MEMORANDUM

TO:	{{contact|full_name}}
FROM:	Martin A. Ginsburg, RN
SUBJECT:	{{case|case_number}} Medical Record Review for Merit
DATE:	{{GENERAL|CURRENT_DATE_LONG}}
RECOMMEND:	**DECLINE**

{{contact|114250}} {{contact|last_name}},

Per your instructions and at your request, this memorandum is a summary of care provided your client, {{case|158650}} {{case|158651}}, related to his care following admission to {{case|158653}} ({{case|158654}}) during his admission to treat an exacerbation of his Chronic Obstructive Pulmonary Disease (COPD) and pneumonia. As you know, during this hospitalization, {{case|158650}} {{case|158652}} suffered a cardiac arrest with subsequent resuscitation that ultimately resulted in substantial brain injury that proved non-survivable.

There is insufficient information in the records provided by {{case|158654}} to substantiate allegations of negligence related to {{case|158650}} {{case|158652}}'s care and observation. This lack specifically relates to activity orders and observation. It is not known, from those provided records, whether activity was ordered as complete bed rest (BR) which indicates the patient is expected to remain in bed with direct staff observation for any event requiring excursion out of bed, or bed rest with bathroom privileges (BRP) which would relieve facility staff of responsibility of direct observation of the patient while out of bed to the lavatory.

It is important to note that orders for BR triggers the use of bed alarms to alert staff to patient efforts to exit the bed when it has been medically determined that such excursions are not safe at that time. If these orders were in place, there may have been a negligent lapse in patient observation and supervision that cannot be proved through the records available. Alternatively; orders for BRP indicate a medical or nursing evaluation leading to the conclusion that the paitent is capable of safely ambulating independently to the lavatory from the bed and does not require direct observation or supervision during this activity.

Baseline heart rate recorded as 70s to 80s overall from what is available. The decrease in rate was very likely secondary to hypoxia. In cases such as this, alarm levels

are critical to determination of monitoring adequacy. Strips timed as:

1. 23:10:11
    a. Heart Rate (HR) ~ 40
    b. Note of Kaitlin notified
2. 23:10:29 (18" later)
    a. HR ~ 32
    b. Note of Kaitlin notified
    c. Note of "Rapid Response Called"
3. 23:15:47
    a. Probable agonal rhythm
    b. Note of "Code Blue Called"
4. 23:19:19
    a. Electrical activity indicative of HR ~32
    b. Note of "Code Blue Called" – likely ongoing report of status
5. 23:22:44
    a. Irregular rhythm
        i. Likely interposition of chest compressions with pulseless electrical activity reported elsewhere
6. Activity noted on strip timed 23:22:44 – indicative of possible return of adequate perfusion
    a. ~12'33" from profound bradycardia to possible sustainable perfusion.

Based on the evidence in the provided medical records it is recommended that this case be declined. This recommendation is based on four fundamental questions:

1) Is there significant or permanent injury or damage?
    a) Yes; the patient suffered a cardiac arrest resulting in his death;
2) Is there an apparent or suggested deviation in the standard of care?
    a) No; as noted, above, in the available records, the documentation fails to identify a requirement for ongoing direct observation while not in bed and therefore no duty to be aware the patient had departed the beds;
    b) No; decreasing heart rate remotely monitored appear to have been addressed in a time frame that is within current clinical guidelines;
3) Is there a direct link between the deviation and the injury or damage?
    a) No; in the absence of a finding of apparent or suggested deviation a link is moot;
4) Is a further review of medical records recommended?

a) No; as noted elsewhere herein there is no evidence found in the records submitted to which a deviating from the current clinical guidelines may be ascribed, therefore; no further review of the record is indicated.

Causes for this finding are as discussed above and rely upon orders and details in the medical record as provided. While more detailed information may alter the dynamic equation related to likelihood of prevailing, it must be evaluated whether the burden of seeking that information is potentially unduly burdensome vis a vis the potential benefit to the family.

Thank you for your confidence in MarGin Consulting to bring the needed expertise to this investigative review of {{case|158650}} {{case|158651}}'s matter.

Please advise of additional information needed or questions I can answer.

Respectfully,

Martin A. Ginsburg, RN
Nurse Paralegal

MEMORANDUM

TO:	{{contact|127415}}
FROM:	Martin A. Ginsburg, RN
SUBJECT:	{{case|127299}} Medical Record Review for Merit
DATE:	{{GENERAL|CURRENT_DATE_LONG}}
RECOMMEND:	**ACCEPT**

{{contact|114250}}. {{contact|last_name}},

Per your instructions and at your request, this memorandum is a summary of care provided your client {{case|127712}} {{case|127299}}, related to placement of an intended Peripherally Inserted Central Venous Catheter (PICC). As explained below, the errant placement of this catheter in the arterial, rather than the venous, system is well known to be causally related to what is termed as "showering" of clots in the arterial system that frequently lead to Cerebrovascular Accidents (CVA) commonly referred to as stroke. These are sometimes Transient Ischemic Attacks (TIA), which are often referred to as "mini–strokes" in that blood flow within the brain is only temporarily disrupted and there is a full recovery following restoration of normal blood flow once the occlusion has cleared.

This review indicates there is sufficient evidence of a deviation from current clinical guidelines to merit further investigation. This recommendation is based on four fundamental questions:

1) Is there significant or permanent injury or damage?
    a) Yes; multiple cerebral and possible spinal cord infarctions leading to a loss of ability to ambulate independently and cognitive deficits;
2) Is there an apparent or suggested deviation in the standard of care?

a) Yes; an intended venous PICC was inserted in the arterial system. This is a widely recognized failure of due care in placement of this catheter whether at the bedside under ultrasound guidance or in a special procedure setting such as Interventional Radiology (IR);

3) Is there a direct link between the deviation and the injury or damage?
   a) Yes; as ibid. this outcome is predictable when catheters are errantly placed within the arterial system and are the result of clot formation at the catheter tip that may dislodge with manipulation of the line or abrupt changes in intrathoracic pressures;
4) Is a further review of medical records clinically indicated?
   a) Yes; as discussed, this outcome is a predictable result of an error that rises nearly to the level of res ipsa loquitor in that under appropriate guidance cannulation of an artery occurred despite the practitioner's intent to cannulate a vein.

In this patient, the allegation is an errant cannulation of the arterial system with a catheter intended to be placed in the venous system, more specifically within the superior vena cava adjacent to the heart so as to be a true "central" line.

This patient has a history significant for:

Past Medical History:

- Actinic keratosis
- Arthritis — osteoarthritis
- Basal cell carcinoma of back
- BPH (benign prostatic hypertrophy)
- CAD (coronary artery disease)- non obstructive
- Diabetes mellitus — Type 2; (FSBS AVERAGE 172, AS OF 7/26/17

- Elevated cholesterol
- Foot deformity
- GERD (gastroesophageal reflux disease)
- LBBB (left bundle branch block)Melanoma in situ of upper extremity, left (*) 07/2007 Lt forearm
- OSA (obstructive sleep apnea)
- Renal cyst
- SOB (shortness of breath)
- Squamous cell carcinoma of left wrist with left wrist-excision LG (margins clear)
- Supplemental oxygen dependent
- Vertigo
- Tobacco abuse

Past Surgical History:

- Lung surgery — 1993 RLL fungal infection
- Knee surgery — right
- Left arm [other] — removed melanoma
- Rotator cuff repair — right shoulder
- Foot surgery — left foot base of the fifth toe removed- total of 5 surgeries left 5th toe
- Total shoulder replacement — 2009 left shoulder
- Debridement of left 5th metatarsal wound/ w placement of amniox graft
- Vasectomy
- Appendectomy
- Back surgery — 04/2017 fusion between L4 and L5 with cage
- Cardio stress test

- Cardiac catheterization — no stents
- Joint replacement right 08/2017 TKA

Per the submitted records; {{case|127712}} {{case|127298}} had a PICC attempted at {{case|150534}} that was placed arterially with its tip within the ascending aorta. This is the portion of the largest blood vessel in the body that provides the exit for blood from the heart to reach what are termed the “end organs” (the brain, lungs for nutrient exchange rather that oxygen exchange, the kidneys, liver, gastrointestinal tract, etc.). Clots in this portion of the aorta are positioned in such a manner as to be available for distribution to any locus in the body.

In the records provided there is a note explaining that {{case|127712}} {{case|127298}}’s symptoms appeared to be more significant than could be explained by the presence of strokes found on MRI if the brain and that there was a possibility of spinal cord infarction (death of tissue) as well. This is wholly consistent with the location of the catheter tip and dislodged clots therefrom.

Notes specific to the placement of the offending catheter are not immediately appreciated in the submitted records. This notwithstanding, the conclusions of our review are that there is quite sufficient information regarding the catheter and its location as well as the adverse outcome that is known to be causally linked to such a catheter placement to overcome the plaintiff burden in this matter.

Recommendations:

1. Organization of the digital medical record with investigation for missing records to assure an engaged expert and counsel that all relevant information is included in expert review:

a. This is not a statement of suspicion that the records are incomplete but a recommendation to perform such a verification prior to submission to a testifying expert to avoid unnecessary delays or lead to an opinion based upon incomplete data. This is a routine recommendation and believed by the consultant to represent due diligence;
b. This would also include creation of a fully bookmarked edition of the records. Such bookmarks would be divided according to attorney preference but would likely be subdivided by note type and then chronologically.

2. Creation of a detailed chronology should be deferred unless an opinion expert witness requires such preparation before undertaking a review.
    a. Detailed chronologies, while informative, are costly and examine more information than is necessary for the production of a targeted timeline;
    b. Such chronology could be time limited to the period of 12/08/2017 through 12/23/2017 permit a detailed examination of information in preparation for a Rule 9(j) review as well as for that review and further reference by experts preparatory to the provision of testimony
    c. Additionally such a time limited chronology has an advantage of reduced firm and client costs;
3. Expert identification effort should begin at the earliest opportunity to locate and vet opinion experts and ensure their availability to assist.
    a. Opinion experts can be expected to interventional radiology practitioners whether physician, Physician Assistant or advanced practice nurse.

Thank you for your confidence in MarGin Consulting to bring the needed expertise to this investigative review of {{case|127712}} {{case|127298}}'s matter. While this level review demonstrates the substantial likelihood of proof of deviation from the current clinical guidelines sufficient to overcome Plaintiff's burden; the assessment of the economics of damages is not, as a matter of routine, included in this level report as this is a clinical review not designed to assess case or verdict history in the jurisdiction of concern.

There are a number of potential direct costs for which there is substantial evidence in the provided records, for example; a wheelchair is now required for mobility, cognitive deficits with an onset coinciding with this error increase the risk of infection while also impacting judgement – a fundamental component of safety. There are others that will require appropriate assessment to detail adequately in an ongoing investigation.

While consideration is given, where appropriate, to future needs and burdens, estimates of costs of future surgery; rehabilitative services; home modifications; outpatient and home care; expected or anticipated hospitalizations, and more represent identifiable economic damages. Non-economic damages are outside our purview and are, therefore, not assessed here.

Please advise of additional information needed or questions I can answer.

Respectfully,

Martin A. Ginsburg, RN
Nurse Paralegal

MEMORANDUM

TO:	{{contact|127415}}
FROM:	Martin A. Ginsburg, RN
SUBJECT:	{{case|158651}} Medical Record Review for Merit
DATE:	{{GENERAL|CURRENT_DATE_LONG}}
RECOMMEND:	**DECLINE**

{{contact|114250}} {{contact|last_name}},

Per your instructions and at your request, this memorandum is a summary of care provided your client {{case|158650}} {{case|158651}}, related to her injuries following a Left Total Hip Arthroplasty (THA) more commonly referred to a hip replacement.

There is some concern as to the capacity to adequately demonstrate a breach of current clinical guidelines. As shown in the appended reference material, up to 50% of nerve injuries are idiopathic, or of unknown or unidentifiable cause. While the remaining injuries are generally attributable to the surgery this injury falls within the "known complications" of the procedure making litigation problematic.

That information noted, there is a journal article that specifically asked orthopedic surgeons about malpractice litigation following hip and knee arthroplasties and found a median settlement values for both nationwide range of $51,000 to $99,000 as long ago as 2007 when their survey was conducted and reported. {Upadhyay, A., York, S., Macaulay, W., McGrory, B., Robbennolt, J., & Bal, B. S. (2007). Medical malpractice in hip and knee arthroplasty. The Journal of arthroplasty, 22(6), 2-7.}

Within the records submitted there are conflicting preliminary diagnoses not adequately described as having been ruled out, though there is some

information indicating that possibility. There remained, even at the time of surgery, unexplained neuralgia (pain within a nerve due to injury or impending injury) that was not further addressed with non–invasive means prior to proceeding with an operative intervention.

Current clinical guidelines are clear in that all non–surgical options are to be explored before subjecting a patient to the inherent risks of an operative procedure. From the submitted records, it would be expected that a reviewer would infer insufficient investigation into causation of the patient's pain which had an onset significant for intermittent effect on gait, intermittent and varied levels of reported pain and muscle spasm in an area known to present as upper leg/buttock neuralgia.

This review indicates there is insufficient evidence of a deviation from current clinical guidelines to merit further investigation. This recommendation is based on four fundamental questions:

1) Is there significant or permanent injury or damage?
    a) Yes; this patient suffers ongoing pain and gait disturbances that are at this point given the patients age and lack of substantial recovery to date, likely life–long;
2) Is there an apparent or suggested deviation in the standard of care?
    a) Yes; there is insufficient documentation in the submitted records of investigative efforts of a neuralgia presentation to definitively rule out such a cause of increasing pain first reported as having its onset some six months prior to surgery, not the several years normally seen in longstanding degenerative changes;
    b) No; perioperative nerve injury is a well-known complication of the posterior approach to this surgery long described in the literature. The rate of complication was substantially reduced to near zero more than 25 years ago when the cause of nerve injury was recognized by surgeons;

3) Is there a direct link between the deviation and the injury or damage?
    a) Yes; from the available records there appears to be a “rush to surgery” where possible neuralgia was not sufficiently investigated leading to an injured nerve becoming more so during an elective procedure;
    b) No; nerve injury is a well-known and recognized complication of this procedure, and therefore cannot be claimed to be the result of a deviation from current clinical guidelines;
4) Is a further review of medical records clinically indicated?
    a) No; given the literature available there is at this preliminary research stage, insufficient information to believe a deviation from current clinical guidelines has occurred during the procedure.

In this patient, the allegation is that improper and negligent technique led to an intraoperative injury to a nerve transiting the pelvis adjacent to the operative site.

Under normal circumstances, both known complications and proximity to an operative site leading to inadvertent, unpreventable, injury to adjacent structure(s) render litigation unlikely to be successful. This perspective must be considered before engaging this client. While the records imply a lack of due diligence in investigative efforts prior to surgery, meeting the plaintiff burden will be a significant challenge.

This level review leads to a strictly clinical finding of inadequate care related to the investigative process regarding the patient’s pain, but this must be tempered with the realization that this case is presented not merely for clinical review but in anticipation of litigation.

The allegation of negligence leading to an intraoperative nerve injury is not supported by the submitted records. An allegation of failure to fully investigate is, somewhat, though not well, supported in the submitted records to warrant prosecution. While preliminary diagnoses do change, there is a variety here as

well as assessment findings inconsistent with the final diagnosis leading to surgery. The Magnetic Resonance Imaging (MRI) study performed failed to identify any actual source of the patient's reported pain. X–ray of the pelvis did show degenerative changes that may potentially result in the neuralgia experienced by the patient but its presentation timeline is much shorter than normally expected.

Patient presentation and pain tolerance play a significant role in the recommendation to "skip ahead" in the process omitting non–invasive options due to intolerable or intractable pain. While that is not the obvious case in this matter, it is a consideration that cannot be dismissed out of hand.

Thank you for your confidence in MarGin Consulting to bring the needed expertise to this investigative review of {{case|127712}} {{case|127298}}'s matter.

Please advise of additional information needed or questions I can answer.

Respectfully,

Martin A. Ginsburg, RN
Nurse Paralegal

MEMORANDUM

TO: {{contact|full_name}}
FROM: Martin A. Ginsburg, RN
SUBJECT: {{case|case_number}} Medical Record Review for Merit
DATE: {{GENERAL|CURRENT_DATE_LONG}}

INFORMATIONAL MEMORANDUM
NOT DISPOSITIVE

{{contact|114250}} {{contact|last_name}},

Per your instructions and at your request, this memorandum is a summary of care provided your client, {{case|158650}} {{case|158651}}, related to his chronic nephrolithiasis (kidney stone formation) by {{case|158653}} ({{case|158654}}) and {{case|158656}} ({{case|158657}}).

While this memorandum is not dispositive, there is sufficient suspicion of a breach to warrant further investigation. Despite this, there is insufficient information, specifically no imaging files, in the records provided to {{case|158650}} {{case|158652}} to fully overcome the plaintiff burden and substantiate allegations of negligence related to {{case|158650}} {{case|158652}}'s care. There is evidence of malpositioning of a ureteral stent on the left. In fact, the end of the stent was ultimately found within the parenchyma (functional tissue of an organ) of the Left kidney leading to hemorrhage resulting in hematoma (internal sequestered clot).

While migration is a known complication of ureteral stent placement, this movement is generally expected to take some time to occur. In the instant case, the malpositioning was found the following day and was evinced by increased flank pain and decreased urine output consistent with obstruction. This fact pattern leads to a high degree of suspicion with significant confidence that the initial placement was not completed in a manner not consistent with current clinical guidelines.

Of note, there was a procedure several days before the stent placement procedure; specifically, a retrograde pyelogram (injection of dye in the kidneys via the ureters) after which there was a radiology study demonstrating an "extravasation of contrast" [18.220b_AIK - Aiken Regional Medical Centers (Certified) p. 1685] from the Left ureter, indicating probable injury at that point. That procedure was performed by {{case|158657}} on 10/19/2017, approximately one week before the offending procedure.

The concerns in this matter stem from the medical record that reports:

> 24 cm double-J nephroureteral stent was positioned satisfactorily in the dilated bladder and proximal collecting system. The guidewire and nephroureteral stent strings were removed. Images demonstrate satisfactory placement of stent. The patient tolerated the procedure well and there were no complications. The patient was transferred to the operative suite in stable condition. [18.220b_AIK - Aiken Regional Medical Centers (Certified) p. 1368]

The imaging used in this procedure should be reviewed by a qualified provider to compare to the report by {{case|158654}} for accuracy of interpretation. It is important to note that while the records available indicate a substantial likelihood of a breach during placement of the Left ureteral stent, the imaging will identify whether the end was, in fact, placed within the renal collecting system or penetrated the parenchyma leading to bleeding as noted in other studies. The substantive findings remain:

1. 66 year Old gentleman presented with bilateral hydronephrosis and bilateral obstructing stones, procedures planned were;
    a. bilateral cystoscopy;
    b. retropyelograms with possible laser and/or possible stents;
2. Diagnoses:
    a. Bilateral hydronephrosis;
    b. Bilateral obstructing stones;
    c. Acute and chronic renal failure;
3. Extravasation of contrast surrounding the mid left ureter;
    a. This finding is significant as it indicates contrast in the space surrounding the Left ureter and not within the ureter as planned;

4. Upper pigtail of the left nephroureteral stent is lodged in the renal parenchyma or perinephric space;
    a. The presumptive source of bleeding;
5. Hemorrhage into the left renal collecting system with reflux into the right

renal collecting system via right ureteral stent.

Based on the evidence in the provided medical records it is recommended that this case be declined. This recommendation is based on four fundamental questions:

1) Is there significant or permanent injury or damage?
    a) Yes; the patient substantial and ongoing pain and distress as a result of ureteral stent malpositioning;
2) Is there an apparent or suggested deviation in the standard of care?
    a) No; as noted, above, in the available records, the documentation fails to provide direct evidence of a breach of current clinical guidelines in the care of this patient;
    b) Yes; malplacement of this stent due to migration is unlikely in the time frame in this record, whereas failure to use due care in placement is more likely than not the result of a failure to recognize such malplacement during implantation;
3) Is there a direct link between the deviation and the injury or damage?
    a) No; in the absence of a finding of apparent or suggested deviation a link is moot;
    b) Yes; if, as suspected, imaging supports the allegation of malplacement during the subject procedure, the procedure itself resulted in the injury;
4) Is a further review of medical records recommended?
    a) Yes; while further review is recommended, it is also suggested that such review focus initially on imaging captured during the subject procedure to determine the

accuracy of the interpretation an reading of the radiologist placing the ureteral stent. This limited review will permit a dispositive finding in this matter.

Causes for this finding are as discussed above and rely upon orders and details in the medical record as provided. While more detailed information may alter the dynamic equation related to likelihood of prevailing, it must be evaluated whether the burden of seeking that information is potentially unduly burdensome vis a vis the potential benefit to the family. Damages in this case may be self–limiting as the bleeding will likely resolve spontaneously upon recovery of the stent remaining in place. It is highly recommended the patient seek out a new provider to assume his care from a urology perspective.

Thank you for your confidence in MarGin Consulting to bring the needed expertise to this investigative review of {{case|158650}} {{case|158651}}'s matter.

Please advise of additional information needed or questions I can answer.

Respectfully,

Martin A. Ginsburg, RN
Nurse Paralegal

MEMORANDUM

TO:	{{contact|full_name}}
FROM:	Martin A. Ginsburg, RN
SUBJECT:	{{case|case_number}} Medical Record Review for Merit
DATE:	{{GENERAL|CURRENT_DATE_LONG}}
RECOMMEND:	**ACCEPT**

{{contact|114250}} {{contact|last_name}},

Per your instructions and at your request, this memorandum is a summary of care provided your client {{case|158650}} {{case|158651}}, related to her demise revealed on autopsy to have been caused by Respiratory Syncytial Virus (RSV) with a concomitant Lactococcus sepsis.

As requested, this review is not based upon a detailed review of medical records but, rather, the {{case|158653}} ({{case|158654}}) {{case|158662}} ({{case|158663}}) discharge notes provided to the family, the autopsy and toxicology reports and, to a lesser degree, a cursory review of the pediatric primary provider notes.

Please note that MarGin has taken the liberty of unilaterally changing the billing method for this review as it did not meet the criteria for a detailed merits screen and opted to bill actual time required to reduce firm costs in this prospective matter.

This review indicates there is sufficient evidence of a deviation from current clinical guidelines to merit further investigation. This recommendation is based on four fundamental questions:

1) Is there significant or permanent injury or damage?
    a) Yes; this child tragically died;
2) Is there an apparent or suggested deviation in the standard of care?

    a) Yes; vital signs upon two separate visits to {{case|158654}} {{case|158663}} showed an infant in distress;
3) Is there a direct link between the deviation and the injury or damage?
    a) Yes; as noted in the submitted autopsy report the cause of death was a combination of RSV and a superinfection with sepsis reaulting from that superinfection leading to {{case|158650}} {{case|158652}}'s death
4) Is a further review of medical records clinically indicated?
    a) Yes; given the literature available as well as the risk to this patient, there is at this preliminary research stage, sufficient information to believe a deviation from current clinical guidelines has occurred and such a suspicion demonstrates a need for a more detailed investigation.

In this patient, the presenting vital signs are the key to recognition of a child in distress. On the morning of 12/29/2017 {{case|158650}} {{case|158652}}, in the care of a parent, presented to the {{case|158654}} {{case|158663}} with a respiratory rate more than 25% higher than the upper limit of normal values upon discharge, Additionally, temperature, heart rate, and blood pressure were still elevated in this child.

Upon discharge home in the care of family following a subsequent visit to {{case|158654}} {{case|158663}} approsimately 14 hours later, vital signs were noted to include a slighty elevated temperature, a low–normal respiratory and a systolic blood pressure aeart rate both more than 30% higher than the upper limit of normal.

A decreazsing respiratory rate in children without a sorrepsonding decrease in heart rate, blood pressure, and temperature is icative of a child on the cusp of acute respiratory failure. This is widely known and well documented in current clinical guidelines.

Recommendations:

1. There are three potential pathways forward, each with its own benefits and burdens:
    a. While considered highly unlikely, a detailed merit screening from the complete record, such as MarGin has provided in the past, may reveal information that would alter the perspective and finding in this case;
    b. MarGin is well positioned to review the complete medical record upon receipt and evaluate causation issues prior to engagement of physician opinion experts to reduce review commitment and cost of these experts while providing additional support for both breach and proximate causation or demonstrating where such support is not likely to be found before engagement of physician experts;
    c. Immediate engagement of physician experts:
        i. In Pathology to review the autopsy, if desired, to further support proximate causation;
        ii. In Pediatric Emergency Medicine to provide breach analysis and opinion as well as recommend supporting opinion experts;
2. HITECH compliant retrieval of the medical records for this child beginning with the initial diagnosis of pregnancy in her mother;
    a. Given the mother's medical conditions during pregnancy there may be mitigating factors available in the pre–natal records that would not carry into the patients records;
3. Organization of the digital medical record with investigation for missing records to assure an engaged expert and counsel that all relevant information is included in expert review:

    a. This is not a statement of suspicion that the records are incomplete but a recommendation to perform such verification prior to submission to a testifying expert to avoid unnecessary delays or lead to an opinion based upon incomplete data. This is a routine recommendation and believed by the consultant to represent due diligence;
    b. This would also include creation of a fully bookmarked edition of the records. Such bookmarks would be divided according to attorney preference but would likely be subdivided by note type and then chronologically.
4. Creation of a detailed chronology is not recommended in this case as the suspected breach(es) occurred on a single date:
    a. Detailed chronologies, while informative, are costly and examine more information than is necessary for the production of a targeted timeline;
5. Expert identification effort should begin at the earliest opportunity to locate and vet opinion experts and ensure their availability to assist.
    a. Opinion experts can be expected to include at least one physician Board Certified in Pediatric Emergency Medicine, one nurse specializing in the care of emergent pediatric care, potentially a physician Board Certified in Infectious Disease, and the pathologist who performed the autopsy;

Thank you for your confidence in MarGin Consulting to bring the needed expertise to this investigative review of {{case|158650}} {{case|158652}}'s matter. While this level review demonstrates the substantial likelihood of proof of deviation from the current clinical guidelines sufficient to overcome Plaintiff's burden; the assessment of the economics of damages is not, as a matter of routine,

included in this level report as this is a clinical review not designed to assess case or verdict history in the jurisdiction of concern. As such, while consideration is given, where appropriate, to future needs and burdens, estimates of costs of future surgery; rehabilitative services; home modifications; outpatient and home care; expected or anticipated hospitalizations, and more represent identifiable economic damages. Non-economic damages are outside our purview and are, therefore, not assessed here.

Please advise of additional information needed or questions I can answer.

Respectfully,

Martin A. Ginsburg, RN
Nurse Paralegal

Blood pressure levels for girls by age and height percentile

BP (percentile)	Systolic BP (mmHg)							Diastolic BP (mmHg)						
	Height percentile or measured height							Height percentile or measured height						
	5%	10%	25%	50%	75%	90%	95%	5%	10%	25%	50%	75%	90%	95%
1 year														
Height (in)	29.7	30.2	30.9	31.8	32.7	33.4	33.9	29.7	30.2	30.9	31.8	32.7	33.4	33.9
Height (cm)	75.4	76.6	78.6	80.8	83.0	84.9	86.1	75.4	76.6	78.6	80.8	83.0	84.9	86.1
50th	84	85	86	86	87	88	88	41	42	42	43	44	45	46
90th	98	99	99	100	101	102	102	54	55	56	56	57	58	58
95th	101	102	102	103	104	105	105	59	59	60	60	61	62	62
95th + 12 mmHg	113	114	114	115	116	117	117	71	71	72	72	73	74	74

MEMORANDUM

TO: {{contact|full_name}}
FROM: Martin A. Ginsburg, RN
SUBJECT: {{case|case_number}} Medical Record Review for Merit
DATE: {{GENERAL|CURRENT_DATE_LONG}}

INFORMATIONAL MEMORANDUM
NOT DISPOSITIVE

{{contact|114250}} {{contact|last_name}},

Per your instructions and at your request, this memorandum is a summary of care provided your client, {{case|158650}} {{case|158651}}, related to her care following admission to {{case|158653}} ({{case|158654}}). During this admission, {{case|158650}} {{case|158652}} suffered a pressure wound to her sacrocoxygeal area.

There is insufficient information in the records provided by {{case|158654}} to substantiate allegations of negligence related to {{case|158650}} {{case|158652}}'s care and observation. This lack specifically relates to nursing documentation as described in the annotations to the submitted medical records. While not detailed in the medical history chronicled by {{case|158654}} consideration is given in this memorandum to a reported history of chronic alcohol (ETOH) use and multiple hospitalizations for secondary pancreatitis.

From a strictly clinical perspective, her history complicates her care. Protein/calorie malnutrition is a hallmark of alcohol (and other substances) abuse and always places the patient at higher risk for a wide variety of clinical complications - including wounds.

These tragedies are always complicated and usually difficult to actually prove. Evidence is generally in the form of "not written = not done" and is circumstantial. While that appears to be available here, the arguments for her increasing her own risk through poor self-care and nutrition make these cases all the more difficult.

While there is commentary from regulatory agencies and organizations calling pressure wounds "never events", it is also recognized that wounds are, at times, unavoidable.

This may well be one of those cases given the entirety of the medical history and level of dependence upon caregivers in this patient. This situation is certainly complicated from a burden of proof perspective.

By way of example, medical history includes:

1. Acute respiratory failure with hypoxia
2. Hyperkalemia
3. Chronic systolic (congestive) heart failure
    a. Decreased mean arterial pressure increases risk of pressure wound formation
4. Acute kidney failure
5. Muscle weakness (generalized)
6. Diabetes Mellitus Type II
7. Clonic hemifacial spasm
8. Anoxic brain injury
    a. Decreased sensorium increases risk of inability to identify or report pain associated with wound formation
9. Atherosclerotic heart disease
    a. Indicative of vascular disease that frequently affect the peripheral vascular system thereby decreasing end tissue oxygen/nutrient supply

This history, even ignoring a history of ETOH (ab)use is indicative of a patient at especially high risk for wound formation. There are vascular and neurologic injuries and damage that increase risk for wounds as well as impair patient ability to recognize the pain associated with wound formation.

Noted in the available records are incidences of dehydration which increase risk for wound formation and support a suspicion of protein/calorie malnutrition, further increasing this risk. To fully support a wound as a proximate cause in a wrongful death action, comprehensive medical records are required. Dehydration may occur in other than purely inadequate nutritional settings. While less likely, this possibility cannot be excluded given the information presented.

There is insufficient information in the provided records to extrapolate a breach in duty or proximate causation regarding the wound at the center of this query. Therefore there is no dispositive finding in this memorandum. The following review is based on the information available but must be viewed in the context to the insufficiency of the records provided by the facility.

1) Is there significant or permanent injury or damage?
    a) Yes; death of the patient and a pressure wound;
2) Is there an apparent or suggested deviation in the standard of care?
    a) No; as noted, above, in the available records, the documentation fails to identify periods of failure to demonstrate missed repositioning for comfort and wound risk reduction;
3) Is there a direct link between the deviation and the injury or damage?
    a) No; in the absence of a finding of apparent or suggested deviation a link is moot;
4) Is a further review of medical records recommended?
    a) Yes; as noted elsewhere herein there is reason to suspect the records provided by the facility are incomplete and prevent a dispositive determination of merit in this matter;
    b) Yes; as noted elsewhere herein, there is reason to suspect inadequate nutritional support leading to an increase in the risk for wound formation or infection;
    c) No; as noted elsewhere herein there is no evidence found in the records submitted to which a deviating from the current clinical guidelines may be ascribed, therefore; no further review of the record is indicated.

Causes for this finding are as discussed above and rely upon orders and details in the medical record as provided. While more detailed information may alter the dynamic equation related to likelihood of prevailing, it must be evaluated whether the burden of seeking that information is potentially unduly burdensome vis a vis the potential benefit to the family.

Thank you for your confidence in MarGin Consulting to bring the needed expertise to this investigative review of {{case|158650}} {{case|158651}}'s matter.

Please advise of additional information needed or questions I can answer.

Respectfully,

Martin A. Ginsburg, RN
Nurse Paralegal

MEMORANDUM

TO:	{{contact|full_name}}
FROM:	Martin A. Ginsburg, RN
SUBJECT:	{{case|case_number}}; {{case|name}} Medical Record Review for Merit
DATE:	{{GENERAL|CURRENT_DATE_LONG}}
RECOMMEND:	**DECLINE**

{{contact|114250}} {{contact|last_name}},

Per your instructions and at your request, this memorandum is a summary of care provided your client, {{case|158650}} {{case|158651}}, related to his care following at {{case|158653}} ({{case|158654}}) related to a wound received in a swimming pool.

There is insufficient information in the records provided to substantiate allegations of negligence related to {{case|158650}} {{case|158652}}'s care and observation. This lack specifically relates to monitoring an infection related to the original trauma.

Upon presentation to {{case|158654}}, {{case|158650}} {{case|158652}} reports a failure to remove the impaled plastic from the pool skimmer in its entirety. After follow-up visit to {{case|158654}} failed to result in notable improvement, {{case|158650}} {{case|158652}} opted to present to Doctor's Hospital for treatment. This option, ironically, led to a delay of approximately two days in diagnosing the infectious agent in the wound. {{case|158654}} received results of a wound culture done upon the patient's initial presentation the day before he presented to Doctor's Hospital. At Doctor's, a wound culture was done and the offending organism identified.

The depth of the infection presented commonly experienced difficulties in treatment. The infection is not generally symptomatic until it has already firmly established, making treatment slightly more complex. In this case, the depth of the infection required surgical debridement (removal of affected tissue) necessary and left a wound of such size as to require mechanical closure assistive device placement in addition to suturing in the form of a Vacuum Assisted Closure (VAC) device.

During treatment at Doctor's Hospital there was no additional material found in the wound during debridement. The infection, which comprised two organisms, one

of which is normal flora of the human skin (Staphylococcus aureus) and the other well known to exist in water environments. The records demonstrate that {{case|158654}} began empiric antibiotic treatment in a timely manner and, upon receipt of the culture results, attempted 9without success) to contact the patient and planned to recommend treatment at Doctor's Hospital. The documentation supports appropriate diagnosis and treatment of a traumatic injury and subsequent infection.

Based on the evidence in the provided medical records it is recommended that this case be declined. This recommendation is based on four fundamental questions:

1) Is there significant or permanent injury or damage?
    a) Yes; the patient suffered an infection from a traumatic break in the skin resulting in the need for surgical repair;
2) Is there an apparent or suggested deviation in the standard of care?
    a) No; as noted, above, in the available records, there was timely treatment and adequate follow-up on the part of the subject provider;
3) Is there a direct link between the deviation and the injury or damage?
    a) No; in the absence of a finding of apparent or suggested deviation a link is moot;
4) Is a further review of medical records recommended?
    a) No; as noted elsewhere herein there is no evidence found in the records submitted to which a deviating from the current clinical guidelines may be ascribed, therefore; no further review of the record is indicated.

Causes for this finding are as discussed above and rely upon orders and details in the medical record as provided. It is unlikely that more detailed information may alter the dynamic equation related to likelihood of prevailing; therefore, it must be evaluated whether the burden of seeking that information is potentially unduly burdensome vis a vis the potential benefit to the patient.

Thank you for your confidence in MarGin Consulting to bring the needed expertise to this investigative review of {{case|158650}} {{case|158651}}'s matter.

Please advise of additional information needed or questions I can answer.

Respectfully,

Martin A. Ginsburg, RN
Nurse Paralegal

MEMORANDUM

TO:	{{contact|full_name}}
FROM:	Martin A. Ginsburg, RN
SUBJECT:	{{case|case_number}}: {{case|name}} Medical Record Review for Merit
DATE:	{{GENERAL|CURRENT_DATE_LONG}}
RECOMMEND:	**DECLINE**

{{contact|114250}} {{contact|last_name}},

Per your instructions and at your request, this memorandum is a summary of care provided your client, {{case|158650}} {{case|158651}}, related to her visit and subsequent admission to {{case|158653}} ({{case|158654}}). Her diagnosis of appendicitis and the following surgery and interventions documented in the records provided are in keeping with current clinical guidelines.

There is insufficient information in the records provided by {{case|158654}} to substantiate allegations of negligence related to {{case|158650}} {{case|158652}}'s care and observation. This lack specifically relates recognition that the events following her surgery were known complications of the underlying procedure. Infection is a known complication of any surgical procedure and is more frequent in intestinal surgeries, especially those treating perforations.

The diagnostic pathway was consistent with appropriate implementation of the Differential Diagnostic method. While the preliminary impression was that of likely kidney stone, the diagnostic testing for this presentation of pain is designed to capture other causes, such as appendicitis, among others. In this patient's case, the system operated as designed to ensure that care was delivered in a timely manner. Unfortunately, in this case, infection and bleeding – both known complications of the initial procedure – developed and lengthened her hospitalization and recovery with devastating results.

Based on the evidence in the provided medical records it is recommended that this case be declined. This recommendation is based on four fundamental questions:

1) Is there significant or permanent injury or damage?
    a) Yes; the patient suffered an infection and bleeding as a probable result of intestinal surgery to repair a perforated

appendix;;

2) Is there an apparent or suggested deviation in the standard of care?
    a) No; as noted, above, in the available records; the documentation fails to identify a deviation or delay in diagnosis;
3) Is there a direct link between the deviation and the injury or damage?
    a) No; in the absence of a finding of apparent or suggested deviation a link is moot;
4) Is a further review of medical records recommended?
    a) No; as noted elsewhere herein there is no evidence found in the records submitted to which a deviation from the current clinical guidelines may be ascribed, therefore; no further review of the record is indicated.

Causes for this finding are as discussed above and rely upon orders and details in the medical record as provided. More detailed information is not likely to alter the dynamic equation related to likelihood of prevailing, and this case must be evaluated in light of whether the burden of seeking that information is potentially unduly burdensome vis a vis the potential benefit to the family.

Thank you for your confidence in MarGin Consulting to bring the needed expertise to this investigative review of {{case|158650}} {{case|158651}}'s matter.

Please advise of additional information needed or questions I can answer.

Respectfully,

Martin A. Ginsburg, RN
Nurse Paralegal

MEMORANDUM

TO:	{{contact|full_name}}
FROM:	Martin A. Ginsburg, RN
SUBJECT:	{{case|case_number}}; {{case|name}}; Medical Record Review for Merit
DATE:	{{GENERAL|CURRENT_DATE_LONG}}
RECOMMEND:	**DECLINE**

{{contact|114250}} {{contact|last_name}},

Per your instructions and at your request, this memorandum is a summary of care provided your client, {{case|158650}} {{case|158651}}, related to her under {{case|158653}} ({{case|158654}}) of {{case|158656}} ({{case|158657}}) following a fall that resulted in a compression fracture of her twelfth thoracic vertebra (T12).

The burst fracture suffered caused a bone fragment to be pushed backward (retropulsed) into the spinal canal. There were initial indication that the spinal cord and nerve roots exiting the column were not impinged. Given these initial findings, conservative management was indicated in the early stages of treatment. Copuled with physical therapy and pain management this treatment modality has a record of success that is well documented in the literature.

In fact, while there is little agreement in the literature regarding the timing of invasive interventions, much has been written on the topic and guidance can be derived from the aggregation of that published information. It is a general medical consensus that surgery is, except in very limited multiple injury trauma presentation, the intervention of last resort. This is based upon the recognition that, while corrective or curative in some situations, surgery extends recovery times, increases short-term pain, risks infection, risks intra-operative injury and is possessed of other challenges that provide ample reason to “start low and go slow”.

In the instant case, the patient presented post fall with a burst/compression fracture of T12 with a height loss of approximately 35% and anterior wedging noted on imaging. Per the provided records; assessment indicated no neurologic deficits associated with this finding. This presentation indicates an opportunity to conservative

management. Patient education appears adequate upon hospital discharge during this initial presentation.

{{case|158650}} {{case|158652}} presented at {{case|158657}} for evaluation by {{case|158654}} on 03APR18. Radiographs taken that day in the office demonstrated a now “near complete collapse of the T12 vertebral body.” Despite this imaging finding, there is no notation of neurologic compromise with pain limited to the site of the fracture. There is note of slowed gait, but no report of increased pain with ambulation that radiates outside the fracture zone.

The tipping point for surgical intervention is neurologic compromise which, in this patient, is not reported until the day preceding her admission for surgical intervention at {{case|158658}} ({{case|158659}}) upon a significant increase in uncontrolled pain. Of note, on 01MAY18, at a visit with {{case|158654}}, it was recommended that the patient leave the office and go directly to the nearest Emergency Department to facilitate an urgent imaging study in the form of a MRI to evaluate the source of intractable pain. The notes of that visit indicate the patient declined to present to an Emergency Department at that time and did so the following morning whereupon she was evaluated and then transferred to {{case|158659}} where surgery was recommended and, subsequently successfully performed.

Based on the evidence in the provided medical records it is recommended that this case be declined. This recommendation is based on four fundamental questions:

1) Is there significant or permanent injury or damage?
    a) No; the patient suffered pain resulting from a burst or compression spinal fracture that became unstable but was successfully treated with surgery;
2) Is there an apparent or suggested deviation in the standard of care?
    a) No; as noted, above, in the available records, the documentation fails to identify a requirement invasive intervention in the face of intact neurologic function distal the point of injury;
3) Is there a direct link between the deviation and the injury or damage?
    a) No; in the absence of a finding of apparent or suggested deviation a link is moot;

4) Is a further review of medical records recommended?
    a) No; as noted elsewhere herein there is no evidence found in the records submitted to which a deviating from the current clinical guidelines may be ascribed, therefore; no further review of the record is indicated.

Causes for this finding are as discussed above and rely upon orders and details in the medical record as provided. It is not likely that more detailed information may alter the dynamic equation related to likelihood of prevailing. Therefore, given the limited damages and absence of permanence of resulting injury, efforts to retrieve additional information must be evaluated may potentially prove unduly burdensome vis a vis the potential benefit to the family.

Thank you for your confidence in MarGin Consulting to bring the needed expertise to this investigative review of {{case|158650}} {{case|158651}}'s matter.

Please advise of additional information needed or questions I can answer.

Respectfully,

Martin A. Ginsburg,
RN Nurse Paralegal

MEMORANDUM

TO: {{contact|full_name}}
FROM: Martin A. Ginsburg, RN
SUBJECT: {{case|case_number}} Medical Record Review for Merit
DATE: {{GENERAL|CURRENT_DATE_LONG}}

INFORMATIONAL MEMORANDUM
NOT DISPOSITIVE

{{contact|114250}} {{contact|last_name}},

Per your instructions and at your request, this memorandum is a summary of care provided your client, {{case|158650}} {{case|158651}}, related to her under {{case|158653}} ({{case|158654}}) related to her diagnosis of bilateral cataracts. There is an allegation that during her second surgery, specifically the surgery to implant an intraocular lens in the left eye; the chair in which the anesthesiologist was sitting broke causing the anesthesiologist to fall jarring the operative table as he fell. The patient further reports the anesthesiologist was taken to the Emergency Department for treatment that included sutures. There is, however, a suspicion for such being the case as the only procedure of the three where there are two signatures for anesthesiology is the surgery that is the foundation for this allegation.

The patient further reports that {{case|158654}} had to change the lens selection during the procedure. The patient advises {{case|158654}} had to get up and go look for what he needed during the operation. The patient adds that this was due to a weak spot in her eye. The operative notes do show such a weakened area in the eye but not the level of difficulty managing this situation as the patient reports.

In assessment notes there is information related to the implanted lens placement shifting upon contraction of the pupil and becoming malpositioned at least partially behind the papillary segment of the iris. Malpositioning or dislocation of an intraocular lens (IOL) implant is a known complication of these procedures with an occurrence rate of approximately 11 per 1,000, or 1.1%. During the procedure of 12/27/2017, the position of the lens was corrected and the pupil was constricted to verify proper placement and positional integrity of the lens.

The report by the patient of a fall and injury involving the anesthesiologist is not supported by the records as provided. There is no substitution of provider noted; however,

the procedure of 12/13/2017 was of more than three times the duration of the previous procedure. The 11/29/2017 Right eye surgery duration was 21 minutes, whereas the similar procedure for the Left eye lasted 68 minutes. Per the procedure note:

> However, during the emulsification the pupil began to constrict and I stopped and placed 4 Gralshaber iris hook retractors at 12, 3, 6 and 9 o'clock. Thi expanded the pupil qatistactorily. I continued to emulsify the nucleus and was able to emulsify it in toto. However, at the end of the cortical clea-up I did notice that there was a rent in the posterior e3psule. f I therefore expanded the incision laterally and was able to put In an MN60AC lens of 21.0 dfopters with good. sulcus fixation anterior to the anterior capsule. There was a small knuckle of vitreous which I removed using Weck-Cell sponges and Varinas scissors. I used Miochol to constrict the pupil and it constricted nicely and appeared to be round with no vitreous to tha wound. I closed the wound using 10-0 nylon sutures. (18.850_OCR_Binder 1 p. 39)

The duration of the procedure might be fully attributable to difficulty in maintaining dilation of the pupil, though this is not noted anywhere in the records. Of note, there are no notes specifically supporting the patient's allegations, including a change of anesthesia provider.

Based on the evidence in the provided medical records it is recommended that this case be declined. This recommendation is based on four fundamental questions:

1) Is there significant or permanent injury or damage?
    a) Yes; the failure of the patient to return to at least baseline visual acuity following intraocular lens implantation after cataract removal in her left eye;
2) Is there an apparent or suggested deviation in the standard of care?
    a) No; as noted, above, in the available records, the documentation fails to demonstrate anomalies during the operative procedure consistent with patient reports and known complications of surgery are not presumptive for deviations from current clinical guidelines;
    b) Equivocal; the additional time to conduct a similar procedure on a second eye is inconsistent with expectations for this procedure even in the face of the known complications of difficulty in dilating the subject pupil and requiring use of hooks to maintain mydriasis during the procedure;
    c) Equivocal; during the procedure in question the surgeon documented that "there was a rent in the posterior capsule" (*id.*

at 39) that was found following placement of the hooks to dilate the pupil and completion of the emulsification and extraction of the native lens;

3) Is there a direct link between the deviation and the injury or damage?
    a) No; in the absence of a definitive finding of apparent or suggested deviation a link is moot;
4) Is a further review of medical records recommended?
    a) No; as noted elsewhere herein there is no evidence found in the records submitted to which a deviating from the current clinical guidelines may be ascribed, therefore; no further review of the record is indicated.
    b) Equivocal; the addition of a second anesthesia provider signature and protracted surgical duration for the subject procedure of 12/27/2017 are indicators of information not provided in the records submitted which would suggest that a repeat request for records per Federal statutes (HITECH) may likely provide additional records and permit a dispositive finding in this matter.

Causes for this finding are as discussed above and rely upon information and details in the medical record as provided. While more detailed information may alter the dynamic equation related to likelihood of prevailing, it must be evaluated whether the burden of seeking that information is potentially unduly burdensome vis a vis the potential benefit to the family.

Thank you for your confidence in MarGin Consulting to bring the needed expertise to this investigative review of {{case|158650}} {{case|158651}}'s matter.

Please advise of additional information needed or questions I can answer.

Respectfully,

Martin A. Ginsburg, RN
Nurse Paralegal

MEMORANDUM

TO: {{contact|full_name}}
FROM: Martin A. Ginsburg, RN
SUBJECT: {{case|case_number}} Medical Record Review for Merit
DATE: {{GENERAL|CURRENT_DATE_LONG}}

INFORMATIONAL MEMORANDUM
NOT DISPOSITIVE

{{contact|114250}} {{contact|last_name}},

Per your instructions and at your request, this memorandum is a summary of care provided your client, {{case|158650}} {{case|158651}}, related to his care following Coronary Artery Bypass Grafting (CABG) surgery at {{case|158653}} ({{case|158654}}). During this period {{case|158650}} {{case|158652}} suffered an infection of his sternum (breastbone) as well as dehiscence (unplanned separation of a wound opening) of his sternal wound on two separate occasions leading to additional surgeries to correct this defect leading also to his diagnosis of infection in the bone.

There is insufficient information in the records provided by {{case|158654}} to adequately demonstrate a deviation from current clinical guidelines as infection is a known complication of surgical procedure. In this particular case, however, the infectious agent is one that leads to sufficient suspicion of such a deviation that further investigation has a reasonable chance to fully refute, or sufficiently demonstrate, such a deviation.

It is important to note that normal surgical sterile procedures would reasonably be expected to prevent just such an infection. For example, in the peer review article edited by R Berman; *Overview of control measures for prevention of surgical site infection in adults* The following observations are made regarding intra-operative infection prevention:

> **INFECTION CONTROL** — An infection control program is an essential part of surgical site infection prevention [5,24]. An effective program can reduce the rate of SSIs by 40 percent [25,26]. The most important factors in the prevention of SSI are timely administration of effective preoperative antibiotics and careful attention to operative technique.

A number of other perioperative infection control interventions have been used to reduce the risk of SSIs, including hand hygiene, use of gloves and other barrier devices by operating room personnel, patient decolonization, skin antisepsis, and method hair removal [27-29]. These interventions reduce patient contact with flora from the hands, hair, scalp, nares, and oropharynx of hospital personnel, which can be potential sources of microorganisms causing SSIs.

Active surveillance and reporting of rates of SSIs to individual surgeons can also reduce infection rates [30,31]. Confidential rates can be reported as surgeon specific, service specific, and hospital-wide and may be categorized within discrete risk index scores. Identifying and monitoring SSI rates among outpatients can be difficult. Methodologies include surveillance by patients and health care personnel (including physicians and nurses), surveillance via pharmacy records, and surveillance via health plan records [32-36]. Surveillance may be limited to "complex" (ie, not superficial incisional) SSIs diagnosed in inpatient settings; a risk index may be used to for stratification of "complex" SSIs [37].

While the most common organisms are bacteria, fungi (yeasts) are common (or normal) human skin flora and transmitted internally by contact. The suspect providers would be the surgeons performing the CABG and first mediastinal closure after first dehiscence. {{case|158656}} ({{case|158657}}), assisted by {{case|158658}} ({{case|158659}}) performed the CABG in a procedure that was entirely routine in appearance based upon the notes and records available. Coincidentally, {{case|158659}} performed the initial re-closure and mediastinal exploration after the first wound dehiscence. {{case|158660}} ({{case|158661}}) during a second closure procedure for dehiscence performed a bone biopsy for culture and Candia parapsiliosis was identified as the offending organism. While not found in large colony size, the reported symptoms were consistent with this finding. Unfortunately, the symptoms of such an infection may sometimes be consistent with having undergone an operative procedure and routine recovery. This type infection may be particularly insidious in that there is quite often a delay between inoculation and symptom onset.

Based on the evidence in the provided medical records it is recommended that this case be declined. This recommendation is based on four fundamental questions:

1) Is there significant or permanent injury or damage?
    a) Yes; the patient suffered additional surgeries and delayed

healing;

2) Is there an apparent or suggested deviation in the standard of care?
    a) No; as noted, above, infection is generally considered a "known complication" of surgical procedures;
    b) Yes; the primary infectious organism is most likely introduced through a breach in hand hygiene or sterile technique;
3) Is there a direct link between the deviation and the injury or damage?
    a) No; this case is complicated by at least two surgeries at the same site before the finding of infection and the "known complication" issue that may present a significant burden to litigation success;
4) Is a further review of medical records recommended?
    a) Indeterminate; while there is reason to believe the patient may prevail, there is a high risk in pursuing this matter. There are certain facts that may be divined and assumptions that may be made based upon the available records but those are not fully dispositive at this level of investigation.

Causes for this finding are as discussed above and rely upon available medical records and appended reference materials as annotated. This case is complicated by the factors noted in this memorandum and puts its status in the "grey" area of highly suspicious but not demonstrably meritorious.

While MarGin does offer a causation evaluation review, we feel in this case, such a review would still be insufficient. If the firm determines to go forward with a further investigation, epidemiology of this infectious agent and the setting should be reviewed. For that, a physician certified in the diagnosis and treatment of infectious diseases would present the best opportunity to identify the degree of risk faced in proceeding with this case.

Thank you for your confidence in MarGin Consulting to bring the needed expertise to this investigative review of {{case|158650}} {{case|158651}}'s matter.

Please advise of additional information needed or questions I can answer.

Respectfully,

Martin A. Ginsburg, RN
Nurse Paralegal