THE FINAL OPTION

DESPITE MAJOR RISKS, GASTRIC BYPASS IS MORE POPULAR THAN EVER

By Rich Rogers and Patrick Block

Obesity has become a major problem in the United States in the last 20 years. Currently, almost two-thirds of the adult U.S. population is overweight and 30 percent are obese. Approximately 14 million Americans are morbidly obese, meaning more than 100 pounds over their ideal body weight.

As so often happens, people look for an easy fix to a complex problem. In this case, elective gastric bypass surgery is the answer to which many have turned.

To those more than 100 pounds overweight, the medical community has touted gastric bypass surgery as the only effective way to obtain permanent weight loss. Proponents have done their best to downplay the major risks of this surgery.

In Portland, the Legacy Good Samaritan Obesity Institute website tells patients that "while a combination of diet and exercise is the healthiest and least invasive way to loose weight, fewer than one in 20 people who are considered morbidly obese can lose weight and permanently keep it off. In 1991, the National Institutes of Health Consensus Conference stated that surgery is the only effective means to obtain permanent weight loss in morbidly obese individuals."

With respect to risks, the Director of the Legacy Good Samaritan Obesity Institute has said that the mortality rate is 0.5 percent despite studies showing the risk to be more than eight times that rate, at 4 percent.

To market these surgeries, surgeons and hospitals throughout Oregon, including Legacy, put on multiple marketing seminars every month seeking to obtain more and more patients for surgery.

The road to gastric bypass surgery

Our client, Marilyn Barney, was drawn in by the marketing and elected gastric bypass surgery as do thousands of others every year. Tragically for Marilyn, it ended her life at the age of 53. She died following 40 days in the intensive care unit at Legacy Good Samaritan Hospital.

Marilyn was born in California in 1947. She married her husband, Jerry, in 1968 after his return from the Vietnam War. At that time of her marriage, Marilyn stood 5'2" and weighed 120 pounds. By 1972, Jerry and Marilyn had two children and Marilyn's weight began to increase. In 1979, Marilyn lost both of her parents in an auto collision and in 1987 her son was killed right before graduating high school. Both of these events were very hard on Marilyn resulting in additional weight gain. In 1992, Marilyn and Jerry moved to Redmond, Oregon, where Marilyn worked for an electrical co-op and Jerry worked for the U.S. Forest Service.

By 2000, Marilyn weighed 270 pounds despite her numerous dieting attempts. She had sleep apnea, esophageal reflux disease and significant problems with her feet, all related to her

After years of dieting, but still weighing more than 270 pounds, Marilyn Barney felt as if surgery was her best weight loss option. Marilyn went into a coma shortly after undergoing gastric bypass surgery.

weight.

By early 2001, Marilyn was desperate to find a way to control her weight. After hearing how well gastric bypass surgery had worked for singer Carney Wilson, Marilyn began looking on the Internet at the possibility of weight loss surgery for herself.

Marilyn quickly discovered that a local surgeon in Redmond was holding monthly marketing seminars for weight loss surgery in the lobby of his office. Every month the surgeon conducted the seminar and had several patients who had undergone weight loss surgery tell those attending of their success stories. The participants then each received color brochures on the surgery and were told that the risk of death was about 1 in 200 patients. However, as of 2001, this surgeon had never actually performed bariatric surgery on his own. Instead, he would perform the pre-surgery workup on these patients and send them to Portland for surgery.

The full court marketing press

In early 2001, Marilyn, Jerry and their daughter, Shonna, all attended the marketing seminar put on by the surgeon. Marilyn was very excited about what she heard. She was impressed with the success stories and felt that finally there was a solution to her weight problem. She then contacted the surgeon to begin the pre-surgical process required before the surgery.

As part of the pre-surgical workup, Marilyn had to undergo a cardiac test, lab tests, a sleep apnea test and a psychological evaluation. The psychological evaluation is required to ensure that the patient does not have any eating disorders that may inhibit weight loss after surgery.

In Marilyn's case, after litigation began, it was discovered that the Redmond surgeon had sent her to a non-licensed psychological evaluator with a Ph.D. in education for her psychological evaluation.

The evaluator never saw Marilyn but instead had his colleague wife perform the psychological examination. Without seeing or talking to Marilyn, the evaluator issued a written report to the surgeon approving Marilyn for the gastric bypass surgery. However, the evaluator did not get around to issuing the report until more than a month after Marilyn had undergone the surgery. By that time, Marilyn was lying in a coma in the ICU at Legacy Good Samaritan Hospital.

After Marilyn went through the pre-surgery workup, the Redmond surgeon had Marilyn schedule an appointment with the surgeon in Portland who would actually perform the gastric bypass surgery. On August 30, 2001, Marilyn and Jerry came to Portland and met with the surgeon one time for about 15 minutes.

The surgeon was busy and hurried. She read Marilyn's medical chart during the meeting. After the meeting, the surgery was scheduled to take place on Oct. 1, 2001.

Laparoscopic roux-en-y surgery

The most common bariatric surgery is the laparoscopic Roux-en-Y gastric bypass. The purpose of the surgery is to reduce the functional size of the stomach by more than 90 percent. That is accomplished laparoscopically by cutting the stomach near the esophagus and creating a pouch with staples that can hold about 70 cubic centimeters of food and fluid. The typical adult stomach can hold approximately 3000 cubic centimeters of food and fluid.

Once the pouch is created, the surgeon cuts the small intestine below the remaining stomach in a section called the jejunum. The small intestine is composed of three sections: the duodenum, which comes off the stomach; the jejunum, the middle part; and, the ilium, which connects to the large intestine.

The surgeon cuts the small intestine in the jejunum and connects the lower part of the jejunum to the small stomach pouch the surgeon previously created, thereby bypassing the remaining stomach. The upper end of the jejunum that runs to the stomach is then reconnected to the small intestine in order for the bile from the bypassed stomach to enter the small intestine for digestive purposes. When complete, the small intestine is in a pattern of a Y.

In performing this surgery, the sur-

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geon makes two connections called "anastomosis," with the small intestine. If these connections are not performed properly, the small intestine can become obstructed or leaks can form along the staple lines or suture lines that are created in making the connections. These complications are extremely serious and will lead to death if not promptly evaluated and treated.

Risks known by physicians

Gastric bypass surgery is known in the medical community to be difficult with major risks. According to Legacy's Obesity Institute Director, "It is a difficult procedure technically because you are doing it on morbid[ly] obese patients so their abdominal wall is this thick. All the organs are surrounded in fat. It is just difficult to see the anatomy. You are struggling with torque so there are technical reasons it is difficult. I think even on a thin person it would be a demanding surgery, you know, there is rearranging anatomy, two anastomosis, and it is high risk because of the surgery and the anatomy and there is a lot of staple lines that can leak and you are rearranging the intestines. And then also the patients are morbidly obese. They don't have a normal immune system. They often have many co-morbidities so they don't have a lot of physiologic reserve. So if they have a complication, they're much less likely to survive than a patient who is ideal body weight." Unfortunately, Marilyn was not given all this information through the marketing seminar or her visits with the surgeons.

Marilyn's surgery

On Oct. 1, 2001, Marilyn entered Legacy Good Samaritan Hospital expecting to leave in three days, and be back to work in three weeks just as she had been told. That never happened.

Marilyn arrived at the hospital at 6 a.m. with her husband Jerry and daughter Shonna. The surgery began at 8:30 a.m. and ended at 1 p.m., which was longer than expected. After the surgery, the surgeon went to the waiting room and spoke to Jerry and Shonna who were concerned because the surgery had taken so long. The surgeon told them it took longer because it was really cloudy and she had to move a lot of stuff around.

After the surgery, things turned from bad to worse. Marilyn began exhibiting multiple signs and symptoms of an obstruction and perforation of her small intestine that are some of the most dangerous complications of a gastric bypass surgery.

Unbeknownst to Marilyn or her family, during the surgery the surgeon had made the lower connection of her jejunum to her small intestine using staples that were too small to make that connection. As a result, blood leaked and clotted in her small intestine causing an obstruction. The obstruction then caused a

perforation or hole to develop in Marilyn's small intestine allowing bile from her stomach to leak into her abdominal cavity.

If an intestinal perforation like Marilyn had is not diagnosed and repaired promptly, it will lead to peritonitis (inflammation of the abdominal cavity), sepsis, multiorgan failure and death. Therefore, it is imperative that the surgeon be diligent in his or her postoperative care to look for any signs or symptoms of a potential intestinal perforation.

In a postoperative gastric bypass patient with an intestinal perforation or leak, such as Marilyn had, the patient will exhibit numerous signs and symptoms of the perforation or leak including low blood pressure, tachycardia, increased hematocrit, increased white blood cell count or increased premature white blood cells called bands, decreased urine output (less than 150 ccs per hour), decreased oxygen saturation level, increased temperature, shortness of breath and abdominal pain. In the late stages, the patient will also become delirious.

Between October 1, 2001 and October 4, 2001, Marilyn developed virtually all of the signs and symptoms of an intestinal perforation. They were all documented in her medical chart by the nurses on a daily basis and available for the physicians to review. Despite all of Marilyn's signs and symptoms of an intestinal perforation, neither the surgeon nor the two first year surgical residents who were attending to Marilyn during this time did anything other than observe her condition as she continued to deteriorate.

Misleading leak test

Marilyn and her husband had no reason to suspect an intestinal perforation or leak either. After the gastric bypass surgery, Marilyn, like all gastric bypass patients, underwent a gastrografin test which physicians commonly tell patients is a "swallow test." The purpose of the test is to check for leaks in the intestinal tract after the surgery. The patient swallows barium and a diagnostic film is taken to see if there are any leaks.

Marilyn was told that her swallow test showed no leaks. However, unbeknownst to Marilyn, the test only checks the upper connection of the jejunum to the surgically created stomach pouch and not the lower connection of the jejunum to the small intestine. Marilyn's perforation or leak was in the area of the lower connection that the test did not check. The surgeon never told Marilyn of the limitations of the swallow test. As a result, Marilyn was under the false impression that she had been thoroughly checked for leaks and there were none.

By the morning of Oct. 5, 2001, Marilyn was completely delirious. The last words her husband remembers her saying were "am I in heaven?" On that

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morning the surgeon came into Marilyn's room and saw bile actually leaking out of one Marilyn's laparoscopic incision sites. At that point the surgeon finally realized that Marilyn had an intestinal perforation and arranged for an emergency surgery to repair it.

After the emergency repair surgery, Marilyn was placed in the intensive care unit on a ventilator. She never spoke another word to her family. Over the next several days Marilyn continued to be septic and developed an extensive wound abscess in the area of the repair surgery. To treat the abscess, Marilyn underwent four wound debridement surgeries in nine days ending with the removal of her entire left chest wall. Despite these surgeries, Marilyn remained septic and finally died on Nov. 15, 2001, in the ICU. On the day of Marilyn's death one of the nurses gave Jerry a slip of paper on which she had written the telephone number of an attorney.

Litigation begins

In October 2004, our office filed suit on behalf of Marilyn's estate in Multnomah County. We named the hospital, Legacy Health System, the surgeon's practice group, The Oregon Clinic, P.C., and the surgical residents' employer, OHSU, as defendants. We initially alleged that the defendants were negligent in performing Marilyn's gastric bypass surgery when it was not indicated and in failing to timely evaluate Marilyn for an intestinal obstruction or perforation when she had signs and symptoms of those complications. The allegations of negligence expanded and became more detailed as we learned more through discovery.

A younger, healthier Marilyn

As is typical in these cases, we took the surgeon's deposition first. During the surgeon's deposition, Rich Rogers was able to get her to admit that Marilyn had multiple signs and symptoms consistent with an intestinal perforation on October 2, 3 and 4, 2001, and that nothing was done to evaluate her for an intestinal perforation. That was a major accomplishment in the case.

Rogers was also able to get at the surgeon's attitude toward her patients,

which played an additional role in valuing the case. Although probably not admissible at trial, during her deposition the surgeon claimed that her difficulty in getting malpractice insurance to perform gastric bypass surgeries was a "crisis" while Marilyn's death was an "unfortunate" event.

The surgeon also admitted to sending high risk gastric bypass patients up to OHSU for surgery because there was a damages cap at OHSU and it was less likely the patient would sue if there were complications.

After completing the surgeon's deposition, we took the depositions of every nurse who attended to Marilyn in the hospital from the time of her gastric bypass surgery to the time of her emergency repair surgery. We also took the depositions of the surgical residents who had attended to Marilyn. All of these witnesses confirmed Marilyn's multiple signs and symptoms of an intestinal perforation. In addition, we took the depositions of the Redmond surgeon who Marilyn first contacted about gastric bypass surgery and the psychological evaluator who approved Marilyn for the surgery in the report issued after the surgery had occurred.

As the depositions proceeded, we continued to consult with our experts, including three gastric bypass surgeons, a radiologist, a pathologist, a clinical psychologist and an economist.

After reviewing the deposition transcripts, the gastric bypass surgeons told us that the surgeon's failure to evaluate Marilyn for an intestinal perforation for four days when she was showing multiple signs and symptoms of an intestinal perforation on each of those days was an aggravated disregard of her professional duties, which is the standard to establish punitive damages through an expert in a medical malpractice case. *Johannesen v. Salem Hospital*, 336 Or 211, 82 P3d 139 (2003) and *Noe v. Kaiser Foundation Hospitals*, 248 Or 420, 425 P2d 306 (1967).

Based on those expert opinions and the aggravated facts of Marilyn's multiple signs and symptoms of an intestinal perforation that were not evaluated over such a long period of time, we filed a motion to amend the complaint to add a claim for punitive damages. We submitted our expert opinions through an attorney affidavit without revealing the name of the expert.

The motion was heard by Judge Henry Kantor on June 13, 2006. At the conclusion of the hearing, Judge Kantor granted the motion. Of importance, Judge Kantor ruled that on a motion to add punitive damages under ORS 31.710 plaintiff could submit his expert opinions to the court through an attorney affidavit without revealing the name of the expert. Judge Kantor also ruled that in Marilyn's particular case the facts alone, without the expert opinion, were sufficiently egregious to warrant punitive damages. Getting punitive damages allowed in the case against the surgeon's clinic gave us additional leverage in settlement discussions with that defendant.

In addition to the post-surgical aspect of the case, we also developed the pre-surgical part of the case. Through consultation with our clinical psychologist expert, we learned that Marilyn should never have been approved for the gastric bypass surgery in the first place. In other words, the surgery was never indicated.

Marilyn had an eating disorder brought on by stress that needed to be addressed psychologically before she ever underwent the surgery. Unfortunately, the psychological evaluator Marilyn saw never determined this problem and approved her for surgery the same as he had approved all other gastric bypass candidates.

Late developments

The case was then scheduled for trial on Oct. 31, 2006. As the case drew near to trial, the surgeon's clinic and OHSU began to seriously discuss settlement. The hospital refused. Through that process,

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we learned that each of the defendants had hired experts to defend only their direct employees' conduct. The surgeon's clinic had hired gastric bypass surgical experts to defend the surgeon, the hospital had hired nursing experts to defend the nurses, and OHSU had hired surgical experts to defend the surgical residents. However, we had alleged and intended to prove that the surgeon was not only an employee of the surgeon's clinic but also an apparent agent of the hospital under *Jennison v. Providence St. Vincent Medical Center*, 174 Or App 219, 225 P3d 358 (2001). Proving that the surgeon was an apparent agent of the hospital would allow us to hold the hospital vicariously liable for the conduct of the surgeon. We also knew that under ORS 31.610 any settlement funds we received from the surgeon's clinic would not offset any amount awarded against the hospital for the surgeon's conduct.

The day before trial, plaintiff settled with the surgeon's clinic and OHSU and got both of those defendants to agree to walk away with their experts. The only remaining defendant was the hospital, which only had nursing experts. Therefore, if we were successful in proving that the surgeon was an apparent agent of the hospital under *Jennison*, we knew that the hospital had no experts to defend the surgeon.

On the morning of trial, we announced to the hospital's counsel that plaintiff had settled with the other defendants and intended to proceed to trial that morning against the hospital only. At first, the hospital's counsel sat there stunned. We watched him as the realization of his predicament finally sank in. It didn't take him long to figure out that without the other defendants, he had no experts to defend the surgeon. He also knew full well that we had good evidence that the surgeon was an apparent agent of the hospital because he had previously moved for summary judgment on that issue and lost. In responding to the summary judgment motion, we had been able to find an archived website of the hospital from 2001 showing Marilyn's surgeon as one of the team of bariatric surgeons of the hospital. In desperation, the hospital's counsel finally stood up and requested an immediate trial postponement. The court denied it as fast as it was made.

The parties then proceeded with jury selection, which concluded by the lunch break. As we broke for lunch, the hospital's claims adjuster approached and wanted to seriously discuss settlement for the first time. Within an hour, we reached a settlement with the hospital and put an end to the litigation.

Family

The two years of litigation had been hard on Jerry. He felt a tremendous relief that it was over and he could finally put Marilyn to rest.

Final thoughts

Despite the marketing, gastric bypass is a high risk surgery performed on high risk patients who have little reserves if complications arise. Most of the gastric bypass cases our office has seen have involved death, like Marilyn's case. In our experience, these cases can be handled successfully by fully understanding the medicine, including abnormal post-surgical signs and symptoms, and retaining highly qualified experts in gastric bypass surgery.

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