IN THE SUPERIOR COURT OF THE STATE OF

DELAWARE IN AND FOR NEW CASTLE COUNTY

VIKTOR F. HODEL, and VERONICA HODEL,	)	
	)	CIVIL ACTION NUMBER
Plaintiffs,	)	
	)	09C-01-227-JOH
v.	)	
	)	
SATOSHI IKEDA, M.D., and ANESTHESIA SERVICES, PA., a Delaware Corporation,	)	
	)	
Defendants.	)	

Submitted: January 9, 2013
Decided: January 18, 2013

MEMORANDUM OPINION

Upon Defendants' Motion in Limine to Exclude Testimony of Robert C. Sergott, M.D.
DENIED, without prejudice

Appearances:

Bruce L. Hudson, Esquire, Hudson & Castle Law, LLC, Wilmington, Delaware, Attorney for Plaintiffs.

Andrew E. Vernick, Esquire, Joshua H. Meyeroff, Esquire, Wharton, Levin, Ehrmantraut & Klein, P.A., Wilmington, Delaware, Attorneys for Defendant Satoshi Ikeda, M.D.

Bradley J. Goewert, Esquire, Thomas J. Marcoz, Jr., Esquire, Marshall, Dennehey, Warner, Coleman & Goggin, Wilmington, Delaware, Attorneys for Defendant, Anesthesia Services, P.A..

HERLIHY, Judge

Defendants Satoshi Ikeda, M.D., and Anesthesia Services, P.A., have moved to exclude the testimony of plaintiffs' causation expert, Dr. Robert Sergott, M.D. Briefly, stated, they argue he lacked sufficient factual information to opine about the cause of plaintiff Victor Hodel's blindness. With some reservation, the Court concludes Dr. Sergott has enough factual basis on which to offer his causation opinion.

Factual Background

Viktor Hodel underwent surgery for an esophageal perforation on November 15, 2006. He reported to Christiana Care's Emergency Room because of upper abdominal pain and respiratory distress. Upon arrival to the emergency room, there were allegedly signs of dehydration, rapid respiration rate, and notations of dark colored urine output. There is a claim he needed immediate re-hydration, but none was undertaken prior the surgery. It is further asserted he had fluid in his lungs compromising his ability to profuse oxygen into his blood.

The operation required Dr. Ikeda to collapse Viktor Hodel's left lung. Sometime during the operation, Viktor Hodel's blood pressure dropped. The record made known to the Court indicates that the lowered pressure lead to hypoperfusion – insufficient circulation of blood and oxygen. This, in turn, caused problems with the quality of blood circulating around his eyes causing him to become blind. His blindness is undisputed.

According to the defendants' motions, plaintiffs have three causation experts. One of them is Dr. Sergott. The claim, as the Court understands it, is that it was Dr. Ikeda's

negligent performance of the esophageal repair surgery which was the underlying cause of the blindness.

Dr. Sergott was deposed on July 5, 2011. As of the time of his deposition, he had not read any records. He was testifying from his own expertise and what Viktor Hodel told him. He saw him twice. During his deposition, the defense showed him the anesthesia report and the operative report. The doctor testified he had been unsuccessful in obtaining any records (it appears he was making efforts to do so directly to the hospital). Dr. Sergott is a neuro-opthamologist which is described as:

> A. [A] hybrid field dealing with problems with visual loss, double vision, neurologic complaints that are related to the central nervous system. So we see patients who have visual disturbances, and often the problem is not within the eye. It's within [] the brain or some systemic medical problems.[1]

To understand the basis of for the defendants' motions, the following portions of Dr. Sergott's deposition testimony are relevant:

> Q. Again, we talked about your opinion was that it was probably related to hypoperfusion in the immediate postoperative period, and now you've said it could be the postoperative period or the intra operative period, correct?
> A. That is correct.
> Q. What is hypoperfusion?
> A. Poor delivery of blood and oxygen to the tissue.[2]

* * * * **

---

[1] Sergott Dep., at 7.

[2] *Id.* at 42.

Q. In Mr. Hodel's case, again, your opinion is that he had an episode or an experience of hypoperfusion which led to his result in blindness, correct?
A. That is correct.
Q. Are you able to tell me when the hypoperfusion occurred?
A. Sometime in the intraoperative or postop – immediate postoperative period.
Q. When you say immediate postoperative period, do you mean after the surgical procedure concluded and Mr. Hodel was in the PACU of the ICU?
I'm not sure what you mean by that.
A. Well, sometime between when he came out of the operating room and when he realized he was blind.
Q. Now, in this case – and, again, you know how many days it was before Mr. Hodel realized he was blind, correct?
A. That is correct.[3]

* * * * *

A. Right. Still, but we have this period in here where we have a 30-point drop, which, percentage wise, is 37.5 percent.
Q. Okay. So it is your testimony that it was sometime during this 45-minute period that the hypoperfustion occurred?
A. I think that's where it's likely. I can't, you know, prove that, you understand, but that's, I think, the likely time.
Q. Well, are you able to say within a reasonable degree of medical probability that it occurred during that time?
A. Yes.
Q. If it occurred intraoperatively?
A. If it – that's appropriate clarification, yes.
Q. And you're not sure if it occurred intraoperatively?
A. That's correct.[4]

* * * * *

Q. Based upon that, would you agree that it's possible that Mr. Hodel's

[3] *Id.* at 44-45.

[4] *Id.* at 54-55.

hypoperfusion which led to his blindness occurred postoperatively?
A. Yes.
Q. Is it more likely than not that it occurred postoperatively versus intraoperatively–
A. Well certainly–
Q. based upon these readings?
A. Certainly the pressures are lower, and that will make it more likely rather than less likely.
Q. So it would be more likely, based upon the blood pressure readings, that the hypoperfusion which led to his blindness occurred postoperatively?
A. Correct.[5]

* * * * *

A. And, you know, based upon – if we assume the operative report is correct and there's a significant amount of problems with oxygen saturation and blood pressure that are not reflected on the anesthesia reports, so that makes intraoperative hypotension – hypoperfusion much more likely than is reflected by the anesthesia reports.
Q. Okay. So, simply put, if the information in the operative report dictated by the assistant surgeon, Dr. Saeed, is correct, do you have an opinion with reasonable medical probability whether or not hypoperfusion low oxygen saturation during Mr. Hodel's surgery intraoperatively was the cause of the bilateral optical neuropathy?
A. Yes, and if this information's indeed correct, then, within a reasonable degree of medical certainty, the low oxygen saturations and now the – the low blood pressures were causative of Mr. Hodel's bilateral ischemic optic neuropathies.[6]

* * * * *

Q. Could the hypoperfusion or the instability that caused Mr. Hodel's blindness have occurred postoperatively?
A. It – it's impossible to tell if it was intraoperatively or postoperatively exclusively. I think [] the clinical picture that has evolved here is we

[5] *Id.* at 60.

[6] *Id.* at 104-105.

have a patient who has had difficulty with blood pressure and saturations. To what degree, we're not sure because of the contradictory information we have, and [] it certainly appears as though that was present intraoperatively and postoperatively. No one can dissect out and label it just one or just the other.

Q. So you're unable to say if the hypoperfusion that lead to his blindness occurred intraoperatively or postoperatively?

A. I can you that it was hypoperfusion that caused his blindness. How much occurred intraoperatively or postoperatively or the two act together, you know, but nobody can reconstruct that.

Q. So you can't give an opinion on that?

A. I can tell you it's the hypoperfusion.

Q. Yeah.

It's the hypoperfusion, but you can't give an opinion as to when the hypoperfusion occurred that caused his blindness?

A. Which event, is it 60 percent here and 40 percent here, or 70/30, that's not something we're able to tell you.

Q. Or zero and 100?

A. It could be that, too.

Q. It could be zero percent intraoperatively and 100 percent postoperatively?

A. It could be, but [] I would look towards a middle ground of some contribution from each.

Q. But you're just not sure?

A. I don't know if I'm not sure. I'm sure of the hypoperfusion, but I'm not sure of what percentage [] I can give you.[7]

Parties' Contentions

Defendants argue that under D.R.E. 702, Dr. Sergott's opinions are inadmissible because the opinions are based on suppositions rather than facts. They contend that Dr. Sergott admitted he did not review any of the hospital medical records before rendering an opinion, nor did he know about the hospitalization aside from what plaintiff told him. Although Viktor Hodel indicated he was blind when he awoke, the hospital records (which

[7] *Id.* at 111-12.

the doctor had not reviewed), indicate he had vision, though limited, before he was discharged. Thus, defendants argue that, because Dr. Sergott's testimony is based merely on a hypothetical patient, they are nothing more than suppositions and speculation.

Plaintiffs argue that contrary to defendants' arguments, Dr. Sergott reviewed the operative report and the anesthesia report and testified that: "[I]f we assume the operative report is correct and there's a significant amount of problems with oxygen saturation and blood pressure that are not reflected on the anesthesia reports, so that makes intraoperative hypotension – hypoperfusion much more likely than is reflected by the anesthesia reports."[8] Additionally, plaintiffs contend that Dr. Sergott opines that the blindness occurred intraoperatively and was the cause of the bilateral optical neuropathy injury.

At the pretrial conference, the Court asked plaintiffs to write to the Court indicating specifically what opinions Dr. Sergott would be offering at trial. Plaintiffs, by letter, indicate that Dr. Sergott will be testifying consistent with his deposition testimony on pages 104, 105 and 116. They submit that Dr. Sergott will testify with a reasonable degree of medical probability that the injury to plaintiff's optic nerve and the resulting loss of vision was caused by hypoperfusion which occurred intraoperatively.

Discussion

Delaware Rule of Evidence ("D.R.E.") 702 governs the admissibility of expert testimony. D.R.E. 702 provides:

[8] Sergott Dep., at 104-105.

> [i]f scientific, technical or other specialized knowledge will assist the trier of fact to understand the evidence or to determine a fact in issue, a witness qualified as an expert by knowledge, skill, experience, training or education may testify thereto in the form of an opinion or otherwise, if (1) the testimony is based upon sufficient facts or data, (2) the testimony is the product of reliable principles and methods, and (3) the witness has applied the principles and methods reliably to the facts of the case.[9]

In determining the admissibility of expert testimony, Delaware courts utilize a five-pronged test.[10] Before admitting expert testimony, the trial judge must determine that: (1) the witness is qualified as an expert by knowledge, skill, experience, training, or education; (2) the evidence is relevant; (3) the expert's opinion is based upon information reasonably relied upon by experts in the particular field; (4) the expert testimony will assist the trier of fact to understand the evidence or determine a material fact in issue; and (5) the expert testimony will not create unfair prejudice, confuse or mislead the jury.[11]

Therefore, for expert testimony to be admissible, it must be both relevant and reliable.[12] The trial judge acts as a gatekeeper and determines whether the proffered evidence is relevant and reliable.[13] Evidence is relevant if it advances the inquiry by

---

[9] D.R.E. 702.

[10] *Sturgis v. Bayside Health Ass'n Chartered*, 942 A.2d 579, 584 (Del. 2007).

[11] *Id. (*citing *Tolson v. State*, 900 A.2d 639, 645 (Del. 2006)).

[12] *Kapentanakis v. Baker*, 2008 WL 3824165, at *3 (Del. Super. Aug. 14, 2008) (citing *Price v. Blood Bank of Del. Inc.*, 790 A.2d 1203, 1210 (Del. 2002)).

[13] *Id.* (citing *M.G. Bancorporation, Inc. v. Le Beau*, 737 A.2d 513, 523 (Del. 1999)).

making a fact of consequence more or less probable.[14] Reliable evidence is "based on the methods and procedures of science, rather than subjective belief or speculation."[15] The party seeking admission of the expert testimony "bears the burden of establishing the relevance [and] reliability . . . by the preponderance of the evidence."[16] The trial judge must not "choose between competing scientific theories, nor is it empowered to determine which theory is stronger."[17] Rather, the trial judge's role is merely to determine "whether the proponent of the evidence has demonstrated that scientific conclusions have been generated using sound and reliable approaches."[18]

It is well settled in Delaware a medical expert may rely on a patient's subjective complaints when formulating a medical opinion.[19] Additionally, as a general rule, the factual basis of an expert's opinion goes to the credibility of the testimony, not the admissibility, and it is for the opposing party to challenge the factual basis of the expert

---

[14] D.R.E. 401.

[15] *Kapetanakis*, 2008 WL 3824165, at *3 (quoting *In re TMI Litigation*, 193 F.3d 613, 669 (3d Cir. 1999)).

[16] *Id.* (quoting *Quinn v. Woerner*, 2006 WL 3026199, at *3 (Del. Super. Oct. 23, 2006).

[17] *Id.* (quoting *State v. McMullen*, 900 A.2d 103, 114 (Del. Super. 2006).

[18] *Id.* (quoting *McMullen*, 900 A.2d at 114).

[19] *See Walker v. Campanelli*, 860 A.2d 812, 2004 WL 2419104, at *3 (Del. Oct. 12, 2004) (ORDER); *Debernard v. Reed*, 277 A.2d 684, 686 (Del. 1971).

opinion during cross-examination.[20] However, when an expert forms an opinion without knowledge of the plaintiff's pivotal medical history, the opinion is not based upon an understanding of the fundamental facts of the case, and cannot provide assistance to the jury.[21] Therefore, in those situations, the testimony must be excluded.[22]

It is important to be clear – Dr. Sergott's credentials and expertise are not being challenged.

There are several distressing features to Dr. Sergott's testimony. First is why he would agree to be deposed without being sure he had all of the pertinent records. It is a mystery to this Court why he believed a physician rendering such an expert opinion on the key issue of causation could or would do so. Second, while it may not be clear from reading the excerpts quoted above, Dr. Sergott's opinions vary to a disturbing degree based on which record he was shown – the anesthesia record or the operation record. And it turns out that since a student anesthetist kept the anesthesia record, there were key mistakes. Third, there is a potential significant discrepancy between Viktor Hodel telling him he woke up blind and hospital records saying for a while postoperatively he had some limited vision.

In plaintiffs' post pre-trial conference filing they state they will rely upon portions

---

[20] *Perry v. Berkley*, 996 A.2d 1262, 1271 (Del. 2010).

[21] *Id.*

[22] *Id.*

of Dr. Sergott's testimony that the injury to Viktor Hodel's optic nerve causing his blindness occurred intraoperatively. They cite to three pages of his deposition, pages 104–105 and 116. It is unclear if this submission is helpful. Based on the testimony the Court has quoted, it is not evident what his opinion at trial will be.

Perhaps plaintiffs are telling the defendants and the Court that his *trial* testimony will be that the optic nerve injury occurred intraoperatively. The Court will analyze Dr. Sergott's testimony from two angles, one is that he will say the injury occurred intraoperatively – or more likely than not that it did – and the other that he offers testimony along the lines of his deposition as quoted earlier, not just the pages plaintiffs cite.

If Dr. Sergott's trial testimony will be as the plaintiffs indicate – an intraoperative one, there lies a problem. The Court has to presume, at this point, that since his 2011 deposition, Dr. Sergott has reviewed all of the pertinent medical records and the depositions of key players, including Dr. Ikeda and any anesthesiologist(s). That would avoid any of the problems that *Perry v. Berkley*,[23] highlights about experts opining without knowing the fundamental facts.

While the Court does not know what records or other pertinent facts Dr. Sergott will recite at trial; it will assume he will have the necessary background information to offer the opinion plaintiffs now indicate he will. There is an important caveat, however,

[23] 996 A.2d 1262 (Del. 2010).

and that is the plaintiffs must first establish that Dr. Sergott, indeed, now has the necessary background information. This will first be done on *voir dire* outside the presence of the jury. Plaintiffs' counsel should inform the Court at side bar that they intend to call him as their next witness but *not* announce his name in the jury's presence.

It goes without saying that Dr. Sergott, if he is permitted to testify, is subject to cross-examination about his deposition testimony.

Allowing Dr. Sergott to testify gets a little dicier if he has not reviewed records other than those the defense showed to him in his 2011 deposition. The concern here is that this is a close question, along the lines of *Perry*, whether he has the adequate foundational basis to offer his causation opinion. His initial opinion during his deposition, was based on his expertise and experience and on Viktor Hodel's recitation of the events, including that he was blind – no vision at all – when he regained consciousness. The rub is that contemporaneous hospital records indicate otherwise about Viktor Hodel's vision status; though they also apparently state there were limitations or impairments.

Again, there will have to be the same *voir dire* process as outlined above. The Court will not assume Dr. Sergott will pass the threshold.

What the Court does not know at this point is where Dr. Sergott's causation opinion fits with other causation experts, if any. The defendants' motion says there are three, but the pre-trial stipulation does not inform as to the other two. This circumstance has hindered the Court in analyzing the admissibility of Dr. Sergott's testimony in light of the

issues the defendants raise. While the Court can speculate, the significance of postoperative versus intraoperative timing of the eye injury is unclear.

In short, there will have to be some offers of proof at trial and the *voir dire* as outlined above before Dr. Sergott testifies.

Conclusion

For the reasons stated herein, the defendants' motion to exclude the testimony of Dr. Robert Sergott is **DENIED**, but without prejudice.

IT IS SO ORDERED.

_____

J.