CAUSE NO. 95-018195

QUINNETTA DUGAS, Plaintiff,	§	IN THE DISTRICT COURT OF
VS.	§	
DOUGLAS A. KARPEN, THE WOMEN'S PAVILION, INC. and THE WOMEN'S PAVILION, P.A., et al. Defendants.	§	HARRIS COUNTY, TEXAS
	§	234TH JUDICIAL DISTRICT

P10

FILED 95 MAR 30 BY DEPUTY

MOTION TO COMPEL EXPERT WITNESSES' REPORT

TO THE HONORABLE JUDGE OF SAID COURT:

Quinnetta Dugas, Plaintiff, files this Motion to Compel Expert Witnesses' Report and would show the court the following:

GOOD CAUSE

1. This case is currently set during the three-week period beginning May 13, 1996.

2. Plaintiff has requested of Defendants that they produce expert reports in production requests directed to each defendant and has requested in interrogatories propounded to each defendant that they state the substance of each expert's opinions and the factual basis for such opinions. Defendants have not provided detailed responses in their interrogatory answers nor have they produced expert reports.

3. In response to Defendants' similarly stated discovery requests, Plaintiff's expert has produced a detailed five (5) page report and a supplemental report. See Exhibit A. Plaintiff requests that the Court compel a written report from each of Defendants' expert witnesses.

PRAYER

WHEREFORE, PREMISES CONSIDERED, Plaintiff requests that the defendants be compelled to produce expert reports at least 48 hours prior to the deposition of Plaintiff's designated expert witness, Dr. Roy Stringfellow, and that Plaintiff have such further relief to which she may show herself justly entitled to receive.

Respectfully submitted,

G. SCOTT FIDDLER
5959 West Loop South, Suite 150
Bellaire, Texas 77401
TBA #06957750
(Tel.) 713/661-1146
(Fax) 713/661-6371
ATTORNEY FOR PLAINTIFF

CERTIFICATE OF CONFERENCE

The counsel for Plaintiff and Defendants have conferred with each other and have and while counsel expect to reach an agreement, no such agreement was reached by the time this motion was filed. If such an agreement is reached, this motion will be withdrawn.

G. SCOTT FIDDLER

CERTIFICATE OF SERVICE

This is to certify that a true and correct copy of the above and foregoing has been this day served on Defendants' counsel in compliance with T.R.C.P.

SIGNED this 30 day of April, 1996.

G. Scott Fiddler

EXHIBIT "A"

Roy C. Stringfellow, M.D., P.C., F.A.C.O.G.
Diplomate of American Board of Obstetrics & Gynecology
Practice Limited to Gynecology & Infertility

June 19, 1995

Mr. Scott Fiddler
5959 West Loop South, Suite 150
Bellaire, TX 77401

Dear Mr. Fiddler:

Thank you for asking me to review the medical records of Quinnetta Dugas. As you know, she is a 20-year-old lady who had a dilation and evacuation abortion at 24 weeks. Her course was complicated by profuse vaginal bleeding caused by a lacerated cervix. She eventually had to be transferred from an outpatient setting to a hospital with operative facilities. She was transfused with thirteen units of blood and required exploratory surgery and eventual hysterectomy.

I have reviewed this case, and I have a number of concerns. I will outline these below. As I continue to review this case, there may well be additional concerns, and I will send you an addendum if necessary.

Ms Dugas presented to the Women's Pavilion in the late mid trimester of her pregnancy requesting abortion. An ultrasound was performed which placed her at approximately 24 weeks gestation. She was counseled that abortion was appropriate, and she was scheduled for a multi-stage D&E pregnancy termination. There is no mention in the records available to me that any other alternatives, such as continuation of pregnancy, adoption, prostaglandins abortion, or saline abortion, were discussed with the patient.

She had Laminaria inserted and then returned the next day and had more Laminaria inserted, and then she returned on the third day for her abortion. Her abortion was done at the Women's Pavilion, which is a free standing clinic. From the records available, it appears that the clinic does not have anesthesia coverage. Nor are there facilities for doing a laparotomy or other major operation, and there are no facilities for a blood transfusion.

The records from the Women's Pavilion are quite sparse and are mostly handwritten. Many of the handwritten notes are practically illegible. I do not have a copy of the handwritten or dictated operative report or pathology report on the fetus. There is no specific mention of anesthesia or analgesia, but there is a mention, at one point in the records, that the patient was lifting up off of

the operating table. This would lead me to believe that the patient had her abortion performed under paracervical block local anesthesia and/or IV sedation. Either of these two methods would provide only minimal pain relief for a D&E termination at 24 weeks.

There, apparently, is ultrasound equipment available at the clinic, as her preabortion ultrasound was performed there. However, there is no mention of use of ultrasound equipment just prior to, during, or after her abortion.

Dilation and evacuation was accomplished probably under local and/or IV sedation analgesia. The patient was taken to the recovery room where her bleeding was observed to be "moderate". She was ambulated, but became nauseated and vomited, and her bleeding significantly increased.

She was taken back to the operating area where an examination was done to rule out cervical laceration or retained products. A repeat curettement was performed. Apparently, the uterus seemed to be fairly well contracted, and there was no obvious cause for the bleeding that could be ascertained. She was then taken back to recovery, and observation continued. I can only find one notation of one dose of Methergine having been given in the recovery area.

Her bleeding persisted as "moderate", but it did not slow down, and it finally became obvious to Dr. Karpen and the clinic personnel that the patient was in extremis. They finally put in a call for an ambulance to transfer the patient to a hospital where appropriate care could be rendered. The time from initial call to arrival of ambulance was approximately half an hour. The patient had been observed for 1 1/2 hours total prior to arrival of the ambulance. At no time was it recognized that the patient was bleeding profusely and was approaching a state of profound shock.

Once the ambulance arrived, Dr. Karpen simply gave instructions to the ambulance attendant and instructed a nurse to accompany the patient to the hospital. Dr. Karpen did not ride in the ambulance, and he was not available to the emergency room personnel to give details of the patient's care.

Upon arrival in the hospital emergency room, she was noted by the emergency room personnel to have "profuse" vaginal bleeding, and she was already showing signs of a serious coagulation defect. Fresh blood drawn at admission that should have clotted within a few minutes took 1 1/2 hours to clot. It was recognized that the patient was in extreme trouble, and she was transfused with four units of blood and prepared for surgery. She was ultrasounded and evaluated by physical examination, but no obvious cause for the bleeding could be ascertained. The doctors feared cervical laceration or perforation.

She was taken to the operating room, and an exploratory laparotomy was performed. There was very little blood within the peritoneal cavity, and there was a relatively small hematoma under the bladder flap involving the left broad ligament. Her physicians reflected the bladder flap and tried to inspect for a perforation in hopes of salvaging the uterus. Unfortunately, blood continued to well up once the peritoneum had been incised, and a specific bleeding site could not be localized.

The patient was very unstable, and there was concern for profound shock. Therefore, it was elected to proceed with a hysterectomy on an emergency basis to try and stem the bleeding. The patient required multiple transfusions and essentially had a total replacement of her entire blood volume (12 to 13 units of blood).

Postoperatively, she had a stormy course secondary to her coagulation defect, pulmonary edema, and a postoperative fever. Her postoperative care was quite good, and eventually these problems were resolved. She was discharged on the sixth postoperative day in relatively good condition, but, unfortunately, minus her uterus.

I see a number of very serious problems with this case.

1. The handout consent form that the patient was given was inadequate and misleading.

The statement was made that an abortion at 20 weeks carried a mortality rate of no more than 11 per 100 thousand. The remark was then made that there are no statistics for gestations beyond this point, but that there could be expected a significant increase risk for each week beyond 20 weeks. Then the statement was made that regardless of the weeks gestation, abortion was safer than delivery of a baby.

A dilation and evacuation of a 24 week pregnancy is an extremely complex and difficult procedure even in the best of hands. Only the most skilled and experienced of abortionists should undertake this type of a procedure. Dr. Karpen has, unfortunately, had two mothers die at his hands doing this same type of procedure, and this should have been more than enough to indicate this was a far riskier procedure than a vaginal delivery.

2. Inappropriate type of abortion.

As already noted, only the most skilled and experienced abortionists should consider a D&E at 24 weeks. A much safer form of abortion would involve installation of prostaglandins into the amniotic cavity. This would usually kill the fetus and initiate contractions and allow passage of the fetus vaginally. The placenta could then be delivered and, if necessary, any retained fragments could be removed by way of a simple D&C. This would have been a much safer procedure, but, the patient was never given the option of this alternative.

3. Inappropriate location.

Termination of an advanced pregnancy of 24 weeks gestation should be performed in a hospital with full operative capabilities and with blood banking facilities. At the very least, the abortion should be performed in a free standing clinic that had the capability of transporting the patient to an appropriate facility that would be no more than five minutes travel away.

The Women's Pavilion, obviously, had no adequate transport facility. The patient was observed for 1 1/2 hours with quite significant vaginal bleeding and, even once the decision had been made to call an ambulance, it took half an hour for the ambulance to even arrive at the clinic. This is completely unacceptable, and the delay experienced by Mrs. Dugas was nearly fatal and, very probably, resulted in loss of her uterus.

4. Inadequate counseling.

There is no evidence that the patient had adequate preabortion counseling. There is no indication that the many alternatives were discussed to any degree, and she certainly was not given a clear picture of the danger she faced with the type of abortion and the locality of the abortion. There is no mention whatsoever that the post abortion syndrome was discussed. This is often a debilitating feeling that women have after abortion that involves immense guilt that they have "killed their baby". This is a very real syndrome and affects a considerable number of women after the abortion process.

A woman having an abortion at a very advanced stage, such as 24 weeks, would be at a much higher risk of experiencing this syndrome. There is no evidence that the patient was counseled that her fetus was potentially viable at 24 weeks. It should have been very clear that it may become known to her in the future that her fetus was potentially viable and that this might have a profound psychological impact. The fact that the fetus' nervous system is very well developed at 24 weeks and that the fetus would have experienced extreme pain, as it was dismembered and torn from the uterine cavity could also severely affect the patient psychologically. There is no evidence from the records that the baby was injected or anesthetized in any way.

5. Inadequate anesthesia.

The pain with a D&C at 24 weeks gestation can be expected to be extreme. This is not only important for the patient's comfort, but extreme pain can elicit extreme movements on the patient's part, and this can greatly increase the risk of laceration or perforation, and it can make appropriate exposure very difficult. In fact, it was mentioned in the clinic records that the patient "lifted up off of the table", and this certainly reflects inadequate analgesia or anesthesia.

Also, in an advanced pregnancy of this nature, a general anesthetic and a hospital setting would have been a much safer avenue for completing the procedure. Should there be excessive bleeding or other indications of injury, laparoscopy or laparotomy could be performed, and the problem could be solved well ahead of the patient reaching a point of profound shock. It is obvious that Ms Dugas was not given adequate anesthesia. Nor was the abortion performed in an appropriate locale.

6. Inadequate use of available equipment.

Ultrasound was available, but was not utilized just prior to, during, or immediately after the two operative procedures. She did not receive ultrasound evaluation until she arrived at the hospital.

7. The extent of the patient's hemorrhage was not recognized.

Ms Dugas' hemorrhage had to be profuse for the patient to become hypovolemic to the point that she developed a coagulation defect and eventually required a 12 or 13 unit blood transfusion. She essentially bled severely enough to have her entire blood volume replaced by transfusion. The bleeding observed in the abortion clinic was often quoted as "moderate," and appropriate transfer was therefore delayed.

She had very little bleeding intra-abdominally, and, therefore, the vast majority of her bleeding had to be vaginal. Inappropriate evaluation of the bleeding resulted in procrastination and nearly cost the patient her life and, very likely, did cost her her uterus and future fertility.

The patient's care after arrival in the emergency room was quite appropriate. Her new physicians made the best of a very bad situation and essentially saved her life.

By contrast, the care at the abortion clinic was grossly negligent in multiple areas and was certainly far below acceptable standards of care.

There are many areas that I have not touched upon that also are of concern. I would be happy to discuss these with you in the future.

Thank you for asking me to participate in the evaluation of Ms Dugas' case.

Sincerely,

Roy C. Stringfellow, M.D.

RCS/rkf

Roy C. Stringfellow, M.D., P.C., F.A.C.O.G.
Diplomate of American Board of Obstetrics & Gynecology
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July 7, 1995

Mr. Scott Fidler
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Fax (713)661-6371

Dear Mr. Fidler:

This letter is in reference to the care rendered by Naomi Nickles/Nickeus, Melissa Bunt/Brent, and Tonya Padgett.

Ms. Nickles assisted Dr. Karpen with Ms. Dugas's abortion. The nursing care of Ms. Dugas by Ms. Padgett was substandard. She did not indicate anywhere on the records that she appreciated the severity of the hemorrhage that occurred and there is no evidence that she tried to see that Ms. Dugas was transferred in a timely fashion. This lack of appreciation and delay materially effected the disastrous outcome Ms. Dugas experienced.

Ms. Padgett and Ms. Bunt allegedly counseled Ms. Dugas prior to the abortion. There is no evidence from the records that the counseling was even remotely adequate. In fact, it was misleading. There is no evidence that either counselor discussed options such as adoption or prostoglandins abortion or saline abortion. They did not mention the extreme danger of a D&E abortion, nor did they disclose that Dr. Karpen had 2 women die undergoing similar procedures. The counseling (or lack of) resulted in the patient going into this procedure that almost cost her her life with a false understanding of the risks involved.

Sincerely,

Roy C. Stringfellow, M.D.

RCS/bt

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