ORIGINAL

SUPERIOR COURT OF THE STATE OF WASHINGTON
FOR THE COUNTY OF KING

SMITH ET AL

Plaintiffs,

V.

VALLEY MEDICAL CENTER AKA ET AL

Defendants.

Case No. 02-2-22378-8 KNT

TRIAL DECISION

THIS MATTER was tried to the Honorable Bruce Hilyer, without a jury, from December 4, 2006 through December 19, 2006. Plaintiff Nancy Smith appeared personally and through her attorneys of record, Brian A. Putra and Michael S. Wampold of Peterson, Young, Putra, Fletcher, Knopp & Wampold, P.S. and Judy I. Massong of Otorowski, Johnston, Diamond & Golden. Defendants Associated Emergency Physicians, Inc. P.S., Jeffrey Goon, PAC, and Lawrence J. Kadeg, M.D. appeared personally and through their attorneys of record, Nancy Elliott and Jake Winfrey of Helsell Fetterman, LLP.

BASED ON the evidence admitted during the trial, the Court makes the following:

Findings of Fact

A. The Onset of Evan Smith's Illness

1. In the very early morning hours on March 21, 2001, normally healthy two-year old Evan Smith, following two days of cold like symptoms, awoke at home with a verified fever which spiked to a high of 104.8 degrees Farenheit. After his mother called with his pediatrician's office, he was given Tylenol and taken at about 5:00 AM to the emergency room at Valley Medical Center ("VMC") by his father, Kieo Smith.

2. The Valley Medical Center emergency room ("ER") is staffed with doctors and physician's assistants employed by Associated Emergency Physicians, Inc. P.S. ("AEP"). The medical providers on duty at that time were Defendant Jeffrey Goon, a licensed physician's assistant and Dr. Larry Kadeg, a licensed medical doctor board certified in family practice medicine.

3. A triage nurse initially saw Evan Smith and took his history, which included his highest temperature at home of 104.8 degrees and his cold-like symptoms. His chart recorded that Evan had a purulent runny nose, that his lungs were fairly clear, and that he had abnormal vital signs including a respiratory rate of 48, with a normal high about 30, and a pulse rate of 174, with the normal rate between 120 – 130. Evan's acuity level was marked "urgent." No blood pressure was taken or recorded.

4. Evan was next examined by defendant Jeffrey Goon. Mr. Goon was an employee of AEP acting within the scope of his employment as a physician's assistant ("PA") and on behalf of his marital community. Mr. Goon ordered a chest x-ray but did not order any blood tests, neither a white blood cell count or a blood culture, which were available at modest cost. The medical records at VMC establish that Evan's condition presented as "fussy, irritable and tired."

5. After Mr. Goon left Evan Smith's room, Nancy Smith arrived at Valley Medical Center. Evan's father, Kieo Smith, left the hospital and went home with his young daughter, Erin Smith.

6. Mr. Goon reviewed his findings and Evan Smith's chest x-ray with defendant Dr. Kadeg. Dr. Kadeg, was an employee of AEP acting within the scope of his employment and on behalf of his marital community. Dr. Kadeg was the supervising physician for Mr. Goon. Dr. Kadeg never examined Evan Smith and never personally talked with Kieo or Nancy Smith but he did discuss the case and the x-ray with Mr. Goon. Mr. Goon and Dr. Kadeg diagnosed Evan Smith with pneumonia.

7. A nurse returned to Evan Smith's room and told Nancy Smith that Evan's diagnosis was pneumonia and for Mrs. Smith to follow-up with an appointment with Dr. Gamrath, Evan's treating pediatrician, in one to two days unless his condition worsened in which case he was to return to the VMC ER. These were the discharge instructions authorized by Mr. Goon and Dr. Kadeg, who also prescribed an oral antibiotic called Zithromax which required filling at a pharmacy. Before Evan Smith was discharged by the nurse at 7:15 a.m., his vital signs were checked again and determined to be lower but still above normal. His respiratory rate was then 32, and his pulse rate was down to 140. Evan's first temperature at the ER was 101.4 F and before discharge was taken at 100.2 F. His reduced fever at the VMC ER was most likely because he had taken Tylenol at home.

8. Some 18 minutes after Evan Smith was discharged, a radiologist at Valley Medical Center read Evan Smith's chest x-ray and dictated his report. The radiologist reported that Evan's chest x-ray was normal with no sign of pneumonia but no one communicated this report to the Smiths nor did anyone request that Evan Smith be brought back to the emergency room for further tests.

9. Evan Smith's parents filled the prescription for Zithromax and gave Evan the antibiotic as directed. Later on the 21,st Evan ate a small amount of rice and a popsicle, but his eating pattern was not normal and his condition did not improve significantly. By the next morning, on March 22nd, he was hard to awaken and increasingly lethargic and by mid-morning his condition had changed markedly. After returning from her morning work, his mother called his pediatrician, Dr. David Gamrath, who saw Evan shortly thereafter, and suspecting meningitis, told

Evan's parents to rush him to Children's Hospital (CH) in Seattle. At Children's Hospital, Evan was not diagnosed with pneumonia, and the records show that his lungs were clear, but he was conclusively diagnosed with pneumococcal meningitis.

B. The Applicable Standard of Care

10. Meningitis is a disease involving inflammation of the meninges or lining of the brain which in Evan's case was caused by a bacterial infection. Today meningitis is relatively rare as a result of the development of the Haemophilus flu (H-Flu) vaccine which has been widely accepted over the past recent several decades. But the source of the infection that lead to Evan's pneumococcal meningitis was not the H-Flu but from a blood infection from a bacterial source known as Streptococcus pneumoniae. Pneumococcal bacteremia refers to a condition in which that bacteria infect the blood stream which can the carry the infection to another location in the body, the most serious of which is to the brain lining causing meningitis. If bacteremia is left untreated, in most cases, ranging from 80-85 %, the body will recover on its own. But in the remaining untreated cases the infection spreads and can then cause focal infections in other parts of the body, i. e. a bone or a joint, but the most serious is meningitis which is potentially disabling and life threatening.

11. There is a significant correlation between a child's fever and the risk of bacteremia which increases as the fever rises with the highest risk at fevers over 104 degrees F. The risk of bacteremia for a child from 3-36 months with a fever of 104.8 F with no known source was in the range of 3 to 10 %. Because Evan's axillary temperature taken at home likely understated his core temperature by about 1 degree F., his chances may have been somewhat higher. Once a child has bacteremia, the risk of it developing into meningitis if untreated ranges from about 2% to 6 %. While this risk is relatively low, the devastating consequences of meningitis warrant investigation and further treatment with appropriate antibiotics which is reflected in the applicable standard of care as further discussed below.

12. While they are educated and trained differently, the standard of care applied to a

physician's assistant is the same as for a medical doctor practicing in the state of Washington in a hospital emergency room. Regarding the standard of care for the issues of concern to this case, the standards applicable in the State of Washington reflect a national standard of care that is no different then the standard practiced within this State.

13. The standard of care for infants 3-36 months who are "febrile" (feverish) depends in significant part on the assessment of whether the child is toxic, just ill appearing or well appearing. Toxic means that the child is demonstrably very ill, lethargic, non-responsive and inconsolable. The standard of care for a "toxic" child presenting with a fever over 39 degrees C (102 degrees F) and no "focus of infection" is immediate hospitalization, lumbar puncture and appropriate inpatient treatment. At the other end of the spectrum, for the child who is "well-appearing" but with a similar fever and no focal infection, the standard of care is somewhat controversial, with several recognized alternatives including "watch and wait," with provides no additional tests and no antibiotics, but with "close follow-up" with the child's pediatrician. When Evan Smith presented at the VMC ER, he did not show signs that he was toxic requiring immediate admission to the hospital, but he was not a "well-appearing" child either. His vital signs were significantly abnormal upon admission and while improved somewhat, were still beyond normal ranges at discharge. His respiratory rate upon admission of 174 indicated some hyperventilation which his mother credibly described as "panting." While his fever had descended as a result of taking Tylenol, the standard of care takes into account a history of fever if taken reliably as it was here. This fever at home over 104 degrees F axillary placed Evan among the highest risk group for bacteremia. The VMC medical record describes Evan as "alert" and also as "fussy, irritable and tired." Based upon that record and the testimony of his parents, Evan appeared ill and was clearly not a "well-child" when he presented to the VMC emergency department and was examined by Mr.Goon.

14. The standard of care for a child who was not well-appearing with a documented history of fever over 104 degrees F. with no focal infection required defendants to either treat Evan with appropriate antibiotics for bacteremia or to do additional screen testing through a blood test to

check his white blood cell (WBC) count, and then if his WBC exceeds 15,000 which would further increase the risk of occult bacteremia, to administer an appropriate antibiotic and obtain a full blood culture, although the full blood culture would likely take more time. In this case, based in part on misreading the x-ray, defendants diagnosed pneumonia and prescribed oral Zithromax, and advised follow-up within 1-2 days unless symptoms worsened in which case the child was to be returned to the ER. The diagnosis of pneumonia was a mistake and it ignored or overlooked other clinical signs that Evan did not have pneumonia at VMC: his oxygen saturation at 97 % did not support the diagnosis, his lungs were clear according to his chart, and his only reported cough did not include coughing up any phlegm materials.

15. Even if Evan had pneumonia at VMC, that diagnosis would not rule out bacteremia because a child can have both conditions simultaneously. Thus the standard of care in Evan's case required that the same septic work up be done (antibiotics or CBC, then antibiotics if WBC exceeds 15,000, and blood culture) as if there was no focal source of infection. While the misdiagnosis of pneumonia at VMC did not by itself cause damage to Evan, the misdiagnosis on the basis of such scant clinical indications together with the absence of a septic work up to investigate and treat suspected bacteremia was a violation of the standard of care which damaged Evan. Even though Evan's high fever put him in a higher risk group for bacteremia, the VMC records show that defendants gave no consideration to the risk of bacteremia, they did not mention it to Evan's parents, they did nothing to investigate or treat for it, and chose instead to rely entirely on their mistaken diagnosis of pneumonia which was not adequately supported, and even if it was, would not have addressed the risk of occult bacteremia.

When the standard of care for the treatment of the risk of bacteremia on March 21, 2001, requires the prescription of an antibiotic as discussed above, the appropriate one is the parenteral antibiotic Ceftriaxone and not the oral antibiotic Zithromax prescribed by the defendants based on their mistaken diagnosis of pneumonia. Authoritative studies recognized in the literature have shown Ceftriaxone to be effective in treating pnumococcal bacteremia and there is no comparable or convincing support for Zithromax. Unlike Zithromax, Ceftriaxone crosses the blood brain barrier

to prevent meningitis and it is also used to treat meningitis. Those studies that establish some lesser efficacy than Ceftriaxone for some oral antibiotics such as amoxicillin do not prove that Zithromax is appropriate to treat suspected bacteremia. Ceftriaxone is a bactericidal antibiotic that aggressively kills bacteria while Zithromax is a bacteriostatic antibiotic that inhibits their growth enabling the body's immune system to ultimately ovecome the bacteria. Further, in the Physician's Desk Reference, the manufacturer warns that Zithromax is contraindicated for bacteremia.

C. **Causation**

16. The pneumococcal meningitis that Evan had is preceded by "prolonged" bacteremia. The precise time period before the bacteremia passes from the blood stream into the meninges is unknown but it is not instantaneous and it is consistent with the time frames of Evan being diagnosed with meningitis upon admission to CH on the 22nd after having bacteremia on the 21st including the time he presented at the VMC ER after his earlier temp spike of 104.8 F. Evan was no more sick appearing while at home after visiting the ER than immediately before, until later on the morning of the 22nd, and he had no documented fever during that period. Since it is known that the type of meningitis involved here is preceded by bacteremia before he got meningitis, and all the doctors agree that he did not have meningitis at the VMC ER, and he did not have pneumonia, more probably than not his high temperature, abnormal vital signs, and ill presentation were manifestations of him having bacteremia while at the VMC ER. The standard of care to assess and treat him required either administration of Ceftriaxone, or a CBC and then Ceftriaxone if his WBC exceeded 15,000, which it would more likely than not, based on his having bacteremia. Thus, under either alternative under the applicable standard of care, preventative Ceftriaxone or WBC first, Evan would have received the antibiotic which is most effective at preventing meningitis. In Evan's case, administration of Ceftriaxone at VMC would have reduced his chances of developing meningitis from bacteremia significantly down to about 0.3%. Ceftriaxone injections were readily available at VMC on March 21, and it is more probable

than not that had Evan Smith been given Ceftriaxone, his bacteremia would not have developed into meningitis.

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D. Damages

17. Evan Smith was two years old when he developed meningitis. He spent four (4) day's in the intensive care unit at Children's Hospital and was in a coma. Nancy Smith worried that her son was going to die. Evan had a seizure while he was at Children's Hospital where he spent a total of twelve days. As a consequence of the pneumococcal meningitis, Evan Smith sustained temporary brain injuries and physical disabilities, and severe to profound bilateral hearing loss which makes him functionally deaf. Also, his 12th cranial nerve is damaged which causes his tongue to protrude to the left. As a result of his hearing loss and related effects, Evan's verbal IQ is borderline deficit. From March 2001 through February 2002 when he received his left cochlear ear implant, Evan had no access to sound Hearing aids did nothing appreciable for him. While Evan now has access to sound through a cochlear ear implant, which uses a microphone and digital technology to stimulate the auditory nerve, he now suffers a permanent impairment of both his hearing and speech which will continue throughout his life. After receiving the cochlear implant, Evan underwent therapy to teach his brain to interpret the new signals as sound and he had to relearn speech as well. His childhood development including potty training was seriously and adversely effected. However, his brain injury has not been proven to be permanent. To maintain his access to sound, Evan will need to maintain and periodically replace his cochlear implant inside of his left ear and externally he will be required to attach a small microphone close to his ear and to carry a small computer device that connects to the microphone and transmits the sounds from the microphone to the electrode inside his ear cochlea. This device permits him access to sound and enables him to conduct an almost normal appearing conversation with another person but it is much less effective when the source of the sound is diffused or from multiple sources. After the cochlear implant was first installed, Evan had to learn how to interpret the new signals as sound and essentially relearn speech as well. At this time he is 2 to 3 years behind his speech

development and while he has made much progress, it is unlikely he will ever catch up completely.

18. The meningitis caused Evan to suffer certain temporary brain damage with related neurological effects including lack of fine motor coordination and poor balance. During this period, he had to wear a helmet to protect himself against injury. However, those physical effects have now resolved but there remain certain effects from his hearing loss which include some lack of impulse control, periods of abnormal frustration and lack of concentration and attention. As a result of his hearing loss and these related issues, Evan's normal development and education has been impaired and such problems will likely be accentuated as school becomes more challenging and complex. It is unlikely that he will be able to complete a college education although a two year program may be achievable. The type of employment available to Evan will be limited as a result of his injuries from meningitis.

19. Evan Smith's past medical expenses, reasonable and necessarily incurred as a result of his meningitis, total $109,071.91

20. Evan Smith's future medical costs and life care costs, reasonably and necessarily to be incurred as a result of his meningitis, total $435,600. Because he has no permenant brain damage, a guardianship will not be necessary. .

21. Evan Smith's loss of earning capacity equals $422,674 based upon a life expectancy of 68.1 additional years.

22. Plaintiff has proven that Evan Smith is entitled to an award of general damages to compensate him for his pain and suffering, loss of enjoyment of life and his life long disability. For his past loss, to compensate him for the period from March 21, 2001 through today, the amount of such damages is $200,000. For his future loss, over his expected life expectancy of 68.1 years, this amount is $1,634,400.

23. Evan Smith and his mother, Nancy Smith, enjoyed a stable, active, and loving parent-child relationship. Evan's Smith's injuries have deprived Nancy Smith of the love and companionship of her minor child. Evan Smith's injuries have damaged the parent-child relationship between Nancy Smith and her minor child.

24. Nancy Smith, on her own behalf, has proven that her relationship with her child has been damaged and will be damaged as Evan's childhood continues. The amount established for her damages is $160,000.

Findings Of Fact designated as Conclusions of Law Fact herein shall be deemed to be included and made part of the Conclusions of Law set forth below.

Conclusions of Law

1. This Court has jurisdiction of the parties and subject matter of these proceedings.

2. The standard of care applicable to this case for both Mr. Goon and Dr. Kadeg is that of a reasonably prudent emergency physician in the State of Washington acting in the same or similar circumstances on March 21, 2001. Mr. Goon and Dr. Kadeg failed to exercise the degree of learning, care and experience to be expected of a reasonably prudent emergency room physician and were negligent when they failed to follow the standard of care for an ill appearing infant of 3-36 months with a history of fever of 104.8 F to investigate or treat Evan for suspected bacteremia and (1) failed to give Evan Smith the parenteral antibiotic Ceftriaxone; or (2) order a white blood cell count, which would have shown an elevated WBC and then injected Ceftriaxone. Further, the defendants breached the standard of care when they mistakenly diagnosed pneumonia and took no other steps to investigate or treat Evan for the risk of bacteremia. If Evan Smith had been given an injection of Ceftriaxone at the VMC on the morning of March 21, 2001, he more likely than not would not have gone on to develop meningitis, bilateral hearing loss, with its associated disabling effects. As a result, the negligence and professional malpractice of Dr. Kadeg and Mr. Goon was a proximate cause of Evan Smith's meningitis, hearing loss and associated effects.

3. Evan Smith is currently 7 years old. No experts have testified that Evan's life expectancy is reduced due to meningitis or his injuries. According to the Office of the Insurance

Commissioner's Life Expectancy Table, October 28, 2004, Evan Smith's life expectancy is 68.13 years.

4. As a result of meningitis, Evan sustained permanent, profound, bilateral hearing loss and associated ongoing effects including poor impulse control, low threshold of frustration with certain activities, and attention problems. To address his hearing loss, Evan had a cochlear implant implanted in his left ear.

5. The plaintiff has met the burden of proof under RCW 7.70.030(1) that the injures of Evan Smith resulted from the failure of the defendants, healthcare providers as defined in RCW 7.70.020, to follow the accepted standard of care, as defined in 7.70.040, of emergency room medical providers in 2001.

6. Defendant Dr. Kadeg is vicariously liable for Mr. Goon's negligence under RCW 18.71A.050.

7. Defendant Associated Emergency Physicians, Inc. P.S. is vicariously liable for Dr. Kadeg's and Mr. Goon's negligence under the common law theory of *respondeat superior.*

8. As a result of the negligence of the defendants, Plaintiff is entitled to an award of damages in the amounts set forth above.

9. The Plaintiff shall be awarded judgment against Defendants in conformity herewith.

Dated this 26 day of Dec, 2006.

Bruce W. Hilyer
King County Superior Court Judge