IN THE CIRCUIT COURT FOR THE STATE OF OREGON

FOR THE COUNTY OF MULTNOMAH

KAREN CARMOCAN and DAN CARMOCAN, husband and wife, Plaintiffs, v. KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST, dba KAISER PERMANENTE SUNNYSIDE MEDICAL CENTER, an Oregon domestic non-profit corporation. Defendant.	06731 Case No. 13 0 5 0 6 7 3 1 COMPLAINT (Professional Negligence and Loss of Consortium) (Claim seeks $1,325,000.00) (Claim not subject to Mandatory Arbitration) Jury Trial Requested

Plaintiffs allege:

PARTIES

1.

At all times material, Defendant Kaiser Foundation Health Plan of the Northwest was an active Oregon domestic non-profit corporation doing business as Kaiser Permanente Sunnyside Medical Center in Clackamas County and Multnomah County, Oregon, and its registered agent for the service of process is located in Portland, Multnomah County, Oregon. Kaiser Permanente Sunnyside Medical Center is located in Clackamas County, Oregon (Defendant Kaiser).

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2.

At all times material, Plaintiff Karen Carmocan ("Karen") was a resident of Multnomah County, Oregon.

3.

At all times material, Plaintiff Dan Carmocan ("Dan") was the husband of Plaintiff Karen Carmocan and is a resident of Multnomah County, Oregon.

GENERAL ALLEGATIONS

4.

At all times material herein, all of the services performed on behalf of Defendant as alleged herein, were performed by employees and/or agents, actual and/or apparent, working in the course and within the scope of their employment and/or agency for Defendant.

5.

Karen completed approximately three (3) years of a course of study in family counseling at Portland State University and Mt. Hood Community College prior to her marriage in 2003 to Dan. After the marriage, Karen and Dan decided that Karen would not pursue her educational goal of becoming a family counselor because it was more important to both of them that they have children and raise a family.

6.

Karen started meeting with Dr. Rachel Algenio in approximately 2008 for the purpose of determining whether Karen would be able to give birth to a child.

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7.

At the time Karen started meeting with Dr. Algenio, Dr. Algenio was employed by Defendant in the role of being Karen's obstetrician-gynecologist.

8.

Karen's primary care provider (family doctor) was located at Kaiser's Rockwood Medical Center located in Portland, Multnomah County, Oregon. However the Rockwood Medical Center did not have the facilities she required and therefore she was required to meet with Dr. Algenio at the Mt. Talbert Medical Clinic, adjacent to Kaiser Sunnyside Hospital.

9.

In October 2008, Dr. Algenio represented to Karen that she had a growth on her uterus. It was not until 2011 when Dr. Algenio advised Karen that the said growth would interfere with her ability to have children and because of such, Dr. Algenio recommended that Karen have surgery to remove the growth from her uterus. Dr. Algenio represented to Karen that if she had the tumor removed she should be able to give birth to a child.

10.

Based upon Dr. Algenio's representations to Karen, Karen chose to have the surgical procedure to remove the tumor for the purpose of being able to give birth to a child and raise a family with her husband Dan.

11.

Had Karen been advised by Dr. Algenio of the severity of risk of the procedure, especially the risks related to Karen's excessive weight, such as the increased risk of intraoperative bleeding that Dr. Algenio intended to perform, Karen would have chosen not to go through the procedure

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and would have in fact continued her formal education, completing her course of study in family counseling at Portland State University.

12.

During a pre-operative consultation, Karen asked Dr. Algenio if she should provide pre-surgical blood that could be used by her during or after the surgery if it was necessary.

13.

Karen made the offer to bank her own blood because while doing research about her surgery, Karen became concerned about the risks associated with blood transfusions. Her concern was heightened after similar concerns were raised to her by family members who are medical professionals. Karen had a right, pursuant to 42 CFR Ch. IV § 482.13, to participate in the development and implementation of her plan of care. Karen had the right to make informed decisions regarding her care. Her right included the right to be informed of her health status and its implications for surgery, to be involved in her care planning and treatment, and to be able to request or refuse treatment. Karen had the right to formulate advanced directives and to have hospital staff and medical practitioners comply with those directives. Karen also had these same rights when Dr. Algenio determined that Karen needed a transfusion on November 5, 2011 and thereafter she did not discuss with Karen that she needed an additional blood transfusion on November 5, 2011.

14.

Karen's concerns were also heightened by a chance meeting one day while she was at Defendant's hospital. Karen met another patient who was providing blood to the Defendant hospital and was in fact banking blood for his surgery to ensure that if any additional blood was

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needed for transfusion, it would be his own blood rather than a third party's blood.

15.

Dr. Algenio represented to Karen that it was not necessary for her to provide pre-operative blood because the proposed surgery was a routine surgery; Dr. Algenio would only recommend that Karen's blood be banked if the procedure was not a routine procedure. Karen was denied the opportunity to participate in her treatment by being persuaded not to bank her blood in advance of the surgery.

16.

Karen underwent surgery on October 31, 2011, and had a uterine myomectomy and right salpingo-oophorectomy. The surgery was performed by Dr. Algenio at Kaiser Sunnyside Hospital. At the time of the surgery Karen was 35 years of age and weighed 410 pounds.

17.

A uterine myomectomy is sometimes also called a fibroidectomy and it is the surgical removal of uterine leiomyomas, also known as fibroids. In contrast to a hysterectomy the uterus remains preserved and the woman retains her reproductive potential. The primary complications that may arise from uterine myomectomy include postoperative bleeding and infection; the risk of excessive bleeding increases if many fibroids in different areas of the uterus are discovered that required multiple incisions or if one or more fibroids are quite large.

18.

Following abdominal myomectomy, there is approximately a 1 in 4 chance that there will be blood loss significant enough to require transfusion; a July 2012 study of 200 patients, published in the European Journal of Obstetrics and Gynecology, the incidence of transfusion was

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24.5%.

19.

During the surgery a fibroid tumor measuring fourteen (14) centimeters, two (2) other small fibroid tumors, and a uterine cyst of the approximate size of six (6) centimeters were removed from Karen. The fourteen (14) centimeter fibroid tumor was the equivalent of the gestational period of a 19-week pregnant uterus.

20.

On October 31, 2011, during the surgical procedure Karen lost approximately 1520 ML of blood. The usual range of blood loss of this procedure is 200-800 ML, average being 500 ML.

21.

After surgery on October 31, 2011, Karen left the operating room at 6:19 p.m. and was transported to the Post-Anesthesia Care Unit (PACU) of Defendant's hospital. While she was in the PACU, she vomited on two (2) occasions.

22.

On October 31, 2011 at approximately 8:09 p.m., Karen began snoring loudly, had shallow breathing, was hypoventilating, and had nausea.

23.

Karen was discharged from Defendant's PACU at approximately 8:30 p.m. on October 31, 2011 and was transported to another area of the hospital.

24.

On November 1, 2011, Postoperative Day One, Karen continued to have loud snoring, shallow breathing, and profuse coughing. Karen was hypoventilating (breathing slowly) and had

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nausea. At this time Karen's white blood cell count (WBC) was 12,200 cells/ml.

25.

A normal white blood cell count is in the range of (3,500 to 10,500 cells/ml). An elevated white blood cell count can be an indication of an infection in the body.

26.

At this time Karen was also treated with non-steroidal anti-inflammatory drugs (NSAIDs) for her pain. Karen's creatinine level at this time was 0.63 mg/dl. The normal range for creatinine for a woman of Karen's age is between 0.60 to 1.2 mg/dl.

27.

On November 2, 2011, Karen continued to have loud snoring, shallow breathing, and profuse coughing. Karen hypoventilated and had nausea. At this time she also vomited. Karen's hemoglobin (Hbg) level was 6.1 g/dl, representing severe anemia.

28.

On Postoperative Day Two, namely November 2, 2011, Defendant's nursing staff directed Karen to get out of bed to ambulate. During her ambulation, Karen became pale and felt dizzy. As a result, she was provided a walker to assist her while ambulating. During a telephone conference with Dr. Algenio, Dr. Algenio directed Karen to attempt to ambulate one more time. As a result of Dr. Algenio's request, Karen again attempted to ambulate. While ambulating, she became dizzy, pale, coughed profusely and had a rapid pulse rate. With the use of a walker, Karen was only able to ambulate approximately 75 feet before she was required to stop and to sit down on a bench due to her lack of energy, which was more probably true than not caused by her severe anemia.

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29.

As a result of Karen's difficulty in ambulating, Dr. Algenio recommended that Karen have a blood transfusion. Karen had lost approximately 1520 ml of blood (three units) during the surgery. Post-operatively she had anemia due to her very low hemoglobin (Hbg) level as a result of the surgical blood loss. On November 2, 2012 Karen's hemoglobin level was 6.2 grams/dL. On November 3, 2012 Karen's hemoglobin level was 6.1 grams/dL. On November 4, 2012 Karen received a blood transfusion with two (2) units packed red blood cells (RBCs). On November 5, 2012, Karen's day of discharge, her hemoglobin level was 5.6 grams/dL.

30.

Anemia is generally considered present when hemoglobin concentrations fall below 12 g/dL for non-pregnant women. The severity of anemia is categorized by the following hemoglobin concentration ranges: Mild anemia is considered when hemoglobin is between 9.5 - 12.0 g/dL; Moderate anemia is considered when hemoglobin is between 8.0 - 9.5 g/dL; Severe anemia is considered for hemoglobin concentrations below 8.0 g/dL.

31.

On Postoperative Day Three, November 3, 2011, when Karen attempted to ambulate, she continued to experience shallow breathing, nausea, dizziness, continued to be pale and had shortness of breath and coughed profusely.

32.

On Postoperative Day Four, November 4, 2011, Dr.Algenio determined that Karen had "cellulitis" and prescribed the antibiotic Cefazolin.

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33.

On Postoperative Day Four, November 4, 2011, Dr. Algenio noted that Karen had severe post-operative anemia. Karen was then administered a transfusion of two (2) units of packed red blood cells (RBCs) in an attempt to raise her hemoglobin level before she was released from the hospital. Subsequent to the blood transfusion, Karen's hemoglobin (Hbg) fell to a level of 5.6 grams indicating Karen continued to have post-operative anemia, and as a result, Karen continued to have dizzy spells, a rapid heartbeat, an increase in breathing, and continued to be pale. At that time with a hemoglobin of approximately 5.6 grams, Karen's hemoglobin level was less than half the minimum normal level for an adult female (normal range 12-16 grams/dL). Subsequent to Karen's blood transfusion, she vomited.

34.

After Postoperative Day Four, November 4, 2011, and before her release on Postoperative Day Five, November 5, 2011, Karen's Hbg (hemoglobin level) or white blood cell (WBC) count was not tested.

35.

Sometime during the late evening hours on November 4, 2011 or the early morning hours of November 5, 2011, Karen vomited again.

36.

During the early morning on November 5, 2011, prior to Karen's 11:00 a.m. hospital release, she continued to have periods of nausea, dizziness, and a rapid pulse of 97 at the time of discharge, which is a manifestation of anemia.

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37.

Dr. Algenio saw Karen every day after surgery to discharge except the day she was released. On the day of Karen's release, there was a very short visit with Dr. Sarah Lambert, who signed Karen's hospital release papers. Dr. Lambert was employed by Defendant in the role of authorizing Karen's hospital release. Neither Dr. Algenio nor Dr. Lambert examined Karen's lungs after she vomited on November 4, 2011 and November 5, 2011. On November 5, 2011, before Karen's release, Dr. Lambert only performed an examination of Karen's abdomen.

38.

At no time after Karen's blood transfusion, when her hemoglobin level dropped from 6.2 grams to 5.6 grams, did Dr. Lambert or Dr. Algenio inform Karen that she had severe anemia and suggest the possibility of another transfusion.

39.

At no time during Karen's hospital stay nor at the time of discharge, did Dr. Algenio, Dr. Lambert, or any other medical doctor inform Karen that she had severe anemia and therefore ran the risk of complications of a low red blood cell count, or in the alternative, having an additional blood transfusion to raise Karen's hemoglobin level.

40.

Due to the negligence of the Defendant as herein before and hereinafter alleged, Defendant failed to provide Karen with an additional blood transfusion before she was released from the hospital or in the alternative failed to recommend that Karen receive an additional blood transfusion before she was released from the hospital causing personal injuries to Karen as hereinafter alleged.

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41.

After Dr. Lambert's examination on November 5, 2011, Karen continued to have periods of shortness of breath, nausea, and severe coughing.

42.

Karen was released from Defendant's hospital on November 5, 2011 at 11:00 a.m. After her discharge Karen had a gradual increase of shortness of breath, her cough became more severe, and she continued to have nausea with emesis.

43.

At the time of discharge Karen was not informed of any complications or symptoms of complications of which she should be aware. Furthermore, at the time of discharge Karen was not given any indication of proper post-operative treatment of her cough, the vomiting, and the shortness of breath. Karen also was not informed at the time of her severe anemic state and the complications that could arise as a result of being severely anemic.

44.

At the time of Karen's release from the hospital, Dr. Algenio had committed three (3) breaches of the required standard of care: (1) Failure to anticipate anemia as consequence of what was sure to be a non-routine case; (2) Causing the anemia by excessive blood loss at the time of surgery; and (3) Failure to replace blood to bring her patient's hemoglobin up to a reasonable level before discharge.

45.

When Karen returned to her residence, she had difficulty ambulating before she was placed in her own personal bed and thereafter she had significant difficulty in sitting upright due to her

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surgery, her weight, and her anemia. She began to cough so severely that she once again vomited. Karen continued to feel dizzy and continued to have great difficulty breathing.

46.

Because of Karen's severe cough, she called one of the Defendant's advice nurses who advised her to take an over-the-counter cough medicine she had available in her home in an attempt to stop her severe coughing. The cough medicine Karen took was ineffective, and as a result, Karen's husband Dan called another advice nurse who directed Dan to bring Karen to the emergency room of the Kaiser Sunnyside Hospital.

47.

As directed, Karen went to the emergency room at Kaiser Sunnyside Hospital at approximately 11:52 p.m. on November 6, 2011. Karen was admitted to the hospital from the emergency room approximately six (6) hours later at 6:16 a.m. on November 7, 2011.

48.

At the time of Karen's re-admission, chest x-rays were taken and she was diagnosed with "bilateral pneumonia hospital-acquired without hypoxia but with sepsis", which adversely affected Karen's body organs, notably the kidneys which are especially vulnerable to damage from sepsis. She had shortness of breath and coughed profusely. A CT pulmonary angiogram showed "bilateral infiltrates", which indicate infection, or in the alternative, aspirated stomach contents (as a result of vomiting) in both of Karen's lungs.

49.

Karen's white blood cell (WBC) level at the time of re-admission was 16,800 cells/cubic mm and her hemoglobin level was 7.0 grams. Her hemoglobin level of 7.0 grams indicated the

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continued presence of severe anemia, thereby reducing Karen's ability to combat the lung infection.

50.

Shortly after Karen was readmitted, antibiotics were administered, including an injection of Vancomycin. The generally recommended targeted serum trough level concentration of Vancomycin is 5-15 mcg/ml. Trough concentrations of up to 20 mcg/ml are acceptable for selected severe infections. On November 8 and 10, 2011, Karen's trough levels exceeded the recommended trough level. On November 7, 2011, at the time of Karen's hospital re-admission, her creatinine level of 0.63, which was normal, but became elevated thereafter when Karen subsequently went in to renal failure.

51.

Throughout the day on November 7, 2011, Karen continued to have a wheezing cough. At approximately 1:44 a.m., Dr. William Goodhue described Karen's clinical symptoms and signs as "whitish productive cough with scant hemoptysis (presence of blood)" and "cough, sputum production, hemoptysis, wheezing, orthopnea, and leg swelling." Karen's pulse oximeter reading was 97%. At 7:09 a.m. Karen had an oxygen saturation of 98% while on two (2) liters of oxygen supplementation. Karen's chest x-ray showed significant airspace disease centrally and bilaterally (in the middle of the lungs and at the edge of the lungs on both sides).

52.

On November 8, 2011 Karen had oxygen saturation of 93% on two (2) liters of oxygen supplementation (measured testing Karen's fingertip measurements using a pulse oximeter). At 4:00 p.m. on November 8, 2011, Karen's Vancomycin trough level was 18.4 mcg/ml. During the

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course of Karen's treatment, one or more pharmacists or other health care providers employed by Defendant participated in the selection and dosing of Vancomycin. Throughout the day and into the evening, Karen continued to cough profusely.

53.

In the morning of November 9, 2011, Karen's lung condition deteriorated rapidly. At 8:04 a.m., Karen's arterial oxygen tension was 43 mg Hg. At 8:16 a.m. Karen's arterial oxygen tension was 45 mg Hg; the normal range for a woman of Karen's age is 84-100 mg Hg.

54.

Because of Karen's worsening lung condition, on November 9, 2011 she was transferred back to Defendant's ICU with a diagnosis of hypoxemic (low blood oxygen) respiratory failure. Karen's low blood oxygen levels continued throughout the day. Karen was placed on a high flow nasal catheter (hereinafter referenced as HFNC).

55.

Due to Karen's drop in blood oxygen levels, Karen's kidneys were short of oxygen, and as a result, Karen's kidney function continued to deteriorate and she went into renal (kidney) failure due to acute tubular necrosis. Karen's Vancomycin trough level was 21.4 mcg/mL on November 10, 2011.

56.

Due to the negligence of Defendant as alleged herein, Defendant failed to provide Karen with medically accepted blood oxygen levels which caused physical injuries to Karen.

57.

On November 10, 2011, Karen's left arm had a peripherally inserted central catheter

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(hereinafter referenced as PICC) inserted and she was provided furosemide (Lasix) to reduce her fluid retention and to assist her kidneys in getting rid of unneeded water and salt from her body into her urine.

58.

On November 11, 2011, Karen's creatinine levels were elevated, and because of concern regarding the potential of high Vancomycin levels to cause kidney damage, her treatment with Vancomycin was stopped. Karen was then placed on breathing assistance in an attempt to reduce her blood oxygen deficit.

59.

On November 12, 2011, Karen's creatinine levels rose further. At that time Defendant's medical staff diagnosed Karen's acute tubular necrosis of her kidneys caused by Karen being prescribed an excessive dosage of Vancomycin and diuresis as a result of the continued use of furosemide. A reasonably knowledgeable practitioner would have known that the trough level of Vancomycin should be maintained at a level of 5-15 mcg/ml.

60.

Karen was released from ICU on November 12, 2011. On the evening of November 13, 2011, Karen continued to have episodes of coughing, shortness of breath, and had an inability to get her bi-level positive airway pressure mask off even though she remained on breathing assistance.

61.

On November 14, 2011, Karen was transferred back to ICU for closer monitoring because of hypoxemic respiratory failure and the need for aggressive diuresis. Karen's blood oxygen

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saturation levels (PO2) dropped to 54 mg Hg, and then lower to (PO2) 49 mg Hg, at which time she was intubated for approximately two weeks so she could be attached to a ventilator. Intubation was performed using a Glidescope. At 8:04 a.m., Karen's arterial oxygen tension (PO2) level was 43 mg Hg. At 8:16 a.m., Karen's arterial oxygen tension (PO2) level was 45 mg Hg.

62.

On November 14, 2011, Karen's serum creatinine level was 7.6 (normal range 0.5 to 1.0 mg/dL for women), reflecting renal failure caused by acute tubular necrosis, which necessitated dialysis, which began on November 15, 2011 and continued into March 2012.

63.

After being transferred back to the ICU on November 14, 2011, Karen's mental status deteriorated wherein she became restlessness, agitated, anxious, and began to climb out of bed. Karen had been receiving her nourishment by the use of a Dobhoff nasogastric feeding tube as well as a jugular vein PICC for the purpose of administering medications. In addition, a urinary catheter was inserted.

64.

Due to Karen's deteriorated mental condition, restraints were used on Karen. The physician or physicians that ordered the restraints did not instruct the hospital nursing staff caring for Karen to remove the restraints periodically to relieve pressure on Karen's back, buttocks, and arms. Defendant's physicians did not provide instructions to the nursing staff to turn Karen side – to -back-to side on a prescribed schedule in order to prevent pressure sores and compression neuropathy of the upper extremities.

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65.

The medical records do not show that the restraints were checked by the nursing staff every thirty (30) to sixty (60) minutes, nor do the medical records show that each of Karen's limbs were removed from restraints at least once per hour. The medical records do not show that Karen was examined every three (3) to four (4) hours to determine the development of the detrimental effects directly attributed to the restraints that had been placed upon Karen such as early pressure sores or compression of the ulnar nerves of her arms. The medical records do not show that a Hill-Rom or other like type hospital bed that provides appropriate therapy support services was provided for Plaintiff during her stay at Defendant's facility.

66.

The restraints used on Karen were not checked as required by Joint Commission on Hospital Accreditation Standard PC.03.05.05 regulations (hereinafter referenced as JCOHA or Joint Commission). Defendant did not review the order for the use of restraints within the four (4) hour limit for adults proscribed by the Joint Commission. Karen should have been evaluated by a physician every 24 hours before a new order for restraints was written.

67.

Due to the negligence of Defendant as herein described, Defendant failed to limit the amount of time Karen was placed in restraints without relieving her restraints as well as not turning Karen's body side to back to side on a prescribed, reasonable schedule. Such caused Karen to acquire bed sores due to pressure on the buttocks and, compression neuropathy of her ulnar nerves.

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68.

On November 14, 2011, Karen was transferred back to ICU because of hypoxia and respiratory distress. She was subsequently placed in an induced coma to reduce metabolic demands and agitation.

69.

On November 14, 2011, Karen's serum creatinine level was 7.6 mg/dL. Her diagnosis at this time was non-oliguric acute kidney injury attributed to acute tubular necrosis (hereinafter referenced as ATN) in the setting of infection. ATN is a medical condition involving the necrosis (death) of cells in the kidney tubule that transports urine to the ureters while reabsorbing 99% of the water. Toxic ATN can be caused by certain medications, including Vancomycin.

70.

Anemia played a significant role in the events that followed Karen's surgery. Karen had a decreased number of red blood cells carrying oxygen to her lungs, kidneys, and her other organs. After Karen's pulmonary aspiration, she developed pneumonia and a subsequent "hypoxemic respiratory failure".

71.

On November 15, 2011, Karen had a right internal jugular dialysis catheter inserted.

72.

On November 16, 2011, Karen was administered a transfusion of two (2) units of packed red blood cells (RBCs). Karen's serum creatinine was still elevated at 6.24 mg/dL.

73.

On November 26, 2011, a tracheotomy was performed, a PICC line was put in place, and

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a nasogastric tube was inserted. (Karen had previously been intubated November 14, 2011.) A tracheotomy was performed to maintain her oxygenation and to replace the intubation. It was determined that, by this stage of her problems, Karen was at risk for the syndrome of a critical neurological illness polyneuropathy. Because of Karen's excessive fatty tissue, there was a submental lipectomy when the tracheotomy tube was placed in Karen.

74.

On November 26, 2011, it was determined that Karen had erosion and irritant dermatitis on her right and left buttock (bed sores) as a result of not being turned side – to – back – to - side. No notation or change was made relating to Karen's bed size relative to her body size and body weight. Karen also developed bilateral ulnar neuropathy as a result of not being properly moved during prolonged bed rest.

75.

On November 29 or November 30, 2011, Karen had a right jugular dialysis catheter inserted. Karen received an additional two (2) units of packed red blood cells (RBCs) for the purpose of raising her hemoglobin level. Since Karen at the time was comatose, Karen's husband Dan authorized the blood transfusion.

76.

On or about December 16, 2011, Karen was brought out of her induced coma. Karen was still restless and restraints were placed on her wrists to prevent equipment removal.

77.

On December 19, 2011, while Karen was still on dialysis, she was able to be off her ventilator all day, at which time she attempted to stand beside her bed. The nursing staff made

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seven (7) attempts to assist Karen in standing, but she was unable to do so, and as a result, was placed back into her bed. Again, Karen became very restless and began to pull at the tubes that had been inserted into her body.

78.

On December 25, 2011, it was determined that Karen had a tender left wrist from her restraints at which time a left wrist x-ray showed there was no fracture.

79.

On December 26, 2011, her creatinine was 5.62 mg/dL, indicating continued impaired kidney function; Karen's hemoglobin (Hbg) level was 9.2 grams/dL, which was still at an anemic level.

80.

On January 1, 2012, Karen reported to Defendant's hospital staff that her left hand had numbness; the numbness was determined to be in an ulnar nerve distribution.

81.

On January 3, 2012, Karen was discharged from the hospital to return home, but was still on kidney dialysis. After Karen was released to return home, she continued to have weakness, pain, and impaired function and pain in her left arm and her left wrist, and similar but lesser symptoms on her right wrist.

82.

On January 14, 2012, Karen was taken back to the emergency room because she was vomiting.

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83.

On or about January 17, 2012, electromyographic studies showed that Karen has severe left ulnar neuropathy proximal, as well as in a lesser amount to her right upper extremity. An MRI of the elbow and proximal forearm was recommended.

84.

An MRI was performed on February 6, 2012 and revealed left upper extremity ulnar nerve swelling in the medial elbow and proximal forearm area.

85.

On March 22, 2012, Karen's kidney dialysis catheter was removed.

86.

On April 18, 2012 a consultation was held with Dr. Schmidt, an employee of Defendant. After Dr. Schmidt reviewed Karen's records he advised Karen that in his opinion Karen's bilateral compression ulnar compression neuropathy was more probably true than not as a result of Karen's prolonged bed rest with little or no turning of Karen's body side to – back to – side from time to time in order to prevent compression neuropathy.

87.

In September 2012, Defendant's urologist diagnosed Karen with Stage 3 kidney disease.

88.

On October 3, 2012, Karen's creatinine level was 1.63 (the normal range for a woman of Karen's age is between 0.60 to 1.2). Karen's white blood count (WBC) was 8.7 and her red blood count was 4.26; both of these values are within the normal range. Karen's hemoglobin was 11.9, still slightly below normal. Her platelet count was 383 (Normal range for platelet count is

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140 to 375).

89.

Karen's kidney function deteriorated and she developed renal failure due to acute tubular necrosis due to a combination of factors. These include low blood oxygen (hypoxia) caused by her pneumonia, anemia due to her low hemoglobin level and the Vancomycin serum concentration being maintained at an excessive level.

90.

Vancomycin is an antibiotic used for severe bacterial infections. The drug is eliminated through the kidney and it can be toxic when used in high doses. A well-known side effect to the use of Vancomycin is kidney damage, which results in abnormal kidney function and sometimes irreversible kidney failure. The damage is more likely to occur when the drug is administered in a higher than normal dose.

91.

As a result of the events herein described Karen suffered from hypoxia. Due to the negligence of Defendant as herein alleged as a result of hypoxia, Karen sustained permanent brain damage and post-traumatic stress disorder.

92.

Due to the negligence of Defendant as herein before and hereinafter alleged, combining and concurring, there was failure to avoid and subsequently treat her anemia, and a failure to limit Karen's intake of Vancomycin, as well as a failure to maintain Karen's oxygen saturation level at a normal accepted range of 96-98%. Karen's blood loss at surgery was three times the usual volume of blood loss for that type of surgical procedure. As a result, Karen was caused to receive

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personal injuries as hereinafter alleged.

93.

As a result of the injuries to Karen resulting from the negligence of the Defendant herein before set forth, Karen's is now unable to carry out her normal daily activities.

94.

Defendant's staff has represented to Karen that if she were to now become pregnant she would need to be placed on kidney dialysis during the time of the pregnancy, and even if she were to be placed on kidney dialysis, Karen would still have little chance of being able to bear a child.

95.

As a result of the failures of Defendant as set forth herein to follow the appropriate standards of care, Plaintiff Karen suffered severe and permanent damages. As a result of the negligence of Defendant as set forth herein, Plaintiff Karen was caused physical and mental pain and suffering, mental anguish, emotional distress, physical disability, and numbness and palsy in her left and right extremities, one or more of which conditions may be permanent in nature. As a result of the negligence of Defendant, Karen also suffered from and will continue to suffer from depression, discomfort, extreme fatigue, frustration, anxiety, difficulty sleeping, emotional distress, concentration difficulties, loss of flexibility, problems with balance and equilibrium, immobility, general muscle weakness, intramuscular skeletal pain, and a loss of energy. As a result of the negligence of Defendant, Plaintiff has suffered post-traumatic stress disorder and a permanent brain injury that will affect her long term recovery; Plaintiff sustained significant memory and executive function deficits stemming from her hypoxia, including neurocognitive dysfunctions and a major depressive disorder as well caused by her inability to perform her normal

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and everyday functions.

96.

Plaintiff's injuries have interfered with her ability to carry out her normal and regular mental and physical activities. Plaintiff has incurred and will continue to suffer physical and mental pain, discomfort, emotional stress, inconvenience, and anxiety. For Plaintiff's non-economic damages she seeks such amount as the jury may deem just and appropriate, in the amount of $1,000,000.00.

97.

Plaintiff's medical, hospital and therapy could continue to be ongoing in the future and Plaintiff will amend this Complaint at the time of trial to reflect the full amount of medical expenses. As a direct and proximate result of the negligence of the Defendant and the above-described injuries, Plaintiff has incurred economic damages in the form of support expenses and will continue to incur support expenses in the future in the amount of $150,000.00.

98.

The conduct of Defendant Kaiser was unreasonable; Defendant failed to follow the appropriate standards of care.

FIRST CLAIM FOR RELIEF

(Professional Negligence Alleged by Plaintiff Karen Carmocan)

99.

Plaintiff Karen realleges paragraphs 1 through 98 as if fully set forth herein.

100.

Defendant Kaiser and the agents acting for it owed Plaintiff Karen a duty to use that

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degree of care, skill and diligence that is used by ordinarily careful physicians in the same or similar circumstances in the community of the physician or similar community in the diagnosis, care, and treatment of Plaintiff Karen.

101.

Defendant Kaiser and its agents breached this duty by failing to use reasonable care and diligence in accordance with acceptable medical practices and procedures in the community in the following manner:

(a) Failure to recognize and anticipate the problems that can occur during and following surgery performed on a person weighing 400 pounds. Among these problems, two (2) are especially pertinent to this case: (1) the increased risk of intraoperative bleeding in a patient when the surgical field is deep below an abdominal wall that is several inches thick; and (2) the increased risk of post-operative pneumonia in a patient whose extremely large body reduces the ability to breathe deeply and move about in the bed;

(b) Failure to communicate to Karen the special risks involved in the proposed surgery and to counsel to an informed decision including the extent of her resolve to proceed and the alternative of exploring other options in her life;

(c) Failure to arrange for Karen's blood to be banked for use during or following surgery, especially since this procedure carries a high incidence of requiring blood transfusion;

(d) Failure to inform Karen of the dangers of a transfusion using bank blood instead of her own;

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(e) Failure to control blood loss during surgery. The estimated blood loss of 1,500 cc was triple the usual blood loss with an open uterine myomectomy;

(f) Failure to avoid the use of nonsteroidal anti-inflammatory drugs for post operative pain control. These drugs can cause both gastric irritation with bleeding and also kidney damage;

(g) Failure to respond with a chest x-ray to symptoms and signs that could suggest pneumonia, especially aspiration pneumonia: a record of vomiting in the recovery room and several times later during her Oct. 1 – Nov. 5 hospitalization, a persistent rapid pulse, and intermittent coughing;

(h) Failure to respond to the presence of severe post-operative anemia. The transfusion of only two units of packed red blood cells only brought her hemoglobin level to 5.6 grams/dL at the time of discharge, less than half of the normal range of 12-16 g/dL for an adult woman;

(i) Failing to inform Karen of her severe anemia at the time of discharge, and to alert her to the risks of severe anemia, which include lightheadedness, the possibility of falls, an increased susceptibility to infection, and a reduced oxygen supply to all body organs, including kidney and brain;

(j) Failure to allow Karen to participate in her own care at the time of discharge, specifically by not allowing her to express her opinion regarding whether or not she should be transfused with banked blood;

(k) Failure to examine Karen's lungs on the day of discharge, November 5, 2011. Such an examination might have revealed the presence of pneumonia, and led to a

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decision to cancel the planned discharge, thereby allowing appropriate treatment of Karen's anemia and appropriate investigation to detect possible pneumonia;

(l) Failure on November 5, 2011 to provide Karen with discharge instruction specific to her problems at that time: her severe anemia, her lightheadedness, her repeated cough, and the specific post-operative issues that attend being extremely overweight, such as diet, skin care, and avoidance of thromboembolic disease (blood clots in the leg veins);

(m) Failure by the operating surgeon to contact Karen by telephone on the day she arrived home (November 5, 2011) or the following day (November 6, 2011). Losing contact with a compromised post-operative patient at this critical time in her management is a failure to follow the appropriate standard of care;

(n) Failure to promptly correct Karen's severe anemia, using transfused red blood cells, upon her re-admission to the hospital on November 6, 2011. The persistent anemia, combined with the documented pneumonia, reduced the supply of oxygen to the kidneys, more probably true than not a cause of the acute renal tubular necrosis that subsequently developed;

(o) Failure to maintain serum levels of Vancomycin within a safe range. Karen's high serum levels of this drug, well known to cause kidney damage, were documented to be excessively high during her treatment, more probably true than not contributing to her kidney damage;

(p) Failure to alert Karen or her spouse that Vancomycin could damage her kidneys, and thus preventing her from participating in the decision to use this drug or an

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alternative;

(q) Failure to follow accepted guidelines regarding the use of restraints. Such failure resulted in bedsores on Karen's buttocks and, more important, bilateral pressure neuropathy of the ulnar nerves of the upper extremities, with persistent tingling, pain, and impaired function of her hands and wrists;

(r) Failure to utilize a Hill-Rom or other like type hospital bed that provides appropriate therapy support services was provided for Plaintiff during her stay at Defendant's facility, which could have prevented Plaintiff's bedsores and bilateral pressure neuropathy of the ulnar nerves of the upper extremities, with persistent tingling, pain and impaired function of her hands and wrists;

(s) Failure to anticipate the risk that Karen might develop post-traumatic stress disorder following her complicated hospital course, and to alert and counsel the family regarding this possibility; and

(t) Failure to follow the Defendant's own guidelines, rules and regulations regarding the conduct of employees, physicians, nurse, and others in regard to communication with the patient, the use of medications, the use of restraints, and the discharge of patients from the hospital.

SECOND CLAIM FOR RELIEF

(Vicarious Liability Alleged by Plaintiff Karen Carmocan)

102.

Plaintiff Karen realleges paragraphs 1 though 101 as if fully set forth herein.

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103.

At all times material hereto, upon information and belief, the medical professionals who treated Karen were acting within the course and scope of their employment and/or agency with Defendant Kaiser.

104.

At all times material hereto, upon information and belief, the medical professionals treating Karen acted in a negligent manner by inappropriately advising, treating, medicating, discharging, administering medications, adjusting medications, restraining and monitoring Karen.

105.

As a direct and proximate result of the failures of Defendant and its employees and agents and to follow the appropriate standards of care, Karen suffered severe damage and permanent impairments and was damaged as more fully set forth herein.

106.

Defendant Kaiser is vicariously liable to Karen for the acts or omissions of its employees and/or agents.

THIRD CLAIM FOR RELIEF

(Loss of Consortium by Plaintiff Dan Carmocan)

107.

Plaintiff Dan Carmocan realleges paragraphs 1 through 106 as if fully set forth herein.

108.

As a result of Defendant's negligence, Plaintiff Dan Carmocan suffered a loss of companionship and consortium with his wife to her damage for lost wages and other economic

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damages in the amount of $50,000.00, plus non-economic damages in the amount of $125,000.00.

109.

Defendant is liable to Plaintiffs for all damages alleged herein.

WHEREFORE, Plaintiff Karen Carmocan prays for judgment against Defendant as follows:

1. For Plaintiff Karen's economic damages in such amount as the jury may deem just and appropriate and in such amount as will be proven at trial, subject to amendment prior to trial, and which at this time is alleged not to exceed $150,000.00;
2. For Plaintiff Karen's non-economic damages in such amount as the jury may deem just and appropriate, not to exceed the sum of $1,000,000.00;
3. For Plaintiff Karen's cost and disbursements incurred herein;
4. For leave to amend the particular allegations of negligence against Defendant as further facts become known; and
5. For such relief as the Court may deem appropriate.

WHEREFORE, Plaintiff Dan Carmocan prays for judgment against Defendant as follows:

1. For Plaintiff Dan's economic damages in such amount as the jury may deem just and appropriate and in such amount as will be proven at trial, subject to amendment prior to trial, and which at this time is alleged not to exceed $50,000.00;
2. For Plaintiff Dan's non-economic damages in such amount as the jury may deem just and appropriate, not to exceed the sum of $125,000.00;
3. For Plaintiff Dan's cost and disbursements incurred herein;

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4. For leave to amend the particular allegations of negligence against Defendant as further facts become known; and

5. For such relief as the Court may deem appropriate.

Dated this 13 day of May, 2013.

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