Exhibit B

Pentz v. Garvin – No. CI-07-08727 – Ashworth, J. – December 22, 2010 – Civil – Malpractice – Admissibility of Evidence – Relevancy – Unfair Prejudice – Expert Testimony – Direct Evidence of Causation – Increased Risk of Harm – Jury Instruction

IN THE COURT OF COMMON PLEAS OF LANCASTER COUNTY, PENNSYLVANIA
CIVIL ACTION – LAW

WILLIAM R. PENTZ and MARY A. PENTZ	:	No. CI-07-08727
v.	:	
ROBERT A. GARVIN, D.O., MAUREEN BARR, C.R.N.A., EPHRATA COMMUNITY HOSPITAL, and ANESTHESIA AND PAIN ASSOCIATES OF NORTHERN LANCASTER COUNTY, P.C.	:	

O P I N I O N

BY: ASHWORTH, J., DECEMBER 22, 2010

Before the Court for disposition is Plaintiffs' motion for post-trial relief following a medical malpractice trial in which the jury returned a verdict in favor of Defendants. For the reasons set forth below, this motion will be denied.

I. Factual Background

The relevant facts established at the trial in this matter are as follows. Plaintiff William Pentz was a 64-year-old gentleman who was diagnosed with prostate cancer. After

consultation with his urologist, it was decided that he would undergo a radical retropubic prostatectomy at Ephrata Community Hospital.

On April 11, 2006, Robert A. Gavin, D.O., an anesthesiologist, performed a preoperative anesthesia evaluation noting no significant anesthetic history.[1] (See Notes of Testimony (N.T.) at 641.) On April 28, 2006, Plaintiff presented to the Ephrata Community Hospital for the prostectomy. (N.T. at 280.) Defendant Maureen Barr, a certified registered nurse anesthetist, delivered the anesthesia care. Dr. Gavin supervised the anesthesia care. Mr. Pentz was evaluated in the anesthesia holding area by Nurse Barr and then taken to the operating room for his surgery. (Id. at 279.) Hospital records note that anesthesia began at 7:37 a.m. and ended at 12:10 p.m. while the notes indicate that the surgery started at 8:07 and ended at 11:24. (Id. at 324.) The intraoperative period was uneventful.[2] (Id. at 335.)

Based on the Anesthesia Record and testimony elicited at trial, reversal agents were administered at 11:15 a.m. and Mr. Pentz was switched from controlled ventilation to assisted ventilation. (N.T. at 340, 350-53.) Between 11:15 a.m. and 11:30 a.m., Nurse Barr employed various means of gauging Plaintiff's return to consciousness and ability to breathe on his own, including monitoring the trend of spontaneous respirations, tidal volume (depth of breath), chest rise and fall, blood pressure and heart rate, train-of-four (response to a peripheral nerve stimulator), oxygen saturation, and BIS monitoring (a measure of the level of consciousness). (Id. at 349-50, 359-62, 366-

---

[1]Mr. Pentz's past medical history included GERD, prostate cancer, hemorrhoids, kidney stones, back pain, glaucoma, and arthritis. His past surgical history included right inguinal hernia and testicular surgery, colonoscopy, and laser surgery of the eye, with no complications of anesthesia. (See Notes of Testimony (N.T.) at 643-44.)

[2]No allegations of negligence were raised with regard to the surgery itself, and the surgeon, Paul J. Sisbarro, M.D., was not a party to this action.

67, 494, 499-503, 515-17.) Nurse Barr also evaluated Plaintiff's hand grip, and his ability to respond to commands and open his eyes, prior to making the decision to extubate. (Id. at 361-62, 530.)

Based on her evaluation of the responses, Nurse Barr extubated Plaintiff at 11:30 a.m. (N.T. at 362-64, 494, 499-503, 515-17.) At that time, "[h]e was sufficiently awake. He was following commands. His oxygen saturation was maintained. He was doing his own breathing. It was nice and rhythmic. It had increased from the tidal volume of 10 to 20 and so forth up to 300." (Id. at 500.)

After the extubation was performed at 11:30 a.m., Mr. Pentz was still hooked up to the operating room monitors, and was receiving oxygen by mask. (N.T. at 494-95.) At 11:37 a.m., Mr. Pentz was transported from the operating room to the PACU (Post Anesthesia Care Unit). (Id. at 504.) He was not attached to monitors or oxygen during his brief transfer to the PACU. (Id. at 497-99.) During the one-minute transport, Nurse Barr noticed that the depth of Mr. Pentz's breathing was not as she would have liked it. (Id. at 503-04.) Immediately upon his arrival in the PACU, Mr. Pentz was attached to monitors and placed on an oxygen mask. (Id. at 504, 506, 511-12.) His vital signs revealed a low heart rate, or bradycardia, and Nurse Barr observed minimal respirations. (Id. at 505-06, 569.) Dr. Gavin was called by Nurse Barr. (Id. at 512.)

Interventions, including the administration of two doses of Atropine and additional reversal agents, and placement of a laryngeal mask airway (LMA) were successful in bringing up Mr. Pentz's heart rate. (N.T. at 510-13.) At 12:40 Mr. Pentz was reintubated and connected to the ventilator.

At 2:40 p.m., Mr. Pentz was transferred to the ICU, ventilated. He was observed to be bradycardic and hypoxic with apneic episodes. The next day, April 29, 2006, Mr. Pentz was transferred from Ephrata Community Hospital to Lancaster General Hospital where he was placed in a Phenobarbital-induced coma to control his seizure activity. Additionally, Mr. Pentz had a tracheostomy performed to assist with long-term management of his ventilation.

Eventually, Mr. Pentz awoke and demonstrated some ability to follow commands but exhibited evidence of myoclonic movements. He also demonstrated possible vocal cord paralysis and dysphasia. On June 1, 2006, Mr. Pentz was discharged from Lancaster General Hospital to HealthSouth Rehabilitation Hospital in Reading, Pennsylvania, where he remained until July 17, 2006.

Mr. Pentz has problems with verbal fluency, memory and attention. He also experiences peripheral jerking of both the upper and lower extremities, severe fatigue and loss of balance. He has great difficulty ambulating and he is generally wheelchair bound or needs assistive devices to move. He continues to receive treatment for his condition.

II. Procedural History

This medical malpractice action was commenced by complaint on August 31, 2007. Plaintiffs William and Mary Pentz asserted claims of medical negligence against Dr. Gavin and his anesthesia group, Anesthesia and Pain Associates of Northern Lancaster, P.C., and Nurse Barr, and her employer, Ephrata Community Hospital. Specifically, Plaintiffs alleged that Dr. Gavin, Nurse Barr and the PACU staff failed to

identify risk factors for administrating anesthesia, failed to properly administer that anesthesia, extubated Mr. Pentz prematurely, and failed to properly protect him against hypoxic episodes and failed to provide timely care. It was further alleged that as a result of Defendants' alleged negligence, Plaintiff William Pentz suffered an acute hypoxic event during which time he was deprived of oxygen.

The trial of this matter commenced on August 2, 2010. At trial, Plaintiffs' negligence case focused on claims of premature extubation and improper post-extubation monitoring. Nurse Barr was the target defendant. The crux of the causes of action presented at trial was that Nurse Barr was negligent in failing to properly assess the patient for potential risks at extubation. Additionally, it was alleged that Nurse Barr was negligent for failing to properly evaluate the patient for extubation criteria and extubating the patient prior to his being sufficiently awake and breathing. Nurse Barr was charged with negligence for failing to request the presence of Dr. Gavin at the time of extubation and for failing to adequately monitor Mr. Pentz following extubation. Plaintiffs further sought to prove that Nurse Barr deviated from accepted standards of care by failing to recognize and treat respiratory depression and hypoxemia in a timely fashion.

The claims at trial against Dr. Garvin were that he failed to adequately and properly supervise Nurse Barr and, specifically, that he failed to be present or failed to direct her to call him to be present at the time of extubation of Mr. Pentz. Additionally, it was alleged that Dr. Gavin was negligent in his pre-anesthesia evaluation of Mr. Pentz.

Trial concluded on August 12, 2010, when the jury returned a defense verdict. The jury unanimously found that Dr. Gavin and Nurse Barr were not negligent. (N.T. at 854-55.) On August 17, 2010, the verdict was molded to reflect that the jury found no negligence by Dr. Gavin and Nurse Barr, and that a verdict shall be entered in favor of Defendants Dr. Gavin, Anesthesia and Pain Associates of Northern Lancaster, P.C., Nurse Barr, and Ephrata Community Hospital, and against Mr. and Mr. Pentz.

Plaintiffs filed a timely post-trial motion seeking a new trial on August 18, 2010. They have raised four issues in their motion: (1) whether, during the cross-examination of Nurse Barr, the Court improperly precluded Counsel from questions regarding her failure to properly chart the administration of Fentanyl; (2) whether the Court improperly precluded Plaintiffs' counsel from cross-examining Defendant's expert nurse anesthetist, Brigid Squilla, C.R.N.A., about Defendant Barr's failure to account for missing Fentanyl on the chart of William Pentz; (3) whether, during direct examination, Plaintiffs' counsel was improperly precluded from eliciting the opinion of their expert witness, James B. Eisenkraft, M.D., regarding whether the negligence of Nurse Barr increased the risk of harm to Plaintiff William Pentz; and (4) whether, during the jury charge, the Court improperly refused to instruct the jury on the issue of increased risk of harm despite Counsel's requests for the instruction. Defendants filed timely responses. The certified transcript was filed on October 7, 2010.[3] Briefs having now been filed by the parties, this matter is ripe for disposition.

---

[3]The Notes of Testimony include excerpts of the proceedings only. It must also be noted that a portion of the direct testimony of Defendant Maureen Barr, C.R.N.A., is repeated in the transcript. (See N.T. at 255-373 and 374-492.) Page references to her testimony are to the first portion contained in pages 255 through 373 only.

III. Standard of Review

The decision to grant or deny a request for a new trial is within the sound discretion of the trial court and will not be disturbed absent palpable abuse of discretion or error of law. **Andrew v. Jackson**, 800 A.2d 959, 962 (Pa. Super. 2002).

> There is a two-step process that a trial court must follow when responding to a request for a new trial. . . . First, the trial court must decide whether one or more mistakes occurred at trial. These mistakes might involve factual, legal, or discretionary matters. Second, if the trial court concludes that a mistake (or mistakes) occurred, it must determine whether the mistake was a sufficient basis for granting a new trial. . . . The harmless error doctrine underlies every decision to grant or deny a new trial. A new trial is not warranted merely because some irregularity occurred during the trial or another trial judge would have ruled differently; the moving party must demonstrate to the trial court that he or she has suffered prejudice from the mistake.

Lockley v. CSX Transp. Inc., 5 A.3d 383, 388 (Pa. Super. 2010) (quoting **Harman ex rel. Harman v. Borah**, 562 Pa. 455, 467, 756 A.2d 1116, 1122 (2000) (citations omitted)). Moreover, a new trial is warranted only where the jury's verdict is so contrary to the evidence as to shock one's sense of justice. **Neison v. Hines**, 539 Pa. 516, 520, 653 A.2d 634, 636 (1995).

IV. Discussion

A. Cross Examination Regarding Fentanyl Wasting

Initially, Plaintiffs contend the Court abused its discretion by precluding the cross examination of Nurse Barr and defense expert nurse anesthetist, Brigid Squilla, C.R.N.A., regarding Nurse Barr's failure to properly chart the administration of Fentanyl. Mr. Pentz received Fentanyl during the course of his procedure. Fentanyl is a Class II narcotic. Federal law and Ephrata Community Hospital policy require controlled dispensation of Fentanyl. The hospital monitored Fentanyl through the Pyxis medication management dispensing system. (N.T. at 16.)

The Ephrata Community Hospital Narcotics Log indicates that Nurse Barr signed out two five-cc ampules of Fentanyl from the Pyxis System at 7:22 a.m. and 7:23 a.m., for use during Mr. Pentz's surgery. Thus, a total of ten ccs of Fentanyl was dispensed.

Nurse Barr notes on the first page of the Anesthesia Record, which runs from 7:30 a.m. until 11:00 a.m., that she administered eight ccs of Fentanyl. On the second page of the Anesthesia Record, which goes from 11:00 a.m. to approximately 11:30 a.m., Fentanyl is written in one of the columns, however, no drugs are noted to be administered. Fentanyl and Desflorane are the only two medications from the prior nine medications noted on page one of the Anesthesia Record that appear on page two of the Anesthesia Record.

Hospital Policy requires that any amount of a Class II narcotic, such as Fentanyl, that is not used during the course of a procedure must be properly wasted. In order to be properly wasted, the remaining narcotic must be emptied or destroyed in front of a witness and both parties must sign that it was properly destroyed. This is entered into

the Pyxis System. (N.T. at 16.) Four other controlled substances, including Demerol, Valium, Versed and Morphine, that were partially administered to Mr. Pentz by other practitioners are noted in the Pyxis Narcotics Log to be properly wasted. The remaining two ccs of Fentanyl from Mr. Pentz's care were not noted to be wasted and were not returned to the pharmacy. The remaining two ccs of Fentanyl were unaccounted for and Nurse Barr was unable to provide any explanation as to their whereabouts.

Prior to the testimony of Plaintiffs' liability expert anesthesiologist, Dr. Eisenkraft, I held an in-chambers conference with counsel to address the admissibility of testimony about Fentanyl wasting. I identified two issues as related to the oustanding two ccs of this medication:

> One, whether or not the two CCs of unaccounted-for Fentanyl has any causation with the ultimate injury sustained by Mr. Pentz[.] . . .
> And the other issue with regard to the Fentanyl is the recordkeeping and the proper wasting or the discrepancies in any recordkeeping with regard to the wasting of the unaccounted-for two CCs. And I see that as two separate issues.

(N.T. at 4.) After hearing argument of counsel, I requested and heard an offer of proof from Dr. Eisenkraft on the subject. (Id. at 15, 31-35.) Plaintiffs' expert stated that he *thought* he would testify that *if* a patient received two ccs of Fentanyl *around* the time of extubation, it would contribute to the respiratory depression, or decreased breathing, as well as a slow heart rate, as exhibited by Mr. Pentz in the PACU. (N.T. at 33; see also Plaintiffs' Exhibit 50B, Dr. Eisenkraft's Report of May 16, 2010 at 3.) I ruled that Dr. Eisenkraft would be permitted to testify on the Fentanyl wasting issue. (Id. at 35.) Plaintiffs, however, elected not to have their expert anesthesiologist testify on the Fentanyl issue. (Id. at 154-55, 616.)

Although Plaintiffs chose not to present testimony in their case-in-chief linking Fentanyl to the alleged injuries, they nonetheless wished to cross-examine Nurse Barr and her nurse anesthetist expert, Brigid Squilla, on the Fentanyl documentation issue described above. The defense objected to this line of questioning.

The issue of Nurse Barr's record or chart-keeping was a contested issue throughout trial. Plaintiffs specifically alleged and set forth to prove that William Pentz did not meet the criteria for extubation and, thus, Nurse Barr was negligent for extubating him when she did. Nurse Barr's alleged failure to document the extubation criteria on William Pentz's chart was critical evidence that she did not properly assess his condition prior to extubation.

Nurse Barr disputed this contention, offering testimony on direct examination that it was her practice to keep detailed anesthesia records, and that she did so in this case. (N.T. at 321-46.) In an attempt to impeach her credibility on the issue of her detailed chart-keeping, Plaintiffs planned to question Nurse Barr concerning her failure to properly document the use and/or wasting of the two ccs of Fentnyl. Plaintiffs' counsel raised the issue with the Court and counsel at sidebar prior to asking any questions. (N.T. at 576-77.) Defense counsel objected to this line of questioning (Id. at 577), and I sustained the objection, explaining:

> The way this case is coming, given the relevancy or the fact that the Fentanyl was never addressed, I'm going to rule now at this time that the prejudicial effect outweighs the probative value in regard to Fentanyl and the recording requirements. I'm not going to allow you to address the Fentanyl, the recordkeeping for Fentanyl.

(N.T. at 578-79.) Plaintiffs claim this was error.

"Our Rules of Evidence vest the trial court with the authority to determine the admissibility of evidence as well as to control the scope of examination." **Rettger v. UPMC Shadyside**, 991 A.2d 915, 925 (Pa. Super. 2010). Rule 403 allows for the exclusion of evidence that is confusing, cumulative, or unfairly prejudicial:

> Although relevant, evidence may be excluded if its probative value is outweighed by the danger of unfair prejudice, confusion of the issues, or misleading the jury, or by considerations of undue delay, waste of time, or needless presentation of cumulative evidence.

Pa. R.E. 403. "Unfair prejudice," for purposes of this Rule, means "a tendency to suggest a decision on an improper basis or to divert the jury's attention away from its duty of weighing the evidence impartially." Pa. R.E. 403, Comment. See also **Feld v. Merriam**, 461 A.2d 225 (Pa. Super. 1983), rev'd on other grounds, 485 A.2d 742 (Pa. 1984).

In addition, the Rules vest the trial court with the necessary discretion to limit a party's presentation in an effort to achieve a just result:

> The court shall exercise reasonable control over the mode and order of interrogating witnesses and presenting evidence so as to (1) make the interrogation and presentation effective for the ascertainment of the truth, (2) avoid needless consumption of time and (3) protect witnesses from harassment or undue embarrassment.

Pa. R.E. 611(a). See **Rettger**, 991 A.2d at 925.

Here, evidence regarding the improper wasting of Fentnyl was irrelevant as it did not establish any medical fact material to the issues being tried. Plaintiffs acknowledged that this evidence was relevant only to the issue of witness credibility. There is no evidence that the two ccs of Fentanyl were administered to Mr. Pentz either prior to or immediately after the extubation. In fact, there is evidence to the contrary.

Nurse Barr's trial testimony and the medical records indicate that only eight ccs of Fentanyl was administered. Any testimony regarding the alleged improper wasting of Fentanyl would have created a confusing "trial within a trial." As I explained:

> . . . I don't know how we eliminate from the jurors' minds the issue of speculating as to what impact [Fentanyl] would have had because we have heard that it's a narcotic and we have heard what it does to the body. And once it's out there left unaddressed, I'm concerned that the prejudicial effect outweighs the probative value.

(N.T. at 616.) I later reiterated:

> . . . [W]hat is presently before me is the specter of what impact, if any, 2 ccs of Fentanyl would have on the plaintiff. I don't know how the recordkeeping aspect of it can be parsed out or separated or sanitized enough so as not to create or cause speculation on the part of the jury of the impact of that 2 ccs.

(Id. at 619.) Accordingly, I ruled that the proposed cross-examination of Nurse Barr was likely to divert the jury's attention from its duty of weighing the evidence impartially and likely to suggest a decision on an improper basis. Thus, pursuant to Rules of Evidence 402 and 403, cross-examination of Nurse Barr on this issue was properly precluded.

On a related issue, Plaintiffs contend that this Court committed error by preventing Plaintiffs' counsel from cross-examining Nurse Barr's expert witness about the Fentanyl wasting. Nurse Squilla testified that "clearly [Nurse Barr] gave great attention to detail" in her anesthesia record. (N.T. at 603.)

On cross-examination, Plaintiffs' counsel attempted to impeach Nurse Squilla's opinion regarding Nurse Barr's record keeping by asking her about the missing Fentanyl

and why it had not been entered on Nurse Barr's otherwise "exemplary" chart.[4] (N.T. at 613-14.) Defense counsel objected to this line of questioning and, after the parties argued their positions in chambers, I sustained the objection, stating:

> I am ruling that the prejudicial effect of raising the specter of the Fentanyl use outweighs the probative value. Even if the attempt is made to limit it to the charting issues, there's no escaping the fact that once we raise the specter or the issue of where did these two ccs of Fentanyl go, it, in my opinion, either causes the jury to speculate as to what impact, if any, the missing two ccs would have on the plaintiff if it had been administered to him, or – and it forces the jury into a situation where they are either forced to speculate or the parties would then feel obligated to call witnesses to address what impact, if any, those two ccs would have.
>
> So I am ruling that plaintiffs will not be permitted to get into any questions regarding the Fentanyl.

(Id. at 612-13.)

The issue of Fentanyl wasting was not even raised in Dr. Eisenkraft's September 11, 2009 expert report (see Plaintiffs' Exhibit No. 50), which set forth the major bases of Plaintiffs' claim for recovery. At trial, Plaintiffs declined to have Dr. Eisenkraft opine on Fentanyl at all. This Court could not allow the jury to be misled into a decision based on speculative considerations unrelated to the medical care rendered in this case.

The jury found that Defendants were not negligent based on facts and testimony relevant to the care rendered. Plaintiffs cannot claim prejudice as the result of this Court's refusal to admit irrelevant and misleading testimony into evidence.

B. Increased Risk of Harm

---

[4]Plaintiffs' contention that the defense represented Nurse Barr's record keeping as "exemplary" is disingenuous. In fact, Brigid Squilla testified that Nurse Barr's care, including "the appropriateness of the medications," not her record keeping, was exemplary. (N.T. at 603.)

Next, Plaintiffs claim the Court abused its discretion and committed legal error by excluding testimony and declining a jury charge on the increased risk of harm causation standard.

Prior to trial, Plaintiffs' liability expert anesthesiologist, Dr. Eisenkraft, produced three expert reports dated September 11, 2009, May 16, 2010, and July 10, 2010. Dr. Eisenkraft's September 11, 2009 report set forth eight deviations from the standard of care that he alleged took place in connection with Plaintiff William Pentz's treatment. At the end of the report, Dr. Eisenkraft set forth his opinion on causation. He clearly and unequivocally wrote that the alleged negligence was a direct cause of Plaintiff's injuries. Dr. Eisenkraft expressed his opinion on causation as follows: "As a result of these deviations, Mr. Pentz suffered a hypoxemic event that resulted in neurological impairment." (See Plaintiffs' Exhibit 50, Dr. Eisenkraft's Report of September 11, 2009, at 7.)

In the subsequent report dated May 16, 2010, Dr. Eisenkraft supplemented his opinion on the issues of pre-anesthesia evaluation and improper extubation. (See Plaintiffs' Exhibit 50B, Dr. Eisenkraft's Report of May 16, 2010, at 1-3.) Although there was no evidence that more than eight ccs of Fentanyl was administered to Plaintiff, "Dr. Eisenkraft's May 16, 2010 report sought to turn the outstanding 2 ccs of Fentanyl into an additional theory of recovery for the Plaintiffs." (See Defendant Barr's Brief in Opposition to Post-Trial Motion at 6.) Explaining that Fentanyl is "a potent opioid that causes respiratory depression" and bradycardia, Dr. Eisenkraft speculated in his report that "if" Mr. Pentz had been given the remaining two ccs of Fentanyl "around" the time

of extubation, "this would well explain the subsequent events." (See Plaintiffs' Exhibit 50B, Dr. Eisenkraft's Report of May 16, 2010, at 3.) At the conclusion of his May 16, 2010, Report, Dr. Eisenkraft reinforced his opinion on direct causation. He confirmed that he viewed Defendants' negligence as the factual cause of Plaintiff's injuries, stating that "[t]he injuries that he sustained in this case would not have occurred absent negligence." (Id. at 5.)

During the presentation of their case-in-chief, Plaintiffs' counsel elicited Dr. Eisenkraft's opinions on deviation from the standard of care and his opinion on causation. Dr. Eisenkraft stated that the negligence alleged was a direct cause of Mr. Pentz's injuries. (N.T. at 159-60.) Despite this, Plaintiffs' counsel asked Dr. Eisenkraft if he had an opinion "whether the care and treatment provided during Mr. Pentz's treatment in the operating room and subsequent in the PACU increased his risk of harm and was a factual cause of his injury?" (Id. at 116.) This question elicited an objection from defense counsel, who argued that as Plaintiffs' expert stated in his reports and on direct examination that the deviations from the standard of care in treating Mr. Pentz were the direct cause of his injuries, Plaintiffs were then precluded from offering expert testimony that Defendants' actions increased the risk of harm to William Pentz. (Id. at 116-17, 126-28.)

Plaintiffs argued in part that Defendants had notice of the claimed increased risk of harm based on its inclusion in the complaint. (N.T. at 123, 129, 137-38, 139-40, 152; see also Plaintiffs' Complaint at ¶¶ 42, 47, 60, 68.) Additionally, Plaintiffs argued that just because Dr. Eisenkraft opined that Defendants' deviations from accepted medical

practice were a direct and proximate cause of Plaintiff William Pentz's injuries should not preclude him from also opining that these same deviations increased the risk of harm to Plaintiff. (Id. at 133-34, 145-46, 152.)

Extensive argument was held in chambers and after thoroughly reviewing the case law on the issue, and after reviewing the subcommittee note following the applicable standard jury charge, I ruled that the increased risk of harm causation standard would not be applied in this case and sustained Defendants' objection. (N.T. at 155-57.) I ruled that Plaintiffs' expert, Dr. Eisenkraft, could not offer an expert opinion concerning whether the negligence of Defendants increased the risk of harm to Plaintiff. I offered the following explanation:

> ['']The principle of increased risk of harm is applicable where direct evidence of causation is an impossibility[.] [W]here no expert can testify that an action or a failure to act directly caused the result but can testify to a reasonable degree of medical certainty that the action or inaction increased the risk of the bad result occurring, that testimony provides a factual basis from which the jury can answer the substantial factor or factual cause question[,] namely, did the risk increased by the malpractice actually cause the injury.['] [Pa. S.S.J.I. (Civ), 11.02, Subcommittee Note at 3.]
>
> Based upon the subcommittee note, and in the absence of any other case law, I believe the facts are such and the report as submitted by Dr. Eisenkraft, Dr. Eisenkraft is able to testify that - on direct causation that the - and the specific language is as follows: ['']As a result of these deviations, Mr. Pentz suffered a hypoxic event that resulted in neurological impairment.['']
>
> I read that as a statement of direct causation. And insofar as he is able to testify that an action or a failure to act directly caused the result, I am not going to allow an instruction on the increased risk of harm and as such, your question with regard to causation should be directed towards direct causation.

(N.T. at 156-57.)

Consistent with this ruling, I refused to instruct the jury on the issue of increased risk of harm despite Counsel's requests for the instruction. (N.T. at 701-02.) It is a fundamental precept of Pennsylvania law that a trial court has the responsibility of charging a jury on all issues *relevant* to the case. **Clayton v. Sabeh**, 594 A.2d 365, 366 (Pa. Super. 1991).

The proposed instruction at issue here, Pa. S.S.J.I. (Civ), 11.02, entitled "Medical Malpractice - Factual Cause," states in relevant part:

> (B) Increased Risk of Harm *[to be read when appropriate]*
>
> When a defendant physician negligently fails to act or negligently delays in taking indicated diagnostic or therapeutic steps, and his or her negligence is a factual cause of injuries to the plaintiff, that negligent defendant physician is responsible for the injuries caused.
>
> Where the plaintiff presents expert testimony that the failure to act or delay on the part of the defendant physician has increased the risk of harm to the plaintiff, this testimony, if found credible, provides a sufficient basis from which you may find that the negligence was a factual cause of the injuries sustained.
>
> If there has been any significant possibility of avoiding injuries and the defendant has destroyed that possibility, [he] [she] may be liable to the plaintiff.
>
> It is rarely possible to demonstrate to an absolute certainty what would have happened under circumstances that the wrongdoer did not allow to come to pass.

Pa. S.S.J.I. (Civ), 11.02(B) (2010). The Subcommittee Note further states:

> [T]here is no cause of action in Pennsylvania for an increased risk of harm. *The principle of increased risk of harm is applicable where direct evidence of causation is an impossibility.* Where no expert can testify that an action or a failure to act directly caused the result but can testify to a reasonable degree of medical certainty that the action or inaction increased the risk of the bad result occurring, that testimony provides a factual basis from which the injury can answer the substantial factor or factual cause question,

namely, did the risk increased by the malpractice actually cause the injury. Id., Subcommittee Note at 3 (emphasis added).

Because medical malpractice is a form of negligence, to state a prima facie cause of action, a plaintiff must demonstrate the elements of negligence: a duty owed by a physician to the patient, a breach of that duty, that the breach of duty was the proximate cause of the harm suffered, and the damages suffered by the patient were the direct result of that harm. **Stimmler v. Chestnut Hill Hospital**, 602 Pa. 539, 555, 981 A.2d 145, 154 (2009) (quoting **Quinby v. Plumsteadville Family Practice**, 589 Pa. 183, 199, 907 A.2d 1061, 1070-71 (2006)). Normally, the plaintiff's medical expert must testify, to a reasonable degree of medical certainty, that the defendant's negligence caused the alleged injury. However, in **Hamil v. Bashline**, 481 Pa. 256, 392 A.2d 1280 (1978), the Pennsylvania Supreme Court adopted the increased risk of harm standard for establishing causation in medical malpractice cases. The Court in **Hamil** specified that the increased risk standard is only applicable to cases where direct causation cannot be proven, because the harm at issue could have occurred in the absence of negligence. Id. at 271, 392 A.2d at 1287.

The Pennsylvania Supreme Court addressed the issue of increased risk of harm again in **Mitzelfelt v. Kamrin**, 526 Pa. 54, 584 A.2d 888 (1990). There the Court reiterated that this relaxed standard for establishing causation is only applicable where the standard of proof regarding medical expert testimony is an impossible standard and the plaintiff is unable to show to a reasonable degree of medical certainty that the physician's actions or omissions caused the resulting harm. Id. at 62, 584 A.2d at 892.

See also **Billman**, 761 A.2d at 1212 (increased risk of harm charge should only be given where the plaintiff's expert cannot testify to direct causation); **Wright v. Conte**, No. 2003-0578-CIVIL (Armstrong Co., Dec. 6, 2007), aff'd 968 A.2d 805 (Pa. Super. 2009) (same). Thus, where a plaintiff's expert testifies to direct causation, the jury should not be charged on increased risk of harm. **Snyder v. Hawn**, 123 Dauph. 232 (2006), aff'd 935 A.2d 34 (Pa. Super. 2007). The case law is clear that a plaintiff cannot proceed under both causation theories; evidence of direct causation precludes application of the increased risk standard.

In the instant case, Plaintiffs' causation expert, Dr. Eisenkraft, was well able to opine in his reports that Defendants' conduct was a direct cause of the alleged injuries. (See Plaintiffs' Exhibit 50, Dr. Eisenkraft's Report of September 11, 2009 at 7; Plaintiffs' Exhibit 50B, Dr. Eisenkraft's Report of May 16, 2009 at 5.) His reports did not state that he was unable, or that it was impossible, to testify that the alleged deviations caused the harm. His reports did not state that the conduct in question merely increased the risk of harm to the patient.[5] To the contrary, Dr. Eisenkraft's reports very clearly and unequivocally rendered an opinion on direct causation. His reports concluded that "[a]s a result of these deviations, Mr. Pentz suffered a hypoxemic event that resulted in neurologic impairment," and that "[t]he injuries that he sustained in this case would not have occurred absent negligence." Id.

[5]Defense counsel further objected to any expert testimony by Dr. Eisenkraft as to increased risk of harm as being beyond the scope of his reports. (See N.T. at 140, 143-44.)

Moreover, throughout the direct examination, Plaintiffs' expert, Dr. Eisenkraft, repeatedly testified to direct causation. He then summarized his opinions as follows:

Q. . . . Doctor, you've been good enough to work through your opinions here this morning concerning the care and treatment provided by the anesthesia team, if you will, Dr. Gavin and Miss Barr.

Do you have an opinion to a reasonable degree of medical certainty as to whether that care and treatement caused the hypoxic event resulting in neurological impairment to Mr. Pentz?

A. Yes.

Q. What is your opinion in that regard?

A. Well, that it did.

Q. And your basis for that opinion?

A. Review of the medical records.

Q. What about the review?

A. Well, looking at the evaluation of a patient, the kind of patient that he was, the sort of surgery that he had, the amount of fluid that he had, the failure to meet the extubation criteria. He was inadequately recovered from the neurological block.

He wasn't really breathing as deeply as he should have been. He was not as responsive as he should have been. He was awake and responsive in the operating room at 11:37 when he was extubated and how come he was now obtunded after a short time, such that they could try to put a breathing tube in or an LMA. You have to be obtunded or depressed to tolerate that.

So I think taken together, he was not – he should not have been extubated in that time. He didn't meet the criteria.

And then having been extubated, he was not being monitored adequately so that they could intervene sooner to prevent the adverse outcome.

When he got to the recovery room, they found he had a slow heart rate. He wasn't breathing very well. They took care of what they had to, the airway, the breathing, the circulation.

But obviously to get a bad neurological outcome, adverse outcome, the situation must have gone on for a prolonged period of time.

(N.T. at 159-61.) With this testimony, Plaintiffs' expert testified that Defendants' negligence was the cause of Mr. Pentz's injuries to a reasonable degree of medical certainty. Therefore, "[Plaintiff's] expert made the requisite link between [Defendants'] negligence and the harm suffered by [Plaintiff]" and the increased risk of harm instruction was not warranted. Accordingly, my refusal to give it did not constitute error.

Moreover, the increased risk of harm instruction addressed the question of causation, not negligence. Thus, even assuming, *arguendo*, that this jury instruction should have been given, the jury never reached issues of causation, having found that Defendants acted in accordance with the standard of care. (N.T. at 854-55.) Thus, any alleged error regarding the testimony of Dr. Eisenkraft on causation had no impact on the jury's determination of whether Defendants adhered to the standard of care, and would be harmless error that would not warrant a new trial. See **Wright v. Conte**, supra.

V. Conclusion

For the reasons set forth above, Plaintiffs' Motion for Post-Trial Relief will be denied.

Accordingly, I enter the following order:

IN THE COURT OF COMMON PLEAS OF LANCASTER COUNTY, PENNSYLVANIA
CIVIL ACTION - LAW

WILLIAM R. PENTZ and MARY A. PENTZ	:	No. CI-07-08727
v.	:	
ROBERT A. GARVIN, D.O., MAUREEN BARR, CRNA, EPHRATA COMMUNITY HOSPITAL, and ANESTHESIA AND PAIN ASSOCIATES OF NORTHERN LANCASTER COUNTY, P.C.	:	

O R D E R

AND NOW, this 22nd day of December, 2010, upon consideration of Plaintiffs' Motion for Post-Trial Relief and the briefs filed by the parties, it is hereby ORDERED that said Motion is DENIED.

BY THE COURT:

DAVID L. ASHWORTH
JUDGE

ATTEST:

Copies to: William A. Atlee, Esquire, Atlee, Hall & Brookhart, LLP, 8 North Queen Street, Lancaster, PA 17608-0449
James P. Kilcoyne, Esquire, Kilcoyne & Nesbitt, LLC, Plymouth Meeting Executive Campus, 630 West Germantown Pike, Suite 121, Plymouth Meeting, PA 19462
Benjamin A. Post, Esquire, Post & Post, LLC, 200 Berwyn Park, Suite 102, 920 Cassatt Road, Berwyn, PA 19312