STATE OF MAINE
CUMBERLAND, SS.

SUPERIOR COURT
CIVIL ACTION
DOCKET NO.:

BARBARA RING, *
*
Plaintiff *
*
v. *
*
ST. JOSEPH HOSPITAL, MICHAEL *
COYNE, M.D., and RANDA EM *
ELMEKKI, M.D, *
*
Defendants *
*

COMPLAINT

NOW COMES Plaintiff Barbara Ring, having been duly sworn, and states as follows for her Complaint.

Parties

1. Plaintiff Barbara Ring is a resident of Brewer, County of Penobscot, State of Maine.

2. Defendant St. Joseph Hospital (SJH) is a registered Maine non-profit corporation that provides health care services in the Bangor, Maine area.

3. Defendant Michael Coyne, M.D., is a physician licensed to practice in Maine with specialties in Internal Medicine and Infectious Disease.

4. Defendant Randa EM Elmekki, M.D., is resident of Portland, Cumberland County, Maine and is a physician licensed to practice in Maine with a specialty in Internal Medicine.

System Failure, Agency, Direct and Vicarious Liability

5. Like any corporation, SJH acts through its employees and its agents, including medical doctors, mid-level providers, physical and occupational therapists, dieticians, technicians, nurses and other staff and personnel who combine to create a system of health-care delivery to a hospital patient.

6. Some of these hospital staff and personnel are required to document their actions in the patient's medical chart, and therefore can be identified in the chart; others are not required to document their actions, but their participation and involvement in the system of medical care may nonetheless be critical to meeting the standard of reasonable care. All references to SJH within this Complaint are intended to be inclusive of all employees or agents of the hospital—whether specifically identified in the medical chart or not; or specifically identified by name in this Complaint or not—who participated in and collectively comprised the system of medical care relied upon by Plaintiff while she was admitted to the hospital, and which Plaintiff alleges, through this Complaint, failed to comply with reasonable standards for delivery of medical care in a hospital-based setting.

7. Plaintiff alleges that each and every person involved in the system of medical care upon which she relied while she was admitted to SJH was, if not a W-2 employee, an actual or implied agent of the hospital, because each person had authority conferred by the hospital to participate in Plaintiff's medical care while she was admitted to the hospital and Plaintiff reasonably believed and relied upon the belief that SJH would appropriately select, in both quality and quantity, sufficient personnel with the necessary qualifications, experience, training and supervision to fulfill his or her role within the system of medical care, such that the system as a whole was safe, met the needs of Plaintiff as a patient and thus complied with the standard of reasonable medical care expected of a hospital like SJH.

8. In this Complaint, Plaintiff specifically contends that SJH was directly negligent based upon the hospital's negligent hiring, training, staffing, supervision, policies, communication, documentation, medical record-keeping, culture and systems, as well as vicariously liable for the negligence of each and every one of its personnel whose conduct, either

individually or in combination with other personnel, contributed to the failure of such individual(s) and the system to meet the standard of reasonable care to Plaintiff.

Factual Background

9. At approximately 8:00 a.m. on February 12, 2018, Ms. Ring presented to the emergency department at SJH. She was seen there by James Hildebrand, M.D. Dr. Hildebrand noted that Ms. Ring was a 64-year-old woman who, over the last few days had developed fevers, chills, nausea, body aches and vomiting; and suffered from extreme fatigue and poor oral intake. Ms. Ring was febrile and tachycardic. She reported right-sided neck pain. She had several areas of skin breakdown on her buttocks. A CT of her abdomen and pelvis showed fluid collection in the area of her recent hip surgery, but nothing suggestive of abscess. The skin on the buttocks was suggestive of cellulitis and Ms. Ring was administered antibiotics. Ms. Ring's neurological exam was positive for headaches, but negative for dizziness, syncope, weakness or numbness. Her musculoskeletal exam demonstrated normal range of motion.

10. That afternoon, Ms. Ring was seen by hospitalist, Sufana Alkhunaizi, M.D., who admitted her to the hospital and performed the admission history and physical. Dr. Alkhunaizi suspected sepsis secondary to the buttock wounds and cellulitis; called for continued antibiotics (Vancomycin and Zosyn); and ordered blood cultures and a wound care consult. Dr. Alkhunaizi also noted that Ms. Ring was not in pain or distress and enjoyed full range of motion in her lower extremities. Later that night, positive blood cultures were called in to the overnight hospitalist and Ms. Ring was placed on Vancomycin and Cefepime.

11. The following day, on the afternoon of February 13, Dr. Alkhunaizi noted that Ms. Ring felt some improvement that morning. She continued to have mild tachycardia and a borderline fever. Dr. Alkhunaizi noted that the positive blood culture results had been reported to

the overnight doctor and that Ms. Ring remained on antibiotics. Dr. Alkhunaizi noted the plan for a wound care consultation, referrals to physical and occupational therapy and monitoring of Ms. Ring's complete blood count (CBC) and basic metabolic panel (BMP).

12. Later that afternoon, Ms. Ring had a wound care consultation with Marian Benner, M.D. Dr. Benner described a stage III sacral pressure ulcer, perineal wounds related to dermatitis and moisture damage. Ms. Ring had normal neurological reflexes. Dr. Benner prescribed antiseptic dressings, an antifungal topical and moisture barrier and offloading. Shortly after the wound consult, Ms. Ring met with Care Manager, Corey Zimmerman, to discuss discharge planning. She met with a nutritionist who found no swallowing difficulties and maintained Ms. Ring on a regular diet.

13. On the morning of February 14, the nurse noted that Ms. Ring was up walking using her walker. Early that afternoon, Dr. Alkhunaizi noted that they had lost IV access overnight and Ms. Ring's fever had spiked that morning. They planned to perform a repeat blood culture and then install a PICC line. Dr. Alkhunaizi found no focal neurological deficit. Her diagnosis remained sepsis from infected buttock wounds, with a plan to remain on antibiotics and consider an infectious disease consultation.

14. Later that afternoon, Ms. Ring had her first occupational therapy session with therapist Lauri Reichel, OT.

15. Ms. Ring returned for a second OT session with Ms. Reichel the following morning on February 15. Ms. Reichel noted Ms. Ring had experienced a significant decline since the previous afternoon. Ms. Ring now could not feel her legs, described "electrical shocks" going down to her legs, and stated that her arms were not working right anymore. Ms. Reichel noted

decreased activity tolerance, decreased function of her upper extremities, and decreased lower extremity proprioception.

16. Shortly thereafter, nurse Linda Hawes, RN, noted that Ms. Ring reported painful electrical feeling going from her neck down to her toes which was present even without movement. The nursing neurological assessments began to document weakness in Ms. Ring's extremities. Nurse Hawes made Dr. Randa EM Elmekki, aware of the situation. Later that afternoon, OT Reichel again noted that Ms. Ring was in pain from electrical shocks running from her head and down her legs to her feet. Ms. Reichel told nurse Hawes that Ms. Ring had experienced a significant decline in abilities, just since the previous day. Ms. Ring attended physical therapy with Hillary Pelkey, PT. Ms. Pelkey likewise noted that Ms. Ring complained of electrical shock sensation down to both legs and exhibited significant weakness. Ms. Ring was no longer able to stand with a two-person maximum assist. Ms. Ring told nurse Melissa Lewis that she had neck pain, her feet were tingling, and she could not hold her fork.

17. Early evening on February 15, Dr. Elmekki rounded on Ms. Ring. She found the patient asleep. She did, however, note that the patient had reported numbness, tingling and weakness. Dr. Elmekki noted that a CT of Ms. Ring's head had come back negative.

18. Dr. Elmekki returned to see Ms. Ring on the morning of February 16. She noted that the patient felt better and that her neurological sensation remained intact. She reported that Ms. Ring had a MRSA bacteremia of unknown source, possibly from fluid collection along the surgical tract for her left hip surgery. Dr. Elmekki noted that an ID consult had been arranged, and that Ms. Ring's white blood cell count was trending downward. She ordered a consultation with an orthopedic doctor for aspiration of the fluid around Ms. Ring's left hip for culture and fluid analysis.

19. A couple of hours later, Ms. Ring was seen by infectious disease doctor, Michael Coyne, M.D. Dr. Coyne concluded that the buttock wounds were an unlikely source of MRSA and that a deep infection was more likely.

20. That same afternoon, the nurse, occupational therapist, and physical therapist noted that Ms. Ring continued to experience painful electrical shocks from her neck down to her legs; upper and lower extremity weakness; and lower extremity numbness and tingling.

21. The following morning on February 17, Dr. Elmekki noted that Ms. Ring complained of neck pain, numbness, tingling and weakness. She noted that she would order a non-contrast CT of the cervical spine. The non-contrast CT showed areas of degenerative change, particularly at C4-5 and C5-6, which result in moderate to severe right-sided neural foraminal stenosis. The radiologists, Yeang H. Chng, M.D. and Justin J. Levine, M.D., provided in their report that "this may be further evaluated with MRI if clinically warranted."

22. Throughout February 17 and into February 18, nursing staff continued to note that Ms. Ring's arms and legs were weak, numb and tingling. By mid-morning of February 18, nurse Hailey Geoghegan, RN described Ms. Ring's extremities as "floppy" with limited movement. About ten minutes later, Dr. Elmekki noted that Ms. Ring's left arm was weaker than her right. She observed that the non-contrast CT of the cervical spine showed no acute fracture or traumatic subluxation.

23. The following morning, on February 19, Dr. Elmekki performed a neurological assessment, documenting 2+ strength in Ms. Ring's upper extremities and 3+ strength in the lower extremities. Ms. Ring's sensation remained intact. She continued to note that Ms. Ring was suffering from MRSA bacteremia of unknown source.

24. Around noon on February 19, Ms. Ring was seen by occupational therapist, Jessica Poland, OT. Ms. Poland reported that when she arrived at Ms. Ring's bedside, Ms. Ring stated "Oh, I'm so glad you are here. All I want is my arms to be moved." Ms. Poland noted that the patient was now unable to move any of her four extremities without total assistance, and had poor sensation, decreased upper and lower extremity range of motion and strength and was not aware of her bowel or bladder. She noted that the patient has been getting worse to the point where she can no longer feed herself. Physical therapist, Amanda Barnes, PT, likewise noted that Ms. Ring now had decreased sensation to deep pressure and light touch from about mid-calf down to her toes in both legs. Ms. Barnes spoke with Dr. Elmekki regarding possible transfer to Mercy Hospital in Portland, but that the doctor requested that therapy continue to work with the patient.

25. Ms. Ring saw the physical and occupational therapists again the afternoon of the following day, February 20. Physical therapist Ashley Haase, PT, noted that Ms. Ring had impaired sensation and an inability to voluntarily produce lower extremity movements on command. Ms. Ring also suffered from increased confusion and impaired proprioception. She demonstrated minimal movement in plantar flexion and dorsiflexion with what appeared to be involuntary movements. She had a positive Babinski sign bilaterally with extension of great toe and dorsiflexion/inversion of her foot, which occupational therapist Jessica Poland believed may demonstrate an upper motor neuro deficit. The nurse and doctor were made aware of these findings.

26. A couple of hours later, Ms. Ring was seen by orthopedic doctor, Jacob Brooks, D.O. Dr. Brooks wrote that "at this point I think symptoms are more related to her cervical spine; with sepsis and cervical spine symptomatology I would be worried about epidural abscess or underlying pathology in the cervical spine or even viral or bacterial meningitis; she would benefit

from a tap and MRI of the cervical spine to delineate these sources; left hip unlikely source of septicemia as it is completely asymptomatic."

27. On the afternoon of February 20, Dr. Elmekki rounded on Ms. Ring. She noted that Ms. Ring had upper extremity strength of 2+ and lower extremity strength of 3+ and that her sensation was intact. She noted that neurosurgery had recommended an MRI of the lumbar spine to rule out epidural abscess. Throughout that afternoon and evening, Ms. Ring remained confused and became progressively more agitated.

28. On the morning of February 21, Ms. Ring had a psych nurse consult with Ron Meserve, RN. He reported that Ms. Ring was suffering from delusions with lucid periods. He suggested Ativan for anxiety and Zyprexa for delirium. By mid-afternoon of that day, behavioral health professional, Amber Sloat, noted that Ms. Ring had developed dysphagia.

29. Dr. Elmekki rounded on Ms. Ring around 4:00 p.m. She reported that Ms. Ring had "no focal neuro deficit," that Ms. Ring's neurological exam revealed 2+ upper and 3+ lower extremity strength and her sensation remained intact. She noted that a rectal tube and foley catheter were both in place. She noted that neurosurgery recommends MRI of the lumbar spine, but it is contraindicated. The plan called for a lumbar puncture. She also noted that she spoke with Dr. Rodrigue who had performed the left hip surgery and that he agreed that aspiration of the hip was not indicated given the MRSA bacteremia.

30. On the morning of February 22, Ms. Ring started speech therapy for her new problem with difficulty swallowing. Speech therapist Marybeth Richard, ST, noted overall oral and facial weakness; reduced range of motion and coordination of articulators; minimal movement of palate and uvula; and reduced laryngeal elevation. She recommended a pureed diet with nectar

thick liquids; assistance with patient feeding due to poor upper extremity strength; and aspiration precautions.

31. Ms. Ring next had a psych consult with Dr. William Schaeffer, M.D. Dr. Schaeffer described Ms. Ring as obtunded and disoriented. He concluded that her delirium could not be cleared until the underlying medical condition was resolved. He noted that she was already on high doses of antidepressant medications.

32. The afternoon of February 22, Ms. Ring was seen by Dr. Coyne for an infectious disease follow up. Dr. Coyne noted that Ms. Ring had suffered from progressive neurologic compromise with increased weakness of her upper and lower extremities. Upon physical exam, he noted that Ms. Ring's weakness was significantly worse than his previous evaluation. He recorded that the lumbar puncture showed her cerebral spinal fluid had elevated white blood count of 103 with lymphocytic pleocytosis at 47% lymphs and markedly elevated protein at 1965. His impression was MRSA bacteremia meningitis, with his differential "very broad from the CSF alone." However, he noted that "in this setting of MRSA bacteremia most likely would be MRSA sequestration with extension to CSF; most suspect area would be l-spine hardware but can be anywhere along spine lumbar to c-spine or mycotic brain aneurysm (CT was negative); imaging of lumbar cervical and thoracic spine if possible as well as MRI of brain and neurosurgical consultation; favor abscess draining into CSF; continue vanco, ampicillin, PPD or qantiferon gold, spine imaging C to L, brain MRI."

33. At approximately 4:30 p.m. on February 22, Ms. Ring was seen by Dr. My-Anh Le, D.O. Dr. Le noted that Ms. Ring was having a hard time lifting her arms but had no loss of sensation to arms or legs. Her grip strength was much worse today than it was yesterday. She noted that neuro recommended an MRI of her lumbar spine to rule out epidural abscess, but due

to a bladder stimulator an MRI could not be done. Dr. Le noted that Ms. Ring was at high risk for aspiration due to delayed initiation of swallow. She observed that Ms. Ring was able to lift her legs off the bed, but it was obvious that she was weak. She was able to wiggle her toes and able to feel touch. She was likewise able to lift her arms off the bed, but she had difficulty doing so because of weakness. She was able to feel touch on the tips of her fingers. Dr. Le indicated that Dr. Weitman, the neurosurgeon, stated that he does not take out Harrington rods and recommended treating meningitis and if the problem does not clear revisit the issue of removing the rods. Dr. Coyne felt strongly that the rods should be removed with no other clear-cut source of infection.

34. Dr. Le rounded on Ms. Ring again the following morning of February 23. She noted that Ms. Ring was confused overnight and was complaining of not being able to move her arms or legs. She had a sensation that her limbs were very heavy and could not lift them. When the speech therapist attempted to evaluate her swallowing, Ms. Ring was unable to perform a chin tuck. She was able to lift her arms off the bed minimally on command; able to wiggle her toes; and able to lift her legs off the bed on command. Her sensation remained intact. Dr. Le spoke with Dr. Wilson from Maine Medical Center who recommended imaging to look for a discrete abscess which, once identified, could be drained and treated with continued antibiotics. Dr. Le also spoke with Dr. Coyne who felt very strongly that the Harrington rods needed to be removed.

35. On the afternoon of February 23, SJH contacted Maine Medical Center and requested that MMC accept the patient in transfer.

36. On February 24, Ms. Ring was transferred from SJH to MMC. MMC's admission history and physical described Ms. Ring as suffering from quadriplegia.

37. MMC performed a CT of the cervical spine with contrast. The contrast-CT revealed an anterior epidural abscess running from C4 to C7, largest at C6. The contrast-CT

showed the abscess was causing severe narrowing of the spinal canal and compressing the spinal cord.

38. On February 25, Dr. Matthew R. Sanborn performed surgery to decompress the spinal cord. Even before surgery, however, Dr. Sanborn advised that given the patient's deficits lasting approximately 4 days, there is a significant chance of permanent impairment. During surgery, Dr. Sanborn described the area around Ms. Ring's cervical spine: "The thecal sac was notably compressed at this level and decompressed nicely after the laminectomy."

39. Ms. Ring was discharged from MMC to nursing care on March 9, 2018. At the time of her discharge, Ms. Ring continued to have little movement of her distal extremities. Her upper extremity strength was only 2/5 bilaterally. She was able to slightly move her index finger and thumb; she could not lift her right leg and could lift her left leg only 1 cm off the bed; she was able to flex her feet, but could not fully wiggle her toes; she could not localize pain sensation and had no reflex in her lower extremities; her Babinski sign remained positive bilaterally.

40. At this time, Ms. Ring continues to suffer from the devastating consequences of her spinal cord injury caused by the compressive cervical epidural abscess. Although Ms. Ring has made some progress since her discharge from MMC, she continues to require daily care and assistance with activities of daily living and remains admitted at the Brewer Center for Health and Rehabilitation (Brewer Rehab). Ms. Ring has ongoing numbness and weakness in her arms and hands. She has not returned to her baseline bowel or bladder function, remains catheterized for her bladder, and requires a strict bowel regimen to evacuate her bowels. She continues to have very limited use of her lower extremities, using a power wheelchair for most mobility although regaining the ability to ambulate very short distances using a walker.

Count I: Medical Negligence

41. Plaintiff realleges the preceding allegations as if set forth fully herein.

42. Defendants owed Plaintiff a duty to provide physician and hospital services to the standard that a reasonable physician and hospital would have provided under the same or similar circumstances.

43. Defendants each individually, and collectively, breached the duty owed to Plaintiff for reasons including but not limited to the following:

a. Unreasonable delay in diagnosis and treating Plaintiff's spinal epidural abscess (SEA)

b. Unreasonable delay in ordering appropriate testing, including the correct imaging studies that would have confirmed Plaintiff's diagnosis of SEA

c. Unreasonable failure to monitor Plaintiff's declining medical condition and to report and act upon this decline and to order the appropriate testing and interventions to prevent the condition from worsening

d. Unreasonable lack or enforcement of policies, practices, or procedures necessary to keep Plaintiff safe and to meet her medical needs

e. Unreasonable failure to employ, train and supervise enough qualified personnel to keep Plaintiff safe and meet her medical needs

f. Unreasonable documentation and communication of information necessary to keep Plaintiff safe and meet her medical needs

g. Unreasonable failure to coordinate Plaintiff's medical care, between and among nurses, therapists, doctors and other medical providers and specialists to keep Plaintiff safe and meet her medical needs

h. Unreasonable failure of the system of medical care delivered by SJH and its individual providers to keep Plaintiff safe and meet her medical needs

44. As a direct and proximate result of the breach of the duty outlined above, Plaintiff has suffered from severe, ongoing, and permanent effects of spinal cord injury, including weakness, paralysis, sensory deficits, pain, lack of bladder and bowel function, and immobility.

Plaintiff continues to require full-time nursing care and assistance with daily living, which she will require for the rest of her life.

WHEREFORE, Plaintiff requests judgment against Defendants and damages in an amount to be determined by a jury, including compensatory damages, past and future medical expenses, emotional distress, lost enjoyment of life, costs, attorneys' fees and such other and further relief as this Court deems just and appropriate.

Dated: November 16, 2021

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