IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION

HELEN MONROE, Administrator of the Estate of REGINA ROMERO, Deceased,	)	
Plaintiff,	)	
v.	)	No. 04 C 7358
UNITED STATES OF AMERICA,	)	
Defendant.	)	

FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER

I. INTRODUCTION

This is a medical negligence and wrongful death action brought against the United States based on events occurring at the United States Department of Veterans Affairs Westside Medical Center ("the VA"), currently known as the Jesse Brown Medical Center, and located in Chicago, Illinois. This case is brought pursuant to the Federal Tort Claims Act ("FTCA"), 28 U.S.C. §§ 2671-80. The court has jurisdiction of the subject matter and the parties. 28 U.S.C. § 1346(b).

This case involves the care and death of 46-year-old Regina Romero who was a patient of the VA from July 18, 2001 until her death on September 5, 2001. Plaintiff Helen Monroe is the Administrator of the Estate of Regina Romero. She

brings this action for pain and suffering of Regina Romero based on the Illinois Survival Act, 755 ILCS 5/27-6, and for loss of society suffered by Mrs. Romero's children based on the Illinois Wrongful Death Act, 740 ILCS 108. The FTCA provides that the law of the place where acts or omission occurred, here Illinois, provides the substantive law for an FTCA claim. 28 U.S.C. § 2674.

The United States answered the complaint and denied that a contract surgeon who performed a surgery on July 18, 2001, Melissa Gilliam, M.D., was an employee of the VA. Plaintiff amended her complaint and added Dr. Gilliam as a direct defendant. Dr. Gilliam moved to dismiss based on the statue of limitations. Her motion was granted in part but denied as to the Wrongful Death claim of the decedent's minor daughter. *See* ***Monroe v. U.S.***, 2007 WL 839992 (N.D. Ill. March 13, 2007). Thereafter, Dr. Gilliam urged that she was an employee of the United States and not individually liable. *See* ***Monroe v. U.S.***, 2008 WL 818263 (N.D. Ill. March 21, 2008) (denying summary judgment because factual dispute existed). This court (Judge Zagel) heard evidence on Dr. Gilliam's employment status and found that the VA exercised such control over her services that she was an employee of the United States, thereby making the United States liable for her conduct. *See* Order dated Jan. 27, 2011 (Docket Entry 114). The individual action against Dr. Gilliam was thereafter dismissed.

The case proceeded to trial on the theory of plaintiff that negligence was committed by Dr. Gilliam on July 18, 2001 and also by the surgeons who treated Regina Romero from after the initial surgery until her death on September 5, 2001.

II. FINDINGS OF FACT

Based on the oral and written testimony, the stipulations and exhibits submitted by the parties, the court finds, pursuant to Fed. R. Civ. P. 52(a), the following facts to have been proven by a preponderance of the evidence.

A. Stipulated Facts

1. In July, 2001, Regina Romero was diagnosed with carcinoma in situ of the cervix and referred to Westside for treatment.[1]

2. On July 18, 2001, Dr. Melissa Gilliam performed a cold-knife cone biopsy of the cervix.

3. A cold-knife cone biopsy, or conization, involves an incision around the circumference of the cervix to remove involved tissue.

4. Dr. Gilliam cut out a seven centimeter by two centimeter portion of the cervix during the biopsy.

5. Dr. Gilliam encountered bleeding during the procedure.

6. She attempted to control the bleeding with packing and pressure.

[1]She was eligible for treatment because her late husband was a veteran.

7. When the packing was removed, the wound was still bleeding and, according to Dr. Gilliam, she attempted to stop the bleeding by injecting Monsel's solution into the vagina.

8. Monsel's solution is a yellowish brown solution of ferric (iron) subsulfate with a low (acidic) pH.

9. Monsel's solution is commonly used by gynecologists to stop oozing from cervical biopsies. It is also used for skin biopsies.

10. When the bleeding abated, Mrs. Romero was taken to the recovery room.

11. Within 30 minutes, she exhibited signs of hypovolemic shock along with signs of bleeding into the peritoneal (abdominal) cavity.

12. She was taken back to the operating room for urgent surgical abdominal exploration.

13. The second procedure was performed by Dr. Gilliam with Dr. Miguel Teresi, a VA attending surgeon, and Dr. Michele Molinari, a VA surgical resident also present in the operating room.

14. Dr. Teresi was a United States employee.

15. Dr. Gilliam performed a hysterectomy to stop the bleeding.

16. A perforation of the uterine wall and entry of Monsel's solution into the abdominal cavity occurred during the cone biopsy performed by Dr. Gilliam.

17. Monsel's solution stops bleeding by binding proteins in blood into a glue-like substance.

18. When put on tissue, the solution denatures certain structures of the cell, causing necrosis, or cell death.

19. A July 26, 2001 CT scan showed free air in the abdominal cavity, a sign of bowel perforation.

20. On July 26, Mrs. Romero was taken back to the operating room for an emergent laparotomy, which revealed bowel perforation.

21. The July 26th laparotomy was performed by Dr. Stuart Lipnick, a VA general surgeon. Dr. Molinari and Dr. Gilliam were in the operating room during the procedure.

22. During this procedure, a portion of jejunum--the middle section of the small intestine--was resected and sent to pathology for analysis.

23. By July 31, the date scheduled for closure of the surgical wound and removal of the feeding tube and cassette cover, Mrs. Romero still was not improving and showed signs of sepsis. Dr. Lipnick took Mrs. Romero back to the operating room for exploratory laparotomy and found fluid and multiple adhesions and abscesses, which were removed.

24. He also found that the previously placed feeding jejunostomy was loose and that the previous anastomosis was allowing leaks. He reinforced his

stitches on the anastomosis and the feeding tube and inserted drains to decompress fluid collection in the abdominal cavity.

25. Until her death on September 5, 2001, Regina Romero suffered a long and painful post-operative course with many complications.

26. Mrs. Romero underwent numerous additional surgical procedures, including washouts, dead bowel debridements and hematoma evacuations.

27. She suffered severe swelling throughout her entire body and particularly in her arms and legs.

28. She suffered from toxic epidermal necrolysis ("TEN"), caused by a drug reaction.

29. She also suffered from a coagulopathy which caused bleeding.

30. Monsel's solutions entered Mrs. Romero's abdominal cavity during the July 18, 2001 biopsy performed by Dr. Gilliam.

31. The Monsel's solution then caused sepsis, multiple complications and, eventually, death.

B. Additional Facts

Based on the evidence, additional facts are found as follows:

31. Regina Romero was referred to the Westside VA by a physician at the Hines VA Medial Center in order to have a cone biopsy because of an abnormal pap smear and colposcopic biopsy which showed carcinoma in situ, a

precancerous cervical disease that had not become invasive. A cone biopsy is diagnostic and often curative. Pathology results of the cone biopsy later confirmed that Mrs. Romero did not have an invasive disease.

32. A cold-knife, cone biopsy--or conization--is an incision with a scalpel around the circumference of the donut-shaped cervix to remove involved tissue. According to expert gynecological testimony, the size of a cervical biopsy specimen is normally about 2 x 2 cm and at most 3 x 3 cm. Dr. Gilliam cut out a 2 x 7 cm portion of Mrs. Romero's cervix. The specimen included a portion of the lower uterus. Removal caused a laceration of the uterine arteries, a perforation at the cul-de-sac of the vagina and excessive bleeding.

33. Dr. Gilliam had difficulty visualizing the source of the bleeding during the conization. When the bleeding was not controlled by pads, she called from the operating suite to her clinical nurse in the out-patient service asking that a ferric subsulfate solution known as Monsel's solution be brought to the operating suite. The operating suite did not stock this product for surgeries.

34. Ferric subsulfate is a chemical styptic agent used by gynecologists and dermatologists for hemostasis after biopsies of skin sites. It is effective because of its oxidizing capacity and its low pH (acidic quality) aids in the denaturing of proteins. It will cause blood clotting, but will also destroy tissue. The proper application of Monsel's solution is with a cotton swab to a body site

that will easily heal. According to expert testimony, the application of the solution to abdominal organs like the bowel can be damaging because these organs are not in the same environment as body skin and do not heal the same way. Dr. Gilliam stated that she instilled Monsel's solution with a syringe directly into the vagina. According to expert testimony, it is never appropriate to inject Monsel's solution into the vagina. Dr. Gilliam's operative notes state that she used "ferric sulfate" (subsulfate).[2]

35. When Mrs. Romero's bleeding abated after the biopsy, she was taken to the recovery room. Within 30 minutes she exhibited signs of hypovolemic shock along with signs of bleeding into the peritoneal cavity. She was taken back to the operating room for an urgent laparotomy (abdominal exploration) and hysterectomy.

36. Before the second procedure was performed on July 18, Dr. Gilliam called for surgical assistance. She was assisted by Dr. Miguel Teresi, a VA

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[2]Drs. Jeffrey H. Shuhaiber, Stuart Lipnick, Miguel Teresi, Michele Molinari, Jei Ryoo, and Jose Clinton from the Departments of Surgery and Pathology, West Side Veterans Center, published an article in the peer-reviewed journal *Surgery* entitled "*More on Monsel's Solution*." Vol 137, Issue 2, 263-4 (Feb. 2005). The article describes Mrs. Romero's case and the use and effects of Monsel's solution. Dr. Lipnick testified about the contents of the article and it was reviewed by the testifying experts. The United States objects to the article [plaintiff's Exhibit 1] as hearsay. However, the article was written by physician employees of the VA who attended the patient in the case described. It is admissible. Fed. R. Evid. 801(d)(2).

attending general surgeon, and Dr. Michele Molinari, a VA surgical resident. Both were employees of the VA at that time.

37. When Drs. Gilliam, Teresi and Molinari opened Mrs. Romero's abdomen on July 18, they observed a copious amount of viscous coffee-ground-like material all over the abdominal cavity. This material was blood clotted by Monsel's solution. They also observed a perforation of the uterine wall with perforation into the abdominal cavity and injury to both uterine arteries. These injuries occurred as a result of the cone biopsy. A hysterectomy was performed to stop the bleeding and the area was irrigated to remove blood material.

38. According to expert testimony, by July 22, Mrs. Romero should have been improving in all aspects. However, she became febrile (feverish), her white blood cell count became elevated and her heart rate remained elevated--all signs of infection. On July 26, Mrs. Romero suffered septic shock. At that time, a surgical resident contacted Dr. Lipnick, a VA general surgeon. A CT scan revealed fluid on the abdomen and Dr. Lipnick made the decision to perform a laparotomy--the opening of the abdomen to see inside. Dr. Lipnick's preoperative diagnosis was "perforated viscus."[3] Dr. Gilliam was present during the procedure.

[3]Viscus refers to any internal organ.

39. The July 26 operative findings included a crust throughout the peritoneal cavity and a necrotic (dead) portion of the small bowel, which was resected. A primary anastomosis was performed, that is, sewing the two remaining ends of the small bowel together. A jejunostomy feeding tube, or J-tube, was inserted into the jejunum. The surgical wound had to be left open and covered with a piece of plastic because of bowel swelling. A subsequent pathology report regarding the small bowel specimen revealed microscopic findings of necrotic tissue on the margins. Necrotic tissue on the margins means that live bowel was sewn to dead bowel or dead bowel was sewn to dead bowel. The pathology report also revealed that the surface of the bowel specimen removed was inflamed all the way to the edges of the specimen. This finding was from the "gross description." "Gross" means visible to the naked eye.

40. Mrs. Romero was returned to the operating room for a planned closure of the surgical wound on July 31. That surgery revealed complete dehiscence, or breakdown, of the July 26 anastomosis, allowing enteric fluid (bowel contents) to leak into the abdominal cavity. There was an abscess between loops of small bowel and around the spleen. The surgeons attempted to drain the abscess, removed the J-tube and irrigated the abdominal cavity. Instead of resecting the dehisced anastomosis, Dr. Lipnick sewed it back together. The

anastomosis later came apart because it contained dead tissue when it was sewn together on July 26.

41. Plaintiff's expert, Dr. Michael Berman, testified regarding the gynecology standard of care during a cone biopsy. Dr. Berman is a gynecologic oncologist and a Professor Emeritus at the University of California, Irvine ("UCI") Medical Center. He completed an obstetrical residency in 1974 and a gynecologic oncology fellowship in 1976. He has been board-certified since 1976 and has been a full professor at the UCI College of Medicine since 1990. He has authored or coauthored two medical textbooks, 32 book chapters and 185 articles in peer-reviewed journals.

42. Dr. Berman's testimony was presented through the submission of his deposition transcript and his report. Dr. Berman testified that Dr. Gilliam removed a 2 cm x 7.5 cm sample during Mrs. Romero's cone biopsy. A sample that size is "never appropriate." The typical sample size is 2 cm x 2 cm and the largest allowable size is 3 cm x 3 cm. Dr. Gilliam testified that she removed a large specimen because she was concerned about extensive cervical disease. According to Dr. Berman, however, it is not proper to remove such a large portion of the cervix. The standard of care requires the performance of a "standard conization" with any remaining abnormal tissue treated in other ways, such as a hysterectomy.

43. Dr. Berman testified that Dr. Gilliam was negligent in: cutting out an excessively large portion of the cervix; perforating the uterus; causing bilateral uterine artery injury; lacerating the cul-de-sac of the vagina resulting in massive bleeding and leading to hypovolemic shock; and allowing entry of Monsel's solution into the abdominal cavity. Dr. Berman stated that, after the hysterectomy, the standard of care required the "surgical team" to recognize the presence of a foreign material and to remove it. The standard of care also required the team to inquire and communicate about what led up to the need for the second surgery on July 18, 2001, including information about the use and effects of Monsel's solution.

44. The defendant did not disclose or present any expert testimony concerning Dr. Gilliam's conduct and did not present any testimony, other than Dr. Gilliam as to some issues, that contradicted any of Dr. Berman's opinions.

45. Plaintiff presented the testimony of Dr. Jeffrey Freed, a general surgeon with over 34 years of experience of colorectal surgery. Dr. Freed has been licensed since 1972. He is board certified in general surgery. Since 1979, Dr. Freed has been colorectal surgery section chief at the Bronx VA Medical Center and, since 1992, a Professor at Mt. Sinai Medical School in New York City. Dr. Freed testified that the surgeons deviated from the standard of care during five different time periods: on July 18, 2001 by failing to explore properly

the abdominal cavity and fully remove blood and Monsel's solution; during July 19-26, 2001 by failing to recognize the need for a CT scan and reexploration; on July 26, 2001 by failing to properly resect the diseased bowel; from July 26-31, 2001 by failing to timely reexplore the bowel; and on July 31, 2001 by failing to resect the failed anastomosis.

46. Dr. Freed testified that Dr. Gilliam caused a laceration of the wall of the uterus where the cone biopsy extended into the uterus. Dr. Gilliam cut through the cervix, the body of the uterus, the wall of the vagina and into the peritoneal--or abdominal--cavity.

47. Dr. Berman stated that "coffee ground" material means blood mixed with an acid. In this case, the material was blood mixed with Monsel's solution. Though the surgical team described an attempt to irrigate the pelvis and abdomen, they could not possibly have done so appropriately. Dr. Freed testified that Drs. Teresi, Molinari and Gilliam deviated from the standard of care in: inadequately exploring the abdominal cavity; and inadequately irrigating the cavity including failing to remove the Monsel's solution.

48. Dr. Freed testified that the surgeons could not possibly have explored or irrigated correctly because their incision was not long enough to allow them to see or access the entire abdominal cavity. In support, Dr. Freed pointed to Dr. Lipnick's July 26, 2001 operative note, in which Dr. Lipnick states that "in

order to visualize the area in question," he had to extend the incision made on July 18. On July 18, it was impossible to comply with the standard of care by looking through the incision made by Drs. Gilliam, Teresi and Molinari.

49. Dr. Freed testified that there was a delay in returning Mrs. Romero to the operating room when she did not get better between July 18 and July 26, 2001. The standard of care required of all of the physicians in the Surgical Intensive Care Unit ("SICU") and on the regular surgical floor was hyper-vigilance during the post-operative course because of the complication on July 18. All of the patient's trends had to be improving. The post-operative standard of care for a patient who underwent a hysterectomy and had significant bleeding required the expectation that the patient would get better every day. Her temperature, pulse, white blood count, appetite, bowel function and respiratory function must get progressively better. This is so because bleeding into the abdominal cavity is known to cause infection. On July 22, Mrs. Romero had a fever and persistent tachycardia, abdominal distension and was vomiting. The VA ordered a blood culture to check for bacteria in the blood, which would be an infection. If a physician is concerned about infection in a patient like Mrs. Romero, 95% of the time, it is in the abdominal cavity. By July 24, Mrs. Romero was chilled, feverish, tachycardia, her white blood cell count was high and she was in significant pain.

50. A reasonably careful physician's required response was an urgent CT scan of the abdomen and pelvis to check for abscess development or the radiological signs of a sick bowel. Dr. Freed stated that this standard of care is unrelated to the presence of Monsel's solution. It was required for all abdominal surgery post-operative patients with signs and symptoms like Mrs. Romero's.

51. Dr. Freed testified that a CT scan by July 24 would have shown positive radiological findings of a sick bowel, such as swelling, inflamation and/or narrowing of the lumen. Those findings required reoperation, which could have saved Mrs. Romero's life in Dr. Freed's opinion. That is so because the bowel had not yet perforated and the abdominal cavity was not bathed in non-sterile bowel contents. Perforation changes the prognosis and lessens the effectiveness of treatment. Waiting until a patient perforates to operate triples the mortality. By July 26, it is undisputed that the bowel had perforated. It is "essentially impossible" that the bowel was radiologically normal on July 24, according to Dr. Freed.

52. Dr. Freed also testified that every physician who examined Mrs. Romero deviated from the standard of care. The standard of care for an abdominal surgery post-operative patient required competent, responsible oversight by a general surgeon. If Mrs. Romero was not examined by an attending

general surgeon, then the general surgery residents responsible for her care were "unproctored." That itself was a deviation from the standard of care.

53. When Dr. Lipnick finally took Mrs. Romero back to the operating room on July 26, he had to extend the original abdominal incision to properly view all of the bowel and the abdominal cavity. After examining the bowel, Dr. Lipnick found one section of damaged bowel. That portion had a perforation and another section looked diseased but with no perforation. Dr. Lipnick cut away a small portion of the bowel and sewed the remaining ends together. At least one end of the bowel he sewed together, however, was not alive. According to Dr. Freed, whatever process was going on would have been visible to the naked eye and went all the way to the end of the bowel section Dr. Lipnick removed. That process was described in the "gross description" section of the VA's official pathology report, meaning that the VA pathologist was able to simply look at the bowel section and see whatever process was making the specimen sick had inflamed it all the way to the edges. According to Dr. Berman, Dr. Lipnick did not need the pathology report to suspect that dead bowel went all the way to the end of the resected portion. According the Dr. Berman, all he needed to know was that the outside of the bowel was inflamed. The standard of care required him to recognize, understand and act on the significance of this finding.

54. Under the standard of care, Dr. Lipnick could have resected the bowel further to be sure he did not sew dead bowel back to live bowel or he could have avoided an anastomosis, closed off one end of the bowel and brought the other portion to the surface in order to allow the bowel to heal. If unsure how far the disease process extended, he could have requested a frozen section from pathology while he waited in the operating room. The one thing the standard of care did not allow was sewing diseased bowel back together because there is "no possibility" that such an anastomosis will stay together.

55. Dr. Lipnick testified that he believed the perforation he saw on July 26 was caused by ischemia, or a period of low blood flow as a result of bleeding. According to Dr. Freed, ischemia, however, almost always affects the bowel "further downstream." Further, ischemia kills the bowel from the inside out and not the outside in. On July 26, Dr. Lipnick knew (or should have known) from viewing the bowel with his naked eye that the mucosa - the innermost part of the bowel - was the only part spared. The cause of a sick or dead bowel in this situation, however, does not change the surgical approach or the standard of care. A surgeon must attach live bowel to live bowel. If he is not sure, he must not perform an anastomosis.

No part of this standard of care depended on knowledge of the use of Monsel's solution which Dr. Lipnick stated, he was not aware of it being used.

However, the use of ferric sulfate is stated in Dr. Gilliam's operative notes contained in the hospital record of Mrs. Romero's care. And Dr. Gilliam was in the operating room when the laparotomy was performed on July 26.

56. Between July 26 and July 31, Mrs. Romero did not get better. When Dr. Lipnick operated again on July 31, he found "complete dehiscence" of the anastomosis he had performed on July 26. His operative note indicates there were no new perforations. The standard of care at this point required "taking apart the failed anastomosis," which entailed cutting the bowel back to healthy tissue and then closing one end and bringing the other end out to the abdominal wall. Instead, Dr. Lipnick sewed the necrotic parts of the bowel back together. This was a deviation from the standard of care according to Dr. Freed.

57. The plaintiff called Dr. Lipnick as an adverse witness. Dr. Lipnick was a VA employee and director of the SICU at Westside. Dr. Lipnick stated that surgical critical care is a primary component of general surgery and it related to the care of patients with acute, potentially life threatening conditions. He testified that the SICU was staffed by surgical residents and that Mrs. Romero was seen at least every day--and mostly twice a day--by a general surgery resident. In the six days between July 19 and July 26, Mrs. Romero was seen and examined at least eleven different times by general surgery doctors--both in the SICU and on the regular floor. On July 26, Dr. Lipnick became involved because a general surgery

resident called him, not Dr. Gilliam. Dr. Lipnick made the decision to take Mrs. Romero to surgery on July 26, not Dr. Gilliam. Dr. Lipnick was not intimately familiar with Mrs. Romero's course before July 26, 2001, and he did not conduct any investigation. Dr. Lipnick stated that he did not know that ischemia was not the cause of the perforation until a telephone call from pathology as he was going into surgery on July 31 revealed the pathology finding that the sample removed on July 26 did not show ischemia.

58. Dr. Lipnick opined that a CT scan was not needed by July 24 because there was an "alternative" explanation for Mrs. Romero's condition. His opinion is that some physicians would have ordered a CT scan, but the "majority" would not. Dr. Lipnick stated that post-surgical infection or sepsis can be characterized by fever, increased white blood cell count and tachycardia. He agreed with an American College of Surgeons' statement that post-abdominal-surgery patients with fever, high white blood cell counts, tachycardia and/or acidosis should undergo timely re-exploration. He admitted that, after abdominal surgery, if there may be bowel injury, a surgeon should not wait until full-blown sepsis to reoperate. In that situation, a surgeon should err on the side of taking the patient back to surgery. Dr. Lipnick also stated that, for patients with bowel injury, the earlier they are reoperated on, the better they do.

59. The VA's autopsy report states that on July 25, a KUB (kidney, ureter, and bladder) X-ray study, showed an acute event, either a bowel perforation or hemorrhage. Dr. Lipnick admitted that a KUB with such findings requires early surgical intervention.

60. Dr. Lipnick confirmed that, to properly visualize the entire abdominal cavity on July 26, he had to extend the July 18 incision made by the other surgeons. He found minimal adhesions with only one necrotic section of bowel. The rest of the bowel was uninjured. Dr. Lipnick stated that a photograph of a picture in his case report shows live tissue at the edges of the specimen he removed. The VA pathology report, however, states that the process affecting the bowel extended to the edges of the specimen resected and it was visible on gross examination. Dr. Lipnick claims that he sewed the two ends of the bowel together because the mucosa-the inner lining--looked fine and he "assumed" the outer wall was fine, too.

61. Dr. Lipnick admitted that a "second look" was required within 48 hours if a surgeon was concerned about whether he had resected back to clean, healthy bowel. A second look was "not necessarily" required for Mrs. Romero, according to Dr. Lipnick, because it had not been long since the July 26 procedure. He conceded that proper management for a patient with an ischemic bowel insult is to resect all of the dead tissue.

62. On July 31, Dr. Lipnick found that the anastomosis had broken down allowing the bowel contents to leak, leading to multiple abscesses. He did not find any other areas of perforation and no other diseased areas of bowel. He stated that the anastomosis failed because both ends of the bowel that he sewed together were not healthy and that one of the main reasons for an anastomosis to fail is the continued presence of dead tissue. He did not resect any more bowel or remove the anastomosis and tie off the bowel. He simply stitched the failed connection back together again and it continued to leak.

63. Dr. Lipnick stated that, on or shortly after August 1, 2001, he concluded that Mrs. Romero's case was hopeless without a "bowel transplant." A bowel transplant would have been required to even attempt to save her. The bowel would "continue to degrade" because of the presence of Monsel's solution. Dr. Lipnick did not report that the bowel was unsalvageable and did not write any note stating his opinion. He had no conversation with the patient's family regarding a bowel transplant nor did he tell the Chief of Surgery that the entire small bowel had died or would die or that the case would be fatal without a bowel transplant.

64. As stated in the autopsy report, the VA's chief of pathology found that the cause of death was: "Sepsis with multiple organ dysfunction syndrome

(MODS) secondary to intra-abdominal chemical and subsequent bacterial peritonitis with widespread tissue necrosis."

65. The VA, acting through its agents and employees, violated the applicable standard of care during the treatment of Mrs. Romero as follows:

(a) Removal of excess cervical tissue;

(b) A uterine perforation and entry into the abdominal cavity;

(c) Use of excess Monsel's solution to stop bleeding;

(d) Failure to adequately explore and irrigate the abdominal cavity to remove clotted blood and Monsel's solution;

(e) Failure to perform a timely CT scan and failure to perform a timely laparotomy;

(f) Failure to properly diagnose and treat a bowel perforation;

(g) Failure to perform a timely "second look" laparotomy; and

(h) Performing an anastomosis on necrotic tissue.

C. Survival Act Damages

66. Damages are recoverable for a decedent's physical pain and mental suffering suffered while alive and conscious. In order to recover these damages, a plaintiff must present evidence that the injured party was conscious at some point after an injury and endured pain and suffering.

67. On and after July 18, 2001, Mrs. Romero suffered a long and painful course with many complications. She was forced to endure multiple additional surgical procedures to "wash out" the peritoneal cavity. Her course was complicated by, among other things, sepsis, disseminated intravascular coagulopathy ("DIC"), adrenal insufficiency, pulmonary embolism and toxic epidermal necrolysis ("TEN"). She suffered severe pain for almost her entire hospitalization. By July 27, Mrs. Romero, through on a ventilator, was arousable and in pain. By July 28, she had generalized and marked edema. Her fingers were so swollen, her ring had to be removed. She began to have blistering on her arms and thighs. She also had a large amount of constant drainage from her open abdominal wounds and she was forced to undergo dressing changes several times per day that were so painful she had to be pre-medicated with morphine. Even with pain medication, Mrs. Romero was making "facial grimaces" during procedures.

68. On August 3, 2001, Mrs. Romero underwent tracheotomy placement. She was febrile and sweating; she had a catheter in her urethra; she had drain tubes sticking out of her abdomen, draining yellow-green fluids; she had an arterial catheter and a central venous catheter; she had a rubber tube suctioning fluid from her abdominal wound; she had a gastronomy-tube; and she was on a ventilator attached to a tube surgically inserted through her neck. She also had

bluish stool with reddened and irritated perineal area and a heat-rash-like redness on her back. She complained of pain over the abdominal area and throat. She had a new pelvic drain placed and continued to accumulate necrotic debris under the plastic cassette covering her abdomen.

69. As of August 4, 2001, Mrs. Romero had generalized edema with her arms so swollen they were pitted. She communicated with her mother by squeezing her hand. She had continued drainage from four drains in her abdomen. She was awake and responsive, and in response to questions about pain, she mouthed "stomach." Her drainage was alternately brown, clear and bloody. On August 9, her arms and legs were mottled, diffusely swollen and cold to the touch. She was bleeding profusely from the abdominal incision and had blood oozing from multiple sites, including her tracheotomy, causing blood to cake around her mouth. Small blisters began to form over her entire body.

70. On August 10, she was lethargic but grimaced with oral suctioning. Over the next several days, she continued to have generalized severe swelling and blisters with bluish discoloration on finger tips and both feet, related to TEN. The blisters covering her entire body oozed and she bled from every orifice due to her DIC. She arrested on August 11 and was revived. Over the next several days, her TEN advanced to oral mucocutaneous involvement and desquamation of the

hands, legs, arms, trunk, face and gums. She remained responsive, aware and in severe pain.

71. By August 29, 2001, Mrs. Romero developed a bedsore on her sacrum requiring debridement. On September 1, her arterial line was removed resulting in "projectile oozing." According to VA records, her mental status remained "good." By September 2, she was responsive only to deep pain. She remained unresponsive only from September 2, 2001 until her death on September 5, 2001. Throughout her course or treatment, Mrs. Romero remained generally alert and in severe pain. Dr. Lipnick testified she was the "sickest" patient he had ever taken care of.

72. The plaintiff submitted a separate "Analysis of Comparable Verdicts." A cited case involved a $1,700,000 verdict for a 57-year-old electrician who suffered with extensive burns for three days before dying. In the present case, Regina Romero sustained burn-like injuries both internally and externally. Portions of her bowel were "burned" by Monsel's solution leading to a cascade of painful and ultimately deadly complications. One of those complications was TEN which caused the top layers of her skin and mucous membranes to blacken, die and slough off, leaving extensive open wounds.

73. In another case, the decedent suffered a punctured duodenum during spleen surgery. That puncture led to complications similar to those

Mrs. Romero suffered and required the decedent to undergo two additional laparotomies before he died one month after the initial surgery. The verdict was $2,000,000 for pain and suffering and loss of a normal life. In the present case, Mrs. Romero suffered 50% longer than the compared decedent and was forced to undergo 14 additional laparotomies, debridements and washouts, sepsis, and other things.

74. The plaintiff seeks $3,000,000 for 46 days of pain and suffering and 49 days of loss of normal life and disfigurement. The United States recommends an award of $1,000,000 if the Court finds liability.

D. Wrongful Death Act Damages

75. The purpose of the Illinois Wrongful Death Act is to compensate the next of kin for the pecuniary losses resulting from the loss of society of a loved one. ***Ford-Sholebo v. U.S.***, 980 F. Supp. 2d 917, 999 (N.D. Ill. 2013). Society has been defined as encompassing "a broad range of mutual benefits each family member receives from the others' continued existence, including love, affection, care, attention, companionship, comfort, and protection." ***Watson v. S. Shore Nursing & Rehab. Ctr., LLC***, 2012 IL App (1st) 103730, 965 N.E.2d 1200, 1208 (2012) (quoting ***Sea-Land Servs., Inc. v. Gaudet***, 414 U.S. 573, 584-87 (1974)).

76. Under Illinois law, the plaintiff is entitled to a presumption that the death of a parent has caused loss of society to a surviving child. ***Ballweg v. City***

of Springfield, 114 Ill. 2d 107, 499 N.E.2d 1373, 1379 (1986). At the time of her death, Regina Romero was 46 years old. According to Life Expectancy Tables in evidence, Mrs. Romero had a life expectancy of 36.7 years. Mrs. Romero's daughter Christina was thirteen years old when Regina died. Christina lived with her mother in Berwyn. Christina's father, Scott Czmil, lived in Addison, Illinois with his wife and family. Christina moved in with her father's family when her mother died.

Mrs. Romero's other child was her son Gilbert, who was 25 years old when she died. As of 2001, Gilbert Romero was not living with his mother and had been incarcerated for periods before her death and while she was hospitalized. At the time of Mrs. Romero's hospitalization and subsequently, Gilbert lived with his grandmother, plaintiff Helen Monroe.

77. Plaintiff has submitted a list of comparable wrongful death verdicts. Verdicts involving an identifiable minor child of the decedent, range between $1,000,000 to $7,689,000. The average verdict for minors was $2,724,280. Courts have recognized that the loss of society for a minor child is more serious than for an adult child.

78. Verdicts involving adult children of decedents have ranged from $750,000 to $3,500,000 for an average of $1,636,615. Plaintiff requests that an award for Christina be $2,500,000 and that an award for Gilbert be $1,750,000.

The United States suggests that, if liability is found, the awards to Christine and Gilbert should be in the range of $1,000,000 to $1,500,000 for Christine and $250,000 to $750,000 for Gilbert.

79. Gilbert and Christine are the heirs at law of the decedent and will participate in the proceeds of her estate consisting of any Survival Act Award.

III. CONCLUSIONS OF LAW

1. Illinois law provides that, for a medical negligence claim, the plaintiff must show: " (1) the standard of care in the medical community by which the physician's treatment was measured; (2) that the physician deviated from the standard of care; and (3) that a resulting injury was proximately caused by the deviation from the standard of care." ***Neade v. Portes***, 193 Ill. 2d 433, 739 N.E.2d 496, 502 (2000). The elements must be proven by a preponderance of the evidence, which is proof that the elements are more probably true than not true. ***Campbell v. U.S.***, 904 F.2d 1188, 1193 (7th Cir. 1990) (quoting ***Hare v. Foster G. McGaw Hosp.***, 192 Ill. App. 3d 1031, 549 N.E.2d 778, 781 (1st Dist. 1989)); ***Bennett v. U.S.***, 2006 WL 495968 *6 (N.D. Ill. Feb. 24, 2006).

2. In a malpractice action a plaintiff must produce expert testimony to establish all three elements of the required proof. ***Wilbourn v. Cavalenes***, 398 Ill. App. 3d 837, 923 N.E.2d 937, 949 (1st Dist. 2010). A physician is held to the reasonable skill which a physician in good standing in the community would use

in a similar case. ***Ford-Sholebo***, 980 F. Supp. 2d at 985 (quoting ***Neade***, 739 N.E.2d at 502). In the present type of situation, the expert need not testify to the standard for Chicago but can instead rely upon nationally uniform standards. ***Wilbourn***, 923 N.E.2d at 953-54.

3. Proximate cause in a medical malpractice case must be established by expert testimony to a reasonable degree of medical certainty. Any causal connection between treatment, or delay in treatment, and the claimed injury "must not be contingent, speculative or merely possible." ***Walton v. Dirkes***, 388 Ill. App. 3d 58, 903 NE.2d 18, 20 (1st Dist 2009) (quoting ***Aguilera v. Mt. Sinai Hosp. Med. Ctr.***, 293 Ill. App. 3d 967, 691 N.E.2d 1, 7 (1st Dist. 1997). If the injury would have occurred even in the absence of the conduct complained of, then such conduct was not a proximate cause of the injury. ***Campbell***, 904 F.2d at 1193 (quoting ***Hare***, 549 N.E.2d at 871). A plaintiff must prove that it is more probably true than not true that negligence was the proximate cause of the injury. ***Id.***

4. Plaintiff has proven by a preponderance of the evidence that, on July 18, 2001, Dr. Gilliam breached the standard of care during a cone biopsy by removing too large a piece of tissue which caused uterine perforation, cul-de-sac laceration, massive bleeding and hypovolemic shock.

Dr. Gilliam also breached the standard of care by inserting Monsel's solution in excessive amounts into the patient's vagina.

5. Plaintiff has proven by a preponderance of the evidence, that on July 18, 2001, after hypovolemic shock of the patient occurred in the recovery room requiring the return to the operating room, Dr. Gilliam and the assisting surgeons breached the standard of care during an emergency hysterectomy. A perforation of the posterior wall of the uterus was identified where the cone biopsy had extended past the cervix to the body of the uterus in an area called the posterior cul-de-sac, an avenue to the peritoneal cavity. Dr. Gilliam and the surgeons who assisted her found a copious quantity of viscous coffee-ground-like material throughout the peritoneal cavity which was identified as clotted blood. The exploratory process and the irrigation procedure to remove all of the blood product was inadequate.

6. Plaintiff has proven by a preponderance of the evidence that the care and treatment of Regina Romero between July 18 and August 1, 2001 deviated from the standard of care in the following instances:

By failing to provide a timely CT scan to discover bowel inflamation before Romero went into shock as a result of a bowel perforation which required an emergency laparotomy and anastomosis on July 26, 2001.

By failing to confirm, by examination and inquiry, or by pathology study if necessary, that before any anastomosis was performed the bowel perforation was not caused by an ischemic condition but rather by the effects of Monsel's solution.

By performing an anastomosis in a situation in which the cause of a bowel (jejunal) perforation was uncertain with the result that necrotic tissue was joined and the anastomosis subsequently failed.

By performing an anastomosis of necrotic bowel tissue after being told by a pathologist that the bowel tissue specimen was not ischemic but was otherwise injured.

7. Plaintiff has proven by a preponderance of the evidence that multiple deviations from proper standards of care were the proximate cause of the suffering and death of Regina Romero.

8. The procedure to determine non-economic damages in a bench trial is to compare damage claims with verdicts and awards in similar cases. ***Jutzi-Johnson v. United States***, 263 F.3d 753, 758-59 (7th Cir. 2001); ***Arpin v. United States***, 521 F.3d 769, 776 (7th Cir. 2008).

9. Under the Illinois Survival statue, plaintiff, as the representative of decedent's estate, is entitled to recover damages for injuries sustained by the decedent up to the time of her death. 755 ILCS 5/27-6. The United States has

stipulated that Mrs. Romero suffered a long and painful post-operative course. There were many complications and surgeries from at least July 18 when she became hypovolemic until her death on September 5. Plaintiff has cited cases which have resulted in awards of in excess of $3 million for periods of suffering under seven days. The United States suggests that, if liability is found, an award of $1 million would be appropriate based on an award in ***Kasongo v. U.S.***, 523 F. Supp. 2d 759 (N.D. Ill. 2007), where the period of suffering was 23 days. In this case the period of suffering was 46 days. The suffering was excruciating. A Survival Act award of $3,000,000, which plaintiff seeks, is appropriate to compensate for the pain, suffering and disfigurement suffered by Regina Romero.

10. Under the Illinois Wrongful Death Act, a decedent's next of kin are compensated for loss of society of a loved one. ***Ford-Sholebo***, 980 F. Supp 2d at 999-1000. Plaintiff requests an award of $2,500,000 for Christine and $1,750,000 for Gilbert.

11. At the time of death, decedent had a life expectancy of 36.7 years. The pecuniary loss of minor children is recognized as greater than the loss of adult children. Plaintiff states that the ***Kasongo*** award of $1 million for loss of society is comparable. The United States suggests that an appropriate award would be between $1,000,000 and $1,500,000 for Christina and between $250,000 and $750,000 for Gilbert.

12. Wrongful Death Act awards of $1,000,000 to compensate for Christina's loss and $250,000 to compensate for Gilbert's loss are appropriate.

IT IS THEREFORE ORDERED that the Clerk of the Court enter judgment in favor of plaintiff Helen Monroe, not individually, but as Administrator of the Estate of Regina Romero, deceased, and against defendant United States of America in the amount of $4,250,000 together with costs of suit.

ENTER:

UNITED STATES DISTRICT JUDGE

DATED: NOVEMBER 6, 2014