint notation was ZERO at 12:58 p.m.
* Dr. F issued her order for an MRI at 12:58 p.m. She claims that all staff in the ED understood that every and any order she issued in the ED was a "stat" order.
* Three minutes earlier, at 12:55 p.m., Dr. F also issued an order to her ED unit secretary to find out who the admitting doctor will be for Jose P; The unit secretary wrote in the chart that he completed the order at 4:26 p.m., but Dr. F agreed that Mr. \*\* may have informed her as to the identity of the admitting doctor (Defendant Dr. P) hours earlier;
* On January 15, 2012, three days after the events that caused P to become a quadriplegic, Dr. P chose to write a "late note" in the progress records. The note says: "when first called by Dr. F, I stated patient was to remain in ER so MRI could be done STAT. As soon as MM result gotten, I called Dr. L." Dr. P testified at his deposition that the phone call to him from Dr. F was between 5:00 p.m. and 6:00 p.m., January 13, 2012. He testified this was the first time he heard of the patient P and his presence in the ED;
* Dr. F testified that her call to Dr. P may have been earlier than 5:00 p.m.; in fact hours earlier. She also testified that Dr. P never told her to get an MRI "stat;" she told him she had ordered an MRI "stat."
* The MRI ordered by Dr. F at 12:58 p.m. was done at 5:31 p.m. according to the time stamp on the actual films (Defendant Nurse 's note says P "left for MRI" at 5:53 p.m. and was back from the MRI at 6:45 p.m.)
* The MRI was recorded on computer; the films were available to read soon after 5:31 p.m.
* Dr. F had heard nothing about the MRI results as of 7:04 p.m., so she went to the computer herself at that time, noting "no call from radiology yet"; she then learned that the MRI showed a C3-5 mass v. infection; that Dr. P was

"aware" and that neurosurgery was being brought in.

The medical staff at MC did not have to immediately know that the patient had a

Spontaneous Spinal Epidural Hematoma (SSEH), but they were required to think "space occupying lesion" from the outset, requiring an immediate MRI to rule out that "worst first" differential. P did not receive the urgent MRI he needed and the immediate surgical intervention that would have saved him from a life as a trach dependent quad.

The failures of standard of care were:

* Inappropriate triage by the Emergency Department nurse
* Failure to assign appropriate priority (Level 2 — emergent). The wrongly assigned Level 4 status (non-urgent) set the pace for the remainder of P's care;
* Inappropriate amount of time spent in the ED hallway
* Inappropriate passage of time before seen by a physician
* Failure of physician to utilize effective differential diagnosis skills based on history and physical;
* Unwarranted emphasis on infectious state
* Failure to timely order a stat MRI and make sure it was done stat;
* General failure to re-prioritize case as urgent;
* Failure on the part of the RN's to properly assess and reassess the patient;
* Failure to follow the established chain of command to re-prioritize the case as urgent
* Inappropriate passage of time before neurology consult;
* Inappropriate differential diagnosis on the part of Neurologist Defendant Dr. L, an agent of the hospital;
* Needless performance of a lumbar puncture that likely made the hematoma worse;
* Failure of hospital to expedite surgery;
* Allowing over 10 hours to pass before coming to a diagnosis and an order for emergency surgery.

P's symptoms were not consistent with Guillain-Barre Syndrome, not consistent with meningitis (with the exception of neck pain), and not consistent with a psychological disorder, yet this was Dr. F's first approach to the differential. This type of clinical presentation required a concern about a possible spinal cord injury where there was still a significant window of opportunity to avoid catastrophe. An MRI was the diagnostic procedure of choice and was the standard of care for this patient upon his arrival at the ED.

At 10:44 a.m., Nurse B charted that the patient could not move, and at 11:17 she charted that the patient had no sensation in his arms and legs. Where were the alarms, the bells, the whistles? The priority level had to change and the nursing plan of care modified.

MC is liable for all negligent acts committed by Defendants Dr. F (her employer \*\*\*Emergency Physicians), Registry (its employee Nurse B), Dr. B (its employer Medical Group), Dr. L (his employer Medical Group) and Dr. P, based upon the ostensible principal/agency relationship recognized by the cases of Mejia v. Community Hospital of San Bernardino (2002) 99 Cal.App.4th 1448; Whitlow v. Rideout Memorial Hospital - filed June 9, 2015, Third District, Cite as 2015 S.O.S. 2896.

In the present case it is noteworthy that the emergency department admission form was not signed by P's mother until 12:28 p.m. (he arrived in the ED at 9:26 a.m.); the hospital admission form was signed at 6:06 p.m. Furthermore, while certain procedure consent forms were in Spanish, the alleged ED and hospital admission forms were only in English. Ms. R speaks and understands Spanish. There is no notation anywhere in the chart that admission forms were explained to Ms. R. These forms were presented during a highly stressful and painful time when neither P nor his mother could possibly understand the legal distinctions allegedly set forth in the admission forms. Ostensible agency applies to this case with regard to MC. MC is liable for the negligent acts and omissions of the other defendants in this case as well as its own admitted employees in its emergency department and hospital.

Dr. F

Dr. F breached the standard of care for an emergency room physician. She was negligent in not being aware of the patient's arrival via ambulance at 9:26 a.m. and then not seeing the patient at all until 10:25 a.m. She was negligent in failing to order an MRI and making sure it was actually carried out STAT. She was negligent in failing to adequately address a proper differential and then heading down a path that the patient's symptoms and test results did not support. She knew all along that a space occupying cervical lesion had to be at the top of the differential list and yet did not timely and immediately seek out a specialty consultation and regardless of what she learned about the results of a CT scan, negligently failed to order the definitive diagnostic tool, the MRI. Dr. F was negligent in failing to recognize that this was a neurosurgical emergency from the first triage, which required an immediate MRI and actions to ready the OR for emergency neurosurgery. Dr. F was in charge of this patient for nearly 10 hours. To allow him to be characterized in the chart as lacking in motor and sensory function and yet not make sure an MRI was performed stat, where the definitive diagnosis would then have led (or should have led) to immediate emergency decompression surgery was below the standard of care; an MRI order at 12:58 was itself unreasonably late; to then not have that MRI performed until 5:31 p.m. is inexcusable.

Dr. L:

Dr. L failed in virtually every way possible to meet the standard of care for a consulting neurologist with a patient in the ED with the signs, symptoms and overall condition of P. A CT scan was NOT the preferred diagnostic tool. The MRI is the definitive, universally accepted test for the presentation in this case and any suggestion otherwise ignores established medical science. Dr. L was negligent in making no effort to review the chart, review the radiology, review the labs, and see the patient before weighing in with recommendations and a plan of action. Dr. F has testified under oath that she wrote this note at 1:02 p.m., characterizing Dr. L's statements to her: "he recommends LP [lumbar puncture] and then admit for MRI c-spine...he states MRI not emergent." Dr. F testified in her deposition (86:8-9) that she understood Dr. L to say to her "do the lumbar puncture and then the MRI." Dr. F then inexplicably said she did not know if Dr. L said a particular order (despite the common sense phrase "and then"), but she did say that she wrote "MRI not emergent" because that is what Dr. L said. Dr. L denies that he ever said to Dr. F that an MRI was not emergent. Yet of note is that Dr. L made it quite plain in his deposition testimony that he placed great importance on learning a cervical CT scan was read as negative, thus sending the notion of a space occupying lesion down on his differential list, an analysis that is simply not the standard of care for neurologists in this or any community.

From the perspective of neurology and neurosurgery, it is well known that the faster one operates in the face of such a diagnosis, the better. There is a general consensus that for such a patient with a history as presented by P, with no evidence of reduction in sensory or motor function in the ambulance on the way to the hospital or in the first hour in the ED, one has a several hours window of opportunity to get the patient into surgery where more likely than not, full on quadriplegia and a tracheotomy will be avoided. Here, decompression did not start happening until over 12 hours after P's presentation to the ED.

Nursing Registry/Nurse B

MC had detailed protocols requiring a nurse to go up the chain of command where a patient's needs are not being met. Nurse B never thought about these protocols because she was negligent herself in failing to document complete examinations of the patient and in failing

to recognize and act on the many delays P experienced as he prayed for a health care provider to pay proper attention to his needs.

Dr. B , Radiologist.

Dr. B was charged with the responsibility of reading and interpreting the CT scan at 10:42 a.m. He either did not actually read the films or missed a rather straightforward presentation. The CT scans clearly show the worrisome collection of fluid that should have been read as demonstrating a spinal epidural hematoma. It is assumed that Dr. B had the proper equipment for review of such films in a Level 2 trauma center. It is assumed that he had the proper software, soft tissue windows and views.

Medical Group

This medical group had a contract with Dr. B, although it was only an oral agreement. MC contracted with \*\*\* to supply radiologists for MC's radiology department. A patient in the position of P, under the Mejia case, can justifiably look to Dr. B's group as well as to Dr. B and MC for compensation for his injuries. The hospital had a contract with MG, not Dr. B. MG placed Dr. B in the hospital. The Mejia and Whitlow cases clearly allow application of the ostensible agency doctrine to Hawthorne, as the entity which supplied Dr. B to MC.

MG apparently claims that its radiologists are independent contractors with the group; MC claims that the radiologists supplied to them by MG are independent contractors to MC. Of note is the written agreement between MC and MG. All that is said in section 4.1 of that agreement is that "the group" is an independent contractor with the hospital. No language is present in the agreement saying that the group physicians are independent contractors to MG. In fact, the MC/MG contract suggests otherwise.

The repeated phrase in that contract is "employed by or contracting with Group" whenever referring to the doctors supplied by MG to work at MC.

In section 4.1 of the contract, MG is responsible for paying compensation, benefits, workers compensation insurance and employee benefits with regard to the group doctors "employed by or contracting with the Group."

Section 4.1 of the MC/MG contract does not create an employer-employee relation between MC and MG or between the hospital and the MG doctors.

In Section 4.3 of the contract, MG provides the malpractice coverage for the Group doctors while they are working at MC. Going back to section 4.1, the Group is required to ensure that the Group doctors do not hold themselves out as employees of the hospital (an irrelevant fact to an emergency room patient, under the Melia case, but a very relevant fact as to Mejia's application to MG).

There is also this from section 2.9 of the contract: "group further represents and warrants to hospital that Group has and will at all times maintain a written agreement with each non-employed physician...receiving compensation from group." Yet we already know that MG in this case did NOT maintain such a written agreement with Dr. B. Since there was no written agreement, that makes Dr. B an employee of HRAMG.

Under the Mejia case, the Defendant radiologist who comes to the hospital assigned by his medical group is treated the same as any staff that renders service for an emergency room patient. That P and his mother knew nothing about MG has no relevance to the application of Mejia to MG to the same extent as Melia applies to the hospital and the radiologist they assigned to interpret the CT scan.

DAMAGES

Attached are the following documents, which speak for themselves regarding the catatrophic damages sustained by P:

* MC Discharge Summary, February 2012
* Rancho Los Amigos Discharge Summary, April 2012
* Defense Doctor's Defense Medical Report, February 2, 2015. The doctor's statement that "he has not had anything to suggest autonomic dysfunction is non-sensical, since his report describes multiple symptoms of autonomic dysfunction.
* Dr. Sharon Kawai's Life Care Plan
* Tamorah Hunt's Economic Damages Report
* Day in the Life Video (see attached disc)

P has overcome one hurdle; he no longer requires a feeding tube. He is able to eat by mouth, under close supervision of course. With proper, complete professional health care on a 24 hour basis for the rest of his life, every professional study of patients such as P in modern America support a life expectancy that takes him to age 57 at the very least.

DEMAND:

Future Medical Care Costs needs: $18,897,911

Future Earnings Loss: $ 2,217,663

Past Medicals (Medi-Cal lien) $ 358,071 (approximate; will need updating)

General Damages: $ 250,000

TOTAL: $21, 723, 645

**STATUS OF SETTLEMENT DISCUSSIONS**

CCP section 998 demands totaling $8M have been served as noted below; each demand expires July 28, 2015:

Dr. F (Emergency Department doctor):

$1,000,000 [NOTE: on July 22, 2015, counsel for Dr. F disclosed an additional

$1M in coverage]

Emergency Physicians Medical Group (Dr. F's group):

$1,000,000

Dr. L (Consulting Neurologist):

$1,000,000

Medical Group, Inc. (Dr. Liu's group):

$1,000,000

Dr. B (radiologist)

$1,000,000

Hawthorne Medical Group

(alleged to be Dr. B's employer/medical group)

$2,000,000

Nursing Registry, Inc./B, RN

$1,000,000

DATED: July 22, 2015 By:

GARY N. STERN