# Court Documents

## February 13, 2017

IN THE CIRCUIT COURT OF PIMA COUNTY

CINDY I. DEMARCO, as Administratrix of the Estate of ANTHONY F. PALMER, Deceased,

Plaintiff,

CIVIL ACTION NUMBER CV 12-915312

VS.

SURGICAL ASSOCIATES, PC; ROBERT JAMES BURKE, MD

Defendants.

# Schedule

**Mock trial details**

**Opening Statements**

Randy Juip for the plaintiff

Billy Bates for the defense

**Case-in-chief — plaintiff**

Testimony of Nancy Nestor

Testimony of Robert Burke, MD

Testimony of Howard Fletcher, MD

**BREAK**

**Case-in-chief — defense**

Testimony of Frank Shorter, MD

**Closing arguments**

Plaintiff

Defense

Plaintiff rebuttal

**Jury deliberation**

**Jury dismissal for lunch**

# Mock Trial Participants

### Justice Sanders – Richard D. Sanders, JD

Rich represents a variety of healthcare providers on a broad range of issues, including business transactions, fraud and abuse compliance (anti-kickback statute and stark), certificate of need issues, medical staff credentialing, Medicare reimbursement, antitrust policy, and legislative activities. He also assists providers in their relationships with federal and state regulatory agencies. After graduating from Duke University in 1992 with a double-major in political science and history, Rich earned his Juris Doctor degree from the Emory University School of Law in 1996. Rich currently serves on the adjunct faculty at Emory University and teaches courses in business and regulatory law.

### Plaintiff Attorney – Randall A. Juip, JD

Randy is a member of Foley, Baron, Metzger & Juip, PLLC, and is an active defense trial attorney. He has served as counsel in medical malpractice litigation, civil rights (42 U.S.C. § 1983)/deliberate indifference claims, business and commercial litigation, state licensing actions, and other complex civil litigation and professional defense matters. Mr. Juip consults on public relations and crisis management issues, and has served as a media spokesperson in various high-profile legal matters. His practice also focuses on assisting professionals with pre-litigation support through careful risk management and business practice consulting, clever and creative problem solving, and claims investigation.

### Defense Attorney – Walter W. "Billy" Bates, JD

Billy has been a partner at Starnes Davis Florie, LLP for more than twenty years and has served as managing partner of the firm from 2006 to 2016. He is a graduate of the University of Alabama and Cumberland School of Law at Samford University. Mr. Bates' practice has been devoted to civil litigation including healthcare litigation, professional medical liability, pharmaceutical liability, and medical device litigation. He has tried in excess of 130 complex civil cases to a jury verdict, including cases in defense of product manufacturers, physicians, hospitals, and corporations.

## In Order of Appearance
# Witnesses

### Plaintiff's Niece – Nancy Nestor, RN

Profession: Registered Nurse
Education: Arizona State University, Bachelors of Science, Nursing – 1993

### Defendant Physician – Robert James Burke, MD

Profession: Medical Doctor – Surgeon
Education: Medical School – UAB – 1998
Internship/Residency – University of South Alabama – 2003
Awards/Honors: Intern of the Year (Year 3)
Resident of the Year (Year 4)
Highest Scoring Resident on National Inservice Test

### Plaintiff Expert – Howard Fletcher, MD

Profession: Medical Doctor – Surgeon
Education: Undergrad – Duke University – 1969
Graduate – Medical College of Georgia, MS, Biochemistry – 1972
Doctorate – Medical College of Georgia, PhD, Biochemistry – 1975
Medical School – Medical College of Georgia, MD – 1979
Residency – University of Utah
Residency – Lutheran Medical Center – 1984
Residency – Georgia
Fellowship – University of Massachusetts

### Defense Expert – Frank Shorter, MD

Profession: Medical Doctor – Surgeon
Education: Undergrad – David Lipscomb College – 1976
Medical School – UAB – 1981
Internship/Residency – University of Tennessee – 1986

# Summary of Incident

Anthony Palmer, a 71 year-old-male presented to the hospital for a scheduled incisional hernia repair with component separation. The patient tolerated the procedure well and had an uncomplicated post-surgical clinical course including; auscultation of bowel sounds, several bowel movements, able to take fluids and food, and ambulated around his room. He was discharged home two days later with a Jackson-Pratt drain in place.

The patient returned to the hospital 3 days later complaining of nausea, vomiting, and abdominal distention. Robert Burke, MD, who performed the hernia repair assumed care of the patient. He noted the patient's last bowel movement was two days prior. Physical exam revealed a soft and distended abdomen. The patient was admitted and made NPO except for ice chips. Flat and upright abdominal films were obtained and showed several loops of very prominent and distended small bowel. Multiple air fluid levels were also seen. There was some stool within the right colon, and the radiologist documented he was concerned about a partial small bowel obstruction. The radiologist's impression was "ileus versus small bowel obstruction."

Dr. Burke's plan was to watch the patient, give fluids, and let the clinical picture develop to help determine if Mr. Palmer had an ileus or small bowel obstruction. The patient had a bowel movement around 8:00 p.m. that evening. According to Dr. Burke, over the first few days of hospitalization, the patient was passing gas, was not nauseous or vomiting, had a bowel movement, and had an initial decrease in abdominal distention. These signs led him to think the patient had an ileus and was improving.

On the fourth day of Mr. Palmer's readmission, Dr. Burke examined him and noted his abdomen was "moderately" distended. A second set of abdominal films were ordered and compared to the earlier films. There were still multiple air fluid levels and moderate distention of the small intestine and fluid distension of the stomach. The radiologist's impression was "multiple air fluid levels consistent with high-grade small bowel obstruction. No improvement since previous images."

Dr. Burke reviewed the X-ray report the next morning and saw Mr. Palmer that afternoon. The patient's wife and niece (Nancy Nestor) were present when he examined the patient. Dr. Burke noted an area of distention confined to the prior hernia incision that was soft and felt like a seroma. His impression was the drain had clogged and fluid had collected in the patient's stomach. He made the decision to open up and drain the suspected seroma at the patient's bedside. Dr. Burke made a small incision, using a scalpel to open a suture at the lower portion of the patient's abdominal incision. The patient's bowel contents were right up against the abdominal wall and when the incision was made, it punctured the bowel wall causing liquid stool to spill out. The patient was taken immediately to the operating room to explore the wound and repair the enterotomy.

The patient was anesthetized via rapid sequence induction. Right before he was given anesthesia, Mr. Palmer vomited and there were concerns of possible aspiration. Once the induction was completed, an NG tube was placed and approximately 3,000 cc of gastric contents were returned. During the procedure Dr. Burke repaired the small enterotomy and the hernia defect was closed.Mr. Palmer was taken to the recovery room in relatively stable condition. He remained on a ventilator secondary to the aspiration. He was taken to ICU where initially he did well, but subsequently developed hypotension and decreased urine output. He was started on the appropriate drips, but subsequently became anuric with severely labile blood pressures. He was made a do not resuscitate and died the next morning. The discharge summary notes the reason for death as cardiopulmonary arrest secondary to massive hypotension and organ failure postoperatively.

A lawsuit was filed by Mr. Palmer's daughter, Cindy DeMarco.

Undisputed Medical Facts

# Causation Summary

***With respect to causation, the plaintiff contends Dr. Burke's acts or omissions caused Mr. Palmer's death in the following ways:***

Dr. Burke's failure to place an NG tube in Mr. Palmer during his hospitalization led to a build-up of contaminated material in his stomach, increased abdominal distention, and an increased risk of vomiting. This material continued to collect over the course of Mr. Palmer's hospitalization, as did his risk for vomiting and aspiration. When Dr. Burke attempted to drain what he thought was a seroma and nicked Mr. Palmer's bowel, he had to take Mr. Palmer back for emergency surgery. Because Dr. Burke did not place an NG tube prior to anesthesia induction to evacuate all this built-up material, Mr. Palmer vomited and aspirated 3 liters of built-up material into his lungs while he was on the operating table. Aspirating this material resulted in Mr. Palmer developing sepsis and ultimately caused his death.

Additionally, Dr. Burke failed to order a CT study during Mr. Palmer's hospitalization, thereby leading to delayed recognition and diagnosis of Mr. Palmer's small bowel obstruction. Had Dr. Burke ordered a CT study, Mr. Palmer's small bowel obstruction would have been identified earlier and surgery would have proceeded in a non-emergent manner. This would have allowed a more measured approach to the surgery and ample time to place an NG tube, thereby preventing Mr. Palmer from aspirating and developing sepsis.

***In response, the defense contends the following on causation:***

The decision not to place an NG tube and Mr. Palmer's aspiration did not cause his death. Contrary to Plaintiff's assertion, Mr. Palmer did not aspirate 3 liters of fluid into his lungs. The medical record demonstrates that 3 liters of fluid were suctioned out of Mr. Palmer's stomach, not his lungs. Thus, none of the 3 liters referenced by the Plaintiff was actually aspirated by Mr. Palmer. This is further confirmed by the medical records which describe the material suctioned from the endotracheal tube at the time of surgery as "light-colored", indicating that minimal material was actually aspirated. If the aspiration had been significant and filled the lungs as the Plaintiff argues, Mr. Palmer's post-operative oxygen saturations would not have remained in the 90s. Moreover, Mr. Palmer's chest x-rays show minimal lung opacity, which further points away from the aspirate filling his lungs.

Additionally, a blood culture performed after the aspiration was negative. If Mr. Palmer had aspirated contaminated fluids sufficient to cause sepsis, it would have gone into his bloodstream quickly and there would be a positive blood culture. Moreover, Mr. Palmer was given antibiotics before and after his emergency surgery, making the development of sepsis would have been highly improbable.

Mr. Palmer's rapid demise points away from aspiration as the cause of death and, instead, indicates that Mr. Palmer's multiple co-morbidities, combined with the stress of undergoing two major surgeries in such a short timeframe, was the cause of his death. Furthermore, even if a CT study had been performed and a partial small bowel obstruction identified, Mr. Palmer would have unfortunately suffered the same outcome because the treatment for both a partial small bowel obstruction and an ileus is clinical monitoring, not surgery.

### In Order of Appearance

# Cast

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| Plaintiff's attorney | Randall A. Juip as himself |
| Cindy DeMarco<br>*Daughter of the deceased* | Joanne Simmons |
| Defense attorney | Walter W. "Billy" Bates as himself |
| Robert James Burke, MD<br>*Defendant* | Garnet Harding |
| Bailiff | Aaron Hamming |
| Justice Sanders | Richard D. Sanders |
| Nancy Nestor, RN<br>*Niece of the deceased* | Harper Wood |
| Howard Fletcher, MD<br>*Plaintiff expert* | Tony Eckstat |
| Frank Shorter, MD<br>*Defense expert* | Gregory Lutz |

# Jury Notes