COMMONWEALTH OF MASSACHUSETTS

Suffolk, ss.
Superior Court
Civil Action No. 2004-03927   Department of the
                               Trial Court

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JESTINA FOX NEBLETT *
*
Plaintiff *
*
v. *
*
DR. SELLEND *
DR. KRENIS *
NURSE NICKERSON et al *
*
Defendants *
*
* * * * * * * * * * * * * * * * * *

CLOSING ARGUMENT OF MR. FLEMMING

Suffolk Superior Court
3 Pemberton Square
Boston, Massachusetts 02108

Before: Hines J.

Wednesday 15 December, 2010

Faye LeRoux
Court Reporter

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P R O C E E D I N G S

1 CLOSING ARGUMENT

2 ON BEHALF OF MS. FOX NEBLETT

3

4 MR. FLEMMING: Thank you, your Honor.

5 Thank you on behalf of Justina Fox Neblett

6 and her relatives and everyone on the plaintiff's

7 side for the attention you have given the case.

8 The jury in our system of justice is what I would

9 like to call the engine that makes the system

10 actually work. Justice Hines, her very important

11 functions and job in controlling the trial, the

12 lawyers are here as advocates trying to do their

13 best to point out what the facts. But in a very

14 real sense the attention is paid to what is the

15 evidence, the facts are found by the Jury. And you

16 are what make the system go.

17 So I share the thoughts that have been

18 expressed by the other attorneys in terms of how

19 important your service is and will be. And thank

20 you for not only your attention up until now but

21 the attention that I know you will give this case

22 when you start your deliberations.

1 John Adams when he was defending some British
2 soldiers who had shot down some Americans just
3 before the Revolutionary war started said in the
4 course of that representation, facts are stubborn
5 things and whatever may be our wishes, our
6 inclinations, or the dictates of our passion they
7 can't alter the state of facts or evidence. And
8 that is what in this particular case we are going
9 to ask you to go by, is to go by what the actual
10 facts in the case are and not the reconstruction of
11 events that has been presented by some of the
12 testimony from the defendants.
13 The first claim in this case is the claim
14 against Dr. Selland. The plaintiff's claim in this
15 particular regard is fairly simple. On
16 August 29th, 2003 Justina Fox Neblett came in for
17 an operation. You've heard what it's called, an
18 MED at two levels with the plan of at least doing a
19 fusion. Now, here workup, there is no issue being
20 raised by us in terms of the adequacy of her
21 workup. There's no issue being raised by us as to
22 whether or not it was appropriate to have had her
23 have some degree of bed rest before progressing to
24 surgery.

1 The issue is when she showed up on that date
2 merely by signing a consent form, did she consent
3 to whatever complications would ensue after the
4 point in time, regardless of whether or not the
5 surgeon performed the operation in accordance with
6 the standard of the average qualified neurosurgeon.
7 Now the mere fact that it's a complication
8 does not absolve the defendant from negligence.
9 Patients have rights. So they are entitled to have
10 the procedure performed in accordance with
11 acceptable medical practices, and if that
12 complication, quote, unquote, occurs, that bad
13 event occurs, then that's an actionable claim under
14 our laws of negligence.
15 So what do we have in this particular case?
16 Because I actually think there is a fair amount of
17 agreement on the surgical aspect of this case. If
18 you remember on the very first day that Dr. Selland
19 testified, even though I think I may have testified
20 in bits and pieces over the course of four days,
21 the very first day. I asked him, during the course
22 of this surgical procedure is it below the standard
23 of good and acceptable neurosurgical practice to
24 put an instrument through the annulus fibrosis,

1 through the anterior ligament into the peritoneal
2 cavity and damage the vena cava? He said, yes.
3 Admitted.
4 He didn't believe that he had done that in
5 this case, but he admitted that if that is what had
6 happened that would be below the standard of good
7 neurosurgical practice. So then we brought you
8 Dr. Lazar. Dr. Lazar, who has performed this type
9 of procedure numerous times. He only does
10 microendoscopic surgery at this point in time.
11 Dr. Lazar came in and he said it's below the
12 standard of care of the average qualified
13 neurosurgeon to cause an injury with an instrument
14 by going through that kind of resistant annulus
15 fibrosis at the back of the disc, to then further
16 go beyond that kind of tough interior longitudinal
17 ligament and go into the retroperitoneal cavity and
18 injure the vessel.
19 No different really from what Dr. Selland had
20 said. The difference was that an issue was being
21 raised as to, well aren't there some other
22 potential causes? Other potential causes, and the
23 other potential cause that was raised is, somehow
24 if during the distraction of the vertebrae during

1 this procedure you have an osteophyte which
2 somehow -- an osteophyte on, let's take L3. An
3 osteophyte, bony growth on one of these vertebrae
4 which somehow has become affixed to the ligament,
5 which then somehow has become adherent to the vena
6 cava that when you distract this it might pull it.
7 Even though nothing is really going into the
8 retroperitoneal cavity, it's just sort of like a
9 pulling and releasing and maybe the vena cava
10 gives.
11 So, the distraction argument that was being
12 raised in this case, that's the only thing that
13 could have caused this to happen besides
14 instrumentation going right into the
15 retroperitoneal cavity. So what happened to that
16 issue? Over time we learned that there are to
17 claims as to how that could've happened.
18 One is osteophyte could have done that.
19 Attorney Foster spent a lot of time referencing
20 documents in his cross-examination about there
21 being significant areas of osteophyte's shown on
22 x-rays. Of course, they're all back here on the
23 posterior side of the disc and in the foramen and
24 here where the bony growth was, and on the actual

1 place where it would have to be to cause this to
2 happen by adherence and distraction. Dr. Lazar
3 showed you. There is a tiny miniscule almost
4 nonexistent osteophyte that simply based upon its
5 size could not of caused this to happen. After he
6 gave that testimony did we hear about the
7 osteophyte defense again? From anybody? Did
8 anybody else come in and try to show you that the
9 osteophyte was bigger than Dr. Lazar was saying or
10 that what Dr. Lazar was saying could be challenged
11 in any respect? No.
12 That evidence came in. End of issue. End
13 of osteophyte issue anyways. And so then what did
14 we do? Well, then we had to go to plan B. And
15 plan B. was, okay, it wasn't an osteophyte, it was
16 scar tissue in the area of the primary -- in the
17 prior surgery that must have caused, again, there
18 being some degree of adherence between the anterior
19 longitudinal ligament and the vena cava and the
20 scar tissue that's in the back, the interior
21 portion of the disc. Dr. Selland raised that and
22 attorney Foster made a big deal out of that. And
23 then that issue went away. Because in 2006, years
24 after this occurrence, we went through that at

1 Dr. Selland's deposition.
2 And eventually I took it up to him and he
3 read it. The simple fact in this case is that when
4 he did the prior surgery at that time, at L4-L5, he
5 operated in the posterior area. He didn't operate
6 in the anterior area close to where the anterior
7 ligament is, close to where the beginning of the
8 retroperitoneal cavity is, close to when the vena
9 cava is.
10 So you heard him read his deposition
11 testimony. There was no prior surgery in the area
12 of the back of the L4-L5 disc; therefore scar
13 tissue there could not have caused the problem. So
14 the distraction issue in this case has been ruled
15 out by the testimony of the witnesses in this case.
16 And who has explained to you how those are even
17 still valid theories?
18 So what are we left with? Dr. Jacobs comes
19 in and just says it's the curette. How did the
20 curette do it? Well, we really don't know because
21 it wasn't important for us to know apparently.
22 Dr. Lazar says it's L-3. It's most likely the
23 pituitary rongeur. Everybody agreed that the most
24 common cause is a rongeur. So Dr. Lazar gave you

1 his opinion based upon a reasonable degree of
2 medical probability that's what happened in this
3 case.
4 Doesn't matter though, because Dr. Selland
5 has admitted that if it's instrumentation, be it a
6 curette, be it a rongeur, it is below the standard
7 of good and acceptable medical practice for a
8 neurosurgeon during this procedure to go into the
9 retroperitoneal cavity and injure the vena cava.
10 The only defense is the one you heard in
11 attorney Foster's argument and you heard from
12 Dr. Jacobs on the stand. Dr. Jacobs basically said
13 look, I looked at the records in this case and
14 Dr. Selland didn't rush into this surgery. He
15 prescribed five weeks of bed rest and that was
16 good, no rush. And he ordered a lot of diagnostic
17 tests, went above and beyond the call of duty in
18 doing that. And I can tell from looking at his
19 records and the way his operative report rates,
20 he's a good doctor. And when this happens to a
21 good doctor it's a complication, it's not
22 negligence.
23 That's his opinion. What does Dr. Lazar say?
24 Even good doctors sometimes make mistakes.

1 So which testimony is more believable? Good
2 doctors never make mistakes and if something bad
3 happens it's a complication, or that good doctors,
4 and I believe Dr. Lazar said, unfortunately
5 sometimes they make a mistake and if it's below the
6 standard of care, it's below the standard of care.
7 But it's up to you to judge the relative
8 believability of the witnesses. The only thing I
9 would throw in on the question of comparing the two
10 witnesses is the conflict of Dr. Lazar's testimony
11 and supposedly the contradictory statements he
12 gave. I think he made it very clear why he
13 answered one question what we and one question
14 another way.
15 Attorney Foster was trying to get him to say
16 things to a certainty, and Dr. Lazar was just
17 trying to be as clear as he could to you that his
18 testimony was based upon a reasonable degree of
19 medical probability. It wasn't based upon an
20 absolute certainty and he wouldn't go that far with
21 attorney Foster.
22 It's a fair point for the lawyer to be making
23 that it doesn't in any way reflect upon his
24 credibility poorly. In fact from my perspective

1 you should give him credit for the fact that he
2 wanted to make it clear to you people exactly what
3 the basis, how far he was going to go in expressing
4 his opinions in this case.
5 That's essentially the case with respect to
6 Dr. to Selland in the performance of the surgery.
7 Although you might want to consider some of the
8 other evidence, which is that Dr. Lazar has never
9 seen it happen in all his years of practice as an
10 endoscopic spine surgeon, and in 50 years doctor
11 Jacobs has never had any personal involvement in
12 it, although he said he heard of it at one time in
13 one of the institutions that he has been associated
14 with during that period of time.
15 This is a rare complication and just because
16 a neurosurgeon is operating in a small area and
17 can't see at times what he's doing, the standard of
18 care, and to get Dr. Selland agree to this, the
19 standard of care requires that you know where you
20 are. Neurosurgeons work in small areas all the
21 time with major important vessels very close by.
22 That's what they're trained to do.
23 With respect to the anesthesiologist and the
24 claims. From the very beginning we thought that we

1 could at least present to you the basic facts of
2 the case using the chart and the testimony of the
3 two CRNA's and the surgeon who came in to try to
4 fix the situation. CRNA Sullivan came in and said,
5 I made these entries -- CRNA Sullivan came in and
6 said that while she was doing the lunchtime
7 coverage between 11:40 and 12:10 in the end, just
8 before 12:10, suddenly four things happened.
9 No reading on the oxygen saturation monitor.
10 No blood pressure recording. End tidal CO2 goes
11 down to, according to her note, 20 to 21. And
12 there were ST depressions on the electrocardiogram
13 monitor. She told you that she viewed those as all
14 being concerning readings. She told you that it
15 took her somewhere between, I think on one occasion
16 she said 30 seconds, then on another occasion she
17 said one to two minutes, to check the machines, and
18 that by 12:10 she was confident in her own mind
19 that this was not a machine related problem, this
20 was a patient problem.
21 She went out and she, according to her
22 testimony, she send somebody out to find Dr. Nakrin
23 get him back in the room. Now, what you have in
24 the jurors note book and also even on this blowup,

1 you really can't see 12:10 up here. But if you go
2 to the original chart, and you'll have this in the
3 Jury room, just for some reason we could never get
4 it in the photocopying process, but it's as clear
5 as can be, 12:10, that she made all of those
6 entries.
7 She also made an entry that she gave the
8 first administration of ephedrine. So then what do
9 we have? Well we have the chart. And CRNA
10 Nickerson came in and at least initially her
11 testimony was I was doing the charting and this
12 charting is accurate and these things happened as
13 they are charted and I may be off a minute or two
14 but I was doing the charting. And what does the
15 chart show us?
16 Well, the chart shows us that indeed nurse
17 Sullivan gave the first dose of ephedrine somewhere
18 between the 12:05 and the 12:10 time frame. Then
19 after Dr. Nakrin and Nurse Nickerson had come in at
20 approximately 12:15 the dose of ephedrine was
21 repeated, the forane was turned of, and if you go
22 or the way down to the bottom here, this is where
23 apparently an additional IV line was put in so the
24 patient could be receiving not only lactated

1 ringers but normal saline, all starting at about
2 this time frame.
3 At 12:15 he is -- in fact at 12:10 there is
4 no blood pressure reading, at 12:15 there is no
5 blood pressure reading, at 12:20 there is no blood
6 pressure reading, at 12:25 there is no blood
7 pressure reading, and 12:30 there is no blood
8 pressure reading. During this period of time and
9 according to Nurse Nickerson all these
10 abnormalities that had appeared at 12:10 continued,
11 with the end tidal CO2 being down, no reading on
12 the oxygen saturation level and even though there
13 is no recording here of what was going on with
14 respect to the cardiac monitor, she said the same
15 thing had been prevailing.
16 So in terms of delay between 12:15 and 12:30
17 the treatment that was started at 12:15 was simply
18 continued and we have nothing in this chart in
19 terms of what was actually going on in terms of the
20 evaluation of the patient.
21 Next item, 12:35. We have at this point in
22 time, some time between, it looks almost like
23 12:35, but maybe it's a little bit before, the
24 repeat ephedrine is given. Then at 12:40 we have

1 the neosynephrine drip being started. Then of
2 course if we go to Nurse Nickerson's note timed at
3 12:40, it says no BP, no oxygen saturation,
4 positive color change, Dr. Selland notified.
5 Supine POS, explore lab by Dr. McBride. And Nurse
6 Nickerson told you we gave the repeat dose of
7 ephedrine at 12:35 as part of the therapeutic
8 treatment of the patient before telling
9 Dr. Selland. We started the neosynephrine to try
10 to constrict the blood vessels as part of the
11 therapeutic treatment that was being provided
12 before telling Dr. Selland. And at 12:40 we told
13 Dr. Selland.
14 Now, that's what the chart says. But the
15 defense is you can't believe the chart. What does
16 the defense say? Well, let's look at some things
17 we can believe. Apparently the one thing that we
18 can believe is that at approximately 12:45, as I
19 read it, the five looks right on the number, but
20 they say 12:40 to 12:45, we have note number five,
21 which is apparently the one that comes after note
22 number one, and it says, a number 7.5 French
23 antecubital catheter started at 12:40 to 12:45 time
24 frame. What did Nurse Nickerson tell you? She

1 told you that was done when the patient was on the
2 gurney. That's what her testimony was.
3 Then after she testified and gave you the
4 timeline everything changed. All of a sudden
5 Dr. Selland isn't being told at 12:40 that there was
6 no blood pressure, at 12:40 Dr. McBride was doing
7 the surgery, and even before then they had to be
8 changing the position to a supine position. You
9 have to backtrack your way from untimed occurrences,
10 they clearly could have simply followed 12:40, the
11 way that that is written, but you've got to assume
12 that the last thing here is the one that happened at
13 12:40 and everything else happened at a significant
14 time earlier.
15 And that's the timeline that they want you
16 to follow. That's what started at some point in
17 this trial. So then we had various witnesses who
18 gave testimony about, okay, now if Dr. McBride was
19 operating at 12:40, when did all of this happen?
20 When I was young I was once told by my father that
21 it wasn't a good idea to play with the facts because
22 some day I would find myself coming around a corner
23 and run into myself coming the opposite direction.
24 I would just like to show you what the

1 testimony in this case shows. So, if Dr. McBride is
2 actually operating at 12:40, various witnesses have
3 come in and they've told you that it would've taken
4 eight to 10, maybe even more time, from the room to
5 be prepared. Because they have got to take all this
6 time to get the back table out and to get the
7 regular table in.
8 And it took some time to get her of the back
9 table and to put her on the gurney. And it took
10 some time for Dr. McBride to come into the room
11 after being called by Dr. Selland. So we get back
12 here and they want you to believe that it is
13 somewhere around 12:20 that Dr. Selland is being
14 told. That's the reconstruction of the chart.
15 Now, why doesn't it work? Because Dr.
16 Nakrin told you that between 12:15 and 12:25 he is
17 working on his checklist. And then he continues to
18 work on his checklist until 12:30 when he -- that's
19 the time he testified, he said at 12:30, I asked
20 that a page be sent for any available
21 anesthesiologists. Then after a few minutes
22 Dr. Hilgenhurst arrives. Then when Dr. Hilgenhurst
23 arrives they talk about it. Dr. Nakrin brings him
24 up to speed, tells you all the things, that at least

1 when he was testifying here sounded like it would've
2 taken him five minutes, so there is a further period
3 of time here as we are heading towards the 12:35 to
4 12:40 time frame.
5 He then rechecks certain signs including the
6 lungs I believe, the heart, and that took him, he
7 says he can do that in less than two minutes and
8 that brings us into in the 12:35 time frame, which
9 is close to 12:40 when Nickerson makes the entry in
10 the chart that that is when Selland is told. And
11 she said: I could be a minute or two off on these
12 things. So what does this tell us? Well, this
13 tells us as according to the defense version the
14 operating room is being prepared for Dr. McBride who
15 was waiting for it. Dr. Nakrin was issuing the
16 page for any available anesthesiologists to come
17 into the room because he had not figured out what he
18 was going to tell Dr. Selland yet.
19 It doesn't make any sense.
20 So what does the other testimony tell you
21 that supports our view as opposed to their view?
22 Well, you heard Dr. Nakrin's deposition testimony
23 from 2006 in which he told you what the therapeutic
24 sequence was. When he read the deposition

1 transcript of the testimony he gave under oath on
2 236, that the therapeutic sequence was ephedrine,
3 repeat ephedrine, neosynephrine, tell Dr. Selland.
4 That's the sequence. That's the order. That's what
5 the chart says. That's what the facts are. That's
6 not the reconstruction, but that's what the facts
7 are.
8 So what do we have? We have a 30
9 minute -- we have approximately a 25 to 30 minute
10 delay in this case between the time that Dr. Nakrin
11 and Nurse Nickerson, assuming that they didn't find
12 out until sometime between the 12:10 in 12:15 time
13 frame, we have a 25 minute delay between them
14 telling the doctor anything.
15 And they say, especially Dr. Nakrin, that he
16 did a fair number of things to rule stuff out. He
17 never really put a timeframe on anything that he
18 did, but no one ever came in and said that these
19 four abnormalities that were being reflected weren't
20 consistent, completely consistent with blood loss,
21 or hypovolemia. They certainly were. Everybody
22 agreed with that.
23 So, what is clear is that at 12:15, at
24 12:20, at 12:25, no communication is made to

1 Dr. Selland. And the defense says, well, you can't
2 be throwing out numbers randomly. BP, none; O-Sat
3 none. That's not what we're saying. But if you
4 spend five minutes between 12:15 and 12:20 for
5 example, there's no additional treatment being
6 provided in terms of changing anything with shots.
7 Dr. Nakrin is doing his rule out check list. He has
8 ruled some stuff out by then.
9 By 12:20, is it too much to ask a Dr. Nakrin
10 to say to Dr. Selland, I don't know what it is yet,
11 this is a serious condition according to the
12 monitors, I don't know what it is yet?
13 No, he doesn't want to do that because he
14 wants -- it was the testimony of defense witnesses
15 in the first instance, who said the reason why he
16 doesn't say anything is because he's working to
17 arrive at a very specific diagnosis so that he can
18 tell the surgeon and so that he can also tell the
19 surgeon what the plan is. That's the defense
20 testimony.
21 So he's working towards it apparently
22 because he's worried that Dr. Selland will do the
23 wrong thing and submit -- subject to patient to
24 unnecessary surgery.

1 12:25, by 12:25 Dr. Nakrin actually
2 testified that now he's becoming more concerned that
3 this is hypovolemia, it's getting even more serious.
4 Between 12:20 and 12:25 they didn't provide any
5 additional treatment to the patient. Maybe he has
6 ruled some more things out, but why doesn't he
7 communicate at that point in time? The patient is
8 getting worse from 12:10 to 12:15 to 12:20 to 12:25.
9 She's bleeding. She doesn't have any vital signs
10 like blood pressure, oxygen saturation levels, and
11 she clearly isn't expiring enough carbon dioxide.
12 Does he tell Dr. Selland any of that? No.
13 12:30 by then it appears he has completed
14 the checklist because at that point in time he is
15 trying to call his boss at home, have him paged at
16 home, he is issuing a page for any available
17 anesthesiologists; and he doesn't tell Dr. Selland
18 at that point in time that he can't figure it out?
19 I have a problem here, I don't have a good answer
20 for it, it's been 20 minutes since we had a blood
21 pressure reading, it's been 20 minutes since we had
22 an oxygen saturation reading. The end tidal CO2 has
23 been abnormally low for 20 minutes. She's got ST
24 depressions consistent with ischemia, insufficient

1 blood flow to her heart for 20 minutes and I don't
2 have a good explanation for it. No, he doesn't.
3 He still doesn't want to submit the patient
4 to an unnecessary operation? So 12:35 what do we
5 have? Well he is still giving ephedrine, which
6 didn't work before. Then we start neosynephrine
7 somewhere around 12:40. Then we finally tells
8 Dr. Selland, and these are his words, not mine, he
9 said: We have a very serious problem with the
10 patient, we need to turn her over and start advanced
11 cardiac care and chest compressions. What's the
12 very definitive diagnosis? She's in serious
13 condition. She was in serious condition at 12:10.
14 The plan he has is a plan which would not
15 have done anything for this patient and in all
16 likelihood would've resulted in a further delay in
17 the diagnosis of what it was that she was suffering
18 from. So unless you have anything, we need to turn
19 her over, that's what he says to Dr. Selland. Quite
20 frankly, I think Dr. Selland deserved more than
21 that.
22 Dr. Selland in fact had something, because
23 he is a neurosurgeon who does back surgery, knows
24 that a tear of the inferior vena cava is one of the

1 most feared complications and it can occur even in
2 the absence of blood in the operative field because
3 you can damage it on the other side and it bleeds in
4 the belly, it doesn't come out in the area of the
5 spine.
6 So it takes him no time to figure out that's
7 what's going on. He immediately calls for a
8 vascular surgeon. Dr. McBride comes in quickly.
9 It's an emergency and they start prepping the
10 patient and do the operation that results in them
11 being able to save the patient's life.
12 Now Dr. Krenis comes in and says, as soon as
13 you see these things that are here you should be
14 looking for something that explains all four of
15 them, as opposed to just being consistent with one
16 or the other or the other. Given the nature of the
17 proceeding that was being done here these were
18 consistent with blood loss that could lead to
19 hypovolemia, and that should've been one of the
20 primary things that the doctor was thinking about.
21 To have 15 minutes, 20 minutes or 25 minutes
22 go by is too long a delay because this is the type
23 of complication that has to be reported right away,
24 because every minute that the patient is losing

1 blood the volume in the patient's system is going
2 down, the circulatory -- the circulation of blood in
3 the system is going down. There is not enough blood
4 so that adequate oxygenation can be provided to
5 organs in the body including the brain, and you've
6 got to think of this and communicate with the
7 surgeon earlier because he might have something.
8 So that's the claim against Dr. Nakrin. If
9 there's any question about this issue of trying to
10 let the anesthesiologists catch up, I mean, we've
11 got two more additional large bore catheters put in.
12 Number six, that one is put in it looks like at
13 1:00, then we have one put in at 1:15 and it isn't
14 until 1:00 that any blood was even given to this
15 patient. So do they want you to believe that the
16 operation started at 12:40 and she wasn't even given
17 any blood until 1:05, 1:00, 1:05? What did they do
18 with this large bore that was inserted only after
19 she was on the operating table at 12:40? Did they
20 treat her with anything? Not according to the
21 chart.
22 The chart is right. The chart is really
23 pretty close to right. It is consistent with the
24 testimony of the person who made it, it's consistent

1 with the testimony given by Dr. Nakrin in 2006, 4
2 years before this trial when he said, these things,
3 the sequence is this, and I think setup on the chart
4 show you that they were all done going up to the
5 12:40 time frame.
6 With respect to CRNA Nickerson. Our claim,
7 I believe, is a simple one. She too, as being in
8 the room, has an obligation if it's unclear what's
9 going on, and she recognized that the unexplained
10 hypertension or hypovolemia in the absence of an
11 obvious blood loss in the operative field should
12 alert an anesthesiologist to the possibility of a
13 tear of one of those retroperitoneal vessels.
14 She should know that. And when she
15 testified, and I believe it was 12:20, 12:25, that
16 things had changed -- things had remained the same,
17 every 30 seconds she was trying to take her blood
18 pressure and couldn't get one. The patient was in
19 serious condition. Did you tell Dr. Selland? It
20 wasn't a leading question. I simply asked, did you
21 tell him? She said, no.
22 Then I asked the question, I don't think
23 there were legal gamesmanship in this on
24 cross-examination, I thought you would be interested

1 in knowing, why didn't she? At that time answer
2 was, I don't know. If Dr. Nakrin had determined
3 that he wasn't going to tell Dr. Selland then Nurse
4 Nickerson had an obligation to do so. Finally, the
5 third degree of liability in the case is that
6 Dr. Selland didn't respond adequately. The
7 testimony with respect to this claim is basically if
8 you believe Dr. Nakrin when he came in and leaned
9 over the drape or canopy, whatever we call it, the
10 piece of paper that separates the surgeon from the
11 anesthesia area, and he said, there are a couple of
12 alarms that have gone off, we're looking into it.
13 I don't think it matters whether he said,
14 keep me posted, or let me know. To me that's
15 basically the same. He knew there had been a
16 problem with the alarms, I guess the problem with
17 the alarms was solved from the testimony in this
18 case, by turning them off. So it wouldn't distract
19 the anesthesiology team from considering what was
20 going on with the patient or it wouldn't distract
21 the surgeon. But there's a commotion in the room.
22 I mean at one point Sullivan is in the room and
23 Nurse Nickerson is in the room and Nakrin is in the
24 room and they're having this conversation. I think

1 Nurse Sullivan said they are 4 feet away, so they
2 are discussing the patient, three people there.
3 They are discussing the patient.
4 Then we have the alarms that went off.
5 Then we have apparently Dr. Nakrin getting on his
6 hands and knees and going underneath the patient to
7 listen to the breath sounds. Going behind the
8 machines checking the machines. Going behind the
9 anesthesia machine to make sure there is no problem
10 there. Eventually Dr. Hilgenhurst is called in
11 somewhere around 12:30, he's in the room, there's a
12 page being sent out to Dr. Bakos. Dr. Lazar says,
13 look when something like this is going on, the
14 surgeon, even though he's doing surgery, should be
15 aware that something unusual is going on in the
16 room. And if he has some notice that there has
17 been a problem with the alarm, he's got an
18 obligation to keep up some form of communication
19 between him and the anesthesia team.
20 It's ironic that the concept of team has
21 been mentioned by a number of people, including
22 Dr. Alan yesterday, but it's a funny definition of
23 team. Because the anesthesia team apparently is
24 worried that the surgeon will do something that

1 will harm the patient. So they don't want to give
2 the surgeon information. So they work on it until
3 basically in this case, they have satisfied
4 themselves they don't know what's going on and at
5 that time, that's when they tell the surgeon and
6 ask him if he has anything.
7 Our expert says that that's not the way
8 it should happen. The reality is that this team
9 should be interacting for the best interest of the
10 client, best interest of the patient, and that
11 there should be some communication when it's
12 apparent that some issue is going on in the
13 operating room.
14 On causation with respect to
15 Dr. Selland. He caused the tear. The tear is the
16 reason why -- is a precipitating cause of
17 everything that follows. And his actions in
18 causing this vena cava tear clearly a substantial
19 significant factor in the harm that ensued.
20 On the causation argument on the
21 anesthesiologist, the testimony that you've heard
22 is that at some point every minute that goes by the
23 brain is being deprived of oxygen. And the extent
24 of the brain injury is going to be increased the

1 longer this goes on. Our position is, 12:20,
2 12:25, there is clearly a 15 to 20 to 25 minute
3 delay here and communicating with the neurosurgeon
4 and giving him a chance to provide his input to
5 figure out what was really wrong with the patient.
6 So that brings us to the question of
7 damages. You will be instructed by the Court that
8 there are basically three components of damages.
9 One is medical bills, and this covers both medical
10 bills that have been incurred in the case and
11 medical care that is reasonably necessary in the
12 future. Second component is called diminution in
13 earning capacity, which is to what extent has the
14 patient been deprived of her ability to earn money.
15 Again if covers past and it covers reasonably
16 expected future damages.
17 The third one is the one that's a little
18 bit greyer than the other two, it's the so-called
19 pain and suffering damages, which includes things
20 like disfigurement, scarring, loss of ability to
21 appreciate life, mental anguish, changes in her
22 mental state. So, what happened to Justina Fox
23 Neblett? Well immediately starting on August 29
24 and continuing to September 7, she was intubated,

1 ventilated and in the ICU.
2 Because of the extent of deprivation of
3 oxygen she experienced acute renal failure and had
4 to go on dialysis. Her liver function was
5 effected. The CT of the brain that was done on
6 September 1, 2003, showed clear evidence of the
7 brain injury and what's called the global palliates
8 portion of your brain. It further states that the
9 brain damage is consistent with an anoxic event,
10 i.e. deprivation of oxygen to the brain.
11 She spends approximately a month in
12 Carney and she has rehab because she's has been
13 completely debilitated, she had infections because
14 of all these lines that she had in her, and she has
15 trouble once again being able to eat. She's
16 vomiting and she's weak and they give her some
17 physical therapy and she goes from being intubated,
18 ventilated, completely in bed, not being able to
19 eat, to be very much improved; meaning she can walk
20 and she can eat.
21 But if you look at the records from
22 Carney, the cognitive difficulties I referenced
23 there. So she's transferred to Spaulding. She
24 goes to Spaulding and then she is there for another

1 month. Again you can look at the records. They
2 recite all the problems that she is dealing with
3 including the cognitive difficulties. She has
4 cognitive therapy and she is there for a little bit
5 less than a month. You will see that the Carney
6 hospital bill is a $107,000.
7 You will see that the Spaulding rehab
8 bill is approximately $36,000. You see that some
9 other doctors and Mass General, I think there are
10 two bills, one for approximately $4000, one for
11 approximately $7500 for treatment they provided.
12 And you'll Dr. Selland's bill for the neurosurgical
13 procedure that he performed which was billed in the
14 amount of $7000.
15 She then went on to have rehab, basically at
16 home, for a short period of time, and I think from
17 the testimony somewhere around the February time
18 frame she went to Barbados where she has been
19 except when she comes back to visit with her sister
20 Olivia.
21 She was 51 years old. She is now 58. At the
22 time this happened she was employed basically as an
23 executive assistant, the equivalent of that, I
24 think you could tell from the testimony, at the

1 Central Bank of Barbados where she had a lot of
2 functions, supervising clerical staff,
3 responsibilities with respect to functions, she had
4 responsibilities at receptions and she was paid a
5 little bit over $73,000 Barbadian dollars.
6 She never went back to work. You'll see from
7 the medical reports that we are submitting from
8 Dr. Martyr and from Dr. Deters that the brain
9 injury that she has basically has very much
10 affected any executive functions that she had. She
11 has a very bad memory. She has apathy and
12 depression and basically a lack of communications
13 with anybody. She doesn't have that much of an
14 interest in life any more. And because of her
15 memory she's going to pose a damage to herself as
16 time progresses.
17 Dr. Martyr makes an interesting analogy,
18 you'll see in the report, he says, she's like a
19 patient with mild to moderate Alzheimer's but with
20 no chance of improvement from any of the
21 medications that Alzheimer patients can take. And
22 it's going to get worse over time.
23 So, she's cognitively impaired. In addition
24 to the medical bills that have been incurred that

1 are mentioned, there are some bills from Barbados,
2 for example, when she developed this intestinal
3 blockage because of the scar tissue from the
4 laparotomy. If you care to read the medical
5 records they actually describe what caused the
6 diagnosis to be made. She had an upset stomach,
7 she actually had stuff coming up her esophagus,
8 coming out of her mouth that was foul-odored like
9 feces, and she was hospitalized and operated on.
10 The bills from Barbados are in here, I believe for
11 that procedure between the surgeon their private
12 nurses in hospitals in Barbados, as opposed to
13 being on staff; it's probably about $20,000
14 Barbadian dollars. If you look at anything and
15 it's from Barbados just remember you have to
16 discount it to American dollars. So if it's 20,000
17 in Barbadian dollars it's really only $10,000 in
18 American money.
19 Then we brought you the experts who told you
20 basically -- tried to quantify to you, and
21 explained how they did it. And the reason they
22 explained how they did it is because if it turns
23 out that you disagree with some of their
24 methodology or some of their assumptions, then you

1 can adjust those figures.
2 So Dr. Rosenthal came in and he told you how
3 he calculated the diminution in earning capacity.
4 He used as best evidence of diminution in earning
5 capacity what she actually had been making, $73,000
6 and change a year in Barbadian dollars, $36,000 a
7 year, give or take a few dollars, in American
8 dollars.
9 And he calculated her claim for diminution in
10 earning capacity going to age 65 as being, my
11 memory is $460,000. That he gave you a figure also
12 that because she had stopped working and didn't get
13 as many years of service, she has a diminished of
14 her future pension, which is about $50,000.
15 If you think any of that is unreasonable, I
16 would just suggest that you think of it this way,
17 he projected it all out like it was future. She's
18 been -- she hasn't been able to work for 7 years.
19 She's already suffered a seven-year diminution in
20 earning capacity that exists right now and you can
21 simply do the math if you accept that her salary is
22 the best evidence of what she could earn, it's
23 seven years times her salary.
24 Because it's already been incurred, we don't

1 need to discount it to present value.
2 Slightly more complicated issue is future
3 medical care. Sandra Lowery tried to explain that
4 to you in detail and to give you her basis. If you
5 think there's anything unreasonable about the
6 things that she suggested you can take them out. I
7 didn't hear anything, from my perspective and the
8 plaintiff's perspective, nothing is unreasonable in
9 what she proposed. Some physical therapy on an
10 ongoing basis, maybe once a month. One neuropsych
11 evaluation just to see -- get a better assessment
12 as to where she is.
13 Some treatments with a pain specialist
14 because she hasn't had it yet, only for the first
15 year to see whether or not there is something they
16 can find out that would take care of her pain
17 situation. Then the biggest component is who is
18 going to take care of her basically because she
19 can't take care of herself and she poses a hazard
20 to herself.
21 So she gave us two alternatives in that
22 regard. And her methodology was, she's going to
23 spend six months in New York and six months in
24 Barbados. I'm going to give you the figures for

1 two things. One, she has to go into a residential
2 care place. She gave you the value of that cost
3 only for the United States because they don't have
4 that kind of place in Barbados.
5 And she gave you as another option, home care
6 having either a basically 24-hour a day home help
7 aid, I think maybe she uses 22 hours per day. Also
8 a live-in person paying them $250 a day combined
9 with two days of 24-hour care because live in
10 people do get some time off.
11 And the dollar figures that she ended up
12 with, and she had a range, the economist then used
13 and projected out to age 78, as her
14 reasonable -- it's either 78 or 80 as her
15 reasonable life expectancy. For plan B was
16 $3.5 million approximately, and that's the home
17 health keeper in the house, provide 24-hour
18 treatment. Or $3.1 million for the residential
19 plan.
20 You can take that and you can say, because
21 you certainly have heard this, Olivia Fox is going
22 to stick with her sister and if you think that the
23 home health aide should only be there 16 hours a
24 day and Olivia is going to be there for the other

1 eight, you can reduce the figures to what you think
2 is reasonable. But I urge you to remember Olivia
3 is older than Justina and Justina is getting up
4 there. Justina's needs are going to increase and
5 there is going to come a point in time when the
6 older sisters can't take care of her. And they
7 can't come back in five years and say, can we get
8 the Jury back and let them reconsider this because
9 we can't take care of her any more. So those are
10 the two ones that you actually heard numbers about.
11 Now I'm going to try to briefly talk about the pain
12 and suffering component of this.
13 They didn't finish the back surgery, you
14 heard that, no question about it. They removed the
15 disk and Dr. Selland himself admitted her back
16 situation is now worse than when she first went
17 into the procedure. So she's got debilitating back
18 pain for that reason. Because they had to repair
19 her by simply tying of the vena cava she now has
20 what's called lower venous hypertension because the
21 blood can't flow back up to the heart like it
22 should. So there's a problem with circulation.
23 She has swollen legs and she has discomfort in her
24 legs because of that situation.

1 She has the problem was the scarring. You
2 have seen the pictures of the scarring and
3 disfigurement because of that massive incision that
4 they had to do. That's permanent.
5 Most disturbing is the brain injury. You
6 have a woman here who was healthy, active, working
7 person with a family who enjoyed her family, who
8 enjoyed interacting with her friends, who was a
9 conversationalist, who was a person who was happy,
10 and now she just doesn't -- the brain injury has
11 left her not caring about things. Not
12 communicating with people. Being depressed. You
13 can see a Dr. Deter's report when he talks about
14 she knows it to, so she knows that she's different,
15 she knows she doesn't talk. She knows she can't do
16 things the way she used to and she's depressed and
17 she's upset about it.
18 She spends her days watching TV and doing
19 solitaire on a game. If you talk to her she'll
20 respond, but she doesn't initiate conversations.
21 She's lost the enjoyment of her kids. She's lost
22 the enjoyment of her sisters, she's lost the
23 enjoyment of her friends, she's lost the enjoyment
24 of life. That's not going to change. That's the

1 way she is now. That's the way she's going to be
2 until the day she dies.
3 So, take your common sense with you into the
4 Jury room, in terms of evaluating the evidence that
5 you've heard and determining what the facts are.
6 And if you do you should come back and you should
7 find that this complication was not accepted that
8 the patient, that this complication was caused by
9 negligence. That there was negligent delay in
10 doing what needed to be done to maintain the
11 patient's condition and prevent the brain damage
12 that occurred.
13 And come up with your assessment based upon
14 commonsense, lifetime experience, as to what you
15 think a fair monetary figure is for damages that
16 she suffered. This is a civil case. It's not a
17 criminal case. We don't accuse Dr. Selland of
18 anything; we've been asserting a claim here. When
19 this case ends the defendants will go back to their
20 lives, I'll go back to my life, the other attorneys
21 will go back to their lives but Justina Fox is
22 going to go back to the way she is and has been and
23 will be for the rest of her life. Thank you.
24

C E R T I F I C A T E

I, Faye LeRoux, do hereby certify that the foregoing proceedings were taken down by me as stated in the caption; that the foregoing proceedings were reduced to print by me, that the foregoing pages 1-42 represent a true and correct transcript of the proceedings, that any and all exhibits remain unaltered and that any and all copies and/or facsimile are true and correct to the best of my knowledge and ability. I further certify that I am neither kin nor counsel to any of the parties and am not financially interested in the outcome of the action.

This certification is expressly withdrawn and denied upon the disassembly or photocopying of the foregoing transcript of the proceedings or any part thereof, including exhibits, unless said disassembly or photocopying is done by the undersigned certified court reporter, and the signature and original seal is attached thereto.

This 11th day of April, 2011.

Faye LeRoux, Court Reporter