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2006 WL 3191785 (Minn.Dist.Ct.) (Trial Order)
District Court of Minnesota.

BRANDT,
v.
WESTERN WIS. MEDICAL ASSOC.

No. C5053091.
June 19, 2006.

Memorandum Facts Plaintiff's Position

On January 22, 2002, Michelle Tschida was admitted to River Falls Hospital where Defendant Dr. Clayton performed a gastrointestinal bypass, cholecystectomy, and an incidental splenectomy. From January 22, 2002, through January 24, 2002, Michelle Tschida's condition deteriorated. Plaintiff claims that she experienced a number of symptoms consistent with an anastomotic leak and intra-abdominal infection and sepsis.

On January 25, 2002, Dr. Clayton consulted with Dr. Todd Morris, a general surgeon at Regions Hospital, and arranged to have Michelle Tschida transported to Regions Hospital for co-management of her care. On January 26, 2002, a CT scan of Michelle Tschida's abdomen was performed that showed a large amount of fluid in her upper abdomen. Dr. Morris diagnosed a "post gastrointestinal bypass now with leak - likely gastrojejunostomy", and ordered her to be taken to the operating room for "exploration, drainage, and control of the leak." Upon entering her abdomen Dr. Morris discovered a large amount of green, foul-smelling material and Dr. Morris discovered a 1 centimeter hole in Michelle Tschida's stomach with fluid escaping. He closed the perforation. Michelle Tschida continued to deteriorate. On January 30, 2002, Dr. McGonigal ordered her to be taken to surgery. Michelle Tschida died while in surgery on January 30, 2002, as a result of massive internal bleeding.

The Plaintiff intends to prove that the defendant Matthew Clayton deviated from the applicable standard of care in that he failed to diagnose and treat the anastomatic leak in a timely manner. Plaintiff also intends to prove that Defendant McGonigal deviated from the applicable standard of care in that he failed to diagnosis and treat the internal bleed in a timely manner.

Plaintiff claims that Ms. Tschida died as a direct result of the negligence of the defendants.

Plaintiff alleges that the decedent's and heirs and next-of-kin have sustained non-pecuniary damages, including loss of comfort, aid, society and companionship as well as pecuniary loss, including medical expenses, wage loss and funeral expenses.

DEFENDANT'S POSITION

Defendants claim that on January 22, 2002, Michelle Tschida was admitted to River Falls Hospital to undergo a gastric bypass procedure. Dr. Matthew Clayton performed the surgery. During the gastric bypass procedure, an incidental splenectomy was required. Following the gastric bypass procedure, Michelle Tschida began experiencing respiratory distress and running a fever. At that time, Michelle Tschida was thought to be suffering from ARDS. Ultimately, Michelle Tschida was placed on a ventilator. Due to River Falls Hospital's inability to maintain ventilator support, Dr. Clayton made arrangements to have Michelle Tschida transferred to Regions Hospital.

On January 25, 2002, Michelle Tschida was transferred from River Falls Hospital to Regions Hospital. On January 26, 2002, a CT scan of Michelle Tschida's abdomen was performed, which showed a large amount of fluid in her abdomen. Dr. Todd

Morris diagnosed a "post gastro-intestinal bypass now with leak-likely gastrojejunostomy." Dr. Morris performed a surgical repair of the leak.

On January 30, 2002, Michelle Tschida's condition deteriorated. At that time, Dr. Michael McGonigal was the physician overseeing Michelle Tschida's condition. During that evening, Michelle Tschida coded. After her condition was stabilized, she was taken into surgery. Michelle Tschida died while in surgery.

Defendant Michael McGonigal, M.D., contends that he was not negligent with respect to his care and treatment of Michelle Tschida. Dr. McGonigal intends to establish that his actions in attempting to determine the cause of Michelle Tschida's deteriorating condition, rather than taking her immediately into surgery, were reasonable and appropriate and met the standard of care.

Matthew C. Clayton, M.D., and Western Wisconsin Medical Associates, S.C., d/b/a/ River Falls Medical Clinic, deny that they were negligent in any respect. The evidence will show that, with respect to the care rendered to Michelle Tschida, Dr. Clayton exercised the degree of care, skill, and judgment usually exercised by reasonable general surgeons under the same or similar circumstances. No act or omission on the part of Dr. Clayton caused, or contributed to cause, Ms. Tschida's demise.

Matthew Clayton, M.D., is a general surgeon practicing in River Falls, Wisconsin. Michelle Tschida was his patient. She had trouble with weight all her life. Her morbid obesity was seriously impairing her health. After a thorough pre-operative work-up and informed consent, Dr. Clayton performed a gastric bypass on Ms. Tschida on Tuesday January 22, 2002.

After the operation, Ms. Tschida did well initially, but developed respiratory distress over the next couple of days. The River Falls Area Hospital did not have the required respiratory therapy staff to provide care to Ms. Tschida over the weekend. On Friday, January 25, Dr. Clayton transferred Ms. Tschida to Regions Hospital in St. Paul for further care. On the day of transfer, Dr. Clayton spoke with Regions general surgeon Dr. Todd Morris about Ms. Tschida. Dr. Clayton claims that was his last involvement in Ms. Tschida's care and he did not co-manage her care.

LAW WISCONSIN LAW

Wisc. Stat. § 655.002. Applicability

(1) Mandatory participation. Except as provided in *s. 655.003, this chapter applies to all of the following:*

(a) *A physician or a nurse anesthetist for whom this state is a principal place of practice and who practices his or her profession in this state more than 240 hours in a fiscal year.*

(b) A physician or a nurse anesthetist for whom Michigan is a principal place of practice, if all of the following apply:

1. The physician or nurse anesthetist is a resident of this state.

2. The physician or nurse anesthetist practices his or her profession in this state or in Michigan or a combination of both more than 240 hours in a fiscal year.

3. The physician or nurse anesthetist performs more procedures in a Michigan hospital than in any other hospital. In this subdivision, "Michigan hospital" means a hospital located in Michigan that is an affiliate of a corporation organized under the laws of this state that maintains its principal office and a hospital in this state.

(c) A physician or nurse anesthetist who is exempt under *s. 655.003(1)* or (3), but who practices his or her profession outside the scope of the exemption and who fulfills the requirements under par. (a) in relation to that practice outside the scope of the exemption. For a physician or a nurse anesthetist who is subject to this chapter under this paragraph, this chapter applies only to claims arising out of practice that is outside the scope of the exemption under *s. 655.003(1)* or *(3)*.

(d) A partnership comprised of physicians or nurse anesthetists and organized and operated in this state for the primary purpose of providing the medical services of physicians or nurse anesthetists.

(e) A corporation organized and operated in this state for the primary purpose of providing the medical services of physicians or nurse anesthetists.

(l)(em) Any organization or enterprise not specified under par. (d) or (e) that is organized and operated in this state for the primary purpose of providing the medical services of physicians or nurse anesthetists.

(f) A cooperative sickness care association organized under *ss. 185.981* to *185.985* that operates a nonprofit sickness care plan in this state and that directly provides services through salaried employees in its own facility.

(g) An ambulatory surgery center that operates in this state.

(h) A hospital, as defined in *s. 50.33(2)(a)* and (c), that operates in this state.

(i) An entity operated in this state that is an affiliate of a hospital and that provides diagnosis or treatment of, or care for, patients of the hospital.

(j) A nursing home, as defined in *s. 50.01(3)*, whose operations are combined as a single entity with a hospital described in par. (h), whether or not the nursing home operations are physically separate from the hospital operations. (Emphasis added)

Wisc. Stat. § 655.007. Patients' claims

On and after July 24, 1975, any patient or the patient's representative having a claim or any spouse, parent, minor sibling or child of the patient having a derivative claim for injury or death on account of malpractice is subject to this chapter. (Emphasis added)

Wisc. Stat. § 655.009. Actions against health care providers

An action to recover damages on account of malpractice shall comply with the following:

(1) Complaint. The complaint in such action shall not specify the amount of money to which the plaintiff supposes to be entitled.

(2) Medical expense payments. The court or jury, whichever is applicable, shall determine the amounts of medical expense payments previously incurred and for future medical expense payments.

(3) Venue. Venue in a court action under this chapter is in the county where the claimant resides if the claimant is a resident of this state, or in a county specified in *s. 801.50(2)(a)* or (c) if the claimant is not a resident of this state.

Wise. Stat. § 655.23. Limitations of liability; proof of financial responsibility

(3)(a) Except as provided in par. (d), *every health care provider either shall insure and keep insured the health care provider's liability by a policy of health care liability insurance issued by an insurer authorized to do business in this state or shall qualify as a self-insurer.* Qualification as a self-insurer is subject to conditions established by the commissioner and is valid only when approved by the commissioner. The commissioner may establish conditions that permit a self-insurer to self-insure for claims that are against employees who are health care practitioners and that are not covered by the fund.

(b) Each insurance company issuing health care liability insurance that meets the requirements of sub. (4) to any health care provider shall, at the times prescribed by the commissioner, file with the commissioner in a form prescribed by the commissioner a certificate of insurance on behalf of the health care provider upon original issuance and each renewal.

(c) Each self-insured health care provider furnishing coverage that meets the requirements of sub. (4) shall, at the times and in the form prescribed by the commissioner, file with the commissioner a certificate of self-insurance and a separate certificate of insurance for each additional health care provider covered by the self-insured plan.

(d) If a cash or surety bond furnished by a health care provider for the purpose of insuring and keeping insured the health care provider's liability was approved by the commissioner before April 25, 1990, par. (a) does not apply to the health care provider while the cash or surety bond remains in effect. A cash or surety bond remains in effect unless the commissioner, at the request of the health care provider or the surety, approves its cancellation.

(4)(a) A cash or surety bond under sub. (3)(d) shall be in amounts of at least $200,000 for each occurrence and $600,000 for all occurrences in any one policy year for occurrences before July 1, 1987, $300,000 for each occurrence and $900,000 for all occurrences in any one policy year for occurrences on or after July 1, 1987, and before July 1, 1988, and S400,000 for each occurrence and $1,000,000 for all occurrences in any one policy year for occurrences on or after July 1, 1988.

(b)1. Except as provided in par. (c), before July 1, 1997, *health care liability insurance may have provided either occurrence or claims-made coverage. The limits of liability shall have been as follows:*

a. For occurrence coverage, at least $200,000 for each occurrence and $600,000 for all occurrences in any one policy year for occurrences before July 1, 1987, $300,000 for each occurrence and $900,000 for all occurrences in any one policy year for occurrences on or after July 1, 1987, and before July 1, 1988, and $400,000 for each occurrence and $ 1,000,000 for all occurrences in any one policy year for occurrences on or after July 1, 1988, and before July 1, 1997.

b. For claims-made coverage, at least $200,000 for each claim arising from an occurrence before July 1, 1987, regardless of when the claim is made, and $600,000 for all claims in any one reporting year for claims made before July 1, 1987, $300,000 for each claim arising from an occurrence on or after July 1, 1987, and before July 1, 1988, regardless of when the claim is made, and $900,000 for all claims in any one reporting year for claims made on or after July 1, 1987, and before July 1, 1988, and $400,000 for each claim arising from an occurrence on or after July 1, 1988, and before July 1, 1997, regardless of when the claim is made, and *$1,000,000 for all claims in any one reporting year for* claims made on or after July 1, 1988, and before July 1, 1997.

2. *Except as provided in par. (c), on and after July 1, 1997, health care liability insurance may provide either occurrence or claims-made coverage. The limits of liability shall be as follows:*

a. *For occurrence coverage, at least $1,000,000 for each occurrence and $3,000,000 for* all occurrences in any one policy year for occurrences on or after July 1, 1997.

b. *For claims-made coverage, at least $1,000,000 for each claim arising from an occurrence on or after July 1, 1997, and $3,000,000 for all claims in any one reporting year for claims made on or after July 1, 1997.*

(c)1. Except as provided in subd. 2., self-insurance shall be in amounts of at least $200,000 for each occurrence and $600,000 for all occurrences in any one policy year for occurrences before July 1, 1987, $300,000 for each occurrence and $900,000 for all occurrences in any one policy year for occurrences on or after July 1, 1987, and before July 1, 1988, $400,000 for each occurrence and $1,000,000 for all occurrences in any one policy year for occurrences on or after July 1, 1988, and before July

1, 1997, and $1,000,000 for each occurrence and $3,000,000 for all occurrences in any one policy year for occurrences on or after July 1, 1997.

2. Notwithstanding subd. 1., in the discretion of a self-insured health care provider, self-insurance may be in an amount that is less than $1,000,000 but not less than $600,000 for each occurrence on or after July 1, 1997, and before July 1, 1999, and less than $1,000,000 but not less than $800,000 for each occurrence on or after July 1, 1999, and before July 1,2001.

(d) The commissioner may promulgate such rules as the commissioner considers necessary for the application of the liability limits under par. (b) to reporting years following termination of claims-made coverage, including rules that provide for the use of actuarial equivalents.

(5) While health care liability insurance, self-insurance or a cash or surety bond under sub. (3)(d) remains in force, the health care provider, the health care provider's estate and those conducting the health care provider's business, including the health care provider's health care liability insurance carrier, are liable for malpractice for no more than the limits expressed in sub. (4) or the maximum liability limit for which the health care provider is insured, whichever is higher, if the health care provider has met the requirements of this chapter.

(5m) The limits set forth in sub. (4) shall apply to any joint liability of a physician or nurse anesthetist and his or her corporation, partnership, or other organization or enterprise under *s. 655.002(1)(d),* (e), or *(em).*

(6) Any person who violates this section or *s. 655.27(3)(a)* is subject to *s. 601.64.* For purposes of *s. 601.64(3)(c),* each week of delay in compliance with this section or *s. 655.27(3)(a)* constitutes a new violation.

(7) Each health care provider shall comply with this section and with *s. 655.27(3)(a)* before exercising any rights or privileges conferred by his or her health care provider's license. The commissioner shall notify the board that issued the license of a health care provider that has not complied with this section or with *s. 655.27(3)(a).* The board that issued the license may suspend, or refuse to issue or to renew the license of any health care provider violating this section or *s. 655.27(3)(a).*

(8) No health care provider who retires or ceases operation after July 24, 1975, shall be eligible for the protection provided under this chapter unless proof of financial responsibility for all claims arising out of acts of malpractice occurring after July 24, 1975, is provided to the commissioner in the form prescribed by the commissioner. (Emphasis added)

Wise. Stat. § 655.27. Injured patients and families compensation fund

(1) Fund. *There is created an injured patients and families compensation fund for the purpose of paying that portion of a medical malpractice claim which is in excess of the limits expressed in s. 655.23(4)* or the maximum liability limit for which the health care provider is insured, whichever limit is greater, paying future medical expense payments under *s. 655.015,* and paying claims under sub. (1m). *The fund shall provide occurrence coverage for claims against health care providers that have complied with this chapter,* and against employees of those health care providers, and for reasonable and necessary expenses incurred in payment of claims and fund administrative expenses. The coverage provided by the fund shall begin July 1, 1975. The fund shall not be liable for damages for injury or death caused by an intentional crime, as defined under *s. 939.12,* committed by a health care provider or an employee of a health care provider, whether or not the criminal conduct is the basis for a medical malpractice claim.

(1m) Peer review activities. (a) The fund shall pay that portion of a claim described in par. (b) against a health care provider that exceeds the limit expressed in *s. 655.23(4)* or the maximum liability limit for which the health care provider is insured, whichever limit is greater.