SUPERIOR COURT OF THE DISTRICT OF COLUMBIA

CIVIL DIVISION

ELOYD ROBINSON, ET AL., PLAINTIFFS, vs. THE METROPOLITAN WASHINGTON ORTHOPAEDIC ASSOCIATION, CHARTERED, ET AL., DEFENDANTS.	2015 CAM 8980

Washington, D.C.
Monday
June 5, 2017

The above-entitled action came on regularly for the Opening Statement by Plaintiffs' Counsel before the Honorable NEAL E. KRAVITZ, Associate Judge, in courtroom number 100, commencing at the hour of 3:20 p.m.

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P R O C E E D I N G S

MR. MALONE: Sure. Thank you. May it please the Court, Dr. Azer, Mr. Rutland, counsel, ladies and gentlemen: Our case begins on a warm summer night four years ago at United Medical Center in Southeast Washington.

Dr. Rida Azer has just finished a long knee surgery on a patient, and that patient is now in the recovery room. This case did not go as well as he wanted it to. It is ended with the patient having half of his knee replaced; not his entire knee replaced. And now the patient is in the recovery room, and the nurses are trying to feel pulses on the man's foot to make sure that the blood has been restored and its natural flow to the leg, because Dr. Azer has cut off the blood flow deliberately during the surgery, so that he can have a clean field to do his operation on the knee.

The nurses are worried. The foot is cool. They aren't feeling pulses with their fingers when they touch the foot. And so they page Dr. Azer. They page him once. He doesn't answer. They page him a second time. He doesn't answer. He never answers the page. He does finally see the patient the following afternoon at his office. In the meantime, no doctor has ever seen the patient in the hospital after the surgery.

And Dr. Azer does not pick up on the fact that the blood flow to that leg that he operated on has been impaired

and has slowed from a normal flow to a trickle. And, gradually, over the next month, while this patient is in the post-operative care of Dr. Azer, the leg dies; and the leg has to be amputated by other surgeons.

We're here in court, because it didn't have to happen. We're here in court because Dr. Azer broke some basic rules of patient safety; some standards of care -- and I think you might've heard the judge say that, and you'll hear that more again -- that reasonably prudent doctors are required to follow to keep their patients safe and healthy and prevent unnecessary harm. And I'm going to give an opening statement that goes through the evidence, and I'm going to move fairly fast.

Our case proceeds in three chapters: Chapter one, Dr. Azer mishandles the surgery, and we'll start even in the pre-op period and go through to the end of the surgery. Chapter two, Dr. Azer neglects his patient in the critical post-operative period. And, chapter three, Dr. Azer negligently kills this patient's leg; and we believe he needs to be held accountable for that.

MR. RUTLAND: Objection, Your Honor.

THE COURT: Objection is sustained as to the statement of personal opinion.

MR. MALONE: I'm sorry. I didn't mean to do that. My personal opinions don't matter, ladies and gentlemen; and

the judge will tell you that. And if I say I believe something, I'm saying "we" generically as plaintiffs; not me personally as a lawyer. Is that okay, Your Honor?

THE COURT: I'd try to leave out the word, "believe," altogether.

MR. MALONE: Sure. Whatever. The evidence will show. Chapter one, a doctor mishandles a surgery. What are the key facts?

First, Dr. Azer takes on a job that is over his head. He is a bone doctor; not an artery doctor; and there's a key difference. Here is an example of a knee bone or more than one knee bone, and the hardware that's put in to do a knee replacement as he was attempting to do on the night of July 16, 2013. What Dr. Azer is not is an artery surgeon who's familiar with the natural blood flow through the leg to the point that they can actually operate on the arteries of the leg; this other kind of surgeon.

And they are frequently consulted by orthopedic doctors -- these "vascular surgeons," they're called -- because any time a patient has an issue with blood flow, the orthopedic surgeon needs to make sure that this leg or foot or whatever is going to be able to withstand the stress of surgery, especially a surgery like this, where Dr. Azer in this case used a tourniquet on his patient's thigh to squeeze all of the blood flow out of that leg south of the tourniquet

while he did his surgery for several hours.

So, preoperatively, in the spring of 2013, Dr. Azer sees a patient who has artery issues. My client, Eloyd Robinson, who at the time was working as a full-time security guard walking a beat near National's Park in the Yards area of National's Park working 40 hours a week, even though he was 82 years old at the time. And he didn't want to retire, but his knee hurt. His knee was worn out. He had bone-on-bone loss of the cartilage; the lining of the joints; and it hurt. And he heard about knee replacement, and he wanted to check it, and he went to Dr. Azer; but he had one more thing: he had a stent in his thigh, and I'll show you a little bit more of a close-up here.

Here's the major highway down the leg. It's called the common femoral artery. It branches out. Every time it branches out, it's called different things, just to keep us all confused as laymen. But the key artery we're going to talk about is called the superficial femoral artery. It is the main artery from the heart that goes to the bottom of the end of the toes.

Here is what Mr. Robinson had in his superficial femoral artery: He had a stent, which is a piece of mesh tubing. You probably heard of heart stents. They're much smaller, but it is the same concept. It's a metal scaffolding that's put in to keep the artery open, because he

had a problem with his big toe. He had a problem with a wound on the toe that wasn't healing. They checked it out. They found that his artery was clogged up in the thigh. He had a roto-router-type surgery to open it up; and they put the stent in; and he was fine after that.

So, why is that relevant to the case? I'll get into that. But, first, let's look for a second of how Dr. Azer set up the surgery in advance and during his prep process. He set it up as a routine knee surgery, but it really wasn't. He says in his records -- and I'm quoting him here -- "I had a discussion with the patient. I shall schedule him for a right total knee replacement." That's on the very second visit that he's had with him.

And, here, he lists the kind of preop workup that he's going to do. Everybody knows that you've got to be checked out by your doctor ahead of time, he sent him for something called "medical clearance"; sent the gentleman back to his internist. And the internist said, "Yeah, he's fine for surgery, and let's just check his heart." And so, the internist sent him to a heart specialist cardiologist.

The cardiologist puts him on a treadmill and does a echo test and says, "You're good to go to the surgery." But nobody checks out that leg. Nobody checks out that leg with the stent in it and whether it can withstand this surgery. So, our first major criticism of Dr. Azer is that he does not

do his homework.

In his own records, it told him about this stent. The report that he got from Dr. Ong -- O-n-g -- the primary care doctor that did the pre-op medical clearance, he said right in this report -- and it's a little hard to read -- but that says, "PCI of right femoral artery." And it gives a date: February 7, 2011. More than that, Dr. Azer's own x-rays in his office, you can see the stent on the x-ray.

There's the thigh bone. The arrow points to the tip of the stent. Those three little dots are what the manufacturer of this little metal tube puts on the end so that every doctor will know that's where it is. Dr. Azer did not know until long after the surgery that his patient had this stent. If he had known about it and if he had asked a vascular surgeon, he would've learned that you're not supposed to use a tourniquet with a patient like this.

What you're going to do, if you put a tourniquet on somebody's thigh that's got metal hardware running through the artery and you're deliberately trying to squeeze that artery closed, with that metal stent in there, you're buying trouble. You're going to crush the stent. Maybe it'll spring back open; maybe it won't. But you're going to get a blood blot in there, and it won't clear out normally, because you've got all of this little, fine mesh tubing in there that's holding it.

All of the textbooks -- *Campbell's Operative Orthopedics*, a major textbook in the field; *The Journal of Arthroplasty* put out by the Association of Hip and Knee Surgeons -- AAHKS -- they all said that. But Dr. Azer failed to do his homework in a second important way, because he knew -- even without knowing about the stent -- he knew that his patient had some blood flow issues.

And he wrote the very first time that he saw the gentleman: "I think a vascular evaluation should be considered." And he didn't do it. Instead, the only report he gets is from the cardiologist about the echo and the other stuff that's done. Now, we go to the night of the surgery. Actually, it's late afternoon. I'm sorry. It took the whole afternoon of July 16th, 2013.

Normally, in a knee replacement, an hour-and-a-half is average. The surgery took four hours plus. Dr. Azer had the tourniquet on that thigh and squeezing it closed at high pressure for, first, a two-hour period and then it was down for half an hour and then another two hours and ten minutes; and that's what happened in the operation. He used the tourniquet and kept it on for a long time at high pressure.

And then, the reason it took so long is he basically aborted the procedure and left only half of the knee replaced. I'm showing a couple of x-rays here. The one on the left is the patient's pre-op. And you can kind of see

that there is not much of a joint there, because it's got bone on bone wear and tear. And on the right, you see that metal plate with the thing sticking down into it? That's his calf bone -- his tibia -- with the bottom part of the knee replacement in it.

How come he didn't finish the job? He said in his operative report that the bone was too soft and crumbling. Well, there are patients across America who have that problem and who get knee replacements every day. And there is hardware that you can use to make up for that. He didn't apparently have the right hardware and just didn't get the job done. He packed, and he cut off the bottom of the femur -- the thigh bone -- to prepare to put his hardware on. And then, because of the crumbling, he decides, "Well, I'll pack it with dead bone and hope that it all kind of grows back and then we will come back maybe a month later."

Nobody does it that way, ladies and gentlemen. You will hear from experts in the field of orthopedic surgery that it's virtually unheard of. You don't want to do a big operation like this in two stages. when you try to do that, you're inviting scarring of the tissue, and it's just not going to heal very well. But that's not the major issue that caused the man to lose his leg.

What happens is he damages that stent or at least blocks the flow through that blood vessel -- that key

highway -- during the surgery. And how do we know that? I'll go to that evidence in one second. That's the end of the chapter one about the doctor mishandling the surgery.

Now, chapter two is that the doctor neglects the leg as it slowly dies. Point one: Dr. Azer does not visit his patient in the hospital. Here's the key note: You can see the handwriting in the middle. It says, "PACU Progress Notes." PACU stands for Post Anesthesia Care Unit. It's just a fancy term for recovery room and surgery. It's where people go in between the operating room and the floor.

And that's where they first start checking to make sure that your leg is warming back up and is getting normal. And we typed out the note so that you can read it a little bit better: "Right foot cold to touch but toes blanching well. Right post-tibial pulse" -- that's the pulse back here behind your ankle -- "present by Doppler." That means they couldn't feel it, but they put a listening thing on that you could barely hear it. "No Dorsalis pedis present." That's this on the top of your foot. So the two major pulses on your foot behind your ankle and on top of your foot. Foot kept warm with blankets. "1810" -- 6:10 p.m. -- "page Dr. Azer about the foot coldness and the pulse absent. 1825, still no response. Call placed again to answering service." He never responded.

What did the patient need right then? A phone call

would've been enough. A phone call to a vascular surgeon to say, "Would you please go check on my patient? His foot isn't warming back up the way it should, and we're not getting the pulses. Take a look and see if there's a problem." They could've done a bunch of stuff. Number one, they would've put the Doppler machine on the thigh. They would've realized that he had the stent in there, because Mr. Robinson carried around in his wallet a little card that told everybody about the stent in his thigh.

They would've found out about the stent. They would have checked the circulation. They would've pinpointed where the blockage was. They could've gone into the artery and pulled out the clot literally. Or if it was so badly damaged from that tourniquet for four hours but they couldn't repair it, they could make a bypass highway; a new highway. Lots of stuff that could've been done.

What happens instead? There are no calls to a vascular surgeon. The next day, Dr. Azer has a patient who's in extreme pain. "9:00 a.m., pain ten out of ten." "12:00 noon, pain ten out of ten." The worst pain someone could have in their life, and Dr. Azer is not coming to the hospital. It's a nine-minute drive from Oxon Hill Road to United Medical Center, and he doesn't make it.

Instead, he discharges the patient without any doctor seeing him after the surgery. Now, the reason you see

patients in the hospital, as opposed to a doctor's office, is they've got a lot of equipment in the hospital to examine the patient and to do special procedures like reestablishing blood flow in an artery, if you needed to, and you can do all of that in the hospital.

What he does instead is he instructs the nurses to tell the wife -- Mrs. Robinson -- "Pack him up in your car and bring him to my office, and I will examine him there." And then we have a postoperative period that lasts a month. And during that time, Dr. Azer ignores some pretty clear signs that he's faced with a dying leg.

And how do we know that? I need to give you a little bit of background. If all of the circulation had been blocked to the entire leg south of the knee, the leg would've been completely black and dead within hours. Eight hours, maybe. But the human body is excellent at figuring out ways around problems. And Mr. Robinson had something which we all do if we've developed long-standing blockages, and this could be anywhere in your body. One thing gets blocked, you develop new arteries to go around it, that's what these arteries are on either side of his knee. They're called "collateral arteries." I think the technical term is "genicular" or something like that.

You'll hear from a vascular surgeon, who'll tell us about that. But the point is this is like, you know, I-495

had been totally blocked to all traffic. They're routing traffic onto local two-lane roads. You know, it'll work for a little bit. It's not going to work for very long.

And in this case, it enabled that leg to limp along for almost a month before the leg was totally dead. So he sees the patient five times over 34 days. The first time is the day after surgery, July 17. Five days after that, the 22nd. And then three times in August: The 2nd, the 16th, and the 19th. By the 19th, that leg is dead. And I'm going to show you some photos later and some evidence that will show you that.

But let's go through the interim period first. Because we have a bit of a hole in the medical records here, because there was no other doctor or any nurse who saw this patient over this entire 34-day period until he comes back to the hospital with a dead leg other than Dr. Azer. His nurses write no notes in his records. All we have in his records is a dictated report that he dictates after the patient has left for the day.

And so, what we do is compare his records with the other evidence we have. And on July 17th, the day after surgery, his records just don't match the other known details. I already told you about the ten-out-of-ten pain as late as noon, and he's discharged around 1:00 o'clock, an hour later. This is an hour after the guy has got

intravenous narcotic drugs to tamp that pain down.

And there is no mention of that in Dr. Azer's note. It's a little hard to read there. I've got it here: "Patient is progressing well. Dressing is changed. Wound is dry and healing well. No tenderness. Circulation is satisfactory in both lower limbs." He just doesn't really acknowledge what had happened earlier that day. And, specifically, we had nurse's notes in the hospital earlier that morning: No pulses on the right foot. This is how everyone except Dr. Azer documents artery flow in a foot or wherever else it is in the body. They refer to specific pulses; pulses that they touch.

And they either say it's "present" or "absent" or "faint" or "normal" or whatever. There's nothing like that. All he ever says is, "Circulation is satisfactory." But was it? Was it satisfactory? He said the same thing July 22nd: Circulation is satisfactory with no details that we can check out. Same on August 2nd: "Circulation is satisfactory."

One more important thing happened on both July 22nd -- the second visit -- and August 2nd -- the third visit -- he put a long cast on the leg from the thigh clear down to the end of the foot, except the toes are poking out. Why is that important? The cast is hard. That area where you've got those collateral arteries flowing through making,

you know, the detour, it's pressing on them and squeezing them.

And so, you've got your secondary highway impeded as well. And it blocks anybody from being able to see what's going on underneath that cast to see, "Is the skin normal? Is it healing or not?" August 2nd, he says in his record that the wound has healed, but the leg is deteriorating at that time. And how do I know that? Mr. Robinson's son, Kevin, was there. Kevin took this cell phone photo. Kevin, to be honest, had a very crummy cell phone. This is not a good photo, but it's good enough. It's kind of pixelated.

And what you see there is that's the surgical wound. That big, long, black thing. And we're now 17 days post-op. This wound is supposed to be pencil-thin. It's not pencil pencil-thin. You can see that. It's wide, and it's black. We asked vascular surgeons and orthopedic surgeons, "What does that tell you as a surgeon?" It says to them that this wound is not healing right. And there's a second thing that you can say on there, you see that discoloration of the bottom side, and there's a little bit of discoloration on the top side of the knee. That's another sign that this skin area is not getting a nice blood flow that's going to heal the wound.

He said the wound is healed, but it wasn't. The next visit, two weeks later, he still says that the wound is

healed. Now, he says there is a problem, though. He says that he thinks there's a blood clot in the veins coming back to the heart. You know, arteries send blood down to our toes. The veins lift the blood back up to our heart. He thinks there's a blood clot in the calf vein, but that wasn't the man's problem. The man's problem was the leg was dying from lack of arterial flow bringing fresh, oxygenated blood down the leg.

August 19th, he sends the patient to the hospital but still says nothing about the condition of the foot. Dr. Azer told us, when I took his deposition, he said, "I only write it down if it's abnormal." Well, let's show what they saw when he came to the hospital later that day. New doctors finally see the leg that day, but it's too late. And here's what they saw and here's what they documented at United Medical Center on August 19th: "The foot is cyanotic." It's blue. The right toes, the heal, the foot, they are all blue. Down there, "the right food is dark in color. No pulses. Cold to touch," all of which was missed by Dr. Azer.

And I'm going to show you, frankly, a gross-out photo. These are his toes coming at the camera. You can see the toenail there. That foot is black and dead. The heel is black and dead. And they took the leg off a few days later, the pathologist said the leg was mummified in parts. And now, I want to show you what the knee looked like and compare

it to that cell phone photo.

You see that that same area -- here's the black line running through; same black line partially, poorly healed surgical wound -- and then you see this pattern of black around here which follows exactly this pattern of kind of splotchy, discolored stuff on the left side of our picture and on the right side of our picture. So that tells us proof positive that what he saw in his office on August 2nd was a leg that was in the process of dying.

Just to finish our chronology. These photos were taken on August 21st I should mention, a couple of days after admission. Why didn't they take them right away? It was obvious to everybody that this foot was dead. The leg was dead. There was nothing that they could do. An artery surgeon -- a vascular surgeon, Dr. Nedd -- saw him a couple of days after admission: "The patient, along with his wife and son were told that he needs to have an amputation done. The level of the amputation will be discussed." There was such extensive damage that they had to cut off the leg above the knee. Everybody who knows about amputations said that that's the worst kind of amputation you can have.

If you can at least preserve the normal architecture -- the normal anatomy of your knee -- and lose all of your calf to your foot, well, that's bad. But it's not nearly as bad as losing it at the thigh. Then the

surgeon goes in couple of days later and he discovers the problem. Operative report: "There was a stent noted in the superficial femoral artery, which was occluded." He pulled it out and closed up the artery. The guy didn't need that artery anymore, because the blood was being cut off. That's chapter two on neglecting this patient.

Chapter three: The doctor is personally responsible for killing the leg.

MR. RUTLAND: Objection.

THE COURT: The objection is overruled.

MR. MALONE: Dr. Azer broke some very basic rules that keep patients safe and healthy. Doctors call these "standards of care." We can translate these standards of care into basic lay language: "Do your homework." Find out what's special about this patient before you operate on him so you can take any special precautions that need to be taken. Common sense. "Do no harm."

"Do no harm" goes back to Hippocrates way before Christ, basic ethical requirement for doctors is "Do no unnecessary harm to your patient." Very important rule of medicine and surgery. "Pay attention." Just pay attention to what's going on in front of you. Pick up the phone when the nurses call and ask you a question. Proceed with caution and not with whatever he was proceeding with.

And, finally, if you caused harm, fix the harm that

you've done. And, again, he didn't have to personally go in and fix that blood flow issue. He just had to call somebody and get it fixed for him. So four basic rules: Do your homework. Do no harm. Pay attention. Fix the harm that you've done all violated here by Dr. Azer.

Now, we have to prove our case to you by what's called "the preponderance of the evidence"; the greater weight of the evidence. You have to evaluate conflicting evidence. Well, one area of conflicting evidence that you're going to have to evaluate is the difference between what Dr. Azer says now compared to what he said in his medical records; and I want to just highlight a few items where the testimony does not match the records.

When I took his deposition -- and a deposition is under oath with a court reporter just like this, and we did it in Dr. Azer's office down on Oxon Hill Road -- he told me that the patient is in poor condition in every way. That was his pre-op assessment that he testified under oath about this patient. Well, we compared that to his records. His very first visit with the patient, he was praising how great he looked. His chronological birth age is 82; yet, physiologically, he's definitely younger looking. He's well-built; looks late 60's.

Second item: "I advised him to avoid the surgery." "Oh, well, what do your records say?" First visit: "I agree

with him. He does need a right total knee replacement." Second visit: "I had a discussion with the patient. I shall schedule him for a right total knee replacement." Where's the advice not to do the surgery? It's not in these records anywhere. Third area: "I was very reluctant, and I did not want to operate on him at United Medical Center." "Well, what did you say in your records?" "I shall perform this at United Medical Center. When I checked, I saw that they accept his insurance." And the reason, I assume, that he mentioned that is because he'd actually sent him to another surgeon to think about having surgery with the other surgeon over in Alexandria, who happened to be Dr. Azer's son, and the insurance was not accepted over there. So, here he is. He's good to go at United Medical Center.

And the fourth area he says now that the patient lost his leg because of diabetes. Here's what he said in his records when he talked to the vascular surgeon and the pathologist after the leg has to be amputated: "The vascular surgeon informed me the stent had developed occlusion of the arterial system. The pathologist informed me that the amputated limb showed complete obliteration of the whole arterial system from where the stent had been performed."

So we say that Dr. Azer is personally responsible for his actions. I need to tell you a little bit about Mr. Robinson. He was a professional athlete. He played in what

was then called the Negro Baseball Leagues touring all around the country in the 1950's. It was an important part of his life clear up into his 80's when he's a security guard, because he had lots of nice memories and talked to strangers about the town that you're from. "You're here at National's Park? Oh, I played ball at your town," and a conversation just like that would go. A guy who even in his mid-60's is the only guy in a group of friends who can go and show off his legs, because they're so handsome and healthy-looking. And then more recently here he is in his security guard uniform. And I drew a little box in orange around the area of The Yards. That's Nationals Park in the lower left where he walked a beat every single night. And what is he then left with?

THE COURT: Please make sure that you remember our conversation before the jury was selected about these photos.

MR. MALONE: Yes, I'm sorry. And by the way, I don't want to imply by these previous photos here, especially those, we're not saying that the guy was going to go back and play for the Major Leagues again or that he was going to be showing off his wonderful knee every day. But it's part of who he is. It's part of his memories and his history, and that history had been taken from him by an operation that had to be done that left him frankly mutilated.

He can get out of that wheelchair from time to time

and take a few steps down the hallway, but it's hard. And, by the way: Along that line, Mr. Robinson, it's hard for him to get around. He's not going to be here every day during court, although he's very much interested. He doesn't want to make a spectacle out of himself coming in and out and getting out of the chair and whatnot. And we're not looking for your sympathy. We don't want that.

What we want to assert here is that Dr. Azer took away this patient's mobility and took away his independence and took away his quality of life. And your job is to balance it out. There's a term that you're going to hear called "compensation." "Compensation" actually comes from an Italian word that just means to "balance it out." You cannot restore his leg. All you can do is come up with a fair sum of money that a reasonable group of people from across our community will say, "You know what? That's a fair number" for something that should've never happened. Thank you very much.

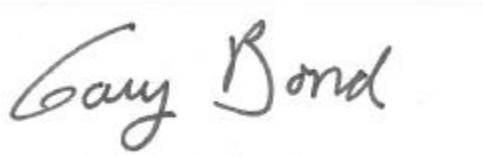
* * *

CERTIFICATE OF REPORTER

I, GARY BOND, an Official Court Reporter in and for the Superior Court of the District of Columbia, hereby certify that at said time and place I reported in my official capacity by means of machine shorthand all testimony adduced and other oral proceedings had in the matter of ELOYD ROBINSON, ET AL., vs. RIDA AZER, ET AL.,, case number 2915 CAM 8980, in said court on the 5th day of June, 2017.

I further certify that the foregoing pages, 1 through 23, constitute the official transcript of said proceedings, as taken from my shorthand notes, and that it is a correct and accurate record of said proceedings.

WITNESS my hand at Washington, D.C., this 26th day of June, 2017.



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