IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF IOWA
CENTRAL DIVISION

ROBERTA L. MINARD, Administrator of Estate of Wilbur J. R. Minard, deceased, and ROBERTA L. MINARD, individually, as the surviving spouse of Wilbur J. R. Minard, deceased,	)	NO. 4:07-cv-00261-RAW
Plaintiff,	)	FINDINGS OF FACT, CONCLUSIONS OF LAW, RULING ON PLAINTIFF'S FED. R. CIV. P. 52(c) MOTION AND ORDER FOR JUDGMENT
vs.	)	
THE UNITED STATES OF AMERICA,	)	
Defendant.	)	

Plaintiff Roberta L. Minard is the surviving spouse of Wilbur J. R. Minard, who died at the Veterans Administration ("VA") Medical Center in Iowa City, Iowa on May 2, 2004. Mrs. Minard is the duly appointed Administrator of her husband's estate. In her Complaint, filed June 14, 2007, Mrs. Minard claims the government negligently failed "to provide timely and proper medical care and treatment" to her husband. The Complaint seeks money damages pursuant to 28 U.S.C. § 2674. Mrs. Minard has complied with the administrative claim filing requirement of 28 U.S.C. § 2675.

The Court has federal question and original jurisdiction. 28 U.S.C. §§ 1331, 1346(b)(1). The case came on for bench trial before the undersigned November 9 through 12, 2009 pursuant to 28 U.S.C. § 636(c). Plaintiff filed a motion for judgment under Fed. R. Civ. P. 52(c) concerning the defense of sole proximate cause.

Post-trial written arguments have been filed and the case is now fully submitted.

The Court has carefully considered the record evidence, the post-trial written arguments and motion, and now finds and concludes as follows on the issues presented.

I.

FACTUAL BACKGROUND AND EXPERT TESTIMONY

A. Course of Events

Plaintiff's decedent, Wilbur J. R. Minard, was born August 8, 1950 in Plano, Iowa. He served in the United States Army from April 8, 1970 until December 14, 1971, attaining the rank of SP4. Part of his service included a tour of duty in Vietnam from September 2, 1970 to September 2, 1971. His military specialty was "Light Weapons Infantryman." Mr. Minard was honorably discharged on December 14, 1971.

Mr. Minard married Roberta Parcel on August 31, 1972. Two children were born of the marriage: Jeremy Minard (d/o/b 02/08/73) and Lacey Minard (d/o/b 09/12/76). Mr. Minard worked as a heavy equipment operator in construction after his military service, then as a painter and finally as a farmer. The couple lived in Unionville, Appanoose County, Iowa and never separated or divorced.

Mr. Minard suffered from peripheral artery disease which progressed over time. He died of complications from the disease a few days after emergency surgery at the Iowa City VA Medical Center

on April 29, 2004. Plaintiff alleges treatment was negligently delayed by the VA and that the delay was a cause of Mr. Minard's death.

Mr. Minard's health was good until about 1992 when he started having blood clots in his legs. The clots began to limit his ability to walk long distances and caused leg pain. He initially sought medical treatment for his condition at the VA Medical Center in Des Moines where he was diagnosed with Leriche's syndrome,[1] a peripheral artery disease affecting the circulation of blood in the legs. (Jt. Ex. #1, Med. Record Vol. 1 at 00390). On June 21, 1994 Mr. Minard underwent aortobifemoral graft surgery, a procedure in which the path between the blocked aortic artery and femoral arteries in the legs is bypassed with synthetic grafts. (*Id.* at 00415-18). According to Mrs. Minard, Mr. Minard did well following the surgery and was able to return to work and his regular activities. However, he continued to be followed by the VA as his leg problems started to return after about a year. (*Id.* at 00109).

In 1998 or 1999 Mr. Minard got to the point he could not walk or work anymore because of his legs. According to Mrs. Minard he started to receive Social Security disability benefits at about this time. In late November 2000 Mr. Minard had a "brush-cutter"

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[1] http://medical-dictionary.thefreedictionary.com/Leriche%27s+syndrome (citing *Mosby's Medical Dictionary* (8th ed. 2009).

fall on his left leg causing injury. (Jt. Ex. #1, Computerized Records at 01510). He was seen at the VA Medical Center in Des Moines where on December 13, 2000 he was treated with anticoagulants and underwent bypass surgery to clear a hematoma in his left groin. (*Id.* at 01426, 01445). Two days later he left the hospital against medical advice after having a bad experience in which his hospital roommate died in the room. (*Id.* at 01426-27). After this episode Mr. Minard sought his care at the VA Medical Center in Iowa City (hereinafter "the VA Hospital").

In January 2001 Mr. Minard was treated at the VA Hospital for an infection arising from his December surgery. (Jt. Ex. #1, Computerized Records at 01423). An abscess was drained. (*Id.* at 01401). The infection was treated with antibiotics during a lengthy hospital stay and resolved without surgical intervention. (*Id.* at 01344 - 01420).

On August 26, 2002 Mr. Minard's right lower extremity graft thrombosed (developed a blood clot). He went to the Mercy Medical Center in Centerville, Iowa (hereafter "the Centerville Hospital") not far from his home and was transported to the VA Hospital in Iowa City by ambulance. (Jt. Ex. #1, Medical Record Vol. II at 00571-576). Mr. Minard was hospitalized for about nine days and treated with anticoagulants. (Jt. Ex. #1, Computerized Records at 01309 - 01335). Over about the next eighteen months he continued to be seen by the VA Hospital Vascular Surgery Clinic and

was provided with anticoagulant therapy. (*Id.* at 01241-01308). Mr. Minard continued to complain about pain in his legs. (*Id.*) Pseudoaneurysms developed in both groins which were monitored by the clinic. (*Id.*)

On April 8, 2004 Mr. Minard was seen for a scheduled follow-up visit. (Jt. Ex. #1, Computerized Records at 01238). An ultrasound showed that he had "markedly enlarged" pseudoaneurysms. (*Id.* at 01240). Mr. Minard was told by the VA doctors that surgery would be required. Pre-operative evaluations were undertaken though surgery was not at that time scheduled. (*Id.* at 01230 - 01237).

At around 2:20 p.m. on April 29, 2004 while they were at home in Unionville Mr. Minard complained to his wife that his legs "were going out" on him. The Minards had previously been advised that in the event anything like that happened, they should go directly to the nearest emergency room. Mrs. Minard testified a VA nurse, "Vickie," had also told them that Mr. Minard would then be "Life-Flighted" (taken by helicopter) to the VA Hospital. Vickie Beach was the VA Hospital vascular care manager in April 2004. She testified she advised the Minards to go to the nearest medical facility for emergency care if Mr. Minard experienced severe pain or a cold "dead leg," something she tells all bypass patients. (Def. Ex. N, Beach Depo. at 8). She said, however, she never would have told a patient or family member that air transport would be

provided as that was not a decision she could make and the VA Hospital did not have a helicopter. (*Id.* at 7-8).

In view of the VA Hospital's limitations and history concerning the receipt of transfers of patients by helicopter and the fact air transfer requests had to be approved by the hospital chief of staff, discussed later (see *infra* at 9, 13-14), the Court doubts Ms. Beach would have told the Minards Mr. Minard would be flown to the VA Hospital from a local hospital.

Mrs. Minard took Mr. Minard to the emergency room at the Centerville Hospital. En route Mrs. Minard asked her husband if he wanted "to live through this" even though it might mean his leg would have to be amputated, something the doctors had talked about before. Mr. Minard responded: "I want to live through this." (Trial Tr. at 71). The Minards arrived at the Centerville Hospital at approximately 2:50 p.m. Dr. Robert Hatchitt was the emergency room physician on duty that day. Dr. Hatchitt was an emergency room physician on the staff of the Mercy Medical Center in Des Moines. He was one of the doctors assigned to help staff the emergency room at the Centerville Hospital.

On arrival Mr. Minard complained of pain in his legs, and left and right groin. His legs were cold and becoming discolored which suggested an arterial blockage to Dr. Hatchitt. From the medical history he took Dr. Hatchitt understood that Mr. Minard had suffered from peripheral artery disease for some time with previous

surgeries and ongoing treatment at the VA Hospital. Dr. Hatchitt performed a physical examination and used a handheld doppler in an attempt to find a pulse in Mr. Minard's legs. He was not able to get any sound pulses which confirmed his belief Mr. Minard had an arterial blockage which required surgery of a kind Mr. Minard could not receive at the Centerville Hospital where no vascular surgeon was available. The situation was a medical emergency as the longer there is ischemia (lack of blood flow) to a limb, the greater the damage.

The Minards requested that Mr. Minard be sent to the VA Hospital where he had been treated. At approximately 3:25 p.m. Dr. Hatchitt contacted the VA Hospital to obtain an accepting physician, a requirement under the federal Emergency Medical Treatment and Active Labor Act ("EMTALA"), 42 U.S.C. § 1395dd(c)(2)(B)(ii). In the meantime, he attempted to stabilize Mr. Minard's condition, also an EMTALA requirement,[2] administering Valium for muscle relaxation, Morphine for pain and fluids.

Dr. Hatchitt's notes[3] indicate he initially spoke to vascular case manager Beach. (Jt. Ex. #1, Medical Record Vol. II at 00754). Dr. Hatchitt testified Ms. Beach said she would have

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[2] The transferring hospital must provide "the medical treatment within its capacity which minimizes threats to the individual's health . . . ." 42 U.S.C. § 1395dd(c)(2)(A).

[3] Unless otherwise indicated, whenever the Court refers to Dr. Hatchitt's notes the reference is to his progress notes contained in the Centerville Hospital medical records.

someone contact Dr. Hatchitt. Dr. Allam, a VA surgical officer of the day, called back and discussed the case with Dr. Hatchitt. Dr. Allam requested a vascular ultrasound of Mr. Minard's lower extremities which would give a better idea where the blockages were. Dr. Hatchitt's notes indicate Dr. Allam advised that if the ultrasound showed no blockage Mr. Minard should be discharged on pain medication, but "if occluded" (blocked) Dr. Hatchitt was to call back for transfer details. (*Id.*) Dr. Hatchitt proceeded to have the ultrasound conducted.

The ultrasound was abnormal. Dr. Hatchitt called the VA Hospital at 4:20 p.m. with the results this time, according to his notes, speaking with a Dr. Adam, another surgical officer of the day.[4] (Jt. Ex. #1, Medical Record Vol. II at 00754). Dr. Hatchitt told Dr. Adam Mr. Minard had a left lower extremity blockage and substantial decreased blood flow on the right.

Dr. Hatchitt and Dr. Adam discussed transferring Mr. Minard by helicopter. Dr. Hatchitt wanted to transport Mr. Minard to the VA Hospital by helicopter to get him there as fast as possible. Dr. Hatchitt believed time was a factor with the blockage

[4] VA Hospital administrator Christopher Wirtjes testified Drs. Allam (a man) and Adam (a woman) overlapped shifts as officers of the day on April 29 and both responded to the situation involving Mr. Minard. Dr. Hatchitt's notes indicate he spoke first with Dr. Allam and second, when he called back with the ultrasound results, a woman he identifies as "Dr. Adams." (Jt. Ex. #1, Medical Record Vol. II at 00754). Dr. Hatchitt's notes are the most accurate indication of which doctor he spoke to and when.

as the affected muscles and tissue would begin dying and cause more pain. Dr. Adam told Dr. Hatchitt the attending VA physician or chief of staff would have to approve a transfer by helicopter. (Jt. Ex. #1, Medical Record Vol. II at 00754).

Dr. Adam informed VA Hospital administrator of the day Christopher Wirtjes of the helicopter transfer request. Part of Mr. Wirtjes' responsibilities involved facilitating transfer by monitoring requests to transfer a patient to the VA Hospital and assisting in the transfer process. Mr. Wirtjes' notes indicate he told Dr. Adam the hospital chief of staff would have to approve the request. (Def. Ex. C). The VA Hospital's written policies provided that "only the [chief of staff] can authorize air ambulance services." (Def. Ex. A at 1).

According to Dr. Hatchitt's notes, at 4:25 p.m. the "University of Iowa" helicopter was called for. Dr. Hatchitt requested the helicopter on his own authority. The helicopter, operated by Iowa AirCare, a division of LifeCom, departed Iowa City for Centerville at 4:31 p.m. (Pl. Ex. 4 at 3).[5] The dispatch records show the Centerville Hospital had first alerted Iowa AirCare at 3:44 p.m. (*Id.* at 1).

Mr. Minard's condition was worsening. He was in extreme pain even with the administration of Valium and Morphine. Having heard nothing since talking to Dr. Adam at 4:20 p.m. Dr. Hatchitt

[5] The Centerville Hospital had a helipad.

was becoming frustrated. It seemed to him as if the doctors he had been talking to did not know the transfer system or how to get the ball rolling. At 4:45 p.m. Dr. Hatchitt called the VA Hospital again and spoke with Mr. Wirtjes. According to Wirtjes' notes, Dr. Hatchitt relayed that Mr. Minard was deteriorating and his leg was turning white. (Def. Ex. C). Mr. Wirtjes reported the information to Drs. Adam and Allam who said they were still waiting to hear from the vascular department about acceptance of Mr. Minard as a patient. (*Id*.)

Piecing together the notes of Dr. Hatchitt and Mr. Wirtjes, and the testimony of Dr. Gregory Carlson, it appears Dr. Adams or Dr. Allam contacted Dr. Carlson, a vascular fellow at the University of Iowa Hospitals and Clinic ("UIHC") who as a part of his fellowship program also worked at the nearby VA Hospital.[6] When he was first contacted Dr. Carlson was told he would have to approve the emergency room doctor's request that Mr. Minard be transferred by helicopter. (Def. Ex. D; Carlson Depo. at 5). Dr. Carlson had never faced this situation and did not know what the policies were. He sought guidance from his supervising vascular surgeon, Dr. Timothy Kresowik who he spoke to twice on the subject. According to Dr. Carlson, Dr. Kresowik was concerned about the risks of helicopter transfer. It was also unclear to them whether

[6] The UIHC and VA Hospital were served by the same group of vascular surgeons.

Mr. Minard presented a true emergency. (*Id.* at 6-7). Dr. Carlson testified if there was such an emergency, they thought Mr. Minard should be sent to a closer tertiary care center, but if not to the VA Hospital, but in either case by ambulance. (*Id.*) Dr. Carlson said he relayed this to Dr. Hatchitt when he spoke to him. (*Id.* at 7).

While the helicopter was en route, Iowa AirCare attempted to get information about whether Mr. Minard had been accepted by the VA Hospital as a patient. Someone from Iowa AirCare spoke to Mr. Wirtjes at 4:35 p.m. and was told Mr. Minard had not yet been accepted. (Pl. Ex. 4 at 3). After this call Mr. Wirtjes reported the situation to VA Hospital acting chief of staff, Dr. John Cowdery. (Def. Ex. B, C).

At 5:00 p.m. Dr. Allam called Dr. Hatchitt to report that Dr. Carlson would be accepting Mr. Minard as a VA Hospital patient, and that Dr. Carlson would call. Dr. Hatchitt then gave an oral report to Dr. Allam on Mr. Minard's conditions and medications. (Jt. Ex. #1, Medical Record Vol. II at 00755). Dr. Hatchitt's notes reflect that he discussed a "6 hour window for surgery" with Dr. Allam. (*See infra* at 16).

At 5:04 p.m. the helicopter pilot reported the weather was not looking good and decided to put down at the Ottumwa, Iowa airport, landing there at 5:09 p.m. (Pl. Ex. 4 at 3).

Dr. Hatchitt's notes reflect that Dr. Carlson called at 5:15 p.m. and that they spoke again at 5:45 p.m. (Jt. Ex. #1, Medical Record Vol. II at 00753, 755). Dr. Hatchitt told Dr. Carlson Mr. Minard needed a vascular surgeon as soon as possible and apprised Dr. Carlson of Mr. Minard's condition. They also talked about transferring Mr. Minard by helicopter, but on this subject their recollections diverge, and Dr. Hatchitt's trial testimony diverged from his notes.

Dr. Hatchitt's notes of the 5:15 p.m. conversation record that Dr. Carlson told him the VA Hospital did not have a helicopter. (Jt. Ex. #1, Medical Record Vol. II at 00755). In the 5:45 conversation Dr. Carlson, again according to Dr. Hatchitt's notes, stated the problem with obtaining a helicopter was that the hospital might not be reimbursed for the expense, and that there were multiple channels that had to be gone through for approval. (*Id.* at 753). In his trial testimony, however, Dr. Hatchitt said he could not recall that Dr. Carlson said anything about reimbursement. Dr. Carlson testified that he and Dr. Kresowik did not discuss the costs of helicopter transfer, nor did he mention the subject to Dr. Hatchitt. (Def. Ex. D; Carlson Depo. at 7).

Dr. Carlson probably said something in the 5:45 p.m. conversation about reimbursement in explaining to Dr. Hatchitt the difficulty in securing approval of Mr. Minard's transfer by helicopter. It is unlikely Dr. Hatchitt fabricated the entry in his

contemporaneous notes. This was, however, a heated discussion between the doctors which may have affected the accuracy of the entry. Dr. Carlson's lack of knowledge about the VA Hospital's policies concerning helicopter transfer make it improbable that he would have made a definitive statement about reimbursement as a factor.

Whatever passed between them, Dr. Hatchitt by this time was angry at the delay in accepting Mr. Minard as a patient and what must have seemed to him to have been the obfuscation about transferring him by helicopter. He wrote in his notes of the 5:45 p.m. conversation that he told Dr. Carlson "this is unacceptable." Dr. Carlson recalls Dr. Hatchitt was very upset to the point of threatening to encourage the family to seek legal recourse. (Def. Ex. D, Carlson Depo. at 8). At this point, after talking with the Minards, Dr. Hatchitt made the decision to transfer Mr. Minard immediately by ambulance to the VA Hospital. (Jt. Ex. #1, Medical Record Vol. II at 00753).

Dr. Cowdery testified he made the decision not to approve the transfer by helicopter. If the Court understands his testimony correctly, he had never approved such a request. He explained that in April 2004 the VA Hospital had neither a helipad nor an emergency/urgent care center, facts Dr. Hatchitt was not made aware of in his dealings with VA Hospital staff. A helicopter would have had to land at the Iowa City airport south of town and Mr. Minard

then transported by ambulance to the VA Hospital, a distance of several miles. He believed helicopter transport would have saved only minimal time, and had the potential to delay Mr. Minard's arrival. On cross-examination Dr. Cowdery acknowledged the UIHC, perhaps a quarter mile away, had a helipad on its roof and that UIHC and the VA Hospital frequently transferred patients between them. He said, however, there was no mechanism whereby a patient air transported to UIHC would pass through the hospital directly to the VA Hospital. A patient transported to UIHC would become a UIHC patient and go to its emergency room. Dr. Cowdery had no involvement in the vascular team's decision to accept Mr. Minard as a patient. Dr. Cowdery testified cost was not a factor in his decision.

The helicopter had been waiting at the Ottumwa airport for instructions.[7] At 5:36 p.m. the helicopter pilot was advised by the dispatcher that the Centerville Hospital had informed that they were still working on acceptance of Mr. Minard at the VA Hospital, probably referring to approval of the helicopter to transfer Mr. Minard since Mr. Minard had by then been accepted as a patient. The AirCare dispatch records indicate the helicopter departed to return to Iowa City at 5:41 p.m. (Pl. Ex. 4 at 3). At about the same time

[7] There is no evidence that the concern about weather which prompted the helicopter pilots to put down at Ottumwa would have prevented the helicopter from going the short remaining distance to Centerville to pick up Mr. Minard.

"Roger" from the Centerville Hospital asked if the helicopter could go to Mercy Hospital in Des Moines and was told that was not possible because of "pilot duty time." (*Id.*) A few minutes later Roger inquired about transportation to UIHC but before responding, the dispatcher was informed that Mr. Minard had been accepted at the VA Hospital and was being transferred by ground transportation. (*Id.*)

It took a while to, as Dr. Hatchitt put it, "package" Mr. Mr. Minard for transfer by ambulance. (Trial Tr. at 43). IV's and pumps had to be switched and supplies made ready, a process which Dr. Hatchitt said typically took 20 to 30 minutes. The ambulance departed the Centerville Hospital with Mr. Minard at 6:13 p.m. and arrived in Iowa City at the VA Hospital at 7:47 p.m. According to a note in the ambulance records, a patient care administrator met them at the door and was "apologetic for the confusion on getting Pt accepted there. He states that the physicians did not communicate with him." (Def. Ex. G at 6). Mr. Minard was transferred to the ICU and a patient report was given to nursing staff. (*Id.*)

Mr. Minard was taken to the operating room at 9:30 p.m. and surgery commenced at 10:15 p.m. Dr. Carlson was the surgeon with Dr. Kresowik present. The operative report noted that at the time he was taken to the operating room, Mr. Minard "had approximately 5-1/2 hours of ischemic time prior to intervention."

(Jt. Ex. #1 Med. Record - Vol. II at 00642). The surgeons repaired the bilateral pseudoaneurysms with new grafts and performed a thrombectomy (blood clot removed). (*Id.* at 00640). Mr. Minard was returned to ICU after surgery, but developed more ischemia of his left leg. (*Id.*) He was returned to surgery for a fasciotomy procedure on his left leg. (*Id.* at 00621). These procedures resulted in revascularization (restoration of blood flow), but Mr. Minard's condition continued to deteriorate and he developed an ischemic bowel. (*Id.*) A below-knee amputation of his left leg was performed. (*Id.*) Mr. Minard continued to decline and on May 2, 2004 the family decided to withdraw support. Mr. Minard died ten minutes later.

B. Experts

Plaintiff's expert, Dr. James Levett, is a cardiovascular thoracic surgeon who practices in Cedar Rapids, Iowa. Dr. Levett testified that from the time a graft occludes there is a four to six hour time range to get the blood flowing again after which the effects of the occlusion may be irreversible. (Pl. Ex. 10, Levett Depo. at 13-15). He testified the appropriate standard of care for a patient with Mr. Minard's condition is "timely diagnosis with immediate plans for [revascularization surgery][8] at an appropriate

[8] Dr. Levett used the name of the surgical procedure -- "thromboembolectomy."

institution" because "[t]hrombosis . . . with limb ischemia is a medical/surgical emergency." (*Id.* at 9).

Having reviewed the medical records, Dr. Levett concluded the diagnosis of Mr. Minard's condition was timely, however, treatment was delayed by two to three hours. The delay, he said, began from the point in time the VA Hospital accepted Mr. Minard as a patient and "likely contributed to the development of the complications which led" to Mr. Minard's death. (Pl. Ex. 10, Levett Depo. at 10 (quotation), 11-12). In his written report Dr. Levett said the delay contributed "in a significant way." (*Id.* Attach. A). He was not sure, but did not think that if Mr. Minard got to the VA Hospital a half-hour earlier that it would have made a difference. He said that if Mr. Minard had arrived an hour earlier that might have made a difference, but it was hard to say. (*Id.* at 31-32). He testified any reduction in the time from the onset of ischemia to the restoration of blood flow would have been of benefit to Mr. Minard. (*Id.* at 32).

Dr. Levett opined that once Mr. Minard reached the VA Hospital he received "very good" treatment. (Pl. Ex. 10, Levett Depo. at 21-22). Thus the relevant delay was in the time it took to transfer Mr. Minard to the VA Hospital. The main point of Dr. Levett's testimony was that the two to three hour delay was a causal factor in Mr. Minard's death. He did not expressly assign fault for the delay.

While Dr. Levett agreed "the referring physician makes arrangements" for transportation of the patient, (Pl. Ex. 10, Levett Depo. at 7), it was his impression that once the VA Hospital accepted Mr. Minard as a patient, Dr. Hatchitt "assumed . . . that the helicopter would be the transport mechanism for the patient. So he didn't investigate other modes of transportation at that point in time. He did later when he was told that the helicopter would not be available." (*Id.* at 12).

Defendant called two medical experts. The first, Dr. Hans House, is a emergency room physician board certified in internal medicine. He is employed by UIHC. Dr. House reviewed Mr. Minard's medical records from the VA and Centerville Hospitals, read Dr. Hatchitt's deposition, the dispatch records from AirCare, and the ambulance records concerning Mr. Minard's transfer. Dr. House daily deals with the transfer of patients to UIHC from other facilities and has handled many requests for helicopter transfers from all over the state of Iowa. In his opinion the emergency nature of Mr. Minard's medical condition was immediately and correctly diagnosed by Dr. Hatchitt. Dr. House accepted that there is generally considered to be a six hour "window" for effective treatment of an ischemic limb from the time of loss of pulse to the beginning of the operation to restore the blood flow. He agreed there was a delay in transfer as a result of the back and forth regarding the

helicopter and placed responsibility for the delay on Dr. Hatchitt as the transferring physician.

In the course of his duties as a UIHC emergency room physician Dr. House has become familiar with helicopter flight times from locations in Iowa. He testified the flight time from Iowa City to Centerville was about 40 minutes and estimated that if the helicopter landed at the Iowa City airport, it would take another 20 minutes to unload Mr. Minard to an ambulance and transport him to the VA Hospital. He thought the delay attributable to transferring Mr. Minard amounted to about an hour and that the delay had a minimal role in the complications which led to Mr. Minard's death.

The defense also called Dr. Jason Johanning, a board certified vascular surgeon who practices in Omaha, Nebraska at the University of Nebraska Medical Center and VA Medical Center. Dr. Johanning also reviewed Mr. Minard's medical records. He came to the conclusion that while there was "confusion" concerning Mr. Minard's transfer to the VA Hospital resulting in what he estimated to be about a one-hour delay, the delay did not have any significant impact on the outcome because Mr. Minard was in a life-threatening situation with a "devastating" clotted-off graft in spite of continuing anticoagulation treatment.[9] (Trial Tr. at 162)

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[9] Dr. Johanning testified that Dr. Hatchitt had the responsibility to arrange for the transfer and that Mr. Minard (continued...)

Dr. Johanning noted the operative report indicated there was complete thrombosis of not only the graft but also of the outflow vessels in Mr. Minard's legs, which Dr. Johanning characterized as a "very, very bad situation." (*Id.* at 170). He estimated Mr. Minard had about a 50% chance of surviving the situation. While not disagreeing with the overall premise that time is important when dealing with a thrombosed artery, Dr. Johanning believed irreversibility of ischemia generally did not start occurring until six to seven or eight hours after a person loses sensation or motor function in the limb and that a one or two-hour delay in revascularization was very common. Dr. Johanning did not assign any fault to the VA Hospital staff for any delay arising from confusion in accepting Mr. Minard as a patient. He described the care Mr. Minard received at the VA Hospital as "acceptable, if not exemplary in the situation." (*Id.* at 161).

All the medical professionals involved in this case, whether as treater or expert, agree that Mr. Minard needed prompt transfer to an appropriate institution for urgent surgical intervention, the earlier the better. The medical experts agree Mr. Minard received appropriate treatment and care at the VA Hospital once he got there. There is also no dispute about the medical cause

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[9](...continued)
could have been put in an ambulance earlier when the VA Hospital accepted Mr. Minard as a patient, but he did not directly fault Dr. Hatchitt for the delay.

of Mr. Minard's death. As a result of Mr. Minard's ischemia, through a process of anaerobic metabolism, cells in his legs started to swell and produced lactic acid and proteins which accumulated. These toxins built up in the nerves and muscles of his legs. The revascularization surgery restored the blood flow to his legs. When the blood flow was restored, the toxins washed out, returned to the heart, and were distributed to other organs of the body, leading eventually to multi-system organ failure. The emergency surgical procedure itself may also have contributed. As the Court understands Dr. Johanning's testimony, one of the common complications of a thrombectomy of an aortic graft is that when the blood clot is broken up, "bits and pieces" of the clot can end up in the arteries supplying the kidneys and bowel. (Trial Tr. at 181). Mr. Minard experienced bowel and kidney ischemia probably associated with these complications.

The ultimate causation issues in this case are whether there was an actionable delay in transporting Mr. Minard to the VA Hospital, the length of the delay, and the causal relationship between that delay and Mr. Minard's death.

II.

DISCUSSION AND ULTIMATE FINDINGS

A. Law

Plaintiff's action is under the Federal Tort Claims Act ("FTCA"). 28 U.S.C. § 2671, *et seq.* Except for pre-judgment interest and punitive damages, the statute makes the United States "liable . . . in the same manner and to the same extent as a private individual under like circumstances. . . ." *Id.* § 2674. An FTCA claim is determined "in accordance with the law of the place where the act or omission occurred," in this case Iowa. *Id.* § 1346(b)(1); *see Molzof v. United States*, 502 U.S. 301, 305 (1992)("The extent of the United States' liability under the FTCA is generally determined by reference to state law.").

Plaintiff's claim is for medical malpractice. In a negligence action the plaintiff "must establish that the defendant owed the plaintiff a duty of care, the defendant breached that duty, the breach was the actual and proximate cause of the plaintiff's injuries, and the plaintiff suffered damages." *Novak Heating & Air Cond. v. Carrier*, 622 N.W.2d 495, 497 (Iowa 2001)(citing *Walls v. Jacob North Printing Co.*, 618 N.W.2d 282, 285 (Iowa 2000)). Specifically in an action for medical malpractice, the plaintiff "must demonstrate the applicable standard of care, the violation of the standard of care, and a causal relationship between the violation and the harm allegedly suffered by the

plaintiff." *Phillips v. Covenant Clinic*, 625 N.W.2d 714, 718 (Iowa 2001)(citing *Kennis v. Mercy Hosp. Med. Ctr.*, 491 N.W.2d 161, 165 (Iowa 1992)); *see Peppmeier v. Murphy*, 708 N.W.2d 57, 62 (Iowa 2005). "Expert testimony is nearly always required to establish each of these elements." *Id.*

With respect to professional services the standard of care of a hospital is the care "which obtains in hospitals generally under similar circumstances." *Kastler v. Iowa Methodist Hospital*, 193 N.W.2d 98, 102 (1971)(quoting *Dickinson v. Maillard*, 135 N.W.2d 588, 5969 (Iowa 1970)). With respect to nonmedical, administrative functions, the standard "is such reasonable care for patients as their known mental and physical condition may require." *Id.*

The Iowa Supreme Court has recognized lost chance of survival is an alternative to traditional recovery in an action for wrongful death. *Mead v. Adrian*, 670 N.W.2d 174, 178 (Iowa 2003). The alternative had its genesis in medical malpractice cases in which the causation element is prone to be more complex because the alleged negligence often combines with "a pre-existing condition to cause the ultimate harm to the plaintiff . . . ." *Id.* at 182 (Cady, J., concurring specially). In such a case the trier of fact, applying the traditional standard, "might fail to find on the evidence that a negligent act was a proximate cause of a patient's death yet believe the negligence deprived the patient of a chance

to survive." *Id.* at 180. To mitigate the all or nothing consequences of traditional recovery under proximate cause principles, the Iowa court has held a lost chance of survival, even a small chance, is compensable as an alternative. *Wendland v. Sparks*, 574 N.W.2d 327, 332 (Iowa 1998)("Even a small chance of survival is worth *something*")(emphases original).

Lost chance damages may be recovered if the plaintiff establishes medical negligence was a substantial factor in reducing the decedent's chance of survival. *See DeBurkarte v. Louvar*, 393 N.W.2d 131, 138 & n.3 (Iowa 1986); Iowa Civil Jury Instruction 200.40. The value of the lost chance is measured by "the percent of lost chance attributed to the intervening act of negligence." *Mead*, 670 N.W.2d at 178 (quoting *Wendland*, 570 N.W.2d at 331). For example, "a decedent with a ten percent chance of survival is entitled to recover ten percent of the amount of damages that could have been awarded if the defendant's negligence had proximately caused the death." *Id.*

In her post-trial argument plaintiff, in outlining her theory of recovery, states that "[t]his is a lost chance of survival case." (Pl. Argument [49] at 2). The Court agrees lost chance is the appropriate framework here where Mr. Minard was "suffering from a potentially deadly affliction that prove[d] fatal" allegedly in part due to defendant's negligence which

delayed treatment. *Mead*, 670 N.W.2d at 182 (Cady, J., concurring specially).

B. Standard of Care, Duty and Breach

There is not much dispute in this case about the standard of care, though there is about to whom the duty extended in relation to Mr. Minard's transfer to the VA Hospital. The Court accepts Dr. Levett's testimony that the standard of care for the medical emergency presented by Mr. Minard was "timely diagnosis with immediate plans for [revascularization surgery] at an appropriate institution." (Pl. Ex. 10, Levett Depo. at 9). This would include prompt transfer to the appropriate institution for the required surgery. Dr. Hatchitt, the emergency room doctor, made a timely diagnosis and immediately recognized Mr. Minard needed the specialized care of vascular surgeons unavailable at the Centerville Hospital.

As the transferring physician Dr. Hatchitt had the duty to obtain acceptance of Mr. Minard at an appropriate institution and to make the necessary arrangements for Mr. Minard's transfer by means appropriate for the circumstances. The VA Hospital, which had been treating Mr. Minard, was an appropriate institution to which to transfer Mr. Minard. Dr. Hatchitt promptly contacted the hospital and sought acceptance of Mr. Minard as a patient. That brings the analysis to the point of the VA Hospital's acceptance of Mr. Minard as a patient and the means by which he would be transferred.

The government takes the position that the entire duty to assure Mr. Minard's prompt transfer at all times remained solely with Dr. Hatchitt as the transferring physician and that the VA Hospital, as the receiving hospital, assumed no duty in the matter. The Court does not agree. Whether to accept Mr. Minard as a VA Hospital patient and whether his transfer should be made by helicopter were medical decisions. Concededly, there is no direct evidence on the subject, expert or otherwise, but the Court can infer from Dr. Hatchitt's testimony about his experience with other hospitals and the EMTALA requirements that a hospital asked to accept a patient for emergency treatment has a duty to make a reasonably prompt response in light of the known circumstances. Otherwise, appropriate treatment may be delayed or denied. As to the means of transfer, if, as here, the receiving hospital agrees to accept the patient but subjects the means of transfer requested by the transferring physician to its approval, the receiving hospital assumes the duty to make a reasonably prompt decision consistent with the need for care and to timely inform the transferring physician of any limitations on its ability to receive the patient by the means requested.

Though the time it took was not what Dr. Hatchitt was used to in his dealings with other hospitals, the Court finds the VA Hospital did not violate its duty to make a reasonably prompt response to Dr. Hatchitt's request that it accept Mr. Minard.

Plaintiff criticizes the VA Hospital's failure to accept Mr. Minard for immediate transfer without the ultrasound as "a cop out." (Pl. Argument [49] at 5). The record indicates Dr. Allam's request for an ultrasound, and the delay associated with it, were reasonable to verify the emergent nature of Mr. Minard's condition and the location of the blockages. Even Dr. Levett said the ultrasound was "a very reasonable thing to do." (Pl. Ex. 10, Levett Depo. at 24). The results were reported by Dr. Hatchitt to Dr. Adam about an hour later, at 4:20 p.m. Having heard nothing for a while, Dr. Hatchitt called back at 4:45 p.m. to express his concerns about the delay, but by 5:00 p.m., forty minutes after having received the results of the ultrasound, Dr. Hatchitt was informed that the VA Hospital would be accepting Mr. Minard. This time period was not unreasonably long.

The standard of care did not require that Mr. Minard be transported by helicopter. No medical expert testified helicopter transfer was mandated by the circumstances. The VA Hospital did not have a place for a helicopter to land. The helicopter would have had to land at the Iowa City airport necessitating transfer by ambulance from the airport to the VA Hospital, an additional leg which would have added time to the trip. The Centerville Hospital was an hour and thirty-seven minutes away by ambulance. Flight time was about forty minutes, but with transfer from the airport the

trip would have in total taken about an hour, not a dramatic difference.

Plaintiff argues the helicopter could have landed at UIHC only about a quarter of a mile from the VA Hospital. That is true, but Dr. Cowdery's testimony that patients landing at the UIHC helipad go to its emergency room and would not simply be passed through to the VA Hospital is uncontradicted. In any event, this also would have increased the total time for helicopter transfer.

The relevant delay was the delay caused by what Dr. Johanning aptly described as the "confusion" about the helicopter. The confusion was the fault of the VA Hospital staff. Dr. Hatchitt's plan to transfer Mr. Minard by helicopter was discussed with Dr. Adam in their 4:20 p.m. conversation. Dr. Adam told Dr. Hatchitt she would have to get approval from the attending physician or chief of staff. She did not tell Dr. Hatchitt that the VA Hospital lacked a helipad. He was given no reason to believe his request to transfer Mr. Minard by helicopter was unusual for the VA Hospital or that approval would be other than *pro forma*.

Dr. Carlson was advised of the request by Dr. Adam or Dr. Allam and given to understand it was up to him to approve the helicopter. He did not know what to do and talked to his supervisor Dr. Kresowik, who preferred ground transportation by ambulance as a safer, more reliable means. When he talked with Dr. Hatchitt at 5:15 p.m. Dr. Carlson told him the VA Hospital did not have a

helicopter. That would not have meant much to Dr. Hatchitt since one had already been called for and was waiting at the Ottumwa airport for instructions. Again nothing appears to have been said to Dr. Hatchitt about the absence of a place to land or to give him reason to believe that approval would not be forthcoming.

Finally at 5:45 p.m. Dr. Hatchitt was told by Dr. Carlson, not that his request for the helicopter had been rejected, but that getting one approved had to go through multiple bureaucratic levels and, as Dr. Hatchitt understood, cost was the problem. Only then did Dr. Hatchitt know there would be no helicopter. By then the helicopter was on its way back to Iowa City and Dr. Hatchitt was left with only one practical alternative, transfer by ambulance. His anger at the situation is understandable.

Mr. Wirtjes became involved when Dr. Adam told him that Dr. Hatchitt wanted to send Mr. Minard by AirCare. Mr. Wirtjes told Dr. Adam the chief of staff would have to approve the request. Dr. Adam said she needed to talk to the vascular surgeon and when she, or Dr. Allam, did so, the surgeon, Dr. Carlson, was evidently told the helicopter was his decision. In the meantime, calls from Iowa AirCare inquiring about the VA Hospital's acceptance of Mr. Minard and his conversation directly with Dr. Hatchitt prompted Mr. Wirtjes to contact Dr. Cowdery and apprise him of the situation. After that Mr. Wirtjes was not involved with the helicopter

decision. Dr. Cowdery says he made the decision not to approve the helicopter, but if he did there is no indication his decision was communicated to Dr. Hatchitt, Dr. Carlson, or other VA Hospital staff.

The decision to approve Mr. Minard's transfer by helicopter was effectively left in Dr. Carlson's hands. He was not aware of what the policies were, had no experience with such requests, and it is evident, beyond talking to Dr. Kresowik, he really did not know what to do. As a result the issue was strung out until 5:45 p.m. when Dr. Carlson informed Dr. Hatchitt of the problems with approving his request for a helicopter. The VA Hospital's decision, such as it was, not to approve Mr. Minard's transfer by helicopter, communicated nearly an hour and a half after the hospital learned of Dr. Hatchitt's request, was not reasonably prompt in light of Mr. Minard's immediate need for surgery. In the Court's judgment, information that the VA Hospital was not equipped to directly receive a patient by helicopter, and rarely if ever accepted transfer of emergency patients by helicopter, could and should have been conveyed to Dr. Hatchitt during his 4:20 p.m. conversation with Dr. Adam so that he and the Minards had an opportunity to consider other alternatives. In any event, a decision on Dr. Hatchitt's request to transfer Mr. Minard by helicopter should have been made and communicated to Dr. Hatchitt at 5:00 p.m. when the VA Hospital accepted Mr. Minard as

a patient. There was no reason for the matter to linger another 45 minutes. It is a fair inference from the record that the appropriate instructions to VA Hospital staff were not given, nor protocols in place to assure accurate and timely information was given and a prompt decision made concerning the request to transfer Mr. Minard by helicopter. The result was confusion. This failure breached the standard of care of a hospital receiving a transferred patient for emergency treatment. The VA Hospital negligently delayed Mr. Minard's transfer.

C. Causation

The first step in considering the element of causation is to determine the period of unreasonable delay attributable to the confusion about the helicopter. There are three ways to look at it. First, if the helicopter had been approved when Mr. Minard was accepted as a patient at 5:00 p.m., the helicopter, already en route and assuming it would not have had to stop at Ottumwa, would have arrived at the Centerville Hospital between 5:10 and 5:15 p.m. Presumably it would have taken about the same amount of time to prepare Mr. Minard for the trip by helicopter as it did for ground transportation by ambulance, about 25 minutes. The helicopter would have departed the Centerville Hospital at 5:40 p.m. and landed at the Iowa City airport about 6:20 p.m. The time necessary to unload Mr. Minard from the helicopter and transfer him by ambulance to the VA Hospital would have taken about another 20 minutes, putting Mr.

Minard at the VA Hospital at 6:40 p.m., just over an hour earlier than his arrival by ambulance at 7:47 p.m.

Second, if Dr. Hatchitt had been informed at 5:00 p.m. that the requested transfer by helicopter would not be approved, Dr. Hatchitt may have decided at that time to send Mr. Minard by ambulance to the VA Hospital. Assuming the same preparation time, the ambulance would have left at about 5:25 p.m., arriving at the VA Hospital about 7:00 p.m., about 45 minutes earlier than Mr. Minard's arrival at 7:47 p.m.

Third, if informed at 5:00 p.m. that the request to transfer Mr. Minard by helicopter was denied, or at 4:20 p.m. of the VA Hospital's limitations on receiving transfer by helicopter, Dr. Hatchitt may have recommended and the Minards might have agreed to try to send Mr. Minard to another hospital by helicopter, most probably UIHC or Mercy Medical Center in Des Moines. Mr. Minard could not have been transferred until he was accepted as a patient at one of those institutions, but if acceptance was quickly obtained it is conceivable, again with time to prepare Mr. Minard for the trip, that a helicopter could have departed the Centerville Hospital at about 5:40 p.m. as in the first scenario. The helicopter would have arrived at UIHC or Mercy Medical Center in Des Moines at about 6:20 p.m., about an hour and a half earlier than Mr. Minard's arrival at the VA Hospital. A lot of assumptions, not well supported in the record, are built in to this last

scenario which make it unsuitable as a basis to determine the delay period. It is unclear whether Dr. Hatchitt would have recommended a different hospital or that the Minards would have agreed. Dr. Hatchitt testified the VA Hospital was the appropriate place to transfer Mr. Minard because the hospital was familiar with him and had his medical records. The Minards had asked to go to the VA Hospital. It would have taken some time to explain options and make the decision to transfer to a different hospital and then Dr. Hatchitt would have had to contact UIHC or Mercy Medical Center and explain Mr. Minard's medical condition and history and the reasons for the transfer request, all of which would have taken time. The receiving hospital may or may not have given quick approval. Dr. Hatchitt might not have been in a position to request a helicopter until after he talked to one of the other hospitals, which would have added time.

Considering the relative likelihood of these might-have-beens, the Court finds the delay attributable to the VA Hospital's negligence was about an hour, more or less. This period is the most closely connected to the frustration of Dr. Hatchitt's plan for the transfer of Mr. Minard.

Dr. Levett testified the two or three hour delay on which he based his causation opinion began to run from when the VA Hospital said it would accept Mr. Minard. That was at 5:00 p.m. It is true two or three hours elapsed after that until Mr. Minard's

arrival at the hospital, two hours forty-seven minutes to be precise. But this includes necessary time to prepare Mr. Minard for the trip and travel time by helicopter, time which would have been expended even if helicopter transfer had been approved at the time Mr. Minard was accepted as a VA Hospital patient. The relevant delay is that resulting from the hospital's breach of duty which the Court has found amounted to about an hour. When asked about an hour delay Dr. Levett said it was hard to say, but it might have made a difference. For their part, Drs. House and Johanning opined that a one-hour delay had little effect on the outcome. The expert testimony thus does not support a conclusion that the period of delay for which the VA Hospital was responsible contributed significantly to Mr. Minard's death.

Between Mr. Minard's arrival at the Centerville Hospital at 2:50 p.m. and the commencement of surgery at the VA Hospital at 10:15 p.m., seven hours and twenty-five minutes elapsed. Of that, about two and one-half hours, between 7:47 p.m. and 10:15 p.m. was preoperative time while Mr. Minard was in the VA Hospital. Plaintiff argues this shows the hospital was not ready to treat Mr. Minard when he arrived and describes the preoperative wait as "inexcusable." (Pl. Argument [49] at 5). The two-and-a-half hour preoperative period is unexplained in the testimony. There is no basis in the record, however, for the Court to conclude it amounted to a breach of the standard of care. The only qualitative

assessment of the VA Hospital's treatment once it admitted Mr. Minard was in Dr. Levett's testimony that he thought the treatment was very good and Dr. Johanning's testimony that the care provided did not deviate from normal practice and overall was acceptable, if not exemplary.

The longer the ischemia in Mr. Minard's legs lasted, the greater was the risk from complications. Any reduction in time from the onset of the ischemia to the restoration of blood flow would have had some benefit to Mr. Minard. The reduction here would have been one hour out of about seven and a half. Even if Mr. Minard had arrived at the VA Hospital about an hour earlier, most of the toxins in his legs would still have accumulated. In the absence of solid expert testimony this makes it speculative to conclude that the one-hour delay resulting from the VA Hospital's negligence was a significant causal factor in the outcome. The Court therefore concludes the VA Hospital's negligence in delaying the transfer of Mr. Minard was not a substantial factor in reducing Mr. Minard's chance of survival. It follows the delay was not a proximate cause of Mr. Minard's death.

D. Plaintiff's Fed. R. Civ. P. 52(c) Motion

The thrust of plaintiff's Rule 52(c) motion [44] is to object to the consideration of sole proximate cause as a defense (the conduct of Dr. Hatchitt or Act of God being the alternative sole causes) because it was unpleaded and would be inconsistent

with the doctrine of comparative fault in Iowa's comparative fault statute. Iowa Code ch. 668. For a number of reasons plaintiff's Rule 52(c) motion [44] will be denied.

First, Rule 52(c), which deals with judgment on partial findings, is not the appropriate vehicle to complain about a pleading deficiency. The rule permits the Court to enter judgment as a matter of law in a non-jury case with respect to a defense even though the judgment is partial and not dispositive. The Court, however, still must make findings of fact and conclusions of law on the issue in question. *See* Advisory Committee Notes to 1991 and 1993 Amendments. Second, in its Answer to the Amended Complaint the government pleaded as an affirmative defense that any action on its part was not the proximate cause of plaintiff's injuries or death, "which were the result of prior or subsequent conditions or occurrences for which it was not responsible." (Answer [18] at 3). Thus plaintiff was on notice that the government contended Mr. Minard's death was due to something other than any action on its part. Third, the Court did not understand the government to be contending that the fault of Dr. Hatchitt, or any Act of God, was the sole proximate cause of Mr. Minard's death. The government does maintain that Dr. Hatchitt as transferring physician, not the VA Hospital, had the duty to make the arrangements for Mr. Minard's transfer and that he could have made different arrangements, but it does not argue he was legally at fault in causing Mr. Minard's

death. The government's argument that Mr. Minard died from complications from surgery which it had no part in bringing about is not an Act of God defense. *See Lanz v. Pearson*, 475 N.W.2d 601, 603 (Iowa 1991)(Act of God defense is limited to unanticipated, unusual or extraordinary forces of nature). Finally, the clear implication in the Court's findings is that Dr. Hatchitt was not in any way at fault in his care and treatment of Mr. Minard, or in arranging his transfer to the VA Hospital. Any criticisms of him, express or implied in the evidence or the government's arguments, are no more than 20-20 hindsight. In the Court's judgment, Dr. Hatchitt made a prompt and correct diagnosis, provided appropriate care within the capabilities of the Centerville Hospital, and acted aggressively in attempting to arrange for the urgently required specialized care at the VA Hospital.

III.

CONCLUSIONS OF LAW

1. Plaintiff established that the VA Hospital breached the applicable standard of care, and therefore was negligent, in failing to promptly respond to the request to transfer Mr. Minard by helicopter to the VA Hospital in Iowa City on April 29, 2004 and in failing to promptly advise the transferring physician, Dr. Hatchitt, of significant limitations on its ability to receive a patient transfer by helicopter.

2. Plaintiff did not establish that the negligence of the VA Hospital was a proximate cause of Mr. Minard's death or that the negligence was a substantial factor in reducing Mr. Minard's chance of survival.

3. Judgment should be entered in favor of defendant and against plaintiff dismissing the Complaint.

IV.

ORDERS

1. Plaintiff's Fed. R. Civ. P. 52(c) motion [44] is **denied**;

2. The Clerk shall enter judgment dismissing the Complaint.

IT IS SO ORDERED.

Dated this 23d day of April, 2010.

ROSS A. WALTERS
UNITED STATES MAGISTRATE JUDGE