THE OVERCOMING OF THE DECEPTION OF A DEFENDANT HOSPITAL IN A MEDICAL MALPRACTICE CLAIM

This case had its beginning in the Fall of 1973 when a young lad by the name of Jeffrey Burling confided to his best friend that he was leaving home, leaving his senior year of high school, abandoning his swim team, all because of unbearable pressures at home. His mother and father were undergoing a bitter and acrimonious divorce. His best friend was appalled. Jeffrey had an opportunity to be All-Conference in the breast stroke and actually had a chance to shatter the existing high school records of Illinois.

The friend convinced Jeff that he he should seek the counsel of the friend's father, a well known lawyer in Chicago, Illinois, and persuaded his best friend to have dinner with him. Jeffrey Burling's best friend was Stephen Jurco, III.

Upon arriving at Stephen's home, Jeffrey's plight was explained to the senior Mr. Jurco. He listened and in his wisdom suggested that since his son, Stephen III, was an only child and the boys had been such fast, close friends during their high school years, that if Jeffrey would follow the rules of the Jurco home, he would contact Jeffrey's mother and father to see if his senior year could be spent with the Jurco family.

Jeffrey's mother and father agreed, Jeffrey moved in with the Jurco family and Mr. Jurco became a surrogate father to this young lad.

Jeffrey did swim and did make All-Conference. Stephen Jurco, III pursued diligently his last year in high school in preparation for Northwestern University, where he wanted to pursue a pre-medical course.

Upon graduation, the path of these lads divided. Jeffrey wanted to go to Florida to work. Stephen Jurco, III wanted to be a doctor.

Over the years from 1973, the friendship remained and the young men were as close as brothers.

On April 16, 1979, while in his first year of residency at Baylor University in Houston, Texas, Stephen Jurco,III received a frantic telephone call from the girlfriend of Jeffrey Burling. It seemed that Jeffrey was in the hospital and he was paralyzed.

Dropping everything, young Dr. Jurco took the first plane out of Houston, Texas bound for Vero Beach, Florida, where Jeffrey lay in the Indian River Memorial Hospital. Upon arriving at the hospital, Jeffrey was found to be on a respirator; he could not talk as a result of an endotracheal tube, but he appeared to be receiving excellent care. He was totally paralyzed.

When Dr. Jurco had a consultation with the neurosurgeon, Dr. Romas Sakalas, a young physician, previously an Assistant Professor of Neurosurgery at the Medical College of Virginia, he detected some disgust from Dr. Sakalas in regard to the treatment Jeffrey had received from Lawnwood Medical Center, a brand new, two hundred twenty-five bed hospital owned by Hospital Corporation of America, located at Fort Pierce, Florida, eighteen miles distant. It seemed that Lawnwood Medical Center, through its Emergency Room personnel, treated Jeffrey as a drowning victim. The paralysis, it was later determined, was a result of the fracture of the cervical spine and not due to cerebral anoxia or a hypoxic situation.

Dr. Jurco called his lawyer-father in Chicago, Illinois and simply told him: "Dad, there's something fishy about Jeffrey's treatment here in Florida and I suggest you get a good lawyer to take a look at it."

Within a few days of the injury, the law office of Montgomery, Lytal, Reiter, Denney & Searcy, P.A. was contacted. A medical authorization was obtained from Jeffrey's mother, who was visiting and caring for him in Vero Beach, Florida. Immediately, the Medical Authorization was forwarded to Lawnwood Medical Center, Inc. requesting all of the hospital records of Jeffrey Burling, as well as copies of the x-rays taken. The request was ignored. Thinking it was an oversight, the law firm again requested the records and x-rays. This was in July, 1979. Again, the request was ignored. Under the then Medical

Practice Act, Fla. Statute 458.16, a physician is commanded upon the request of a patient or his representative to furnish copies of all reports made of any examination or treatment. This pertains to a hospital also.

An investigator was dispatched from West Palm Beach, Florida to Fort Pierce, Florida, where the Lawnwood Medical Center is situated, some sixty miles distant, to physically obtain the records. Upon his arrival, he was advised that the records had been checked out and were unavailable. This was the middle of September, 1979.

It is quite unusual in Florida for a medical provider 'o fail to produce medical records and copies of xrays. Most hospitals and physicians are very much aware of the statutory authority and the compulsory nature of it. This gave the first inkling that something was amiss so far as Jeffrey Burling and his treatment were concerned.

Within two weeks, a Medical Mediation Claim was filed. At that time, October, 1979, Florida operated under the Medical Malpractice Act, which had as a pre--requisite a requirement that any medical malpractice claim be presented to a Mediation Panel, consisting of a Judge, a lawyer and a physician. Under the Medical Mediation Act, however, subpoena power was given. In October, after suit was filed, a subpoena was issued and the records finally obtained in December of 1979.

Jeffrey Burling was taken to the Lawnwood Medical Center at 7 P.M. on April 16, 1979. The records indicated that he remained in the Emergency Room from that time until approximately 10:55 P.M., when he was transferred to the Intensive Care Unit of the same hospital. He was discharged April 17, 1979 to the Indian River Memorial Hospital at 10:45 A.M. The records that the law firm received were sparse, consisting of less than thirty pages, and did not contain certain records required by the Joint Commission on Accreditation of Hospitals to be kept.

Briefly, it was determined that Jeffrey, almost twenty-four years old, was working as a carpet layer in Fort Pierce, Florida, making approximately $250.00 to $300.00 per week. He worked as an

independent contractor, but he had a partner and the two of them were excellent in their trade. Often the two made more than $600.00 weekly.

On April 16, 1979, one of the co-workers at the carpet retail house employing the services of Jeff had a birthday. It was decided that Jeff and the rest of the friends would celebrate the occasion by having some drinks at the local A.B.C. Lounge.

Knocking off early, around 3 P.M., Jeffrey and his friends proceeded to the A.B.C. Lounge and there Jeffrey drank beer. Because he had complete amnesia, he could not testify as to how many beers were consumed. Likewise, three of his friends who accompanied him could not so testify.

It was known and undisputed that at approximately 6:00 or 6:30 P.M., Jeffrey returned to his apartment, located some seven or eight miles from the city limits of Fort Pierce, Florida. Jeff had a small apartment in a compound where there were five or six other one story places to live. The apartments were surrounded by a pond, which was approximately one hundred fifty feet in length and fifty feet wide. The weather was warning up and when the three men arrived, Jeffrey noticed the landlord's grandchildren swimming in the pond. The weather was warm and Jeffrey decided to take a dip. It was his custom to play games with the children, he acting as a shark, swimming under water, and generally having fun with them.

After talking to the children and discussing with them a short vacation they had just had, Jeffrey entered his apartment, changed his clothes and his friend and co-working partner saw him dive into the pond. His friend then turned to other things and after a few minutes, heard the screams of the children. Jeffrey did not come up and they were unsure whether or not he was playing with them by swimming underwater, hiding in the inner tube or was in trouble. Jeffrey's friend, Steven Pfeiffer, yelled for Jeffrey, he heard no response and Steven waded into the pond. He found Jeffrey on the bottom with his arms outstretched, and placing his arms under Jeffrey's arm pits, dragged him to the side.

Immediately, the Emergency Medical Unit was called. The Unit arrived within four minutes of the call. Within seven minutes, they left the area and within another five minutes arrived at the Emergency Room.

When the Paramedics arrived, they found Jeffrey comatose, his eyes were fixed and dilated and he was cyanotic.

The Paramedics immediately immobilized Jeffrey, placed him on a spine board and placed sand bags on his neck to stabilize him and keep him from moving.

When Jeffrey Burling arrived at the Emergency Room of Lawnwood Medical Center, Inc., he arrived on a back board, he was strapped down and sand bags were about his neck.

The Medical Records indicated that the Taiwanese physician, Dr. C. C. Liu, diagnosed Jeffrey as a "near drowning" victim. It was noted that he was cyanotic, had no spontaneous respiration, his pupils were fixed and dilated, and immediately, an endotracheal tube was inserted. X-rays of the skull, chest and cervical spine were ordered. An alcohol blood level was ordered, a complete blood count and an emergency profile (ACA -- Automatic Chemical Analyzer) for BUN, glucose, chloride, sodium and potassium were also ordered. This will become highly sionificant as we progress.

In reading the x-ray report (which was dictated April 17, 1979, the morning after the x-rays were taken), the following was read:

> "AP and lateral portable films of the skull show no gross fractures or other abnormalities. However, on the lateral film of the skull and C-spine, there appears to be some mal-alignment at the level of C-3,4. This may be due to the fact that the neck is rather rigid and the film was taken in the supine position. However, if indicated, lateral films of the C-spine may be obtained; otherwise, no other fractures are identified."

Page 2 of the radiology report, dated April 17, 1979 stated:

> "Re-examination of the cervical spine by a lateral film shows a comminuted fracture of the fifth cervical vertebra. There is a fragment projecting anteriorly and posteriorly and there is mal-alignment of the cervical spine, although there is no appreciable displacement. The posterior margins of the cervical spine show some reversal of the normal curvature and straightening of the cervical spine. There is slight projection of the inferior border of the fractured vertebra over the upper border of the sixth cervical vertebra and this is in the range of about 2 mm."

There was no neurological assessment indicated in the records and no movement one way or the other was indicated in the records. It was noted, however, that both hands were restrained. Indeed, the hospital, when finally producing the records, inadvertently included supplemental nurses notes which indicated that the patient had to be restrained because he was "trying to pull out the tubes with both hands, to the extent he had to have his hands restrained." This supplemental note, it turned out, was a result of an immediate investigation which began on April 17, 1979.

But for the inadvertence of some hospital employee in including these supplemental nurses' notes - which was in fact a statement written on hospital chart paper -- perhaps Jeffrey Burling would never have obtained a verdict.

Obviously, the hospital did not know that these statements had inadvertently been included.

Because the records were so incomplete and because we knew that an investigation had immediately been started, it was felt that the only way to obtain true statements from the treating medical personnel was to play their own game and pretend that we had their complete investigation file.

When the depositions of the nurses were first set, a used brown envelope previously sent to us by the hospital, but containing other matters not connected with this case, was used and the statements were inserted. When the deposition of the nurse who had given one of the statements was taken, he, a male nurse, was asked whether or not he forwarded to us this brown envelope, which he denied. We then gingerly took out his statement and thoroughly impeached him with it. From that point on, the Administrator, physicians and nurses did not know what we had, so far as their statements were concerned. We feel that this was a turning point, in that as the case progressed, other medical personnel involved in the care and treatment of Jeffrey Burling became more candid and honest.

By reason of the experience in reviewing thousands of pages of records during our handling of personal injury litigation and medical malpractice work, it was obvious that the records simply stunk. Obviously, there had been a.misdiagnosis, because x-rays that were taken on April 16, 1979 did not show the complete cervical area. Indeed, when the x-rays were obtained, there was a lateral x-ray of the skull

showing four cervical vertebra. It appeared that this was actually an attempt at a lateral view of the cervical spine. That turned out not to be so. The deposition of Dr. George Theodorou, the radiologist who read the x-rays, was taken about eight months after the Medical Mediation Complaint was filed. During the taking of his deposition, for the first time, in June of 1980, we found that the lateral cervical spine x-ray taken April 16, 1979 was missing. We had been misinformed by the hospital, thinking that we had all of the x-rays taken. The cervical spine x-ray of Jeffrey Burling was not there. The lawyer for the hospital was as surprised as we were. He thought that the hospital had submitted all of the x-rays to him.

Having taken the deposition of the Taiwanese Emergency Room physician, his excuse for not treating Jeffrey Burling as a spinal cord victim was because he was advised by the Radiology Department that the x-ray of the cervical spine was negative for fracture. Indeed, the physician to whom Jeffrey was assigned so that he could be admitted to the hospital from the Emergency Room, one Oswaldo Benitez, M.D., who was a Cuban refugee, testified that he indeed saw the x-rays in the Emergency Room, and while he was not an expert in radiology, he saw no abnormalities. We proved by the radiologist that any physician graduating from medical school could have seen the fracture at C-5 of Jeffrey Burling, had it existed. Thereafter, we returned to the office and amended our complaint and alleged that the physicians had read the x-rays as negative on April 16, 1979 when Jeffrey Burling was admitted to the Emergency Room, and while in the exclusive care of the hospital personnel, found himself with a C-5 fracture the following morning. The Hospital was consequently liable under the doctrine of <u>res</u> <u>ipsa</u> <u>loquitur</u>. The Amendment was ordered by the Court and within thirty days the lateral x-ray of the cervical spine was mysteriously found by the hospital, whose Administrator stated that it came through the mail from a place unknown. That lateral view of the cervical spine showed only C-i through C- 4, but likewise showed some straightening, indicating injury and a mal-alignment which could well be consistent with fracture at a lower level. No other x-rays were taken.

Thus, we had an Emergency Room physician and the attending physician stating that the x-rays were reported negative for fracture and a lateral cervical x-ray (no AP of the cervical spine was taken), which did not show through the seventh cervical vertebra.

No one could explain why, although a C-spine was ordered, a C-spine was not obtained.

In the records on the same chemistry report as the requested emergency profile (ACA) was found a blood alcohol of Jeffrey Burling of 293% mg. Under Florida law, this made him almost three times drunk. The experts of the hospital stated that such a finding could indicate near brain death. Our experts said "Poppycock," in that in a community hospital of a large city, it is not unusual to see such percentages as high as 400. However, they agreed that Jeffrey could hardly have been able to carry on a normal conversation with the grandchildren of the landowner and have walked and dived into the pond without staggering, had he been that drunk.

In addition, stamped on the chemistry profile was Jeffrey Burling's name and hospital stamp. We later discovered that beneath the stamp was the name "John Doe."

While taking the depositions of the hospital personnel, we took the deposition of a young Nurse's Aide, by the name of Adrienne Griffin. She is the one who remembered well making out the request for lab tests, which consisted of the CBC, the ACA screen, the blood alcohol, portable chest, skull and C-spine x-rays. On her deposition, she stated that she would never have put "John Doe" in the request for a blood alcohol and ACA screen, by reason of the fact that when she made out the request for the skull and cervical spine x-rays, she filled in the information as to name, age, sex and address in detail. Jeffrey Burling's name, address and vital statistics were included. Therefore, Adrienne Griffin stated that he was not a "John Doe" and the chemistry slip was obviously made out by someone other than her. The 293% blood alcohol was a pure fake. It was placed in there by the hospital as an excuse, presumably by the negligent physicians for their failure to do a neurological assessment.

It appears that the attending physician and the Emergency Room physician evidently believed, because they so testified, that one reason the fracture was not diagnosed was that the patient was comatose and his neurological system was affected by the high alcohol content. What an absurdity!

After determining that at the time of the taking of the depositions of the Emergency Room physician and the physician to whom Jeffrey Burling was assigned, Dr. Benitez, that we did not have the x-rays in their totality, we re-set those depositions. The second deposition of Dr. Liu was taken and he testified that he had been mistaken in his original deposition and that he was not told that the x-rays were negative for fracture by the Radiology Department, but he was told that what the Radiology Department could see was negative for fracture, but that the x-rays were inadequate to rule out cervical fracture. He stated that he related this information to Dr. Benitez. Dr. Benitez, the Cuban doctor who could hardly speak English, denied this and stated that he was advised by the Taiwanese physician that the x-rays were negative for fracture. The Radiology Department, through Dr. George Theodorou, who received his training in Athens, Greece and likewise had a language problem, denied even being at the hospital to read the x-rays on April 16, 1979. The jury, by the way, exonerated Dr. Theodorou and his group from the verdict rendered. They rejected Dr. Liu's testimony.

One of the most prominent forensic physicians alive today is Dr. John Feegel, Assistant Medical Examiner for Fulton County in Atlanta, Georgia. He has been on the Staff at Emory University, University of South Florida and the University of North Carolina, as well as being the Medical Examiner of Hillsborough County, Tampa, Florida. In addition to his Board Certification in Forensic Pathology and Anatomical Pathology, he likewise is an attorney. Dr. Feegel was sent these records to render his opinion as to their validity. At trial, he testified that in his opinion, without question, the records were faulty and had been tampered with. He stated that in treating a drowning victim, it was absolutely necessary to know the glucose, chloride, sodium and potassium levels because of the delicate balances of those chemicals so far as the patient was concerned. He testified that no physician, unless he had an absolute reckless

indifference for the life of the patient, would guess at the potassium, sodium and chloride levels. Also, he testified that when an unconscious patient is brought to the Emergency Room as a result of a water injury, "you want to determine whether or not he perhaps is in diabetic coma, and a glucose test is likewise essential."

When the emergency profile (ACA) was ordered, and there were no findings, it was obvious that the chemistry report was missing. Usually, the BUN, glucose, chloride, sodium and potassium tests would be done at the same time that a blood alcohol was done.

The chemistry report was likewise not stamped with a time in and a time out, as was customary and required. This could not be explained by the technologist.

By happenstance during the trial, and after Dr. Feegel had testifed that the records were faked, in his opinion, we were re-examining the hospital records from the Indian River Memorial Hospital. We had subpoenaed the Indian River Memorial Hospital records for trial, demanding all records in their original form so that we could see them at trial.

Included in the original records from the Indian River Memorial Hospital was a copy of the record of Jeffrey Burling that had accompanied him from Lawnwood Medical Center to Indian River Memorial Hospital. In reviewing these records, it was immediately seen that the records that accompanied Jeff were not the same records that the Lawnwood Medical Center had given to us pursuant to our subpoena.

Dr. Benitez had made significant changes. He added that Jeffrey's pupils were dilated and the patient was comatose. This addition was to excuse himself from doing a neurological examination on the grounds that the patient was completely and absolutely comatose and was not a candidate for neurological assessment. Dr. Benitez had likewise changed an original finding that the upper extremities were "okay" to "the upper extremities marked weakness, possible fractured cervical spine with cord damage."

We certainly learned a lesson by this case. Whenever there is a patient transferred from one institution to another, the records accompanying the patient should be obtained and a comparison made between those records and the records of the transferring hospital.

Previously, the hospital Administrator had testified that it was a "hanging offense" for a physician to change records. The jury took the Administrator for his word.

The bottom having dropped out of the defenses of the hospital, their next attack was that the patient, Jeffrey Burling, was a quadriplegic when he arrived at the hospital, never having any movement and the nurses simply restrained him because he had some spastic C-5,6 movement at the elbow and he was inadvertently therefore hitting his endotracheal tube, as opposed to making an effort to grab it with his hands.

The quest began. The radiological technicians agreed that had they had x-rays such as those shown to them, they would not have stopped, but would have continued to make an effort to take appropriate x-rays unless they were told by the physicians to stop. Benitez and Liu denied that they ever advised the technologists to stop taking x-rays.

An LPN with the Intensive Care Unit on the 11 P.M. to 7 A.M. shift stated that when Jeffrey was received at ICU, he was "moving around a lot on the bed. He was turning from side to side."

When pressed, she said, "All I know he was all over the bed and he became quieter during the night." She stated that there was much less movement during the night.

John Black, the landlord of Jeff, visited him in the hospital and around 9:30 or 10 P.M. had to leave because his wife was working a night shift. John Black went in to see Jeff, placed his hand on his shoulder, wished him good luck and advised him that he would see him in the morning. He then stated: "Give me five." John Black testified that Jeffrey Burling understood and gave him a firm handshake at that time. There cannot be finger movement or a firm grasp with a C-5 lesion to the spinal cord.

One Brenda Campbell, a registered nurse in ICU from the 3 P.M. to 11 P.M. shift, that is when Jeffrey Burling was taken to ICU, recalls that Jeffrey was on a back board. She did not recall any sand bags. He was very restless and thrasing about the bed.

One Sara Forbes, another staff nurse at ICU, remembered Jeff. On the 3-11 shift, she noted that Jeff was struggling. There were quite a few people with Jeff. He was continued in leather restraints on his

arms and hands. He was being held down by more than two people. There was nothing that indicated that he was quadriplegic and she was surprised to find out the following morning that he was quadriplegic. She saw only that he was moving and needed to be held down.

When Edna Jackson, who received Jeffrey from the Emergency Room to ICU at the staff change (she was just about to get off work) gave her deposition. She stated that he was very restless and would have fallen off the stretcher had he not been restrained.

Somehow, the sand bags at Jeffrey's neck disappeared between the Emergency Room and ICU.

Jeffrey Burling was removed from the Emergency Room to ICU on a backboard. However, he was removed from that backboard to a bed and cranked up to a 45 degree to 70 degree angle.

Most damaging, however, was the testimony of Mary Sirmons, a registered charge nurse, who came on at 8:00 A.M. on April 17, 1979. She found Jeff quadriplegic. She immediately asked what in the world happened. She listened to a taped report from a nurse, Mary Mullen, who cared for Jeff during the night. That taped report informed her that "as the night progressed, he had less movement in both his upper and lower extremities." With a C-5 cord quadriplegia injury, there cannot be movement of the lower extremities.

Mary Mullen, a part-time registered nurse, who took care of Jeffrey Burling from 11 P.M. until the 8 A.M. shift, testified that during the night, when she removed the restraints from Jeffrey, she noticed that the arms moved jerkily and were uncoordinated. About 3 A.M. she called x-ray. She was told that the x-rays had not been read. Until that time, she assumed the x- rays were negative. At about 4 A.M. there was no grasp and no leg movement noted. She noted some flailing of the arms. She called no physician. She did nothing but report her findings to Nurse Sirmons the next morning.

After two and a half hours deliberation, the verdict was $10,000,000.00.