VIRGINIA
LAWYERS WEEKLY

Vol. 30, No. 40 valawyersweekly.com March 7, 2016

VERDICTS & SETTLEMENTS

Nurse failed to tell surgeon that patient called with post-op complaints

$1.85 million Verdict

A 62-year-old female had blood work done to evaluate an inflamed tick bite. Testing showed elevated liver function results. Further investigation lead to a discovery of a large gallstone. Surgery was recommended and was performed in September 2012 in Fredericksburg.

At surgery the surgeon took an intraoperative cholangiogram, preplanned to make sure she had no other gallstones in the common duct. The surgeon saved one image from the intraoperative cholangiogram and it was, according to plaintiff's experts, abnormal. Plaintiff's case against the surgeon was that in light of the cholangiogram he should not have proceeded with cutting what he believed to be the cystic duct because the cholangiogram "predicted" that he was about to create a major biliary injury.

The surgeon and his experts testified that the cholangiogram image he took did not tell the entire story because it was but a "moment in time." The surgeon testified that what he saw on the screen before taking the picture showed a normal cholangiogram. At surgery, the surgeon inadvertently removed a large segment of the common hepatic duct and the right and left hepatic ducts, leaving bile to drain into the patient's abdomen. Neither the surgeon nor the pathologist noticed the extra biliary tree parts post-operatively.

The patient went home that day and traveled to her second home in North Carolina, with the surgeon's permission.

There were then a series of phone calls back to the surgeon's office. On the afternoon of surgery the patient's husband called and spoke to a nurse. He told the nurse that his wife is in a great deal of pain. He requested a change of medication from the Percocet to Vicodin. The nurse told him this was normal post-op pain and that Vicodin wasn't going to help. The surgeon never heard about this call.

On the fifth post-operative day, the patient called again, this time complaining that the Percocet wasn't covering the pain, she could not eat anything and she had left shoulder pain. She spoke with a different nurse who told her this is all normal. That nurse did not tell the surgeon either. Instead, she ordered the Percocet stopped and, using the surgeon's DEA number, called in a new prescription for Vicodin to the pharmacy. The pain continued for another nine days but because the patient was under the impression that the nurse had spoken to the surgeon, and that the surgeon said this was "normal," she did not call back to the office.

ABRENIO

Two weeks after surgery, the patient started spitting up bile and now felt even worse. It was later determined that she had four liters of bile, causing bile peritonitis and all sorts of adhesions in her abdomen. She called the surgeon's office and spoke to the same nurse she has spoken to on day five. The nurse told her to go to the emergency room and "bring your records with you when you come for your follow up visit with the surgeon next week." Again, she didn't tell the surgeon of the call even though at trial she testified that this "sounded a little weird to her."

The patient was evaluated at Wake Med in NC, emergently transferred to a hospital where, after initial testing, a surgeon who did not have much experience in repairing major biliary injuries like this, took her to surgery, creating a massive vertical scar.

While in surgery that surgeon began sending photos to a liver transplant surgeon, who told him to place drains, close, and transfer the patient to his service. That initial surgery was about 6 hours because there were by now massive adhesions and it took a long time to locate what remained of the right and left hepatic ducts. The common bile duct was found with a surgical clip on it (as one might expect after the misidentification).

While she was in the hospital for her first surgery, the surgeon who did the gallbladder surgery called and left several messages on the patient's cell phone, telling her how sorry he was and how he had to apologize because no one in his office told him about her calls.

Several months later she had a definitive repair in a 12 hour surgery by the transplant surgeon (David Gerber, MD), who created a much smaller horizontal incision. Gerber had to go inside the liver to locate what remained of the right and left hepatic ducts. He also had to deal with both the massive adhesions from the bile peritonitis AND the adhesions from the first exploratory surgery. Evidence at trial was that had Dr. Gerber seen her first, she would have avoided the massive vertical incision and scarring.

GLASS

A year later she had a huge abdominal mesh implanted because of the hernia caused by the combination of the large vertical (caused by the surgeon who had little experience doing this type of a repair) and smaller horizontal incisions which basically crisscrossed. That also was about an 8 hour operation. She went about 2 ½ years before stricturing down her repaired anastomosis between what remained of her right and left hepatic ducts and her duodenum. That was an 8 day admission for implantation of stents. Shortly thereafter she had a procedure to remove the stents. She also testified that her hernia was now recurring and she was likely headed to yet another surgery.

The surgeon was sued for the original gallbladder surgery. The nurse was not named individually because at the time the lawsuit was filed it was unclear whether the patient's messages of continued pain had actually been passed on to the surgeon. Plaintiff pleaded a claim against the corporation contending that either the messages had or had not been passed to the surgeon but that either way, the corporation was liable.

Past medical bills were $340,000. There was testimony at trial, some of which came from the defense experts, was that the damages caused by the nurse's failure to pass the messages would have been greatly reduced. The two week delay caused the need for the multiple abdominal surgeries, the later abdominal wall repair, a massive vertical scar and, arguably even the stenting procedure. (One of the defense experts testified that most the damage to the common bile duct was caused by the effects of the bile during the two week delay.

The plaintiff's case was finished by 10:30 the second day of trial. The court adjourned the afternoon of the second day of trial because of scheduling issues with two defense experts. The jury received the case (and three pizzas, courtesy of the Court) at 12:40 p.m on the third day of trial and returned its verdict in favor of the surgeon but against the practice group (for the negligence of the nurse) at 3:00 p.m. (See also the story, VLW, Jan. 25, 2016).

[16-T-006]

Type of action: Medical Malpractice

Injuries alleged: Gallbladder Surgery and Follow Up

Name of case: Christine Hommel v. Surgical Associates of Fredericksburg

Name of judge: Gordon F. Willis

Date resolved: Jan. 6, 2016

Verdict or settlement: Verdict

Amount: $1.85 million

Attorneys for plaintiff: Benjamin W. Glass III and James Abrenio, Fairfax

Attorneys for defendant: Robert Donnelly and Robyn Ayres, Richmond

Plaintiff's experts: Glenn Sanders MD, General Surgery, Maryland; Michael Leitman MD, General Surgery, New York; David Gerber MD, hepatobililary surgeon repaired the injury, North Carolina; Sherri Smith LPN, nursing standard of care, Midlothian

Defense Experts: Stephen Hill MD, General Surgery, Roanoke; Christopher Steffes MD, General Surgery, Detroit

Insurance carrier: The Doctor's Company